# MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

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

Thursday, April 10, 2025
10:34 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
BETTY RAMBUR, PhD, RN, FAAN
WAYNE J. RILEY, MD, MPH, MBA
SCOTT SARRAN, MD, MBA
GINA UPCHURCH, RPh, MPH

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

AGENDA PAGE

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

Recess................................................25

Structural differences between the PDP and MA-PD markets
- Shinobu Suzuki, Tara Hayes, Andy Johnson............26

Lunch.................................................90

Assessing the utilization and delivery of Medicare supplemental benefits
- Stuart Hammond......................................91

Recess...............................................171

Exploring the effect of Medicare Advantage on rural hospitals
- Jeff Stensland, Dante Domenella....................172

Recess...............................................227

Paying for software technologies in Medicare
- Dan Zabinski, Jennifer Druckman,
- Geoff Gerhardt, Nancy Ray..........................228

Adjourn..............................................272

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

2 [10:34 a.m.]

3 DR. CHERNEW: Hello, everybody, and welcome to
4 the April MedPAC meeting. It is the last meeting of this
5 cycle. I think it's been a particularly interesting and
6 productive cycle. We will sadly say farewell to Larry and
7 Amol, which makes this always a bit of a bittersweet
8 meeting.

9 But in the meantime, we are going to try and
10 actually get some work done, and we're going to start with
11 a topic that we have been investigating for two years plus,
12 and that is longer-term reforming of the physician fee
13 schedule, and for that we are going to start with Brian.

14 MR. O'DONNELL: Good morning. Today we'll
15 discuss approaches to reform physician fee schedule updates
16 and improve the accuracy of relative payment rates. This
17 presentation is a continuation of the work the Commission
18 published in its June 2024 report to the Congress and that
19 the Commission discussed at its November and March meetings
20 this cycle.

21 Given broad Commissioner support on these topics
22 over the last two years, at this meeting Commissioners will

1 vote on two draft recommendations.

2 Viewers can download a copy of this presentation

3 in the handout section of the control panel on the right-

4 hand side of your screen.

5 Before we begin, we'd like to thank our

6 colleague, Rachel Burton, for her contributions to this

7 work.

8 And now, I'll start with some background on

9 current-law updates to the physician fee schedule.

10 This slide shows that -- with the exception of

11 one-time payment increases from 2021 to 2024 -- fee

12 schedule updates are below 1 percent per year and are

13 directly specified in statute. This means that updates

14 don't automatically adjust to changing economic conditions,

15 such as increases in inflation.

16 Beginning in 2026, annual updates will vary based

17 on whether a clinician is in an A-APM or not, meaning there

18 will be two conversion factors, a lower one, updated by

19 0.25 percent per year for clinicians not in an A-APM and a

20 higher one updated by 0.75 percent per year for clinicians

21 in A-APMs.

22 MACRA also addresses other aspects of clinician

1 payments, such as A-APM bonuses. We will not discuss A-
2 APMs in this presentation, but as we discuss in your
3 mailing materials, policymakers may choose to incorporate
4 an appropriately sized and structured A-APM bonus to
5 achieve its goals.
6 Ensuring beneficiary access to care is a key
7 factor in evaluating the adequacy of physician fee schedule
8 rates. And, over many years, the Commission has found that
9 beneficiary access to care has been comparable to the
10 privately insured.
11 For example, the Commission's annual survey has
12 found that comparable shares of Medicare beneficiaries and
13 privately insured people report problems finding a new
14 clinician. Clinicians accept Medicare at similar rates as
15 commercial insurance despite lower payment rates from
16 Medicare. Volume and intensity of care per beneficiary has
17 increased over time, and other, longer-term indicators of
18 access, such as the number of applicants to medical schools
19 and the number of clinicians billing the fee schedule, have
20 also remained positive.
21 Despite these positive access findings, the
22 Commission has expressed concerns about future access

1 because MEI growth, which measures the change in the costs
2 of running a clinician practice, is projected to exceed fee
3 schedule updates by more than it did in the past. MEI
4 growth outpaced fee schedule updates by just over 1
5 percentage point per year for the two decades ending in
6 2020. MEI growth likely substantially exceeded updates
7 from 2020 to 2025. And, from 2025 to 2034, the projected
8 annual difference between MEI growth and fee schedule
9 updates is larger than the average difference in the two
10 decades ending in 2020. With projected differences being
11 1.5 percent per year for clinicians in A-APMs, and 2
12 percent per year for clinicians not in A-APMs.
13 This larger gap between MEI growth and fee
14 schedule updates could negatively affect beneficiary access
15 in the future. Despite these positive access findings, the
16 Commission has expressed concerns about future access
17 because MEI growth (which measures the change in the costs
18 of running a clinician practice) is projected to exceed fee
19 schedule updates by more than it did in the past.
20 MEI growth outpaced fee schedule updates by just
21 over 1 percentage point per year for the two decades ending
22 in 2020. MEI growth likely substantially exceeded updates

1 from 2020 to 2025, and, from 2025 to 2034, the projected
2 annual difference between MEI growth and fee schedule
3 updates is larger than the average difference in the two
4 decades ending in 2020, with projected differences being
5 1.5 percent per year for clinicians in A-APMs, and 2
6 percent per year for clinicians not in A-APMs. This larger
7 gap between MEI growth and fee schedule updates could
8 negatively affect beneficiary access in the future.
9 Given this concern, to reform fee schedule
10 updates, the Commission has contemplated replacing the dual
11 fee schedule updates based on A-APM participation with an
12 update based on a portion of MEI growth. A key concept
13 that has emerged as part of this process is that historical
14 evidence suggests that a full MEI update has not been
15 needed to maintain access to care. In designing the
16 updates, policymakers could consider a range of specific
17 designs, such pairing an update of MEI minus one percentage
18 point with an update floor or ceiling. We discuss those
19 options more in your mailing materials.
20 Updates based on a portion of MEI have multiple
21 benefits, including that they automatically adjust to
22 changes in inflation, which as we've seen over the last

1 several years can be substantial and difficult to predict;
2 improve predictability for clinicians, beneficiaries, and
3 policymakers; and simple to administer, as they would apply
4 across-the-board to all fee schedule services; and balance
5 beneficiary access with beneficiary and taxpayer financial
6 burden.
7 Setting higher default updates would not negate
8 the need for future monitoring. The Commission would
9 continue to monitor access to care each year and recommend
10 higher or lower updates, as needed.
11 Having summarized the evidence on updates,
12 access, and the Commission's analysis of these topics, I'll
13 now go to the first draft recommendation, which reads:
14 The Congress should replace the current law
15 updates to the physician fee schedule with an annual update
16 based on a portion of the growth in the Medicare Economic
17 Index, such as MEI minus 1 percentage point.
18 In terms of spending, the draft recommendation
19 would increase spending by between $15 billion and $30
20 billion over five years.
21 The draft recommendation should maintain
22 beneficiaries' access to care by maintaining or improving

1 clinicians' willingness and ability to treat them. It would
2 also increase cost-sharing and premiums for beneficiaries.
3 I'll now turn it over to Geoff for the second
4 half of the presentation.
5 MR. GERHARDT: The second half of our
6 presentation will explore issues related to the accuracy of
7 relative payment rates under the physician fee schedule.
8 Ensuring that relative payment rates are as
9 accurate as possible is important because misvaluation can
10 result in incentives to furnish more of some services and
11 fewer of others. Misvalued services can also influence
12 where services are furnished and incentivize vertical
13 consolidation.
14 It's also worth noting that many commercial
15 insurers base their rates on fees schedule RVUs, so
16 misvaluations can carry through to other parts of the
17 health care system.
18 In 2006 and 2011, the Commission made a series
19 recommendations on how to improve the accuracy of RVUs.
20 The recommendations were focused on providing CMS with
21 assistance in reviewing recommendations from the RUC, and
22 independent data collection to support those efforts.

1 At the November and March meetings, the
2 Commission discussed some ways in which fee schedule
3 relative values can be misvalued and how to address those
4 issues.
5 On the following slides, we'll look at three
6 illustrative examples of where codes appear to be misvalued
7 and potential policies to address those misvaluations.
8 First, I'll review updates to the aggregate
9 allocation of work, PE, and malpractice insurance RVUs.
10 Second, I'll discuss why global surgical codes are
11 misvalued and two ways that payment for those codes could
12 be improved. I'll also talk about why the fee schedule may
13 overpay for indirect practice expenses in certain
14 circumstances and how that issue might be addressed.
15 Finally, I want to mention that the three issues
16 we address here are meant to be illustrative. This is not
17 an exhaustive list, and there are other ways relatively
18 valuation could be improved.
19 The first example regards how the distribution of
20 physician practice costs are used to determine RVUs. On an
21 aggregate basis, the share of RVUs devoted of work,
22 practice expense, malpractice insurance are supposed to

1 reflect the distribution of those costs in a typical
2 physician practice. The method for making these
3 allocations is complex, but it starts with looking at how
4 the Medicare Economic Index says those costs are
5 distributed.
6 CMS continues to use cost shares on MEI data from
7 2006, even though more recent data are available. Those
8 data should appropriately reflect the costs of running a
9 typical physician practice.
10 Delays in updating the RVU cost shares means that
11 relative payment rates no longer reflect how practice costs
12 are actually distributed. Long delays in updating the
13 aggregate distribution of RVUs increases the chances that
14 payment rates will experience large changes once they are
15 updated.
16 The second example involves global surgical
17 codes. Global surgical codes bundle together payments for
18 all services that occurred on the day of a procedure, as
19 well as postoperative visits furnished by the performing
20 clinician during the following 10 or 90 days.
21 Generating relative payment rates for these codes
22 involves making assumptions about the average number of

1 postoperative visits furnished by the performing clinician
2 during the global period. Studies have shown that that for
3 most global codes, fewer postoperative visits were actually
4 furnished than are assumed in the payment rates. This
5 results in overpayment for many global codes and increased
6 beneficiary liability.
7 One way of addressing this issue is to convert
8 all 10- and 90-day global codes to so-called zero day
9 codes. This approach involves removing expenses associated
10 with postoperative visits from the total RVUs for each code
11 so that each postoperative visit is paid separately.
12 Another way of addressing the issue is to revalue
13 global codes so that payment rates accurately reflect the
14 average number of postoperative visits that are actually
15 delivered.
16 Our third and final example concerns how indirect
17 practice expenses are paid when a fee schedule service is
18 furnished in a facility setting, such as a hospital
19 outpatient department.
20 As shown in the red circle, when a service is
21 performed in an HOPD, indirect practice expenses -- those
22 related to overhead costs -- are paid to both the clinician

1 and hospital. This approach is based on the premise that
2 all physicians are maintaining separate offices which are
3 financially independent of a hospital.
4 However, the share of physicians who are employed
5 by a hospital, or whose practices are owned by a hospital,
6 is increasing rapidly. This suggests that a growing number
7 of clinicians are not paying for their own indirect
8 expenses which could result in overpayment for these costs.
9 In these circumstances, arguably the fee
10 schedule's facility indirect practice payment should be
11 revalued when a service is furnished in a facility.
12 This brings us to the second draft
13 recommendation, which reads:
14 The Congress should direct the Secretary to
15 improve the accuracy of Medicare's relative payment rates
16 for clinician services by collecting and using timely data
17 that reflects the costs of delivering care.
18 In terms of implications, given statutorily
19 required budget neutrality rules, this recommendation is
20 not expected to affect total program spending.
21 Addressing distortions with relative payment
22 rates could improve care for beneficiaries by reducing

1 incentives for clinicians to overprovide or underprovide
2 certain services. In addition, these policies are expected
3 to make relative rates more accurate, which is likely to
4 have redistributive effects on payments to providers.
5 And with that, I'll leave you with both draft
6 recommendations and hand things back to Mike.
7 DR. CHERNEW: Perfect. So it is great to see
8 where we've come with all of this. So just to remind the
9 Commissioners, this is going to be an abbreviated
10 discussion because we have had a lot of discussion about
11 this. I don't see anyone particularly in the queue, but I
12 am going to wait for a second. What we will do is if you
13 want to make a comment on the first recommendation, that
14 is, looking speaking, the MEI one, we have time for a few.
15 We have to do a formal roll call vote, so Dana will then do
16 a roll call vote. Then we will see if anyone wants to say
17 something about Recommendation 2. That's the timely data
18 recommendation, broadly. And then we'll vote on that.
19 So I'm pausing.
20 MS. KELLEY: I think Larry had a comment here.
21 DR. CASALINO: Yeah, thanks, Dana. Yeah, I
22 recognize that time is short for this session. I don't

1 want to set a bad example on my last day as a Commissioner.
2 But I am going to vote yes on both recommendations, but I
3 don't feel like I can do it without an extremely brief
4 comment.
5 I think it is so important that there be a
6 predictable, inflation-based formula for updating the fee
7 schedule. But I am willing to vote for the recommendation,
8 and the principle on which it stands, tying payment updates
9 to inflation.
10 But I do want to emphasize that the
11 recommendation mentions, quote/unquote, "such as Medicare
12 Economic Index minute 1 percent." It isn't specifically
13 for MEI minus 1 percent, and that we recommend to Congress
14 it be somewhere between 0 and 1 percent of MEI.
15 So if I had my way the formula would be a payment
16 update equal to or only slightly below MEI. One percent is
17 a bit more than that.
18 And then just to finish, I also want to emphasize
19 very much that I encourage Congress to follow the MedPAC
20 2023 recommendation for higher payments when a physician
21 sees a low-income beneficiary. I think that's really
22 important. And that would apply to most physicians really.

1 Thanks.

2 MS. KELLEY: Tamara?

3 DR. KONETZKA: Mostly I just want to say I really
4 appreciate the text that was added, going through the
5 nuances of both ceilings and floors. I mean, personally, I
6 think I would have liked this recommendation even more if
7 it had alluded to not a specific number but a ceiling and
8 floor as possibilities. But I am totally fine with the way
9 it is written now because I think the text goes into this
10 nuance.

11 I wanted to say, you know, one more thing about
12 the ceiling, because we talked more about the floor and
13 about the MEI minus 1, and I just wanted to sort explain
14 why I think it's so important that Congress consider a
15 ceiling if they adopt this recommendation. And that is, if
16 you can imagine a crazy high inflation rate, like 7 percent
17 or 8 percent. If it's MEI minus 1, you know, what we're
18 basically saying is that we're going to make physicians
19 almost whole, but all of that burden is going to go to
20 beneficiaries, you know, that 6 percent or whatever
21 increase. So the chapter does do a great job now, I think,
22 of explaining that there is beneficiary burden associated

1 with this recommendation.
2 So I won't dwell on it, but I think it's really
3 important that ceilings and floors be considered. Thanks.
4 MS. KELLEY: Brian.
5 DR. MILLER: Thanks, and I agree with Larry,
6 especially, that saying "such as." It should be MEI minus
7 1. And then in building of Tamara, there should be a
8 ceiling and a floor, because you don't want the inflation
9 rate to go crazy, and you also don't want it to be very,
10 very small.
11 I also wanted to point out one thing. We just
12 got this letter from the American Occupational Therapy
13 Association, which I wanted to highlight some data in here
14 that I think is important for us all to think about, which
15 is that they noted that OTs have to accept Medicare or they
16 are unable to service any other Medicare benes. And they
17 have this nice chart in Figure 1 which showed that from 206
18 to 2024, while, obviously, the fee schedule rates have been
19 relatively flat, that applications to OT schools have
20 decreased by 50 percent, which is, I think, a sing that
21 when you have flat fee rates and you have a volume
22 intensity response, that the labor force responds

1 appropriately.

2 So I think that is further evidence that we need

3 to think carefully about the PFS update and having a floor

4 and a ceiling. Thank you.

5 MS. KELLEY: Betty.

6 DR. RAMBUR: Thank you. I do support this, but I

7 just have to, I think, echo a bit of what Tamara said and

8 Brian. We are recommending an increase. We hear providers

9 screaming about inadequate reimbursement, and we hear

10 people screaming about the lack of ability to pay for care.

11 And so this issue of increased cost sharing of premiums I

12 think is really serious.

13 So I support the ceiling and floor, and it really

14 goes in a bit to the next piece. But addressing the

15 misvalue of codes I think is absolutely critical and should

16 be absolutely high priority. Thanks.

17 MS. KELLEY: Cheryl.

18 DR. DAMBERG: I want echo Tamara's comments. You

19 know, I really appreciate the additional text around

20 ceilings and floors. I think I would have been more

21 strongly in favor of the recommendation had those two items

22 been added. And I think particularly the ceiling, because

1 my concern is similar to what the other Commissioners have
2 raised about baking in higher prices that consumers are
3 going to have to pay for in terms of out-of-pockets as well
4 as Federal spending. Thank you.
5 DR. CHERNEW: Okay. I think we can get to a
6 vote. So we have to do a formal roll call vote, so Dana,
7 I'm going to let you do that.
8 MS. KELLEY: Okay. Voting on the recommendation,
9 Draft Recommendation 1, that:
10 The Congress should replace the current law
11 updates to the physician fee schedule with an annual update
12 based on a portion of the growth in the Medicare Economic
13 Index, such as MEI minus 1 percentage point.
14 Voting yes or no. Amol?
15 DR. NAVATHE: Yes.
16 MS. KELLEY: Lynn, are you able to give us a --
17 thumbs up from Lynn. That's a yes. Thank you. Paul?
18 DR. CASALE: Yes.
19 MS. KELLEY: Larry?
20 DR. CASALINO: Yes.
21 MS. KELLEY: Robert?
22 DR. CHERRY: Yes.

1 MS. KELLEY: Cheryl?
2 DR. DAMBERG: Yes.
3 MS. KELLEY: Stacie?
4 DR. DUSETZINA: Yes.
5 MS. KELLEY: Kenny?
6 MR. KAN: Yes.
7 MS. KELLEY: Tamara?
8 DR. KONETZKA: Yes.
9 MS. KELLEY: Josh?
10 DR. LIAO: Yes.
11 MS. KELLEY: Brian?
12 DR. MILLER: Aye.
13 MS. KELLEY: Greg?
14 MR. POULSEN: Yes.
15 MS. KELLEY: Betty?
16 DR. RAMBUR: Yes.
17 MS. KELLEY: Wayne?
18 DR. RILEY: Yes.
19 MS. KELLEY: Scott?
20 DR. SARRAN: Yes.
21 MS. KELLEY: Gina?
22 MS. UPCHURCH: Yes.

1 MS. KELLEY: And Mike.
2 DR. CHERNEW: Yes, and a shout-out to Larry for
3 his strong passion about this issue.
4 Okay. We are now going -- I am just looking to
5 see if anyone wants to say something about the second
6 recommendation. As I look in the queue, I will say that
7 the issue from the occupational therapist letter, that is
8 almost about the relative free schedule as it is about the
9 average fee schedule, so it applies to both. But in any
10 case. And I agree, it was actually a well-craft,
11 informative letter.
12 Robert.
13 DR. CHERRY: Yeah, thank you. Just a brief
14 comment on Recommendation 2. This has been recommended a
15 couple of times back in 2006 and 2011. I think probably
16 one of the reasons why we are still using outdated data is
17 because this is a very laborious, detailed process.
18 Hopefully, in our current state, we will be able to use an
19 AI tool to actually apply to the data and be able to update
20 the RVUs in a way that kind of makes sense and make it less
21 laborious and have utility associated with it.
22 So I just wanted to mention that, because I think

1 they will still have trouble, unless some of those newer
2 tools are utilized. Thank you.
3 MS. KELLEY: Betty.
4 DR. RAMBUR: Actually, I was just going to share
5 the same thing that Robert said. But I think it is
6 absolutely critical that we think about costs and misvalued
7 codes, as I mentioned. And I just want to underscore the
8 need for independent, expert panel to assist review of RUCs
9 recommendations. Thanks.
10 MS. KELLEY: That's all I have, Mike.
11 DR. CHERNEW: Yep. Thank you all for your
12 discipline. We should go around for the roll call vote.
13 MS. KELLEY: All right. Voting on Draft
14 Recommendation 2, which reads:
15 The Congress should direct the Secretary to
16 improve the accuracy of Medicare's relative payment rates
17 for clinician services by collecting and using timely data
18 that reflects the costs of delivering care.
19 Voting yes or no. Amol?
20 DR. NAVATHE: Yes.
21 MS. KELLEY: Lynn? Thumbs up from Lynn. Thank
22 you. Paul?

1 DR. CASALE: Yes.
2 MS. KELLEY: Larry?
3 DR. CASALINO: Yes.
4 MS. KELLEY: Robert?
5 DR. CHERRY: Yes.
6 MS. KELLEY: Cheryl?
7 DR. DAMBERG: Yes.
8 MS. KELLEY: Stacie?
9 DR. DUSETZINA: Yes.
10 MS. KELLEY: Kenny?
11 MR. KAN: Yes.
12 MS. KELLEY: Tamara?
13 DR. KONETZKA: Yes.
14 MS. KELLEY: Josh?
15 DR. LIAO: Yes.
16 MS. KELLEY: Brian?
17 DR. MILLER: Emphatically yes.
18 MS. KELLEY: Greg?
19 MR. POULSEN: Yes.
20 MS. KELLEY: Betty?
21 DR. RAMBUR: Yes.
22 MS. KELLEY: Wayne?

1 DR. RILEY: Yes.
2 MS. KELLEY: Scott?
3 DR. SARRAN: Yes.
4 MS. KELLEY: Gina?
5 MS. UPCHURCH: Yes.
6 MS. KELLEY: And Mike.
7 DR. CHERNEW: Yes.
8 And so before I thank you, we're going to take a
9 very quick break and come back to talk about MA and Part D.
10 But I will just say one thing for those listening at home.
11 The recommendations tend to be broad. There is
12 language you pointed out is "such as," and we kept out the
13 ceiling and the floor language. And in the second
14 recommendation it is sort of very general. That is broadly
15 intentional, and I strongly encourage people, when the
16 report comes out in June, to read the excellent work in the
17 chapter, because it gets much more granular and much
18 meatier there, and it avoids sort of hemming in, say,
19 Congress, on what they want to do, and having big debates
20 about exactly what the ceiling and the floor should be, or
21 how to do it.
22 So we did spend a lot of time -- thank you,

1 Tamara, for some exchange on this -- about wording of some
2 of this in the chapter. And for the Commissioners, you
3 will get a chance to read the chapter and the text. So I
4 do want to emphasize the text in the chapter is really
5 important, and it helps guide our interactions with a whole
6 range of stakeholders.
7 So again, thank you all, for all of the work on
8 this is. It is really heartwarming to see it get to where
9 we got to. And let's take a 5-minute break, and then move
10 on to the next really challenging topic.
11 [Recess.]
12 DR. CHERNEW: Welcome back, everybody. One of
13 the issues that we are really focused on is the interplay
14 between the Medicare Advantage and the traditional Medicare
15 program, and one of the places where those two programs
16 kind of bump together is actually in the Part D program.
17 So understanding the relationship of standalone Part D plan
18 and the part of MA-PD and how that all works, ends up being
19 really important to understanding how beneficiaries
20 perceive the choice of MA versus the choice of TM in terms
21 of one way or another the vast majority who are going to
22 want some type of drug coverage. And so how does

1 [inaudible].

2 And to tell us about that we're going to start
3 with Shinobu.

4 MS. SUZUKI: Good morning. Tara, Andy, and I are
5 here to continue our conversation from last November. At
6 the November meeting, we highlighted concerning trends for
7 the PDP market, including those that could affect payments
8 to plans and profitability. Many Commissioners expressed
9 interest in this work, so we are here to provide findings
10 from additional analysis we have conducted since then. The
11 audience can download a PDF version of these slides from
12 the menu on the right-hand side of your screen.

13 Before we start, we would like to thank our
14 colleagues, Luis Serna and Stuart Hammond, for their
15 helpful insights as we prepared this work.

16 Today we will start with a quick background on
17 the Part D program. Next, we will review concerning trends
18 that we discussed last November and policies that may
19 contribute to those trends. Then we will discuss factors
20 that may differentially affect costs and payments for PDPs
21 and MA-PDs. Finally, we will explain why and how Part D's
22 redesign may amplify the effects of current policies and

1 structural differences between the two markets. We will
2 conclude with next steps and discussion.
3 The Part D program relies on competition among
4 private plans, which vary by premium, cost-sharing,
5 formulary, and pharmacy network. There are two distinct
6 markets within the Part D program: stand-alone
7 prescription drug plans, or PDPs, that offer drug coverage
8 for fee-for-service beneficiaries and Medicare Advantage
9 prescription drug plans, referred to as MA-PDs, which
10 provide both medical and prescription drug coverage for MA
11 enrollees.
12 Part D market is highly concentrated with most
13 large firms offering plans in both markets. In 2024, 5
14 largest firms accounted for 75 percent of all Part D
15 enrollment nationally and over 80 percent of the state's
16 Part D enrollment in many states. Consistent with the
17 shift from fee-for-service to MA in the broader Medicare
18 program, Part D's enrollment has also shifted from PDPs to
19 MA-PDs. Some of the trends we will review next directly
20 relate to this shift. As we continue the discussion, it is
21 important to note that Part D is just one piece of the
22 complex choice faced by Medicare beneficiaries. At the

1 same time, the lack of relatively attractive PDP options
2 could be consequential in driving beneficiaries' choice
3 between MA and fee-for-service.
4 In this slide and the next, we review the
5 concerning trends in the PDP market that we discussed in
6 November. Any one of these trends by itself may not be an
7 immediate cause for concern, but all of these trends
8 combined raises concerned about the long-term stability of
9 the PDP market.
10 The first trend relates to premiums charged for
11 the basic benefit. The figure shows average basic premiums
12 for PDPs and MA-PDs that primarily serve beneficiaries who
13 do not receive Part D's low-income subsidy, which provides
14 extra help with premiums and cost-sharing for individuals
15 with limited income and assets. Between 2014 and 2024, we
16 found that the average basic premiums for non-benchmark
17 PDPs consistently exceeded those of MA-PDs.
18 The second trend is that the number of PDPs
19 offered has declined in recent years, which affects the
20 availability of benchmark plans. Benchmark plans are the
21 only premium-free option for fee-for-service beneficiaries
22 with the low-income subsidy, and functions as a default

1 plan for LIS enrollees who otherwise would not have
2 enrolled in a Part D plan. In 2025, on average, there are
3 4 PDPs that qualified as a benchmark plan in each region,
4 down from an average of 10 in 2014.
5 The third trend is that PDPs, on average, had
6 higher costs but lower average risk scores than MA-PDs.
7 The figure on the top shows average gross drug costs for
8 PDPs in blue and MA-PDs in orange. In contrast to the
9 pattern for the gross costs, for the risk scores MA-PDs had
10 higher values than PDPs, with the difference generally
11 increasing over this period.
12 The last trend is that PDPs were more likely to
13 incur losses in Part D's risk corridors compared with MA-
14 PDs. This could be related to the diverging trends in
15 gross costs and risk scores, as risk scores directly affect
16 Medicare's payments to plans. Both of these bring to
17 question the accuracy of the risk scores and the resulting
18 payments which requires alignment of costs and payments in
19 the aggregate, which we will come back to later in this
20 presentation.
21 So, why does the stability of the PDP market
22 matter? One obvious reason is that it provides options for

1 drug coverage for fee-for-service beneficiaries.
2 Currently, enrolling in a stand-alone PDP is the only way
3 fee-for-service beneficiaries can obtain Part D coverage.
4 In addition, premium-free PDPs, or benchmark plans, serve
5 an important role in ensuring fee-for-service beneficiaries
6 who receive the low-income subsidy have drug coverage at no
7 cost.
8 There are certain MA and Part D policies that may
9 affect plan offerings and payments under Part D, which we
10 will go through in the next few slides. First, MA-PDs have
11 an additional funding source, MA rebates, to enhance their
12 Part D offerings. MA rebates allow MA-PDs to charge low,
13 or $0, premiums, without lowering their bids. Rebates also
14 allow MA-PDs to subsidize the costs of supplemental Part D
15 benefits. PDPs do not have any additional funding source so
16 that their bids and the full expected costs of any
17 supplemental benefits determine their enrollee premiums.
18 While rebate-financed benefits do provide
19 additional financial protection and more generous coverage
20 for MA-PD enrollees, it could also affect the competition
21 in Part D.
22 Second, MA-PDs have an additional opportunity to

1 adjust their MA rebates to meet their target Part D
2 premiums by reallocating MA rebate amount in their bids
3 after the national average bid and LIS benchmark amounts
4 are announced. This allows MA-PDs to achieve their target
5 premium amount, which, for some plans, are the LIS
6 benchmark amounts. On a practical note, the reallocation
7 ensures that MA enrollees receive the full value of MA
8 rebates. It also helps stabilize MA-PD premiums, and for
9 some plans ensures their premium-free status for LIS
10 enrollees, and allow plans to maximize LIS premium revenue.
11 PDPs, on the other hand, do not have this additional
12 opportunity or funds. PDPs aiming to qualify as benchmark
13 plans but miss the LIS benchmarks may lose their LIS
14 enrollees or receive lower premium revenue.
15 The last policy we want to highlight is how the
16 MA-PDs can offer dual-eligible special needs plans that
17 limit enrollment to beneficiaries who receive the LIS. The
18 ability to offer separate plans for LIS enrollees may
19 provide advantages to plans because LIS enrollees face
20 little or no cost-sharing or premium liability. They face
21 very different financial incentives than non-LIS enrollees.
22 Differences in incentives may affect how plans

1 design their formularies and benefits for LIS
2 beneficiaries. For example, D-SNPs use defined standard
3 benefit that applies a percentage coinsurance to all drugs,
4 which is not typically popular with non-LIS beneficiaries
5 who prefer fixed-dollar copays. PDPs do not have the
6 ability to perfectly limit enrollment by LIS status. As a
7 result, they may face greater challenges in balancing the
8 need to offer an attractive benefit while managing spending
9 to keep premiums low.
10 Now, Tara will talk about the relationship
11 between costs and payments and the factors that may
12 contribute to the differences in the trends in the two
13 markets.
14 MS. O'NEILL HAYES: So what is the relationship
15 between costs, risk scores, and payments to plans?
16 We use risk-standardized costs to compare the
17 alignment of costs with payments between MA-PDs and PDPs.
18 Risk-standardized costs reflect actual beneficiary costs
19 standardized for a beneficiary with average expected costs.
20 For a given beneficiary, a higher risk score will result in
21 lower risk-standardized costs.
22 On average, MA-PDs have lower costs relative to

1 what is predicted by their risk score while PDPs have
2 higher costs relative to what is predicted by their risk
3 score. Therefore, MA-PDs will receive a higher payment
4 than PDPs, on average, for beneficiaries with similar
5 costs.
6 Now we'd like to provide a glimpse of the size of
7 the cost differences we're talking about. The chart shows
8 each plan type's average risk standardized costs relative
9 to the overall Part D average in percentage terms.
10 Average risk-standardized costs for PDPs, shown
11 in blue, were above the overall Part D average, in each
12 year shown, falling on the top portion of the graph,
13 ranging from 9 to 13 percent above the average. In
14 contrast, cost differences for MA-PDs are shown in orange,
15 falling on the bottom half of the graph in each year, with
16 costs ranging from minus 7 percent to minus 14 percent,
17 meaning that they consistently had risk-standardized costs
18 below the overall average. The total difference in risk-
19 standardized costs between PDPs and MA-PDs, shown below the
20 figure, was 23 to 24 percentage points from 2019 to 2022,
21 and 16 percentage points in 2023.
22 In addition to the policies Shinobu just

1 mentioned, there are other factors that may affect relative
2 costs and payments for PDPs and MA-PDs.
3 Factors that may contribute to the difference in
4 risk-standardized costs include:
5 1) differences in how plans manage the benefit
6 through formulary design, such as constructing cost-sharing
7 tiers to encourage the use of lower-cost drugs and applying
8 utilization management tools to further influence which
9 drugs are used;
10 2) differences in diagnostic coding behavior
11 between MA and fee-for-service beneficiaries on the medical
12 side may translate to differences in risk scores for MA-PDs
13 and PDPs;
14 3) other factors that systematically affect
15 spending on medications.
16 Considering the first of the three potential
17 factors that may be contributing to differences in risk-
18 standardized costs by plan type, we assessed plan
19 formularies for MA-PDs and PDPs in 2024 and 2025,
20 considering plan generosity and benefit management based on
21 coverage rates, tier placement, and the application of
22 utilization management tools. Each of these components are

1 ways plans may use their formularies to encourage enrollees
2 to use lower cost products and manage their benefit
3 spending.
4 We looked at coverage for all Part-D eligible
5 products, as well as subsets of products of particular
6 interest, such as those that are both high-cost and highly
7 utilized, the most frequently used generics, and a few
8 specific brand-name products that have been found in recent
9 years to maintain coverage and use despite the availability
10 of lower-cost generics. Our findings for the subset
11 analyses were generally directionally consistent with our
12 findings for all products which we discuss on the next two
13 slides.
14 This chart shows formulary coverage rates and
15 tier distribution for MA-PDs, on the left, and PDPs, on the
16 right, in 2025. The tiers at the bottom of the columns
17 typically have the lowest cost-sharing, while those at the
18 top typically have the highest cost-sharing. Thus, the
19 more products placed on lower tiers, the more generous the
20 plan is likely to be to a beneficiary, in terms of out-of-
21 pocket costs.
22 In 2025, the average MA-PD enrollee had coverage

1 for 63 percent of all products eligible for coverage under
2 Part D, compared with 59 percent of products for the
3 average PDP enrollee. Further, MA-PDs placed more products
4 on lower tiers than PDPs in both 2024 and 2025. And while
5 coverage rates declined slightly for both plan types in
6 2025, MA-PD enrollees, on average, continued to have more
7 favorable coverage based on overall coverage and tier
8 placement.
9 Next, we assessed the frequency with which plans
10 apply any of the three types of utilization management
11 tools: quantity limits, prior authorization, and step
12 therapy. This chart shows the share of products for which
13 plans apply UM in 2025, with MA-PDs on the left and PDPs on
14 the right. The share of all Part D products covered, as
15 shown on the left side, is shown by the line at the top of
16 the chart.
17 Note that rates of utilization management use are
18 calculated as shares of each plan type's covered products.
19 So, in 2025, MA-PDs applied some form of utilization
20 management to 51 percent of the 63 percent of products they
21 covered. Both MA-PDs and PDPs apply UM to roughly half of
22 their covered products, and both use quantity limits most.

1 Prior authorization is required for roughly a fourth of all
2 covered products, and step therapy is rarely used. While
3 the differences between MA-PDs and PDPs are small, on
4 average, MA-PDs manage access to medications through the
5 use of UM for a slightly smaller share of products than
6 PDPs.
7 DR. JOHNSON: Now we will discuss how coding
8 behavior may influence risk-standardized costs.
9 The capitated portion of Medicare's payments to
10 Part D plans is adjusted by risk scores, which are an index
11 of beneficiaries' expected spending on Part D drugs. Risk
12 scores increase a plan's payment rate for beneficiaries who
13 are expected to have higher Part D spending.
14 The RxHCC model used in Part D is similar to the
15 CMS-HCC model used in MA. Both models use demographic
16 information and medical conditions to predict enrollee's
17 costs. Diagnoses are grouped into condition categories and
18 related conditions are ranked into hierarchies based on
19 severity.
20 We have long recognized that the differing
21 incentives to code diagnoses in fee-for-service and MA have
22 resulted in higher MA risk scores due to coding intensity.

1 These differing incentives likely affect Part D
2 risk scores because the diagnostic data for both the MA and
3 Part D risk adjustment models comes from the same physician
4 and hospital claims and encounter data, and there is
5 substantial overlap in the diagnoses used in the MA and
6 Part D risk models. Eighty-two percent of diagnoses in
7 RxHCC model are also in the CMS-HCC model.
8 To assess the impact on Part D risk scores, we
9 modified our method of estimating coding intensity in MA by
10 making three main changes. First, we address differences
11 in the share of enrollees in the part D risk model segments
12 for LIS, non-LIS, and institutionalized populations.
13 Second, we estimate demographic risk scores using gross
14 Part D plan liability. Finally, we estimate coding
15 intensity separately for MA-PDs and PDPs relative to the
16 whole Part D population.
17 We do this because the RxHCC model is normalized
18 across all Part D enrollees. This is one key difference
19 with CMS-HCC model where higher MA coding intensity
20 increases payments to plans above fee-for-service levels.
21 In Part D, coding differences do not affect overall Part D
22 spending, but they can generate different payments to plans

1 for similar enrollees.

2 Our estimates show that differences in coding
3 intensity produced higher risk scores for MA-PD enrollees
4 and lower risk scores for PDP enrollees relative to the
5 overall Part D population.

6 In 2019, MA-PD risk scores were about 4.7
7 percentage points higher than PDP risk scores due to coding
8 intensity, which increased to about 9.2 percentage points
9 higher in 2022, before falling to 7.6 percentage points
10 higher in 2023.

11 For years we analyzed, coding intensity resulted
12 in higher payments to MA-PDs and lower payments to PDPs
13 because the RxHCC model was normalized to a 1.0 risk score
14 across the whole Part D population.

15 Starting in 2025, CMS uses separate normalization
16 factors for MA-PDs and PDPs, based on historical risk score
17 trends that will account for the difference in projected
18 risk scores in the two markets. However, differing coding
19 intensity within the MA-PD market and within the PDP market
20 would generate payment differences across plans that do not
21 reflect actual Part D costs.

22 Tara laid out the differences in risk-

1 standardized costs between MA-PDs and PDPs and we have
2 begun to assess potential reasons for those differences,
3 starting with the two discussed today.
4 First, our formulary analysis does not suggest
5 that MA-PDs achieved lower costs by applying more
6 utilization management tools to the drugs used by their
7 enrollees. Second, we showed that differences in coding
8 intensity explain a portion of the differences in risk-
9 standardized costs between MA-PDs and PDPs. However, even
10 after accounting for differences in coding intensity, there
11 is a large difference in risk-standardized costs for MA-PDs
12 and PDPs, suggesting that there were other factors to
13 consider.
14 We will continue to assess the reasons for
15 differences in risk-standardized costs as well as the
16 effects of applying separate normalization factors for MA-
17 PDs and PDPs.
18 We also want to highlight how the Part D benefit
19 redesign may interact with current policies and affect the
20 trends for the PDP market that we mentioned earlier. The
21 financing of Part D's prescription drug spending is divided
22 between cost-sharing paid by beneficiaries when they fill

1 prescriptions, and payments to plans through enrollee
2 premiums and taxpayer subsidies paid by Medicare.
3 Two key changes made by the IRA increased the
4 share of Part D spending that is risk adjusted. First, the
5 IRA shifted spending from cost sharing to payments to plans
6 by enrollees and Medicare. This means that Part D is now
7 more generous, covering a greater share of drug costs,
8 particularly for those who have high drug spending. Second,
9 it shifted a large share of Medicare's payments to plans
10 from reinsurance to the capitated direct subsidy, which is
11 the portion of the payment that is risk adjusted. These
12 increases in benefit costs and in plans' insurance risk,
13 heighten the importance of Part D's risk adjustment.
14 Another potential concern is the initial impact
15 of the redesign on bids and premiums. As we discussed in
16 January, the national average bid amount rose by nearly 180
17 percent in 2025, due to the IRA and other factors. Large
18 increases in PDP bids and variation across plans led CMS to
19 implement the Part D Premium Stabilization Demonstration,
20 which lowered monthly enrollee premiums by up to $15 for
21 all participating PDPs, and it capped the annual increase
22 in premiums to no more than $35. Even with the

1 demonstration, enrollee premiums varied widely across PDPs.
2 For MA-PDs, on the other hand, average enrollee
3 premiums decreased slightly and continued to remain below
4 PDP premium levels.
5 This highlights the effects of two policies we
6 discussed earlier, first, the ability of MA-PDs to use MA
7 rebates to keep their Part D premiums low, and second, the
8 opportunity for MA-PDs to adjust their MA rebate allocation
9 after their initial bid. These policies may have helped
10 MA-PDs keep their premiums stable despite the upward
11 pressure on Part D premiums overall.
12 Differences in risk-standardized costs may also
13 have affected premiums for MA-PDs and PDPs. Plans with
14 higher risk scores relative to their costs will have lower
15 risk-standardized bids and premiums. For example, if
16 coding intensity increases average risk scores for MA-PDs
17 relative to PDPs, MA-PD bids and enrollee premiums will be
18 lower.
19 Because the impact of MA rebates on the
20 difference in PDP and MA-PD premiums, maybe even larger
21 under the IRA redesign, these policies may contribute to
22 the shift in enrollment from PDPs to MA-PDs.

1 And now we'd be happy to address your questions
2 and hear any feedback or comments on the material we
3 presented today. This material will be published as an
4 informational chapter in our June 2025 Report to the
5 Congress. And now we'll turn it back to Mike.
6 DR. CHERNEW: Thank you, all. This is such a
7 complicated topic, and that is such a thorough
8 presentation. We are going to jump in with questions, and
9 I think Kenny is first in Round 1. Is that right, Dana?
10 MR. KAN: Thank you for an insightful, 71-page,
11 prereading chapter. I think the chapter does a good job
12 laying out some of the concerns between standalone Part D
13 and also MA-PD. I am thankful that CMS believes in the
14 stability of the standalone Part D market. As suggested on
15 page 55 of 71, 80 percent of the chapter that they have
16 introduced, separate normalization factors, which
17 essentially a hit to MA-PD, but gives relief to Part D.
18 And then 90 percent of the chapter, on page 64, introduces
19 the whole Part D Premium Stabilization Program that CMS has
20 done.
21 For the benefit of the reader, would it be
22 possible to reference this in the executive summary up

1 front, that CMS recognizes that these are concerns, and the
2 agency has taken steps to remedy some of these initiatives?
3 I believe that it would be helpful to an uninformed reader
4 so that we don't end up overcorrecting an issue that is in
5 the process of being corrected. Thank you.
6 MS. KELLEY: Greg.
7 MR. POULSEN: Yeah. Two really quick questions,
8 which I think I know the answer to, but I have made
9 incorrect assumptions in the past. In the chapter it talks
10 about $112 billion for the plans in 2023. Is that just the
11 federal government's portion or does that include the
12 premium and cost-sharing from the beneficiaries inclusive
13 in that number?
14 MS. SUZUKI: So I believe that it is a number
15 reflecting Part D subsidies that Medicare pays. So it's
16 low-income cost-sharing subsidy that's included there, as
17 well, premium and cost-sharing subsidies, and the direct
18 subsidy and the reinsurance.
19 MR. POULSEN: Perfect. Thanks. That was my
20 assumption. I just wanted to make sure.
21 The other question I have is when drug prices for
22 drugs that are identified for negotiation, when that takes

1 place, does it apply directly to MA-PDs or is it only
2 available through negotiation on their part?
3 MS. SUZUKI: Those prices apply to all plans, so
4 both MA-PDs and PDPs will have to pay that amount to the
5 pharmacies, and there is a back-end way for pharmaceutical
6 manufacturers to effectuate those prices, either
7 retrospectively or prospectively.
8 MR. POULSEN: Okay. Thanks.
9 MS. KELLEY: Amol.
10 DR. NAVATHE: Thank you, Shinobu, Andy, and Tara
11 for fantastic work here. I have three questions. The
12 first one is probably related to normalization factor and a
13 statement that we have in the chapter on page 60. So you
14 note in this, kind of in the preamble of this paragraph,
15 that in 2025, CMS now uses separate normalization factors
16 for MA-PD and PDP. And then you go on to say, and I'm
17 going to actually read it because I think you state it well
18 here better than I will state it, "However, systematic
19 differences between PDPs' and MA-PDs' encoding would still
20 compromise the ability of the RxHCC model to accurate
21 predict costs, because the coefficients from the model are
22 estimated on the pooled population of MA-PD and PDP data."

1 So I was just hoping you could clarify for us.
2 Even after the normalization factor, which I think on first
3 blush seems like, hey look, we're able to adjust for these
4 two different pieces, these two different groups
5 separately, why does that still not completely mitigate the
6 potential for these systematic differences to exist?
7 DR. JOHNSON: That is a good question. I do
8 think the normalization factor takes care of a lot of the
9 differences, but if the differences in coding between the
10 MA-PD and the PDP markets reflect a different relationship
11 between spending and coding for those two markets, the
12 coefficient, would reflect the average of those two
13 differences. So there still could be some effects on
14 accuracy or between the two markets that is related to
15 coefficients that are developed on the entire Part D
16 population.
17 DR. NAVATHE: Okay. I think I got that. So can
18 I try to repeat this back in terms of an example, just to
19 make sure I understand.
20 So if we think about coding practices, and in,
21 say, this is a hypothetical so not actually true, but I'm
22 just going to use it as an illustration. So in the MA

1 world, say hypothetically we have a lot more coding of
2 diabetes, and I know some of this has changed with V28, but
3 assume for a second there are multiple types of diabetes
4 and there are complicated versus less complicated, et
5 cetera. So there is more overall coding and there is more
6 subsetting that is happening. And then we are predicting
7 the use and the cost of prescription drugs. So there is
8 this differential.
9 So if I understand what you are saying correctly,
10 is that relationship between these diabetes diagnoses and
11 prescription drug spending themselves be quite different
12 between the MA-PD population and the standalone PDP
13 population. And although we have a separate normalization
14 factor, because the model is still assuming that the
15 relationship between the diabetes code and the spending is
16 common, effectively, that we can mitigate some of it with a
17 normalization factor, but those differences in the
18 coefficients actually are assumed to be equal, even if they
19 are not actually equal, and that is what is resulting in
20 this systematic difference beyond?
21 DR. JOHNSON: Yeah, that's a good example. I
22 think maybe another way to say it is if there were two

1 separate risk models calibrated, one specifically for the
2 MA-PD population and one specifically for the PD
3 population, if you looked at the differences in the
4 coefficients for a given HCC, those differences could be
5 small and this is not a major issue, or they could be
6 large. Just something we're not quite sure yet.
7 DR. NAVATHE: Okay. Great. Thank you. That's
8 super helpful. I just wanted to make sure I understood
9 that piece correctly.
10 The second question I have is totally switching
11 gears, and perhaps a little related to Greg's question.
12 But on page 64, we note that the average direct subsidy
13 increased by about five times, to about $142.67, from $30
14 or so. So as part of these expectations or projections in
15 2025, I was just curious -- I couldn't discern from the
16 table, and it might be just that I missed it or I'm not
17 interpreting it correctly.
18 But overall, in the 2025 expectations, how was
19 overall Medicare spending on Part D expected to change?
20 MS. SUZUKI: So we have not done a close analysis
21 of how the spending is expected to change in divvying up
22 between all those different things. But one thing we have

1 highlighted in our chapter is that these are expectations
2 that are based on historical data. And in 2024 and 2025,
3 they use data from two years back. And some of the change,
4 we think, is due to how the actual spending that underlies
5 the bid changed between 2022 and 2023. So not all of the
6 increase you're seeing are due to the IRA.
7 And what we also have looked at is prior to the
8 bids coming in, CMS had done some estimate saying that IRA
9 could affect the total spending direct subsidy amount by up
10 to doubling up the amount, on average. And so this is very
11 different from what you see here, because this is
12 confounded by other factors that are feeding into how the
13 expected amount for 2024 looks versus 2025.
14 DR. NAVATHE: Okay. That's super helpful. And
15 this is separate but related a little bit. So in the
16 context of bids going up and premiums going up, however, if
17 I'm understanding in part what you're saying is although
18 there are some IRA-related pieces and some that are IRA-
19 related, overall, although those bids went up and the
20 premiums go up, it's not that federal spending has gone
21 down. Actually, it seems like federal spending has
22 actually gone up under Part D.

1 MS. SUZUKI: I think to the extent that we
2 expected the benefits to be more generous, we think that
3 the spending itself will go up. And the other piece is IRA
4 had a provision to limit the beneficiary share of the
5 increase. And so the subsidy rate, as we have calculated
6 before, has gone up, as well.
7 DR. NAVATHE: Okay. Great. Perfect. That's
8 clear. Thank you.
9 Last question, and I apologize. I know I'm
10 taking some time here. So I read with interest the work
11 around applying the DECI method here. The intent of that
12 work, as I understand it, is really around what are the
13 differences in coding essentially. What I was curious
14 about is, is there any academic literature that has looked
15 at alternative risk scores, like there's this Rx risk score
16 that is using prescriptions as opposed to coded diagnoses,
17 for example. Is there academic research that we could
18 point to that tries to separate some of the coding patterns
19 to see how risk-adjusted spending would look different
20 between the MA-PD population and the standalone PDP
21 population?
22 DR. JOHNSON: We could look into that. I think

1 the one method you're referencing is a method that uses
2 prescription data, and then I think it still does a
3 crosswalk to diagnoses, it applies like a risk score that
4 is based on diagnoses coded versus a risk score where
5 diagnoses are imputed from prescription drug data. But we
6 can continue to look into that and some other methods to
7 see if we can learn more about that.
8 DR. NAVATHE: Perfect. Okay. Thank you so much.
9 MS. KELLEY: Brian.
10 DR. MILLER: Okay, first of all, thank you for
11 this chapter. Seventy-one pages is actually super short
12 for this topic. I know it could easily be 200 pages, so I
13 appreciate that, and I appreciate all the detail, and it
14 was very digestible in what is probably the hardest space
15 in Medicare.
16 I had a really simple question. Apologies for
17 being a little bit nit-picky. Table 1, page 15. Do we
18 agree that the PDP geographic market definition, as
19 determined by the U.S. versus CBSI is the right market
20 structure, geographic market, sorry, definition.
21 MS. SUZUKI: Market concentration?
22 DR. MILLER: Yeah, the market concentration.

1 MS. SUZUKI: So we looked at states partly
2 because PDP regions are generally a state or multiple
3 states.
4 DR. MILLER: Well, I think that there are 17 -- I
5 might be getting the number wrong. I looked at the chart
6 earlier -- I think there are seventeen regions. I guess
7 what I am encouraging us is when there is establish cased
8 law for mergers, we should probably use the geographic
9 market definition that the DOJ, fighting with whichever
10 private corporation with the judge, obviously,
11 adjudicating, we should probably use the geographic market
12 definition that's in the case. So I would strongly
13 recommend that we change that from nationwide or state to
14 the PDP regions. It may or may not change the numbers that
15 much, but we probably should do that to be consistent
16 across government agencies.
17 And then I would also note that for concentration
18 rather than share of enrollment we probably should be doing
19 HHIs.
20 MS. SUZUKI: We did look at HHIs. Results are
21 very consistent with the 80 percent or more in each state.
22 And we're happy to add that information, as well.

1 DR. MILLER: Thanks, yeah. So I would do the,
2 instead of top five nationwide or state, I'd do it by PDP
3 region instead of share of enrollment. We could do HHI by
4 the various markets, and maybe if there are couple of large
5 market participants, we could denote what their HHI is.
6 Thank you. That's it. Great chapter. Thank you
7 for not having it be 200 pages.
8 MS. KELLEY: Gina.
9 MS. UPCHURCH: Yes. Thank you guys, so much for
10 a wonderful chapter. I'm so thankful that we're paying
11 attention to this because it's critical to the
12 beneficiaries. So again, congrats.
13 I know you looked at formularies and trying to
14 discern if there is any shifting going on between PDPs and
15 MA-PDs in terms of access. Did you happen to look at like
16 -- I didn't pick up on this, but one insurance company and
17 how they treat their plans differently, and was the
18 difference within that one company, in terms of how they
19 make things more or less accessible?
20 MS. SUZUKI: So not for this particular analysis.
21 But in the past, we have found that plan sponsors do use
22 different formularies for their MA-PD offerings and PDP

1 offerings. And for just a few drugs we can see that a lot
2 of times they may use copays on their tiers more often in
3 MA-PDs, and continue to use coinsurance for their PDP
4 offerings.
5 MS. UPCHURCH: That's right. We see that too.
6 So I just want to point that out. When we talk about how
7 hard it is for consumers to make decisions, even that,
8 within the same plan sponsor there are different
9 formularies and different ways of paying for drugs.
10 In Table 4 in our reading, we talk about the
11 Medicare total subsidy. Getting at Greg's comment a little
12 bit, but that Medicare total subsidy, does that include
13 what states pay in terms of full benefit dual payments that
14 come from states, and does it include the DIR fees, which
15 are rebates from the manufacturers and clawbacks from the
16 pharmacies? Is that income that goes to pay part of the
17 Medicare subsidy? Is that included?
18 MS. SUZUKI: So this just shows the subsidy that
19 Medicare pays to plans for the drug costs, but that does
20 include all of the rebates and whatever fees. So it's on
21 the net cost. But in terms of the clawbacks, that's more
22 of an accounting issue. But that's credited to the SMI

1 trust fund, and it's not shown here.
2 MS. UPCHURCH: I got you. Okay. Thank you. And
3 then just two more brief questions here. So the 6 percent
4 premium cap that's in place for last year and this year,
5 it's noted to not be binding in 2026. Do we have an idea
6 of what that means? Is that the expectation that premiums
7 are going to go up way more than 6 percent next year?
8 MS. SUZUKI: Six percent is in law through 2030,
9 is my understanding. So until then, the 6 percent cap will
10 continue to apply. There is a different formula after
11 that.
12 MS. UPCHURCH: Okay, and I know it's just for the
13 base premium. Thank you. I'll look into that.
14 And lastly, just to make sure I understand this,
15 so for a few years, employer group waiver programs, were
16 sort of going away when Part D began, and then we pay these
17 subsidies to the insurers to keep their retirees in plans.
18 And I look like, if I'm reading this, on page 10, that
19 they're actually growing up, that there are more employer
20 group waiver plans than in the past? I may be reading that
21 wrong from this chapter, and I'm just curious. If that's
22 true, do you know why? Are they helping their retirees

1 avoid all this craziness every year?

2 MS. SUZUKI: So we have not looked closely

3 recently, but there have been some changes, for example,

4 the U.S. Postal Service, which their retirees, into Part D.

5 And you would see some jump there.

6 The big changes that happened earlier, so we're

7 not sure how fast it's growing, but it has grown in the

8 past.

9 MS. UPCHURCH: Okay. Thank you, guys.

10 MS. KELLEY: Larry.

11 DR. CASALINO: Yeah. I have a few questions.

12 I'm not sure which slide it is, maybe the fourth or fifth

13 slide, that shows the change in risk scores over time for

14 PDP. Can we show that? While we're pulling it up, my

15 question really is, it's surprising to see a decline in

16 risk scores for the PDP. I think the context for this

17 statement is that it's easily in our minds to make an

18 analogy between Medicare fee-for-service and MA, which MA

19 has a strong incentive to code more diagnoses and

20 traditional Medicare doesn't. But the analogy isn't really

21 accurate because in this case both the PDP and the MA-PD

22 prescription drug plans have an incentive to code more

1 strongly.

2 So I guess my questions about this graph are, is

3 this is a real decline for PDPs, or is this because of

4 normalization?

5 DR. JOHNSON: Part of the decline is related to

6 the normalization that's normalized to the entire Part D

7 population. And so when we see the gap growing, that does

8 reflect some differences in coding. But whether or not

9 that gap is centered closer to the MA-PD risk score or the

10 PDP risk score largely reflects the change in enrollment

11 factors.

12 I think, as you know, there are incentives to

13 have higher risk scores for both MA-PDs and PDPs, but I

14 think linking that to our Part C coding intensity analysis,

15 we note that it's same physician and hospital claims

16 encounter data that are the basis for MA-PD and PDP risk

17 scores. And so that that is, on the fee-for-service side,

18 providers documenting those codes with fee-for-service

19 service relatively lower incentives to document codes. And

20 PDPs don't have that relationship with those providers,

21 whereas on the MA side, there is a relationship between the

22 MA side of the plan and the hospital and physician who are

1 doing the codes.
2 DR. CASALINO: That's very helpful. I think
3 that's really important, right, the difference in the
4 relationship with providers, because it's really the same
5 companies, right, that dominate the PDP market and the MA-
6 PD markets. So you'd expect them to have equal incentives
7 to increase their risk scores, and equal ability. But I
8 guess the difference in the relationships with providers
9 might be the difference in ability.
10 Okay. The last question, or really a suggestion,
11 but I think around one kind of suggestion. The word
12 "structural differences" is in the title and it keeps
13 appearing throughout the reading. I may have missed this,
14 but I'm not sure we have anyway -- by the way, it was a
15 fabulous chapter -- I'm not sure we defined what we mean by
16 structural differences or kind of list them anywhere. It
17 would be great to have a definition really early in the
18 presentation. I see you smiling and I'm not sure why. It
19 would be great to have a definition early in the readings,
20 and then a list of those differences. Because it's the
21 kind of thing we can read over, and think you understand
22 it, and you may not really.

1 DR. JOHNSON: That's a good point. I think part
2 of what you're saying is reflecting that, in using the term
3 "structural differences" initially and sort of refined that
4 to focusing on this specific set of policies, and then the
5 set of analyses that are trying to identify the reasons for
6 the difference in standardized costs. So an updated set of
7 terms and definitions would be helpful. Thanks.
8 MS. KELLEY: That's all I have for Round 1, Mike.
9 DR. CHERNEW: I was about to say that, but then
10 I'm like maybe someone messaged Dana alone.
11 Okay. So I think we are going to start Round 2,
12 and I think that is going to be Stacie.
13 DR. DUSETZINA: Thank you so much. This was an
14 excellent chapter. So I have a few comments that relate to
15 some of the figures and analysis, things that I would, you
16 know, have on my wish list.
17 I'm going to start with Figure 14 in the
18 materials that breaks down the coverage in tiering by MA
19 and PDPs. And one thing I wondered is if you had thought
20 about separating the basic and enhanced PDPs, in
21 particular, to see if there were any difference between
22 those options for beneficiaries. That would go on my list

1 of one subsetting that I would love to see.
2 On page 46, there is a discussion around the
3 selection of high total spending products, and I wondered
4 if you had either excluded protected class drugs from that
5 analysis or would maybe consider doing that in a subgroup
6 analysis, just because those are not places where plans can
7 really differentiate on coverage, and they would probably
8 disproportionately have a lot of the high-cost drugs in
9 that category.
10 On page 47, you mentioned a few products that
11 have had very large drops in use, and the one thing I would
12 just caution is that some of those have had generic or
13 biosimilar entry. So I would just make sure that when
14 you're looking at that drop that you take into account all
15 of those other options that might be substitutes for those
16 products, if we're naming names in the chapter.
17 And then on page 51, in Figure 20, one of the
18 things I kept wondering -- so this was around generic and
19 brands being covered on similar tiers. I wondered to what
20 extent were the products that were generic authorized
21 generics that were offered by the manufacturer rather than
22 other generics made by other companies. Just for context

1 for the others in the room, authorized generics are
2 basically unbranded version, produced by the same drug
3 manufacturer. They can enter those products at any time,
4 so they don't have to have other generic manufacturers
5 competing. And often what happens is the net price to the
6 payer, the plan sponsor, is sometimes lower for the brand
7 than it is for the authorized generic. So I think having
8 just that context.
9 I suspect it might be for some of them,
10 especially the inhalers that were on the list.
11 On page 65, one of the things you talk about is
12 plans having tools or using tools to make the benefits
13 less generous. And I think it would help to mention there
14 that there are basic coverage rules. So there's only so
15 much room that plans have because of required coverage of
16 drugs for beneficiaries and also like the minimum coverage
17 requirements.
18 Okay. Almost done. The issues you raise around
19 the LIS and the benchmark plan availability I think are so
20 critical and important, and especially the ability for MA
21 plans to segment the LIS population out. You know, I think
22 it really doesn't create a level playing field because, as

1 you noted with the D-SNPs, they go to the standard benefit
2 design, and most people shopping for a plan who are paying
3 cost-sharing are not going to pick that plan. The
4 deductible is way too high. The coinsurance is too high.
5 So I think that it would be interesting to kind
6 of think about is it needed for the PDP market to also be
7 able to segment their plans. Like should there
8 specifically be options geared towards people with LIS,
9 where they have the ability to compete more directly. And
10 I think it's something like only one or two benchmark plans
11 in the PDP market now. So I think it really is sort of an
12 urgent thing to fix.
13 And then one of the things that I don't know if
14 it's appropriate in this particular chapter, but you get to
15 the point of thinking about beneficiaries' choices on the
16 very low premiums, very attractive cost-sharing, and MA-PDs
17 versus the PDPs. You know, it's to the point where when I
18 was helping different people with thinking about benefit
19 design, they almost didn't believe. They though it was a
20 scam that they could get a zero-dollar plan. They were
21 like, "This can't be accurate." Like they didn't believe
22 it. And you're like, "No, no, no. That's accurate."

1 So I just kind of wondered, is it worth, here or
2 elsewhere, thinking about the people who aren't switching
3 and shopping for plans, and how much of a burden that ends
4 up contributing to what they're paying and their cost for
5 their drugs over time.
6 I'm very excited about this work. As I often tell
7 people, when I give a lot of feedback it means I really,
8 really loved it, so thank you very much. I really
9 appreciate the work.
10 MS. KELLEY: Cheryl.
11 DR. DAMBERG: This was a great chapter. Super
12 informative, and I think Congress will love it.
13 So as I read through this material a number of
14 things stood out to me. First and foremost, I am concerned
15 about the significant decline in the number of freestanding
16 prescription drug plans in the market. And I think this
17 decline is not good for consumers or the Medicare program
18 writ large. And I'm concerned that that freestanding
19 prescription drug market, as we've known it, is risking
20 collapse. I think that is concerning.
21 But I think it seemed like there are a number of
22 factors that are kind of motivating this, and per Larry's

1 comment, I didn't know whether to call them kind of
2 structural features, incentives, rules of engagement. So I
3 think clarifying some of the language there would be
4 helpful.
5 But kind to restate some of what is in the
6 chapter, I think the ability to use rebate dollars creates
7 market distortions, given the ability of MA plays to buy
8 down premiums, reduce cost-sharing, which the freestanding
9 plans cannot do. And so this, again, to echo Stacie's
10 comment, creates an uneven playing field. And the rules
11 currently overly favor MA and really contribute to the
12 decline of the freestanding market.
13 Secondly, the ability of MA plans to submit
14 second bids or adjust their premiums, once CMS publishes
15 the Part D subsidy amount, to further lower the MA plan
16 premium amount to be more competitive is another example of
17 how the rules create an uneven laying field for the
18 freestanding plans.
19 Third, the ability of MA plans to segment the
20 market gives them greater market advantage and tailored
21 products, which can be a positive. But also pricing to the
22 disadvantage to the freestanding plans.

1 So I think there really is an absence of what I
2 would call a well-functioning, level playing field in terms
3 of the competitive marketplace, given these different rules
4 of engagement. And it isn't clear to me that this is
5 really the desired outcome or the overall policy goal. So
6 I have many concerns in that space.
7 I would like to see MedPAC continue this work. I
8 think this was super rich in content. So I'm hoping as we
9 move forward, we can continue to explore the effects of the
10 IRA on this space.
11 And the other thing, sort of building off of one
12 of Amol's comments about the risk coding, I'd be interested
13 in seeing if, when you compared the adjusted risk
14 standardized cost between MA and PDP, you know, if you
15 introduced a coding adjustment to account for the greater
16 coding in MA, how different would those costs be between
17 the two product lines? Thank you.
18 MS. KELLEY: Brian.
19 DR. MILLER: Thank you again for the chapter. A
20 couple of thoughts. On page 55 we note that the risk
21 normalization factor for standalone PDPs will be
22 implemented for 2025. Specifically to that, I do think

1 that should go really early in the chapter, because from
2 the description that you guys wrote it seems like this
3 might solve not all the problems but a lot of the
4 imbalances. I hear a lot of other Commissioners' concerns
5 about the differences in these markets, and it actually
6 sounds like CMS recognizes that, is ahead of the problem,
7 and beat us to the punch in a good way. So maybe putting
8 that in the first page or two and adding some clearer,
9 stronger language that this could address many of the
10 concerns that we have. That way we don't get ahead of
11 ourselves.
12 I know that on page 57 we mentioned the DECI
13 method. I note again that the CMS report shows that this
14 only predicts 1 percent of spending. We probably, as a
15 Commission, shouldn't be using a failed model that was
16 rejected by a government-run health plan and an outside
17 consultant.
18 Some policy thoughts, after my analysis and
19 structural thoughts. Just to be direct, I'm a little
20 confused by we are upset that MA-PD plans are offering
21 lower premiums than standalone PDPs. I think that this is
22 sort of to be expected after the IRA benefit change, both

1 where the lowered out-of-pocket maximum and the
2 catastrophic component, which was a good change, but
3 massively changed the physical responsibility.
4 MA is an integrated, coordinated benefit, and if
5 you actually look back to the '80s, MA HMO plans offered a
6 prescription drug benefit, and back in either '84 or '86, I
7 think it was four-fifths of MA HMOs had prescription drug
8 coverage. We only got that in standalone Medicare as a
9 standalone benefit, passing a law in 2003, almost 20 years
10 later. Which shows that benefits innovation is a real
11 thing and not just an oxymoron.
12 Now, we can all agree that that benefit for
13 prescription drugs back in the '80s probably was not the
14 best benefit, but it was the start of it then moving over
15 to the fee-for-service space.
16 So really what I'm hearing from everyone else,
17 just sort of summarizing those concerns but looking at it
18 through a different lens, is that the MA models has worked.
19 We might not like the risk coding stuff, but it sounds like
20 that is being addressed, and that MA has out-competed the
21 PDPs.
22 I do think that standalone PDPs are important.

1 Having fee-for-service with its pretty robust network is an
2 important option. But we can't ignore what happened with
3 the IRA, right. So the IRA lowered the out-of-pocket
4 maximum from $2,250 to $2,000 -- again, not an unreasonable
5 thing. We took out the donut hole, which again made sense
6 because that wasn't nice to Medicare benes. And then
7 knowing that there is drug price inflation in the
8 marketplace, we imprudently changed the plan responsibility
9 from 20 to 60 percent in the catastrophic phase over one
10 year. And then we're surprised that the standalone PDP
11 market destabilizes a bit.
12 This should not really surprise us. There are
13 still at least five competitors, it looks like, in the
14 market, having anywhere, it looks like, 85 percent market
15 share. So it's trending not in the right way, but that's
16 still a relatively robust market from sort of FTC,
17 Department of Justice, Antitrust Division sort of market
18 dynamics, market structure.
19 But again, I mean, the IRA is what drove this
20 consolidation, so why are we surprised about that when we
21 increased fiscal responsibility for plans in a commodity
22 product market, because standalone PDPs are a commodity

1 product market, and then we squeezed the plans. When you
2 squeeze someone in a commodity market, whether it's peanut
3 butter and jelly, car transmissions, tires, you know, or
4 forks, or health benefits, big shock that it turns that
5 commodity product into a loser.
6 So I think we only really have ourselves to
7 blame. But we're also stuck with the benefit design that's
8 been created, so we should be practical and find a way to
9 deal with it. I don't think that means dumping more money
10 into standalone PDPs or bashing MA, especially since this
11 risk adjustment coding intensity issue sounds like it's
12 going to be fixed.
13 I think what we need to think about is driving
14 value in the prescription drug benefit, which sounds like a
15 bunch of policy gobbledy-gook. So let me be more specific.
16 I think we need to include value-based contracting tied to
17 outcomes for high-cost drugs. That is an operational and
18 policy question that we need to answer. And then I think,
19 most importantly, we really need to address biosimilars,
20 which I know that Gina and Stacie have brought up many
21 times over the past year or two, and I think we need to
22 address that.

1 So I would look at things that we can do to drive
2 value-based design and value-based contracting in the
3 prescription drug benefit rather than saying let's just
4 give standalone PDPs more money, or MA is bad and let's
5 just hit that. So let's focus on solving the hard policy
6 problem that this excellently written chapter has now laid
7 out for us. Thank you.
8 MS. KELLEY: Gina.
9 MS. UPCHURCH: Thanks again for this work. I am
10 concerned, like several Commissioners have said, about the
11 unstable market, and I really appreciate that Cheryl
12 pointed out the second opportunity to bid coming from the
13 MA-PD, so they can maximize their income when that's not
14 granted to the PDPs. So we need to think about that.
15 I think one of the things missing throughout
16 this, because I see it a lot, is not just the premium
17 difference, it's having a deductible. It's huge. It's
18 $590 now, a year. So for you or me it may not be that big
19 of a deal, but for a lot of people it is a non-starter. So
20 they are going to go to a plan that does not have a
21 deductible. And so many of them do move over to Medicare
22 Advantage because of the drug benefit. So that is creating

1 an unstable market.

2 So as much as we can talk about the deductible.

3 And my curiosity is why do we have that? Why don't we just

4 have cost-sharing from the beginning, of the 25 percent, to

5 simplify the benefit and to make sure it's not a barrier

6 for people with more limited incomes that aren't quite

7 eligible for LIS, not just because their income is not low

8 enough but because of the very strict assets test that go

9 with that. So I'm just hopeful we'll think about that. In

10 addition to the premium, again, the deductible, I think we

11 just need to hammer that that is a barrier for a lot of

12 people.

13 You know, we talked about, on page 5, that we do

14 this a lot, and I have to point it out. We say a lot of

15 people prefer features like reduced premiums and cost-

16 sharing liability. I just want to point out if you give

17 somebody $200 to buy a Medigap policy and a Part D, and it

18 covers the premiums for both, that's $2,400 in a year. And

19 then say you've got to pay your Part B deductible, which,

20 $256, $257. So you're talking $2,657. That is way less

21 than the max out-of-pocket for all of the Medicare

22 Advantage plans.

1 So if you're somebody that uses a lot of health
2 care, you are not saving money by being in a Medicare
3 Advantage plan. I just want to keep pointing that out to
4 people. The sicker you are, the more expensive Medicare
5 Advantage plans are. I'm not saying they're wrong, and
6 they are a great solution for a lot of people. I am not
7 anti-Medicare Advantage. But to keep saying that it's less
8 cost-sharing, I think, is not correct.
9 The other thing I would just talk about, when we
10 talked about increased spending, with the Medicare Part D,
11 and we knew that it would rise for a couple of years after
12 the Inflation Reduction Act, I just want to point out that
13 there were two other major things with the Inflation
14 Reduction Act -- the price negotiations, renegotiations of
15 certain medications, and the biggie that started, I think,
16 in 2023, is the inflation reduction. So the drug
17 manufacturers, if they increased their prices year over
18 year higher than inflation, they have got to give that
19 money back to Medicare.
20 So when we say there's increased spending, on the
21 redesign, but what about the other parts of the Inflation
22 Reduction Act that is keeping the prices down? That's just

1 not discussed here. I just wanted to make sure we thought
2 of that.
3 And lastly, I'm concerned about the Part D
4 market, in general, because of the power that's been given
5 to the plans and the PBMs, that has especially, especially
6 with vertical integration, that has damaged and challenged
7 the viability of community pharmacies. So I just want to
8 keep pointing that out, that Part D, if you mention Part D
9 at a pharmacy conference, you get evil stares. I had to
10 speak at the American Pharmacy Association last year and, I
11 mean, people wouldn't even speak to me afterwards. So I
12 was talking about the benefits of Part D, and it really has
13 hurt pharmacies. So I just hope we keep that on the front
14 burner.
15 But thanks again for the wonderful work.
16 MS. KELLEY: Larry.
17 DR. CASALINO: I would say that not speaking to
18 Gina is a big mistake, because every time she opens her
19 mouth, I learn something, literally.
20 You know, I think the issue we're talking about
21 is necessarily very technical and detailed a discussion
22 about it. So it may not be obvious to people what should

1 stay and that the situation could become quite bad, quite
2 quickly, and what the consequences of that would be. And I
3 do think that, certainly you guys know that. You've been
4 in our discussions here where we've talked about it. It
5 couldn't come across more clearly in the chapter than it
6 does, I think.
7 I'm not arguing that Medicare Advantage is bad.
8 I don't mean to argue that at all. But I would argue that
9 overpaying Medicare Advantage plans by whatever billion you
10 want to come up with -- we've come up with $83 billion a
11 year -- and having the Medicare Advantage plans using part
12 of that $83 billion to subsidize the MA-PD plans make a
13 very unlevel playing field with PDPs. That is a problem, I
14 think.
15 And so there may be some problem, which as Brian
16 has said, is maybe being solved, at least to some extent,
17 with MA-PDs coding more intensively than PDPs and the
18 prescription drug programs. But the bigger issue is that
19 you use rebates from MA, in general, which are used then to
20 unlevel the playing field when dealing with Part D.
21 So I would like to see that explained just
22 clearly in the chapter, because I think you have to

1 understand more than I would've understood when we first
2 started talking about this, what's really at stake and how
3 things could play out.
4 And then I'd like to see some discussion of how
5 and why the Part D market might unwind, and what the signs
6 of that might be in advance. We may be seeing some; we may
7 not. What a death spiral this is and how it could lead to
8 a death spiral. If the price difference between the MA and
9 the PDPs continues to increase, we'll get only the sickest
10 people in the PDPs, and the PDP market will unravel. If
11 there's no PDP market there's really no traditional
12 Medicare anymore. And people can have their opinions about
13 what is good or bad about that, but I think people should
14 clearly understand this sequence of logic, which I think is
15 pretty simple and pretty clear how we could wind up with no
16 PDPs pretty quickly, and how that could lead to not
17 traditional Medicare, essentially, pretty quickly.
18 I don't think I'm overstating the situation.
19 This is stuff I was completely unaware of before you guys
20 started doing the work you're doing.
21 MS. KELLEY: Scott.
22 DR. SARRAN: First, again thanks for a remarkably

1 well-researched, well-written work.

2 Largely I'm going to be a plus-one on Larry,

3 Cheryl, and Gina. Starting with Larry's point, as I read

4 through it and sat through this morning's presentation and

5 the discussion, I became more and more concerned that, in

6 fact, what we are seeing is an implicit rather than an

7 explicit policy decision, and the policy decision being to

8 allow traditional Medicare, via the uneven playing field

9 between PDP, on one hand, and MA-PD, on the other hand, to

10 wither away.

11 And we're not quite there yet, so I don't think

12 we can say that particular part of the sky is necessarily

13 falling yet. But I think it's pretty easy to envision some

14 realistic scenarios over the next, call it two or three

15 cycles, years, where if the gap between PDP and MA-PD

16 become greater then, in fact, we will see that, and what we

17 will have is an increasingly small percent of increasingly

18 wealthy beneficiaries choosing to stay in traditional

19 Medicare, because they can afford it and they're not price

20 sensitive, and everyone else will be in MA-PD.

21 And is that the right thing for the country? It

22 may or may not be, but that should be an explicit policy

1 decision, not one we back into inadvertently. So I think
2 just a really high index of suspicion, or not suspicion,
3 concern rather. I'm not finding anything suspicious about
4 the behaviors of any players. I think everybody is
5 behaving rationally.
6 The huge differences in both the incentives and
7 the tools available for coding between MA-PD plan sponsors
8 and PDP plan sponsors is really striking, and huge
9 important, and that doesn't go away, regardless of Version
10 28, regardless of everything else CMS may do to be
11 appropriately more stringent on the use of the tools and
12 techniques to drive up coding. MA-PD plan sponsors always
13 will have a markedly greater incentive to drive up coding
14 than they would as a PDP plan sponsor, and they have many
15 more tools in their toolbox.
16 And what should concern us when we think about
17 that particular issue is that these are, by and large, the
18 same plan sponsors. So again, not suggesting any nefarious
19 behavior, but if I'm a plan sponsor and I'm selling both
20 MA-PD and PDP, and I've got one product, MA-PD, with a
21 large profit margin, all sorts of tools in my toolbox
22 around provider alignment, et cetera, creative benefit plan

1 design, et cetera, to drive up that profit margin, and I've
2 got another product that I'm selling where it is, as Brian,
3 I think, correctly pointed out, it's a relatively speaking
4 commodity type product with very limited ability to squeeze
5 out profit, and maybe even less ability, net of the IRA,
6 than I used to have, to even drive a predictably small
7 profit, what am I going to do, and what are you incenting
8 me to do? What is the market incenting me to do?
9 So again, I just think we really need to be
10 concerned.
11 What I'd like to see us, net of that, do, is to
12 fairly quickly at least start tossing out some potential
13 solutions. And I agree with Brian's point. This is not
14 simply about pushing money, or shouldn't be simply about
15 pushing money towards PDP. It should be about how do we
16 better level the playing field so that there is an
17 opportunity for PDP plan sponsors to make realistically a
18 small but finite margin, and to chip away at the incentive
19 those plan sponsors today have to drive, in essence, the
20 failure of PDPs, which creates the success of their MA-PD.
21 So my biggest suggestion, then, is let's take the
22 next step over the next cycle and start at least teeing up

1 solution sets. Because if we wait a year or two, it may be
2 too late. Thanks.
3 MS. KELLEY: Larry on this point?
4 DR. CASALINO: Briefly on this point. That was a
5 great comment, Scott. I just want to emphasize, it doesn't
6 have to be nefarious behavior at all. If you are a health
7 plan CEO and you have a very profitable MA product, MA-PD
8 product, and a not-so-profitable PDP, well, of course
9 you're going to try to move people into that. And then if
10 it happens to destroy traditional Medicare that's not a bad
11 thing for you.
12 But it doesn't have to be nefarious behavior on
13 the part of the health plan CEO. It wouldn't really be
14 doing a good job for their shareholders if they're
15 stressing an unprofitable plan as much as a profitable one.
16 MS. KELLEY: Robert.
17 DR. CHERRY: Yeah, thank you for this great
18 report. You know, whenever I read these pharmacy chapters
19 I learn something new all the time, so thanks for unpacking
20 all of this.
21 My comments are not to make the 71 pages 350. I
22 just want to say that right off the start. But they are

1 closely related, I think, to some of what Larry's comments
2 were earlier around the whole concept of structure.
3 A lot of the theme of the chapter has to do with
4 risk. So it's risk-standardized costs. It's pricing.
5 It's coding, et cetera. And we take a step back, and what
6 is the problem that we are trying to solve, and we want to
7 make sure that, or Medicare beneficiaries, when they go to
8 a pharmacy, that they have that medication there, that it's
9 the right medication, it's cost effective in terms of the
10 copays and things like that.
11 And so some of what you're outlining is one
12 element in the risk bucket. And I think that to really
13 understand completely the sustainability of how we have
14 things structured, we need to entertain other types of
15 risks to.
16 So I just mention that, and it may seem
17 tangential, but one element of risk is supply chain. We
18 have seen that before the pandemic, where there were these
19 sporadic outages of drugs for various reasons, usually
20 related to manufacturing. We definitely saw it during the
21 pandemic with all the supply chain disruptions. We saw it
22 last year with IV fluids and Adderall. And then most

1 recently, based on current events, concerns about the
2 outsourcing of manufacturing, as well.
3 So this all comes down to, I think some of the
4 structural issues that Larry was asking us to kind of
5 unpack, which is how are the formularies with these plans
6 actually selected? And what is the element of risk to the
7 beneficiary, or confidence that the beneficiary would have
8 that when they go to their pharmacist that that drug is
9 going to be there, based on formulary decisions?
10 So in some cases, if you could have the
11 availability of the drug, and it's cost effective, that's
12 great, but maybe there's a premium associated with making
13 sure that there is a formulary that mitigates against
14 certain types of risk, even cybersecurity.
15 So I think that when we take a look at sort of
16 the risk-access equation, I think there is more probably
17 that needs to get kind of bundled into this over time. But
18 again, the intent is not to make it a 350-page thesis,
19 though.
20 But thank you for all the good work.
21 MS. KELLEY: Amol.
22 DR. NAVATHE: Thanks for this fantastic work. I

1 think largely I'm going to be echoing and piling on and
2 agreeing and so forth. But I think it's worth doing
3 because I think this is a particularly high stakes
4 situation. And I just think it's worth kind of
5 emphatically reaffirming or restating that, in a sense.
6 I think, to some extent, I agree with a lot of
7 the comments that my fellow Commissioners have made here,
8 that I think that the point here is not necessarily viewing
9 any particular organization here as malintented or as a bad
10 actor anyway. But I think it is fundamentally that there
11 is an asymmetry between the way the markets here are trying
12 to function. And I think there are some tensions here.
13 So I think on one hand, yes, the point is we want
14 to level the playing field, to a certain extent. The
15 stakes are high because if we can't get beneficiaries
16 access to prescription drug coverage outside of MA, then it
17 essential risks the entire option of fee-for-service, where
18 while a few more than half are voting with their feet with
19 go into MA, there is also a very, very large population who
20 have decided to opt for fee-for-service. And if that
21 becomes an unaffordable option, then clearly from a choice
22 perspective we've missed or done a major disservice, I

1 think, to the Medicare beneficiary population.

2 And I think the tensions are real here. What I

3 mean by that is to some extent there are these additional

4 flexibilities that MA plans get, and those flexibilities

5 may, in part, be symmetric, but they're actually not

6 necessarily bad. In fact, in a lot of ways I think they're

7 very good for beneficiaries.

8 So I think, for example, this notion that the

9 same organization is providing the medical and the pharmacy

10 benefit together and shares the risk across that

11 organization is something for a number of years I think

12 folks have been talking about, which is medical pharmacy

13 integration. And that's great because then we can have

14 more generous benefits on the pharmacy side, and whether

15 that's for insulin or some other medication, that actually

16 decreases costs on the medical side. And that's really

17 beneficial for beneficiaries, and it's actually beneficial

18 for society from a total cost perspective, as well.

19 So to some extent it doesn't make sense that we

20 want to disentangle that, because I think that's really

21 good for beneficiaries, if that's functioning well.

22 I think the same can be said -- and these are all

1 points that are made in the paper and other Commissioners
2 have made, so nothing new, per se, but I would say the
3 ability for the benefit customization that has happened. I
4 think we've talked about it in the context of segmentation.
5 I think there is also kind of benefit customization, and
6 that, in the broader space of MA but also in the PD space,
7 I think is a real asset, or could be an asset.
8 So to me I think, in some sense, I also am very,
9 I think -- Cheryl said it and I think others have said it -
10 - I'm very enthusiastic, and I think it's really important
11 for the Commission to continue working on this issue,
12 because in some ways more than any other issue that we are
13 working on, it maybe has the most existential question for
14 aspects of the Medicare program and for beneficiary choice.
15 I think there is perhaps a way to also approach
16 this thinking about it not only from the perspective of how
17 do we do right in the context of how the MA part of the
18 program functions, but also do we need to enable greater
19 flexibility, do we need to enable or create additional,
20 whether it's benefits or flexibilities, on the Part D side,
21 or just change the way that that part of the program works,
22 to ensure the stability, and perhaps, as we've said, kind

1 of level the playing field.

2 So I mean that basically to say we should work on
3 both sides of this balance. There is an aspect of the
4 piece that's the MA side, but then there's also just the
5 Part D standalone market side. And so I feel very strongly
6 this is just probably the most important thing that we are
7 actually working on, and I hope we can continue to really
8 push forward the thinking. Thank you.

9 MS. KELLEY: Kenny.

10 MR. KAN: Thanks again for an insightful chapter.
11 I acknowledge some of the concerns that some of my fellow
12 Commissioners have shared regarding the asymmetry between
13 standalone Part D and MA-PD. As MedPAC Commissioners, as a
14 respected group of Commissioners, I believe that we need to
15 find balance between fiscal prudence and beneficiary
16 access. At the end of the day, the current $37 trillion
17 national debt is unsustainable. While I love that every
18 beneficiary has zero deductible, that is just not
19 realistic. That basically could add 30 to 40 percent to
20 the total cost of a Part D program.

21 We have already seen how the direct subsidy cost
22 has exploded because we, as a nation, decided to -- the

1 previous cost-sharing was too high, and so we brought it
2 down. So at some point we have to decide what are the
3 tradeoffs that we are willing to make.
4 I also hear some of the concerns that it's not a
5 level playing field. Again, I do want to just emphasize
6 that as Brian has indicated, that CMS has already
7 implemented some initiatives to help remedy this.
8 I worry when I hear concerns about proposing some
9 solutions, as I believe that it is premature. I believe we
10 need to wait for the landscape to stabilize with IRA, the
11 upcoming two rounds of drug price negotiation, to
12 stabilize, to ensure that we don't overcorrect and thereby
13 spurring greater consolidation. Thank you.
14 MS. KELLEY: I have one comment, a short comment
15 from Lynn, and that's all I have for Round 2.
16 Lynn agrees with Amol and Scott's comments. She
17 says we should be very careful to protect choice for the
18 beneficiary, including MA and fee-for-service options.
19 DR. CHERNEW: Okay. This is a great discussion.
20 It is obviously a really important area. I will say a few
21 very quick level-setting things, and then we will go to
22 lunch.

1 The first thing is just so you know, right now we
2 are not contemplating a rec. It is not clear what a right
3 recommendation would be. There are a lot of challenges in
4 how we do this writ large. I think there are also a lot of
5 ongoing moving pieces, so it's always hard to jump and say
6 do something when there's actually some things that are
7 being done. So we will have to ponder that as we go
8 forward.
9 But of all the meetings, this is the easiest one
10 to say we're not going to make a rec this cycle, because
11 we're not going to make a rec this cycle.
12 There's a complicated framing here that I just
13 want to emphasize. This session, and appropriately so,
14 focuses on issues between the PDP and the PD market, the
15 standalone PDP and the MA portion of it. And that's true.
16 But I actually think a lot of the root cause of these
17 problems is between TM and MA. And a lot of what you're
18 seeing happening is when MA is paid what MA is paid, and
19 then they buy down the Part D premium, we think about the
20 premium as less. But remember, a lot of the reasons why
21 the premiums is less is because we're thinking about what
22 the person is paying, not the part that's been bought down

1 through the benefit. And I don't, frankly, think that we
2 have a hope of solving that particular issue unless we
3 focus on some of the MA work, and for those that follow
4 MedPAC, we are interested in the Medicare Advantage market.
5 And so I think that's the connection in the PDP part.
6 There are some unique things. So I agree with
7 what Amol said, and I'm glad he said it, that the
8 integration between an MA plan and a drug plan is probably
9 useful. And I would actually go a step further. I think
10 actually there may be some value in having integration
11 between the pharmacy benefit management activity and the
12 plan, in a whole range of ways. There is a lot of vertical
13 integration here. There are pros and cons. There is
14 transparency issues. There are a whole bunch of things.
15 But it is challenging to sort out where you think, and how
16 you think you want to separate out these ownership issues,
17 because it is simply not clear how it plays into another
18 complicated market, which is the market for drugs and the
19 innovation and drug pricing, and a whole bunch of other
20 things that are challenging.
21 So where we are right now is I think we've done a
22 pretty good job, and certainly we could do a better job,

1 but I think we've done a pretty good job of pointing out
2 that in the current environment, with the salience of drug
3 coverage, that it is very hard to maintain this balance
4 between the TM side and the MA side. Notice I didn't say
5 the Part D and the MA-PD part. It's hard to maintain that.
6 And that has strong ramifications for people's access to
7 care and how they have to subject themselves, and that
8 works in a bunch of things in the choice environment.
9 But we are going to have to figure out where we
10 can make strategic improvements in this space, where we
11 might have to holistically think about what's going on, and
12 how it interfaces with other work we're doing on aspects of
13 the Medicare Advantage market.
14 So as drugs become a really important part of
15 care management -- they have always been, but I will just
16 venture to say they are increasingly, starting from a high
17 level, increasingly a really important part of care
18 management and quality, for many, many, many diseases, and
19 ensuring people have affordable access to those medications
20 is actually front and center. But we do have to figure out
21 how we can deal with the fact that we've set up the A/B
22 side, just structurally so differently than we set up the

1 PDP side. And then with the payment issues that we've
2 identified in other work, how that sort of skews a bunch of
3 choices for everybody.
4 So I wish I had more answers to say, so I will
5 just say to folks at home, we really do want to hear from
6 you, so please reach out to us. You can reach us, I think
7 it's at meetingcomments@medpac.gov. And you can email us,
8 call us, whatever it is. People send us letters. We do
9 read your letters. That will all be useful. We very much
10 appreciate you joining us. We will be back for a series of
11 other topics related to Medicare Advantage, supplemental
12 benefits, for example, and a few others, after the break.
13 But right now we're going to take lunch, and
14 we'll see all of you back here at 1:30, I think is the
15 schedule.
16 So again, thank you. And to Shinobu, Tara in
17 absentia, and Andy, it is amazing how much you know about
18 all of this stuff that's going on. So again, super thanks.
19 [Whereupon, at 12:35 p.m., the meeting was
20 recessed, to reconvene at 1:30 p.m. this same day.]
21
22

1 AFTERNOON SESSION

2 [1:32 p.m.]

3 DR. CHERNEW: Okay. I hope you are all doing
4 well at home. We are all doing well here. We are going to
5 continue our discussion of MA-related topics which is on an
6 issue that we have been really struggling with for a while,
7 which is understanding what is happening in the MA
8 supplemental benefits world. So to take us through that we
9 are going to start with Stuart. Stuart.

10 MR. HAMMOND: Good afternoon. Today's
11 presentation will provide information about the
12 supplemental benefits offered through the Medicare
13 Advantage program. The audience can download a PDF version
14 of these slides in the handout section of the control panel
15 on the right side of the screen.

16 This presentation is the second on MA
17 supplemental benefits during this analytic cycle. In
18 October, we provided an overview of the types of
19 supplemental benefits plans offer. In the discussion,
20 Commissioners emphasized the importance of having data on
21 the use of supplemental benefits. Commissioners also asked
22 for additional information about how MA plans administer

1 supplemental benefits.

2 For today's presentation, I'll begin by reviewing

3 the types of supplemental benefits MA plans offer, and the

4 amount that plans estimate spending on the benefits. I'll

5 describe what we know about how plans administer

6 supplemental benefits, then give an overview of the data

7 sources that are available for assessing use of the

8 benefits. I'll end by presenting the findings from our

9 analysis of MA encounter data and the Medicare Current

10 Beneficiary Survey.

11 The MA program gives beneficiaries the option of

12 receiving benefits from private plans rather than from the

13 traditional fee-for-service Medicare program. MA plans are

14 required to cover basic Medicare Part A and Part B

15 services, but may also provide "supplemental" benefits to

16 their enrollees.

17 Supplemental benefits have the potential to

18 address challenges that many Medicare beneficiaries face,

19 such as issues with their vision, hearing, and oral health.

20 Some benefits may also address health-related social needs,

21 such as food insecurity or access to transportation.

22 Supplemental benefits are financed primarily by

1 "rebates" that are added to the monthly payments Medicare
2 pays MA plans. Rebates are based on the difference between
3 a plan's bid and a county-specific payment benchmark, as
4 well as on a plan's star rating.
5 We estimate that, in 2024, Medicare paid MA plans
6 a total of approximately $83 billion in rebates. In the
7 bids they submit to Medicare, MA plans are required to
8 estimate how much of their rebate they intend to allocate
9 to each of four broad categories of supplemental benefits.
10 Those are non-Medicare services, reduced cost-sharing for
11 Medicare-covered services, Part D benefits, and reduced
12 Part B premiums. We provided detail about each of these
13 benefits in our October presentation.
14 Today's presentation will focus on the largest
15 category: non-Medicare benefits, shown in dark blue in the
16 figure. This category includes coverage for services that
17 are not covered by fee-for-service Medicare, such as
18 dental, vision, and hearing services.
19 Of the roughly $83 billion dollars they received
20 as rebates in 2024, we estimate that plans used about $38
21 billion to provide non-Medicare covered services. That
22 estimate includes amounts that plans retain for

1 administrative costs and profit margins.
2 This figure shows the same information as the
3 previous slide, but separates the information for
4 conventional plans and special needs plans, or SNPs, shown
5 on the left and right, respectively. Each column
6 represents the average, annual, per-enrollee rebate plans
7 received in 2024. The segments of each column show how the
8 plans projected using the rebates.
9 The dark blue segments show how much of the
10 rebate plans estimated using for non-Medicare services.
11 Conventional plans, shown on the left, estimated using
12 roughly a quarter of their rebate on non-Medicare benefits.
13 SNPs, shown on the right, estimated using a substantially
14 larger share, or roughly 85 percent, on these benefits.
15 Some of this difference is attributable to the
16 fact that SNPs have a weaker incentive to reduce enrollees'
17 cost-sharing, because many SNP enrollees are dually-
18 eligible and have their cost-sharing paid for by Medicaid.
19 In their bids, plans also project how much they
20 will spend on various types of non-Medicare-covered
21 services. The projections are done at a relatively high
22 level of aggregation. Dental, vision, and hearing benefits

1 are projected separately, but many benefits, such as gym
2 memberships or over-the-counter spending cards, are grouped
3 into a catch-all category, which we've labeled here as
4 "other."
5 In 2024, conventional plans estimate that dental
6 benefits would be the largest category of non-Medicare-
7 covered benefits, accounting for 42 percent of the rebate
8 dollars allocated to non-Medicare benefits.
9 For SNPs, the "other" category was the largest
10 category, accounting for more than three quarters of the
11 rebate dollars allocated to non-Medicare benefits. We'll
12 talk more about what those benefits may entail in a minute,
13 but for now, the take-away is that conventional plans use a
14 significant share of their rebate on dental benefits, while
15 SNPs use their rebates primarily on "other" types of non-
16 Medicare services.
17 In October, Commissioners expressed interest in
18 learning more about the types of organizations MAOs
19 contract with to provide supplemental benefits. In
20 response to this interest, we reviewed the websites of more
21 than 25 MA parent organizations, as well as the websites
22 for entities involved in providing supplemental benefits.

1 Several themes emerged from our review.

2 We found that dental and vision benefits were

3 often administered by dental or vision insurance companies

4 that manage the supplemental dental or vision benefit on

5 behalf of an MA plan. However, some MA plans administer

6 these benefits internally.

7 To provide non-medical supplemental benefits,

8 such as food or transportation benefits, plans often

9 contract with vendors that provide the benefits. Plans may

10 also contract with community-based organizations, but

11 information about these arrangements was harder to find on

12 plan websites.

13 We found that MAOs frequently administer

14 supplemental benefits through vendors or providers with

15 which the insurer is vertically integrated. In some cases,

16 this means using a vendor owned by the same parent

17 organization as the plan. In other instances, it means

18 requiring that members access supplemental benefits

19 exclusively through providers owned by the plan's parent

20 organization.

21 However, our review provides a glimpse of how

22 plans may be administering supplemental benefits. The

1 comprehensive information about the entities involved in
2 providing supplemental benefits is not available, so we are
3 unable to characterize whether our results are
4 representative.
5 The data we have presented thus far comes from
6 plan bids, which provide only a highly-aggregated view of
7 how plans project using rebate dollars. However, as
8 Medicare's spending for MA supplemental benefits grows, it
9 is increasingly important for policymakers to have reliable
10 information about the extent to which enrollees use the
11 benefits available to them.
12 Such data are necessary for answering important
13 questions such as how many enrollees used each type of
14 benefit, are benefits used by enrollees who could most
15 benefit from their use, how much do plans and enrollees
16 spend on each benefit, and do the benefits affect
17 enrollees' health? Without this information, it is
18 difficult to assess the potential value of the benefits to
19 MA enrollees and the taxpayers who fund the program.
20 The rest of today's presentation will focus on
21 the data sources that are currently available for assessing
22 the use of supplemental benefits. We focus primarily on MA

1 encounter data, but will consider other data sources as
2 well.
3 MA plans are required to submit to Medicare
4 encounter records for each item and service provided to
5 their enrollees, including for supplemental benefits.
6 Complete and accurate MA encounter data should, therefore,
7 be the most detailed source of information about the
8 services MA enrollees use, but gaps in the data limit their
9 usefulness.
10 As shown in the table, the limitations vary
11 depending on the type of service. For dental services, we
12 do not have reliable encounter data because CMS's system
13 for collecting encounter data was not configured to accept
14 most dental claims prior to 2024. For vision and hearing
15 benefits, CMS's system has long been configured to accept
16 these types of records, and there are well-established
17 procedure codes that plans can use to submit encounter
18 records.
19 For other benefits, such as gym memberships,
20 there are not well-established procedure codes
21 corresponding to the benefits. As such, plans have
22 reported being confused about if, and how, to submit

1 records for these services.

2 Surveys like the Medicare Current Beneficiary

3 Survey provide some information about dental benefits, but

4 generally don't ask about other benefits and don't provide

5 sufficient detail for answering many important questions.

6 We analyzed MA encounter data for 2021 to assess

7 whether the data might be a useful source of information

8 regarding supplemental benefits. We identified several

9 limitations of the data. First, except for vision and

10 hearing services, there are generally not procedure codes

11 that correspond to many of the supplemental benefits plans

12 offer. This can make it difficult for plans to submit

13 data, because CMS's system requires that records have a

14 valid procedure code. It also makes it difficult to know

15 which codes to look for when analyzing the data.

16 Second, there is no mechanism for assessing

17 completeness of the data. For other types of services,

18 such as inpatient and skilled-nursing services, the

19 Commission has previously found that encounter data are

20 often missing records reported in other datasets.

21 Third, we cannot always distinguish between

22 records for supplemental benefits and those for other

1 services. For example, we sometimes cannot distinguish
2 between supplemental benefits and basic Medicare services.
3 In our analysis, we first looked to see whether
4 plans that offered vision and hearing benefits submitted
5 any corresponding vision or hearing encounter records.
6 Remember, these are the services for which CMS's system was
7 properly configured and for which there are available
8 procedure codes that plans can use to report utilization.
9 We found that most plans offering these benefits submitted
10 at least one corresponding encounter record in 2021.
11 For vision benefits, more than 95 percent of
12 plans offering the benefits submitted at least one
13 corresponding encounter record. The results were similar
14 for hearing exams. For hearing aids, only 85 percent of
15 plans that offered a hearing aid benefit reported a
16 corresponding encounter record.
17 The plans that did not submit any records account
18 for a relatively small share of MA enrollment, however.
19 For all four benefits, more than 99 percent of enrollees
20 were in plans that submitted at least one encounter record
21 for the benefits the plan covered.
22 We next looked at, for each plan and for each

1 type of service, the percentage of enrollees with a
2 corresponding encounter record. The percentage varied
3 considerably across plans and across services. This figure
4 shows the distribution of the submission rates for vision
5 and hearing services. Results for conventional plans are
6 shown in orange, and results for SNPs are shown in blue.
7 The boxes indicate what percentage of enrollees typically
8 had an encounter record for each type of service. The
9 figure is enrollment weighted, so each box encapsulates the
10 submission rates for plans enrolling half of MA enrollees.
11 Consider, for example, the results for vision
12 exams, shown on the far left of the figure. The orange box
13 shows that, among MA enrollees who were in plans that
14 covered vision exams, half of those enrollees were in plans
15 that submitted encounter records for about 40 to 50 percent
16 of their enrollees. Some plans submitted records for as
17 many as 75 percent of their enrollees, indicated by the
18 line above the orange box, and some plans reported no
19 records, indicated by the line extending below the box. As
20 we would expect, looking from left to right across the
21 figure, submission rates were lower for eyewear than for
22 eye exams. Likewise, submission rates for hearing were

1 lower than for vision services, and rates for hearing aids
2 were lower than for hearing exams.
3 Overall, these submission rates suggest that,
4 despite some technical limitations, it may be feasible to
5 use encounter data to assess enrollees' use of vision and
6 hearing benefits.
7 Next, we looked at the encounter data for other
8 supplemental benefits. Recall that these are the services
9 for which there are often not standard procedure codes
10 corresponding to the benefits plans offered. We worked with
11 our staff physician to identify codes that could plausibly
12 be associated with the supplemental benefits plans offer.
13 Let's consider some examples that illustrate the challenge
14 of identifying and using such codes.
15 First, consider a relatively simple case,
16 coverage of a personal emergency response system. This
17 benefit is likely to be offered in a relatively consistent
18 manner across plans, and there are codes that clearly
19 correspond to the relevant services.
20 Next, consider a slightly more complicated
21 example, a fitness benefit. Most MA plans offer a fitness
22 benefit, but the benefit can take a variety of forms. Some

1 plans offer gym memberships, some pay for exercise classes,
2 and some provide exercise equipment.
3 We found several exercise- and fitness-related
4 codes that could be used to report on fitness benefits, but
5 the codes we identified do not clearly align with the way
6 plans typically structure the benefits. For example, there
7 is a code for an annual health club membership, but it is
8 unclear whether an MA plan could use this code to report an
9 enrollee's use of a monthly gym membership.
10 Lastly, a more complex example, food-related
11 benefits. Plans can offer one, or multiple, food-related
12 benefits. They can offer meals to patients recently
13 discharged from the hospital, or on a less-limited basis;
14 they can pay for grocery deliveries, give members a grocery
15 allowance on a prepaid debit card, or arrange for the
16 delivery of food and produce. An MA organization can offer
17 multiple of these benefits within a single plan.
18 We found several food related codes, but there is
19 not an obvious crosswalk between existing codes and the
20 benefits plans can provide.
21 Nevertheless, we created lists of codes for 15
22 groups of supplemental benefits and searched the encounter

1 data for uses of those codes.
2 This table shows the results for 10 of the
3 benefits we assessed. Results for the other benefits we
4 analyzed are included in your reading materials. The first
5 column of the table shows the percentage of MA enrollees
6 who were in plans that offered the benefit in 2021. The
7 middle column shows the number of procedure codes we used
8 to look for encounter records related to each benefit. The
9 third column shows the percentage of enrollees who had an
10 encounter record that included at least one of the codes on
11 our list, among plans that covered the relevant benefit.
12 For most benefits, a relatively low percentage of
13 MA enrollees had a corresponding encounter record. For
14 example, we found that although more than 90 percent of MA
15 enrollees were in a plan that offered a fitness benefit in
16 2021, less than one percent of those enrollees had an
17 encounter record that used one of our fitness-related
18 codes.
19 In contrast, 71 percent of enrollees in plans
20 offering an annual physical exam had a corresponding
21 record. However, the codes for physical exams might
22 sometimes be used to report on basic Medicare services, so

1 it is unclear how many of the records we found are
2 associated with the supplemental benefit. Altogether, it
3 is difficult to say whether we found relatively few records
4 because plans did not submit records for their enrollees'
5 use of supplemental benefits, or because few enrollees used
6 those benefits.
7 Now we'll turn to supplemental dental benefits.
8 Recall that CMS's encounter data system was not configured
9 to accept dental claims prior to 2024, and that only 2021
10 encounter data were available at the time of our analysis.
11 We looked in the encounter data and confirmed that, for the
12 most part, plans do not appear to be consistently
13 submitting records for dental services.
14 Because encounter data for dental services are
15 not available, we used data from the Medicare Current
16 Beneficiary Survey, or MCBS, to assess how MA enrollees use
17 and pay for dental care. While the MCBS can provide some
18 insight, the data provide information only for a sample of
19 MA enrollees and cannot be used for more detailed analysis.
20 The data also have some limitations. For example, the data
21 count all utilization regardless of whether the MA plan
22 paid for the services.

1 To assess beneficiaries' use of dental care, we
2 grouped MA enrollees and fee-for-service beneficiaries
3 according to whether they had a source of dental coverage.
4 Here, we show the results for non-dually eligible MA
5 enrollees who were in plans that offered dental coverage.
6 To provide context, we also show results for fee-for-
7 service beneficiaries who had no dental coverage. Results
8 for other groups of beneficiaries are included in your
9 reading materials.
10 Among non-dually eligible MA enrollees with
11 dental coverage through their MA plan, between 50 to 60
12 percent of enrollees visited the dentist in a year. The
13 rate was relatively consistent between 2017 and 2022. The
14 rate was slightly higher than the rate for fee-for-service
15 beneficiaries with no source of dental coverage. Note that
16 these are unadjusted comparisons.
17 Non-dually eligible MA enrollees reported paying
18 about 61 percent of their dental costs out-of-pocket in
19 2017, but the percentage fell to 35 percent by 2022. This
20 coincides with a period during which MA rebates increased
21 rapidly, suggesting that some plans may have invested those
22 dollars in providing more generous dental coverage. Fee-

1 for-service beneficiaries without dental coverage paid a
2 significantly higher share out-of-pocket, typically above
3 90 percent. In both MA and fee-for-service, some
4 beneficiaries reported being unable to access needed dental
5 care due to cost.
6 In 2024, CMS implemented new policies to collect
7 and improve data on MA enrollees' use of non-Medicare
8 benefits. Specifically, CMS issued guidance for submitting
9 encounter records for these services and developed a method
10 for identifying the benefits corresponding to each
11 encounter record in the encounter data. Additionally, the
12 encounter data system has been updated to accept dental
13 records for dental services. These data will not be
14 available for analysis until 2026 or 2027.
15 In addition, plans are now required to report
16 aggregated information about their enrollees' use of
17 supplemental benefits and their spending on those services.
18 However, the usefulness of this new data will be somewhat
19 limited because it will be reported at the MA plan level.
20 We anticipate that this data will be available for analysis
21 sometime in late 2025 or 2026.
22 While these are steps in the right direction, we

1 anticipate that some data-related challenges will remain,
2 particularly in the early years of data collection. We
3 plan to monitor the data as they become available.
4 Overall, our analysis of the available data shows
5 that Medicare does not currently have good data about MA
6 enrollees' use of supplemental benefits. In 2024, Medicare
7 paid MA plans about $83 billion to provide supplemental
8 benefits, and plans projected using a large share of those
9 funds to provide non-Medicare services.
10 Gaps in the data make it difficult for us to
11 assess the value that supplemental benefits may provide to
12 enrollees and the program. Preliminary analysis suggests
13 that it may be possible to use encounter data to assess the
14 use of vision and hearing services, but the data appear to
15 be insufficient for analyzing use of other supplemental
16 benefits. Recent actions by CMS may improve our
17 understanding of supplemental benefit utilization, but
18 those data are only just starting to be collected and
19 reported to Medicare.
20 For Commissioner discussion, we welcome your
21 questions and feedback on the materials. As a reminder,
22 this material and the material from our October

1 presentation will be included as an informational chapter
2 in our June 2025 report to the Congress.
3 And with that, I will turn it back over to Mike.
4 DR. CHERNEW: Terrific. I think there is a ton
5 of interest in what is going on with supplemental benefits.
6 And to start off the Round 1 questioning, I think we have
7 Greg.
8 MR. POULSEN: Yeah, this really is interesting.
9 Thank you. It's enlightening. Do we have a sense -- you
10 mentioned, and dental is the one that comes to mind, just
11 because it's the biggest -- what percentage of enrollees
12 are in an MA plan where the dental supplement is
13 administered by a separate organization versus the same
14 organization? I'm kind of guessing that even though the
15 numbers may be small, the percentage of enrollees may be
16 fairly large, but I don't know that.
17 MR. HAMMOND: That's a great question. We don't
18 have good data about which entities plans are contracting
19 with to provide the dental benefits, so we're not able to
20 say.
21 MR. POULSEN: Perfect. That may answer my second
22 question, which was do we have a sense among those MA plans

1 that are contracting with a separate entity, do they have
2 access to the encounter data? That is, could they report
3 it if they wanted to, or would it be mysterious to them, as
4 well?
5 MR. HAMMOND: So generally, in the instances
6 where plans are working with some kind of vendor or third
7 party to administer benefits like this, the vendor will
8 provide the claims data or the information necessary to
9 populate a claims report to the MA plan, and then the MA
10 plan will generate the encounter record and submit it to
11 CMS.
12 MR. POULSEN: So we'd have the access to that.
13 Okay. Perfect.
14 MR. HAMMOND: We should, yes.
15 MR. POULSEN: Thank you. Great stuff, by the
16 way.
17 MS. KELLEY: Cheryl.
18 DR. DAMBERG: Great work. I love this topic, and
19 I look forward to continuing to see more work in this space
20 in the coming cycle.
21 Maybe following on Greg's question, I'm still
22 struggling a little bit about the data improvements that

1 we'll be seeing in the future. And I feel like there are
2 certain things that sort of lend themselves to kind of
3 traditional coding, and then there is probably other
4 information that does not. Has MedPAC staff, say, worked
5 with the plans and the vendors to sort of gain some insight
6 on what type of information is being shared between the
7 vendor and the plan to kind of better understand how we
8 might go about capturing the needed information?
9 MR. HAMMOND: So CMS has put out some guidance
10 for plans to use when they are submitting the supplemental
11 benefit records, starting in 2024, and those guidance
12 provide some insight as to how the data might look. We
13 have talked to a few vendors and with a couple of folks
14 from the MA plan side about are they working with their
15 vendors to update the types of information they are
16 collecting, and it does sound like they are kind of in the
17 process of collecting that information from their vendors
18 to make sure they can populate the records. But I don't
19 think we will have a better insight on that until we have
20 the 2024 data available.
21 MS. KELLEY: Tamara.
22 DR. KONETZKA: Great. First, thanks for this

1 great work. I really appreciate your resourcefulness in
2 finding and triangulating all these different data sources
3 when there is obviously no clear, good data source.
4 Two quick questions. One, you didn't present
5 this in the slides, but in Table 7 in the mailing
6 materials, on page 46, I understand the reason for focusing
7 on vision, dental, and hearing, but I'm really interested
8 in some of the other services. And these home and bathroom
9 safety devices and modifications and in-home support
10 services, it looks like very few plans offer them. But
11 then in those plans, a very high percentage of people, like
12 63 to 100 percent of people, get the home modifications.
13 Are those all SNPs, and really focused on people who have
14 long-term care needs?
15 MR. HAMMOND: So I think one thing we can do is
16 we can go look into which codes are seeing a lot of use in
17 that, so we can try to provide a little bit more
18 information.
19 In terms of interpreting the third column of that
20 table, one thing I would point out is that there can be a
21 bit of a mismatch between the number of people who are sort
22 of counting towards your numerator in that third column and

1 the number of people you include in your denominator,
2 because there are multiple benefits that could count as
3 like home and bathroom safety devices. The way that you
4 put together the numerator and the denominator there can
5 make the kind of percentage of enrollees with an encounter
6 record look quite high. So I think that's how we're
7 getting to 100 percent for some plans, if that makes sense.
8 DR. KONETZKA: Okay. All right. I might have a
9 little more to say on that in Round 2. But my second
10 question is about the procedure codes and your example of
11 the annual gym membership and you don't know if people are
12 going to fill that one out or not. In some ways this seems
13 like a kind of stupid problem that should be easy to solve,
14 which probably means it's really complicated to solve. And
15 maybe I should know this, but, okay, how did that procedure
16 code get created in a way that was so restrictive -- not
17 just that procedure code but all of these -- and what would
18 it take to come up with a uniform set of procedure codes
19 that would apply to many of these supplemental services we
20 want to track?
21 MR. HAMMOND: So some of the codes that we were
22 able to identify, that we have asserted could be used to

1 report encounter records for supplemental benefits, are
2 things that were created either for tracking quality
3 metrics in the fee-for-service side of the program, or
4 related to pretty specific demonstration programs. And so
5 the codes were created historically for a very specific
6 use, and we included them simply because it is feasible
7 that a plan could look in the list of available codes and
8 pick that out and decide that they were going to use that
9 code to populate encounter records for the benefit they
10 were providing.
11 With regards to whether it's possible to create
12 new codes, what CMS is doing for the new submission
13 requirements, starting with 2024, is rather than coming up
14 with new codes, they are having plans use kind of field in
15 the encounter data claims that is currently unused, for the
16 most part, and they having the plan list the actual
17 alphanumeric code for what benefit that record corresponds
18 to.
19 So I'll make up a category here, but if in the
20 forms that plans populate when they report their benefits,
21 each type of service is given a code, and it's
22 alphanumeric. So you could have Benefit B-16, and let's

1 say that corresponds to something like a dental record,
2 that B-16 would show up on the encounter record. So in the
3 future, if you're looking to use the encounter data to
4 analyze use of supplemental benefits, you won't look for
5 procedure codes. You'll look for those codes corresponding
6 to the benefits.
7 MS. KELLEY: Stacie.
8 MR. MASI: Sorry, Kenny, did you want to get in
9 on this point?
10 MR. KAN: Yes, thanks. Stuart, I know you spoke
11 to quite a few industry folks. I'm wondering -- because
12 what I put anecdotally is that while the health plans can
13 push to try to get that encounter record populated, outside
14 of dental, vision, and hearing, I also hear, anecdotally,
15 one of the difficulties in tracking benefits other than
16 those three is that the providers are struggling to, well,
17 there are issues with either like getting an actual NPI
18 data, to NPI, to coding it, and then getting the interface
19 through health plan. I'm wondering where you put that.
20 MR. HAMMOND: So many of the vendors or providers
21 who are providing the supplemental benefits, you are right,
22 do not have NPI, national provider identifiers, because

1 they are not medical providers under the Medicare program.
2 CMS does provide default NPI codes that plans can use to
3 submit encounter records for services delivered by entities
4 that are not Medicare providers. So the NPI issue is a
5 problem, but CMS seems to have provided a solution for
6 dealing with it.
7 MS. KELLEY: Yes, go ahead, Stacie.
8 DR. DUSETZINA: Great. Thank you. This is
9 excellent work and very interesting, and a huge amount of
10 data problems, as was already noted. I promise this is not
11 a philosophical question, but I wanted to know if there is
12 information about like what happens to the unused benefits?
13 So for example, the cash cards that people get, or debit
14 cards, or whatever. If that's unspent, does it just go
15 back to the plan, or do we have any idea on how that
16 filters back through?
17 MR. HAMMOND: So that's a good question. With
18 respect to the cards specifically, some plans do all
19 beneficiaries -- so typically the plan will give the
20 beneficiary an allowance, let's say quarterly or monthly,
21 and some plans do allow that amount to roll over from
22 month, or quarter to quarter.

1 Plans, in their bids, are supposed to project how
2 much they anticipate spending on each benefit, and that
3 should reflect their expected costs. But there is a chance
4 that they will recognize some profit or loss based on that
5 projection and whether it's accurate or not. So I think it
6 would very much mirror the way that the rest of the bidding
7 process works, where plans make a projection, and then may
8 experience some profit or loss.
9 MS. KELLEY: Kenny, did you have another question
10 for Round 1?
11 MR. KAN: Yes. So a great, insightful writeup,
12 77 pages. I enjoyed every word of every page of it.
13 So just two questions. Number one, as noted in
14 the detailed prereading chapter, CMS is aware of the issue
15 that we need to do a better job of reporting supplemental
16 benefits, and they have taken steps to implement a lot of
17 steps that you mentioned, including addressing some of the
18 provider issues.
19 Would it be possible to sort of include those in
20 the executive summary up front, that CMS is aware of the
21 issue and we will continue to monitor how effective those
22 implementation steps are? That is question one.

1 MR. HAMMOND: Sure. We can include that.
2 MR. KAN: Okay. Then second question. Regarding
3 concerns that maybe the beneficiaries are not aware of the
4 supplemental benefits, I believe that beginning January 1
5 of 2026, MA organizations must mail a notice annually, but
6 not sooner than June 30th, and not later than July 31st of
7 the plan year, to each MA beneficiary, with information
8 pertaining to each supplemental benefit available during
9 that plan year that the enrollee has not begun to use.
10 So I think it would be helpful to highlight that,
11 that we expect the reporting on this to improve over time,
12 and that the beneficiary's awareness of this benefit would
13 also increase over time. Do you think that is possible, to
14 highlight that in the executive summary?
15 MR. HAMMOND: Yeah, we can mention that.
16 MR. KAN: Thank you.
17 MS. UPCHURCH: And just to clarify that, isn't
18 that supposed to happen starting this year, this June? And
19 then I want to know the administrative costs of it. It's
20 going to be a lot.
21 MS. KELLEY: Betty.
22 DR. RAMBUR: Thank you. This is fascinating and

1 really important work. It is appreciated.

2 So maybe this was in the report and I just missed

3 it or I didn't realize how important it was when I was

4 reading it. But on Slide 21 you talk about the new

5 encounter data submission requirements. I'm curious about

6 the consequences of lack of compliance with that. What's

7 the cost of not playing?

8 MR. HAMMOND: CMS does provide some annual

9 reviews of the quality of plans and the encounter data and

10 gives them report cards, but with regards to a financial

11 penalty or anything like that, there's nothing in place.

12 DR. RAMBUR: I will have more on that in Round 2.

13 MS. KELLEY: Gina.

14 MS. UPCHURCH: I have a lot in Round 2, but Round

15 1, just one quick question to follow up. I appreciate

16 Kenny's question. We have in a footnote there that health

17 risk assessments are part of the annual wellness visit.

18 When I first joined the MedPAC I remember you all kept

19 going, "Health risk assessments, don't do them. Don't do

20 them." And I thought, this seems crazy. Why aren't we

21 assessing people's risk?

22 So I now realize it's part of the annual wellness

1 visit, so it seems redundant, or it should be redundant in
2 many ways. So I just feel like when we dismiss HRAs or
3 health risk assessments, we should also point out they
4 should be part of the annual wellness visit. So it's not
5 that we don't think risk assessments are a good thing.
6 It's just additional risk assessments that may lead to
7 upcoding and that kind of thing. But I just want to make
8 that clear.
9 DR. CHERNEW: I'm sorry for jumping in, and we'll
10 see how this goes. I don't think it was the risk
11 assessments, the initial one or the additional ones, that
12 we were objecting to. I think it had to do with how they
13 get used in the codes.
14 MS. UPCHURCH: Yes.
15 DR. CHERNEW: So you can do as many as you want,
16 and you could use them wherever you want.
17 MS. UPCHURCH: Right. I just didn't know it was
18 part of the annual wellness visit. That was in a footnote,
19 and I thought, ooh, that was super helpful, and we just
20 need to make sure people know that. Thanks.
21 MS. KELLEY: Larry.
22 DR. CASALINO: A minor comment and then a broader

1 question. So at least one encounter is a pretty low bar,
2 to your health plan, and you want to see if you have at
3 least one vision encounter for our vision supplemental
4 benefit. Given that most of the numbers were very high,
5 like 99 percent, it's not that informative really.
6 I wonder, have you tried it with a different
7 cutoff, like the 100 encounters, or would that be hard to
8 do? Could you provide data for that next time around?
9 MR. HAMMOND: Sure. We can look at different --
10 DR. CASALINO: Yeah, I think that would be good.
11 I think it would probably give some extra information.
12 And then the question I have is, I'm trying to
13 understand the ways that MA plans can essentially profit
14 through offering supplemental benefits. So I have three
15 questions about that. One is, well, this first one isn't
16 really a question. Clearly, they can attract more
17 beneficiaries to the plan, right, and that could be
18 profitable, so that was pretty straightforward.
19 But you may have answered this a few minutes ago.
20 If the bid for what they say they are going to spend on
21 supplemental benefits turns out to actually spend less on
22 that, do they actually get to keep that money, essentially?

1 If you say I'm going to spend $100 on supplemental
2 benefits, but, in fact, you only spend $80, what happens to
3 the $20?
4 MR. HAMMOND: I think it does become part of your
5 profit on that line of the business.
6 DR. CASALINO: So that is a way to profit,
7 potentially. Go ahead. I'm sorry.
8 MR. HAMMOND: It would, potentially. I will say
9 that they do, in future bids, report their spending, their
10 actual spending, on each line.
11 DR. CASALINO: They don't have to give it back,
12 but they just have to report what happens.
13 MR. HAMMOND: Exactly. And CMS says that they
14 monitor for, I think the pattern that you're alluding to,
15 where there might be a concerning difference between
16 projections and actuals.
17 DR. CASALINO: Got it.
18 DR. CHERNEW: There is also an MLR restriction
19 that limits.
20 DR. NAVATHE: But how does that factor into the
21 MLR? Does the fact that it's not spent but it's built into
22 the actuarial projection, does that distinction make its

1 way into the MLR calculation?

2 MR. HAMMOND: So the MLR is based on actual

3 spending, and it's for all spending on the plan, not

4 specific to a specific line of service. So you could have

5 an MLR that was below the 85 percent for a specific line of

6 business, or type of service, so long as your overall MLR

7 met the 85 percent threshold.

8 DR. CASALINO: But amount spent on supplemental

9 benefits do count towards the MLR?

10 MR. HAMMOND: Yes, lower.

11 DR. CASALINO: I'm sorry, Amol. Were you going

12 to say more?

13 DR. CHERNEW: If you said it cost you $100 to

14 provide a benefit, and you only actually spent $10 on the

15 benefit, that would make your MLR, overall, in aggregate,

16 lower.

17 DR. CASALINO: Yeah.

18 DR. CHERNEW: Because it's based on actuals.

19 DR. CASALINO: So it's a separate problem, but

20 that's a good point.

21 DR. NAVATHE: Well, it sounds like it's a

22 separate mechanism. It's a separate mechanism to address

1 the medical expenditure piece, and this, I guess, Stuart,
2 to some extent, not to put words in your mouth, but in the
3 next year when they report the actuals, those are the same
4 actuals that are being used as part of the MLR calculation.
5 MR. HAMMOND: Yes.
6 DR. NAVATHE: Right. Okay.
7 DR. CHERNEW: I don't want to belabor this point,
8 but since Larry said it, and since this is a Larry issue,
9 when there is vertical integration between the provider of
10 the benefit and the seller of the benefit, it's hard to
11 know exactly what's going on.
12 DR. CASALINO: Right. But that helps meet the
13 medical loss ratio. Yeah, they're paying themselves,
14 basically.
15 And for people at home who don't understand this,
16 if it was a vertical integration, you can basically pay
17 yourself instead of some provider, but that counts toward
18 the medical loss ratio. I mean, it's legitimate, but it's
19 important to understand.
20 DR. NAVATHE: But Larry, I think the other point,
21 just to add there, is that -- sorry, I know we got deep
22 into this -- the issue is less, at least from my

1 perspective, and I'm curious about you all's perspective --
2 but it's less in some sense that you are paying yourself.
3 It's more that you are able to set the internal transfer
4 price, and that internal transfer price is not necessarily
5 indexed to what's available in the market, or what have
6 you.
7 DR. CASALINO: Thanks. That's helpful. I think
8 that's it, actually.
9 MS. KELLEY: Paul.
10 DR. CASALE: Well, my question may have been
11 answered in some of this conversation. But just for my
12 clarification, you mentioned that some of the MA plans,
13 they administer supplemental benefits through entities in
14 which they are vertically integrated.
15 So in areas where we have encounter data, do we
16 have a sense as to the beneficiary participation, any
17 differences in participation rates between the plans that
18 have the vertically integrated services versus those who
19 don't?
20 MR. HAMMOND: So we, unfortunately, don't have
21 good data on which encounter records correspond to the
22 providers that are vertically integrated with the plans.

1 And so we haven't been able to look at that.

2 MS. KELLEY: I think that's all we have for Round

3 1.

4 DR. NAVATHE: Robert, did you want to get in

5 here?

6 MS. KELLEY: Did someone else want to? Go ahead,

7 Robert.

8 DR. CHERRY: Yeah, thanks. You know, I had a

9 question, I'm trying to understand, at least around one

10 area, what is a standard benefit versus a supplemental

11 benefit. And it's specifically around diabetes care. So

12 when we think about diabetes care there is a few elements

13 from a quality perspective. You know, it's monitoring the

14 hemoglobin A1c, or glucose, it's foot care, and it's eye

15 care.

16 So are diabetic patients that are enrolled in MA

17 plans, are they getting their eye care as part of the

18 standard plan, or do they have to rely on a supplemental

19 benefit to do that?

20 MR. HAMMOND: So traditional fee-for-service

21 Medicare does cover, for example, eye care in the cases

22 where it is related to a medical condition. But for things

1 like a routine vision exam or glasses, those things would
2 need to be covered through the supplemental benefit.
3 DR. CHERRY: So you can't have vision services,
4 for example, that are covered under kind of the base part
5 of the benefit, as well as other benefits that are covered
6 through the supplemental benefit. Thanks for clarifying.
7 MS. KELLEY: Okay. I think that is all we have
8 for Round 1. So shall I move straight to Round 2, Michael.
9 It is Cheryl.
10 DR. DAMBERG: All right. Thanks. So given both
11 the large total spend by the Medicare program, meaning
12 taxpayers and beneficiaries, not just MA beneficiaries on
13 supplemental benefits, I agree that it's important to
14 collect and analyze the data, so I look forward to future
15 rounds once some better data reveals itself. And clearly,
16 we need to know how these dollars are being spent and what
17 value they're delivering.
18 One of the things that I was wondering, for
19 future work, is whether we have some mechanism for going
20 after enrollees who aren't using the benefits that are
21 offered and trying to find out why they're not using them.
22 So some of that can happen in the form of focus groups, and

1 I know you guys do that.

2 But I was also wondering if there's an
3 opportunity within the context of the CAHPS Enrollee Survey
4 to find out who is using what, kind of in a more systematic
5 way, can be a broader population look. And maybe embed
6 some questions about if they're not using them, why not.
7 So maybe something to consider collaborating with the CAHPS
8 team, CMS, on that.

9 I do think that, as you pointed out numerous
10 times in this chapter, that our current data are
11 insufficient to understand this space. I too, like Larry,
12 thought that the threshold of one claim was pretty low, so
13 it will be interesting to see how that looks if you set a
14 different threshold.

15 And maybe this is where Betty was going, but I
16 sort of wondered, depending on kind of what plans are
17 submitting in the future, as CMS reviews those data
18 submissions, might there need to be some type of incentive
19 for plans to submit complete encounter data, or possibly
20 face a penalty for incomplete submissions.

21 I would also like to see MedPAC continue to
22 dedicate some resources to tracking supplemental benefits,

1 and in particular, future work to explore the way in which
2 parallel benefits could be offered in traditional Medicare
3 to enable greater competition between the two product
4 lines. And that work could look at what it would cost to
5 finance, where that financing could come from, you know,
6 would that involve using some of the rebates dollars and
7 pushing it over to the fee-for-service side.

8 And then, lastly, given the wide variation in the
9 form and generosity of coverage, and the fact that
10 consumers only see a checkmark on Medicare PlanFinder, and
11 it's really hard to decipher all the different offerings, I
12 do think MedPAC needs to think about standardization of
13 benefits in this area, to promote transparency and improve
14 the ability of consumers to choose.

15 MS. KELLEY: Stacie.

16 DR. DUSETZINA: Great. Thank you so much. I
17 think this is excellent work, and it is really a hard data
18 problem to solve, so I'm excited once we have more
19 information coming through to be able to look at this
20 again.

21 You know, I think the two issues that really
22 stood out the most to me are the vertical integration piece

1 and the potential for kind of having more profits for the
2 companies that are setting these other companies up to
3 distribute the benefits.
4 I think looking into that more, it very much
5 feels like some of the thing we see in the prescript drug
6 supply chain, you know, where it's like the entities, you
7 can't really trace the dollars very well. But it does seem
8 like there's a possibility of people maybe not getting to
9 take full advantage of their benefits, the money that's
10 going towards these.
11 I very much like Cheryl's point about the need to
12 improve the transparency for people when they're purchasing
13 benefits. You know, just a checkmark that you have it, but
14 the range of what that means can be so variable, I think it
15 would be something important to look into and try to
16 correct so that people actually know what they're buying.
17 And standardizing these benefits would be nice.
18 You know, the other thing that I was just kind of
19 thinking, for the setup for the presentation, the graphics
20 that you present around the special needs plans and the
21 conventional plans and the dollar amounts we're talking
22 about here, I think it would be great to have those in the

1 chapter. I mean, it's kind of shocking when you see,
2 especially for the special needs plans, that other
3 benefits, and also the total dollar amount we're talking
4 about, is just an enormous amount of money to be going
5 towards benefits that we don't track. So I think that
6 would really help to reemphasize and set the stage for the
7 report in a way that people are like, okay, this is why
8 we're super interested in this topic.
9 But exceptional work, and great presentation.
10 MS. KELLEY: Brian.
11 DR. MILLER: I think I nerded out a lot on this
12 chapter. And when I saw that you had done it all by
13 yourself, I thought what a heroic effort, because that's a
14 lot to put together, so thank you.
15 MR. HAMMOND: If I can just jump in, I did not do
16 it all by myself. There are a lot of folks involved.
17 DR. MILLER: Okay, good. Regardless, it was a
18 lot of work, and I really appreciate it.
19 More of my questions are not really a critique of
20 analysis. It's more like adding more context and then some
21 thoughts for all of us.
22 I really liked the part at the beginning where we

1 said MA plans may offer their enrollees supplemental
2 benefits such as, and then you enumerated, reduced cost
3 sharing for Part A and Part B services, reduced Part B and
4 D premiums, enhanced Part D benefits, and coverage for
5 services such as dental, vision, and hearing, which are the
6 three most common. I think that was helpful.
7 I also think that in the slide deck that you
8 shared, on Slide 8, where we had the conventional MA plans
9 and then the SNPs, and you had that wonderful graph, bar
10 chart, showing where the benefits are and what the
11 differences are across the conventional and SNPs, I think
12 we move that earlier into the discussion.
13 And then I think early in the discussion,
14 actually, I know that we spend a lot of time talking about
15 dental, vision, hearing, and other things. I think it's
16 actually important that we spend more talking about the
17 supplemental benefits that seem routine and may be a little
18 bit boring. So I apologize if I put everyone else to
19 sleep. But talking about the reduced cost sharing for Part
20 A and B services, reduced Part B and D premiums, and
21 enhanced Part D benefits, those are additional benefits.
22 We should talk about, you know, what the value of those is,

1 how they are used, who is using them.

2 I am assuming, as a physician, that most everyone

3 is using them, but I don't know that. And so I think if we

4 add that in addition to the analysis of dental, vision, and

5 hearing, it will give a better picture of what those

6 supplemental benefits are. Because I recognize, from

7 thinking with a regulatory hat, we are more concerned about

8 someone offering a benefit that's not really used or not

9 meaningful or it's not easy to access. I think we should

10 contrast that with the ones that are probably used more as

11 an example of here's something that is clearer to

12 beneficiaries that they then use, and it has a lot of value

13 to them. By the way, here are the plans, experimenting

14 with other supplemental benefits, which maybe we have more

15 mixed review of. Sort of like a box office, sort of maybe

16 not flop, but some of them might not go as well as we want

17 on the supplemental benefits. So showing what works and

18 what hasn't worked.

19 And then, of course, quantifying the value of

20 those. I think we noted that there were $2,329 in MA

21 rebates, and we can and have debates about where those are

22 coming in, the measurements, et cetera. But it sounds

1 like, from looking at the math, that for conventional MA
2 plans, 73 percent of those are going to the prescription
3 drug plan, the premium reduction, et cetera. So we should
4 have more of that discussion up front.
5 Because I agree that the dental, vision, and
6 hearing and other benefits can be attractive to
7 beneficiaries, but there is that amazing 2022 Commonwealth
8 Fund study that showed why beneficiaries are picking MA,
9 and they're picking it for the supplemental benefits, which
10 are specifically often Medigap and PDPs. So we should have
11 that dynamic. I know it sounds perhaps dumb for me to even
12 be mentioning this, because we all are spending time
13 reading hundreds of pages, and you guys are analyzing
14 thousands of data files.
15 But the average reading of this chapter doesn't
16 understand the different benefit structure between fee-for-
17 service Medicare and Medicare Advantage, and the average
18 reader is not necessarily going to understand that people
19 are making the cost [audio disruption] issue of Medigap and
20 Part D is the option that drives a lot of people into MA,
21 which is not necessarily a good or a budget thing. It's
22 just factual. And that for some of the beneficiaries who

1 might be on the fence, some of those other supplemental
2 benefits might sort of push them in one direction or the
3 other.
4 So I think if we add that discussion early, about
5 the reduced cost-sharing, call it Medigap, whatever you
6 want to call it, and the Part D plan, that will make that
7 sort of consumer choice I think a lot clearer. And that
8 will then highlight that Commonwealth Fund study, which is
9 pretty good.
10 MR. HAMMOND: Sure. Yeah. So I think we agree
11 those are important supplemental benefits. We presented a
12 bit of detail on them in October, and our full intent is to
13 combine that material with what you saw today, to make sure
14 that context is in there.
15 DR. MILLER: Yeah. And so I put that in one
16 chapter so it's clear. I realize I just made a chapter
17 longer after requesting for two years that everything be
18 shorter.
19 DR. CHERNEW: Just to clarify, because it's
20 important, there's a distinction between papers and
21 chapters.
22 DR. MILLER: Right.

1 DR. CHERNEW: So this is a paper, but it's going
2 to all be combined into one chapter. We will bring
3 material from different papers into that chapter. Again, I
4 had to look to Stuart to make sure I got that right.
5 DR. MILLER: So that, I think, will make it a lot
6 stronger and a lot clearer about what works and doesn't
7 work.
8 So then sort of questions for us, I think, as
9 Commissioners, after going through that sort of long
10 structural discussion, actually, one more quick structural
11 thing.
12 We may want to note explicitly that many of the -
13 - because the SNP plan supplemental benefits are different,
14 that the D- and I-SNPs, or D-SNPs, by definition, they have
15 Medicaid. Most of the I-SNP benes are dual-eligible. The
16 supermajority are. And so if we note that with Medicaid
17 serving as functionally their Medigap wrap plan, that will
18 make it clearer why the SNP plans look so different. I'm
19 not saying what the SNP plans are doing is good or bad.
20 Just you don't need to reduce Part A, B, and D cost-sharing
21 if you have Medicaid already. Because otherwise if you
22 look at that and you don't have that context, it's harder

1 for the reader.

2 So then I think something for all of us to think

3 about, of course, is the history of benefits innovation,

4 and maybe we could put some of that in there. And again,

5 it sounds like I'm out of Dilbert and I'm escaped -- I'm a

6 fugitive from the cubicle police. Tough crowd.

7 So benefits innovation is a real thing. Going

8 back in time to the '80s, the prescription drug benefit was

9 nonexistent for most beneficiaries, because in 1965 we

10 didn't have many prescription drugs. You had like one

11 drug, a couple of drugs that you could use for

12 hypertension. And so then the predecessor to MA plans,

13 obviously imperfect, were experimenting with benefits

14 innovation. Some of the things that they offered were not

15 particularly useful. Prescription drug coverage was

16 something that took off in the '80s, particularly among HMO

17 models, many of which then, and still now, are vertically

18 integrated -- Kaiser, Geisinger, and others.

19 And so that benefits innovation. Yes, we need

20 more information. But I think when we turn to

21 standardization as the answer for the question of consumer-

22 facing choice, that that's a mistake, because we

1 potentially may destroy that benefits innovation. You or I
2 or any of us can look at some of these supplemental
3 benefits and we'll all have judgments about what we think
4 is valuable and what we think is not. It's important to
5 note that the CMS actuary has to approve the bid, and the
6 concerns about the medical loss ratio, if you're not
7 meeting your medical loss ratio requirement, you're sort of
8 in deep Kahuna in the subsequent plan years.
9 So there are pretty strong regulatory mechanisms.
10 I know that folks are concerned about vertical integration.
11 Vertical integration is not necessarily bad. It's not
12 always good either. But if, again, looking at a Kaiser or
13 a Geisinger, even UPMC, no organization behaves perfectly.
14 But having that integration of health care financing and
15 care delivery allows for that redistribution of financial
16 risk and clinical risk and sort of reorientation of care.
17 So I'm not categorically concerned, and I don't
18 think any of us should be categorically concerned if a
19 vertically integrated enterprise is delivering a holistic
20 health benefit. Now, if it doesn't actually benefit the
21 beneficiary, that is a different question. But I don't
22 think that we should be opposed, as a Commission, to

1 vertical integration, because it's one of the few things
2 that actually has worked to fix some of care delivery in
3 health care. And many of those organizations I gave are
4 examples of that.
5 I also think that we need to be sensitive to our
6 customer, which is Congress, and Congress has pushed for
7 more personalization and customization. So us defaulting
8 to standardization I don't think would make us a good
9 advisor to Congress. I think perhaps the answer to more
10 choice is how do we create better filters. And when I
11 think about this, it means we need a better multichannel
12 education effort. So the "Medicare and You" handbook,
13 maybe there should be a better discussion of supplemental
14 benefits in there, and what supplemental benefits are
15 typically offered in Medicare Advantage, and what are the
16 questions that beneficiaries should be asking.
17 SHIP counselors could be a great guide. Maybe
18 that's something else that we focus on to help
19 beneficiaries understand supplemental benefits, to make
20 sure that they're getting a supplemental benefit that is
21 meaningful to them, and it's not a marketing gimmick, and
22 it's something that they can actually use.

1 We could also, as Cheryl noted, the PlanFinder is
2 not in great shape with respect to supplemental benefits.
3 Improving the PlanFinder would be another potential channel
4 to improve that. We could also -- and this may not be
5 popular, but you could change how brokers talk about
6 supplemental benefits. CMS has done a lot of marketing
7 regulation. Some of it good. Some of it bad.
8 So we have all these channels, whether it's
9 brokers to educate beneficiaries, whether it's the
10 PlanFinder to provide information, whether it's the
11 "Medicare and You" handbook. Whatever it is, we have
12 multiple filters, and the beneficiary can choose which
13 filter they want. And we should be agnostic about which
14 filter they want, but work to improve them. And that means
15 working with CMS to improve the "Medicare and You"
16 handbook. It means working with CMS's IT staff or giving
17 specific recommendations about what we think of
18 constructing consumer choice to improve the PlanFinder. It
19 means listening to brokers, whether we agree or disagree
20 with them, to understand what their conversations are like
21 about supplemental benefits. Are they having
22 conversations? Maybe they should be having more

1 conversations.

2 And so I think recognizing that we have all of

3 these channels. These channels have strengths and

4 weaknesses, and making these channels better for the

5 beneficiary so that they get benefits that work for them, I

6 think is important. I just used the word "benefit" and

7 "beneficiary" like five times in the same sentence, so

8 apologies.

9 I think another thing that is worth considering

10 is to sort of level-set about what supplemental benefits

11 are. I don't think that we want UnitedHealthcare

12 developing apartments or Humana shipping you broccoli, or

13 Centene sending us gym clothes. But at some level we also

14 need to think, just holistically, about scoping what the

15 business of health benefits manager is, or health benefits

16 offerer, in this case, carrier.

17 So I just wanted to make those points for us to

18 consider. Thank you.

19 MS. KELLEY: Robert.

20 DR. CHERRY: Yes. I'd like to thank you for this

21 paper -- getting the terminology so that's great. It's

22 really great work. And I think for a lot of us it's an

1 interesting and fascinating topic because the idea of using
2 rebates and investing in supplemental benefits is a really
3 good concept here.
4 It's easy to get hypercritical of things, but MA
5 is taking off so quickly that we're literally flying the
6 plane and building it at the same time. I think what we'll
7 have to do is be much more explicit in terms of what that
8 final build will look like.
9 So as an example, the problem we are trying to
10 solve is, are the supplemental benefits providing value.
11 So if you look at, let's day, dental, for example, and if
12 they're getting, let's say, routine dental checkups, are we
13 having a reduction in tooth extractions and root canals.
14 And if the individual does need a tooth extraction, how is
15 that working as a supplemental benefit? What is the cost-
16 sharing like?
17 So there's an overlap between the value
18 proposition and, of course, the benefit design.
19 The same is true for hearing, as well. So if
20 there is surveillance to detect hearing loss, and there is
21 loss and it reaches a critical threshold, based on clinical
22 criteria, and a hearing aid is necessary, who picks up the

1 cost for the hearing aid? And are we providing value in
2 detecting that hearing loss early, so that the individuals
3 is able to have, you know, a sound quality of life.
4 A lot of this is really dependent on the
5 encounter data, so we really need to insist that the
6 encounter data is more than just a checkbox of whether
7 dental care was provided or not, but really linked to
8 outcomes, as well.
9 The other way of tackling it, too, and not just
10 with encounter data but also the contracts that the plans
11 have with third-party vendors. And nothing wrong with sort
12 of outsourcing those benefits. But if this was like a
13 hospital, for example, and there was a clinical contract
14 with a vendor, there is an expectation that there are
15 performance metrics associated with it. And so another way
16 of finding out whether or not these supplemental benefits
17 are providing value is a sort of a regulatory demand that
18 performance metrics be included in the contracts, and
19 perhaps even certain elements standardized so it could be
20 easily pulled and centralized, so we could see if they are
21 providing value.
22 So those are just a couple of suggestions there.

1 But I think as we start to iterate on the paper, I think if
2 we can get a little more specific on exactly what that
3 vision should look like, then it's easier to start building
4 the infrastructure around it.
5 But otherwise, a fantastic read, and thank you.
6 MS. KELLEY: Tamara.
7 DR. KONETZKA: Great. So many great comments
8 that I'm following here, so I think mine can be pretty
9 brief. But a couple of points. They're mostly about
10 things that you're going to -- well, things I just want to
11 emphasize would be important to do, and things that I'm
12 very interested in. One is the supplemental benefits I
13 mentioned before, about the in-home modifications, those
14 kinds of things, I know that's not a big piece of this, but
15 in some stream of work, and maybe it actually belongs with
16 the work on SNPs and some of our other work.
17 But I'd really love to keep following those, even
18 as we follow dental, vision, hearing, perhaps in more
19 depth. I'd really love to follow those, find out who is
20 using those, and how it intersects with the other things
21 that they're using. How it intersects with their use of
22 the home health benefit. How it intersects with their use

1 of Medicaid, if they're duals, Medicaid home and community-
2 based services. Just to get a sort of bigger picture as to
3 what role these supplemental benefits might be playing, and
4 then subsequently the value of supplying those benefits in
5 that way, rather than one of those other methods. So I
6 would love, if we find the bandwidth within one of these
7 streams of work, to follow that.
8 The other thing I would just like emphasize, and
9 this is echoing something that Cheryl and Stacie said, is
10 that I'm really glad that assessing the value of these
11 services, as hard as that is right now, is on your list.
12 And I just think that's a really important, sort of end
13 goal, to assess the value of these services. Because
14 clearly, through the way we set up the rebate system, fee-
15 for-service, traditional Medicare is sort of subsidizing
16 those supplemental benefits, and we just need to know what
17 value we're getting for those services, and whether we
18 should continue to subsidize them that way. And also, as
19 Cheryl mentioned, maybe that's a model for if we do find
20 they are valuable, maybe those should also be offered to
21 traditional Medicare beneficiaries. So trying to get at
22 that value equation, perhaps through some of the

1 suggestions that Robert just made, I think is super
2 important, and I wanted to emphasize that.
3 And then finally I wanted to plus-one, this is
4 not really about this conversation, but I wanted to plus-
5 one a continued emphasis on looking at standardization of
6 benefits. I think that when you have plans that vary in
7 marginal ways on 100 different things, that's not really
8 real innovation. I don't think that gives really different
9 value to people. And even like a good filter doesn't
10 really help in enabling a consumer to sort of make the
11 right choice.
12 So I think you can standardize to an extent that
13 really doesn't hurt innovation, true innovation, and it
14 would make the consumer choice framework much simpler.
15 So that's it. Thank you.
16 MS. KELLEY: Gina.
17 MS. UPCHURCH: Stuart, thank you. I think you
18 win the most references award with this chapter, and I know
19 it took a team to do it, so thank you for this great work.
20 In full disclosure, I am with a SHIP counseling
21 site, so we have lots of experience with this. I have four
22 comments here.

1 First of all, I think one thing that's missing in
2 the chapter is that a lot of people end up having to
3 reimburse for some of these things. They don't get cash
4 coming in front. They have to pay for that dental care and
5 then file for reimbursement. I thought maybe I'm losing
6 it, so I emailed one of my staff, going, "There's still
7 reimbursement of a lot of the plans." Here's what she
8 wrote:
9 "For vision and dental it varies. For example,
10 Blue Cross Blue Shield North Carolina, has the BlueFlex
11 card for vision but not for dental. That's run by Liberty,
12 a third-party administrator, and it creates confusion for
13 the beneficiaries, because they want to use their Blue
14 Cross, but they should use Liberty for their dental
15 benefit. And this is totally different from Experience
16 Health, which is also run by Blue Cross Blue Shield,
17 because those people have to get reimbursed for their
18 dental care, $500 for preventive, and then $1,500 for
19 comprehensive. And they have to understand what that
20 means.
21 "For Aetna, the vision benefit is split. You
22 have to see their network of providers for your exam. But

1 for glasses, members get reimbursed up to the allowed
2 amount. But you can go anywhere. But, of course, you get
3 a discount, but you have to file for reimbursement.
4 Through the EyeMed Network you get a discount." I mean, it
5 goes on and on. It's just too much.
6 So one of the points I want to make related to
7 that, so when you're helping somebody with a PlanFinder
8 it's a checkbox, right? Yes, dental, vision, hearing, gym
9 membership, this kind of thing. You don't know whether
10 it's Silver Sneakers or not, looking at the PlanFinder
11 tool.
12 You can go to the Summary of Benefits. So that's
13 about 10 to 15 pages, a little bit more detail. Still
14 doesn't tell you how to process and make these things work.
15 So then you go to the tome, Evidence of Coverage.
16 Thank goodness it's not mailed, because that would be so
17 many trees going to the Evidence of Coverage. It's on the
18 website, so you have to have access to the Web, digital
19 literacy. To find these things, they're buried often. So
20 mostly you have to call to find out exactly how the thing
21 works.
22 So to me, it's impossible to really, when you're

1 counseling people, to be truly informed about benefits to
2 make decisions, because there's so much variance, and it's
3 all over the place. So you can't really be truly informed.
4 My last point is that we know, in the U.S., we
5 spend so much more on medical care, and what we don't hear
6 a lot is we spend a lot less on social care in the United
7 States. And I have a question about whether we should be
8 running our social care dollars through insurance companies
9 and plans.
10 So we're having insurance companies that
11 administer the social benefits. When I was reading this
12 chapter I was finding myself going amen, amen, talking
13 about community-based agencies or organizations, whether
14 they be governmental or non-governmental, you know, being
15 hard because they can't scale it. They don't have the
16 capacity often to have these big contracts.
17 But relationships really matter, especially for
18 older adults and adults with disabilities. So I hate that
19 we're doing runaround, a lot of the CBOs. You know, you're
20 hiring these third-party administrators. When there's
21 money to be made, all of a sudden they're experts in the
22 field, popping up in your community.

1 Meanwhile, we have long waiting lists. ACO seems
2 to have dissipated. They oversee the block grant funding
3 at the local level, Older Americans' Act, and we have long
4 waiting lists for home-delivered meals, transportation,
5 home modifications, Department of Social Services in-home
6 aid. So we are terribly underfunded, social care and social
7 care agencies. We could take that $2,000 per enrollee,
8 that we're all paying for, as taxpayers subsidizing
9 Medicare or Part B beneficiaries, then our traditional
10 Medicare subsidizing people in on Medicare Advantage plans,
11 we could take that $2,000 and really fund these community-
12 based agencies that are trusted, instead of running this
13 money through insurance companies.
14 Okay. So this is my last comment. Each plan
15 sponsor also has to develop all this infrastructure to make
16 this happen, and I'm wondering how much does that cost?
17 How much are we paying for this infrastructure? So the
18 idea that I have is that whether it's dental, vision, and
19 hearing, which are very valuable, or these additional
20 things, do we need to give people an HSA? I mean, if we're
21 going to have this extra money, decrease the administrative
22 overhead by just giving people an HSA and saying here are

1 the things they can be used for. If we do it that way,
2 it's competitive. They have to go to the individual and
3 say, "Here's this dental care at this price." Oh, I could
4 get my cleaning over here for cheaper."
5 You could track it with your card. And frankly,
6 I think it's a little paternalistic for us to create these
7 programs, because poor people, or just people in general,
8 know how they want to spend their money.
9 So I'm beginning to wonder if we just need to
10 hand them -- if we're going to keep giving people these
11 extra benefits, maybe just give them an HSA. I totally
12 agree that we need standardization. I also think we need
13 stabilization. So year after year, your dental was
14 reimbursable. Now you've got to go to this dentist. It's
15 too much.
16 So we standardization and stabilization, and I
17 hope we will consider, if we're going to continue driving
18 social services through health care insurance companies,
19 that we think about an HSA. Thanks.
20 MS. KELLEY: Scott.
21 DR. SARRAN: Excellent work, Stuart. As I was
22 sitting there reading through things and listening today,

1 it seems to me that there are three parts to this whole
2 piece about supplemental benefits. One is standardization,
3 and we've had some good discussion about that. Second is
4 transparency, visibility into the utilization of those
5 benefits, and that's your excellent work that you presented
6 and we've discussed today. Those are essential for sure.
7 What I think we're still missing on, but I think
8 it's actually achievable, is in order to really close the
9 loop, if you will, on whether the private sector is able to
10 innovatively offer benefits that are not just of value but
11 are improving outcomes we need some way of getting a sense
12 of how the benefits are, in fact, leading towards better
13 outcomes. And it strikes me that the CAHPS survey might be
14 a perfect vehicle for that.
15 I think, if I remember correctly, that right now
16 there is only one generation question in CAHPS that touches
17 on this, and I think it's something, "Does your health plan
18 offer you extra benefits because you have a health
19 condition?" So that is somewhat tangential to what we're
20 thinking about here.
21 But if you think about, for example, dental,
22 vision, hearing, food, and exercise -- top five -- you can

1 have CAHPS questions that start, "Does your plan offer any
2 or all of the following five?" And then second question
3 would be, "Did you use any or all of those?" And then for
4 dental, vision, hearing, the question could be, "Did it
5 help your reduce your out-of-pocket spending this past
6 year?" Second question could be, "Did it help you address
7 concerns with your teeth, your dental care, your vision,
8 your hearing?" Third question, which is sort of the
9 ultimate, would be, "Did it help you improve your function
10 or your quality of life?" And other people are much better
11 than I am at understanding how you would word those.
12 For food you could ask, "Did this address any
13 food insecurity?" For exercise, "Did it enable more
14 consistent, better health habits?" Something like that.
15 So it just seems to me that that's what we want
16 to get at, I think, is those three things, unless we go to
17 an HSA model, which is for sure worth exploring, then I
18 think we do want to see some improved standardization or
19 increase in standardization. I think we definitely need, as
20 you teed up today, much better visibility into what's
21 actually being utilized.
22 But I'd really like to see us at least tee up the

1 possibility. I know we're not ready to make
2 recommendations, but think about how CAHPS has been a very
3 useful tool for getting at ultimately what we care a lot
4 about, which is beneficiary function and outcomes, that
5 that could be a perk, potentially, a perfect vehicle for
6 sort of closing that final loop.
7 MR. MASI: Kenny, did you want to get in here?
8 MR. KAN: Thanks, Paul. Stuart, in your SNP you
9 show 77 percent out of benefits. I suspect most of that is
10 the flex cut OTC benefit. Is that true?
11 MR. HAMMOND: So those data are based on the
12 projections from plans and don't provide sufficient detail
13 to say which services are within that other category.
14 MR. KAN: So the reason why I'm clarifying that
15 is I see that Scott and Gina actually raised the HSA idea.
16 Being that the D-SNP market and in a lot of C-SNP markets
17 there is already an HSA. It's called FlexCard. So that's
18 already being done. So this is one of the examples of
19 benefit innovation, to Brian's point, that the private
20 sector will find a way to innovate. Thank you.
21 MS. KELLEY: Betty.
22 DR. RAMBUR: Thank you. Fascinating chapter and

1 interesting conversation.

2 Before I launch into my comments, I just want to
3 say that the HSA idea is a very intriguing one, and I
4 certainly think that should be exploring, seeing how it's
5 worked in other sectors.

6 Listening to the presentation, I'm not sure what
7 it really costs to obtain the data, but it seems like a lot
8 of it is right there, and regardless of that, we're
9 spending a lot of money as a nation, and these are very
10 vulnerable purchases. So we have to have that data.

11 Cheryl mentioned penalty for incomplete
12 submission. I would think that's the very first step. It
13 should be a condition of participation. If you want to
14 play in this lane, here are the rules. I mean, I think it
15 was Reinhardt that said something like "competition without
16 some regulation is called a brawl."

17 So I think that's really important because I
18 think the paradox of choice is really serious. There is so
19 much choice that there isn't any choice. And I do think
20 some level of standardization actually can enhance the
21 market working, because people can know what they're
22 purchasing or not. And I know that we're not discussing

1 that now, but I think that's important.
2 I want to plus-one on Robert's and others'
3 suggestions about outcomes and potential for parallel
4 benefits in traditional Medicare.
5 So those would be the things that I would see as
6 really important next steps. Thanks.
7 MS. KELLEY: Larry.
8 DR. CASALINO: Yeah, Stuart, really nice work,
9 even if you didn't do it all yourself. My thoughts aren't
10 quite as organized as I might like but I'll make up for
11 that by talking faster.
12 [Laughter.]
13 DR. CASALINO: It's not more coherent. So I
14 think it was Cheryl who said it would help if we knew more
15 about why people aren't using benefits that are available
16 to them, and if there's a way to learn more about that I
17 think that would be useful. In some cases, beneficiaries
18 are probably not aware of some of the supplemental
19 benefits, but my guess is that the bigger problem is
20 they're hard to understand, they're hard to use, and often
21 very limited when you actually get behind the checkmark or
22 demo and vision and see who can give it to you, how many

1 times can they give it to you, what's the network, is there
2 prior authorization, do you get reimbursed or is it paid
3 for up front. These are a lot of things.
4 I mean, I, myself, with the insurance I've had
5 over the years, employer-based commercial insurance, often
6 on dental and vision I don't think I've done very well.
7 It's just too complicated to figure out, even for someone
8 who can use the internet, and so on and so forth.
9 So I think having the checkmark obviously is not
10 enough. That's kind of ridiculous. So learning more about
11 why beneficiaries don't use benefits.
12 I think we're not really talking about
13 standardization. I know that will happen again in the
14 future. But it's hard not to mention it in a discussion
15 like this.
16 You know, I think Brian's concept that in early
17 stages of anything -- let's just say benefits here --
18 standardization may not be that desirable when there's
19 still a lot of room for innovation. On the other hand, the
20 choice problem for beneficiaries is really ridiculously
21 hard, and in general, with the supplemental benefits even
22 harder. And this is an acute problem, and we're spending a

1 lot of money on it.

2 So at the very minimum, without doing widespread

3 standardization, thinking ways to make beneficiaries'

4 choices plan easier but also trying to find ways that they

5 can understand what the beneficiaries they have are, and

6 especially how they can use them. That would be innovative

7 to do that.

8 And then just to finish up, two quick things.

9 One is, it would be really good if you can get it, to have

10 more information on the extent of CMS monitoring. Well,

11 first of all, are there plans that consistently

12 overestimate what they're going to spend on benefits? I

13 don't know if you have a sense of that or not, but if you

14 do it would be great to hear it. If you don't, it would be

15 great if that information is available.

16 So are there plans that consistently overestimate

17 spending on benefits? Does CMS monitor that? What's the

18 magnitude of the overestimate, and does CMS ever do

19 anything about it? I think that's all really important,

20 and it would be great to get more information on that.

21 And the last thing I'll say, a little off topic

22 but Gina brought it up. I think we aren't talking about

1 this that much on this Commission, but I think we do want
2 to be careful about medicalizing social benefits, and
3 particularly placing these social services in the hands of
4 -- you know, we wouldn't put social services in the hands
5 of ExxonMobil. Why would you put them in the hands of a
6 corporation that's just about as large at health care?
7 Local does matter.
8 And I'll just finish off by saying years ago I
9 was a part of a group for CMS that actually went to a call
10 center for one of the big HMOs, and they were trying to
11 sell how great they did on managing their patients' care.
12 And I think the call center was in Atlanta, and it was this
13 big, bright office with lots of nurses sitting next to each
14 other in cubicles, calling patients. And if I remember
15 correctly, they were calling patients in rural Mississippi.
16 And it was just a joke. I mean, you had this
17 bright, young nurse, saying, "How are you today, Mrs. So-
18 and-So," blah-blah-blah, just as fast as she can, going
19 down her checklist. And the patient is saying, "Well,
20 honey, you know, I'm kind of poorly today." "Oh yes,
21 well," and then going to the next question. It was
22 completely worthless, worse than worthless.

1 But that's kind of what you get if you turn --
2 this wasn't really social services, but I think that's what
3 we would get if we turned social services over to
4 ExxonMobil, for example.
5 MS. KELLEY: Amol.
6 DR. NAVATHE: Thanks, Stuart, for this fantastic
7 work, and I appreciate all the dialogue and comments from
8 the Commissioners. I think it is a complex topic, at a
9 high level, and certainly I think the work that you've done
10 here has at least helped to start to lay some of the
11 groundwork around what's happening, a big question, which I
12 think the reading materials also very nicely lay out, is
13 it's a big question that's about value, and that's very
14 challenging.
15 I think, in some sense, it is interesting to kind
16 of observe how supplemental benefits have evolved over
17 time. On one hand, I think clearly these are really
18 important, I think if you think about the cost-sharing
19 reductions, the premium reductions, et cetera. Those
20 themselves just purely financially are very important. And
21 then there's the other dimensions of the non-medical
22 services also that clearly have a big impact, although I

1 think we know a little bit less about that than the health
2 outcomes piece of that. That's kind of interesting.
3 One of my reflections about this, which is
4 interesting, which may partly touch on this very general
5 HSA concept, is to some extent there is nothing stopping
6 the plans from trying to maximize how much they take their
7 supplemental benefit calculation, in terms of dollars, and
8 then put that into the premium reduction piece or the cost-
9 sharing reduction part. But at least anecdotally, my sense
10 is that's not what's happening. There is some allocation
11 of that that's happening outside of that, to these other
12 potential supplemental benefits, whether it's vision,
13 dental, hearing, or even beyond that, and we've seen more
14 and more of that occur.
15 Which strikes me in a couple of ways. So there's
16 imperfect competition here but there's some competition.
17 It strikes me that there's one. Obviously, there's
18 benefits to premium reductions for the plans. That's
19 something that accrues to everyone, whereas it's not
20 something that will be imperfectly used. So that may have
21 some benefit, at least for a profit-motivated plan.
22 On the other hand, it also highlights that

1 relative to just putting the dollars right back in the
2 pocket of the beneficiary, it seems that there is demand
3 for these other types of supplemental benefits. And to
4 some extent I think if we think about this in the context
5 of just how health care utilization works or how health
6 care works in our quasi-market sort of structure, if you
7 just put money back in my pocket and said, "Okay, Amol. Go
8 figure out how to get dental, vision, and hearing
9 services," like that's actually not necessarily that easy.
10 I don't have my own dental network, so I would have to
11 figure that out.

12 So having some structure that is provided to the
13 beneficiary as part of delivering these supplemental
14 benefits is itself probably quite intrinsically useful.
15 It's not just the dollars that are attached to that.

16 So I think we should just be thoughtful about how
17 we think about these pieces. I think there is the dollars
18 element of it that is certainly very important, but I think
19 there is also the structure of how we're supporting the use
20 of these different services that are clearly important. I
21 mean, I don't think anybody would disagree that dental and
22 vision and hearing are important for quality of life, for

1 any Medicare beneficiaries.
2 So I think that's just kind of one point I wanted
3 to make about this kind of structural aspect of how these
4 dollars end up impacting lives.
5 I agree with many of the other points that have
6 been made about health outcomes and value. I think, in
7 general, if you think about the Medicare program from a
8 statutory perspective, it was originally very clear that
9 it's about treating disease. And many of these
10 supplemental benefits obviously are extending beyond that
11 paradigm.
12 And so I think on one hand I think it would be
13 incredibly important to try to assess, to the extent that
14 these supplemental benefits are actually impacting health
15 outcomes, it would be great to know that, and I think,
16 Cheryl, you point it out well, some of these outcomes
17 actually may not be very discretely measurable from a
18 traditional health outcomes framework. We might have to go
19 ask the beneficiaries. We might have to do focus groups.
20 We might have to figure out how this is affecting their
21 overall quality of life. It may not show up in a mortality
22 statistic, or it may not show up in some other kind of hard

1 outcomes, which makes this certainly very challenging, and
2 I appreciate that challenge. I think it's great that we're
3 at least starting to inch toward that direction.
4 I also very much want to echo the comments that
5 Commissioners have made about transparency of choice. The
6 PlanFinder piece of this, the checkbox part I think
7 certainly makes sense. I think when we look at the overall
8 supplemental benefits landscape, what strikes me is that
9 there are areas where there is a lot less consistency in
10 the types of supplemental benefits that are being offered,
11 whether that's non-emergency medical transport or food
12 services or other areas. And so maintaining plan
13 flexibility there seems like it's paramount, because it
14 would be very hard to try to standardize something like
15 that.
16 On the other hand, if you look at dental, vision,
17 and hearing, which are so consistently offered, but then
18 there are so many different flavors of that ice cream, then
19 I think that kind of seems like the right setup in terms of
20 a relatively targeted way that standardization could help
21 support both competition and choice, in a meaningful way.
22 So I think we should be nuanced about how we talk about

1 these, because I think there are differences when we think
2 about the relatively large list now of supplemental
3 benefits that comprise that whole list.
4 The last point, because I can see Mike is getting
5 a little uneasy now, the last point I'm going to make here
6 is I think this symmetry point, we talked about it in the
7 Part D standalone versus MA Part D piece, the symmetry is
8 certainly not there, by definition, I think, between what's
9 happening in the MA program and what's happening in fee-
10 for-service here, which is challenging.
11 I think on one hand it feels like -- and I think
12 Tamara and Cheryl, I think maybe others, have mentioned --
13 well, what would it look like if we tried to bring some of
14 these benefits into the fee-for-service program? And while
15 I guess I don't know about the policymaker receptivity to
16 that or the politics of this, I do think it is a useful
17 conceptual exercise. And the reason I say that is because
18 to some extent it is really about what is the willingness
19 to pay of taxpayer, of policymakers of the government,
20 really fundamentally taxpayers, to finance these kinds of
21 benefits.
22 Because in some ways, because although they're

1 available on the MA side, there is intrinsically a
2 financing that's happening that could accrue back to the
3 taxpayer. Those savings, whether we believe that it's
4 relative to fee-for-service or higher than fee-for-service,
5 at the end of the day there is clearly expenditure that is
6 happening here, and that could either be passed back to the
7 taxpayer or it could be expended on these benefits.
8 So if we think about it from a flipped paradigm
9 of how much, in the fee-for-service program, would we be
10 willing to finance those for, that gives us a bit of a sort
11 of starting point, I guess, for that discussion. And I
12 think it's obviously hard because of the value piece of
13 this. But I just wanted to put a plug in for that sort of
14 conceptual basis.
15 So thank you, and Mike, sorry for going with the
16 long comment.
17 DR. CHERNEW: Yeah, that was long.
18 MS. KELLEY: Josh.
19 DR. CHERNEW: That was too long.
20 DR. NAVATHE: It's my last meeting, Mike. It's
21 my last meeting.
22 DR. CHERNEW: Yeah, I know.

1 DR. LIAO: Okay. Stuart, great work. Hearing
2 things from the other Commissioners I will try to be brief.
3 I think what I've heard, and I agree with data limitations
4 undergird so much of what we're talking about, we need more
5 data and better data. I think the other thing that I'm
6 impressed upon here is benefits aren't benefits. So we've
7 heard about presence of benefits doesn't equal the extent
8 or scope of them. I completely agree with that.
9 I think I very much resonate with Gina's point
10 that even having extensive, it doesn't mean that the use of
11 it is easy or even logistically doable. So I think
12 thinking those through.
13 And then I had a very similar thought to what
14 Amol and others have reflected too, which is that some may
15 be more amenable to pass outside of the current system
16 which is offered through plans, and some for non-monetary
17 reasons probably should stay. And so if we think about
18 benefits in that way, kind of the type of benefit, the
19 presence, the extent, and then ease of use, I think as we
20 get more data, I would love to kind of pass it through
21 those filters.
22 You know, ultimately, I think what we want in

1 anything that stays within this paradigm we have with MA is
2 implementation. So do we implement what we want? We want
3 reach, they get to the beneficiaries we want them to get
4 to. The more I think about effectiveness, obviously,
5 value, and what are the impacts here, and then maintenance,
6 so not just one year but multiple years, can that be
7 maintained that way.

8 So I think the last thing I would say in all of
9 that is I agree with other comments about standardization.
10 I think it's not black or white, and I think when you think
11 about variation across all the things I just mentioned, I
12 think dialing up some standardization is probably not bad.
13 I don't think it needs to throttle down the innovation, as
14 well. So thank you.

15 DR. CHERNEW: Okay. I'm going to do a very, very
16 quick sum-up since we're 10 minutes over. It is a very
17 important topic, and we will keep doing it.

18 So in no particular order, the first thing is
19 mailing things out to people isn't close to awareness, as a
20 general point of view. Don't send me anything because I
21 won't be aware. Not all beneficiaries should use all
22 services, so I think we shouldn't necessarily be worried.

1 I wouldn't go out and find someone, "Oh, you look like you
2 need a dental cleaning. You better go get one." I think
3 some things don't get used by everybody.
4 I don't think use is sufficient to assess value,
5 and that came out of Robert's and Scott's comments, and I
6 also actually don't think measuring use is necessarily
7 necessary to measure value. You could ask the value people
8 are getting from plans and not know all the various things
9 they're using.
10 So at the end of the day, all of this stuff leads
11 to how much admin costs we want to do to gather all this
12 stuff. I would much rather know it than not know it, but I
13 also worry a lot about the admin costs of getting it, and
14 for someone who has worked, for example, in the
15 transparency data for prices, and was told that was going
16 to be easy to get because they paid the prices, it's a
17 disaster.
18 I think it's important to ask why any claim would
19 offer a low-value service. If you want to attract
20 beneficiaries, why offer something they don't want? So one
21 answer is there is some set of people that want it, so
22 there's a selection concern. Are you trying to manage

1 selection? And then there's this vertical integration
2 concern that I won't belabor now to go into.
3 And the last thing I'm going to say is this HSA
4 idea is actually really, really intriguing, for a whole
5 bunch of reasons. But since I first heard about it
6 yesterday, we haven't fully given it some thought. But
7 that will potentially, at the minimum, get discussed.
8 We're going to take a 5-minute -- oh, Paul is
9 going to say something about a past recommendation, and
10 then we're going to take a 5-minute break.
11 MR. MASI: Yeah. Thank you for this conversation
12 and for this feedback. This is very helpful. Two things
13 real quick. So first, I just wanted to manage expectations
14 a little bit about all of the wonderful ideas we heard
15 here. I'm not going to name names. We will do our best to
16 incorporate what we can for this June chapter, in our June
17 reports, but obviously we heard a lot of continued interest
18 for doing additional work here, so some of that work will
19 spill out into future cycles, as well. So, as always, we
20 heard you and thank you for being patient.
21 And then just kind of a reference librarian note.
22 There was a lot of discussion around more complete data and

1 interest in more complete data. And I wanted to surface
2 that in 2019, the Commission made a recommendation both for
3 a framework as well as both incentives and penalties for
4 trying to improve the completeness of encounter data. And
5 that's something that we're happy to keep in mind as we
6 pursue this work.
7 DR. CHERNEW: Okay. Now we're going to take a 5-
8 minute break. We're going to come back. We're going to do
9 a tight 5 -- is that something that people say? I never
10 say that. But we're going to come back at like 3:12, and
11 then we're just going to start.
12 [Recess.]
13 DR. CHERNEW: Welcome back, everybody. We are
14 going to again continue our work on different aspects of
15 Medicare Advantage. This is essentially material that will
16 be not in our June report but is sort of the beginnings of
17 how we hope to approach a really important topic, which is
18 how Medicare Advantage is affecting providers. And if you
19 followed any of our December and January meetings, this is
20 really a core MedPAC challenge, I think a core
21 congressional challenge.
22 And so for that we are going to start with Jeff,

1 and Dante, it is great to see you there.

2 DR. STENSLAND: All right. Good afternoon. The

3 audience can download these slides by clicking on the link

4 in the upper righthand corner of your screen.

5 Today we explore the effect of Medicare Advantage

6 on rural hospitals. As you saw in your mailing materials,

7 we are not making conclusions today and do not plan to

8 publish this paper in June. Instead, we are looking for

9 ideas from Commissioners and from the research community on

10 future steps and methods for evaluating how Medicare

11 Advantage growth has affected rural hospitals and could

12 affect rural hospitals in the future. We are still at the

13 exploratory phase of research where our analysis and

14 methods are evolving.

15 Over the years we have talked to rural providers

16 and had focus groups with rural beneficiaries.

17 Increasingly, rural beneficiaries are seeing value in the

18 MA program and choosing MA over fee-for-service. However,

19 on our site visits to rural providers, we have heard

20 concerns about the effects of MA expansion on their

21 hospitals. Over the past two years, we visited eight rural

22 hospitals and spoke with administrators from several

1 others. We consistently heard concerns about Medicare
2 Advantage, including regarding prior authorization, denied
3 claims, MA steering patients away from relatively high-cost
4 rural providers, and concerns about rural hospitals'
5 ability to collect rates that are equivalent to fee-for-
6 service rates from MA plans.
7 All rural hospital representatives we spoke to
8 prefer fee-for-service Medicare as a payer over MA as a
9 payer.
10 The limited literature on MA in rural areas does
11 not provide an explanation for rural hospital
12 administrators' concerns. For example, one study published
13 this year concluded MA was associated with reduced
14 inpatient volume and reduced inpatient revenue. However, a
15 second study from two years ago concluded MA growth was
16 associated with slight improvements in rural hospitals'
17 financial condition. Neither study tied their results to
18 qualitative interviews or examined specific types of
19 services.
20 A third study looked at a cross-section of
21 hospitals and found higher margins at rural hospitals that
22 were in markets with greater MA penetration. However, they

1 stated that this was a correlation and may not be causal
2 because MA growth was not random, with MA growing faster in
3 rural towns with larger populations.
4 These three studies are limited in scope and do
5 not explain the concerns about MA rural hospital
6 administrators expressed on our site visits. Because of
7 that we decided to conduct our own research.
8 The roadmap for presenting our research is as
9 follows. We will start by describing the importance of the
10 special payments rural hospitals. We then discuss the
11 growth of MA. Third, we will compare how often rural MA
12 and fee-for-service beneficiaries bypass rural hospitals.
13 Then we will provide some evidence suggesting inpatient
14 volume declines when MA expands. And finally, looking at
15 data through 2023, we show that we have not found that MA
16 expansion has had a statistically significant effect on
17 rural hospital finances. And then I will explain how we
18 can have volume declines without revenue declines.
19 This slide shows the higher fee-for-service rates
20 that Medicare pays rural hospitals. Let's start with the
21 first row, which looks at critical access hospitals, also
22 known as CAHs. CAHs receive cost-based payments that are

1 about 40 percent above standard PPS rates. Because
2 Medicare is a large share of CAH revenues, this 40 percent
3 supplement to their rates represents a material part of
4 their total revenue. As we see in the second column, about
5 18 percent of the average CAHs revenue is due to the extra
6 payments they get due to their CAH status.
7 Given CAHs average profit margin of 4.2 percent,
8 these supplemental payments average 429 percent of the
9 average CAH profit margin. The implication is that CAHs
10 would face financial difficulty if MA did not pay rates
11 close to the special cost-based payments they receive from
12 fee-for-service.
13 The second row is rural PPS hospitals. Their
14 special payments are about 11 percent above standard rates
15 and are equivalent to only about 3 percent of all-payer
16 revenue. The net result is that for traditional PPS
17 hospitals, these special payments are less than their
18 average profit margin.
19 On our site visits, hospital administrators state
20 that MA plans generally pay rates based on fee-for-service
21 rates.
22 What this slide shows is how important it is for

1 CAHs to be able to continue to negotiate rates that are
2 similar to what they receive from fee-for-service Medicare.
3 This raises the question, why are we brining this
4 up now, and why is there so much concern about MA? These
5 extra payments to CAHs have been going on for 20 years.
6 The growing concern about MA is correlated with
7 increasing MA enrollment in rural areas. From 2018 to
8 2024, MA market share in rural areas grew by 20 percentage
9 points, with 47 percent of eligible rural beneficiaries
10 enrolled in MA by 2024. Rural enrollment is also
11 concentrated, with three insurers controlling 67 percent of
12 the rural MA market.
13 During our beneficiary focus groups, we asked
14 beneficiaries why they chose MA. Many said it was a lower-
15 cost option. MA allowed them to have an out-of-pocket
16 maximum liability without having to buy a Medigap plan.
17 They also appreciated receiving several extra benefits,
18 that Stuart just discussed, such as dental coverage,
19 hearing benefits, Part D drug coverage often for no extra
20 premium, and prepaid debit cards that can be used to
21 purchase over-the-counter medicines or groceries, in
22 certain circumstances. On average, these MA spending on

1 these supplemental benefits is over $2,000 per year.
2 Also, as we discussed in detail in your mailing
3 materials, CMS relaxed network adequacy requirements
4 starting in 2021. This made it easier for plans to enter
5 rural markets and enroll rural beneficiaries.
6 The reduced network requirements, and increasing
7 supplemental benefits, could both contribute to the growth
8 in MA that we have seen in recent years.
9 Now we shift to the concerns we heard on our site
10 visits. One concern was that MA patients will bypass the
11 rural providers and go to SNFS or lower-cost hospitals for
12 care. Shifting patients to lower cost sites of care is an
13 objective of MA, but that objective needs to be balanced
14 against the desire to maintain access to care in rural
15 areas. In this slide, we define bypass as when a rural
16 beneficiary uses a hospital that is 15 miles further from
17 their home than the nearest hospital.
18 We examined how often patients that were closest
19 to a rural hospital bypassed that hospital for one of four
20 services. We examined emergency room visits, which were
21 expected to have low bypass rates, MRI scans, which are
22 usually scheduled and expected to have high bypass rates.

1 We also examined bypass for the five most common conditions
2 at critical access hospitals, such as pneumonia and urinary
3 tract infection admissions.
4 Finally, we examined post-acute care in swing
5 beds. We examined this because payment rates for post-
6 acute care in swing beds at CAHs tend to be high and our
7 interviewees on our site visits said it was hard to get MA
8 to approve those post-acute care admissions.
9 Let's start by looking at critical access
10 hospital data in the first two rows. The first columns
11 shows that 21 percent of MA beneficiaries who lived closest
12 to a critical access hospital, traveled to a hospital that
13 was at least an additional 15 miles from their home for
14 emergency care. This was higher than the 14 percent rate
15 for fee-for-service beneficiaries that lived close to the
16 CAH. Note that we expect beneficiaries to not always use
17 their local hospital. For example if they were in a car
18 accident away from their home, they may use the nearest
19 hospital to the car accident. Therefore, these bypass
20 rates should be seen as fairly low.
21 For MRI scans rates were higher, and they were
22 similar for MA and fee-for-service patients.

1 The biggest rate of bypass is for inpatient care.
2 We see 60 percent of MA beneficiaries living near a CAH
3 bypassed the CAH for more distant hospital. Among fee-for-
4 service patient 37 percent bypassed. We also see
5 relatively high rates of bypass in the last column. This
6 means that 47 percent of MA beneficiaries that lived
7 closest to a critical access hospital bypassed that
8 hospital for a SNF or other source of post-acute care that
9 was 15 or more miles further from the patient's home.
10 Now let's look at rural PPS hospitals in the
11 bottom two rows. Here we tend to see lower rates of
12 bypass, and those rates tend to be more similar for MA and
13 fee-for-service patients. The biggest difference continues
14 to be inpatient admissions. The data indicate that 44
15 percent of MA patients that lived closest to a rural PPS
16 hospital bypassed that hospital for inpatient care.
17 Now comes the big caveat. We do not know if MA
18 is inducing the bypass or if people that are more likely to
19 bypass are more likely to enroll in MA. This graphic shows
20 a correlation, but doesn't prove causation.
21 If MA encourages more bypass for inpatient
22 services, we should see a greater decline in all-payer

1 admissions in markets with faster MA penetration increases.
2 In this slide we show fixed effects regression results. We
3 look at individual hospital admission levels over time. We
4 then ask whether admissions at that hospital were lower
5 than otherwise expected in years when MA penetration was
6 high.
7 Look at the first row. The first coefficient is
8 0.38. Because our dependent variable is the log of
9 admissions, This coefficient implies that a 10-percentage
10 point increase in MA penetration would reduce CAHs' all-
11 payer admissions by about 3.8 percent. We see an even a
12 bigger coefficient on post-acute swing bed days, implying
13 that a 10 percentage point increase in MA penetration
14 reduces post-acute swing bed days by 8.5 percent. This
15 would imply that MA plans are reluctant to pay high rates
16 for post-acute care, and that is consistent with the
17 incentives inherent in the MA program. That also matches
18 what we heard on site visits. The last column looks at
19 combined inpatient, observation, and swing bed days. The
20 net effect is smaller but still statistically significant.
21 I also include population growth in the slide
22 just to show that this generally matches what we would

1 expect with positive coefficients, though they are not
2 always significant.
3 The results for PPS hospitals are similar but
4 smaller in magnitude.
5 The results from this regression are consistent
6 with what we heard on site visits and with the bypass data
7 I just showed you.
8 Now I shift to the counterintuitive results. In
9 this slide we examine MA growth and its association with
10 changes in revenue, costs, and profit margins.
11 Intuitively, we may expect a decline in revenue following
12 MA penetration growth because we saw a decline in
13 admissions. That is not what we see. We see no material
14 effect on revenue, costs, or profits. If you look in the
15 first box. We see a coefficient of 0.01. I added the
16 standard errors to this graphic in parentheses to indicate
17 that the effect on revenue, costs, and all-payer margins
18 are not only close to zero, but they are smaller than the
19 standard errors, indicating they are nowhere close to being
20 statistically significant.
21 One reaction to this may be to assume that the
22 financial data is too noisy to generate statistically

1 significant results. However, we added the effects of
2 population growth to the slide. Population growth
3 generally does have a statistically significant effect on
4 revenue and costs. This suggests that when there is a
5 factor that has a strong effect on revenue and costs, it
6 will show up as statistically significant in the model.
7 The surprising results naturally leads to the
8 question of whether there could be some omitted variables
9 or other factors that distorts the regression results.
10 Dante, who is a visiting research fellow at MedPAC, will
11 now talk about an alternative method that could address
12 some potential biases in this model.
13 MR. DOMENELLA: One key concern with the previous
14 analysis is that MA penetration is not random. For
15 example, growth in MA penetration may also be associated
16 with changes in the underlying health of the population.
17 If changes in underlying health are also correlated with
18 changes in hospital volume or profitability, then the
19 relationships between MA penetration and volume and
20 profitability that we estimated on the previous slides
21 would be biased. Therefore, we leverage the entry of an MA
22 insurer into rural counties as quasi-random variation in MA

1 penetration. The idea is that if the entry of an insurer
2 predicts MA penetration, we can use entry to investigate
3 how hospital volume and profitability change after an
4 insurer enters. Putting the effects together, we can then
5 estimate the unbiased effect of MA penetration on hospital
6 volume and profitability in an instrumental variables
7 framework. The primary assumption that this approach relies
8 on is that MA entry can only affect hospital volume or
9 profitability through its effect on MA penetration.
10 To graphically show this strategy, we first show
11 how the entry of an MA insurer affects MA penetration. On
12 the x-axis, we see the year relative to insurer entry. For
13 instance, -2 corresponds to two years before entry and 2
14 corresponds to 2 years after entry. On the y-axis, we see
15 the effect of insurer entry on MA penetration. The dot is
16 the point estimate, and the bars are the 95 percent
17 confidence intervals.
18 These numbers represent the difference between
19 the counties affected by an entry and those not or not-yet
20 affected. The figure first shows that, prior to entry,
21 there is not much of a difference in MA penetration between
22 those affected by an entry and those not affected. This is

1 good news, since it makes us more comfortable interpreting
2 future changes in MA penetration to the entry of the
3 insurer and not to something else. Following entry, MA
4 penetration increases gradually. In the first year after
5 entry, MA penetration is 0.5 percentage points higher, and
6 5 years out it is 3.5 percentage points higher. The
7 average increase is 2.2 percentage points.
8 We then show in this figure how the entry of an
9 MA insurer affects inpatient stays. Again, the x-axis
10 shows the year relative to entry. Now, the y-axis shows
11 the effect of insurer entry on log inpatient stays at CAHs
12 and rural PPS hospitals combined. We present the combined
13 data, because the CAH and rural PPS hospital graphics look
14 similar.
15 Again, before an insurer enters, we do not see
16 much of a difference between those affected by an entry and
17 those not affected. After entry, we see little discernible
18 effect of MA entry on inpatient stays. While the
19 confidence intervals are fairly large, especially later in
20 the time horizon, we lack conclusive causal proof that MA
21 entry affects inpatient volume. When we jointly estimate
22 the effect of MA penetration on log inpatient stays using

1 MA insurer entry as an instrument, we find no statistically
2 significant effect of MA penetration.
3 Finally, in this figure we show how the entry of
4 an MA insurer affects a hospital's operating profit margin.
5 Now, the y-axis shows the effect of insurer entry on the
6 operating profit margin again at CAHs and PPS hospitals
7 combined. Before an insurer enters, we do not see much of
8 a difference between those affected by an entry and those
9 not affected. After entry, we also see little discernible
10 effect of MA entry on the operating profit margin, so we
11 lack conclusive causal proof that MA entry affects a
12 hospital's operating profit margin. When we jointly
13 estimate the effect of MA penetration on the operating
14 profit margin using MA insurer entry as an instrument, we
15 again find no statistically significant effect of MA
16 penetration.
17 In conclusion, both the fixed effects model and
18 the instrumental variables model fail to show statistically
19 significant effects of MA penetration on hospital profit
20 margins.
21 Now I will turn it back to Jeff to tie the
22 various analyses together.

1 DR. STENSLAND: All right. Just to summarize our
2 finding, First, we see that MA patients bypass rural
3 hospitals more than fee-for-service patients, and
4 consistent with the bypass data, our fixed effects
5 regressions suggest that there is a reduction in inpatient
6 admissions at the hospital when MA expands. In our
7 instrumental variables analysis, we also see a negative
8 coefficient on MA expansion of a similar magnitude, but it
9 is not statistically significant.
10 So this what I would call moderate but not
11 definitive evidence that we are seeing a decline in
12 admissions. However, don't see hospital revenue decline
13 when MA decreases. Those coefficients were close to zero,
14 and not statistically significant in either of our models.
15 This raises the question: Why isn't the
16 potential volume decline associated with a revenue decline?
17 The answer could be declining volume, decreasing MA
18 penetration, which is associated with declining volume
19 tends to increase fee-for-service and MA prices.
20 So why are these prices increasing when MA is
21 increasing? First, consider PPS hospitals. Most rural
22 hospitals receive a low-volume adjustment. Therefore, when

1 volume declines, prices increase. Also, for formulaic
2 reasons that would take too much time to go through here,
3 when volume shifts from fee-for-service to MA, a hospital's
4 uncompensated care payments per discharge increase, for
5 formulaic reasons. These uncompensated care payments could
6 be matched by MA if they pay fee-for-service rates, which
7 all of them have said that they generally do. The net
8 result is the lost revenue, which may come from reduced
9 volume, could be partially or fully compensated for with
10 increased prices per MA discharge and fee-for-service
11 discharge when MA expands in a market.
12 In the case of critical access hospitals, recall
13 that they are paid cost-based reimbursement. Therefore,
14 when volume declines, fixed costs are spread over fewer
15 discharges, and the price per discharge increases. Also
16 recall, that on our site visits, we were told MA plans pay
17 per diem payments based on fee-for-service costs per day.
18 This is not the actual costs of the MA discharge.
19 Therefore, because MA patients tend to have longer lengths
20 of stays, as we discussed last spring, MA revenue per
21 discharge may actually be higher than fee-for-service
22 revenue per discharge. That is due to longer lengths of

1 stay and per-diem payments.

2 This effect of MA on prices per unit could

3 explain the findings in the literature and the findings in

4 our regression results.

5 To wrap up, I want to say that this is a work in

6 progress, and we will continue to revise our analysis.

7 Through 2023, the data suggest MA growth has resulted in

8 reduced inpatient volume in rural areas, though it is not

9 definitive, but it has not significantly affected revenue

10 or profits, and those results are generally consistent

11 across all our models.

12 Going forward we will refine our analysis and

13 think about whether these findings will continue into the

14 future and if they hold for different types of MA plans.

15 I will now turn it back to Mike to start your

16 discussion.

17 DR. CHERNEW: Terrific. And we are just going to

18 jump into Round 2.

19 UNIDENTIFIED VOICE: Round 1.

20 DR. CHERNEW: Thank you. What I was thinking is

21 I hope we don't spend too much time going through all the

22 various econometric things because we don't have time to go

1 through all the econometric things. If you have clarifying
2 questions -- and I'm happy. Remember, this isn't going to
3 appear in a chapter. I'm happy to have separate
4 conversations, but I don't want to spend five minutes
5 sorting out all the econometrics.
6 DR. CASALINO: You don't want to spend half an
7 hour talking about the instrument?
8 DR. CHERNEW: I don't. But in any case, Tamara,
9 let's see what you want to say about this.
10 DR. KONETZKA: Thank you. Thanks for this great
11 work. I won't go into any of the details of econometrics
12 but I will say I am gratified that the paper really
13 acknowledges the different selection issues that might be
14 at play and really tries to get at them through some of
15 these methodologies. And so I'm pretty comfortable with
16 the fixed effects analysis, for example. So kudos to
17 pushing the methodology on this issue.
18 My question is basically, when we think about the
19 potential for MA to negotiate or lower their prices and not
20 pay fee-for-service, my question whenever I encounter
21 something like this, like fears about what they're going to
22 do in the future, is why wouldn't they do that already?

1 And so the fact that they keep paying fee-for-service
2 rates, or similar to fee-for-service rates, I guess my
3 question is why. You get at this a little bit indirectly,
4 but just a little bit more directly, like are there
5 underlying structural incentives, like network
6 requirements, et cetera, that makes this not really such a
7 big fear that they're going to sort of keep lowering their
8 prices and pay these hospitals less.
9 DR. STENSLAND: I think, you know, to me I would
10 start with, okay, getting these rates is a really big deal
11 to these critical access hospitals, so therefore, we want
12 to really pay attention to it. But when we look at the
13 data, we see they pretty much always have these rates in
14 the contracts. Everybody tells us this is what's in the
15 contracts. They say they don't always get paid because
16 there could be some claim denials or other things, and this
17 is the AHA data saying maybe we have a 2 percent lower
18 payment-to-cost ratio for MA and then fee-for-service. So
19 then the question is, well, maybe this will just continue,
20 and maybe that's true.
21 I think there are two things that have changed
22 that may give us pause. The one thing that's changed is

1 the network requirements have gotten looser with the
2 express purpose of trying to have more MA in rural areas.
3 But whether that is actually a positive for the beneficiary
4 or not is not clear.
5 The other thing is we've seen much bigger growth
6 in MA. So when you talk to these rural hospital
7 administrators, 10 years ago, if they couldn't come to an
8 agreement with an MA plan they lost those patients, it
9 wouldn't be such a big deal. But as MA becomes a bigger
10 and bigger share of the market, and given that three
11 companies have 67 percent of the market, there is this
12 question of is the negotiating position of the rural
13 hospital going to be reduced over time.
14 And there's also the question of, it kind of
15 depends on how big the benchmarks are too. If the
16 benchmarks are very generous and you're getting paid
17 substantially more than fee-for-service for having these
18 patients in, it may be easier to keep the full payment rate
19 in. That's kind of a long-winded answer, but that's my
20 answer.
21 MS. KELLEY: Okay. I have a couple of questions
22 from Lynn. She says thank you for the wonderful chapter.

1 The analytic approach is very impressive and she learned a
2 lot from the analysis. Great work. She loved the rural
3 bypass analysis, by far the best research she's seen on
4 this topic.

5 She is concerned about only 266 CAHs qualified
6 for the swing bed analysis, and wonders how many CAHs have
7 more than 10 swing bed discharges per year.

8 DR. STENSLAND: That would be -- I don't have the
9 figure in front of me, but I think it is the 266 that had
10 more than 10 discharges per year. Is that for the MA or
11 fee-for-service? I'm not sure which one. Yeah, 266 CAHs
12 had more than 10 MA discharges per year. Now 889 of them
13 had more than 10 fee-for-service discharges per year. So
14 that implies, especially given that there's a similar
15 number of fee-for-service and MAs, that the MA, it's harder
16 to have MA people admitted to your critical access hospital
17 for post-acute swing bed care. And this matches what we
18 heard on our site visits, in that the MA plans are
19 reluctant to approve this post-acute swing bed care
20 because, in part, that they're paying these CAH cost-based
21 rats, which are four times what they would pay if they sent
22 it somewhere else.

1 MS. KELLEY: She also wanted to know if you know
2 how much CAH rates vary from year to year. Do plans adjust
3 the rates dynamically or are they based on prior years?
4 And while profitability may be okay over time, how is cash
5 flow working? Many CAHs have very limited reserves. Is
6 there any correlation between closures or consolidation of
7 CAHs and MA penetration?
8 DR. STENSLAND: You know, we looked a little bit
9 at that, and we haven't seen any correlation there. My
10 best guess is there's some offsetting effect of you getting
11 higher prices and maybe lower volume, and we don't see a
12 correlation.
13 When she was talking about -- what was the first
14 part of the question?
15 MS. KELLEY: How much do CAH rates vary from year
16 to year.
17 DR. STENSLAND: Okay. so usually what happen is
18 CAHs are given the rate letter, and the rate letter is
19 updated every six months or a year, where the MAC says this
20 is what we think the costs per day are going to be for this
21 critical access hospital. And then the critical access
22 hospital gets the rate letter from the MAC, they send it to

1 the MA plan. The MA plan starts paying that rate. On the
2 outpatient basis, the rate letter will also say we're going
3 to pay you X percent of charges. So the CAH sends that to
4 the MA plan, and they pay them X percent of their charges
5 for their outpatient services. And that's the way it works
6 in most cases, and one place where they actually try to do
7 some cost report reconciliation. But that's the general
8 way it works.

9 MS. KELLEY: She just had two more questions. Do
10 we have any data on the relative profitability of MA in CAH
11 communities versus non-CAH communities? And because of
12 higher local costs on the benchmark, does this create
13 greater opportunities for arbitrage through steerage than
14 other opportunities for MA plans?

15 DR. STENSLAND: I don't think I'll speculate on
16 that, but certainly the bigger differential in pieces,
17 which I think is what Lynn is getting at, means you benefit
18 more by steering patients from one place to another. Like
19 the giant difference in post-acute care prices is going to
20 give you a big incentive to steer people away from critical
21 access hospital swing beds for their post-acute care.

22 MS. KELLEY: Thank you.

1 DR. CHERNEW: I thought we might have been asking
2 about the profitability of the plans.
3 DR. STENSLAND: We don't have any data on like
4 how much profit plans are making on their business in
5 individual counties.
6 DR. CHERNEW: Yes. So it's hard to tell plan
7 profitability across counties. But I will say they're
8 entering counties, so they're probably not losing money in
9 the counties they're entering. Just a guess.
10 MS. KELLEY: Okay. I have Cheryl next.
11 DR. DAMBERG: Thanks for a great chapter. I had
12 a question. So while the contracted price is similar to
13 the fee-for-service price, there is a statement in here
14 that MA plans try to make payment reductions or deny
15 payment due to lack of medical necessity. So what I
16 couldn't recall in the data, are you able to track how
17 often they are denying claims?
18 DR. STENSLAND: We can't track that.
19 DR. DAMBERG: Okay.
20 DR. STENSLAND: We ask them and they give us some
21 subjective feelings of what they think in terms of their
22 getting declined, and they often have antidotes. The best

1 piece of information I've seen from one of our site visits
2 is there was somebody who tracked the number of times their
3 people had to try to get the claim paid. So like what
4 share of the time do we touch it once, if we get. What
5 share, two, three, four. And you would see, for the MA
6 claims versus the fee-for-service claims, they were more
7 likely to be touched two, three, or four times, rather than
8 just one time, and get paid.
9 DR. DAMBERG: So the hospital is bearing a lot of
10 administrative costs to process these claims.
11 DR. STENSLAND: Yes.
12 DR. DAMBERG: Okay. Thanks.
13 MS. KELLEY: Robert.
14 DR. CHERRY: Thank you for the strong work here.
15 I have question. It's more on Slide 9, regarding rural
16 bypass rates for ED, MRI, and patient admissions in swing
17 states in the post-acute space. So I'm not sure bypass is
18 actually the right word. It brings a certain context to
19 mind.
20 But if you have, let's say, a low-acuity patient
21 that doesn't require an ambulance, and they're being
22 brought in by someone else or driving themselves, they

1 might choose to go to a hospital that's further away if
2 it's in network, and the closer hospital happens to be out
3 of network, because the out-of-pocket costs might be less
4 or because they're motivated because their care team is at
5 that hospital, even if it's further away.
6 The other example is the closer hospital could be
7 in network but they might choose the out-of-network because
8 their provider that told them to go to the emergency
9 department happens to be in network. So sometimes the
10 facility and the provider don't match, and a patient may be
11 making a decision to go to one hospital or the other,
12 depending on if the provider and/or the facility is in
13 network or not.
14 So my question is, what is around whether it's
15 around ED visits or inpatient admissions, did you take into
16 consideration whether or not the facility or the provider
17 were in network, and that may be what is driving a patient-
18 made decision as opposed to an ambulance or some other
19 reason.
20 DR. STENSLAND: All we can say is that, you know,
21 essentially for the fee-for-service patients, everybody is
22 in network. For the MA patients, any sort of higher bypass

1 rate that you see, that could be due to network and
2 everything else that might come into play.
3 DR. CHERRY: Yeah. That's what I kind of
4 thought, so thanks.
5 MS. KELLEY: Kenny.
6 MR. KAN: Staying on page 9, just curious. Have
7 you taken a look at the data regarding non-ED outpatient
8 visits? Because in March, the Commission actually approved
9 a recommendation on the bene cost-sharing to sort of limit
10 that, to shift it away from a cost-plus reimbursement. So
11 I'm just curious if some of this "bypass" could be
12 attributed to the sphere of the co-insurance whereas with
13 MA you know what you get. You know, there's a little bit
14 more certainty and predictability, which is one of the
15 benefits of MA.
16 DR. STENSLAND: Yeah, I don't think we see it in
17 the data. Like if you look at the MRI scans, the MA is
18 often a fixed payment for your outpatient, and the fee-for-
19 service is often, it was 20 percent of your charges. But
20 when you look at the bypass rates for the critical access
21 hospitals it's 45 percent for MRI for MA and 44 for fee-
22 for-service. So you don't see a big difference. And

1 generally, when we talked to the people on our site visits,
2 we said, "Do you see this as a problem?" and generally they
3 say they don't see it, I think because something like only
4 16 percent don't have the supplemental insurance, and
5 amongst those 16 percent, I think a lot of them don't
6 understand how actually the coinsurance is set in these
7 rural communities. Because it's fairly complicated, and
8 also, it's possible that the people that don't have
9 supplemental insurance, that aren't paying that, might be
10 less sophisticated or have less resources to pay anyways.
11 MS. KELLEY: Amol.
12 DR. NAVATHE: Thanks, Jeff and Dante. Great
13 work. So one question, which is a bit of a clarification
14 from some prior questions, and then a separate analytic
15 type of question.
16 When you're talking about why, I think Tamara had
17 asked a question, why would we see lower rates or if there
18 is market power, kind of that gist of question, is it a
19 factor here? Am I correct that if they're out of network
20 then the default payment rate becomes Medicare fee-for-
21 service? So in some sense, especially if we look at like
22 acute inpatient admissions, where they are probably not

1 super elective, is that the kind of reference point, in
2 some sense, so therefore it's not really that effective to
3 try to negotiate against that, because then the provider
4 can just say I'm not going to be in network. Then he's
5 going to come and admit them because they need to be
6 admitted, per EMTALA and that kind of stuff. Is that also
7 a factor at play here?
8 DR. STENSLAND: That's often what they say when
9 they're surveyed. It's a big factor in the negotiations,
10 and that kind of anchors things.
11 DR. NAVATHE: Okay. Great.
12 DR. STENSLAND: You know, we occasionally see
13 some people that say, "Oh, we're able to negotiate 101
14 percent of the fee-for-service rate," but, you know, you're
15 in a super-tight band.
16 DR. NAVATHE: Okay. Super helpful. And then my
17 second question is, I think this is Slide 9 and Slide 10,
18 where you're showing the kind of descriptive bypass rates
19 and then the regression results. And you point out that
20 there is a distinction between the MA and the bypass for
21 inpatient stays, for example. But if you look at the
22 critical access versus the rural PPS, they're a little bit

1 different but they're actually pretty similar overall, and
2 at least in the regression they're almost certainly going
3 to be overlapping in their confidence intervals.
4 So if we look at this, and we kind of believe
5 this, does that tell us, to some extent, that the payment
6 differential is very unlikely to be a factor in driving the
7 bypass piece of this, because the rural PPS payments, those
8 hospitals aren't getting paid the higher CAH rate. So it
9 kind of lumps into cost-sharing a little bit also. Is that
10 a fair way to interpret what's happening here?
11 DR. STENSLAND: I think that's a fair way to say
12 that the -- first of all, the difference on inpatient
13 admissions aren't that big.
14 DR. NAVATHE: Right.
15 DR. STENSLAND: And so it looks like, from the
16 inpatient side, that we're not seeing that much of a
17 difference between the CAH and the rural, I think, due to
18 the implication that there isn't some big price
19 differential driving a big difference.
20 We do see a little bit of a difference, maybe you
21 could say, in the post-acute swing bed place, and that's
22 where the price differential is big. Because if you are a

1 rural PPS hospital, you just get a SNF rate for your swing
2 bed patients. So you're getting one-fourth as much as the
3 CAH is getting.
4 DR. NAVATHE: Right. Yeah, that totally makes
5 sense to me, because I would think that in the post-acute
6 setting there's a lot more opportunity for the plans to
7 also use some sort of utilization management tool that
8 could influence that. Whereas on the inpatient admission
9 side, that's probably not impossible because of elective
10 admissions. But probably a lot less of a factor.
11 So that's why I was kind of focusing my
12 interpretation based off the inpatient piece. Okay.
13 Awesome. Thank you.
14 MS. KELLEY: Brian, you had something on this
15 point, but why don't you just go ahead with your Round 1
16 questions also.
17 DR. MILLER: Okay. On this point was about
18 network care. So it matters what type of MA plan it is,
19 right. If it's a PPO and your out-of-network care that's
20 reimbursed at fee-for-service rates. If it's an HMO and
21 it's non-emergency care, I'm not sure that it's subject to
22 that, because I think that is for emergency care out of

1 network you are paid at the fee-for-service rates in an
2 HMO. Scott is nodding his head in agreement.
3 So I think the plan benefit design, network
4 design, features matter.
5 DR. NAVATHE: Oh, I see. I personally didn't
6 realize that. I thought that the default for out of
7 network was fee-for-service, and the reason that, for
8 example, in dialysis you see the higher rates is because of
9 the capacity constraining, and the need to get like a
10 service --
11 DR. MILLER: Yeah, so dialysis, I guess,
12 technically, could be considered an emergent service,
13 right. Because if you don't have dialysis, you will --
14 DR. NAVATHE: Right, right. Okay.
15 DR. MILLER: I could be wrong, but I'm pretty
16 certain that's the distinction, for the HMO/PPO. It's been
17 a little while since I looked it up.
18 DR. STENSLAND: I think I have the statute in a
19 footnote in the paper, and it all depends on whether you
20 are responsible for the payment or not. So I think Brian
21 is right. If you're an HMO and this is out of network --
22 DR. MILLER: And it's not emergent.

1 DR. STENSLAND: -- and it's not emergent, you're
2 not responsible for that payment. So then the MA plan is
3 not responsible for that payment. But if it was emergent
4 or for some other reason, and there wasn't enough network
5 people so you did become responsible for it, then you have
6 this default.
7 DR. MILLER: Yeah, and the question you're asking
8 now about dialysis I imagine would be very easy to argue
9 that it is emergent, hence why many of those facilities --
10 Scott is shaking his head no.
11 DR. SARRAN: That's why plans pay so high for
12 dialysis, because they said you're going to have to form a
13 network.
14 DR. MILLER: Gotcha.
15 DR. SARRAN: -- a duopoly.
16 DR. MILLER: Yes. Problematic duopoly. So I had
17 two very quick Round 1 questions. One, I like the fact
18 that you went and visited facilities, talked with
19 everybody. Did you talk to patients in the hospitals and
20 the clinics, in addition to the -- I saw a list, all the
21 way from the ambulance driver to the board member, which is
22 great.

1 DR. STENSLAND: No, we didn't talk to patients.
2 DR. MILLER: But recognizing, of course, there
3 are always privacy concerns about that, that might be
4 something to consider at some point.
5 DR. STENSLAND: What we do do is we have
6 beneficiary focus groups. So we talk to people who have
7 been patients and say what was your experience like. But
8 we didn't think it was appropriate for us to go into a
9 hospital and walk into somebody's room and say --
10 DR. MILLER: No, no, I get that. But I'm saying,
11 when you're visiting the facilities to get that experience
12 of the people who maybe had recently had a clinic visit or
13 recently been hospitalized or recently been in a swing bed,
14 that could be beneficial, because then you can integrate
15 that with the direct feedback, positive and negative, from
16 ambulance driver to board member. But I agree, you
17 shouldn't go barging into anyone's rooms when someone is
18 hospitalized with pneumonia. That wouldn't be very nice.
19 My second question gets to the design issue. Did
20 we do the bypass analysis by plan type, say PPO, regional
21 PPO, HMO, or private fee-for-service plan? Because that
22 has very important implications. The reason I ask is that

1 an HMO plan could be not so functional in a rural area,
2 whereas a PPO plan, or a regional PPO, might be more
3 functional, have different results. And it might be that
4 the rural hospitals are having more difficulties with HMO
5 plans and less so with the regional PPO or PPO plans.
6 DR. STENSLAND: That's a good point. We could
7 try that. In the rural areas, the PPO model dominates.
8 MS. KELLEY: Betty.
9 DR. RAMBUR: Thank you. Very fascinating work.
10 I am sort of snagged on this issue of the bypassing of the
11 swing beds, and I understand from the plan's point of view
12 that makes total sense. And you probably don't have this
13 data, but to keep an eye out for it, I'm curious what the
14 beneficiary and their families' experience would be,
15 because wouldn't it end up that person in the post-acute
16 care being further from home? So it seems like that's
17 fairly significant in some very rural, isolated areas. I
18 don't know if you ran into anything about that. It kind of
19 dovetails on Brian's question. But I'm really interested
20 in the swing bed piece, post-acute.
21 DR. STENSLAND: The only thing that I have
22 related to that is I think when we looked at the swing beds

1 last time, maybe it was in the spring, in almost all cases
2 there is almost always a SNF within 30 miles of the
3 hospital. So it becomes subjective if you think that is
4 too far to go to save X dollars.
5 DR. RAMBUR: I do live in some really vast
6 states, 30 miles probably, so that answers my question.
7 Thanks.
8 MS. KELLEY: Larry.
9 DR. CASALINO: Yeah, I had a couple of questions.
10 Three, actually. One is, Jeff said denied claims don't
11 show up in the data. If you're a hospital and you submit a
12 claim and they deny it, that doesn't show up in the claims
13 data? For some reason I thought it did, but you're much
14 more likely to know that than I am.
15 DR. STENSLAND: No, I would have to go back.
16 When we did some looking at how that worked. Stuart might
17 have a thought, but I would have to go back and get that
18 for you.
19 DR. CASALINO: Okay. Because the question that
20 was asked originally about what are denial rates, that is
21 obviously an important question if you get it. Okay.
22 Second, so you showed fairly convincingly that

1 the administrators are wrong if they think that MA coming
2 in first and financially. Is that a fair interpretation?
3 And if it's not, then I don't have any other questions.
4 But if it is, why are they mistaken? You got kind of
5 unanimous feedback about that.
6 DR. STENSLAND: I'll give you my hypothesis, and
7 if there are any researchers out there you can test this
8 hypothesis. But what you think is I think the
9 administrators could very well know that they're having
10 more denials from MA than fee-for-service, and so they very
11 well may know that their payment-to-cost ratio is lower for
12 MA than it is for fee-for-service. And they may assume
13 that, okay, that means if we get more people into MA, our
14 revenue is going to go down.
15 But what I think they might not be aware of is
16 kind of the minutiae of now the payment system works. And
17 when you have more MA you get a higher price, due to things
18 like the way the uncompensated care payments work, which I
19 wouldn't be surprised if zero hospital administrators have
20 really thought about how that works.
21 So you're starting out here with fee-for-service
22 paying you more than MA, and then MA moves in and they both

1 move up, because now you're getting higher payment rates
2 due to the mechanisms of how those rates are determined,
3 through things like uncompensated care. And they may still
4 see that MA is paying less than fee-for-service, but what's
5 happened is you still have that differential but all the
6 boats were lifted a little bit.
7 DR. CASALINO: When you say paying less, you mean
8 less than the fee-for-service rates.
9 DR. STENSLAND: Yes.
10 DR. CASALINO: I'm sorry. That isn't what you
11 mean. You mean more denials.
12 DR. STENSLAND: Yes. Like the actual collections
13 would be a little bit less than you would collect under
14 fee-for-service.
15 DR. CASALINO: All right. And then my last
16 question is, even after you discussed it with Amol and
17 Brian -- it may just be me -- I still don't quite
18 understand what rates are what. So you refer fairly often
19 to paying fee-for-service rates. By fee-for-service rates
20 you don't mean kind of any old PPS hospital. You mean the
21 CAH's rates.
22 DR. STENSLAND: Yeah. The CAH's MA rates, it's

1 hard to overstate how much the MA rates are built on the
2 fee-for-service chassis.
3 DR. CASALINO: But is the payment rate that they
4 match the fee-for-service rate that a non-CAH hospital
5 would get, or is it the fee-for-service rate that a CAH
6 hospital gets?
7 DR. STENSLAND: It's essentially, they say, oh,
8 what did fee-for-service pay you per day last year for your
9 admissions. We'll pay you that. So they don't really
10 even try to go to try to compute what the cost is. They're
11 just saying what did fee-for-service pay for that specific
12 hospital last year; we'll pay that.
13 DR. CASALINO: Don't they have to, legally?
14 DR. STENSLAND: They have to for -- as we were
15 saying, if it's an emergency visit or something else where
16 they're responsible for paying. So if there were something
17 like -- this is why I had the MRI in the bypass there,
18 because conceivably that hospital could be out of your
19 network for an MRI, which wouldn't be an emergency
20 situation usually. And then so you could end up bypassing
21 it, due to the fact that your HMO wouldn't pay for your MRI
22 in that facility, because it wasn't in network.

1 DR. CASALINO: -- paying less in that situation.
2 Is it that the hospital receives the same amount as they
3 would receive from CAHs, but the patient pays more and the
4 health plan, therefore, has to pay less, if it's out of
5 network?
6 DR. STENSLAND: If it's out of network and not an
7 emergency?
8 DR. CASALINO: Out of network, not an emergency,
9 what is the plan responsible for paying?
10 DR. STENSLAND: The plan might not be responsible
11 for paying at all.
12 DR. CASALINO: But the patient is.
13 DR. STENSLAND: But the patient would be.
14 DR. CASALINO: And the patient is paying, we
15 don't know what.
16 DR. STENSLAND: Yeah.
17 DR. CASALINO: All right. Thank you.
18 MR. MASI: Could I jump in real quick? So I
19 think one thing we've heard is interest in future work,
20 clarifying exactly who is responsible for what in different
21 situations. We're hearing that loud and clear. That's an
22 important set of information and we'll make sure to clarify

1 that as this work continues moving forward.

2 The second thing I wanted to emphasize is one of

3 the first sentences that Jeff said at the beginning of the

4 presentation, where at this point this work is very

5 exploratory so we're not drawing conclusions. We're very

6 much sharing the analysis we've done so far, and we're

7 really eager for feedback and ideas for future refinement.

8 So I just wanted to clarify that.

9 MS. KELLEY: Are we ready for Round 2, Mike?

10 DR. CHERNEW: Did Scott --

11 MS. KELLEY: Oh, I'm so sorry.

12 DR. CHERNEW: We are ready for Round 2, Mike.

13 MS. KELLEY: Okay.

14 DR. CHERNEW: And that means Greg.

15 MS. KELLEY: Greg is first, yes.

16 MR. POULSEN: Okay. Well, this is terrifying. I

17 mean, this is a great topic, great paper, great

18 presentation, and really complicated. And the fact that

19 rural hospitals are concerned is understandable.

20 You know, this is something that you hear a lot

21 from me, but I think that the outcomes of this are very

22 different depending on the MA plan that we're talking

1 about. Some tend to put real focus on rural areas and are
2 focused there. I will say what I'm about to say is much
3 more informed by rural PPS than by critical access
4 hospitals, because I just have more experience there.
5 I also wish that I could be watching Lynn's body
6 language with what I'm about to say. She may or may not
7 agree with me, so we'll see.
8 You know, integrated health plans, I think, that
9 cover rural areas have a remarkably strong track record of
10 not only paying in a way that is attractive to the rural
11 facilities but actually enhancing the care that takes place
12 in those communities. I think that we see, and probably
13 none of the folks that you talked to, I'm guessing, find
14 that you can have a really virtuous combination of local
15 accountability and enhanced, usually requiring local
16 enhanced telehealth, to bring a combination to the rural
17 communities that just simply isn't available in rural
18 communities in other settings and other environments. And
19 then they can connect payment mechanisms that are very
20 difficult to do in fee-for-service. And so there are
21 skills and, by the way, reward structures, that aren't
22 available in fee-for-service either.

1 You know, the basic model that I'm thinking of
2 here, and that exists in certain places is feasible in
3 rural communities that don't have integrated health systems
4 or health plans that are working with them as an owner.
5 But it requires a level of accountability that is not
6 comfortable for most rural hospitals. So the idea of
7 basically a rural capitation for the community that's being
8 covered. But there are examples of that where that's
9 worked in a really effective way. It tends to be in a
10 fairly small number at this point.
11 But it seems to me it would be unwise not to keep
12 in mind that there are real success stories in certain
13 places, and the organizations that come to mind are places
14 like Sanford in South Dakota, Gundersen in Wisconsin,
15 Presbyterian in New Mexico. To a lesser extent,
16 organizations like Geisinger and Intermountain that tend to
17 have big facilities but also some rural facilities have
18 examples of this, and they're capitation-like in
19 communities. And in some ways, it's an absolutely
20 wonderful model because these are people that know each
21 other, they take care of each other, they have the ability
22 to embrace and do the kind of things that when we

1 contemplate really successful managed care, they are able
2 to do that in really successful ways. But it takes a level
3 of cooperation that is difficult to do en mass. It takes
4 more focus.
5 But I'd sure hate to have us lose the thought
6 that that kind of really innovative but really capable
7 approach is possible in rural communities. So I'd just
8 like to toss that in, and in future rounds we may want to
9 contemplate talking to some of those folks.
10 So thanks very much.
11 MS. KELLEY: Okay. I have a Round 2 comment from
12 Lynn. She thinks, in Table 3, percentage change is more
13 important than percentage point increase. She is concerned
14 about how only 266 CAHs qualified for the swing bed bypass
15 analysis, given that this is a fundamental and common
16 service in CAHs. She is not sure she would eliminate all
17 CAHs that have less than 10 MA swing admissions, because
18 some MA plans may not allow swing beds at all.
19 She would qualify any CAH that has a minimum of
20 10 fee-for-service swing bed admissions for the analysis,
21 regardless of MA utilization.
22 fee-for-service cost-based reimbursement goes up

1 when volume goes down, was one point that was made,
2 buffering the effects of MA steerage and protecting the
3 CAH. The question Lynn has is, how much money does MA make
4 from CAH steerage, and how much does this steerage cost the
5 federal government in increased fee-for-service payments to
6 maintain access in CAHs.
7 And my next person in the queue is Brian.
8 DR. MILLER: Okay. A couple of thoughts. One I
9 know that throughout the day we've randomly talked at
10 various points about coding intensity. I just wanted to
11 touch for a second before I hit the rural issue, that CMS
12 kept the 5.9 percent coding intensity adjustment, and I
13 listened in on their call and looked at the transcript.
14 And they said they found that the minimum adjustment for
15 calendar year 2026 applied uniformly sufficient to reflect
16 the differences in coding patterns between MA plans and
17 providers under fee-for-service Parts A and B. Therefore,
18 we are finalizing our posed MA coding pattern adjustment
19 for calendar year 2026.
20 So that means the Biden administration and the
21 Trump administration have kept the 5.9 percent coding
22 intensity adjustment, thinking that that is sufficient.

1 They run the fee-for-service program but they are also the
2 regulator, as we know, of the Medicare Advantage plans. So
3 if they are seeing the data and they think the that coding
4 adjustment is sufficient, and we think our coding intensity
5 adjustment, or that same coding intensity adjustment is not
6 sufficient, we should be asking a question about why our
7 analysis is different, and so different from CMS's. So I
8 just wanted to flag that for us as a general MA question.
9 This whole question, back to the specific rural
10 issue, I have to say I'm a little bit surprised but also
11 not surprised. So do we think that the 1965 world of fee-
12 for-service, any-willing-provider network with no
13 utilization review is a reasonable benefit design for a
14 rural areas? I mean, I don't think that is necessarily
15 working well right now. I think the wheels have fallen off
16 the fee-for-service bus a little bit, and I think this is a
17 sign that perhaps we need to think about fee-for-service
18 differently to make it more affordable, make it more
19 targeted, and think about modernizing parts of the fee-for-
20 service program, whether fee-for-service needs to be more
21 like a PPO model or have differential cost-sharing for
22 different facilities to drive volume to those high-quality

1 rural facilities, those high-quality rural CAHs, so that
2 they can survive and serve the beneficiaries who need
3 access to care.
4 So the stress from MA, I think, another way to
5 look at that is that this is a sign that we need to think a
6 little differently about fee-for-service Medicare.
7 I also have to say to some degree some of the
8 rural hospital concerns about Medicare Advantage, to me,
9 make me a little suspicious, because I read Beckers, and
10 all I hear in Beckers is complaints about Medicare
11 Advantage. I don't hear those same complaints from the
12 hospital industry about Medicaid managed care, ACA plans,
13 ESI plans. All of those markets have utilization review.
14 They all have networks. They all have the same tools that
15 are used in the Medicare Advantage marketplace.
16 So if there were a specific problem in the
17 Medicare Advantage marketplace, I would expect to hear
18 hospitals complaining about that from other payers too.
19 That we do not hear those complaints makes me wonder if
20 there is a political reason for the complaints about the
21 Medicare program, because they like that fee-for-service,
22 any-willing-provide network without any utilization review,

1 and there is a centralized constituency that can be
2 lobbied, which is not necessarily the case for, say, the
3 state Medicaid MCO models, which have multiple
4 participants, who have a state-federal partnership, or the
5 ESI market which is much more fragmented, or the ACA
6 market, which is also more fragmented.
7 So I do think that there are utilization review
8 questions about process, in particular, that we should
9 address so that rural hospitals have fair access. We
10 should not be questioning whether utilization review should
11 exist, and we should have some degree of skepticism that we
12 are only seeing these complaints from rural hospitals about
13 the Medicare Advantage market and not about any of the
14 other managed care markets which make up all of their payer
15 mix. And if we're going to be direct about it, the
16 Medicaid MCOs are way more aggressive about utilization
17 review, and have way more narrow networks. So the fact
18 that we are not seeing those same complaints, to me, is a
19 huge red flag.
20 And looking at this work, I think it is really
21 interesting that we didn't find a systematic effect on
22 hospital profitability. We did find some changes in

1 utilization. We did find some anecdotal complaints about
2 utilization review, which I agree with definitely have
3 utility. There needs to be a better process for
4 utilization review. You need clearer ways that are
5 electronic and easy to submit information. You need
6 clearer timelines for how utilization review occurs, and
7 clearer guidelines for what the criteria are.
8 But I think when I look at this chapter, what
9 it's telling me is that having really, really rich Medigap
10 with an any-willing-provider fee-for-service network is
11 unaffordable and it's broken in rural areas. And also that
12 Medicare Advantage HMO models are also broken in rural
13 areas. Which suggests to me that perhaps the answer is
14 more of an MA-PPO or an MA private fee-for-service plan
15 option, or a modernization of Medigap.
16 So these are the sort of things that I think we
17 should explore in rural areas to help rural hospitals,
18 rural beneficiaries, rural doctors, which is benefit design
19 and managed care as a tool that we can use to make Medicare
20 affordable again for rural beneficiaries while making sure
21 that we clearly address the process issues with utilization
22 review.

1 And we should make the fax machine lobby be sad.
2 We don't want any faxes for utilization review. It should
3 be pretty easy, if you're a critical access hospital and
4 you have a patient that is hospitalized, and you have to do
5 utilization review or authorization for continuing
6 hospitalization, the doctor should be able to immediately
7 send the information from the electronic health record, not
8 a third-party portal, not a fax machine, not a PDF. Thank
9 you.
10 MS. KELLEY: Paul.
11 DR. CASALE: I'll be brief. Adding my thanks to
12 a really great paper.
13 I still think about that Slide 9, the
14 differential utilization of ED, and particularly clinical
15 conditions, and I know certainly the cost and coverage, et
16 cetera, could certainly be driving it. But I'm just
17 wondering if some of it could be clinically driven. And
18 under the common inpatient admissions, which has the
19 largest, on the list of those conditions, some of them are
20 more ambulatory-sensitive than others, and I just wonder if
21 it's possible to look at those conditions individually to
22 see if their differential is different for things like

1 septicemia versus pneumonia and such. It might just help
2 provide some further insight as to whether some of this
3 might be clinically driven. Thank you.
4 MS. KELLEY: Tamara.
5 DR. KONETZKA: I will also be brief. This is
6 just a pretty big-picture comment that is probably way
7 oversimplified. But I was increasingly uncomfortable
8 reading this chapter because basically we have a system
9 where we sort of subsidize rural hospitals that we want to
10 survive, using a per-admission differential kind of
11 payment. And then we're worried about, as MA grows, we are
12 worried about reduced hospital volume and lower prices
13 being paid to providers. And I think in any other world
14 those would be good things, that we're negotiating lower
15 prices and that hospital admissions are going down,
16 notwithstanding some difference in bypass versus actual
17 admissions going down.
18 So I guess my big-picture comment is that seems
19 just very odd, and we're kind of looking at it sort of very
20 much within the box here of how to deal this MA versus
21 traditional Medicare payment and the effects on the
22 hospitals. And this is where I realize it's

1 oversimplifying, but maybe we need to think about a
2 different way of subsidizing these hospitals rather than
3 these sort of cost-based, per-admission addons, right, that
4 we want these hospitals to survive, and rather than hoping
5 MA keeps up with traditional Medicare payments, and hoping
6 that's enough to keep these hospitals in business, that
7 there might be some other kind of lump sum or more direct
8 kind of payment, very different system. That's it.
9 MS. KELLEY: Scott.
10 DR. SARRAN: My sense is the big-picture take-
11 home from this work and its discussion is that we've got
12 two parties who are sort of talking past each other and not
13 working effectively together, with some real exceptions, as
14 Greg pointed out. So the hospitals make the points that
15 the hassle factor is huge, I get denials, I don't get paid
16 correctly. Your work suggests that at the end of the day
17 they do okay financially, which I can believe, but after a
18 huge hassle factor, they don't have a big administrative
19 staff to absorb that factor.
20 The plans' perspective, and I'm going to
21 oversimplify perhaps, is the hospitals don't play ball,
22 they're not willing to take risks, they keep wanting to get

1 paid for medically unnecessary services, and so it's a
2 lose-lose. And what's disturbing about that is, okay, on
3 the fee-for-service side, we recognize there are a lot of
4 round peg, square hole issues between PPS and rural
5 hospitals, so Medicare has correctly created all these
6 work-arounds, these bridges between round pegs, square
7 holes, CAHs, et cetera, right, cost-based payments. What
8 we want, on the MA side, of course, is for the private
9 sector to figure out the round peg, square hole.
10 So what I suggest is it would be worthwhile, I
11 think, to do some interviews with some of the more
12 successful partnerships between rural systems and MA plans.
13 If nothing else, it will be informative about what has
14 undergirded those successes, particularly plans that have
15 grown and achieved excellent Star ratings in rural areas.
16 Because my bet is if they've done that, they've done it by
17 a collaboration with, rather than beating up their local
18 providers.
19 MS. KELLEY: Cheryl.
20 DR. DAMBERG: Thanks very much for this chapter.
21 This is challenging work and I appreciate you throwing all
22 those analytic methods at it. And just to echo Tamara's

1 comment, controlling for these potential confounds and
2 selection effects is no easy task.
3 But I do think it's important to continue to
4 monitor payments by MA plans to rural hospitals and the
5 implications related to their financial health. And I
6 guess one of the things that caught my attention was that
7 the MA enrollment is concentrated with these three largest
8 MA organizations. And I think this builds a little bit on
9 Paul's comment about when you look at bypass, some of these
10 might be clinically driven related decisions.
11 And so I guess in a next stream of work I'm
12 wondering can we start looking at some of the heterogeneity
13 that's going on, as opposed to kind of some average effect.
14 So whether that's for looking at the bypass work or looking
15 to see are these effects more concentrated among hospitals
16 that are dealing with the three largest payers. But I
17 think it's worth thinking a bit more about trying to ease
18 out some of the difference across these different hospitals
19 MS. KELLEY: Mike, I think we're all set, unless
20 I've missed anyone.
21 DR. CHERNEW: Okay.
22 MR. POULSEN: Can I make a real quick comment? I

1 was trying to make it on point. But I think that when we
2 talked about the concern that people complain
3 disproportionately about Medicare Advantage versus other
4 programs that are also potentially using the same tools, I
5 think it relates to the point that we just made, which is
6 there are organizations -- and there are three of them --
7 that have a disproportionate share, and a couple of those
8 tend to be viewed as using, as a very strong tool in their
9 toolbox, denials and the onerous preauthorization. I think
10 that's why it's happening. I don't think it's for
11 political reasons. I think it's just that that's where
12 it's concentrated.
13 DR. CHERNEW: Okay. We've made up a little bit
14 of time, like that airplane that's trying to make it up in
15 the air, and I want to move on. We're going to take a very
16 quick break. I just want to say one thing.
17 This session, which actually I really enjoyed for
18 a number of technical and substantive reasons, combines two
19 important areas -- rural care and Medicare Advantage. And
20 one reason why we started here was not so much that we're
21 going to push to some recommendations, or this was intended
22 to drive us to any recommendations, but because there's a

1 lot of claims going back and forth that are constituent are
2 often worried about. So being able to answer sort of who's
3 right in this big debate or who's wrong in this debate or
4 what do we think about this debate is sort of a useful
5 thing to know. This allows us to simply say what we think
6 the facts are in relative ways. And, of course, facts are
7 hard to always say with certainty, but that's sort of why
8 we went down this path.
9 In doing so it will provide some prototype for
10 how we think about a bunch of other things. But right now
11 this is really just analysis to present the facts, what we
12 know about issues that many people that ask us questions
13 are actually interested in.
14 So to Dante, thank you so much. It's nice to see
15 you at our last meeting cycle, you get to sit here. And
16 Jeff, thanks for sitting here next to Dante. I really did
17 enjoy this.
18 We are going to take a very quick break and then
19 we're going to transition into software as a service. So
20 let's try and get back here by 4:30 at the absolute latest.
21 [Recess.]
22 DR. CHERNEW: Welcome back. We're going to bring

1 today home with a topic that we have mentioned before, and
2 we continue to ponder, which is software technologies, how
3 we pay for them in Medicare. And I think, Dan, you are
4 starting.

5 DR. ZABINSKI: Good afternoon. I'd like to start
6 by thanking Angie Grey-Theriot for her work on scheduling
7 interviews with software companies and insurers and for
8 taking notes during those interviews.

9 In this session, we will present a new episode in
10 our work on Medicare payment for medical software
11 technologies. The goal of this session is to get
12 Commissioner feedback on the material that we present and
13 to identify issues to focus on in our future analytic work.
14 For the audience, the slides for this presentation can be
15 accessed from the control panel on the right side of your
16 screens.

17 In the first part of this presentation, we will
18 discuss the definitions and characteristics of two types of
19 medical software technologies, software as a service, or
20 SaaS, and prescription digital therapeutics, or PDTs.

21 Next, we will discuss statutory requirements for
22 Medicare coverage and payment, which will be followed by an

1 overview of the current payment status of medical software
2 across fee-for-service Medicare payment systems.
3 We will then discuss results from interviews we
4 had with four software development companies and one
5 commercial insurer in which we learned about the process of
6 getting this software approved by the FDA, getting
7 insurance coverage, billing for use of the software, and
8 how the users of these products pay the developers and how
9 the users are reimbursed through insurers. We will close
10 with a discussion.
11 In previous work on paying for medical software
12 technologies, we produced a chapter in our June 2024 report
13 to the Congress. This chapter included the following
14 topics: a presentation of the technologies that were
15 covered under the fee-for-service Medicare payment systems;
16 the FDA's requirements for clearance or approval;
17 Medicare's requirements for payment approval. And we found
18 that over time, CMS has approved increasingly more software
19 technologies.
20 Finally, we used claims data to estimate use and
21 Medicare payments for medical software technologies under
22 these fee-for-service Medicare payment systems. We did

1 find that CMS has had difficulty setting payment rates
2 under the Medicare physician fee schedule.
3 The medical software technologies that we are
4 focused on are those that are used or prescribed by
5 clinicians for one or more purposes without being part of a
6 hardware medical device. These medical software
7 technologies fall into two categories: software as a
8 service, or SaaS, and prescription digital therapeutics, or
9 PDTs.
10 SaaS includes algorithm-driven software that can
11 be assistive to clinicians' medical assessments,
12 augmentative to diagnostic tools, especially imaging, or
13 autonomous in the sense that the software can make clinical
14 diagnoses. An example is an AI-based diagnostic system
15 that detects diabetic retinopathy.
16 PDTs are software products prescribed by
17 clinicians that treat an illness or injury and are
18 typically furnished to patients on a cell phone, tablet, or
19 smartwatch. An example is a software that delivers
20 cognitive behavioral therapy to treat chronic insomnia on a
21 patient's mobile device.
22 The first step getting a medical software

1 technology paid under the Medicare payment systems is to
2 obtain FDA approval or clearance.  FDA considers these
3 technologies to be medical devices.  FDA uses a 3-tier
4 system to categorize medical devices by risk:  Class I,
5 Class II, and Class III, where Class I is the lowest risk
6 and Class III is the highest risk.
7 FDA classifies most SaaS and PDTs as Class II,
8 meaning the FDA considers these technologies to pose a
9 moderate risk and are subject to special controls such as
10 performance standards, post-market surveillance, or patient
11 registries.
12 As Class II devices, SaaS and PDTs are typically
13 cleared through the 510(k) or DeNovo pathways.  Under the
14 510(k) pathway, the developer demonstrates the technology
15 is "substantially equivalent," meaning it is as safe and
16 effective as another technology already on the market,
17 referred to as a predicate.
18 Under the DeNovo pathway, the technology does not
19 have a predicate. In these situations, the applicant may
20 have to furnish clinical data that demonstrates that the
21 benefits of the technology outweigh the risks.
22 This graphic shows a typical flow of payments

1 that occur between technology companies, technology users,
2 and insurers. On this slide, we use a physician's office
3 as an example.
4 In this example, a technology company enters into
5 an agreement with a physician to supply the technology for
6 a fee. There may be some negotiation between the parties.
7 Sometimes the fee will be on a subscription
8 basis, where the physician pays a monthly or yearly
9 subscription fee with a small additional fee per use to the
10 technology company. Other times the fee will be on what is
11 known as a "per click" basis, where the physician pays the
12 technology company for each use of the technology.
13 The physician then bills the insurer for
14 furnishing the service that includes the technology, and
15 the physician receives a payment from the insurer if the
16 requirements for coverage and payment are met.
17 SaaS technologies first gained Medicare payment
18 status in 2018. To gain payment status, SaaS items must
19 satisfy three criteria: It must be approved or cleared by
20 the FDA, and then after FDA approval, it has to fit into a
21 Medicare benefit category, such as inpatient hospital care
22 and hospice under Part A and durable medical equipment and

1 outpatient services under Part B, and it must not be
2 explicitly excluded by law.
3 Finally, it must meet other statutory
4 requirements including being reasonable and necessary for
5 the treatment of an illness or injury. Note that these
6 criteria do not include improved outcomes or cost
7 effectiveness requirements.
8 SaaS items meeting these criteria are paid under
9 several fee-for-service Medicare payment systems including
10 the OPPS, physician fee schedule, and the IPPS.
11 In contrast to SaaS items, most PDTs do not meet
12 the statutory requirements for Medicare coverage. However,
13 coverage of PDTs for mental health treatment under the
14 physician fee schedule has begun in January 2025. But the
15 DME fee schedule is the payment system applicable to most
16 PDTs, and PDTs generally are not consistent with Medicare's
17 definition of DME and don't fit into other benefit
18 categories.
19 Medical software technologies have separately
20 payable status in several of Medicare's fee-for-service
21 payment systems. These technologies appear to be most
22 prominent in the hospital outpatient prospective payment

1 system, the OPPS, which currently has separate payment for
2 SaaS items in 19 HCPCS codes, which are billing codes in
3 the OPPS.
4 The physician fee schedule pays separately for
5 the same SaaS items as the OPPS. Also, the physician fee
6 schedule has a PDT for digital mental health therapy.
7 SaaS items are covered under the inpatient
8 prospective payment systems, the IPPS, but those items are
9 generally different from those covered under the OPPS and
10 physician fee schedule. And SaaS items are generally
11 packaged into payment for the relevant MS-DRG, rather than
12 paid separately.
13 The final fee-for-service payment system for
14 medical software technologies is the durable medical
15 equipment, or DME, fee schedule. There's coverage and
16 payment for some PDT items under the DME fee schedule, but
17 most PDTs do not meet the DME requirements.
18 Most of the 19 HCPCS codes for SaaS items that
19 have separately payable status under the OPPS provide
20 enhancements to imaging scans, so they're considered
21 augmentative. An example is SaaS items that provide
22 estimated fractional flow reserve from computed tomography

1 angiography, FFRCT, for patients with symptoms of coronary
2 artery disease.
3 For most SaaS items paid under the OPPS, use in
4 HOPDs for fee-for-service Medicare beneficiaries was low in
5 2023, but an exception was FFRCT, which had appreciable
6 volume of 14,000 uses and Medicare payments of $12.7
7 million. But no other HCPCS code had more than 570 uses or
8 more than $0.3 million in fee-for-service Medicare
9 payments.
10 Use and payments for SaaS items also has been low
11 in the physician fee schedule. In 2023, no HCPCS code for
12 SaaS items had more than 3,600 uses or more than $0.2
13 million in payments under the PFS. Most SaaS items paid
14 under the physician fee schedule are carrier priced because
15 CMS has had difficulty setting the practice expense portion
16 of physician fee schedule payment.
17 Under carrier pricing, payment is set by Medicare
18 administrative contractors, the MACs, usually on a case-by-
19 case basis. Therefore, there's typically a lot of variation
20 in payments. This contrasts with national payment rates
21 that CMS sets for most services.
22 Turning to the inpatient prospective payment

1 systems, the IPPS, under the IPPS, payments are for bundles
2 of services for treating conditions diagnosed and specified
3 in Medicare-severity diagnosis related groups, the MS-DRGs.
4 Under the IPPS, there is typically not a separate payment
5 for technology like SaaS because it is usually bundled into
6 the payment rate of the applicable MS-DRG.
7 But manufacturers of new technology can apply for
8 a new technology add-on payment, an NTAP, which provides
9 additional payments for two to three years after which the
10 item is bundled into the payment rate of the applicable MS-
11 DRG.
12 Currently, the IPPS has four SaaS items that have
13 NTAP status, but there is only one SaaS item had NTAP
14 status in 2023, and this item had 3,200 uses and $3.2
15 million in NTAP payments, and also the NTAP payments was
16 zero dollars for 56 percent of those uses.
17 Turning to the DME fee schedule, which is very
18 different from the other payment systems we've covered.
19 Medicare covers and pays for DME, which are medical
20 equipment prescribed by a physician and needed at a
21 patient's home, if it meets these five criteria: can
22 withstand repeated use; has an expected life of at least

1 three years; is primarily and customarily used to serve a
2 medical purpose; generally, is not useful to an individual
3 in the absence of an illness or injury; and is appropriate
4 for use in the home.
5 Most PDTs do not meet all criteria for DME
6 coverage and payment because they are usually used on a
7 patient's personal device, such as a phone, table, or
8 smartwatch, and these devices are not primarily used to
9 serve a medical purpose, which violates the third criterion
10 we just covered.
11 Now we turn to Jennifer who will discuss results
12 from interviews that we conducted with software development
13 companies and a private-sector insurer.
14 MS. DRUCKMAN: To gain a better understanding of
15 the challenges facing stakeholders in the markets for SaaS,
16 we interviewed four SaaS development companies and one
17 commercial insurer. The developers included two that
18 produce augmentative SaaS items and two that produce
19 automated software that diagnoses conditions.
20 Over the next few slides, we'll discuss what we
21 learned from the interviews by themes. We'll start with
22 the developer's perspective.

1 The first interview theme was the time it took
2 for the software developers to get FDA approval or
3 clearance. The developers that were first to apply for FDA
4 approval or clearance waited longer for decisions than
5 developers that were able to use an existing item as a
6 predicate. Some developers mentioned that the time and
7 cost of approval or clearance is a challenge for start-ups.
8 Lastly, some developers indicated that they had to obtain
9 additional approvals for situations they did not
10 anticipate, such as changes to software interfaces or
11 algorithms.
12 The next theme was regarding insurance coverage
13 of their technology. The developers reported that once
14 fee-for-service Medicare and Medicare Advantage covers and
15 pays for an item, other insurers such as Medicaid and
16 commercial insurers often follow. However, the developers
17 noted that Medicaid coverage was often challenging because
18 they had to work with individual states to obtain Medicaid
19 coverage. They also had to work with individual insurers
20 to obtain commercial plan coverage. Developers said that
21 insurers' coverage and payment of the technology was slower
22 than necessary because it was difficult to get insurers to

1 understand the value of their technology.
2 After a technology gains insurance coverage,
3 health care providers can bill the insurers for use of the
4 technology, but billing of a technology requires a billing
5 code. Unless an applicable billing code is available, the
6 developers said that the coding assignment process took
7 longer than they had anticipated, sometimes years.
8 Most developers interviewed expressed unhappiness
9 with the payment amounts established by insurers, including
10 Medicare and Medicaid, saying that the payment amounts are
11 too low.
12 Next, we turn to the insurer's perspective. The
13 main theme conveyed by the commercial insurer we
14 interviewed was the need for effectiveness data. This
15 commercial insurer emphasized that the technology
16 developers need to show the net benefit of the technology
17 to patients, which is not typically required for FDA
18 approval or clearance. This insurer said that the
19 technologies have a lot of promise, but many are new and
20 lack robust evidence, especially in the context of
21 comparative effectiveness, such as whether the technology
22 achieves the same or better results as existing technology,

1 or whether the side effects of the technology are known and
2 less bothersome than existing technology.
3 Finally, this insurer said that the technologies
4 are often created by nonclinical staff who may not be
5 familiar with the rigorous effectiveness data that the
6 insurer needs to pay for services furnished using the
7 technology. This can lead to delays in payment and
8 coverage.
9 We've reached the end of the presentation. For
10 discussion, we'll answer any questions, and we seek
11 feedback on our materials. We plan to continue to monitor
12 coverage, use, and Medicare spending for SaaS and PDTs. We
13 are interested in Commissioner ideas for future analytic
14 work.
15 Now I will turn it over to Mike.
16 DR. CHERNEW: Jennifer, thank you. Dan, thank
17 you. I think we're just going to jump into Round 1, and I
18 think we have this right, it is going to be Gina starting
19 Round 1.
20 MS. UPCHURCH: Anything with "prescription" in
21 the title gets my attention, so I appreciate that. PDT,
22 prescription digital therapeutics.

1 First of all, I really appreciate this. This is
2 a great overview of the situation, and I love that you
3 interviewed the people who are developing the technology as
4 well as the people who would be purchasing it. I think
5 that was really clever to give us both of those
6 perspective. And the insurance person that was talking
7 about everybody's got the secret sauce, but let's see, does
8 it really matter, and it is worthy, I think we need to pay
9 attention to that.
10 There's something in there that says payment for
11 PDTs for mental health treatment under physician fee
12 schedule began in January of 2025. Is that part of the
13 cost-neutral CPT codes? How does that get paid for?
14 MS. DRUCKMAN: So I believe it's carrier priced
15 for the amount of the payment, but they do have codes for
16 those services.
17 MS. UPCHURCH: So you don't have to decrease the
18 cost of other things because you're adding this. It's
19 additive.
20 MS. DRUCKMAN: Correct, in the PFS.
21 MS. UPCHURCH: In the PFS. Okay. All right.
22 Thank you.

1 MS. KELLEY: Josh.
2 DR. LIAO: Jennifer and team, thank you for this.
3 One, I have a couple of clarifying questions that I hope
4 are brief, related to how these -- I'm going to focus on
5 the SaaS side of things -- how it makes its way into these
6 different systems you talked about. So for example, in
7 IPPS, my understanding is, in that NTAP, an applicant would
8 have to submit through MEARIS and then submit some type of
9 information. And there's a cost threshold, and then you
10 take a 65 percent proportion of that.
11 When they submit to MEARIS, do they need to give
12 detailed proceeds, contract agreements, et cetera, or is it
13 simply a charge of the cases that include the SaaS that
14 they are reporting?
15 DR. ZABINSKI: I didn't catch the first part of
16 the question.
17 DR. LIAO: When the submit the application for
18 NTAP through MEARIS, what is the kind of cost data
19 requirements for the applicant? Do they simply say this is
20 the charge of our DRGs that use the SaaS, therefore it's
21 expensive, or do they have to give you receipts, contracts,
22 those types of things?

1 DR. ZABINSKI: The bottom line, it has to be
2 shown that it is costly in relation to the applicable MS-
3 DRG. I don't know what the percentage is, but that's the
4 guideline. The other things it has to meet is, it can't be
5 substantially similar to existing technologies, and it also
6 has to show that it has some clinical superiority to
7 existing technologies.
8 DR. CHERNEW: I think Josh is asking if they like
9 audit what the actual cost is, or if they just say, "Hey,
10 it was $10,000."
11 DR. ZABINSKI: CMS, I know they collect an
12 estimate of the cost from the developer, okay. If there is
13 information that are available, say, something that has
14 some figurative similarity to it, they will use that
15 information, as well.
16 DR. LIAO: That's helpful. The reason I ask is
17 my understanding, which could be wrong, and I'd love to
18 learn more about it, would be that, one, you're saying this
19 is how much the SaaS costs, you have to give some
20 information, of course, but the other route to get NTAP
21 approval is to say our charges that DRGs that include the
22 SaaS are this much more than DRGs that don't have it, and

1 that's a charge base. They standardize for wage index and
2 IME, et cetera, but it's a charge. And so the veracity of
3 that is unclear to me, so it's just helpful for me to know.
4 A quick follow-on to that, for codes that make
5 their way into OPPS, is it a similar process for applicants
6 if they submit through MEARIS and go through something
7 similar? How do we get those 19?
8 DR. ZABINSKI: Well, mostly you get the FDA
9 approval first, and then they try to get themselves a
10 HCPCS, or a CPT code. And then it has to fit into a, well,
11 if it's OPPS it fits into a benefit category. And that's
12 pretty much it. Now, these items cannot get, say -- even
13 though they're considered devices, they cannot get pass-
14 through status, because CMS considers them to be services.
15 But other than that, just getting the FDA approval and
16 getting a HCPCS code, that's pretty much it.
17 DR. LIAO: Got it. And then one last question.
18 I really appreciated your review of how carrier prices, or
19 what happens in the fee schedule. Do you happen to know if
20 MACs are doing this through LCDs or truly case by case?
21 You know, are the creating some local policy or taking it
22 claim by claim?

1 MS. DRUCKMAN: I believe they're taking it claim
2 by claim to set the pricing.
3 DR. LIAO: Okay. So they're not learning from an
4 LRMP or LTD that could be promulgated.
5 MS. DRUCKMAN: There may be. I don't think we've
6 searched for them. I think it's relatively new. There may
7 be some coming out.
8 DR. LIAO: Great. Thank you.
9 MS. KELLEY: Brian.
10 DR. MILLER: Thank you. So I will save my policy
11 questions for Round 2. So a couple of technical things.
12 One on Slide 6, the diagram with the technology company,
13 doctor, and the insurer, I do think that we should have a
14 relationship between the technology company and the insurer
15 that belongs on this diagram. And I'm also wondering where
16 the beneficiary is, because they should be in here
17 somewhere, and they should probably have a relationship
18 with the doctor, the technology company, and the insurer.
19 So I think those two edits to that figure.
20 And then I had a couple of questions. Do we know
21 how much collectively Medicare has paid for software under
22 OPPS, PFS, and IPPS, both separately and collectively, on

1 an annual basis, since 2018?
2 DR. ZABINSKI: Off the top of my head I don't
3 know. We could get that pretty easily.
4 DR. MILLER: Yeah, so that would be, I think,
5 great to put in there. And I think, then, in addition to
6 that, we should add the total amount of annual spending for
7 those years in those categories, because that will, I
8 think, illustrate quite well how little we are spending on
9 software.
10 I also appreciated the high specificity of noting
11 that 19 HCPCS codes are covered. I almost massacred that
12 acronym. It's hard to pronounce. How many, for the folks
13 listening, how many HCPCS codes are there in OPPS?
14 DR. ZABINSKI: For covered services, somewhere in
15 the ballpark of 6,000.
16 DR. MILLER: So to be clear, Medicare reimbursed
17 19 HCPCS codes for software, and there are over 6,000 HCPCS
18 codes. Okay, so we should make that clear.
19 And then my next question is, how many PFS or
20 physician fee schedule services are there?
21 DR. ZABINSKI: Probably similar, in the same
22 ballpark.

1 DR. MILLER: So it would be helpful --
2 DR. ZABINSKI: Probably about 9,000 or 10,000.
3 DR. MILLER: So we hit five digits. Wow. So
4 there are more services than the price of my last car. How
5 many PFS services did we cover for software, fully
6 autonomous software? Do you know?
7 DR. ZABINSKI: Fully autonomous. Well, one.
8 DR. MILLER: One. So Medicare covered 1 out of
9 10,000 PFS services, so we should also make that clear.
10 And how many PDT items are covered under DME?
11 DR. ZABINSKI: That has been -- you know, that's
12 --
13 DR. MILLER: That's not easy. That's why I'm
14 asking.
15 DR. ZABINSKI: I mean, I'm aware of 3.
16 DR. MILLER: Okay. And how many items are
17 otherwise covered under DME?
18 DR. ZABINSKI: No idea on that.
19 DR. MILLER: So we should figure that out. For
20 each of these areas, what I'm getting at is we should
21 clearly enumerate how many items or services are covered
22 for software, and then how many there are in the total

1 category, how much has been spent on software, and how much
2 has been spent in the total category. And my Round 2
3 questions will make it clearer why I'm asking that. To be
4 continued. Thank you, guys.
5 MS. KELLEY: Tamara.
6 DR. KONETZKA: Super interesting work. Thanks.
7 My question is, you know, aimed at trying to understand a
8 little more about the PDTs. It seems that the difficulty
9 of getting them covered under the DME is probably a little
10 unfair or outdated. Like when those rules were developed,
11 they weren't thinking about PDTs or software or anything
12 like this. People are putting them on their phone, and
13 they can use their phone for other things, but they're only
14 going to use that software for that particular purpose.
15 So my question is, if physicians actually
16 prescribe these things, and consumers end up paying for
17 them, have you come across literature that actually shows
18 their effectiveness, or is it mostly marketing literature?
19 Or are there actually studies that show some of these
20 producers and whether they, for example, reduce other kinds
21 of utilization, such that one would actually want to cover
22 them?

1 MS. DRUCKMAN: I think the research varies by the
2 device, and I think that's what the insurer was conveying
3 when we were interviewing them, is they felt that various
4 devices didn't have a similar level of robust evidence in
5 the way you're asking.
6 MS. KELLEY: Scott.
7 DR. SARRAN: This is kind of building off that
8 last question. You said there's three PDTs that are
9 covered currently.
10 DR. ZABINSKI: That's what I'm aware of. There
11 might be more.
12 DR. SARRAN: Do you know for what type of issues?
13 DR. ZABINSKI: Yeah. Let's see, there's one for
14 insomnia, there's one for substance use, and one for pain
15 management.
16 DR. SARRAN: Okay. And I think you mentioned
17 they are carrier priced and each MAC determines the fee.
18 Is the coverage, though, determined by the MAC or was there
19 an NCD?
20 MS. DRUCKMAN: I don't believe there's been an
21 NCD, so the coverage and the payments --
22 DR. SARRAN: The coverage and the payment are

1 local. Okay. so there's no NCDs in effect now that cover
2 a PDT.
3 MS. DRUCKMAN: I don't believe so.
4 DR. SARRAN: You don't think so. Okay. Thanks.
5 MS. KELLEY: That's all I have for Round 1,
6 unless I've missed someone.
7 DR. CHERNEW: No, I think that's good, and I
8 think we're going to start with to be continued.
9 MS. KELLEY: Brian.
10 DR. CHERNEW: A continuation.
11 DR. MILLER: To be continued. I was also saying
12 that I can offer my MedPAC comments for the cure for
13 insomnia, at lower cost, because I believe in product
14 competition.
15 So I think fundamentally this is a space not for
16 analytical work but for policy work, and I think perhaps
17 I'm looking at this fundamentally differently. The
18 question is, how can technology serve a beneficiary? How
19 can we produce service or product innovation to decrease
20 cost, expand access, improve quality, improve convenience?
21 So the big thing missing from here is direct-to-
22 consumer AI autonomous products. The whole point of

1 technology is, one, to automate back-office processes. The
2 second use is to augment existing clinical care, as in be
3 part of the care process delivered by a human. And then
4 the third component is to automate portions of care so
5 humans can do other things. I don't think doctors, nurses,
6 and pharmacists are going to be replaced any time soon, but
7 some of the components of task that we do can, and probably
8 should, be automated.
9 So my questions about number of items covered,
10 number of dollars spent compared to number of items
11 covered, number of those actual services and items
12 delivered in the category, number of dollars spent, I think
13 is important because it shows that we haven't made that
14 fundamental transition to a tech-enabled or tech-driven
15 service delivery health economy, which is something that we
16 need. We don't have enough doctors. We don't have enough
17 nurses. We don't have enough CNAs. We don't have enough
18 pharmacists. We don't have enough NPs. We don't have
19 enough PAs. All the GME, GNE dollars in the world will
20 help that but not fix that problems, because we have a
21 labor productivity issue.
22 So some of the technology that we want to do, and

1 I think we, as a Commission, probably want to encourage, I
2 would imagine, and perhaps I'm projecting too much, is to
3 augment some components of care and dis-intermediate other
4 components of care so that the human capital can do other
5 things. I think that that universal prescription digital
6 therapeutics and software used by physicians is too narrow,
7 and frankly, a little bit paternalistic. There are a lot
8 of things that patients don't need a physician for. Maybe
9 they need a nurse practitioner for. Maybe they need a
10 physician assistant. Maybe they need a registered nurse.
11 Maybe they just need a home health aide. Maybe they just
12 need software, or they need software and then later they
13 need a nurse practitioner.
14 So I think that the challenge for us is to say --
15 and if the goal of the chapter is to lay out that we aren't
16 covering or paying for anything, the software or autonomous
17 software, we have done a good job and we should make that
18 clear, and that's what my questions want us to make clear.
19 But I do think that we should be doing policy
20 work to ideate around how we can cover for and pay for
21 tech-enabled services to create product and service
22 competition, and purer tech-driven services serving the

1 Medicare beneficiary.

2 I personally have no problem if the Part B

3 provider is a nurse practitioner, a doctor, or Apple or

4 Microsoft. You know, to use a couple of examples it could

5 also be some small software company out of someone's

6 garage. I also feel like we are sort of having the

7 telehealth discussion that the Medicare program had in

8 2005, 2010, 2015, and 2020 before the pandemic, where we

9 said not many services are delivered by telehealth. It's

10 going to have all these concerns about induced demand. I

11 have all these quality and safety concerns. And then we

12 had a global pandemic where an insane number of people

13 died, and suddenly we had to do telehealth. We

14 transitioned to it in six weeks and it actually worked

15 pretty well, and expanded access, increased convenience,

16 maybe it increased quality. Unclear. And there wasn't a

17 huge pile of unmet induced demand.

18 So I don't want us to have that same discussion

19 with technology. So I think that we should make those data

20 points clear about we're not delivering and paying for many

21 services via technology and a small fraction of a percent-

22 to-dollar spent. Make that argument very clear, and then

1 say, okay, and start to think about it as a Commission, how
2 are we going to pay for tech-driven services and tech-
3 augmented services. Because we want that.
4 Fundamentally, human-driven care is error-ridden.
5 We're not infallible. We all make mistakes. I've made
6 mistakes. Others have made mistakes. We will continue to
7 make mistakes. So bringing technology to make it safer,
8 more efficient, more convenient is something that we should
9 do. It will also lower cost. And then we should think
10 about ways that we can pay for tech-driven service, that
11 has maybe human follow-up later or maybe doesn't even need
12 a human.
13 So I'd say that we need to tidy up the bucket of
14 we're not covering these services and clearly quantify that
15 and make that clear, and then think about how we can
16 actually do so. Because if we don't, we are doing the
17 Medicare population a big disservice. Thank you.
18 MS. KELLEY: Josh.
19 DR. LIAO: Thanks again for this work. I think
20 three kind of principles. First, recognizing this is a bit
21 participatory, I think we all feel the shift in technology
22 in different parts of life. But this is kind of a little

1 bit going to where the path may proverbially go.

2 The second is that I think as Brian alluded to a

3 little bit, this is bigger than just hospital-physician

4 services, but I'll try to focus my comments just on that

5 part, given the focus of the presentation today.

6 And then the third is, on the one hand, we want

7 to promote access and innovation and access to that

8 innovation. On the other hand, we want it to be what is

9 affordable and is good quality and has good outcomes, in

10 other words, good value for taxpayers or beneficiaries in

11 the program. I think that is just going to be a tension,

12 and if the upward trend continues with these technological

13 advancements, I think that will only be more of the case.

14 So with that, just a few kind of things related

15 to maybe ideas for future work. I think if PE

16 determinations and RVU valuation continues to be hard, it

17 would be nice if there was a way to have kind of MAC

18 carrier prices evolve from case-by-case too, even LCDs, in

19 a few regions and localities that could then be used to

20 inform Medicare. Number one.

21 Number two, my understanding is that one of the

22 challenges with the PE valuation is maybe outdated data

1 with the PPI survey from the AMA. My understanding is they
2 just closed the most recent survey, 2024, at the end of
3 last year, so it may be worth looking at again, if
4 beneficial.
5 The third thing, and I haven't completely thought
6 this through, but just thinking about something Brian got
7 to. We're talking about SaaS that changes work and that
8 changes clinical care, but there are all of these things
9 that change back-of-office administrative work, that's
10 going to affect indirect PE, you know, service fees and
11 other kind of operational things, revenue cycle management,
12 prior authorization, wait times, all those things. And I'm
13 just highlighting that. As we think about PE, it's not to
14 think about the direct PE but also the indirect. And I
15 think how that shakes out and what that does to allocations
16 and proportioning things out, I think relevant to at least
17 framing up for readers in any future writing.
18 Just a couple more things. I do think in OPPS
19 and IPPS there's a little bit of an asymmetry, and in IPPS
20 we are really kind of bundling things within the DRG and
21 then saying if you are substantially more costly, then we
22 will go to this NTAP process for you. I think given that

1 it's a three-year runway, it's new, it's revisited, that
2 make sense. I'd love to see cost rebased a little bit
3 more, so maybe that's something we can explore, meaning the
4 initial application when it's truly a new technology,
5 depending on what actually the per click or subscription
6 cost are two years in. So I think that's a small
7 adjustment.
8 But on the PPS side, I understand, I think, how
9 we got to this place, where they are separately payable,
10 but I worry that it keeps things focused on kind of a per-
11 service focus. I think we don't really care, ultimately if
12 the AI is a convolutional, recursive neural network. We
13 care that it's making physician work easier, it's making
14 other clinical team members' work easier, we care about
15 outcomes.
16 So I would love to see ways to think about how we
17 take OPPS and make it more, maybe it's bundled, maybe it
18 should think about care models, but other ways it's tied to
19 outcomes we care about, not so much the technology, per se.
20 Anyway, thanks a lot.
21 MS. KELLEY: Stacie.
22 DR. DUSETZINA: This is such an interesting area.

1 Thanks, you guys, for the really great presentation. So
2 one of the things that I think would be really helpful when
3 we drive into these is a little bit more detail about what
4 these and what they're treating, how they're used. Because
5 it is a little bit hard to just wrap your head around it,
6 and the software as a service versus the digital
7 therapeutics, I think, are pretty different in how they're
8 being used. So I think a little bit more concrete
9 information on those things when diving into this space
10 would be really helpful.
11 One of the things, at least for the digital
12 therapeutics side, so for software as a service I am
13 fighting a little bit with myself of why isn't that on the
14 provider on the hospital side of things? I think, again,
15 more details about like how it actually does differentiate
16 the care, and it shouldn't just be wrapped into the DRG
17 base payment, for example, I think would be helpful.
18 But digital technologies, this one is also super
19 tricky because it's like in a lot of ways these
20 technologies remind me of drugs, where there's a lot of
21 development costs, but then once it's on the market then
22 it's just -- you're going to profit maximize. And I do

1 wonder at what point should some of these be inside or
2 outside of the payment system. And I think, again, more
3 details on what they're being used for and clinical
4 benefits of them would be helpful.
5 Separately, I've had conversations about one of
6 these products where people are talking about just really
7 trying to maximize the price per user as much as they
8 possibly could, and wanted to push the price up and try to
9 get pricing sort of more similar to a drug product. And
10 there is a tension, I think, for a developer where it's
11 like, if you're developing something that's like a
12 cognitive behavioral therapy treatment, it's like you could
13 go after a cash-pay market if you have an app, or you could
14 go through this prescription market and mark the price up
15 really high.
16 But it's really hard to navigate. Like when
17 someone was explaining to me that you have to get a
18 prescription that you have your pharmacist turn on for you,
19 like that you can't download the app and just use it.
20 So I think there are some really interesting and
21 challenging things about this area, both from a paying for
22 it, should we pay for it, are the outcomes good enough. So

1 I guess I would ask for a little bit more concrete on the
2 clinical details to start to wrap our head around it. But
3 I think it's a really great start and really interesting.
4 Okay. One more thing I was thinking about was
5 CMMI seems like it could be really interesting kind of
6 place to test how this is working. I know these are knew
7 and we are just starting to roll these out, but especially
8 the mental health, the cognitive behavioral therapy kind of
9 digital therapeutics. It seems like a lot of things we
10 would want to know would be hard to measure in claims or
11 other sources where we just don't have enough insight into
12 how people are experiencing those benefits and their
13 improvements. It seems like it could be a natural place to
14 test how well do these work for beneficiaries and the
15 overall cost and outcomes and benefits.
16 MS. KELLEY: Betty.
17 DR. RAMBUR: Thank you. This is so interesting
18 and I'm really at the beginning and exciting. I have a
19 couple of micro comments and then more overarching.
20 Brian mentioned Slide 6, and including the
21 beneficiary, which I agree. I'd also suggest that not all
22 of these will be physician centric, so we should think

1 about the care team, as well as the beneficiary direct to
2 the manufacturer. And I also have to plus-one on Josh's
3 comment on focusing on the outcomes.
4 My more macro comment is, we think it would be
5 valuable to think of this as just one stream in the need to
6 modernize Medicare. Nobody would expect a 1965 Studebaker
7 to deliver a contemporary experience. And so many of the
8 tentacles of our origins in 1965 are still strangulating
9 us. And so we're trying to always put these things in.
10 So this is, I think, very exciting and really a
11 great beginning. Thanks.
12 MS. KELLEY: Robert.
13 DR. CHERRY: Thank you for this. This is a fun
14 conversation. It reminds me sort of the early days of the
15 iPhone, which is what is it and why do I need it. But
16 let's just presume, for a moment, that we have this
17 clinical software, that's been validated, and it improves
18 outcomes, you know, whatever it is.
19 I think one of the issues, and I think Brian was
20 alluding to this, is that it's not just about the doctor,
21 because often there is a hospital or a health system that's
22 purchasing the software on behalf of the physicians that it

1 may employ, including other doctors that may be able to
2 take advantage of that software, even if they're not
3 directly employed by the facility. So sometimes the
4 hospital is actually the purchaser of the service, and it
5 could be cloud-based, it could be AI, and evolving. And it
6 could be pretty expensive.
7 So if you look at a large health system, they
8 might have a $50 million IT budget -- hardware, software,
9 other things included. And then because it exceeds the
10 MEI, in a few short years that $50 million budget could be
11 $60 million, and you haven't even added anything on it.
12 And then once you decide to add one of these clinical
13 software tools, then you also not only have the developer
14 costs, what they're going to charge you, but then you also
15 have to interface it into your system, you have upgrades to
16 do, you have to to make it do interfaces, there are
17 upgrades to other software that it is interacting with.
18 And even with the eye exams with retina, there is
19 still hardware associated with that. So what if you have
20 to enhance your resolution on your monitors in order for it
21 to be actually effective?
22 So all of this does add on to the cost, and let's

1 say on the hospital side, because you're purchasing this on
2 behalf of your doctors, your IT budget is growing faster
3 than the expected rate of inflation.
4 At some point in time I think we have to kind of
5 prioritize what technology do we actually want to associate
6 with payments, and to make sure that those payments are
7 sustainable for hospitals, as well as individual physician
8 practices, to be able to sustain over the long term.
9 Because right now we're sort of just, okay, here is a
10 technology, we think we can prove, and we'll attach a
11 payment to it, but there's not a real, like, strategy.
12 Like where do we want to put our dollars into. So if it's
13 AI, for example, then that's fine. So as AI matures and it
14 has clinical use cases, then maybe that's the payment
15 system we align with.
16 But I think right now, the dollars are so few
17 that it's almost like we need to take a step back and
18 understand what the overall strategy is in terms of driving
19 health care.
20 DR. ZABINSKI: And I will say that one of the
21 software developers that we talked to said that one of
22 their challenges is getting contracts with hospital system.

1 DR. CHERRY: I think just for the reasons I
2 mentioned; the budget is becoming more constrained every
3 year because the costs of just maintaining what you have is
4 really difficult. And it becomes harder to add on, and
5 then you have to figure out what to prioritize. And I
6 think it will be important to supplement that somehow, but
7 how we do it, how much, and what technologies specifically
8 do we think will help our health care delivery model long-
9 term is something that we need to kind of think about.
10 MS. KELLEY: Cheryl.
11 DR. DAMBERG: Thank you very much for this
12 chapter and continuing to educate us on this space. I
13 support MedPAC continuing to focus here and better
14 understanding these tools and how they are evolving. And I
15 think one of the challenges we face is this is still very
16 nascent, and trying to figure out, building off of Robert's
17 comment, sort of what's the strategy here. And I think,
18 overall, I find myself, and maybe it's kind of early in
19 this process, but I'm sort of leaping ahead to trying to
20 think about what's MedPAC's role here. And is it
21 articulating the key policy questions that Congress should
22 be thinking through? Is it building a framework to think

1 about payment policy, about what's appropriate payment, how
2 to avoid low-value care delivery?
3 So I think as we kind of continue to move down
4 this path, it would help me to have a better understanding
5 of what is it that we're trying to do in this space.
6 MS. KELLEY: Greg.
7 MR. POULSEN: Thanks very much. I also
8 appreciate the good work and the thoughtful approach.
9 Maybe I'm piggybacking a little bit on what
10 Stacie and Robert says, but I've got this feeling -- well,
11 let me start by saying where possible, I think it is
12 important for us to try and retain the link of software to
13 existing services that we pay for, because many of them are
14 intended to augment or replace or modify those things, as
15 opposed to creating an entirely different and likely more
16 expensive and additional cost. I think we need to be very
17 cautious about that.
18 I think that it's going to be very tempting. I
19 know it's going to happen. Stacie mentioned it compared to
20 drugs, and it's going to be really tempting to say, "Wow.
21 This will be great. It'll save millions of dollars by
22 improving people's sleep pattern." That's great. And then

1 looking at it as some sort of here's the value that it
2 brings, hence, it's worth a huge amount of money.
3 As opposed to comparing it to what's the
4 alternative mechanism to get there, which, in many cases,
5 will be, you know, somebody will create, put it on the
6 iPhone, it's a $5 app. And I notice that on the examples
7 that we presented, both of them, if we did the division,
8 unless I screwed something up, were a thousand bucks a pop.
9 You showed the number and the total expense.
10 So these are not iPhone sort kind of apps, and
11 there are probably recurring costs, and I think that's the
12 expectation. Once somebody something for a medical
13 purpose, suddenly it's engendered with enormous numbers of
14 zeroes after it, as opposed to one or two.
15 So I think we just need to be really thoughtful
16 and careful about how we go forward with this, or a decade
17 from now we're going to look back and say, "My goodness,
18 what have we done? We created a whole new cost category
19 that we're now funding."
20 So I think that it's really important that we,
21 wherever possible tie it to an existing service and say,
22 you know, this will help my hospital or my practice to be

1 more effective and more efficient, help me to do something
2 more effectively for my patients. Therefore, it's
3 something that ties into an existing code. We've done that
4 for a long, long, long time. Software is nothing new.
5 We've been doing it for my whole career. So the idea of
6 doing that seems reasonable.
7 And so I just would encourage us to be cautious
8 before we head down the path, and I think you all are
9 saying that, so this is no great insight. But we need to
10 be cautious that we don't create enormous new expenses that
11 we're going to wish in the future we hadn't set that
12 precedent. So thanks.
13 MS. KELLEY: Scott.
14 DR. SARRAN: Very good work It's an important
15 topic, for sure. I want to essentially comment by building
16 off Greg's. If I put a payer mentality on it, there is a
17 tremendous, I mean, tremendous, slippery, slippery slope
18 and boundary set of issues that the PDTs bring up. I'm
19 commenting on PDTs, not on the SaaS. As a principle, not
20 everything that improves health, function, and/or well-
21 being is something we can or should pay for, via MA or
22 private payer, in the same kind of thing.

1 And so I think there is a lot of usefulness. I
2 recognize there is something archaic and paternalistic
3 about it, but I think there is a lot of usefulness to
4 thinking about, on one hand, PDTs that are, whether it's
5 physician or any provider in the PFS -- physician, NP, PA -
6 - directed and incorporated into a plan of care rather than
7 a patient who is, in essence, self-prescribing and self-
8 administering. I mean, the analogy is there, and I think
9 they're a stretch, but analogies often are useful, even
10 though they're stretches.
11 OTC drugs versus prescription. One gets paid for
12 by a payer, another by out-of-pocket. PT and OT. My
13 shoulder hurts. I can't just walk through PT and say I'd
14 like 30 or 40 sessions of PT. I have to go see a provider
15 and ask to be incorporated into a plan. You have to have a
16 diagnosis of a condition, an injury, or a disease, and
17 there has to be a plan of care under a physician/NP/PA
18 supervision.
19 So because of the slippery slope and the
20 boundaries, I just would reinforce, in the PDT space I
21 think we probably are best, in the foreseeable future,
22 about thinking about the usefulness of maintaining the sort

1 of current boundary, that it's either, on one hand,
2 physician-directed, incorporating it into a plan of care,
3 therefore payer responsible, or on the other hand, it's
4 self-directed, therefore patient out-of-pocket. Which is,
5 by the way, not to say that there aren't going to be a lot
6 of self-insured employers who may see the value for their
7 population, and there might even be small insurers in the
8 commercial space who see this as a value-add that they can
9 use to attract certain kinds. Remember, that's fine. But
10 since we're commenting on Medicare, I just have a lot of
11 those concerns. Thanks.
12 DR. CHERNEW: And we think that is the end of
13 Round 2, and as always, we make up a lot of time.
14 I love this topic. It is perplexing in a bunch
15 of ways. So a few broad points, besides thank you,
16 Jennifer, thank you, Dan.
17 First, this is a paper, not a chapter. We are
18 trying to sort out what to do. A lot of this is
19 information, as we figure out where to get, so we aren't
20 yet close to knowing what to do, although we can continue
21 to talk about it. If you have ideas, please let me know.
22 We understand the importance of this.

1 I think the economics of this, even relative to
2 telehealth, is substantially more complicated because of
3 the heterogeneity of these things. The marginal cost tends
4 to be low, so it's hard to fit it into a fee-for-service
5 pricing mechanism. We worry about innovation, so then we
6 have to figure out how to encourage innovation, so we don't
7 want to have explosive costs. I completely agree. We also
8 don't want to discourage innovation. Ultimately, it could
9 be really high value. So that makes it pretty complex.
10 There is also this challenge with how you would
11 think through cost-sharing on these. In fact, just as an
12 aside, we're worrying about that for telehealth. We're
13 worrying about that for portal messages. My general view
14 is as technology advances and you get a lot of these
15 complicated definitional issues, it challenge the core
16 notion of how we thought about medicine and services and
17 what they were. That is probably, broadly speaking, a good
18 thing, except it does make our payment models somewhat
19 challenged.
20 So we will leave it there for now and just say
21 thank you. I do think -- and again, this is, I think, the
22 third time we've gone through versions of this, a few times

1 at the retreat. We understand the broad importance of the
2 potential for new technology to transform the way care is
3 delivered, in a good way, and we broadly speaking want to
4 encourage that. And we understand the heterogeneity and
5 the risks associated with that. So we will stick, for now,
6 in that conundrum, with this paper, not chapter.
7 For those of you at home, please, please reach
8 out to us. You can reach us at meetingcomments@medpac.gov.
9 We do want to hear about any comments you have on this
10 topic or any of the other ones we've talked about this
11 afternoon, this morning. You can call us about the ones
12 for tomorrow or the ones we've talked about at any other
13 point this cycle. We want to hear from you. That's really
14 the point.
15 To the Commissioners, thank you very much for all
16 of your time and attention to all this material, and as
17 always, the staff has done an exemplary job with a number
18 of very important and extremely complex topics. And so I
19 really do appreciate all the time and effort, collectively,
20 of all the work that was done.
21 Paul, do you want to add anything?
22 MR. MASI: No.

1 DR. CHERNEW: Then we will sign off for now, and
2 we will come back tomorrow with some work on post-acute
3 topics. So again, thank you all very much, and see you
4 tomorrow.
5 [Whereupon, at 5:26 p.m., the meeting was
6 recessed, to reconvene at 9:00 a.m., on Friday, April 11,
7 2025.]
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, April 11, 2025
9:01 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
BETTY RAMBUR, PhD, RN, FAAN
WAYNE J. RILEY, MD, MPH, MBA
SCOTT SARRAN, MD, MBA
GINA UPCHURCH, RPh, MPH

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

AGENDA PAGE

Access to hospice and certain services under the hospice benefit for beneficiaries with end-stage renal disease and beneficiaries with cancer
- Kim Neuman, Grace Oh, Nancy Ray......................3

Recess...............................................73

Regulations, star ratings, and FFS Medicare policies aimed at improving nursing home quality
- Carol Carter, Eric Rollins..........................74

Adjourn.............................................125

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

2 [9:01 a.m.]

3 DR. CHERNEW: Hello, everybody, and welcome to
4 our last meeting of this cycle. It is always a bit
5 bittersweet. I think we've had an excellent cycle. We've
6 done a lot of things. We have to say goodbye to some good
7 friends. But we are going to not dwell on that now.
8 We are going to jump right into the substance.
9 And of the areas that we have been very interested in is
10 hospice. There is a lot of hospice going on, and today Kim
11 and Grace are going to talk to us about some work on access
12 to the hospice benefit. So, Kim.
13 MS. NEUMAN: Good morning. Today, we are going
14 to discuss issues related to access to hospice care for
15 beneficiaries with ESRD, end-stage renal disease, and
16 cancer. Before we begin, I'd just like to remind the
17 audience that they can download a PDF of the slides on the
18 right-hand side of the screen.
19 CMS and others have raised questions about access
20 to certain high-cost services under the hospice benefit
21 that may be palliative for some hospice patients,
22 specifically, dialysis for beneficiaries with end-stage

1 renal disease and radiation, blood transfusions, and
2 chemotherapy for beneficiaries with cancer. We have
3 embarked on a project to understand more about the role of
4 these services in hospice care and what the implications
5 may be for beneficiary access to care and how Medicare pays
6 for hospices services.
7 We discussed this project as part of our November
8 2023 hospice workplan presentation, and it is an issue
9 Commissioners have expressed interest in.
10 So today we will present some initial analysis of
11 these issues. This work will not be a chapter in the
12 upcoming June 2025 report, but we anticipate more work on
13 this topic next cycle, based on your feedback.
14 So, here is a roadmap for our presentation.
15 First will have some background on hospice and an overview
16 of the project. Then we will talk about the role of
17 certain specialized services in hospice. Then we'll move
18 to findings of our data analysis and review of literature
19 including limited data on how frequently hospices furnish
20 certain services, what we know about hospice use among
21 beneficiaries with ESRD and cancer, we will touch on
22 summary of experience with some models of concurrent care,

1 and then we will discuss what we learned stakeholder
2 interviews. Finally, we'll conclude with a summary and
3 next steps.
4 So first some background on hospice. The
5 Medicare hospice benefit is designed to provide symptom
6 relief, comfort, and emotional support to beneficiaries
7 with a terminal illness who choose to enroll. For a
8 beneficiary to be eligible for hospice, they must have a
9 life expectancy of six months or less if the disease runs
10 its normal course, as determined by their physician.
11 Beneficiaries can remain in hospice for longer than 6
12 months as long as they continue to meet this criterion.
13 Enrollment in the hospice benefit is voluntary.
14 It is a choice made by individual beneficiaries and their
15 families. When a beneficiary chooses to enroll in hospice,
16 they agree to receive palliative care for their terminal
17 illness and related conditions under hospice benefit and
18 forgo care for those conditions outside of hospice.
19 Services for conditions unrelated to the terminal
20 condition continue to be covered outside of hospice by fee-
21 for-service or Part D, and this is something we will talk
22 more about later.

1 One other thing to note is that hospice is carved
2 out of the MA benefits package and fee-for-service Medicare
3 pays for hospice for beneficiaries in Medicare Advantage
4 and fee-for-service.
5 Next, the hospice payment system. Hospice
6 providers assume financial risk for all services that are
7 reasonable and necessary for palliation of the terminal
8 condition and related conditions. Medicare pays the
9 hospice provider a prospective daily rate. The payment
10 rate is based on four levels of hospice care. Routine home
11 care is the most common level of care, accounting for over
12 98 percent of days.
13 An important feature of the hospice payment
14 system that is relevant for today's topic is that Medicare
15 pays the hospice the same daily rates regardless of the
16 number of visits the hospice furnishes or the cost of non-
17 visit services the hospice furnishes to the patient on a
18 given day.
19 Several factors are motivating our work to look
20 at access to hospice care for beneficiaries with ESRD and
21 with cancer. Prior Commission analyses have shown that
22 beneficiaries with ESRD are much less likely to use hospice

1 at the end of life than beneficiaries.
2 In fiscal year 2024 and 2025 hospice proposed
3 rules, CMS raised the issue of access to certain services
4 under the hospice benefit. CMS said it had heard anecdotal
5 reports that beneficiaries believe Medicare prohibits
6 hospices from furnishing dialysis, radiation, blood
7 transfusions, and chemotherapy to hospice enrollees. CMS
8 stated that these services are covered under the hospice
9 benefit if the hospice provider determined they were
10 beneficial in terms of being palliative and providing
11 symptom relief for an individual patient.
12 In addition, CMS indicated it had received
13 comments from hospices that the cost of these services
14 exceeds Medicare's payment rate to hospice providers,
15 making it challenging for hospices to provide them. CMS
16 sought comment on a number of issues including whether
17 hospice payment changes were warranted.
18 So this work has two aims. First, we examine
19 access to hospice care for benes with ESRD and cancer, and
20 then we discuss current experiences with provision of
21 dialysis, radiation, blood transfusions, and chemotherapy
22 in hospice. The approach we have taken is to review the

1 literature, analyze available Medicare data, and conduct
2 interviews with clinicians, hospice providers, dialysis
3 providers, and family caregivers. As I said, today's
4 presentation represents our first look at these issues, and
5 your feedback today will help guide future work.
6 So, let's first focus on the role of specialized
7 services in the hospice benefit. When services such as
8 dialysis, radiation, blood transfusions, and chemotherapy
9 are furnished to beneficiaries who are not enrolled in
10 hospice, they are often used with a goal of extending life.
11 For some hospice patients, however, these types of services
12 may be palliative, meaning they provide symptom relief.
13 Medicare permits, but does not require, hospices
14 to offer these types of specialized services for palliative
15 purposes. Medicare leaves it up to the hospice provider to
16 determine if the service is consistent with its philosophy
17 of hospice care.
18 These kinds of services raise complex issues for
19 hospices. Because these services can be life extending or
20 palliative or both, depending on the circumstance, it
21 raises the question of when the purpose of the service
22 becomes comfort and falls within the scope of the hospice

1 benefit. These determinations are likely very
2 individualized, specific to the clinical circumstances of
3 an individual patient at a specific time in their disease
4 progression and the medical judgment of their physician.
5 A second complexity concerns the potential effect
6 of the provision of these services on a patient's prognosis
7 and eligibility for hospice. If a service is both
8 palliative and life extending, the hospice physician would
9 need to determine the service's expected effect on the
10 patient's life expectancy and whether the patient would
11 meet the hospice eligibility criteria while receiving the
12 service.
13 Medicare generally lacks data on how frequently
14 hospice providers furnish certain services like dialysis,
15 radiation, blood transfusions, and chemotherapy. Current
16 hospice claims data do not include information about when
17 hospice providers furnish these services. The only claims
18 data available on hospice enrollees' use of these services
19 while in hospice is for those services that Medicare fee-
20 for-service pays for separately, outside of the hospice
21 benefit, because the services are reported to be unrelated
22 to the terminal illness.

1 On the hospice cost report, hospices report data
2 on their costs by category of expense. The cost report has
3 separate fields for palliative radiation and palliative
4 chemotherapy. The cost report does not have separate
5 fields for dialysis or blood transfusions so we are not
6 able to separately identify the costs of those services.
7 Looking at hospice cost report data for
8 freestanding hospices in 2023, only 3 percent of providers
9 reported incurring costs for palliative radiation and 1
10 percent reported costs for chemotherapy. Larger and
11 nonprofit hospices were slightly more likely to report
12 incurring costs for these services than other hospices.
13 There are caveats to note with the cost report
14 data. The completeness and accuracy of data reported in
15 these specific fields is unknown. We don't know whether
16 some hospice providers report costs for these services in
17 other categories than in the more specific categories.
18 Given comments CMS received about the cost of
19 these types of services exceeding Medicare's hospice
20 payment amount, we wanted to get a sense of the cost of
21 these services. We don't have data on how much it costs a
22 hospice provider to furnish a treatment like dialysis,

1 radiation, and a blood transfusion. But to get a very
2 rough sense of cost for these types of treatments, we
3 estimated the average fee-for-service payment amount for
4 these services when they were furnished to beneficiaries
5 who were not enrolled in hospice. The estimates shown in
6 the chart are for 2019, the last year before the pandemic.
7 Also, in the chart are the 2019 hospice daily payment rates
8 for routine home care.
9 As you can see, the estimated average fee-for-
10 service payment for these treatments generally exceeds
11 Medicare's hospice daily payment rate. For example, at the
12 beginning of a hospice stay, Medicare's hospice payment
13 rate for routine home care was $194 per day. In
14 comparison, for beneficiaries not enrolled in hospice, the
15 average fee-for-service payment rate for dialysis was $284
16 per treatment day.
17 In making these types of comparison, it is
18 important to keep in mind a beneficiary might get a
19 treatment on a single day or on multiple days during their
20 hospice stay, but not every day.
21 Not shown in the chart, if the beneficiary needed
22 an ambulance transport to receive a treatment that would

1 add significantly to the cost of furnishing the service.
2 Next, I will turn it over to Grace to talk about
3 results from our additional analyses of claims data and
4 results from stakeholder interviews.
5 DR. OH: We used fee-for-service Medicare claims
6 data to ascertain what can be known about access to hospice
7 and use of specialized services covered outside of hospice
8 and paid for by fee-for-service Medicare. First, we looked
9 at hospice use among beneficiaries with ESRD and
10 differences in use by beneficiary characteristics, as well
11 as their use of dialysis covered outside of hospice and
12 paid for by fee-for-service Medicare.
13 Then, for beneficiaries with cancer, we focused
14 on those with blood cancer who may rely on blood
15 transfusions, and compared their hospice use against
16 beneficiaries with other types of cancers and those without
17 cancer.
18 Among decedents with ESRD, we found that hospice
19 use remains lower for this population than for all Medicare
20 decedents. Between 2010 and 2023, hospice enrollment grew
21 by 4 percentage points among decedents with ESRD, compared
22 with 8 percentage points among all Medicare decedents. In

1 2023, 31 percent of decedents with ESRD received hospice
2 services compared with 52 percent of all Medicare
3 decedents.
4 Hospice lifetime length of stay is also lower
5 among decedents with ESRD, at 6 median days in 2023,
6 compared with 18 median days for all Medicare decedents.
7 Next, we looked at the characteristics of fee-
8 for-service Medicare decedents with ESRD who used hospice
9 in 2019, the last year before the COVID pandemic. Of the
10 roughly 53,000 Medicare fee-for-service beneficiaries with
11 ESRD who died in 2019, about one-third elected hospice.
12 Relative to decedents who did not use hospice, a greater
13 share of these decedents who did use hospice were older,
14 white, not dually eligible, newer to dialysis, and had
15 Alzheimer's.
16 Rates of inpatient admissions as well as days in
17 skilled nursing facilities and home health in the last year
18 of life were similar between decedents who did and did not
19 use hospice. As for ICU visits in the last 30 and 7 days
20 of life, use was lower among decedents who used hospice
21 than those who did not.
22 Finally, 8 percent of those who used hospice died

1 in the hospital compared with 60 percent among those who
2 did not use hospice.
3 Again, we lack data on whether decedents with
4 ESRD in hospice received dialysis that the hospice paid
5 for. However, we have data on whether hospice enrollees
6 received dialysis outside of hospice through fee-for-
7 service claims. Recall, this occurs when the dialysis is
8 considered and reported to be unrelated to the terminal
9 condition. We found that 1 in 8 decedents with ESRD who
10 elected hospice received dialysis that was paid for by fee-
11 for-service Medicare. Use of dialysis outside of hospice
12 was higher among decedents in for-profit hospices.
13 Shifting our focus to decedents with cancer, we
14 found that in 2019, decedents with cancer were more likely
15 to use hospice, though for a shorter time, relative to
16 decedents without cancer. Among hospice decedents with
17 cancer, those with blood cancer were less likely to use
18 hospice and had shorter stays than decedents with other
19 types of cancers.
20 As the table on the right shows, hospice use rate
21 was the highest at 66 percent among decedents with other
22 cancers besides blood cancer, followed by 57 percent among

1 decedents with blood cancer, and 45 percent among decedents
2 without cancer.
3 The median lifetime length of stay in hospice was
4 the shortest among decedents with blood cancer at 9 days,
5 followed by 16 days for decedents with other cancers, and
6 20 days for decedents without cancer.
7 In 2019, very few hospice beneficiaries with
8 blood cancer received blood transfusions paid for by fee-
9 for-service Medicare during their hospice stay. The same
10 was true of radiation treatments for hospice enrollees with
11 any cancer. These results are not surprising because these
12 services are typically directed at cancer symptoms and
13 would likely be considered "related" to the patients'
14 terminal prognosis. If the hospice determined these
15 services would be helpful to a patient for symptom control,
16 the hospice, and not fee-for-service Medicare, would have
17 responsibility for paying. However, we lack data on how
18 often hospice patients received these services under the
19 hospice benefit.
20 In addition to fee-for-service claims data
21 analysis, our research in the last year included a
22 literature review of concurrent care models. Concurrent

1 care refers to models of care under which patients continue
2 to receive certain conventional treatments while enrolled
3 in hospice.
4 Within Medicare, there have been several
5 initiatives aimed at testing or implementing various
6 approaches to concurrent care, including CMMI's Kidney Care
7 Choices Model, the ACO REACH model, and the MA VBID model.
8 Currently there is limited information on the impact of
9 these models on of life experiences for hospice enrollees.
10 In MA VBID, few hospice enrollees received concurrent care,
11 according to initial evaluations.
12 The Medicare Care Choices Model, or the MCCM, was
13 a small demonstration that tested non-hospice palliative
14 care for certain beneficiaries who were hospice eligible.
15 The evaluation report found participants were more likely
16 to ultimately elect hospice, and that the model had a
17 positive effect on indicators of end-of-life care quality.
18 There are also examples of provider-led
19 partnerships between dialysis organizations and hospices.
20 In your reading materials we highlight two models of
21 concurrent hospice and dialysis use, in Pittsburgh,
22 Pennsylvania, and Seattle, Washington. These models

1 furnish dialysis to their patients with ESRD after they
2 enroll in hospice, with the dialysis paid for by the
3 hospice under the hospice benefit.
4 Finally, we will present findings from the
5 interviews we conducted in 2024 and 2025. We interviewed
6 12 non-hospice clinicians in several specialties including
7 oncology, hematology, nephrology, and palliative care;
8 clinicians and administrative personnel from 9 hospice
9 providers and 3 dialysis providers, including hospice
10 medical directors, hospice physicians, nephrologists,
11 nurses, social workers, and other administrative staff; and
12 multiple family caregivers of decedents who used hospice.
13 Providers and clinicians that we interviewed
14 varied by region, urban and rural status, ownership type,
15 and practice setting. The hospices we interviewed were
16 mostly medium or large in size.
17 In these interviews, we focused on dialysis,
18 radiation, blood transfusions, and chemotherapy, and asked
19 each interviewee about their perspectives on a range of
20 issues, including their views on the role of these services
21 in hospice, how they affect patient decisions about hospice
22 enrollment, and hospices' experiences with providing these

1 services.

2 Hospice clinicians and relevant specialists we
3 interviewed generally viewed dialysis, radiation, and blood
4 transfusions as having the potential to be palliative and
5 provide symptom relief in certain circumstances for some
6 hospice patients. There was less consensus among
7 interviewees about the role of chemotherapy in hospice.

8 Interviewees indicated that some dialysis- or
9 transfusion-dependent patients do not enroll in hospice or
10 enroll very near the end of life due to concerns about
11 having to cease these treatments in hospice because they
12 will typically die within days to weeks without treatment.
13 The need for palliative radiation may affect the timing of
14 hospice enrollment for some beneficiaries with cancer.

15 Not all hospices that we interviewed furnished
16 these services. Those that did furnish them had multiple
17 reasons for doing so depending on the individual
18 circumstances of the patient, including to provide symptom
19 relief, to ease decision to transition to hospice for
20 patients who wish to do so, and to help patients reach
21 specific goals, such as attending a family wedding.

22 Most interviewees indicated that the cost of

1 these services generally exceed the Medicare hospice per
2 diem rate and are cost prohibitive for many hospices to
3 furnish under the hospice benefit, especially small
4 hospices.
5 Interviewees told us there are other specialized
6 services that may also be palliative for some hospice
7 patients, but cost is also a barrier to providing those
8 services.
9 We heard that transportation from hospices to
10 dialysis facilities, hospitals, or clinics to receive these
11 services can add financial and logistical challenges for
12 hospices. A few hospices indicated that while their
13 hospice covers the cost of the treatment, patients are
14 responsible for obtaining access to transportation from
15 family, caregivers, or community transportation.
16 Hospices also told us that the cost of providing
17 these services varies by the contracts they are able to
18 execute with dialysis facilities and outpatient hospitals
19 and clinics, and the negotiated rates.
20 Lastly, hospices varied in their policies and
21 protocols to furnishing these services to their patients.
22 For example, hospices told us they furnish one to five

1 fractions of radiation for pain management, and dialysis
2 for 4 to 8 weeks, or up to 10 to 12 treatments. One
3 hospice we interviewed had no pre-specified limit on
4 dialysis. As for blood transfusions, most hospices we
5 interviewed said they generally furnished red blood cells
6 but not platelets, under the hospice benefit, between once
7 a week to once a month. Chemotherapy was less commonly
8 offered among interviewees.
9 To achieve a patient's comfort, some hospices
10 collaborated with the patient's nephrologist and dropped
11 the frequency of dialysis to two treatments per week or de-
12 prescribed certain lab tests and ESRD medications. These
13 treatment modifications were made for patients for whom the
14 treatment burden started outweighing the potential
15 benefits.
16 Hospices were also guided by their philosophy of
17 care. A few hospices explained they did not provide these
18 specialized services because they were too aggressive and
19 inconsistent with their hospice philosophy.
20 In summary, there is limited data for us to
21 examine how frequently dialysis, radiation, blood
22 transfusions, and chemotherapy are provided under the

1 hospice benefit. Claims data indicate less hospice use
2 and/or shorter stays among beneficiaries with ESRD and
3 beneficiaries with blood cancer
4 From our interviews, we heard that concerns about
5 ceasing treatments in hospice may affect whether and when
6 some beneficiaries enroll in hospice; that these services
7 may have a palliative role for some hospice patients,
8 depending on an individual patient's condition; and that
9 the cost of specialized services generally exceed
10 Medicare's daily payment rate, and makes it challenging for
11 hospices to furnish these services.
12 Based on our initial findings, we have identified
13 three issues to consider for future work if there is
14 Commissioner interest.
15 First, to address the gaps in Medicare data
16 around the provision of certain services by hospice
17 providers, we could explore the potential for enhanced data
18 reporting. These data could give us the capacity to assess
19 hospice enrollees' utilization of services such as
20 dialysis, radiation, blood transfusions, and chemotherapy,
21 the characteristics of these beneficiaries and their
22 providers who furnish these services, and how much Medicare

1 pays for their hospice care.

2 Second, the literature as well as our interviews
3 suggest that Medicare's hospice payment system may create a
4 disincentive for hospices to offer high-cost services that
5 may be palliative for some hospice patients. Future work
6 could explore whether changes to the hospice payment system
7 are warranted to improve the payment accuracy for these
8 services. For example, we could explore developing an
9 outlier payment or other approaches.

10 Lastly, interviewees said that concerns about
11 ceasing services such as dialysis and blood transfusions
12 dissuades some beneficiaries who wish to elect hospice from
13 doing so. Here, we could explore the potential to develop
14 a "transitional program," through which hospice enrollees
15 would have the option to receive services, paid for by fee-
16 for-service Medicare, for some transitional time period or
17 up to a specified number of treatments.

18 We welcome any questions and feedback you might
19 have on the materials presented today and on the potential
20 future analytic work.

21 I will now turn it back to Mike.

22 DR. CHERNEW: Grace, thank you. Kim, thank you.

1 I think we're going to just jump right into the Round 1
2 questions, and if I have this right, Robert was the first
3 Round 1 question.
4 DR. CHERRY: Thank you and good morning. It's
5 really a fascinating topic. Thanks for bringing this
6 forward. I think the primary driver around this is that
7 you notice that among decedents, those that have end-stage
8 renal disease, only 31 percent are choosing hospice care
9 versus non-renal, and non-end-stage renal disease it's 52
10 percent. Several of the reasons you mention include lack
11 of claims data -- that may be a driver as well -- but also
12 the payment issue may be disincentivizing the choices on
13 high-cost services.
14 There may be another reason to that, that I'm not
15 clear about, and that's the basis of my question. So
16 although dialysis and blood transfusions and chemotherapy
17 is a covered hospice benefit, is it a regulatory
18 requirement that they have that service available? In
19 other words, is there a regulatory requirement that even
20 though they may disagree whether or not palliative
21 chemotherapy is a viable option, are they required to at
22 least have a contracted service with a vendor, in case they

1 do want to offer it on a selected patient? Because that
2 could be part of the reason too, is that there is sort of
3 regulatory issue here.
4 MS. NEUMAN: So hospices are not required to
5 offer specialized services such as palliative radiation and
6 palliative chemotherapy. The Medicare Policy Manual
7 indicates that it up to the determination of the hospice,
8 based on the patient's individual condition and whether it
9 would provide symptom and relief, and based on the
10 hospice's caregiving philosophy. So they are not required
11 to furnish the service. It is up to the hospice.
12 DR. CHERRY: Yeah, thanks for clarifying, because
13 I imagine you might see differences in choices around even
14 things like palliative chemotherapy, if one sort of group
15 agrees that it's something that should be done but another
16 group disagrees, despite the differences in the payment
17 rates. But that's helpful. Thank you.
18 MS. KELLEY: Tamara.
19 DR. KONETZKA: Thanks. Great work. Two quick
20 questions. The first one is about the costs, especially in
21 the ESRD population. So we know from prior MedPAC work and
22 other work that they are paid a per diem rate for hospice,

1 and there are many days where no services are provided,
2 right, and then the highest costs are at the beginning and
3 at the end of the hospice stay. And so the sort of per-day
4 payment comparison to me wasn't that meaningful. I'm
5 wondering if you did any sort of initial calculations that
6 looked at like a per-stay, how much does palliative
7 dialysis add to that cost relative to the per-stay payments
8 they're getting.
9 DR. OH: For this round of analysis we focused
10 mostly utilization patterns and have not looked into costs.
11 But we can circle back on that.
12 DR. KONETZKA: That would be great. Thanks. The
13 other question, and this may be for you guys or may be for
14 the clinicians in the room, as well, is when we think about
15 the evolution of hospice, it was really sort of initially
16 targeted toward cancer patients with a clear prognosis, and
17 now we have like many, many Alzheimer's patients on
18 hospice, where the prognosis is not so clear. But the
19 rules were amended or it kind of works because you can sort
20 of get recertified for hospice, even if the prognosis is
21 less clear.
22 So I'm wondering, in the ESRD case, how much

1 uncertainty is there about the prognosis, and is that a
2 contributing factor to maybe people not getting referred to
3 hospice? You know, like ESRD, is it more like the
4 Alzheimer's case or is it more like the cancer case, where
5 we know how long they're going to live?
6 DR. OH: From some of the clinicians that we
7 interviews there were some that indicated there is still
8 some form of uncertainty regarding patient prognosis, but
9 for the patients that they spoke about referring to
10 hospice, they had other strong markers of functional
11 decline and other comorbidities that made it more certain
12 that they would be eligible for the six months or less
13 prognosis eligibility criteria for hospice. So I think it
14 does vary by patient.
15 DR. CASALINO: Can I just speak on this point for
16 a minute? There may be other clinicians here better
17 capable of speaking to this than I am. But I think ESRD is
18 different from certainly chemotherapy or radiation. I
19 mean, palliative chemotherapy or radiation are not going to
20 prolong the patient's life. In fact, the chemotherapy may
21 shorten it. But with ESRD, the patient is going to die if
22 you stop. It depends if they have any kidney function at

1 all. If they don't have kidney function, which probably
2 most ESRD patients don't, you're going to die in a week or
3 two, maybe really uncomfortable, maybe not. But it is
4 different, and you can see why people on dialysis do not
5 want to be in hospice, because there's uncertainty, because
6 they're just going to die. It's like killing them, right.
7 I think that's different.
8 There may be cases in which that's true, blood
9 transfusion, as well, but it depends on the individual
10 circumstances.
11 Do other clinicians think that what I've just
12 said is accurate? So this is kind of a special but very
13 important case. A lot of people are on ESRD.
14 DR. CASALE: Yeah, I think you articulated it
15 very well. I mean, depending on the kidney function, some
16 people can survive for a period of time off dialysis, but
17 to your point, generally once they stop dialysis their
18 demise is going to be fairly imminent. Which is probably
19 why, as you said, they're reluctant to get on the hospice
20 until they really --
21 DR. CASALINO: In other words, you don't want to
22 bring a comatose patient in by ambulance and dialyze them

1 when they're going to die in two days. But if they look
2 like they might have a month or two or three, stopping
3 dialysis is almost like -- I mean, it's almost like
4 assisted suicide, really. I haven't thought about that
5 phrase before, but you're definitely killing them sooner
6 than they would otherwise die.
7 DR. CHERRY: Yeah, on this point the only
8 exception is if the patient goes to hospice care but wants
9 to have their dialysis, withdrawn. Then that’s little bit
10 cleaner.
11 MS. KELLEY: Thanks, Larry, Paul, and Robert.
12 Brian, did you also have something?
13 DR. MILLER: Yeah, I was going to say, renal
14 failure is probably one of the more calm ways to pass on to
15 the other side. I think people with renal failure,
16 obviously the choice to discontinue dialysis is a choice
17 that they make. I think it's really problematic if we
18 start sort of getting into the weeds on individual
19 services, given that there's mix of people who practice and
20 a mix of people who don't practice or people who have
21 practiced.
22 I think that for us, we want to stay at the level

1 of making more general policy recommendations as opposed to
2 targeting whether someone should be providing a specific
3 service in a particular sector, especially in a place like
4 hospice, where there are a wide range of views and probably
5 a wide range of correct answers. And if we went around the
6 U-shaped table, we'd all probably say something slightly
7 different.

8 And so, if anything, I think we want do more to
9 preserve decentralized, localized, personal choice between
10 the patient and their physician, and not get in the way of
11 that.

12 MS. KELLEY: Amol, did you also have something
13 here?

14 DR. NAVATHE: Yeah. I just wanted to clarify
15 because I actually think we're not answering Tamara's
16 question. So I think, if I ask Tamara's question, she's
17 not asking us, is dialysis life-sustaining, which I think
18 is kind of the answer that we're giving her, and I think
19 the answer is yes, I think that's why we're doing this
20 work. And the question that Tamara asked was more around
21 is prognosis for somebody on dialysis different, or have a
22 different confidence interval or variation or whatever,

1 relative to people with other diseases that have terminal
2 capability, like cancer.
3 And I think the answer, generally speaking, prob
4 ably is that it is probably challenging to generalize,
5 because as a general thing I think you would say it is
6 different because most people who are on dialysis don't end
7 up dying from the dialysis itself, or the renal failure.
8 They end up dying from a lot of other collateral issues of
9 not having good kidney function. So it can be hard to
10 predict, because it ends up being much more about what is
11 their frailty and other factors that are involved.
12 So I think prognostication is just different for
13 patient with dialysis. On dialysis, I think that's the
14 question that you were asking.
15 MS. KELLEY: Stacie.
16 DR. DUSETZINA: Great. Thank you, Grace and Kim.
17 This was excellent work.
18 So I have a question about for people who were on
19 MA before they entered hospice and how it works to go back.
20 So I think on page 10 it mentions that you can kind of go
21 back if you want to reengage with active treatment. I
22 wasn't sure if there were any challenges for people who had

1 been on MA who wanted to go back to MA to get on active
2 treatments.
3 And the other part is also MA related. You
4 mentioned that the MA plans still get Part C rebates even
5 when somebody transitions on to hospice, and I wanted maybe
6 a little bit of clarity about do you go back to TM for
7 active treatment if you've gone on to hospice, or can you
8 just go straight back to your MA plan with no wait periods?
9 MS. NEUMAN: So if you disenroll from hospice in
10 the middle of a month and you're a Medicare Advantage
11 enrollee, then you will continue to receive services paid
12 by fee-for-service until the end of that month. And then
13 at that point your MA plan will pick up your care at the
14 start of the next month. So that's how it works. And then
15 I think I'm missing the second part.
16 DR. DUSETZINA: Yeah. There was a comment about
17 when you enroll into hospice, then TM takes over. But it
18 said that Medicare still pays the Part C rebate. I wasn't
19 sure why.
20 MS. NEUMAN: I don't know if I can say why. One
21 piece that could come into play for a beneficiary in
22 hospice is that MA, some of the supplemental benefits is

1 like cost-sharing. So if someone were getting a service
2 unrelated to the terminal condition outside of hospice, and
3 they went to their network provider, they might still get
4 that reduced cost-sharing kind of situation. So I'm not
5 sure I can give you the rationale, but that might be a
6 circumstance of where it could come into play.
7 MS. KELLEY: Gina.
8 MS. UPCHURCH: To follow up on Stacie's question
9 a little bit, in that same explanation it says that
10 somebody's carve-out for hospice, not only do the MA plans
11 get the rebates, but it sounds like the Part D drug benefit
12 stays with the Medicare Advantage plan, but then later it
13 says it reverts, in a footnote. So where are the drug
14 benefits? I thought there were some drugs that were
15 charged to hospice and some that were charged to Medicare
16 Advantage Part D, or the standalone Part D plan. Can you
17 clarify that?
18 MS. NEUMAN: Yeah, sure. So everything that is
19 related to the terminal illness and related conditions,
20 including drugs, falls under the hospice benefit. So if
21 the medication is unrelated, then it would fall under Part
22 D, if the beneficiary has Part D, either an MA-PD or a

1 standalone PDP.
2 MS. UPCHURCH: I think from our many previous
3 work you all have done, it's very confusing, I think,
4 sometimes to pharmacists who to bill. And I think we just
5 need some clarity about that. Like if they get an inhaler,
6 is that related to because they can't breathe very well
7 because they are end-stage congestive heart failure, or
8 it's their hospice, or is it something else? You know, do
9 they have allergies?
10 So I think that's just something we need to
11 clarify, because I think that is confusing in the pharmacy
12 world.
13 The other thing -- these are just very nitpicky.
14 On Table 3, page 18, you talk about the Medicare payment
15 rates. Is that getting at 100 percent of the payment rate,
16 not just the 80 percent? The title of it, it says,
17 "Medicare Payment Rate." That's 100 percent of the
18 allowable, is what you're referring to?
19 MS. NEUMAN: Yes. And recall hospice does not
20 have cost-sharing, but these other services would. But it
21 is 100 percent regardless.
22 MS. UPCHURCH: Great. Thanks for the reminder

1 about the cost-sharing. I forgot about that.
2 And then lastly, on Table 5, on page 25, I don't
3 understand. So it says, "use of certain health care during
4 the last year of life among decedents," and then there's
5 all zeroes for people who elected hospice. Median number
6 of SNF days, 0, 0, 0. Does that mean literally nobody used
7 a SNF day? What does that mean? I can't quite understand
8 why there would be zeroes.
9 MS. NEUMAN: So that's the median. That's the
10 median beneficiary. So there are beneficiaries on the tail
11 who did use SNFs. It's just at the median --
12 MS. UPCHURCH: I gotcha. Okay. So it’s not a
13 normal distribution curve. Thank you. That helps.
14 Thanks.
15 MS. KELLEY: Larry.
16 DR. CASALINO: Can you remind us, or tell us,
17 what the rationale was or is for traditional Medicare
18 rather than MA to pay for hospice?
19 MS. NEUMAN: I'm not sure I can speak to exactly
20 why. It could be sort of the history of how the benefit
21 was developed in 1983. The MA program was being developed
22 around that time, too. So it could be a historical piece

1 of it. We can also go and look and see if we can see
2 anything written specifically.
3 DR. CASALINO: If you can find something, that
4 would be good, because we're not really focusing on it here
5 but it is sort of a big deal, right, to get switched over.
6 That would be nice for people to understand that that
7 happens.
8 And then just seconding what I think Tamara said.
9 I think the daily cost analysis versus the cost of
10 radiation, for example, is good, but I think it would be
11 also useful to take, for example, the median hospice stay
12 and say, okay, what would be the total cost of paying at
13 the daily rate, and what would be the total cost of, say if
14 the median was 20, what would be the total cost of 6 or 7
15 dialysis treatments, for example. I think that would be
16 helpful.
17 And then the last thing. The reading said that
18 individual hospices, quote/unquote, "caregiving philosophy"
19 determines whether the patient will get chemotherapy or
20 radiation or dialysis or whatever. How are patients and
21 families supposed to figure out what the hospice's
22 caregiving philosophy is? I mean, I assume they meet with

1 the hospice, but I've heard some pretty bad anecdotes about
2 those meetings, and some good ones, as well.
3 MS. NEUMAN: So I think when a patient is
4 considering entering hospice there are conversations that
5 go on between the hospice provider and the patient and
6 their family about what services the hospice offers. And
7 when we interviewed hospices, they talked a bit about how
8 they have conversations with families about what services
9 they're looking for in hospice and what their hospice
10 offers. So I think that is sort of the place where those
11 kinds of communications go on.
12 DR. CASALINO: Maybe a paragraph or two just
13 about that too could be helpful.
14 Thanks. Really interesting, and kind of
15 provocative in terms of thinking about solutions.
16 MS. KELLEY: Brian, go ahead.
17 DR. MILLER: A clinical comment. So when you go
18 into hospice and they take you, obviously your internist or
19 hospitalist has the discussion with you, and then you meet
20 usually with the hospice social worker, and then either the
21 hospice nurse, nurse practitioner, physician, one of the
22 providers usually comes and talks with that patient and

1 their family and sort of outlays what the scope is, what
2 the degree of support is. Especially for those who are
3 going home with home hospice, it's how many hours a week,
4 how many days per week, what type of services you get, the
5 type of after-hours accessibility and support. And so
6 that's usually laid out pretty clearly.
7 Obviously, people are so upset when they go into
8 hospice so they might not retain all of that, but that's
9 usually shared with them, and then there is an opportunity,
10 of course, to continue that conversation. So that
11 information, for that specific local hospice is usually
12 given before entry.
13 DR. CASALINO: They're usually pretty clear
14 whether they are going to get dialysis or not.
15 DR. MILLER: Yeah, and usually even the
16 hospitalists or the outpatient PCP would have had that
17 discussion even before bringing the hospice in, because if
18 the patient wants to continue dialysis, and dialysis is not
19 available in that hospice, then the primary care doc or the
20 hospital medicine physician is having that discussion with
21 the patient and the family before even bringing the hospice
22 care team in. So it's usually pretty clear.

1 MS. KELLEY: Scott.
2 DR. SARRAN: Very nice work, Kim and Grace. I
3 particularly like how well you were able to take learnings
4 from some qualitative interviews, and I think we're seeing
5 how often the qualitative interviews are an important part
6 of our work, so kudos on that.
7 Three quick questions. First, just a quick
8 mechanical kind of question. So if hospice and the patient
9 agree that they're going to have one of these services
10 under the hospice benefit -- let's just pick radiation --
11 how does the claim actually get processed? Does that claim
12 go to hospice provider?
13 MS. NEUMAN: So if the hospice is paying for it,
14 there is no Medicare claim for the service. It's like an
15 expense, any other expense that they would engage in caring
16 for their patient.
17 DR. SARRAN: Okay. So they just have to figure
18 out, just as an MA plan, how they're going to pay. Okay.
19 That's really interesting. Part of hospice, at least some
20 hospices' discomfort with providing these services may be
21 not just the actual cost, if it were costed out at fee-for-
22 service Medicare rates, but the mechanics, and the

1 challenges of in essence -- in essence -- functioning like
2 an MA plan having to have a network. That's an interesting
3 thing.
4 Second question. If a patient wants one of these
5 services while they're on hospice, and hospice says, "No,
6 that's not in our philosophy of care," what recourse is
7 available other than disenrolling? Are there appeals
8 mechanisms? Is there something else that the patient and
9 family can do?
10 MS. NEUMAN: So I think that as was discussed a
11 little bit earlier, a lot of these conversations are going
12 on before someone even decides to elect. But if they
13 decided to elect and then either they decided it wasn't for
14 them, or they had a different expectation on either side of
15 what the services would involve, as you said, one option is
16 for the beneficiary to revoke and go back to regular
17 Medicare, so to speak.
18 I don't know. We can look into whether there is
19 anything in an appeals process that this would trigger.
20 I'm not sure.
21 DR. SARRAN: Okay.
22 MS. NEUMAN: I'm not sure. We'll look into it.

1 DR. SARRAN: All right. And the third question
2 is, during your interviews did you learn anything about any
3 specific issues or concerns related to the interface
4 between hospice and MA in these kinds of dynamics and
5 situations?
6 MS. NEUMAN: This is one area where specific to
7 what we were interviewing about, so these four services,
8 this is one area where we didn't hear much about MA.
9 DR. SARRAN: Thanks.
10 MS. KELLEY: Kenny.
11 MR. KAN: Quick question. On page 9 of the
12 slides regarding the partnership, I'm wondering if there
13 were any things that you learned from the partnership that
14 could potentially be scalable? Because you mentioned
15 something about a partnership between hospice and a
16 dialysis center, I believe.
17 MS. NEUMAN: So we have a little bit more on
18 those partnership in the paper, and we discuss some of the,
19 sort of the models that they're using. The two examples
20 that we give have different approaches to sort of how
21 they're targeting the services. One approach has a limit
22 on the number of dialysis treatments. The other does not

1 have a limit. But they also have a palliative care piece
2 of their program, and that also seems to be a big chunk of
3 what is happening there.
4 So I think what we learned from sort of reading
5 about those two models is that there are sort of different
6 ways to go at it, and at the same time it's showing that
7 there are some providers out there that are finding ways to
8 do this.
9 MR. KAN: Thanks. That is what I thought I read,
10 too. I was just trying to figure out if that was
11 potentially scalable, because this appears to be a little
12 bit of a niche population in the problem we're trying to
13 solve here. But I think Amol raised a really good point,
14 which I wasn't aware, is that ESRD benes who end up passing
15 on, sometimes experience other known symptoms, non-ESRD
16 symptoms. Thanks.
17 MS. KELLEY: Cheryl.
18 DR. DAMBERG: Thank you for all the work you did
19 to pull together this chapter. It was really interesting.
20 I just want to echo Scott's comment. I think the
21 qualitative interviews you did were really informative, so
22 I appreciate that work.

1 I had a question on Slide 20, because I'm trying
2 to, again, figure out the scoping of this work. So it says
3 that the interviewees told you that there were other high-
4 cost services that may be palliative, which I am assuming
5 are outside of the ones you specifically asked them about.
6 And I was wondering if you got any addition information
7 that. And as we kind of think about this work, are we
8 thinking about a broader set of services potentially?
9 MS. NEUMAN: So I think that the interviews sort
10 of raised that question. We asked about the four services,
11 and then we said, "Is there anything else we should be
12 thinking about?" So people volunteered different kinds of
13 services that either had the feel of dialysis and blood
14 transfusions as far as concern about ceasing the
15 treatments, or maybe something that doesn't have that feel
16 but is more like something that is palliative and
17 expensive.
18 So we heard from folks that there are certain
19 other services that are high cost and may be challenges to
20 hospices. So it does raise the question, I think, and
21 something for you all to think about as sort of whether we
22 should be thinking a little bit more broadly. You know, we

1 started with the four services because CMS flagged them,
2 and it seemed like a really good place to start. But, you
3 know, there are options on how to go about this.
4 MS. KELLEY: Josh.
5 DR. LIAO: Thanks for this work. Just a quick
6 question here. On page 21, Table 4, as putting that in one
7 of the references I think from an academic research setting
8 in 2018 together, I just want to make sure I'm kind of
9 interpreting the numbers correctly. You show in that table
10 that median length of stay is 6 days versus 18 days. This
11 is for the patients with ESRD who get dialysis versus who
12 don't, and that the lifetime stays is also shorter.
13 And then there was a bullet in that study that
14 talked about how most ESRD patients who get hospice, it
15 happens in the last three days of their life, which I read
16 is just very late. And so I did a little bit of a deep
17 dive into that study, and it looks like that period of
18 time, from 2014, even though the percentage of people who
19 use hospice doubles, or more, that proportion stays the
20 same. It's at 42 and it doesn't change.
21 So I'm wondering if that might be a direction
22 that you have either seen in your data or might be fruitful

1 for future work.

2 MS. NEUMAN: So I just want to make sure we're

3 answering your question. Is the question related to the

4 short length of stay sort of being persistent?

5 DR. LIAO: It's that observation, I guess. The

6 question here is just is that something you were able to

7 see in the data? I suspect not based on what I've seen,

8 but I know this is the first round, and could that be

9 something to think about?

10 DR. OH: I think we can look at the share of

11 beneficiaries with ESRD who enroll in hospice in the last

12 3, 7, and however many days of life.

13 DR. LIAO: I'm just struck that here, use is not

14 used, and even though length of stay in overall lifetime is

15 helpful, the duration between that is very relevant when

16 you're thinking about future areas of support. Thank you.

17 MS. KELLEY: Kenny.

18 MR. KAN: I withdraw my question. It was

19 answered previously.

20 DR. CHERNEW: Kenny was double Round 1.

21 MS. KELLEY: I think then we are done with Round

22 1, and we can go to Round 2.

1 DR. CHERNEW: Round 2.
2 MS. KELLEY: And Stacie, you're first.
3 DR. CHERNEW: Please all just be aware
4 [inaudible].
5 DR. DUSETZINA: Thank you so much. Again, thank
6 you for this incredible work, and I think the work that you
7 all did with the interviews to get more input from
8 different stakeholders was very, very valuable.
9 You know, I think that one of the things that is
10 super important here is that when you read that the
11 decision to provide these services is based on the
12 philosophy of the place where you're staying, I just don't
13 find that to be really acceptable. I think we either
14 decide that these are services that people need to have
15 access to because they're important for some patients who
16 want to elect into hospice or we don't. And while I agree
17 that in a lot of markets you probably do have these
18 informed decisions and discussions before picking a
19 hospice. In rural areas, you don't have all of those
20 choices available to you. Like you can end up in a
21 situation where there's really only one hospice provider,
22 and if their philosophy doesn't match your health care

1 needs, you then can't take advantage of the services.
2 So I really love this work. I think it's
3 important to dive into this and figure out how do we
4 support hospices in providing these services for patients
5 that need them, so that patients who want to elect into
6 hospice have access to services that will help them to live
7 as best as they can, as they go through this phase.
8 So I think that one of the things that kept
9 sitting with me, as a non-clinician, I know a lot about the
10 blood cancer space, and I've heard a lot about the concerns
11 there. Having more clarity on what does it mean for people
12 with dialysis or blood cancers or other cancers, like what
13 do these services provide to them. And also the burden.
14 You know, I think that also played into the philosophy of
15 sites, that this is really burdensome for patients to go
16 and get these services. Like just having a little bit more
17 clarity on that could help to orient to why these services
18 are so critical, for the average reader.
19 I think for moving this work forward, it would be
20 really nice to think about doing some modeling of spending
21 implications if we paid either more for these services, if
22 fee-for-service paid for these services on an ad hoc basis,

1 you know, how would that interact with people who had come
2 from MA. Should you just have, like for people coming with
3 these specific conditions, a slightly higher average daily
4 payment? Just kind of modeling out some different options
5 and what that would cost the program I think would be
6 really beneficial.
7 I also like the idea of a transitional program,
8 but again, modeling out some different options of how that
9 would work. Obviously, we don't want to add too much money
10 here, because there are lots of days that you could
11 potentially pay for. But I think if we can get a better
12 payment, or get more targeted payments so that people have
13 access to these services it would be great.
14 And then one other thought is, for people who
15 aren't getting fully informed information from their
16 clinicians as they are transitioning, could there be an
17 opportunity to add this information to Medicare Compare? I
18 know personally, when having looked for hospice services,
19 that was a really great source of information for thinking
20 about how people had experienced the services, and if you
21 had an indicator for access to these services when
22 enrolled, that could be a good way for families to filter

1 and make those decisions when they maybe don't have as much
2 support from their care team.
3 So thank you again for the exceptional work. I'm
4 really excited to see this moving forward.
5 MS. KELLEY: Scott.
6 DR. SARRAN: Again, excellent work, and I hope we
7 continue down the road.
8 I have experienced all these situations fairly
9 frequently as a clinician, and occasionally as a family
10 member or close friend, and one of the grounding principles
11 I think for these discussions is that these are all
12 terribly painful, difficult discussions that go on. There
13 are just no easy scenarios in any of this.
14 And I think, as Brian pointed out, I think what
15 we want, from a public policy perspective, is to do the
16 right things to enable optional patient-centered shared
17 decision-making, because again, these kinds of decisions,
18 does somebody have a palliative service such as either
19 radiation, transfusion, et cetera, under the umbrella of
20 doing what is most consistent with what that patient has
21 elected in terms of an overall palliative and curative
22 intent, we want to enable that by our public policy, and

1 then, to some extent, get out of the way from the actual
2 decision-making.
3 I think, that said, there is an evolving clinical
4 consensus that the historic distinctions between a service
5 being either always curative or always palliative, that
6 those distinctions are not consistent with optimal care.
7 So if there is a clinical generalization, I think it's that
8 you can't be that rigid anymore and still deliver optimal
9 or enable optimal care.
10 And I think you point out, that I'm going to
11 reinforce, that there is a consequence of our being overly
12 rigid, which is that then some patients don't elect hospice
13 in the first place, when their intention is to pursue an
14 overall palliative route than a curative, and that's a
15 shame -- "a shame" is too light a word -- or patients don't
16 receive the optimal bundle of services consistent with
17 their goal, and that's awful, because then that means, by
18 definition, they're not getting optimal palliation, and
19 that should be a never event when somebody is electing
20 hospice.
21 So I think we should keep exploring how do we
22 best enable that, and I think there are some roads we can

1 continue to go down, and Stacie and others have pointed out
2 one of them. One of them could be we could, quote, "force"
3 hospices to cover these full range of services. We can
4 explore it. I tell you, I think that's not going to work
5 well, if for no other reason there are small hospices who
6 just reasonably could be quickly put underwater by even a
7 small number of patients electing these, and that will
8 further force the dynamic of small hospices getting out of
9 the business, and they are all being bought up by big, for-
10 profit players, which is not what we want to do.
11 I think we should explore whether these services
12 are carved out of the hospice benefit, because what that
13 does then is it removes the disincentive to offer them.
14 Then at least the hospice has no reason not to enable those
15 if the patient asks. So I think that's worth exploring in
16 terms of what that would look like, what mechanically that
17 would have to look like, what the cost would be. I think
18 that would be trivial in the scheme of things but worth
19 exploring.
20 Or we could, as you put on Slide 23, sort of
21 rethinking the whole overall structure of hospice. You
22 labeled it as a "transitional program." It is certainly

1 worth exploring, but I don't think that's going to be any
2 kind of quick fix, because that obviously would take a lot
3 of people doing a lot of rethinking about how things are
4 structured.
5 So again, I'd like to see us continue down the
6 road, and again, the primary lens should be how do we best
7 enable individualized decision-making.
8 MS. KELLEY: Brian.
9 DR. MILLER: Okay. I actually have a lot of
10 thoughts about this one. I appreciate you delving into this
11 space. It's not an easy space to research and have
12 comments on. Invariably, people end up with lots of
13 opinions and feel very strongly about it, so I appreciate
14 you now getting that.
15 A couple of thoughts. One is when you enter
16 hospice, you have often had exhaustive discussions, so it's
17 not a one-time conversation. It's seven days in a row in
18 the hospital, your hospitalist had a discussion with you
19 and your family and the patient, obviously, of course,
20 about what your tradeoffs are, what your plan is, what's
21 going on. Sometimes it's weeks. Sometimes it's months.
22 So the decision to enter hospice is usually a

1 pretty informed one. I don't think that we have any clear
2 evidence. It's from what I'm seen, as a clinician, or in
3 the research, that people are not having exhaustive
4 discussions. If anything, patients are often tired of us
5 bringing it up. Nobody likes to confront that we are all
6 going to the same place, at different speeds, and we
7 especially do not like to be told that we are traveling
8 faster than we believe, or than others would have us
9 believe.
10 So I do think that the hospice physicians do an
11 amazing job, along with the primary care docs and
12 hospitalists, of having these discussions with patients and
13 their families. I am not worried about that.
14 I am very worried about us getting sort of
15 involved in specifying services here that are in
16 everywhere. I think that the government and the Medicare
17 program have gotten in the way of the physician-patient
18 relationship many times, and that at least in this area I
19 see the potential for more problems and fewer solutions.
20 So I would favor not us weighing or weighting in more into
21 the specifics of what service a hospice is providing,
22 recognizing that that gray area is very gray. And so us

1 writing rigid rules might not be the best idea, or
2 suggesting that someone else write rigid rules, more
3 accurately.
4 I agree with Scott that regulation favors big
5 business and consolidation. The more regulation we add and
6 the more requirements that we suggest adding, the more
7 those small businesses, and the hospice industry has
8 historically been a lot of small businesses, offering
9 personalized, customized care to people at the end of life,
10 which is, frankly, something that we all will need at some
11 point. Some of us may or may not elect hospice, but it
12 would be nice that if we elected hospice that we had the
13 choice of a small business that is local to us, knows us,
14 knows our doctors, and knows the area. I don't want us to
15 inadvertently make a recommendation to turn us into big
16 hospital, big plan, big pharma, big whatever it is, which,
17 to some degree, we have done for almost every other service
18 in the Medicare program, as much of MedPAC's work has
19 shown.
20 I do think that we should integrate this benefit
21 into MA, so I think if we were going to do anything with
22 hospice, as opposed to specifying coverage or not coverage

1 of this service or that service or this type of clinician
2 or that type of clinician, that it's better for us to focus
3 our energies and the energies of our staff who are working
4 this space on how do we integrate hospice into MA.
5 To get to Larry's earlier question, my
6 understanding, which could be wrong, is that the benefits
7 came around the same time as MA was getting introduced and
8 tuned up. But one of the many predecessors, and I think
9 it's historical accident as opposed to intentional
10 exclusion. But we should add that into the chapter. I
11 know that doing that is statutory, and public policy news
12 search back in the '80s is not going to be easy. I do not
13 envy you guys having to do that.
14 I do worry that these comments from the hospice
15 industry, while I recognize that beneficiaries make
16 tradeoffs, is that I think those tradeoffs are pretty
17 informed, and if a hospice wants to offer these services,
18 they should offer them, and if they don't offer them,
19 that's the hospice, physicians, and the patient, like
20 patients can still get a lot of hospice-like care without
21 enrolling in hospice. You can still get an amazing amount
22 of care. Now, it's not the same focus as hospice, but it

1 can be tailored sort of like that. So let's not forget
2 that there are other components of home health and
3 habilitative services that patients who aren't in hospice
4 but are very near to hospice can also get.
5 An example being if you get discharged from the
6 hospital, you can go to a skilled nursing facility and get
7 hospice-like care without actually being enrolled in
8 inpatient hospice. So there's sort of a range of choices
9 that patients have. So I am a little less worried if
10 someone can get one specific service or another at a
11 specific hospice provider because there's a range of
12 gradations across Medicare because of the range of services
13 that Medicare finances and makes sure are delivered.
14 I am concerned, though, about what I would call
15 bad corporate behavior in hospice world. I know that
16 historically there has been some attention that hospice has
17 very long length of stay patients who might be at the
18 borderline -- I'm sure that you all have run into this in
19 your work -- that borderline of maybe they shouldn't be in
20 hospice, the people who are in hospice and then recertified
21 after six months. Is that correct?
22 MS. NEUMAN: Yeah, there's a percentage of

1 patients who have very long stays.
2 DR. MILLER: Yeah, and so on the other hand, I
3 know that there's also efforts by the hospice industry to
4 find patients who have very short stays to counteract that.
5 So there's a population of patients in the hospital that,
6 unfortunately, we all, as clinicians, know are not going to
7 exit the hospital and that they might be there for several
8 days and be under medical care by a team or a surgery team,
9 whatever, and we expect, and fully expect that they are
10 going to pass away in the hospital.
11 I know that there's an effort by hospices,
12 nonprofit and for-profit, to have those patients be
13 administratively discharged from the hospital and then
14 admitted to inpatient hospice, whereas in the normal course
15 of medical care they would just be on the general surgery
16 service, the ICU service, the hospital medicine service for
17 a couple of days, get excellent care from nursing, and then
18 pass away. So hospice industry, instead, wants to harvest
19 those patients and use them to lower their length of stay
20 and increase their profitability or to also decrease the
21 hospital industry's mortality, because those patients would
22 get discharged and then admitted to the hospice, while not

1 physically moving.

2 That sort of regulatory gamesmanship is happening

3 in hospice industry. I personally find that super

4 concerning and, frankly, super unethical to do that.

5 I don't think that we want to create more space

6 for gaming in the hospice industry, so I think if we start

7 to add services and specify specific services that must be

8 covered and increase payment rates, we are going to

9 encourage the hospice industry to slice and dice patients

10 more to improve their finances and scale up, have a variety

11 of mergers, and create these massive platform businesses as

12 opposed to focusing on small businesses that provide

13 localized, customized, and personalized care. And I think

14 that, at the end of the day, for the hospice industry in

15 particular, or the beneficiaries, that's really where we

16 want them to get their care. We want it to be

17 personalized, customized, provided by people that know the

18 community, know the doctors, know the patients, and know

19 their families. Thank you.

20 MS. KELLEY: Betty.

21 DR. RAMBUR: So thank you so much for this

22 important work. I think it's what we want for ourselves

1 and our families. And I think one of the most important
2 thing in my life was when my father was dying, people
3 saying to me, "Just remember, the question is will this
4 help him die more comfortably." And so I think that's a
5 really important responsibility.
6 Just a few small points. Like others, I was very
7 surprised that hospice philosophy determines the services
8 used, and any further illumination on intersections with
9 financial incentives and disincentives I think would be
10 very valuable. For example, are there Medicaid policies
11 for dual eligible that shape it? And the reason that I
12 think this is so important is that incentives beat
13 philosophy almost every time. I can think of a few
14 variables, and I'm sure you can too.
15 This is really important, I think, as underscored
16 by page 20 in the document, that pointed out the
17 variability from 15 percent to 47 percent, not explained by
18 rural/urban. So that's huge. So any dissection of
19 ownership I think would be very helpful.
20 A number of things have been mentioned about the
21 MA carveout, and if possible, to have a little table on the
22 history of that. When I first came on MedPAC I tried to do

1 homework to understand the history of it, and I could find
2 that it happened but not the rationale. I can think of
3 some rationales, but some kind of table would be helpful, I
4 think.
5 And then with that, the questions that Stacie and
6 Gina had about the ins and outs. You know that off the top
7 of your head, but if you could put that in a diagram
8 without being too much work, that would be really helpful,
9 because I think it's confusing to me, and I think it would
10 be to others.
11 And then finally, Tamara brought up the issue of
12 cognitive disorders. Scott talked about the long term. I
13 think this needs to be an ongoing stream, hospice and our
14 need to modernize Medicare, because, you know, maybe
15 cognitive disorders will someday go away, but they are here
16 for a while, and when they are there will be some other
17 long-term thing we're dying of. So I think we really need
18 to remember it's not 19--, whatever it was, and people just
19 dying of cancer.
20 But thank you for this really important work.
21 MS. KELLEY: Cheryl.
22 DR. DAMBERG: As I was reflecting on some of the

1 future directions that you flagged, sort of what initially
2 came to mind was, oh, you need to develop some
3 appropriateness criteria, because this seems like very
4 murky about when things are palliative versus not.
5 But I think I share the views that have been
6 expressed by several other Commissioners in that we really
7 need to ensure flexibility and the ability to customize,
8 given patient preferences and their specific needs. So I
9 would hope that as we move forward with thinking about
10 possibly altering the payment structure here in some way
11 that we try to maximize that flexibility and ensure that,
12 as Scott mentioned, that we can customize to individual
13 needs. So whether that's a carveout, that could be one
14 path that offers maximum flexibility, I think that's
15 something to keep in mind.
16 MS. KELLEY: Tamara.
17 DR. KONETZKA: Okay. So basically, I just wanted
18 to -- I think I'm off. Okay. I wanted to express support
19 for what's in your work plan, but I think actually all of
20 those directions were pretty exciting, but sort of moving
21 back a step before we can even do those kinds of things.
22 To me, there are a couple of problems to be solved. One is

1 I suspect that because of some of the confusion around
2 this, ESRD patients are probably underutilizing hospice,
3 and we want to keep exploring why that's happening and try
4 to fix those problems.
5 And one thing that strikes me from the chapter is
6 that there still needs to be some clarification around the
7 rules. I mean, to me it seems a little bit crazy that some
8 hospices would argue that palliative dialysis is outside of
9 the bundle because it's unrelated to the hospice diagnosis.
10 That, to me, seems like all providers and all hospice
11 providers should sort of be clear on what's in the bundle
12 and what's not in the bundle. And that, to me, is sort of
13 the first step. Sort of conceptually, what balance do we
14 want to set around what services should be provided, if
15 it's appropriate in that individual setting. And I don't
16 think that should be left to individual hospices and the
17 culture of the hospice.
18 And then the second step is, I think, to go back
19 to those financial calculations and really look at
20 different lengths of stay and how and whether those
21 additional palliative care costs, whether they're
22 appropriately already included within the bundle and

1 payments are sufficient to cover that, and whether that's
2 true for smaller hospices and larger hospices, or if we
3 need to adjust the payment in some way. But I think it
4 sort of starts with clarifying the rules around what's in
5 the bundle, what should be provided if it's determined
6 that's an appropriate thing for the patient, and start with
7 that clarification and move on to the financial
8 calculations, obviously over the course of an entire stay
9 and sort of simulating out like what happens if we actually
10 get ESRD patients into hospice earlier, will that still be
11 sort of financially feasible within a bundle. Thanks.
12 MS. KELLEY: Okay. I have a Round 2 comment from
13 Lynn, who was this is great work. Thank you. She strongly
14 supports palliative care for cancer and ESRD patients to
15 encourage utilization of the hospice benefit for these
16 patients. She would like more exploration of the payment
17 system with projections of costs and potential savings.
18 And I have Gina next.
19 MS. UPCHURCH: I support this work moving
20 forward. I did withdraw my comment. But I really
21 appreciate the interviews that you did. I appreciate the
22 comments of the other Commissioners. And I do think we are

1 underutilizing hospice in many ways, and I love the idea of
2 transitional potential. Thanks.
3 MS. KELLEY: Paul.
4 DR. CASALE: Yeah, thank you for this work.
5 Really interesting. Just thinking more particularly around
6 the ESRD patient, and getting back to Tamara's first
7 question about what's the prognosis for ESRD patients who
8 are on dialysis, and to Amol's comment that they have many
9 other medical conditions that might lead to reducing life
10 expectancy.
11 But when I think about dialysis, I mean, it is a
12 life-prolonging therapy, so palliative dialysis, in the
13 examples of sort of uremia and fluid overload, those would
14 be expected if you stopped dialysis. And so I struggle a
15 bit about how dialysis within hospice works in terms of
16 being palliative.
17 But I guess that links to what's already been
18 said, and you pointed out, that the median stay in hospice
19 for ESRD is six days, so obviously very short.
20 So I'm wondering in the work going forward, is
21 data available about patients with ESRD who may go into
22 hospice and then disenroll from hospice in order to get

1 back on dialysis and then potentially re-enroll at a later
2 date, maybe not necessarily understanding fully
3 anticipating what would happen, even though it was
4 explained to them exactly what would happen if they stopped
5 dialysis, because it can be a little tricky in terms of, as
6 Larry pointed out, some have some residual kidney diseases.
7 So their course can be so variable.
8 So anyway, the idea of enrolling, disenrolling
9 related to dialysis, and then re-enrolling I think would be
10 interesting.
11 MS. KELLEY: Larry.
12 DR. CASALINO: Yeah. Very briefly, I agree with
13 what, I think, probably a lot of us think, which is that
14 hospice is underutilized and we'd like to see it utilized
15 more, and probably for many patients for longer periods of
16 time.
17 I think that it sounds like Brian's patients are
18 lucky, patients in his institution, maybe in terms of the
19 shared decision-making that goes into hospice, but I think
20 that's at one end of the spectrum it's very good. But I've
21 got direct experience, both as a clinician and as a family
22 member of very different experiences in decision-making

1 about hospice, and they're really kind of horrible, and
2 it's so horrible that I really don't want to describe them
3 here.
4 So anyway, my second point is I agree with Paul
5 that ESRD is different. You know, if you stop it, the
6 patient is going to die. And sometimes it's quite a
7 peaceful death, usually in a week or two, but sometimes
8 not. You have fluid overload that could be very hard to
9 treat in a patient whose kidneys don't work. You can get
10 pericarditis, which can be very painful, and other nasty
11 things. So I think it needs to be maybe thought about
12 differently, and I'm not sure how, than some of the other
13 conditions you mentioned.
14 And then the last thing to say is I think this
15 shows we're clearly still kind of groping here, and one
16 thing to work toward, I think -- I had an econ professor at
17 Berkeley, Oliver Williamson, and this thing I really
18 remember from his actually, it's not what he got the Nobel
19 Prize for, is always seeking to define what he called
20 "discrete structural alternatives." So are there three or
21 four different ways that we could deal with a problem, as
22 you guys are emphasizing, and what are their pros and cons,

1 as far as we can tell? And different Commissioners have
2 thrown out, in kind of embryonic form, just in limited
3 discussion here, some of the things that you could consider
4 as a basis for one discrete structure alternative.
5 But if you do more interviews, ask people very
6 specifically, can you tell me one, two, three, what are
7 different ways that you can envision -- what's the problem
8 and what are the three ways we can deal with them? What do
9 you see as the pros and cons?
10 So I think for further work you guys do, and
11 actually for Commissioner thinking, seeking to that. In
12 general, that's what we do at MedPAC, and that's what the
13 staff does is present what Williamson called discrete
14 structural alternatives. And I think here, where we're
15 kind of groping around, I think it would be very useful to
16 work towards that.
17 MS. KELLEY: Amol. So think you so much for this
18 work, taking on, I think kind of bringing it to the
19 attention around different utilization rates. I think it's
20 fundamentally important.
21 So I have a few different comments, I think
22 partly sort of motivated by the clinical piece and then

1 using that as a launching point to step back.

2 I think there is one challenge here around how
3 we're thinking about it that I think is probably somewhat
4 variable across how we're interpreting it, just as a group,
5 and probably is a reflection of what's happening in the
6 real world, which is that we are kind of making this
7 observation that beneficiaries who are on dialysis for ESRD
8 are less likely to be in hospice. And I know when we look
9 at when they die, they're less likely to have used hospice
10 for length of stay, et cetera. And the tricky part here is
11 that there is a dimension, that Tamara has kind of flagged,
12 which is, well, what is the prognosis of people with ESRD,
13 especially as their clinical condition worsens in the
14 context of ESRD?

15 But there's another setting here, which is
16 probably very common also, which is that they have another
17 reason that they are near end of life, and they happen to
18 have ESRD, and that's, I think, one of the issues that
19 becomes particularly challenging here. Because say you
20 have another terminal condition -- call it cancer or
21 something else -- but you need dialysis to continue to live
22 whatever that full duration of that shorter lifespan is.

1 Then enrolling in hospice is essentially saying I'm
2 foregoing that normal prognosis of three or four or five
3 months, from my cancer or from my end-stage rheumatoid
4 arthritis, or whatever it is, and instead if I move on to
5 hospice and get off of dialysis, as Larry and Brian and
6 others have pointed out, that means I'm basically accepting
7 to die in two weeks or less.
8 And that is a really challenging situation. And
9 I think, in my opinion, that is where this is the most kind
10 of clinically stark situation and probably the situation
11 that puts beneficiaries and their families in the hardest
12 situation. As opposed to the situation where it is my end-
13 stage renal disease itself that is leading to my limited
14 prognosis, which I think fits a little bit better into this
15 attritional hospice paradigm.
16 So I wanted to bring that up, because I think
17 that is really, at least when I read these materials,
18 that's the clinical situation that I find very bothersome,
19 and that has a lot of resonance. And I take care of
20 patients who have end-stage renal disease and who have gone
21 through this problem, so I think it definitely, on a
22 personal level, very much resonates.

1 The second point I would say is I also agree with
2 Scott's characterization that the traditional way that we
3 used to view this notion of curative versus palliative
4 intent has now become much more itself gray. I mean, there
5 are a variety of different therapies now that are certainly
6 -- yeah, there's a mix of the palliative and curative
7 nature of what the treatment does. So there may be some
8 that are really, really helpful at decreasing suffering
9 that might have a small improvement in your lifespan, and
10 there may be others that have a very high chance of being
11 curative but also have the benefit of having some
12 palliative benefit.
13 So how do we characterize those and how do you
14 think about it? I think it gets tricky. So this is why I
15 think it's really fantastic that you have raised these
16 points, because I think it does deserve a more fuller
17 examination in the context of how technology has improved
18 things in health care. And now we have the Medicare
19 program, originally designed in 1965, and we have to now
20 think about how the Medicare program has to be modernized.
21 So I really appreciate you bringing this forward.
22 In terms of kind of path forward, I think

1 certainly it seems to me, and I think this is probably
2 consistent with what you all have said, for sure, I think
3 the guidance that we've gotten from Mike and Paul and from
4 kind of generally where we are is we're certainly not at a
5 state yet where we can design solutions, because I think we
6 don't even know exactly what the problem is, and what we'd
7 be trying to solve for.

8 I think what seems like would be helpful is
9 almost to go back to principles and say, well, what are the
10 principles here that we're after? I can articulate my own
11 view on this, to a certain extent, which is we should
12 contemplate, to some extent, how we ensure that the
13 beneficiaries have flexibility to pursue whatever their
14 goals are, from their care and their life, and then in
15 symmetry to that, we should ensure that the providers of
16 their health care are able to provide the services that
17 they need to meet their needs in the appropriate way, and
18 aren't in some sort of unintentional way, placed in
19 financial harm if they have to try to meet the beneficiary
20 need. That would obviously create a conflict, and I think,
21 in part, what you have surfaced here is that that may be
22 happening in certain situations, maybe not in all

1 situations but in certain situations.

2 So I just would give a kind of full-throated
3 support for pursuing this work. I think there are a number
4 of dimensions in which additional data would help. I think
5 teasing out some of these additional clinical situations,
6 where end-stage renal disease is the reason for the shorter
7 prognosis versus it is a concurrent condition but it has
8 this very particular dynamic in that it's needed for
9 achieving that full prognosis even and lifespan.

10 So I love the interviews. I think we probably do
11 more fact-finding around here before we can come up with a
12 sense of whether there is an incremental type solution,
13 which could be something that we could add onto the
14 existing structure, or whether, in fact, this is something
15 that might need a little bit more fundamental redesign of
16 how we think about hospice and palliative care, and how and
17 whether that might make sense both fee-for-service and MA
18 programs.

19 So thank you so much for bringing this up for our
20 beneficiaries' sake.

21 DR. CHERNEW: Okay. We are going to move on. If
22 you wanted to talk, sorry. Send me a message, because

1 we're going to end on time, and there are a lot of people
2 who want to talk next session, and they really need to be
3 able to talk. So I'm just going to say a few very quick
4 things to summarize, and then we're going to take a 3-
5 minute break.
6 The first one is we're not at the point now where
7 we're going to make recommendations. Part of what we're
8 trying to do is just understand and respond to concerns
9 that certain people, because of how risk is apportioned or
10 not getting access to appropriate care if they're in
11 hospice. That's sort of just where we are.
12 I think the core challenge that has arisen is the
13 way we divide risk, what the hospice pays for, what is paid
14 for by other people, is complicated. And we had a bunch of
15 clinical rules, and as Scott pointed out, those clinical
16 rules are increasingly hard to argue because we're saying
17 is this palliative, is it not. The grayness around the
18 rules is just really hard to interpret it. It is
19 administratively burdensome. So it's just really hard to
20 know what to do.
21 So I think, in part because I want to talk for 10
22 minutes but will talk for 20 seconds, is we do not yet have

1 a planned solution for a problem that we have not yet even
2 completely quantified, so we will continue to think through
3 this. But the notion of how we think through risk,
4 particularly if you put small hospices at risk, what are
5 they at risk for and how it interacts with a bunch of
6 integration and with MA plans, are all issues that we will
7 consider.
8 But right now what we're going to do is thank Kim
9 and thank Grace for both doing the interviews, doing all of
10 the analysis, and we will come back and continue to think
11 about hospice, because as everybody said, end-of-life care,
12 in general, whether in hospice or not, is really important
13 care, and we want to make sure that people have access to
14 appropriate care in a way where we remain good stewards of
15 sort of Medicare resources. And that turns out to be quite
16 a challenge, particular in this area.
17 Let's take a -- now that's my fault -- 2-minute
18 break, and we're going to come back at 10:35, which is on
19 time, to have a session.
20 [Recess.]
21 DR. CHERNEW: Okay. We are back. We are going
22 to be talking about quality of care and ways to improve it

1 in nursing homes, and we're going to jump to Carol. Carol,
2 go ahead.
3 DR. CARTER: Okay. Good morning. For our last
4 presentation, we're going to take a look at regulations,
5 star ratings, and fee-for-service programs aimed at
6 improving nursing home quality. I'd like to remind the
7 audience that they can download these slides in the handout
8 section on the right-hand side of the screen.
9 Last cycle, you expressed an interest in looking
10 at beneficiaries who live in nursing homes. In October, we
11 described those beneficiaries, the nursing home industry,
12 and the long-standing challenges to improving their care.
13 Last month, we examined institutional special needs plans
14 that could be an effective way to deliver care to nursing
15 home
16 residents.
17 Today's presentation focuses on regulations, star
18 ratings, and fee-for-service programs aimed at improving NH
19 quality. First, we'll look at regulations. To participate
20 in Medicare and Medicaid programs, nursing homes must meet
21 federal requirements regarding quality of care, quality of
22 life, residents' rights, and safety.

1 Surveyors are required to inspect nursing homes
2 at least every 15 months and assess each home's compliance
3 with the extensive set of rules. Surveys are done by state
4 inspectors. Deficiencies are rated based on their severity
5 and scope. Nursing homes must correct the deficiencies or
6 face penalties, denial of payments, or removal from the
7 Medicaid and Medicare programs. In 2024, penalties made up
8 three-quarters of the enforcement actions.
9 Regulations also lay out staffing requirements.
10 For example, nursing homes must have an RN on duty 8
11 consecutive hours a day, 7 days a week, and have sufficient
12 staff to meet the care needs of their patients.
13 Reports by GAO and the Office of Inspector
14 General over past 20 years have documented quality problems
15 such as infection control, resident safety, elder abuse,
16 underreporting of serious deficiencies, and inadequate
17 staffing on weekends. While there have been improvements
18 in some areas, especially when there has been focused
19 attention on specific problems, such as the use of
20 antipsychotic medications or restraints, the overall
21 quality remains a persistent problem.
22 Inspections are chronically underfunded and

1 result in high vacancy rates in surveyor positions, and
2 delays in the required inspections. In 2022, OIG
3 concluded the survey process misses serious problems or may
4 not lead to effective correction. That same year, the
5 National Academies questioned if the lack of effective
6 regulations was due to inadequate implementation and
7 enforcement, or the inherent limits to what regulation can
8 achieve.
9 CMS has publicly reported various measures of
10 nursing home quality on the Care Compare website since
11 2009. Beneficiaries, MA plans, and health systems use this
12 information to guide decisions about where to get care and
13 which nursing homes to be included in a network of
14 preferred providers. The idea behind the star ratings is
15 that by publicly reporting the quality of individual
16 providers, nursing homes would improve their care.
17 Nursing home quality is rated on three domains:
18 the inspection, staffing levels, and quality measures.
19 Nursing homes receive a star rating for each component, and
20 these 3 are combined into an overall star rating.
21 On the left, you see that the inspection rating
22 is based on the deficiencies found in the facility

1 inspection. Each deficiency is assigned points and a
2 nursing home's performance is compared to other nursing
3 homes in the same state. There is a set distribution of
4 ratings within each state. The top 10 percent receive a 5-
5 star rating and the bottom 20 percent receive a 1-star
6 rating.
7 In the middle, the staffing rating is based on 6
8 measures: 3 measures of staffing levels and 3 measures of
9 staffing turnover. A nursing home's performance is
10 compared to the national distribution of these
11 performances.
12 On the right, the quality rating is based on 15
13 measures: 9 long-stay measures and 6 short-stay measures.
14 Again, each nursing home's performance is compared to the
15 national distribution.
16 The overall rating combines these performances,
17 starting with the inspection rating and then adding or
18 subtracting a star for performances on the staffing and
19 quality domains. There are more details in the paper about
20 the measures and the how the composites are derived.
21 This chart shows the share of nursing homes with
22 1-star and 5-star ratings by domain in 2024. One-star

1 ratings are in dark colors, the 5-star ratings are in light
2 colors.
3 On the far left, the staffing ratings are in
4 green. Twenty-two percent of nursing homes had 1-star
5 ratings and 9 percent had 5-star ratings. This is in stark
6 contrast to the ratings of quality, the next pair over, in
7 orange. The distributions of the inspection ratings, the
8 next pair over, reflect the required distributions. On the
9 far right in purple are the overall ratings. Twenty-four
10 percent have 1-star ratings and 18 percent had 5-star
11 ratings.
12 This chart shows the distributions of 1-and 5-
13 star ratings by ownership and size, and again, the one-star
14 ratings are in dark colors, the 5-star ratings are in light
15 colors.
16 A higher share of nonprofit nursing homes had 5-
17 star ratings compared with for-profit homes. On the left,
18 28 percent of for-profit homes, in dark green, had 1-star
19 ratings, and 13 percent had 5-star ratings. In contrast,
20 the next pair in orange, 11 percent of nonprofits had 1-
21 star overall ratings and 32 percent had 5-star ratings.
22 We see similar disparities by size, with a much

1 higher share of small homes having 5-star ratings compared
2 with large homes. Not shown but in the paper, we found that
3 the distributions of star ratings was similar between urban
4 and rural facilities.
5 We reviewed the literature on the effectiveness
6 of the Care Compare website and found that there was some
7 evidence that consumers use the ratings to select higher-
8 quality homes but use and awareness of the website was low.
9 It also found some evidence that providers try to improve
10 their performance.
11 However, there have been some unintended
12 consequences.
13 The web-based ratings may exacerbate inequities between
14 high- and low-income beneficiaries since higher-income
15 beneficiaries were more likely to use the website.
16 There was evidence that some providers pay less
17 attention to measures that are not captured in the ratings.
18 Further, some providers may use coding and
19 documentation strategies to enhance their ratings.
20 And perhaps most importantly, the ratings do not
21 consider patient experience. The Commission has a standing
22 recommendation for CMS to move forward with finalizing a

1 patient experience measure for SNFs.

2 Now, we'll turn our attention to fee-for-service

3 Medicare payment policies.

4 The first program we examined is the SNF value-

5 based purchasing program. Like all value-based purchasing

6 programs, it increases or decreases payment rates based on

7 facility performance. The program began in fiscal year

8 2019, and its key features are specified in statute. It

9 was required to use one measure to gauge performance --

10 readmissions -- and to use a methodology to ensure reliable

11 measure results. The scoring must reduce payments for the

12 lowest 40 percent of performances. The payout pool is

13 funded by a 2 percent reduction to payment rates, and the

14 program must pay out to providers between 50 and 70 percent

15 of the withheld payments.

16 In a mandated report in 2021, the Commission

17 raised several concerns about the design, and those are

18 listed on the right-hand side. They include the number of

19 measures, the reliability standard, the scoring, the

20 payouts, the lack of accounting for the social risk

21 factors of the patients treated at each SNF, and the size

22 of the withholds.

1 The Commission concluded that the SNF VBP design
2 was sufficiently flawed that it should be eliminated and
3 replaced with a new program.
4 Since then, CMS has begun to make key changes to
5 the program. The Congress granted the Secretary the
6 authority to add measures, and over the next 2 years CMS
7 will add 7, for a total of 8 measures. CMS improved the
8 reliability standard and incorporated social risk factors
9 into its scoring of performance.
10 That said, there are remaining concerns.
11 Regarding reliability, there is an inherent tradeoff
12 between including more providers in the program, by using a
13 lower reliability standard, and using a higher standard
14 that will exclude low-volume providers. The revised
15 approach CMS has taken could be improved so that it is less
16 likely to reward random variation rather than actual
17 performance.
18 Three features that are in statute have not
19 changed: the scoring, the retaining some of the withhold
20 as savings, and the size of the withhold. The Commission
21 stated that VBP programs should be budget neutral, and that
22 if the Congress wishes to lower the level of payments it

1 has other levers to accomplish this, such as the annual
2 update.
3 In terms of results, since program began in 2019,
4 the readmission rate has increased. Each year, the
5 adjustments to payment rates have ranged from reductions of
6 2 percent to increases of about 2 percent, and payments
7 have been lowered to about 70 percent of providers.
8 MedPAC and GAO have both concluded that the
9 incentives are too small to change behavior. The cost of
10 the investments required to improve quality are likely to
11 exceed the size of any rewards.
12 Since Medicare accounts for an average of just 14
13 percent of facility revenues, the program's reach will
14 always be limited.
15 Another fee-for-service payment policy we
16 examined was a CMMI demonstration that ran between 2012 and
17 2020. Its objective was to lower avoidable
18 hospitalizations among nursing home residents. In the
19 first phase, the initiative funded clinical and educational
20 activities such as hiring RNs to provide direct care or to
21 enable the adoption of technology that would enhance care
22 coordination. The second phase offered financial

1 incentives to nursing homes and clinicians to treat in
2 place residents with one of six conditions.
3 The results of the evaluation were mixed. The
4 first phase raised program spending but lowered the
5 probability of an avoidable hospitalization. It had no
6 effect on mortality or other quality measures.
7 There was no clear evidence that the financial
8 incentives of the second phase accomplished more than the
9 clinical and educational activities of Phase 1, and the
10 demonstration was not extended.
11 Finally, we turn to ACOs. An ACO is a set of
12 providers that voluntarily enter into an arrangement that
13 holds them accountable for cost and quality for a group of
14 beneficiaries. Nursing home residents are typically a very
15 small share of an ACO's assigned beneficiaries. Two-thirds
16 of ACOs have less than 1 percent of their assigned
17 beneficiaries living in nursing homes.
18 Nursing homes may not see a financial benefit to
19 partnering with ACOs. Our interviews indicate that nursing
20 homes weigh the lost revenue from fewer high-payment SNF
21 days and ancillary services against the opportunity for
22 referrals and perhaps some portion of earned savings. Our

1 interviewees told us that whether ACOs share earned savings
2 with the nursing homes is a function of their relative
3 negotiating positions. For example, in markets with many
4 nursing homes, a nursing home may not have much leverage in
5 securing an agreement to receive a share of earned savings.
6 It is hard to draw any conclusions about the
7 quality of care furnished to nursing home residents because
8 the quality results are reported for the ACO's entire
9 attributed population, not for their nursing home
10 residents. In addition, the quality measures are not
11 tailored to the nursing home population, and nursing home
12 residents are excluded from the calculation of some
13 measures, such as those based on the CAHPS patient
14 experience survey, which is not conducted for nursing home
15 residents.
16 One less common type of ACOs are High Needs ACOs
17 that may be better suited to focus on the nursing home
18 population. These are smaller ACOs that have experience
19 serving beneficiaries with complex medical conditions, who
20 often are dually eligible.
21 In 2025, there are 13 High Needs ACOs.
22 The most recent CMS evaluation High Needs ACOs

1 found that of their assigned beneficiaries, about two-
2 thirds were dual-eligibles and about half had a nursing
3 home stay of more than 100 days in the prior year.
4 Relative to a comparison group, the High Needs
5 ACOs lowered hospital, emergency department, SNF, and
6 specialty care, and all of those were statistically
7 significant.
8 The ACOs also decreased hospitalizations and
9 readmissions, though reductions were not uniformly
10 statistically significant.
11 To summarize, there are a variety of regulations
12 and programs aimed to improve quality, but there's not a
13 lot of evidence they have worked. Studies by OIG, the
14 National Academies, academics, CMS evaluators, and MedPAC
15 have concluded that the survey and certification is
16 ineffective; the star ratings have had limited success; the
17 SNF VBP has not been, and is unlikely to be successful; and
18 the CMMI demonstration had mixed results and was not
19 continued. And finally, most ACOs are not designed to
20 focus on the nursing home population.
21 That concludes our presentation. We're glad to
22 answer any questions you have about today's presentation.

1 This material will be included as an
2 informational chapter in the June 2025 report to the
3 Congress along with the background material we reviewed in
4 October 2024, and information on institutional special-
5 needs plans that we considered last month.
6 And now we will turn things back to Mike.
7 DR. CHERNEW: Carol, thank you. As you said,
8 this material is going to be combined with a bunch of other
9 material as we work through this workstream on people that
10 live in institutions, institutionalized populations. And
11 so it is actually important to get a sense of how you're
12 feeling and what you're doing. And I take blame for this.
13 I have one person in the Round 1 queue, as far as I can
14 tell, and that is Stacie.
15 DR. DUSETZINA: Really excellent work, Carol.
16 Thank you so much. My question is about, in the
17 introduction you talk about the incentive for sending
18 people back to the hospital Medicare payment rates. And
19 one of the things I was kind of thinking through is does
20 that also happen for people who are self-pay when, if you
21 were a Medicare beneficiary but you were self-pay because
22 you haven't spent down to get your nursing home covered

1 through Medicaid, do you have higher or lower payments than
2 Medicare? So if you were hospitalized, and you came back,
3 and Medicare started covering that time, would that be like
4 more money for the site than if you were self-paying, or do
5 we have a good sense of how much the daily rate is for a
6 self-pay individual?
7 DR. CARTER: So when a beneficiary is living in a
8 nursing home and they go back to the hospital, if they come
9 back to the same nursing home and qualify for as needing
10 skilled care, Medicare will pay for the 100 days as long as
11 they continue to require skilled care. That payment rate
12 is higher than self-pay rates, and to the best of our
13 ability, we have really limited information on Medicare
14 Advantage rate, and, of course, Medicaid rates.
15 DR. DUSETZINA: So one thing that might be
16 helpful is then the family also has a similar incentive to
17 the nursing home, to go from Medicaid rates or self-pay to
18 Medicare covering it. It might just be helpful to have a
19 little table that gives an example of the daily rates for
20 each of those payers, self-pay, Medicaid, and Medicare,
21 just for context.
22 DR. CARTER: We don't have self-pay rates because

1 they're not reported in the cost report. We don't have
2 information about that. I can look to see what I could put
3 together. But even just walking through that incentive.
4 And I probably would note that it is very disruptive for
5 beneficiaries to go to hospitals and then come back, which
6 is why I think the CMMI demonstrated focused on potentially
7 avoidable, because those guys really should only go to a
8 hospital when they need to be going.
9 MS. KELLEY: I have a Round 1 question from Lynn.
10 She wants to know what the current role of the QIO in
11 nursing home quality, and can we look deeper at their
12 activities costs and outcomes?
13 DR. CARTER: We did look at that and decided not
14 to include it in the paper because their role has been
15 pretty limited. So maybe I could put something in a text
16 box if we decided that that's warranted. But their role
17 has been pretty limited.
18 MS. KELLEY: That's all I have for Round 1.
19 DR. CHERNEW: I'm blown away. This is good,
20 though, because again, this is going to be important stuff
21 and we're going to go through this now. So I think Tamara
22 is number one in Round 2. Tamara.

1 DR. KONETZKA: Yeah. I beat Scott. So thank you
2 for this great work, as always. I appreciate so many
3 things about this chapter, as always, your careful work. I
4 appreciate the fact that we're taking a hard and broad look
5 at care for one of our most vulnerable groups of
6 beneficiaries. And I like the fact that these different
7 potential levers for improving quality are sort of
8 examined, side by side, all in one chapter.
9 My comments are largely about sort of putting
10 these different levers into a broader context and
11 synthesizing them a bit. So I hope my comments are really
12 helpful for framing and some sort of suggestions for work
13 going forward.
14 I'll start by saying that nursing home quality
15 continues to be a crisis, as it has been for 35 or 40 years
16 now. But really a crisis in that despite all of these
17 efforts, there is always this sort of lower tier of nursing
18 homes, in particular, where some really horrible things
19 happen, some really bad examples of neglect and abuse. And
20 it's been a struggle over the years to raise that lower
21 tier, which is often large nursing homes in low-income
22 neighborhoods.

1 That said, there is also a problem on average as
2 we saw from, for example, all the calculations by MedPAC
3 and others saying that under the CMS staffing regulations,
4 which are probably now not going to be implemented, that
5 most facilities, even those staffing ratios were pretty
6 minimal, according to a lot of experts, that most
7 facilities currently would not meet those. So there's an
8 average quality problem, as well, but perhaps that lower
9 tier is sort of a more serious problem.
10 Okay. So digging into a couple of the specific
11 levers that you looked at, first for all about the
12 inspections. I think it's really important conceptually to
13 distinguish between regulatory inspections and compliance
14 and quality improvement. So regulatory inspections serve a
15 very specific purpose, and that is to ensure compliance
16 with minimal standards. They're just really trying to weed
17 out those bad apples.
18 And there's been discussion over the years of
19 having them take a more proactive quality improvement role,
20 but they're really not set up to do that. Like that's not
21 their function. So we really shouldn't be expecting
22 anything other than sort of trying to identify the really

1 poor performing facilities out of a regulatory system. So
2 it's important to sort of put that in context.
3 In general, I think there's just been too much
4 emphasis on the inspections over the years, and there's
5 this idea that if we just regulated and enforced harder,
6 we'd finally get better quality in nursing homes. And I
7 think after decades of trying that we should acknowledge
8 that that's not the case.
9 That said, this is a particularly vulnerable
10 population, and we have a largely for-profit industry with
11 incentives to minimize costs. So there's always going to
12 be a role for regulation, so I wouldn't throw out the
13 regulatory system. It's just not going to achieve what a
14 lot of people would like it to achieve. So there's a role
15 there.
16 And clearly, as you mentioned in the chapter,
17 many state survey agencies are underfunded and
18 understaffed. Every nursing home was supposed to be
19 surveyed once every 15 months, and some states, in the last
20 data I saw, are like several years behind. There are
21 nursing homes in some states that haven't been surveyed in
22 two or three years. So that's clearly a problem. It's

1 sort of consistent with the workforce issues, in general.
2 Nursing homes have trouble hiring staff, but those RNs are
3 the type of people who would actually work for these survey
4 teams.
5 Okay. So we need to actually invest in the
6 inspection system, but it's not going to solve our broader
7 quality problems.
8 Public reporting, and forgive me because I've
9 been studying this for like 21 years, from every angle
10 possible, so I can recreate these star ratings in my sleep.
11 So I have some strong feelings about this. And I think you
12 captured it well in the chapter, and that is that it does
13 serve a purpose, right. There is some face validity to the
14 ratings. And the research does show that consumers use the
15 ratings. There are shifts in market share because of the
16 ratings. And providers do care about the scores and try to
17 improve them, in various ways.
18 But I think, again, the context here is we
19 shouldn't expect this to be a panacea, because the biggest
20 predictor of where people go to a nursing home is distance
21 from their home, and the ability to find a bed. Those two
22 things are really important, and probably override quality

1 most of the time. So we shouldn't really expect public
2 reporting to give us dramatic effects, in terms of
3 improving overall quality.
4 The other thing I would say, and this is where if
5 we have bandwidth to do more work in this, I would love to
6 see some of this, as I've said before, everybody
7 acknowledges that probably the most important input into
8 nursing home quality is sufficient staffing, and there are
9 different aspects of staffing. But you just need to have
10 enough staff in the building. And the way the inspection
11 system was set up, it's really highly dependent, as you
12 said in the chapter there's like a 0.89 correlation between
13 the inspection ratings and the overall ratings. And that's
14 because the data on staffing used to be bad, and that was
15 great.
16 So I think the data on staffing have been good
17 since 2017, and it's time to, in my opinion, to really
18 revamp that whole star rating system, and really start
19 putting much more weight on the staffing, which everybody
20 agrees, right, providers, consumers, policymakers,
21 advocates, everybody agrees is sort of the essential
22 element. So I would love to see us, one, continue to

1 monitor staffing and think of that as our best measure of
2 quality in nursing homes, or certainly the best structural
3 measure, and perhaps even think about ways in which that
4 rating system could be improved and how we could re-weight
5 it, because I think you sort of need to start over, because
6 of the way the star ratings are constructed now.
7 I won't say much about the value-based purchasing
8 and the CMMI demonstrations because I think, again, they're
9 really marginal. Like maybe some of the tweaks to those
10 systems could produce some better outcomes, but they
11 weren't that well designed, and even they improve, what
12 we're going to see is very marginal changes. So it's sort
13 of the same story.
14 So overall I think what I feel most strongly
15 about, and maybe this can then feed into the framing of the
16 chapter, is that each of these policy levers has a role to
17 play, but they don't really add up to a coherent system
18 that promotes true quality improvement above minimal
19 compliance, and we're not even doing well at getting
20 minimal compliance.
21 So after multiple decades of trying all these
22 different things, I think it's naïve to just think that

1 improvements in any one of these is really going to make a
2 big dent.
3 Personally, I think we won't make real progress
4 without fundamentally changing how we finance long-term
5 care, more broadly defined, like beyond nursing homes, and
6 we likely need an influx of funding. And again,
7 personally, eventually I'd love to see a federal benefit
8 that modernizes Medicare and acknowledges the sort of great
9 unmet need on that long-term care needs of Medicare
10 beneficiaries, in the short term realizing that that's
11 probably not realistic in the short term.
12 You know, if we just look narrowly at the nursing
13 home space and the incentives involved, as we talked about
14 in the last session, I'm pretty excited about models like
15 I-SNPs. There's still a lot we don't know about I-SNPs, so
16 I just really want us to continue that work and figure out
17 if the intended effects are working and what the unintended
18 consequences are that may not even be sort of on our radar
19 yet.
20 So that, I think, is a promising model for two
21 reasons. I think it gets rid of some of the perverse
22 incentives around hospitalization, and also it gives you

1 this influx of staffing, which is, as I said, key to
2 everything, because just having that nurse practitioner in
3 the nursing home is probably going to make a lot of
4 difference.
5 So just overall, great chapter. I'd love to see
6 the framing of the chapter and maybe the end of the chapter
7 end with a little more analysis and synthesis of each of
8 these. I do think we should add a paragraph on the QIOs,
9 because that will sort of be raised as why aren't the QIOs
10 taking care of this. But I think, yeah, to me it's mostly
11 about framing and hopefully continuing some of the staffing
12 work. Thank you.
13 MS. KELLEY: Scott.
14 DR. SARRAN: Truly a body of excellent work, so
15 thanks for the great job you've done getting your hands
16 around, from several different angles, an important space.
17 I realized I'm in my fifth decade of work in this
18 space, first as a provider, then a payer, now on the policy
19 side. And Tamara used the phrase "crisis of quality."
20 There is no question, I think, that the quality issues in
21 this space are pervasive, persistent, and significant, in
22 terms of impacting beneficiaries' quality of life. And I

1 always keep reminding us the beneficiaries we're discussing
2 here all have, by definition, significant functional
3 impairments, most have fairly significant cognitive
4 impairments, and virtually all of them are unable to truly
5 advocate for themselves and navigate effectively the fee-
6 for-service health system. So that's important grounding.
7 Tamara kind of went through this, but I keep
8 coming back to the definition of insanity, doing the same
9 things and expecting different results. And it's not that
10 any of the initiatives that you've done a really nice job
11 of reviewing are not necessary. They're all necessary and,
12 as Tamara pointed out, they all can be improved. But
13 they're not sufficient in and of themselves nor in totality
14 to drive the magnitude of improvements in quality. So
15 whether it's mandates without funding, or public
16 transparency of results, carrot sticks, coaching, or call
17 it the usual managed care players -- community-based MA or
18 community-based ACOs -- they're not going to get us to
19 where we need to be.
20 So I think it's important to ask ourselves why
21 not, right. And to me the fundamental issue is that it's a
22 mistake in thinking about whom we can hold accountable to

1 improve results. So when you think about all these
2 initiatives to date, that are still going on -- and again,
3 not that they can't be improved -- but they all presume
4 either that it's the nursing facility we can hold account -
5 - that just does not work; we've proved that. They lack
6 both the dollars and the resources beyond the dollars, the
7 human resources to dramatically change the care. They just
8 can't do it. So expecting that we either punish them or
9 reward them, they're going to do what they can.
10 Or we expect that the community-based accountable
11 care vehicles -- community-based MA plans, ACOs -- they're
12 going to do it. No. They don't have, as you've done a
13 nice job illustrating, they don't have the requisite amount
14 of time, energy, and focus on that space.
15 Or we expect that the educated consumer is going
16 to do it, by choosing the better home. Well again, you did
17 a nice job of pointing out the flaws in that.
18 So I really do think that leads us back to, okay,
19 what can we do? What is a different approach? And Tamara
20 teed it up nicely. I think it is looking at how, call it
21 the least intriguing positive results of I-SNPs, and the
22 high-needs ACO, give us the best path towards a much better

1 set of solutions.

2 So the way I would like us to frame sort of the

3 result of all the three sessions is what would it take,

4 from a public policy perspective, what would it take for us

5 to be able to answer the question in a responsible way as

6 to whether some combination of, on the MA side, I-SNPs, on

7 the fee-for-service side, high-needs ACOs, would be a safe,

8 effective, scalable set of solutions for the quality in

9 this space. Because that is where, I think, our best next

10 steps are, is exploring, okay, if we believe that the

11 current approach is not going to get us there, and we

12 believe that there is at least some evidence that changing

13 the focus on who is the accountable entity might get us

14 there, what would that need to look like? So that's where

15 I'd like to see us go. So thanks very much for your work.

16 MS. KELLEY: Stacie.

17 DR. DUSETZINA: So again, thank you very much. I

18 think my only, you know, just broad comment here is the

19 percentage of one-star nursing homes is just so concerning

20 to me, and I think Tamara's comments were really helpful

21 for weighing in on, and the chapter, how those are

22 calculated and how that needs to change.

1 It feels like you really don't have enough
2 information, if you were a consumer trying to pick a place
3 to go, whether you're self-pay, whether you're going to
4 spend down and have Medicaid coverage. So I think it is
5 urgent that we have measures that actually reflect care
6 quality in a better way. So again, this work is so
7 critical for people.
8 I would say a little bit of additional detail on
9 just where Medicare doesn't cover people and that gap where
10 you're left in the self-pay space would be really helpful,
11 because again, I'm not sure the average person is as aware
12 of how little their benefits cover in this space. So just
13 reframing so people understand this is going to be a
14 problem that a lot of us will face with our family members
15 and ourselves in our future, and why it's so important to
16 tackle.
17 MS. KELLEY: Brian.
18 DR. MILLER: I had only one comment, and as
19 people went around, I had more comments, so I apologize.
20 I'd note that Scott had a five-star comment in Round 2,
21 under Michael Chernew regulations. I unfortunately may
22 drop to three or four stars due to the expanded length, so

1 I apologize in advance.
2 So a few things. One on staffing. I noted that
3 we didn't take a formal position on the staffing
4 requirement but that we did have a chapter on a proposed
5 rule, which I believe is very atypical for MedPAC. Is that
6 correct?
7 MR. MASI: I'm not sure about the chapter you're
8 referring to.
9 DR. MILLER: Well, we talked about the staffing
10 ratios right after the proposed rule for the staffing
11 ratios.
12 MR. MASI: So for a long time the Commission has
13 done work looking at what we know about staffing, so I
14 don't think that work was in response to the staffing rule.
15 DR. MILLER: Regardless, I think that we need to
16 be sensitive to our customer, which is Congress, which is
17 looking at repealing the staffing rule. So I know that
18 many people think that the staffing rule is important.
19 Perhaps that should get us to rethink what our
20 recommendations are.
21 I also don't think that Congress right now is
22 looking for hundreds of billions of dollars in spending

1 recommended by us to create a federal long-term care
2 benefit in Medicare when we have Medicaid as the current
3 long-term care benefit. I think that we all recognize that
4 perhaps there are things that could be done different in
5 Medicaid, but I do think that we need to focus on our
6 customer, which is Congress.
7 At the same time, there was this excellent quote
8 that you all put in, which said that the National Academies
9 has questioned whether the lack of effective regulations is
10 due to inadequate implementation and enforcement or to
11 inherent limits on what regulations can achieve. That
12 quote is probably the best encapsulation of all the
13 problems in this space, regardless of what the payer is.
14 Now I know that we here are focused on Medicare,
15 and I do agree with everyone else, and in particular with
16 Tamara, that the system is completely broken. I also note
17 that thinking about basal regulations, as Tamara pointed
18 out, versus performance are distinct things, and I think
19 part of our problem is that we look at what is inherently a
20 regulatory survey certification system as a performance
21 system, and it is not.
22 I think one of the things that we should do,

1 which is challenging but is worth undertaking, is think
2 about who is going to do what. There are probably some
3 things that CMS needs to do as basal regulation. Are there
4 things that states should be doing instead? Do we want
5 states to have a stronger role in regulation of nursing
6 homes and have CMS focused more on performance? I'm not
7 saying that that is the right answer, but I do think that
8 that could be a very constructive way to think about this
9 problem.
10 Because we have a clearly non-functional
11 regulatory system that doesn't work for the beneficiary, it
12 doesn't work for the regulator, and it doesn't work even
13 for the industry, and it hasn't worked for over 20 years.
14 And we don't really have a performance system, either, to
15 push the industry towards performing for beneficiaries.
16 So I think rethinking what is the basal
17 regulation and then what is the performance ask is really
18 important. I think in doing that, when we think about what
19 is the basal requirement and what is the performance, with
20 some process and a lot of outcome metrics, gets us away
21 from that rigid staffing rule. For example, if the
22 question is the basal regulation is if you can call, can

1 someone help you, like that's really what the issue about
2 staffing is, is can you get help. So if we do that, if you
3 can fill that in a way that makes sense -- and I don't know
4 what that answer is. That answer might be hiring more
5 staff for some facilities. For other facilities it might
6 be rejiggering tasks.
7 If you think about with hospitals that have
8 requirements to have 24/7 coverage for lots of different
9 services, whether it's neurosurgery, interventional
10 cardiology, or whatever, you think about, some hospitals
11 have the neurosurgeon sitting in-house, twiddling their
12 thumbs in the call room, because they have high enough
13 volume, and other hospitals have the neurosurgeon at home,
14 within a certain drive time and mileage requirement. I
15 think we are all familiar with that, especially with many
16 of my colleagues here who have run hospitals.
17 And so I think what we want to do is we want to
18 push nursing homes to think more like that, which
19 frequently would involve probably having more or different
20 staff. But that the regulation and performance should be
21 around functions and needs of beneficiaries as opposed to
22 do you have this many FTE doing this specific thing.

1 Because if we think that the current skilled nursing
2 facility is not working for the beneficiaries, and we agree
3 that the regulatory system is broken, doubling down on that
4 with very specific rigid requirements is just going to
5 anchor us more in a system that we all admit has not worked
6 very well.
7 I think the other thing that we need to think
8 very carefully about, which is getting to some of Stacie's
9 questions that we has asked in the chat and Tamara's
10 comments that she has mentioned verbally and Scott's
11 comments that he mentioned verbally, is to think, and
12 specifically for this chapter -- so now I'm going back now
13 from the big picture to our specific chapter, which you all
14 did an excellent job writing, and I learned a lot, to be
15 honest reading -- is that perhaps in addition to thinking
16 differently about who is doing a basal regulation versus a
17 performance, is that we need to think differently about
18 quality oversight for subacute care beneficiaries versus
19 the long-term care beneficiaries.
20 Because if you got your hip replaced and you are
21 going to a sub-acute rehab for two or three weeks, right,
22 then you have different needs, probably different medical

1 needs, probably different service expectations than someone
2 who is a dual-eligible, who lives in that facility, and is
3 going to get all of their care there, and has greater
4 impairments of independent activities of daily living and
5 activities of daily living.
6 So perhaps in addition to thinking about the
7 bifurcation of basal regulation versus performance for
8 skilled nursing facilities, and that will help us drive the
9 market in a better and more dynamic fashion rather than a
10 very rigid fashion, and help push them towards new models
11 of care, we also then need to think about those two
12 populations, which are both very large but very distinct,
13 some of whom visit a skilled nursing facility for a while -
14 - a couple of weeks, maybe a month -- and then the folks
15 who live in the facility. And I think then we can probably
16 give better recommendations to Congress about how to push
17 CMS to do quality regulation in a way that is going to help
18 those populations who have different needs.
19 I think back to Scott's comment for the long-term
20 care beneficiaries, a lot of that lever will be through I-
21 SNPs, to promoting integrated, coordinated care for folks
22 who no longer live in the community, are not going to be

1 able to get back to the community, and need a skilled
2 nursing facility as their place of residence and also as
3 their place and coordinator and organizer of medical care.
4 So I think if we focus on diverting -- as I said,
5 there are sort of two diversions. One is basal regulation,
6 and then performance, and then by population, skilled
7 nursing facility quality for those who are visiting for
8 sub-acute rehab, short, defined period of time, and then
9 people who are going to live in the skilled nursing
10 facility as long-term care. And then we can come up with
11 specific recommendations for Congress about how to reshape
12 those regulatory systems so that they are more functional
13 for beneficiaries, that they're more dynamic, right,
14 because you want those regulations to change over time as
15 the market changes, and same for the performance and
16 quality. And then also to better serve those distinct
17 populations.
18 Because if we're all saying that the system is
19 broken, then we should try and think about making it better
20 in a way that is dynamic, flowing like a river as opposed
21 to encased in concrete. Thank you.
22 MS. KELLEY: Robert.

1 DR. CHERRY: Yeah. Thank you for the
2 presentation. Even though a lot of the presentations are
3 in some ways templated, but in many ways they're not. And
4 whenever you hear about a new sector, in these meetings,
5 they have a new angle that has you thinking differently.
6 And I think for me the aha moment is, you know,
7 that old phrase, when you design systems in a certain way
8 you're getting the same results every time, based on how
9 you actually design those systems to work.
10 My thoughts are really reflective of also what
11 Tamara and Brian have commented on. You know, the star
12 ratings, the way they're structured, is really unusual,
13 particularly the inspection process being included with the
14 star ratings. Because when you have site surveys, based on
15 CMS standards, that is the floor. There is an expectation
16 that you pass your survey process. It's not really part of
17 a star rating, per se. The fact that it's bundled
18 together, that does feel sort of unusual and atypical. I
19 know Stacie was concerned about the number of one-star
20 ratings that already exist. If you pulled out the
21 inspection process, which is really kind of mandatory,
22 you'd have even more one-star facilities, as well.

1 So that's something that I don't think really
2 should be included in the star ratings, because as Brian
3 has mentioned, it's not really a performance improvement
4 issue. If you can't pass your inspection, you just don't
5 get star ratings at all. You are zeroed out, essentially.
6 And what you have left is the quality measures
7 and staffing. How much the staffing should be weighted
8 will lead to others, but you have 15 quality measures, you
9 know, you have several staffing measures. Some of those
10 staffing measures can be weighted a little bit differently
11 because of the importance of staffing within the nursing
12 homes.
13 However, even with staffing, there should be a
14 floor to that, that should be enforced through the
15 inspection process. So then what you're looking for in
16 quality ratings is something a little bit better than the
17 floor that actually exists through your surveys, because
18 that's really how you measure performance. You know, how
19 is that particular facility doing better than others
20 because they have innovative ways of investing in their
21 staff to really deliver the care that's absolutely
22 necessary.

1 I do have some thoughts about the inspection
2 process itself and why it may or may not be working
3 optimally, but I'm not close enough to the sector to really
4 make some concrete statements on that, because I think a
5 lot of it is just speculation.
6 But I do think that there needs to be a step
7 back, to think about how these surveys are done, so that
8 they have a level of rigor and focus and enforcement
9 associated with it, and pull it out of the quality ratings.
10 But otherwise I love your presentation. Nicely
11 done. Thank you.
12 MS. KELLEY: Gina.
13 MS. UPCHURCH: Thanks. Really great work, and
14 I'm so thankful that we're paying attention to folks, some
15 of the most vulnerable folks.
16 So as a SHIP coordinating site, one of the
17 biggest surprises to people is that Medicare does not cover
18 long-term care. And we go over it and over it. So I agree
19 with some of the comments that have been made, but people
20 need to understand that in order to have Medicare, fee-for-
21 service Medicare, cover long-term care, or excuse me,
22 short-term rehab in a SNF, you have to have had three

1 midnights -- the three-midnight rule -- in a hospital.
2 So to Scott's comments, we're dealing with
3 hospitals that have emergency rooms, they can't get people
4 up to rooms, they have boarding. I wonder about this
5 interaction with, oh, this person, they are going to need
6 some long-term care. Are they going to the hospital when
7 they really don't need to, to get Medicare to cover it
8 briefly? I don't know, but I feel like those interactions
9 need to be thought about a little bit.
10 But this three-day rule, where does that come
11 from? Why is it not a four-day rule, or a two-day rule?
12 And I just would like to know a little bit more about the
13 three-day rule, and is that a positive for the whole system
14 or is it something that really limits? Because otherwise
15 you're just going to be private pay. You're not going to
16 get any help, or if you spend down to Medicaid, obviously.
17 The other thing that I hear the most about when
18 we talk about people getting short-term rehab paid for by
19 Medicare in a skilled nursing facility is the use of AI in
20 ways to, with Medicare Advantage plans in particular, to
21 have people leave before sometimes the family members and
22 the providers think they need to leave. And we heard about

1 that in some of our Medicare Advantage chapters. So I just
2 think that needs to be pulled in, that sometimes people
3 aren't even able to take advantage of the benefits because
4 of some of the artificial intelligence not being used in
5 ways that we would prefer it to be used.
6 Third and fourth things. So I happened to be a
7 consultant pharmacist for a while in a very nice skilled
8 nursing facility. It was part of a CCRC. And I would do
9 drug regimen reviews. So I was independent. I was hired
10 by the School of Pharmacy to do this work.
11 So there should be maybe a little bit about how
12 pharmacy engages in skilled nursing facilities with drug
13 regimen reviews. Sometimes they're hired independently and
14 sometimes they're actually the same company that does the
15 dispensing. And the reason I raise this is because there
16 could be a potential conflict of interest around those
17 things.
18 And I worry a lot about polypharmacy and, quite
19 frankly, a lot of times the drug regimen reviews are these
20 little chart things that don't really have meaning. I had
21 two people within like a month period that I made a
22 dramatic difference in their lives. One had free-flowing

1 phenytoin that made them look intoxicated when their
2 albumin was low, for those of you who are clinical, and the
3 second one was somebody with very end-stage breast cancer,
4 who, while she was on morphine, she wasn't on anything like
5 ibuprofen because it might hurt her kidneys. And she was
6 in writhing pain. And I said, "We're going to put you on
7 ibuprofen," and I talked with the provider.
8 So the interdisciplinary team really mattered in
9 the pharmacy benefit. Sol if we have any idea of how the
10 pharmacy benefit is working to improve care in these
11 skilled nursing facilities when Medicare is paying for it,
12 why not if it’s not really helping.
13 And the last thing I would say is I know in
14 Durham they asked for volunteers to go visit skilled
15 nursing facilities, and another group of volunteers to go
16 visit assisted living. I don't know if that's a federal
17 requirement or what, but they're volunteers that go
18 randomly to these places to talk to the ombudsman and that
19 kind of thing, to see how things are going. I love that.
20 I think it's a great thing. I don't know who mandates it
21 or where it comes from. Is that a national thing, or not?
22 That might be good to know.

1 Thank you so much for this work.
2 MS. KELLEY: Cheryl.
3 DR. DAMBERG: Thank you for this work. I think
4 you did a good job of spotlighting a number of issues in
5 this space, so I'm glad we're focusing attention here.
6 I had comments in three areas. So first, I agree
7 there is a need to revamp the star ratings program in this
8 space, and Robert, you stole some of my thunder. I
9 definitely think the inspection piece should be pulled out
10 and should be sort of a minimum threshold requirement,
11 maybe as a condition of participation.
12 And then in terms of what remains, so we've got
13 staffing, we've got some quality of care measures, but we
14 continue to be missing the patient experience. So
15 definitely if we could add that as part of the mix of what
16 a rebound star ratings program would look like.
17 I also think that we need to continue to
18 emphasize or reinforce the need to consider social risk
19 factors in adjusting those performance measures to increase
20 the validity of those measures when making comparisons
21 across nursing homes.
22 The second area, in terms of the inspections, one

1 thing caught my eye in terms of the inspections are done at
2 state level and there is a lot of variation across states
3 in how those are performed. And it struck me that given
4 CMS is relying on these audits that there should be some
5 type of standardized training across the states for people
6 who do these audits.
7 And then lastly, I wholeheartedly agree that the
8 current size of the value-based payment incentive is too
9 small to be meaningful to these nursing homes to do much of
10 anything different.
11 MS. KELLEY: Betty.
12 MS. BARR: I'll just plus-one on the value-based
13 incentive payment being too small to really create the
14 incentive.
15 A couple of points. I just have to say that I
16 see our responsibility being to taxpayers and Medicare
17 beneficiaries, not a particular molding of what we say or
18 think to a particular group, no matter who they are. So I
19 will just share my thoughts on this.
20 I am very concerned about this space. This is
21 obvious, but if you're in a nursing home it's because you
22 need nursing care. And the incentive, financial incentive,

1 is to keep the staffing as low as possible. So, of course
2 organizations, particularly for-profit, are going to
3 respond to that.
4 I traditionally had not been supportive of
5 staffing ratios because I saw it as a regulatory response
6 to a market failure. But there is more and more data, and
7 I'm thinking particularly about staff turnover and burnout.
8 A study just out in January looked at California. This is
9 hospitals, but less intention to leave, higher job
10 satisfaction, and less nurse burnout in place that have
11 adequate staffing. So I certainly agree with Tamara that
12 we really need to be looking at staffing.
13 I'm particularly concerned about turnover,
14 because I imagine myself, when it's my turn to be a
15 confused elder, which is probably not so on the way, and
16 there is a dizzying array of people coming in and out,
17 that's very upsetting and very disconcerting. And to know
18 those individuals and their families and their values, you
19 really need to have a stable staff.
20 I want to just plus-one on the I-SNPs. I have
21 done a little bit of homework on them. I have long been
22 aware of the data that found that nurse practitioners who

1 are embedded in long-term care facilities, that there was
2 less turnover on that. And apparently some I-SNPs really
3 have virtually everybody in the setting enrolled, so that
4 nurse practitioner becomes part of the community, versus
5 others where they are scattered between many and just have
6 a few.
7 So as we look at I-SNPS, if we can kind of get a
8 little below that, to the fabric of them, because I do
9 think, when somebody comes in very occasionally, it's like
10 "Who are you?" But if you're in there all the time, you're
11 part of the community, and you would love these people -- I
12 mean, I've worked in a long-term care facility and it's
13 frustrating as it can be -- you also love these people and
14 care about them and their families.
15 So I think anything we can do to really ensure
16 that the right thing is done, that is the thing, and what
17 we would want for ourselves and our families. Thanks.
18 MS. KELLEY: Larry.
19 DR. CASALINO: Yeah, just a couple of things. It
20 is so confusing to everyone in the general population, but
21 even on the Commission here, I think, are we talk about
22 nursing homes or are we talking about SNFs, or are we

1 talking about long-term care or are we talking about SNF
2 care? The title of the work today is nursing homes, and I
3 and other Commissioners were routinely speaking about
4 nursing homes.
5 But it's really important for clarity, for
6 ourselves and the general public, to really, when are we
7 talking about nursing homes/long-term care, and when are we
8 talking about SNFs. Otherwise I think it gets too
9 confusing. And the long-term care segment of things is
10 pretty vague.
11 So I take it from the people who are experts on
12 this that regardless of which you're taking about, trying
13 to improve quality, there are different ways of trying to
14 do it. They haven't been very effective for a long time.
15 I don't think that means it's not worthwhile doing what you
16 guys are doing, trying to figure out ways to improve those
17 ways to try and improve quality. But the expectation I
18 think is that it should be limited for that, and especially
19 in the long-term care part of nursing homes.
20 So I just want to say, because I don't think
21 we've said it enough, is I certainly agree that in the
22 current environment a new Medicare benefit to cover long-

1 term care is unlikely. I think it's safe to say that.

2 But I would invite any member of Congress or

3 anyone who has anything to do with this area to go and

4 spend 10 minutes in a predominantly Medicaid long-term care

5 facility, of which there are many, many, many, many.

6 They're really the norm rather than the exception. Just

7 spend 10 minutes there. I mean, I've told my wife very

8 clearly, if I'm going to go into one of those places and it

9 looks like I'm not going to get out, I'd rather just die.

10 I'm not sure what she can do about that, but she is

11 ingenious.

12 [Laughter.]

13 DR. CASALINO: But I'm serious. I can't say

14 enough. That's all it would take, 10 minutes. And I think

15 a need for a policy, a Medicare policy, that covers long-

16 term care I think would be very, very, very clear. Because

17 on the long-term care side, the chances for improvement

18 with the current pace are really pretty much zero.

19 Actually no matter how much we try to jigger around, I

20 would say zero is not an exaggeration.

21 MS. KELLEY: Mike, that's all I have for Round 2.

22 DR. CHERNEW: Perfect. So if I don't remember to

1 say it later, Larry, expressing your end-of-life care
2 preference in your last comment really, I think,
3 exemplifies how all of MedPAC should go. But anyway, at
4 least now we all know, and thank you, and again, thank you
5 just in general. We will certainly miss you, and the same
6 will be true to Amol. So thanks to both of them publicly.
7 We want to say a few things about this session,
8 and paradoxically, because I scared you all out of Round 1
9 queue, which was the shortest Round 1 queue we ever had --
10 thank -- we'll have some time to actually have a broader
11 discussion, which I would actually appreciate if people
12 want to say things.
13 The first point is, we certainly pick the topics
14 we are interested in, based on what we hear from the Hill.
15 It's really important that we provide useful information to
16 them on the topics that they think are important, that I
17 have visited them some more, and certainly Paul and the
18 staff do, to try to understand their needs and make sure
19 we're responsive.
20 That said, we don't shape what we say based on
21 what we think they want to hear, regardless of which party
22 happens to be in power or where we think collectively they

1 do or don't want to go.

2 Our goal is to provide evidence so that they can
3 make the tradeoffs that they are elected to make, and we do
4 that with the acknowledgment that we are trying to be good
5 stewards of societal resources and make sure that Medicare
6 beneficiaries have access to the care and services that
7 they need. And I think if we do that, people who are a
8 higher pay grade than I, about what we do, we'll be able to
9 do that. I view us as sort of an analytic entity,
10 hopefully providing information that helps them, regardless
11 of what they do or don't want to do. So we can help them
12 do the things they want, and maybe stop them from doing the
13 things that they think they want but might not have the
14 effects they think they would have. I don't know, but
15 right now we're just trying to provide the information.

16 So that's the big picture thing about that.

17 The broader point about this chapter, the
18 narrower point about this chapter, is here is sort of my
19 general framing of what is obviously a very troubling
20 situation, and it's troubling because of a bunch of
21 different types of fragmentation and other issues. But if
22 I were to boil it down, I would boil it down this way.

1 We have a problem. We can try and quantify parts
2 of the problem. Some of the problem is an average issue.
3 Some of the problem is a lower-tail issue, and the
4 solutions might be different in both cases. But the sort
5 of big policy question is, do we need to put more money
6 into the sector, and if so, how would we do that in the
7 most efficient way possible and let the people who control
8 the purse strings decide how much they do or don't want to
9 put in. But if they're going to put money in, they should
10 do it in the most efficient way possible.
11 And, of course, in lieu of putting in more money
12 -- and again if we can, we will always be looking for
13 things to do in lieu of putting in more money -- is how
14 could we make the system, and the current fundings,
15 generally speaking more efficient. It is probably of
16 management, bad choices, bad information, a whole range of
17 things like that.
18 And so I think we're going to constantly be sort
19 of juggling a combination of how can we make the system
20 more efficient with the same resources, and if we need to
21 think through more resources or other things, how would we
22 think about funding all of that. And that's where I think

1 we will go, broadly. This is what I would call a
2 workstream, which means it's a multicycle thing. And we
3 are sort of at the informational phase.
4 I do think it is complicated. I would just pick
5 one thing that came up and Robert and Cheryl mentioned, on
6 the inspections and conditions of participation, stuff like
7 that. And that certainly sounds quite reasonable. I 100
8 percent agree with a lot of that, although I think the
9 problem is you have folks in settings where if they were no
10 longer allowed to be in that setting, they would have to go
11 to another setting. So you really need to think through
12 the disruption. I think one of the things that is very
13 clear in this context is disruption is not a great thing.
14 So as we go through it, we are far away from
15 getting to recommendations. It is both thinking through
16 what the direct effects, the intended effects, and what the
17 unintended effects might be, because you don't want to
18 inadvertently, in an effort to try and achieve a particular
19 goal, cause a bunch of other problems that you have to sort
20 through.
21 All the sectors we deal with are hard. I think
22 someone mentioned yesterday, I think it was Brian that

1 mentioned it, that the pharmaceutical sector was the most
2 complicated sector. I might be wrong about that, Brian. I
3 think you might have said that. But it turns out that
4 there are some aspects of this sector that are particularly
5 complicated because of the interplay with Medicaid and the
6 SNF nursing home sort of distinction, long-term stay
7 distinction, and some of these other issues about when the
8 pay rates are so different across the sectors it creates
9 incentives that are hard for us, as MedPAC, to sort through
10 what we would do. And I think it's hard for policymakers,
11 as well, what they would do, as Brian mentioned, are state,
12 federal issues, a whole bunch of other things. So maybe
13 this is more complicated. Or maybe everything is
14 complicated. Who knew?
15 But in any case, if anyone wants to add or ask,
16 that would be great. Otherwise, I'm going to again thank
17 Amol and Larry and the staff for an amazing cycle.
18 Okay. So a round of applause for Amol and Larry.
19 [Applause.]
20 DR. CHERNEW: A round of applause for the staff.
21 [Applause.]
22 DR. CHERNEW: In general, for those of you

1 listening at home, we can't hear your applause but we are
2 sure you are applauding, at least judged by the many, many
3 favorable letters we get complimenting what we do, and we
4 really do appreciate those fan letters.
5 But please send more at
6 meetingcomments@medpac.gov, and we really do want to hear
7 from you about these topics. The nice thing about, for
8 example, this topic, and even the hospice topic earlier, is
9 we are in the beginning stages of the hospice work. We're
10 in the middle of this work, where it's going to go. So
11 there is really an opportunity to provide information and
12 help us shape our thinking and help us avoid doing things
13 that might have unintended consequences that we didn't
14 anticipate.
15 So again, thank you all. Travel safety. We will
16 be back again next year, and again, we really do appreciate
17 all that you've done. So thanks.
18 [Whereupon, at 11:45 a.m., the meeting was
19 adjourned.]
20
21
22