MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, March 6, 2025
10:02 a.m.

COMMISSIONERS PRESENT:

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

2 [10:02 a.m.]

3 DR. CHERNEW: All right. Hello, everybody.
4 Thank you for joining us. This is our March MedPAC
5 meeting, and we have a lot of great topics, and so I'm
6 really looking forward to the next day and a half.

7 We're going to start with one that has been a
8 long time in coming. So, every year, we do an update
9 recommendation or an update discussion for the physician
10 fee schedule, but that process, in its nature, is always
11 prescribed for just sort of the next year. And it has been
12 pointed out that the physician fee schedule writ large may
13 need more fundamental attention than simply what should
14 happen for the next year.

15 So we're now coming towards the end, I hope, of
16 an extensive cycle body of work, looking at bigger changes
17 to the physician fee schedule, and so we're going to start
18 today going through what will be some draft
19 recommendations.

20 And, Rachel, I think you are up first.

21 MS. BURTON: Good morning. Rachel Burton here,
22 filling in for Geoff Gerhardt.

1 Today Brian O'Donnell and I will discuss
2 approaches to reform physician fee schedule updates and
3 improve the accuracy of relative payment rates. This
4 presentation is a continuation of the work the Commission
5 published in its June 2024 report to the Congress and a
6 Commission meeting last November. Viewers can download a
7 copy of this presentation in the handout section of the
8 control panel on the right side of your screen.
9 Geoff and Brian wanted to acknowledge me for my
10 assistance with this work, so I've now done this.
11 [Laughter.]
12 MS. BURTON: We'll start the presentation with
13 some background, including the Commission's principles for
14 assessing the adequacy of physician fee schedule payment
15 rates and the Commission's past findings with regard to
16 beneficiary access to care. We'll then discuss some
17 concerns with future fee schedule updates and a potential
18 fix the Commission has discussed over the last two cycles
19 and end this section of this presentation with a draft
20 recommendation from the Chair.
21 Brian will then pivot to discussing concerns with
22 the accuracy of the fee schedule's relative payment rates

1 and present the Chair's second draft recommendation to
2 improve the accuracy of relative payment rates.
3 We'll end with Commissioner discussion and
4 feedback on the Chair's two draft recommendations.
5 Depending on Commissioner feedback, a vote on
6 recommendations could take place in April, and this
7 material could be included in the Commission's June 2025
8 report to the Congress.
9 First, we'll discuss some background. The
10 physician fee schedule pays for about 9,000 different
11 clinician services. These services are provided in a wide
12 variety of settings, including non-facility settings, such
13 as clinician offices, and facility settings, such as
14 hospitals.
15 Each of the 9,000 services can be discrete, such
16 as the performance of an x-ray, or can represent a bundle
17 of care, such as a surgical procedure and the post-
18 operative visits provided by a surgeon.
19 Payment rates for fee schedule services are
20 determined based on the number of relative value units, or
21 RVUs, assigned to a service, the conversion factor, and
22 other adjustments. RVUs can vary across services and can

1 change based on where a service is provided.

2 There are three types of RVUs: for work, which
3 accounts for factors such as the time, effort, and skill of
4 the clinician furnishing a service; practice expenses; and
5 malpractice insurance.

6 Within the broad category of practice expenses,
7 there are two distinct types of practice expenses, direct
8 and indirect, which Brian will say more about later.

9 RVUs are multiplied by a conversion factor to
10 calculate a payment amount. The Congress has used
11 different approaches to update the conversion factor over
12 time. Current updates are largely based on MACRA, which
13 I'll discuss on the next slide.

14 This slide shows that with the exception of one-
15 year payment increases from 2021 to 2024, which are noted
16 in orange text, fee schedule updates are below 1 percent
17 per year and are specified in statute. This means that
18 updates don't automatically adjust to changing economic
19 conditions, such as increases in inflation.

20 Beginning in 2026, updates will vary based on
21 whether a clinician is in an advanced alternative payment
22 model or not, meaning there will be two conversion factors,

1 a lower one updated by 0.25 percent per year for clinicians
2 not in A-APMs and a higher one updated by 0.75 percent per
3 year for clinicians in A-APMs. MACRA also specifies A-APM
4 participation bonuses and payment adjustments for
5 clinicians in MIPS. We addressed those topics in the
6 Commission's June 2024 reports to the Congress but won't
7 focus on them in this presentation.
8 In assessing whether Medicare's payment rates are
9 adequate, the Commission's principles hold that payments
10 should ensure beneficiary access to care, reflect efficient
11 care delivery, and promote high-quality care.
12 Payment rates should also reflect good
13 stewardship of taxpayer resources. From 2016, the year
14 after MACRA was passed, to 2022, the Commission recommended
15 current law updates in its annual reviews of payment
16 adequacy. However, in response to increased levels of
17 inflation and other issues, the Commission recommended
18 higher-than-current-law updates in recent years.
19 Specifically, from 2023 to 2025, the Commission recommended
20 updates of a portion of the growth in the Medicare Economic
21 Index, or MEI, which is a common inflation metric that
22 measures the average price change for inputs involved in

1 furnishing clinician services and additional safety-net
2 add-on payments for treating low-income beneficiaries.
3 As I mentioned in the previous slide, beneficiary
4 access to care is a key factor we use to evaluate the
5 adequacy of fee schedule payment rates. For many years
6 now, our survey has found that beneficiary access to care
7 has been comparable with that of the privately insured.
8 We also find that clinicians accept Medicare at
9 similar rates as commercial insurance, despite lower
10 payment rates for Medicare. Volume and intensity of care
11 per beneficiary has increased over time, and other longer-
12 term indicators of access, such as the number of applicants
13 to medical schools and the number of clinicians billing the
14 fee schedule, have also remained positive.
15 In the next few slides, I'll go over two concerns
16 Commissioners have expressed about future fee schedule
17 updates and a potential fix the Commission has discussed
18 over the last two cycles.
19 One concern has to do with the MEI. MEI growth
20 outpaced fee schedule updates by just over 1 percentage
21 point per year for the two decades prior to the pandemic.
22 MEI growth then likely substantially exceeded updates from

1 2020 to 2025. From 2025 to 2034, the average annual
2 difference between projected MEI growth and current law fee
3 schedule updates is projected to be larger than during the
4 pre-pandemic period. This difference is projected to
5 average 1.5 percent per year for clinicians in A-APMs and 2
6 percent per year for clinicians not in A-APMs.
7 Although the Commission has historically found
8 that Medicare beneficiaries had comparable access to care
9 as the privately insured, the larger gap between MEI growth
10 and fee schedule updates could negatively affect
11 beneficiary access in the future.
12 A second concern is that the differential updates
13 specified under current law will initially provide a very
14 small incentive to participate in A-APMs, and in later
15 years a very large incentive.
16 For example, as shown in the figure, in 2027, A-
17 APM clinicians' payment rates will be 1 percent higher than
18 other clinicians' rates, but by 2045, they will be 10.5
19 percent higher.
20 To reform fee schedule updates, the Commission
21 has contemplated replacing the dual fee schedule updates
22 based on A-APM participation with a single update based on

1 a portion of MEI growth. The Commission was broadly
2 supportive of this approach over the last two years.
3 In designing the specific fee schedule update,
4 policymakers could consider a range of reasonable options,
5 such as MEI minus 1 percentage point with a minimum update
6 floor.
7 Regardless of the specific approach, the key
8 concept is that historical evidence suggests that a full
9 MEI update has not been needed to maintain access to care.
10 Such a change to fee schedule updates is intended
11 to ensure continued beneficiary access to care while
12 limiting financial burdens on beneficiaries and taxpayers.
13 Updates based on a portion of MEI have multiple
14 benefits. They would automatically adjust to changes in
15 inflation which, as we've seen over the last several years,
16 can be substantial and difficult to predict. They would
17 improve predictability for clinicians, beneficiaries, and
18 policymakers. They would balance beneficiary access with
19 beneficiary and taxpayer financial burden, and they would
20 be simple to administer, as they would apply across the
21 board to all fee schedule services.
22 As we mentioned in your mailing materials,

1 setting higher default updates would not negate the need
2 for future monitoring. The Commission would continue to
3 monitor access to care each year and recommend higher or
4 lower updates as needed.
5 Having summarized the issues with current law
6 updates and the Commission's review of the topic over the
7 last two years, I'll now turn to the Chair's first draft
8 recommendation, which reads "The Congress should replace
9 the current law updates to the physician fee schedule with
10 an annual update based on a portion of the growth in the
11 Medicare Economic Index, such as MEI minus 1 percentage
12 point."
13 The draft recommendation would increase program
14 spending relative to current law. The draft recommendation
15 should maintain beneficiaries' access to care by
16 maintaining or improving clinicians' willingness and
17 ability to treat them. It would also increase cost sharing
18 and premiums for beneficiaries.
19 I'll now turn it over to Brian.
20 MR. O'DONNELL: The second half of this morning's
21 presentation will explore issues related to the accuracy of
22 relative payment rates under the physician fee schedule.

1 At the November meeting, the Commission discussed
2 some ways in which fee schedule relative values can be
3 misvalued and how to address those issues. Ensuring that
4 relative payment rates are as accurate as possible is
5 important because RVUs affect the distribution of Medicare
6 payments across different services, specialties, and places
7 of service.
8 Misvaluation can result in incentives to furnish
9 more of some services and fewer of others. Misvalued
10 services can also influence where services are furnished
11 and incentivize vertical consolidation.
12 It's also worth noting that many commercial
13 insurers base their rates on fee schedules RVUs so
14 misvaluations can carry through to other parts of the
15 health care system.
16 In 2006 and 2011, the Commission made a series of
17 recommendations on how to improve the accuracy of RVUs.
18 The recommendations were focused on providing CMS with
19 assistance in reviewing recommendations from the RUC and
20 independent data collection to support those efforts.
21 At the November meeting, Commissioners discussed
22 three broad concerns about the accuracy of relative values.

1 While there is some overlap with the previous
2 recommendations, the issues I'll talk about are in many
3 ways distinct and warrant additional attention of
4 policymakers.
5 First, concerns have been raised about the
6 timeliness and accuracy of data on clinician practice
7 costs, which are used to help determine RVUs.
8 Second, the data and assumptions that are used to
9 determine RVUs may not reflect current practice patterns.
10 Third, the fee schedule does not currently
11 account for financial relationships between clinicians and
12 facilities, such as a hospital.
13 Earlier in this presentation, Rachel discussed
14 three types of RVUs. I'll now review what the different
15 types of RVUs pay for and how they are distributed within
16 the fee schedule.
17 Work costs include the salary and benefit of any
18 clinician who can bill the fee schedule, and as seen in the
19 pie chart, accounts for about half of total weighted RVUs.
20 Direct practice expenses include medical
21 equipment, medical supplies, and non-physician clinical
22 labor, and accounts for about 12 percent of total RVUs.

1 Indirect practice expenses covers overhead costs
2 like rent and administrative staff and accounts for 34
3 percent of total RVUs.
4 Malpractice insurance accounts for the remaining
5 4 percent of RVUs.
6 At an aggregate level, the distribution of
7 clinicians' costs determine the share of total RVUs
8 allocated to each category in the pie chart. In other
9 words, about half of the total RVUs are for work because
10 about half of the cost of running a clinician practice is
11 associated with work.
12 On the following slides, we'll look at three
13 illustrative examples where codes appear to be misvalued
14 and potential policies to address those misvaluations.
15 First, I'll discuss updates to the aggregate
16 allocation of work, PE, and malpractice insurance RVUs.
17 Second, I'll discuss why global surgical codes
18 are misvalued and two ways that payments for those codes
19 could be improved.
20 Finally, I'll talk about why the fee schedule may
21 overpay for indirect practice expenses in certain
22 circumstances and how that issue might be addressed.

1 I want to mention that this is not an exhaustive
2 list and that there are numerous other examples of how the
3 rate-setting process could be improved.
4 The first example regards how the distribution of
5 physician practice costs are used to determine RVUs. As
6 mentioned on the previous slide, on an aggregate basis, the
7 share of RVUs devoted to work, PE, and malpractice
8 insurance are supposed to reflect the distribution of those
9 costs in a typical physician practice.
10 The method for making these allocations is
11 complex, but it starts with looking at the MEI and how the
12 MEI says those costs are distributed. The MEI has been
13 updated many times over the years, reflecting changes in
14 physician practice costs. The most recent MEI is based on
15 data from 2017. Prior to that, the MEI was based on data
16 from 2006.
17 Normally, CMS would update the distribution of
18 RVUs concurrently with any updates to the MEI. However,
19 when the most recent update was released, CMS elected to
20 continue using the 2006 version of the MEI.
21 The delay in updating the RVUs means that
22 relative payment rates no longer reflect how practice costs

1 are actually distributed. Long delays in updating the
2 aggregate distribution of RVUs increases the chance that
3 payment rates will experience large changes once they are
4 updated.
5 The second example involves 10- and 90-day global
6 surgical codes. Global surgical codes bundle together
7 payments for all services that occurred on the day of a
8 procedure as well as post-operative visits furnished by the
9 clinician who performed the procedure during the following
10 10 or 90 days.
11 Generating relative payment rates for these codes
12 involves making assumptions about the average number of
13 post-operative visits furnished by a performing clinician
14 during the global period.
15 Studies have shown that for most global codes,
16 fewer post-operative visits were actually furnished than
17 are assumed in the payment rates. This results in
18 overpayment for many global codes and higher beneficiary
19 liability since cost sharing is based on the total global
20 payment rates, which includes visits that are not
21 occurring.
22 One way of addressing this issue is to convert

1 all 10- and 90-day global codes to so-called "zero-day
2 codes." This involves removing expenses associated with
3 post-operative visits from the total RVUs for each global
4 code so that each post-operative visit is paid separately.
5 Another way of addressing the issue is to revalue
6 global codes so that payment rates accurately reflect the
7 average number of post-operative visits that are actually
8 delivered.
9 Our third and final example concerns how indirect
10 practice expenses are paid when a fee scheduled service is
11 furnished in a facility setting, such as a hospital
12 outpatient department. For most services furnished in a
13 non-facility setting, such as a clinician office, fee
14 schedule rates include payment for clinician work, both
15 types of practice expenses, and malpractice insurance.
16 When a service is furnished in a hospital, fee
17 schedule facility payments include work, indirect practice
18 expenses, and malpractice insurance, but not direct
19 practice expenses.
20 For services furnished in an HOPD, the hospital
21 receives payment for both indirect and direct costs. As
22 shown in the red circle, this means that when a service is

1 performed in an HOPD, indirect practice expenses are paid
2 to both the clinician and the hospital. This approach is
3 based on the premise that hospitals need to be paid for
4 their overhead costs and that all physicians are
5 maintaining offices which are financially independent of a
6 hospital. This assumption, in turn, means that all
7 clinicians should be paid for indirect practice expenses in
8 order to maintain that independent office.
9 However, the share of physicians who are
10 financially affiliated with hospitals has been growing,
11 while the share that are maintaining independent offices is
12 shrinking.
13 Data from the American Medical Association show
14 that the percentage of physicians in practices that are
15 financially independent of a hospital dropped between 2012
16 and 2022.
17 Conversely, the share who are employed by a
18 hospital or work in a practice owned by a hospital have
19 increased substantially.
20 While there are many factors behind this shift,
21 paying both clinicians and hospitals for the same costs
22 could be helping to encourage vertical consolidation.

1 Regardless of how the current payment approach
2 affects clinician-hospital consolidation, it appears that a
3 growing number of clinicians are not paying for their own
4 indirect practice expenses. In those cases, arguably, the
5 fee schedule should not include payment for indirect
6 practice expenses.
7 Addressing this could involve reducing or
8 eliminating indirect PEOPLE RVUs for facility services when
9 there is reason to believe that the clinician furnishing
10 the service is not independent of a hospital. The impacts
11 of such a policy would depend to a large degree on how it
12 is designed and implemented.
13 To gauge the potential impact, we simulated how
14 fee schedule payments would be impacted under four ways of
15 implementing the policy.
16 Depending on the simulation, PE payments would
17 decline by between $1 billion and $4.5 billion per year.
18 The simulations show the net reduction in total payments
19 among all services furnished in a facility range from 2
20 percent to 11 percent. In order to maintain budget
21 neutrality, the reduction in payment rates for affected
22 services would result in an increase in payment rates for

1 all non-facility and some other facility services. Our
2 simulations show average increases in non-facility payment
3 rates of between 1 and 7 percent.
4 Addressing the issue of potentially duplicative
5 indirect PE payments by reducing those payments could
6 increase incentives to provide those services in the non-
7 facility setting and reduce incentives for independent
8 practices to consolidate with hospitals.
9 This brings us to the Chair's second draft
10 recommendation which reads: "The Congress should direct
11 the Secretary to improve the accuracy of relative payment
12 rates for clinician services by updating cost data
13 regularly and ensuring that the methodology used to
14 determine payment rates for different services reflects the
15 settings in which the clinicians practice medicine."
16 In terms of implications, given budget neutrality
17 rules, this recommendation is not expected to affect total
18 program spending. These policies are expected to make
19 relative rates more accurate, which is likely to have
20 redistributive effects on payments to providers.
21 In addition, addressing distortions in relative
22 payment rates could benefit beneficiaries by reducing

1 incentives for clinicians to over-provide or under-provide
2 certain services.
3 And with that, I'll leave you with both of the
4 Chair's draft recommendations, and I'll turn it back to
5 Mike.
6 DR. CHERNEW: Rachel and Brian and Geoff as well,
7 thank you. This is such a complicated issue. I've had
8 several tutorials, and I almost understand. So there's a
9 lot going on here. We'll just go right through Round 1 for
10 clarifying questions, and then we'll move into Round 2.
11 And I think, Cheryl, you are number one in the
12 Round 1 queue.
13 DR. DAMBERG: All right. Thank you.
14 Great chapter. Definitely continue to learn a
15 lot in this space.
16 I have a question on page 19. So while the text
17 reads that access is similar between Medicare and
18 commercial, there was one sentence where it talked about a
19 very small portion of beneficiaries wait a substantial
20 amount of time for appointments. And I was kind of curious,
21 like, is that 1 percent? Is that 3 percent? Like, is
22 there an actual percentage you can put against that?

1 MR. O'DONNELL: So I think what we were trying to
2 convey there is that we looked at wait times for Medicare
3 beneficiaries and compared it to private, and they're as
4 good or better for Medicare. And then when you drill down
5 on the percentages within Medicare that wait kind of a week
6 or two weeks, I think it's kind of -- it's a value judgment
7 on your end on how much you wait quantifies as a long time.
8 And so in the March chapter, which Rachel did, we
9 parsed it out by waiting one week or two weeks or three
10 weeks so we can add more information about the exact length
11 of time and the percentages of beneficiaries that they
12 waited, but that's in the March chapter.
13 DR. DAMBERG: Yeah. And I was trying to remember
14 whether it was more heavily for primary care or specialty
15 care or similar. So I just think maybe clarifying a little
16 bit there would help.
17 MR. O'DONNELL: Sure. We can add that.
18 DR. DAMBERG: Yeah. Thanks.
19 MS. KELLEY: Brian.
20 DR. MILLER: I just wanted to say thanks for
21 doing all this. It's a hell of a lot of work to go through
22 this with all of us sitting around the table nitpicking

1 this very detailed topic, which is not easy.
2 Really appreciated you adding the comments about
3 the RUC and the additional information about the volume and
4 intensity and response. Just wanted to thank you for your
5 work.
6 MS. KELLEY: Okay. I have a question from Larry.
7 DR. CHERNEW: Okay.
8 MS. KELLEY: Three questions.
9 First, he thought that the draft recommendation
10 would mention a floor for updates if MEI is low; for
11 example, 1 percent, with perhaps a floor of half of MEI
12 equals 0.5 percent.
13 DR. CHERNEW: I don't know if that's a Round 1
14 question. I'm not sure it's being clarified. That seems
15 like a Round 2 comment. But I will say the rec could be
16 what the rec 1 can be.
17 I think what we have tried to outline in the text
18 -- and that discussion comes up in the text -- is there's
19 several things that one might do in terms of a floor. So
20 let's say -- I think -- I think I want to save that
21 discussion until we go to Round 2. The rec is now worded
22 the way the rec is worded now. I think the implementation

1 issues would be separate.

2 MS. KELLEY: Okay. Larry also wanted to say, at

3 first glance, a recommendation for fee schedule updates

4 that are below inflation year after year might strike many

5 as unfair, and he thinks that we've done an excellent job

6 of explaining why this recommendation is better for the

7 country and has advantages for physicians.

8 Importantly, we've also explained that cumulative

9 updates over the past 20 years would have been higher under

10 this recommendation than under what actually happened, as

11 explained on page 36.

12 That said, though we do emphasize that MedPAC

13 would continue to monitor access and make a new PFS update

14 recommendation if it seems warranted, he thinks there are a

15 few places in the readings -- for example, on pages 5, 32,

16 and 34 -- where this could be emphasized by stating

17 something like "Based on historical evidence, such an

18 update would be sufficient to maintain beneficiary access

19 to care, at least in the short to medium term." So he

20 wondered if something like that could be added.

21 MR. O'DONNELL: Thanks, Larry. Thanks for

22 reading our materials. I like the page references, and

1 we'll talk about adding that kind of context in there.
2 MS. KELLEY: And then one last question. Readers
3 might take Figure 3 to show that total Medicare payments
4 for a 99215 office visit are equal, regardless of whether
5 the visit occurs in a physician office or a hospital
6 outpatient facility. He doesn't think we meant to show
7 that. Can we explain?
8 MR. O'DONNELL: Sure. And this figure is meant
9 to show the kind of overlap in indirect practice expenses
10 when the service is furnished in a non-facility and
11 facility settings. And we did -- Larry, we played around
12 with stacking these bars or not stacking the bars, and so
13 we can continue to kind of make it clear that under current
14 law, when performing the OPD, the total payments are
15 higher. I think we separate them as they are in the
16 mailing materials to kind of emphasize the duplicative
17 nature, but again, we can take a shot at making that more
18 clear in the materials.
19 MS. KELLEY: And I have Scott next for Round 1.
20 DR. SARRAN: First, kudos. Great work. I
21 particularly like how -- and appreciate how your work has
22 enabled us to get to, I think, pretty good consensus, as

1 will be likely reflected in our discussions through April,
2 on a very complex set of problems. And we've made some
3 very tangible solutioning in it possible.
4 Two quick questions. First -- and I apologize if
5 this is really basic -- can you help me make sure I'm
6 completely clear on when and how MEI is updated and what
7 the latency is and so forth?
8 MR. O'DONNELL: Sure. And I think part of the
9 confusion is probably because it's complicated, and we're
10 living in two different worlds right now. So I don't think
11 there's a set schedule. It's not like every five years or
12 every four years. So it's somewhat on an ad hoc basis.
13 When they updated it last, they used 2017 data.
14 They actually finalized that update, and that new MEI is
15 used for the price increases. So when you say MEI growth,
16 you're talking about price increases. That's actually
17 used. But then when they said we're not going to use it to
18 rescale the RVUs, which is to make the RVUs fit the
19 distribution of the new MEI -- so for that, we're still
20 using 2006 data. So we're kind of living in two different
21 worlds right now.
22 And what we're saying is, like, maybe we should

1 live in the most current world for both of those kind of
2 uses of the MEI.
3 DR. SARRAN: And the second is a little bit of an
4 internal process question. Am I right in understanding
5 that in Draft Recommendation 2, we left out a comment or a
6 recommendation about dealing with the global surgical
7 codes?
8 MR. O'DONNELL: So I can let Paul and Mike jump
9 in, but I think the idea was to be a little bit higher
10 level in our language on the recommendation. And so I
11 think, emphatically, we are not leaving out the globals.
12 I think our intent was to include that fix in the
13 first bullet point on the rec, so updating the cost data
14 regularly. So when you think about the kind of cost to
15 furnish a global surgical period or service, it includes
16 both the surgery and the post-operative visits. So, in our
17 mind, that kind of bullet point would cover that global
18 kind of fix, and I think we can make that really clear in
19 the text surrounding the recommendation.
20 DR. SARRAN: Thanks.
21 MS. KELLEY: Robert.
22 DR. CHERRY: Thank you. Great work.

1 When I first saw the draft recommendation, there
2 was part of it that wasn't quite clear, and it's in Draft
3 Recommendation 2, the second bullet point, which talks
4 about the fact that payment rates for different services
5 should reflect the setting. In some ways, the way the
6 wording is constructed, it feels contradictory to previous
7 votes on site neutrality. So maybe you can clarify if that
8 is contradictory or not contradictory or whether we need to
9 update the language that this lines up well with sort of
10 previous conversations that we've had.
11 MR. O'DONNELL: Absolutely. And we can add that
12 context.
13 Just for the readers at home, there's a section
14 in our mailing materials where we talk about how this
15 interacts with site neutral, and I definitely think that
16 this does not conflict with any of our site-neutral
17 recommendations. And we thought through that kind of
18 explicitly. But we'll add some more of that text to kind
19 of go through the mechanics of it.
20 MS. KELLEY: Lynn, Round 1?
21 MS. BARR: Two quick Round 1 questions. I think
22 the more you talk about this, the less I understand it.

1 But when we're talking about the MEI data in 2006
2 and 2017, it's still updated every year, right? I mean,
3 it's like that's the core data. But we're not, like,
4 actually dealing with 2006 inflation rates, right?
5 MR. O'DONNELL: So the 2006 data -- so there's
6 two uses for the MEI.
7 MS. BARR: Right.
8 MR. O'DONNELL: One is to figure out the
9 distribution of RVUs, and the other one is to measure input
10 price increases.
11 MS. BARR: Right.
12 MR. O'DONNELL: And so for the distribution of
13 RVUs, we are stuck in 2006.
14 MS. BARR: Got it.
15 MR. O'DONNELL: But to measure inflation, we are
16 using a 2017-based MEI.
17 MS. BARR: Which is adjusted annually for
18 inflation.
19 MR. O'DONNELL: Right. And so we --
20 MS. BARR: Okay. That's just what I wanted to
21 make clear is that we're not stuck in 2017.
22 MR. O'DONNELL: Yeah. So it's 2017. You think

1 of it as like cutting up the slices of a pie, and then we
2 use price proxies like the Employment Cost Index. And
3 those Employment Cost Indices are the thing that's updated.
4 So when you say, oh, MEI has increased by 3 percent this
5 year, it's referring to the most recent, let's say, 2024
6 inflation data.
7 MS. BARR: Okay, okay. Great. Just wanted to
8 clarify that. Thank you.
9 DR. CHERNEW: I'd just say that right now, the
10 formula doesn't include the MEI increasing. So it's just
11 being used for part of the cost.
12 MS. BARR: Right. I just wanted to make sure I
13 understood technically what the increase was.
14 And then when you're talking about addressing --
15 in this slide, that, you know, addressing duplicative
16 payments by reducing indirect P, I always worry every time
17 we mess with the system. You know, there's always
18 unintended consequences. This is obviously due to budget
19 neutrality, et cetera. This is all just -- we're not
20 really going to have savings. We're just going to have
21 shifting of dollars, you know, which may be good, may be
22 bad. I'm not really sure how they all end up.

1 But my question is that do you really think that
2 the magnitude of this would actually change behavior? I
3 guess that's what got me on that statement.
4 MR. O'DONNELL: Yeah. And so I do think that's a
5 judgment call. But I think one of the things we tried to
6 do to say is this worth it, which I kind of think is what
7 your question is --
8 MS. BARR: Yeah.
9 MR. O'DONNELL: -- we went through the
10 simulations, and we went with kind of the larger kind of
11 targeting to say let's try to target all the kind of
12 services we're concerned about.
13 But then we also did a really skinny model where
14 we said let's just target these services for which we're
15 the most confident, and even under the skinniest model,
16 it's over a billion dollars being shifted each year. And
17 under the larger models, it's closer to 4- or $5 billion.
18 So I think the question -- so that's the kind of
19 mathematical answer.
20 And I think the question for you in terms of
21 judgment is if we shift $4 billion from kind of facility
22 services to non-facility services, would that affect

1 behavior? I think that's the $30,000 question. But that's
2 the data I can give you.
3 MS. BARR: Got it. Got it. But, yeah, I guess
4 that's what -- like at an individual level, we're talking
5 like a couple percent. I mean, it's like what are we
6 talking about individually, I guess, is sort of a --
7 MR. O'DONNELL: Yeah. So we put some high-level
8 tables in the material, but for some services, it might be
9 only a few percentage points. For other services, based on
10 a number of factors, it could be 5, 6, 7, 8 percentage
11 points. And so when you start getting in those ranges, it
12 starts to kind of make me think that there would likely be
13 impacts in behavioral responses. But that's a judgment
14 call, just to be clear.
15 MS. BARR: Yeah, yeah. Can you give me like a
16 sense of like what percentage of the 1- to $4 billion would
17 be more than 5 percent? Because I really struggle with
18 physicians doing anything for less than 5 percent when I
19 think about, like, what's going to be the real impact.
20 MR. O'DONNELL: Yeah. So what we could do is we
21 have all the data on a HCPCS level, and we can go through
22 and try to say for X, Y, or Z percent of codes, the effect

1 would be from, you know, whatever, more than 5 or more than
2 3 or whatever the numbers. So we can do some of those
3 quantifications for you when we publish.
4 MS. BARR: Thank you.
5 MS. KELLEY: I think that's all I have for Round
6 1. So unless I've missed someone, we'll go to Round 2.
7 DR. CHERNEW: That's correct.
8 MS. KELLEY: And I have Greg first.
9 MR. POULSEN: Yeah, thank you very much.
10 Let me just pile on in terms of saying great
11 work. This is really, really good stuff, and I know
12 there's a lot, lot, lot of detail here.
13 I'm also really grateful to everyone involved for
14 being proactive on this. It would be easy to say, which
15 the chapter alludes to, that things seem to look okay.
16 We're hanging in there. Access is pretty good. It's good
17 for folks relative to private insurance, et cetera. It
18 would be easy to sort of stop there, and I'm really
19 grateful we're not because the tail on this is really long.
20 We don't start to see problems until it
21 accumulates over a long period of time, and even more
22 troubling, fixing it takes a really long period of time.

1 If we get behind the eight ball on this, it could take a
2 decade to fix. So gratitude for grabbing this one, even
3 though there's no crisis involved in the short term. So
4 thanks for all that.
5 I do think we're headed towards an era of greater
6 volatility, which I think indicates a good reason to look
7 at this differently than we have in the past.
8 The American Medical Association clearly would
9 love to see us update our index tied to egg prices.
10 [Laughter.]
11 MR. POULSEN: But I sort of only half say that
12 tongue in cheek because I think with the very good Figure 2
13 in the paper -- that's page 27 -- it shows MEI and other
14 things since the year 2000. That graph would look very
15 different if we'd taken the 25 years before the year 2000
16 rather than the 25 years after the year 2000. And if we'd
17 looked at this during those years, we'd have seen swings
18 that were dramatically more aggressive than what we've seen
19 here.
20 And it's my thought that saying an MEI minus 1
21 percent looks very different if MEI hovers between 1 and 3
22 percent or 1 and 3.5 percent than if it's more volatile and

1 we see swings, which is not impossible. And if you go back
2 30 years, it happened where we would see MEIs in the 8, 10,
3 even -- I think 11 is the highest that I recall. And MEI
4 minus 11 percent minus 1 is very different than 1 percent
5 minus 1 or 3 percent minus 1.
6 And I mentioned this last time, but as I went
7 back and looked at the real data, it makes me think that --
8 I like this concept very much and I think the idea is good.
9 I think we might be well served just in an era of potential
10 volatility -- and we haven't seen it fully yet, but in an
11 era of potential volatility, to tie it to something like 75
12 percent of MEI as opposed to minus a flat percent, which I
13 think would be more comforting in an era of high volatility
14 and more tied to what we would actually like to accomplish.
15 So that's not a critique of MEI minus 1 or MEI
16 minus some other percent, but I think it might be more
17 effective to have a percentage of MEI in an era of when we
18 have potentially high levels of volatility.
19 The other area that I wanted to just mention
20 briefly is in the chapter we talked about the important
21 topic of physicians who participate in A-APMs versus those
22 who do not. It mentioned that we, the Commission, have

1 mentioned that that's been troubling in some ways in the
2 past, but it also -- in the chapter, we mentioned that it
3 has benefit to some degree as well and that we had not come
4 down.
5 It seems to me; we may have made a judgment which
6 is implicit rather than explicit that we're choosing not to
7 put our focus on a differential for participation in A-APMs
8 versus not.
9 I'm not going to go into a long thought in terms
10 of whether that is a good thing or a bad thing to
11 incentivize participation in A-APMs, but I do agree fully -
12 - and the graph -- and I don't remember which slide number
13 it was -- showed that the participation in A-APMs would
14 compound to a dramatic degree over a period of time, and
15 that seemed troubling. And I agree with that.
16 What I would like to not do, though, is to
17 implicitly throw out an incentive to participate in A-APMs
18 altogether without having a good solid discussion on that,
19 which I don't think we've had.
20 And so, again, much like the other, I would
21 suggest that maybe what we throw out is if we want to
22 encourage participation in A-APMs, that we do that as an

1 add-on each year that does not accumulate. So you take
2 wherever you are and add X percent to it as opposed to you
3 add it and then add it and then add it, where you'd have a
4 compounding effect over the period of time, as your graph
5 showed very clearly and effectively.
6 But I don't think we'd necessarily want to, as
7 part of this paper where we don't discuss it explicitly,
8 say that we no longer think that we should incentivize
9 participation in A-APMs through this mechanism.
10 So that would be just two friendly amendments as
11 we go along. Thank you very much again for the great work.
12 MS. BURTON: I think maybe a reason we didn't say
13 a lot about an APM add-on in this paper is that we focused
14 on that in November, and there's kind of mixed views among
15 Commissioners about whether we need an APM bonus, how long
16 it should be in place. So that's why it's sort of
17 downplayed in this paper.
18 MR. POULSEN: No, I totally agree with that, and
19 I do not -- and I'm not critical that we haven't addressed
20 that here. It seems to me that some people reading it may
21 assume that we've addressed it in the negative, and that's
22 what I would like not to do.

1 What I'd like to do is to make sure and say we're
2 leaving that open. If we do want to make a recommendation
3 for a benefit for participating in A-APMs, we do think that
4 the compounding effect that we see, where it doesn't impact
5 you very much in the current year, but it would impact you
6 a great deal down the line, may be not the appropriate way
7 to approach it. I think that would be appropriate to put
8 in this paper. But I would like to see it left more open,
9 whether we want to reward participation in A-APMs or not,
10 because I don't think we have in this paper discussed the
11 benefits of that.
12 DR. CHERNEW: So just very quickly, there's
13 supposed to be -- I think there is -- in fact, I know there
14 is -- a paragraph in the paper that's supposed to say a
15 version of that. To the extent that that's not clear, we
16 can work on that paper.
17 But, as Rachel said, the discussion about the
18 form and the merits of an A-APM bonus was beyond what we
19 can get into. So just for those at home, we are -- I will
20 say this explicitly. We are not implicitly trying to say,
21 get rid of the A-APM bonus. Nor are we implicitly trying
22 to say keep it in some other form. We are simply trying to

1 say that is a different issue, and so we'll deal with that
2 differently. And we will revisit the text in the chapter
3 that is supposed to say that.
4 MR. POULSEN: I think that's great. I mean, I
5 read the chapter twice, and it didn't come out very
6 explicitly, and the fact that we, in the recommendation
7 itself, do very explicitly say, here's how we recommend
8 that we approach it -- and that's not part of it -- I think
9 it would be very, very easy to miss. So thanks a bunch.
10 MS. KELLEY: Stacie.
11 DR. DUSETZINA: Okay, great. Thank you so much
12 for this work.
13 I really appreciate the updates made, especially
14 on the access to care and emphasizing the difference
15 between Medicare and commercially insured people. So I
16 think that that really helps -- and also pointing to, like,
17 what, you know, payment could change as far as access goes.
18 So I think those are great updates to this.
19 I also just wanted to say that I do appreciate
20 Recommendation 1. I think tying this to MEI is a very
21 smart way to go, and I wanted to maybe reemphasize the
22 point that Scott had made about the Draft Recommendation 2

1 on that kind of first bullet point. It might need a little
2 bit more detail. I do see the appeal of having it be a
3 very broad recommendation because I -- you know, who cannot
4 argue that updating cost data regularly would be a bad
5 idea? But I think having a little bit more detail in
6 there, in addition to updating it, like -- and kind of the
7 follow-through of that, rebasing services and such, but
8 this is really great work and very supportive of the
9 recommendations.
10 MS. KELLEY: Lynn.
11 MS. BARR: Great work. I support the
12 recommendations.
13 MS. KELLEY: Cheryl.
14 DR. DAMBERG: I want to go on record as
15 supporting the recommendations; however, with a footnote.
16 For Recommendation 1, I would be interested in seeing it
17 expanded to include a ceiling and floor, as we had
18 previously discussed.
19 And then related to Recommendation 2, I
20 wholeheartedly support the need to improve the accuracy of
21 the payment rates
22 And related to the updating of cost data

1 regularly, "regularly" can mean different things to
2 different people, and it seems to me that at a minimum, CMS
3 should be updating those cost data, say, every three to
4 five years. So I think a little more specificity there
5 could be helpful, although I realize we're not in the
6 business of micromanaging or overstating or over-
7 prescribing. But I do think that what we've seen
8 historically in terms of those updates has been woefully
9 insufficient.
10 And then I think this issue of the double
11 payments for indirect practice expenses for services
12 delivered in the hospital outpatient department is a really
13 important issue, and again, there, you know, we have, I
14 think, one or two sentences in passing that talk about the
15 need for collecting better data on clinician-hospital
16 relationships.
17 And I think one thing that I've noted across a
18 lot of the chapters we discuss is the need for better
19 understanding of relationships between different providers,
20 and I think I would try to emphasize that more.
21 MS. KELLEY: Tamara.
22 DR. KONETZKA: First, thanks for this great

1 analysis.
2 Second, I basically second everything Cheryl just
3 said.
4 I also broadly agree with the recommendations.
5 I'll sort of reemphasize things I've said before
6 about Recommendation 1, and that is I think it's really
7 very important to have a more sustainable default. And to
8 me, the emphasis is on the sustainable and the predictable,
9 right? I think it's really disruptive to have these sort
10 of battles every year and crises where Congress has to fix
11 the rate.
12 I think in terms of the actual amount; I would
13 also love to see a little bit more. I mean, I'm okay with
14 recommendation as is given that there's maybe disagreement,
15 but I would love to see more specificity about a ceiling
16 and a floor.
17 I personally feel like we should be very, very
18 cautious. I'm very interested in the ceiling part of it,
19 even more than the floor. I feel like we should be very,
20 very cautious because, as I've said before, I think these
21 access problems are still hypothetical.
22 That doesn't mean that the concerns are not well

1 motivated. I think people have explained very clearly why
2 they're worried, but they remain hypothetical, right? We
3 don't really see in the access measures we have that access
4 for Medicare beneficiaries is a big problem.
5 And the cost to beneficiaries are quite real. I
6 mean, I think the number that was in the mailing materials
7 was, you know, an extra $100 billion, right? And so that
8 translates into beneficiary premiums going up, cost sharing
9 going up, MA benchmarks going up. Those are very real, and
10 this problem is still somewhat hypothetical.
11 And, you know, in reality, we actually see
12 spending on physician services go up every year because of
13 the volume and intensity, and so I think we really need to
14 keep that in mind.
15 I feel like the mailing materials did a good job
16 of sort of reminding people that there's a cost to
17 taxpayers and to beneficiaries here, but I would love to
18 see that translate a little bit more into the
19 recommendation, if possible.
20 I think that Greg's comments about sort of the
21 volatility of MEI really gave me food for thought, too, and
22 so I think some analyses of different ceilings and floors

1 that would be a cautious approach and also wouldn't provide
2 a ton of volatility, I think, would be very helpful.
3 And then, into the future, I think we just
4 continue to monitor access, right, because these things can
5 be adjusted over time if people feel these access problems
6 are emerging.
7 The final thing I'll say is that we've had a lot
8 of discussions about sort of fairness and morale among
9 physicians and all of those things. Again, I don't think
10 that those weigh heavily when we think about the taxpayer
11 costs of increasing rates. But I also think it's important
12 to remember that Medicaid payment rates probably aren't
13 going to solve those things, right?
14 So, again, I just would like to see a more
15 conservative approach and maybe a little more specificity
16 in the draft recommendation that makes it a little more
17 conservative.
18 Thanks.
19 MS. KELLEY: Betty.
20 DR. RAMBUR: Thank you.
21 I really appreciated this chapter and the
22 comments, and I'm going to try to not repeat but maybe just

1 pile on a few things.

2 I also had the sense that Robert did that it

3 seemed a little conflicting with site-neutral. So I think

4 it's really important that that's clear.

5 I just wanted to give a big shout out for pages

6 27 and 28, where you described the impact of provider

7 relief funds and the paycheck protection. Say that five

8 times. I thought that was very well done, and I hadn't

9 been clear on that before.

10 I want to pile in a little bit on what Greg had

11 said. I have been a supporter of bonuses because it's

12 still been so hard to transition to alternative payment

13 models because of all the momentum in fee-for-service, and

14 as you've all heard me say many times, we can't get to

15 chronic condition prevention and management in a reactive

16 fee-for-service system.

17 And I really wish in the future we would look at

18 this voluntary versus condition-of-participation issue. I

19 think of Paul Ginsburg who, at one of my second meetings,

20 said if the prospective payment system and DRGs were

21 voluntary and under consideration, everybody would say that

22 they couldn't do it. And I was there when that happened --

1 I'm that old -- and it happened with neck-snapping
2 alacrity. Just boom, it happened.
3 I strongly support the ceiling and floor issue,
4 and Tamara raised some issues I'm very concerned about.
5 What about deflation? Where can we expect deflation? I'm
6 channeling Bruce Pyenson here now. But for those of you
7 that are young -- and I'm sorry to go on, on this, but when
8 I was a pup, people would be hospitalized for 10 days with
9 a cataract surgery. They had sandbags beside their head.
10 They couldn't turn their head. And there was at least the
11 reports. I have surgeons at about 100 a year, maybe. Now
12 it's 15 to many, many more. And where is the deflation?
13 And I've read that if a $1,500 TV in 1970
14 inflated at the cost of health care, it would be, like,
15 $23,000 today. Now, obviously, those have deflated. But I
16 think in this conversation, we have a responsibility to
17 taxpayers to think about that end of it. So that goes to
18 my strong support, channeling or piling on Brian.
19 Including the RUC, I think is really, really,
20 really important.
21 And the previous recommendation of having an
22 independent body for a sort of a veracity check -- and if

1 it ends up being the same, that's great. But are other
2 industries able to really direct prices, fixed prices in
3 that way? I'm very, very concerned about that. And even
4 my sophomore students have to have concurrent validity in
5 something they do, and so I think that that's extremely,
6 extremely important.
7 On page 46, you detail the impact of
8 consolidation. I think that's important, and we need to
9 continue that line of work.
10 And then, finally -- and this may not be
11 associated, but I can't lace through the impact of AMA
12 ownership of CPT codes and if that has any way that it
13 laces through this.
14 But overall, I support the direction, but I
15 really hope we start thinking about deflation where it
16 should happen, so we can really put the money where it
17 needs to be, where things really are more expensive.
18 Thank you.
19 MS. KELLEY: Brian.
20 DR. MILLER: I had really short comments. I have
21 two sentences, and they got longer as people talked, so
22 apologies.

1 I do support the Chair's recommendation for a PFS
2 update of MEI minus 1. A few additional comments. That
3 was my original-only sentence.
4 I don't support Greg's amendments, either of
5 them.
6 Regarding ceilings and floors, I agree that we
7 should have ceilings and floors. I'd also note though that
8 through the legislative process, which we're not writing
9 "leg" -- we're sitting here giving general policy advice --
10 through the legislative process, budget constraints will
11 add ceilings and floors for us. So I understand people are
12 worried about that. I'm less worried, because I think that
13 that will happen naturally.
14 Regarding Tamara's comments on volume and
15 intensity, I think that that ignores the harm to
16 beneficiaries. Do we want physicians having a bunch of
17 five-minute visits, or do we want to pay them wisely and
18 have them do that 20 or 30 -- visit for the patient who has
19 25 medications and heart failure with reduced EF, COPD,
20 poorly controlled diabetes, below-the-knee amputation,
21 hypertension, depression, and generalized anxiety disorder,
22 who has four hours of home health aide three days a week?

1 I think we all want that beneficiary to have a 20- or 30-
2 minute visit, not a 5-minute visit, because the physician
3 is cycling through.
4 I also agree with Larry's historical comments
5 about burnout and morale. I know it sounds a little
6 froufrou-y, but it's not -- there's actually pretty good
7 peer-reviewed evidence that burnout affects quality.
8 Again, thinking about that beneficiary, I think
9 we want them to have an energized and supported physician,
10 and I think that that partnership is important.
11 As for the second recommendation about the rec, I
12 agree that there are many problems with the rec, to put it
13 mildly.
14 I also agree that the American Medical
15 Association owning CPT codes is very important for us to
16 focus on and is definitely problematic. I wonder, for this
17 recommendation, which is specifically telling Congress to
18 direct the Secretary to improve the accuracy of relative
19 payment rates, which is already currently CMS's job, which
20 CMS has failed at for around 20 years across multiple
21 administrations, given that we have a new and positively
22 assertive, intellectually curious Secretary -- and there

1 will soon be a new CMS administrator -- and that there's a
2 need for oversight from the committees of jurisdiction, I
3 wonder if we should collectively wait and see if action is
4 taken, and then, if not, put forward this recommendation.
5 MS. KELLEY: Kenny.
6 MR. KAN: Excellent chapter. I support both the
7 Chair's recommendations.
8 MS. KELLEY: Okay. I have a Round 2 comment from
9 Larry. He was very surprised to see that the
10 recommendation does not say anything about a minimum update
11 floor. He thinks that it seems like the entire chapter is
12 based on the idea that there would be such a floor. For
13 example, in the discussion that if MEI minus 1 with a floor
14 had been used over the past 20 years, payments to
15 physicians would have been higher than they were, not
16 counting Congress's one-time special add-ons. He would
17 have trouble voting for a recommendation that does not
18 include a floor.
19 On Lynn's point about the size of the changes not
20 being large enough to influence physician behavior, he
21 doesn't think the primary way to think about this is to
22 think about physicians deciding, service by service, where

1 to provide the service. Rather, the issue is that
2 cumulatively, the changes would make it harder for
3 hospitals to offer to pay physicians more than they earn in
4 private practice.
5 And then I have Josh next.
6 DR. LIAO: Great. I think the word that keeps
7 bouncing around in my head reading this chapter is really
8 about "tradeoffs." I think the chapter did a very nice job
9 doing that, kind of framing that every approach has its
10 tradeoffs. I really appreciate the context for BPS, SGR,
11 MACRA, to that extent. I appreciate the tradeoffs between
12 measures of access or not. It is not a crisis moment, but
13 they are lagging, and even if comparable to commercial, it
14 is not optimal. As a clinician, you see that, and so how
15 to do that more anticipatorily but in a way that is
16 judicious and accounts for taxpayer and beneficiary costs
17 and other things, I think is really important.
18 So from all of that, not to bury the lead, I
19 support the draft recommendations, both of them. I would
20 just double-click on that point of if we are going to open
21 a parenthesis and say such as the risk of getting into the
22 kind of semantics of it, if we are going to suggest

1 something like a minus 1, it would be nice to see floors
2 and ceilings there.
3 MS. KELLEY: Scott.
4 DR. SARRAN: This is somewhat building off of
5 Josh.
6 Notwithstanding the problems other people have
7 raised in terms of the way RUC currently works as well as
8 problems with the whole round peg/square hole of fee-for-
9 service payments not being optimal for promoting excellent
10 team-based chronic care, notwithstanding the concern about
11 perhaps relatively small amounts year by year really
12 impacting physician behavior, I so much resonate with what
13 others, including Greg, have pointed out, that it is really
14 possible to get behind -- and I think we are starting to
15 get behind -- in terms of access, and it being very
16 difficult once, if that becomes a profound problem, it
17 being very difficult to correct quickly. So for all those
18 reasons, I think this is the right direction, and I
19 strongly support it.
20 I always believe being -- that said, I always
21 believe being more explicit is better than being vague
22 until we reach a point where we're stepping our swimming

1 way outside our swim lane. So I think putting in something
2 about their -- our recommending a ceiling and floor makes
3 good sense. I think probably it would be going beyond our
4 scope or however we say it to specify what we think the
5 ceiling and floor should be, but just to say we think
6 should be a ceiling and floor.
7 And then the last comment and question sort of I
8 have is whether we could make -- whether we could or should
9 be more explicit in recommending a better approach to
10 updating MEI. We've got in there that we want it to be
11 more -- we want to use more frequently updated data, but I
12 wonder if we could take a little step down the explicit
13 road of what that could look like in order to be most
14 helpful to the people on the receiving end of our
15 recommendation.
16 Thanks.
17 MS. KELLEY: Robert.
18 DR. CHERRY: Yeah. Thanks again for the great
19 work.
20 I'm generally supportive of the draft
21 recommendations, but I do have a caveat, of course, around
22 Recommendation 2.

1 I agree with previous comments that the first
2 bullet point is probably overly broad, so it may not be
3 helpful. And the second one appears to contradict, at
4 least the way it's written, you know, the site-neutrality
5 position that we currently have. So I think if we can
6 clean that up, it may play over a bit better.
7 And then just as an aside, the chapter mentions
8 that the wait times are comparable to other payers that are
9 out there. I realize that conclusion is drawn based off of
10 these surveys that are conducted with different
11 beneficiaries, but I am skeptical of that, because there
12 are hospitals that participate in submitting their data to
13 performance improvement companies, and that data is
14 timestamped. So hospitals and certain physician practices
15 know when their appointments have been scheduled by the
16 patient, and they know when they actually occur.
17 And so that median lag time is something that
18 many facilities actually benchmark against each other, and
19 sometimes there are actually differences that show up
20 between payers.
21 The data is there. It's just that it's not
22 readily accessible to MedPAC staff, and I do wonder in

1 certain circumstances whether we can partner with some of
2 those companies to better understand the Medicare
3 beneficiaries a bit better.
4 But, other than that, the chapter is well
5 written, well done. Thank you.
6 MS. KELLEY: Paul.
7 DR. CASALE: Adding my thanks, terrific work,
8 great chapter.
9 I do support both recommendations.
10 And just one comment. I'm not convinced that the
11 metric of volume and intensity of service is provided. The
12 beneficiary is really a good measure of access. I know we
13 talk about this a lot, and you do tremendous work around
14 this. And I think we need to just emphasize we need to
15 continue to iterate the data on how we measure access.
16 Thank you.
17 MS. KELLEY: Mike, that's all I have for Round 2.
18 DR. CHERNEW: Yeah. Right. That's all I have
19 for Round 2, too.
20 But, Gina, did you want to say something quickly?
21 And then I'm going to ask Wayne to say something quickly,
22 and then I'm going to say something.

1 MS. UPCHURCH: No. I put something in the chat,
2 but I generally support the recommendation but err on the
3 side of being conservative, certainly with the cap, because
4 there's so much that we could be doing to improve the
5 health of Medicare beneficiaries that Medicare is currently
6 not paying for. So I just generally support both
7 recommendations.
8 Who is responsible for creating the MEI?
9 MR. O'DONNELL: So CMS maintains the index.
10 MS. UPCHURCH: CMS. Okay. They do it. Okay.
11 Just curious. Okay. Thanks.
12 DR. RILEY: Yes, Mike, I support the
13 recommendations. Great discussion. It's a perennially --
14 you know, topic that the physician community obviously pays
15 a lot of attention to because of its complexity and its
16 impact, both whether you have a private practice or are
17 more frequently engaged in a practice connected to a
18 hospital. So I support.
19 DR. CHERNEW: Okay. So thank you.
20 A few quick things to sort of summarize where we
21 are. This has been a very useful discussion.
22 There's a constant tension between what goes in

1 the recommendation and what goes in the text, and we try
2 and keep the recommendations reasonably broad, although, as
3 you know, we will often have a "such as" somewhere. The
4 word "regularly," which is not defined, as you pointed out,
5 I think those are all reasonable views.
6 I don't know the extent to which we want to be
7 sort of more prescriptive in the recommendation and more
8 flexible in the text. But it's a little bit what Brian
9 said, and I think that's kind of right. And we'll
10 certainly take this conversation into account when we
11 revisit the wording. So that's sort of one general theme
12 or tension.
13 With regards to the issue of ceiling and floors -
14 - and I put some of this out, but the inflation can be very
15 volatile, right? And so the question is, to what extent do
16 physician fees get pulled along with that? So imagine you
17 set up in a very simple world that you were going to update
18 according to MEI. Just mathematically, that's what you're
19 going to do. You would have all the volatility of
20 inflation, but in real terms, you'd have none of the
21 volatility because the inflation is just being adjusted.
22 And if you switch to MEI minus 1, you're getting a lot of

1 the volatility, but you're basically saying we're going to
2 shade a little bit below what inflation is. Inflation,
3 again, that's being 8. We're at 7.
4 If you do the fraction Approach, which as an
5 aside, we had, right, because we were doing a half before,
6 right -- and one of the reasons we switched because the MEI
7 times a half turns out to be more volatile in real terms.
8 In rapid inflation times, say you had 8, then you're 4
9 percentage points under. And in flat inflation points, say
10 2, then you're only 1 percentage point under.
11 So there's this question about what we're trying
12 to solve. I think, in general, we're trying to maintain
13 some approximation that real inflation adjusts itself,
14 which is why we actually switched from the one half to the
15 minus 1, because that does a better job of tracking
16 inflation than the one half does if inflation itself is
17 volatile.
18 We were doing a lot of this work when inflation
19 was pretty stable, and so it didn't make that big of a
20 difference. But I'm not in the business or have the
21 expertise to predict it, so I won't. But, anyway, that was
22 the idea behind the formula.

1 But even more important than that, it was all in
2 a "such as" in the sense that we are going to leave this to
3 CMS.
4 In terms of the ceiling and floors, one other
5 point. A floor -- we talk about this in the chapter for
6 those at home. A floor of, like, don't let it go negative,
7 seems to make sense to people, like we don't want to cut
8 your fees in a particular way, so that seems to make sense.
9 The ceiling is much harder to come up. Not that
10 there shouldn't be a ceiling, you shouldn't think about a
11 ceiling, it's just much harder to know what that ceiling
12 should be in an analytic way.
13 And so you may have heard Larry's comment that
14 you might want to have actual real MEI, and again, I'm not
15 advocating for that for all the reasons that are in the
16 chapter, that cost beneficiaries more and there's not
17 necessarily a crisis in access. But what we're trying to
18 avoid in sort of a ceiling discussion was then having a
19 debate about what it was. So we thought that the debate on
20 a floor would be kind of a little easier, but we still
21 didn't say what the floor should be. We kind of just leave
22 it a little bit to CMS to decide what they may want to do.

1 And I want to emphasize this last point, which
2 might actually be the most important point. Whatever is in
3 the recommendations is not overriding the need to have a
4 regular examination, as we do every year for the March
5 chapter. We are -- and I think some of this may have been
6 you, Tamara. If it wasn't, I'm sorry for who I'm
7 forgetting and who I'm crediting or blaming -- is the
8 changing of the fall creates a level of predictability and
9 stability that deals with some uncertainty about what's
10 happening. Effectively, they've been doing MEI minus 1.
11 They've been doing it in a somewhat complicated way.
12 And so it's really not meant to override the need
13 to examine physician fees and access and all the things
14 that have been discussed, which I agree with, as much as to
15 get a default that in all honesty I believe is just a
16 little bit more realistic than the default that they
17 currently have. That's sort of where we are.
18 So I'm going to say something about site-neutral
19 in a minute, but with regards to that part of the
20 discussion, we will give some thought to what should be in
21 the recs, what shouldn't be in the rec, what should be in
22 the text, and what shouldn't be in the text. But I'm not

1 that hung up on what it is.

2 I do have a sense that I don't want to be overly

3 prescriptive in exactly what we're voting because it just

4 makes it harder to sort out. But I think a lot of the

5 value is in the underlying text.

6 With regards to site-neutral -- I know, Betty,

7 you want to -- do you want to jump in now before --

8 DR. RAMBUR: Just on that.

9 DR. CHERNEW: Okay. Go on.

10 DR. RAMBUR: Briefly, I forgot to mention the

11 other thing, at least, that I'm not clear on is how the

12 explosion of private equity-owned practices would affect

13 MEI. So if owners are extracting more, do prices go up,

14 and how does that lace through? So that's just another

15 piece that I'm not clear on.

16 DR. CHERNEW: That's a Round 1 question that I

17 don't know the answer to.

18 DR. RAMBUR: No, I just -- and we don't have to

19 go into it now, but I just -- I think that's another thing

20 to at least consider.

21 DR. CHERNEW: So this is the portion of the

22 session where I just take complete blame. We should

1 probably have more of these sessions at times.

2 There was a version of the rec that didn't have
3 the word "setting." It had the word "manner," reflected
4 the manner in which clinicians practiced. And the argument
5 in favor of "manner" was it was just vague. The argument
6 against the word "manner" was it was just vague. Who knows
7 what the "manner" meant?

8 What we're getting at explicitly, which is
9 different than the site-neutral point, is that when
10 providers are employed by a system, the physician fee --
11 I'm putting the facility fee aside -- the physician fee
12 portion is reduced. The RVUs are reduced but not in
13 totality. There's still a facility point that's in there.

14 So if you -- and then there is a chapter that
15 says there's also -- if you're doing it in an outpatient --
16 hospital outpatient department, you then get the facility
17 fee part. So there's this question that that facility
18 portion of the fee schedule for service provided by an
19 employed physician in a hospital outpatient department is
20 meant to support, conceptually, the office that that
21 physician maintains outside of the outpatient department,
22 which may in fact not be true.

1 And so we were -- when we were talking about
2 "setting" in that context, we're really trying to talk
3 about that, the extent to which the -- there's this other
4 office set of expenses that wouldn't be captured in the
5 facility expenses in an HOPD. That was kind of the idea.
6 But the key point is that was intended -- and
7 then the core distinction here is that was intended to be
8 done all within the physician fee schedule part. In other
9 words, it's really just having the physician fee schedule
10 be priced accurately so that you're not paying, say, a
11 facility part of the physician fee schedule for an office
12 that just doesn't exist. That's basically what the idea
13 behind that was.
14 The site-neutral part is slightly different in
15 that we're -- the service is being done somewhere else, and
16 the question is how we're paying for the facility fee and
17 the physician fee schedule when it's done in an office
18 versus the facility fee and the OPPS when it's done in an
19 outpatient department. And we tried, and we can certainly
20 revisit.
21 I think the points are actually quite -- your
22 comments are quite clear that although there is a section

1 in the chapter that was intended to anticipate and clarify
2 this -- and I think -- so kudos, you did a good job -- we
3 can always revisit that and try and do better to make sure
4 it's clear what we're going on. So this is not intended --
5 and Brian said this. This is not intended to conflict with
6 any of our site-neutral work. It's really intended to get
7 at a different issue.
8 And it might be when we -- Paul will say
9 something in a minute. It might be when we regroup, we
10 decide to take the word "setting" out of the recommendation
11 and put back "manner" or some other word that you may want
12 to send me sometime, or we might want to keep the setting
13 and then sort of explain more explicitly what's going on.
14 It's just that was the issue of a world in which physicians
15 all have independent offices and then they go practice in a
16 hospital outpatient department, which is a separate entity,
17 is not necessarily the world that we live in. And so
18 that's the part that we are trying to address.
19 And the sort of theme is really just do your best
20 to kind of get that all right without saying exactly how to
21 do that and acknowledging that it's sort of hard.
22 But that's my sense of where that is, and I do

1 appreciate your comments. It is actually really invaluable
2 to hear how you read the material, knowing how the material
3 was sort of what we were intending to do. So that's
4 actually quite helpful, and I'm grateful.
5 Paul.
6 DR. CASALE: First, I think, Robert, did you want
7 to get in here?
8 DR. CHERRY: Yeah, I have my first R3. Wow.
9 [Laughter.]
10 DR. CHERRY: So just on your point, Michael, so I
11 totally get that you're threading the needle here. One
12 suggestion, because you know that whole conversation that
13 we had way back when around psych neutrality, around what's
14 safe and appropriate, maybe using the word "appropriate"
15 might be a good language to insert here. So, in other
16 words, that the payment rates for different services should
17 reflect what's appropriate.
18 The reason why we inserted that word
19 "appropriate" is that it gave -- potentially it was
20 incorporated into law, CMS, some latitude in terms of
21 considering the acuity of the patient and what is the best
22 practice setting based on the intensity of services. So

1 it's just maybe that might be an alternative "manner" or an
2 alternative to "settings" to say what's "appropriate."
3 DR. CHERNEW: Yeah, I do think this requires us
4 to go back and actually look at the words we wrote and then
5 think about your comments and the words that we could
6 write.
7 I will say in the site-neutral -- and, Brian and
8 Rachel, please jump in. The site-neutral part of this is
9 really about balancing between the PFS and the OPPS aspects
10 of how one pays for the facility or the practice expense
11 portion of it.
12 This one is a little bit more about just within
13 the physician fee schedule part when something's done in a
14 facility. So you're just you're going to do it in HOPD.
15 So I don't know enough about medicine, about what things
16 have to happen in HOPD. So if something had to happen in
17 HOPD, you know you want the OPPS to capture the facility
18 cost of that, and then the question is how much do you want
19 to add on for some other facility potential thing in the
20 fee schedule thing that goes along with it? So we're
21 balancing -- we're not thinking about physician services
22 delivered in the office as much as when something is

1 delivered in the hospital for a particular service, how are
2 we thinking about the existing expenses? So there's the
3 expense done by the HOPD, which is covered by the OPPS, but
4 then there's this other expense which sometimes does or
5 sometimes doesn't exist, which is the physician's office
6 outside of the HOPD that they're otherwise maintaining.
7 And how do we capture the actual expense for that for
8 services that we know are going to be provided, say, in an
9 HOPD?
10 And again, I may have misstated that. It was
11 perfectly clear in my mind, but every time I read the
12 transcript, I realize that I'm not clear. So that's why I
13 should turn it over to Paul.
14 MR. MASI: Okay. Thank you.
15 And I just wanted to briefly reflect. This is a
16 really good conversation, and thank you for all this
17 feedback.
18 And kind of stepping way back, I heard really
19 substantial and broad agreement, substantial agreement that
20 there's interest in reforming the current approach to
21 updates to something that would be more predictable and
22 then also a lot of agreement around the idea of improving

1 how relative values and relative payments are set under the
2 fee schedule. I appreciate that all of these details -- it
3 being Medicare, the details are really important, and we'll
4 take all this back to try to reflect that in the chapter.
5 And, obviously, Mike's right about there's some
6 art and nuance about what's in the bold-face recommendation
7 language and what's the discussion in the chapter that
8 we'll do our best to reflect.
9 But I did just want to react that I heard
10 substantial agreement and we're kind of in the process of
11 landing the plane and just getting whatever details
12 involved in landing a plane are done. I'll try to avoid
13 plane metaphors for the rest of the meeting.
14 [Laughter.]
15 MR. MASI: Thank you.
16 DR. CHERNEW: And that's probably what I should
17 have said.
18 But, in any case, we are now going to take a
19 break, and we're going to come back and talk about critical
20 access hospitals and cost sharing. And we will be back at
21 11:40, actually. So we get about a little bit -- about a
22 15-minute break. So we'll see you all then.

1 Thank you, Geoff and Rachel and Brian.
2 [Recess.]
3 DR. CHERNEW: Welcome back. Everybody. We are
4 going to launch into our work on cost-sharing for
5 outpatient services at critical access hospitals. This is,
6 broadly speaking, in the family of a lot of interest we
7 have in paying for care in rural areas, so I am very much
8 looking forward to this.
9 Just to remind all the Commissioners and those of
10 you at home, we will be having a vote after this. So once
11 we go through Round 1 and Round 2, when we get to the end,
12 Dana will do the roll call, and we will have a vote on a
13 recommendation that is about to be presented.
14 In any case, I think now Jeff is starting. So
15 Jeff.
16 DR. STENSLAND: Okay. Today we are returning to
17 our work on cost-sharing for outpatient services at
18 critical access hospitals. For those online, these slides
19 can be downloaded by clicking on the link in the upper
20 right-hand corner of your screen.
21 To recap where we are on critical access hospital
22 cost-sharing, recall that in September 2024, we discussed

1 how outpatient CAH cost-sharing is set at 20 percent of
2 charges and does not have a cap, unlike the cap in the
3 prospective payment system. Then after significant
4 Commissioner interest in changing CAH cost-sharing, we
5 presented the Chair's draft recommendation to shift
6 outpatient cost-sharing from 20 percent of charges to 20
7 percent of the CAH's payment rate in our January 2025
8 meeting. That draft recommendation also included a cap on
9 coinsurance per outpatient procedure.
10 Today, the Commission will vote on that
11 recommendation, and then after receiving additional
12 feedback from you and our outside reviewers, the mailing
13 materials will become a chapter in our June 2025 report to
14 Congress.
15 Just to remind you about our last presentation,
16 the basics of how CAH coinsurance currently works are
17 program payments to critical access hospitals are set at
18 101 percent of their cost minus coinsurance, not including
19 the effect of the sequester.
20 Coinsurance is set equal to 20 percent of
21 charges, and charges are list prices that are often far
22 higher than hospital costs, meaning 20 percent of charges

1 can be a large portion of the total payment amount.

2 In addition, charges can vary widely from

3 hospital to hospital and across services within hospitals.

4 This can create large inequities in coinsurance billed to

5 beneficiaries. For comparison, OPPS hospitals' cost-

6 sharing is 20 percent of each hospitals' administratively

7 set payment amount. This tends to be far lower than

8 charges.

9 In aggregate, there was about $3.3 billion in

10 coinsurance billed to beneficiaries and their supplemental

11 insurers in 2022 for outpatient services at CAHs. Program

12 payments were about $3.2 billion, and total payments for

13 services that require coinsurance were about $6.5 billion.

14 This means that about half the fee-for-service outpatient

15 payments to CAHs were coinsurance.

16 There were 1.9 million fee-for-service

17 beneficiaries using these services and they, or their

18 supplemental insurers, paid, on average, $1,750 in

19 coinsurance for their outpatient services at CAHs during

20 2022.

21 About 84 percent of rural beneficiaries have

22 supplemental insurance that will pay the coinsurance. But

1 about 16 percent of rural beneficiaries do not have
2 supplemental insurance. They will be billed 20 percent of
3 charges directly as their coinsurance.
4 On average, coinsurance was to 52 percent of the
5 payment amount, but in the case of the 4 percent of the
6 procedures that were done at hospitals with the highest
7 mark-ups, the full cost of the claim was billed as
8 coinsurance. The program did not pay anything. This
9 occurred for about 1 million outpatient services in 2022.
10 As we showed you in January, how much coinsurance
11 is billed to the beneficiary all depends on charges. Even
12 for hospitals with identical costs, as we show in this
13 example, the coinsurance can vary substantially if the
14 hospitals have different mark-ups.
15 In the first column we show that if a hospital's
16 service cost $600 to provide, and that hospital charged
17 $1,000 for that service, then its coinsurance would be
18 $200. In contrast, look at the last column. The costs are
19 the same but this is a high mark-up hospital, where the CAH
20 charged 400 percent of costs, or $2,400 for the same
21 service. The coinsurance there would be $480.
22 The take-way point is that the coinsurance's

1 share of the total payment will depend on how much the
2 hospital marks its charges over costs.
3 Another difference between CAHs and traditional
4 hospital coinsurance is the existence of a cap on
5 coinsurance at traditional hospitals. In 2025, the cap is
6 $1,676 per procedure, which is the amount of the inpatient
7 deductible. The idea being that a beneficiary should not
8 pay more for coinsurance for a single outpatient procedure
9 than they would for an inpatient stay.
10 Let's walk through the comparison of OPPS and CAH
11 coinsurance, highlighting the cap. Let's start with the
12 OPPS hospital in the first column. Assume the joint
13 replacement surgery costs the hospital $13,000 to provide,
14 and it charged $26,000. The OPPS payment rate is
15 prospectively set at $12,867 for hospitals with a wage
16 index of 1. This is the third row. The coinsurance is the
17 smaller of either the cap or 20 percent of the payment
18 rate. In this case, the cap is lower and OPPS coinsurance
19 would be $1,676.
20 In contrast, look at the second column. The CAH
21 has the same costs and charges as the OPPS hospital.
22 However, the coinsurance at the CAH is set at 20 percent of

1 charges and has no cap. Twenty percent of the $26,000 is
2 $5,200. The point of this example is to show that the
3 coinsurance difference between an OPPS hospital with a cap
4 on coinsurance and the critical access hospitals without a
5 cap can be substantial.
6 In January, we presented the Chair's draft
7 recommendation to shift coinsurance to 20 percent of the
8 allowed payment amount. To give you some idea of how much
9 this would have cost back in 2022, we examined 2022 CAH
10 claims. We computed what coinsurance would have been if it
11 was set at 20 percent of the estimated cost of the service
12 as reported on each claim. We found that beneficiary
13 coinsurance would have been about $2.1 billion lower. This
14 is about a 60 percent reduction in coinsurance, on average.
15 This would lower coinsurance for beneficiaries that do not
16 have supplemental insurance and reduce inequities of
17 coinsurance across CAHs, resulting in improved coinsurance
18 fairness.
19 The total cost of keeping aggregate payments to
20 the critic access hospital the same and shifting a larger
21 share of CAH payments to the program would have been about
22 $3.2 billion. This is higher because it includes the

1 effect on MA benchmarks and MA spending. This additional
2 spending would have been funded 75 percent by the program
3 and 25 percent by beneficiaries through higher Part B
4 premiums.
5 This brings us to the draft recommendation. It
6 reads:
7 For Medicare fee-for-service beneficiaries, the
8 Congress should:
9 Set coinsurance for outpatient services at
10 critical access hospitals equal to 20 percent of the
11 payment amount for services that require cost-sharing, and
12 place a cap on critical access hospital coinsurance equal
13 to the inpatient deductible.
14 This recommendation will increase spending
15 relative to current law, as we discussed.
16 With respect to the impact beneficiary and
17 providers, it would reduce cost-sharing liability for
18 beneficiaries who use critical access hospital services.
19 It would also reduce Medigap premiums for beneficiaries in
20 states with critical access hospitals. It would also
21 increase Part B premiums for all beneficiaries. We do not
22 believe there would be a material impact on the critical

1 access hospitals' revenues or the hospitals' willingness or
2 ability to treat beneficiaries.
3 I will now turn it back to Mike to start your
4 discussion.
5 DR. CHERNEW: You know, it is amazing how long it
6 has sort of taken us to get to some of these issues, so I
7 am glad we are looking at a lot of rural things. And you
8 guys did a great job, so thank you.
9 I think we are just going to start going through
10 the Round 1 queue, and the first person I have in the Round
11 1 queue is Lynn.
12 MS. BARR: I'm just going straight to saying yes
13 to the recommendation. No reason for Round 2.
14 I love this. Thank you, guys, and thanks to
15 everyone for supporting this work. I really, really
16 appreciate it.
17 Just a couple of notes, Jeff. When we mention
18 the, I believe, 16 percent of the patients do not have
19 supplemental insurance, I was surprised to learn, in the
20 other reading materials, that the Medigap Plan N does not
21 cover excess coinsurance. And so those that are in N,
22 which is the third most popular plan.

1 So I think we're understating the problem. And
2 then, again, in my rural community, employers did not pay
3 the excess coinsurance, and there's more Medigap that's
4 employer-based than no. And I know we don't have the
5 information on that, but I just think we are understating a
6 problem a little bit, and want to make sure we are clear on
7 that.
8 And as you talk about the implications, just
9 putting the dollars around, you know -- could you go to the
10 implications slide? -- but just putting a little bit of
11 dollars around the various buckets. So for me it reduces
12 the Medicare, increases Part B premiums for all
13 beneficiaries. That "increase Part B premiums for all
14 beneficiaries" is the part that I'm worried about, and it
15 is such a minor amount, but it will immediately polarize
16 people. I think we said it was like $13 a year. Is that
17 correct.
18 So could we just make sure that we are constantly
19 reiterating that that is just really a de minimis amount
20 and that was previously supported by overpayment by others.
21 But thank you so much. I really appreciate this.
22 MS. KELLEY: Greg.

1 MR. POULSEN: Ooh, I wasn't expecting it so
2 quick. I'm used to being like four down. Yeah, that was
3 not specific to who I was following. I thought I was like
4 number 4, not number 2.
5 I just wanted to clarify. I think this was in
6 there but I probably missed it. Does Medicare pay net of
7 billed coinsurance or received coinsurance?
8 DR. STENSLAND: Medicare pays net of the billed
9 coinsurance, but then if the coinsurance is not paid, then
10 Medicare will pay bad debts, or they pay 65 percent of the
11 unpaid.
12 MR. POULSEN: Sixty-five percent.
13 DR. STENSLAND: So if the bill was $100, and that
14 was the charge is $100, and there's $20 of coinsurance, or
15 20 percent of the charges. And the beneficiary doesn't
16 pay, then the Medicare program would pay 65 percent of that
17 20. They would pay $13, later, as a bad debt payment.
18 MR. POULSEN: Gotcha. Okay, thanks. That's
19 really all I was trying to think. I was trying to see if
20 there was another offset that we could find where the
21 critical access hospitals would benefit, and therefore we
22 could reduce the amount of payment, but I think you've

1 already said we are already doing that by the 65 percent as
2 opposed to the 100 percent. So thank you very much.
3 If we're trying to save time, Lynn, I'm with you.
4 I'm in favor, so I like this.
5 MS. KELLEY: Gina.
6 MS. UPCHURCH: Okay. The last two questions have
7 sort of blown my mind a little bit, but this is my
8 question, and I think they're related to what just came up.
9 First of all, thank you for this great work, and
10 I am also supportive of this, as far as I understand it
11 right now.
12 So when I think of secondary coverage to
13 Medicare, I think of it in four buckets. One, you could
14 not have that coverage, and for some reason I didn't know
15 that Medicare paid bad debt up to 65 percent. This seems
16 news to me.
17 So, in fact, these critical access hospitals are
18 getting paid 65 percent of their charges, the excess
19 charges.
20 DR. STENSLAND: Well, if it's not paid, yes.
21 MS. UPCHURCH: So really, we are just helping
22 them with the 35 percent by changing this policy, if it's

1 not paid.

2 DR. CHERNEW: I think the purpose here is less

3 about helping the hospitals and more about helping the

4 beneficiaries.

5 MS. UPCHURCH: I see, yeah, okay. Got that.

6 Okay.

7 So there are people that have no -- you know, and

8 they have to pay it on their own, which this is intended to

9 help them. The people that have a Medigap -- so my

10 question, and let me go to the other two -- they could have

11 Medicaid secondary coverage, and they could have employer-

12 sponsored plan. Okay.

13 So my first question is about the people who have

14 the Medigap. Are we sure that if there's this savings, and

15 we adjust that instead of based on charges it is going to

16 be based on this new formula or whatever, 20 percent of the

17 actual cost, not actual 20 percent of the actual cost but

18 the coinsurance being the 20 percent, are we for sure that

19 that gets passed on? Does the Medigap policy shrink their

20 premiums? How do we know that, because they have this

21 flexibility in terms of it has to be more than 65 percent

22 of its individual policy, or 75 percent medical loss ratio

1 if it is a group policy. But how are you for sure this
2 translates into them shrinking premiums?
3 DR. STENSLAND: Well, we assume that it would.
4 As their costs go down it would reduce their premiums. We
5 don't know for certain, but if you look at the medical loss
6 ratios for most of these policies, they are well above the
7 75 percent, and there would be some competition, in theory,
8 since they are selling products that are very similar. You
9 know, if you are selling a Type N and somebody else is
10 selling a Type N, there should be some price competition
11 there.
12 MS. UPCHURCH: Right. Well, there's price
13 competition when you are buying a supplement, but you're in
14 one there's not a lot of shopping around, especially in
15 some states when you can't really because there will be
16 medical underwriting. So there's not a huge amount of
17 competition if we can keep that price down. That was one
18 question I had. How do we know this translates into
19 everybody else's Medigap premiums going down.
20 The second one is, do we have any idea how this
21 impacts the state Medicaid payments as a secondary coverage
22 for duals and/or how this employer-sponsored plans, would

1 they see this as obviously beneficial to them, and does
2 that have any influence on what taxpayers are paying?
3 DR. STENSLAND: It would be beneficial to the
4 employers to the extent that they pay it. It would be
5 beneficial to Medicaid programs to the extent that they pay
6 it. But a lot of the Medicaid programs don't actually pay,
7 because they're saying, oh, you're getting X dollars from
8 Medicare, which is already above our Medicaid rate, so
9 we're not going to pay.
10 So if you look at the bad debts that these
11 critical access hospitals have, a large share, I think at
12 least half, are Medicaid bad debts, where Medicaid is not
13 paying on cost-sharing.
14 MS. UPCHURCH: All right. Great. Thank you.
15 MS. KELLEY: Kenny.
16 MR. KAN: Great chapter. I support the draft
17 recommendation.
18 MS. KELLEY: Robert.
19 DR. CHERRY: Yeah, nicely done. Just a couple of
20 questions. One, I know that the financial impact to the
21 critical access hospital is pretty minimal, but are you
22 concerned that there might be several closures as a result

1 of this, or not?

2 And then the other part is, are we cost-shifting
3 some of this to the states or local counties, where, in
4 some situations, there may be critical access hospitals
5 that may not be closing down but they still need the source
6 of revenue, for whatever reason, and therefore it is up to
7 sort of local resources to make up the gap?

8 DR. STENSLAND: I don't think there would really
9 be any negative effect on the critical access hospitals, or
10 expect any additional closures, because we are framing this
11 as the rate paid to the critical access hospital remains
12 the same. So their revenue stays the same. And the actual
13 coinsurance that their customers are paying goes down. So
14 if anything, that should have maybe a slight positive
15 impact on the number of customers they get.

16 So in essence, I don't see any downside for the
17 critical access hospital, or any secondary effects then on
18 extra costs for the local administrative counties or
19 anybody else.

20 DR. CHERNEW: I am going to say something that
21 may or may not be true, so I realize people are watching at
22 home and this is risky. This is basically a shift from

1 people who live in rural areas and what they are
2 responsible for to the government then picking that portion
3 up. So the providers are meant to be held whole. Anyway,
4 the providers are meant to be held whole, and we are just
5 trying to protect the individuals against cost-sharing,
6 which could be quite egregious given the formula, and have
7 the government pick up that portion in their stead, but not
8 actually take the money out of the facility. That is, I
9 think, the goal.
10 MR. POULSEN: Jeff, you glossed over this really
11 quickly, but I think the point is really worth point out,
12 which is the potential for people to remain in their
13 community, and going to the critical access hospital is
14 increased because their amount that they have to pay --
15 right now they probably have head horror stories from their
16 neighbors where they got a horrendous bill for something
17 that seemed outrageous, and this would reduce the
18 likelihood of that happening.
19 So I think the point you made, which is this, on
20 balance, should be beneficial, is probably true.
21 MR. MASI: And maybe we can take just a moment.
22 I think Larry wanted to ask a question about whether

1 actually some critical access hospitals would be a little
2 bit better off because of this cost-sharing issue that we
3 are talking about. I remember Jeff has a great handle on
4 this. He walked through some of these mechanics in
5 January.
6 And I think kind of the high level is we expect,
7 on average, CAHs to be substantially made whole. I think,
8 because of Medicare, there are complications around how bad
9 debt is treated here, but then also offsetting that there
10 is a little complication around sequestration. And when we
11 pencil out both of those smaller effects, I think the two
12 things to really emphasize are they are very small, and
13 they roughly offset each other.
14 So that brings us back to kind of our big picture
15 finding that we think for any hospital this is going to be
16 not materially effective for their bottom line. And as
17 Mike said earlier, this is really an issue of beneficiary
18 fairness.
19 MS. KELLEY: Gina, did you have another Round 1
20 question?
21 MS. UPCHURCH: I did. Lynn said something about
22 excess payments with some of the supplements. I just

1 wanted to clarify. So if somebody has a supplement that
2 doesn't cover excess payments, that means you are paying a
3 non-participating provider up to 115 percent of Medicare.
4 That's not relevant to this discussion, is it?
5 DR. STENSLAND: I'll double check, but I don't
6 think it's relevant to this.
7 MS. UPCHURCH: So we're really just talking about
8 getting people to the 100 percent.
9 DR. STENSLAND: Yeah. I think that is talking
10 about physician payments, like physician fee schedule, and
11 this is talking about hospital outpatient. So I don't
12 think it's applicable.
13 MS. UPCHURCH: Right. Okay. I just wanted to
14 make sure. Thanks.
15 MS. KELLEY: That is all I have for Round 1.
16 DR. CHERNEW: And I think Stacie is going to
17 start Round 2.
18 MS. KELLEY: Correct.
19 DR. DUSETZINA: I'm just going to try to start
20 Round 2 every time now. Thank you all very much for this
21 work. I think that this one of the most no-brainer policy
22 recommendations we can make, so my comments are really

1 about, like, a little bit like Lynn's comment about how do
2 we make sure that when people read the implications, they
3 don't have a negative reaction around everybody's premiums
4 going up.
5 So plus-one to doing what we can in the
6 implications to emphasize some of the fairness issues here.
7 Like another one might be to emphasize that this would make
8 coinsurance similar to people receiving care in other
9 outpatient service sites. So just kind of reminding people
10 that this is disproportionately burdening a group of people
11 paying based on charges, that is not actually the case for
12 most other beneficiaries when they seek care.
13 I also just appreciated the feedback we got from
14 the last session about the clarification around rural
15 health centers versus clinic, and also that you all moved
16 that to the appendix. I think this just makes this body of
17 work clearer and more focused. So I think that really will
18 help move this forward.
19 Excellent work. I'm very supportive of moving
20 this forward.
21 MS. KELLEY: Cheryl.
22 DR. DAMBERG: I just want to say I'm really

1 thrilled at all the progress that's been made around this
2 stream of work and the fact that we are now at a
3 recommendation. And I do want to go on the record as
4 saying I support the Chair's recommendation. I think this
5 really is an issue of fairness and not penalizing those
6 people who receive care at critical access hospitals.
7 And I will double down on what Lynn said about
8 modest impact on Part B premiums. I think the issue of
9 fairness is just so -- it's just such a standout here, that
10 that modest differential pales in comparison. So I think,
11 again, really underscoring that and helping people see
12 that consumers should not be left to the vagaries of
13 differential mark-ups at hospitals in paying charges, you
14 know, which are kind of funny money to me, as opposed to
15 the actual cost of providing the service.
16 MS. KELLEY: Betty.
17 DR. RAMBUR: Thank you. I support the
18 recommendations for all the reasons that have been said,
19 including underscoring the modest impact.
20 I can't help but have a little bit of a broader
21 comment -- I'm sorry, it's a little bit of a comment drift.
22 But I did notice, on page 13, it talked about large CAHs

1 having orthopedic surgery, and I know that was very common
2 in the state of Vermont when I was there. And they were
3 very candid that they couldn't stop doing that because of
4 how lucrative it is. And it really underscored to me, is
5 that mission drift? Do we care? But it's really about
6 what we pay for and how.
7 And it's not related to this particular piece,
8 but I thought it was really interesting that in the
9 appendix, which I appreciated you separating out, as of
10 December 2024, they are no longer required to primarily do
11 primary care. And that was really the heart of the initial
12 initiative. So I think it relates to our broader work of
13 getting payment right, because people are going to follow
14 the revenue.
15 I really support this, and I think we really have
16 to pay attention to our rural areas where 20 percent of the
17 country lives, something like that. So thank you for the
18 great work, and I think it really takes things forward.
19 MS. KELLEY: Scott.
20 DR. SARRAN: Yeah. I just want add my kudos to
21 the work, the quality of the work, and I think we all are
22 particularly appreciative of how your work drives us to a

1 really clear solution. This is huge important point, and I
2 strongly support the recommendation.
3 MS. KELLEY: That's all I have, Mike.
4 DR. CHERNEW: So thank you for that discussion.
5 I hear a lot of unanimity, and we will see, because now we
6 are going to go to the formal portion of the vote. Last
7 session, when we were doing the draft recommendation,
8 hearing what your feelings were was important. But now you
9 are just going to go on record as a vote.
10 So we have to do this in a roll call way. Dana
11 is going to call the roll. So Dana.
12 MS. KELLEY: Okay. Voting on the recommendation,
13 which reads:
14 For Medicare fee-for-service beneficiaries, the
15 Congress should:
16 Set coinsurance for outpatient services at
17 critical access hospitals equal to 20 percent of the
18 payment amount for services that require cost sharing, and
19 place a cap on critical access hospital outpatient
20 coinsurance equal to the inpatient deductible.
21 Voting yes or no. Amol?
22 DR. NAVATHE: Yes.

1 MS. KELLEY: Lynn?

2 MS. BARR: Yes.

3 MS. KELLEY: Paul?

4 DR. CASALE: Yes.

5 MS. KELLEY: I'm not looking at the screen.

6 Larry, can you give us a thumbs up? I don't see him.

7 Okay. We'll hold for Larry.

8 DR. CHERNEW: He's not on camera, because if --

9 MS. KELLEY: Oh, he's on. That's a thumbs up.

10 Thank you, Larry.

11 DR. CHERNEW: Did we get a brief Larry view?

12 MS. KELLEY: Thank you, Larry.

13 DR. CHERNEW: Okay.

14 MS. KELLEY: Robert?

15 DR. CHERRY: Yes.

16 MS. KELLEY: Cheryl?

17 DR. DAMBERG: Yes.

18 MS. KELLEY: Stacie?

19 DR. DUSETZINA: Yes.

20 MS. KELLEY: Kenny?

21 MR. KAN: Yes.

22 MS. KELLEY: Tamara?

1 DR. KONETZKA: Yes.

2 MS. KELLEY: Josh?

3 DR. LIAO: Yes.

4 MS. KELLEY: Brian?

5 DR. MILLER: Wholeheartedly yes.

6 MS. KELLEY: Greg?

7 MR. POULSEN: Yes.

8 MS. KELLEY: Betty?

9 DR. RAMBUR: Yes.

10 MS. KELLEY: Wayne?

11 DR. RILEY: Yes.

12 MS. KELLEY: Scott?

13 DR. SARRAN: Yes.

14 MS. KELLEY: Gina?

15 MS. UPCHURCH: Yes.

16 MS. KELLEY: Mike?

17 DR. CHERNEW: Yes.

18 MS. KELLEY: Okay then.

19 DR. CHERNEW: And with that we are going to

20 adjourn for lunch, and we will be back at 1:30, to talk

21 about Medicare insurance agents. So for those of you at

22 home, we do want to hear your thoughts. Please reach out

1 to us on the website or at meetingcomments@medpac.gov. A
2 lot of you do send us letters, and we do read them,
3 seriously, so thank you for that. Stacie, I think you
4 mentioned one, actually, in your comments, so thank you.
5 So for those at home we do want to hear from you,
6 and for those here, thank you for your comments, and we
7 will see you all after lunch.
8 [Whereupon, at 12:09 p.m., the meeting was
9 recessed, to reconvene at 1:30 p.m. this same day.]
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18 AFTERNOON SESSION
19 [1:32 p.m.]
20 DR. CHERNEW: Welcome to the afternoon of our
21 March meeting on Thursday. I will say, from around the
22 room here, there is a lot of enthusiasm for how this

1 afternoon is going to go. I hope it plays out that way.

2 But we have had a longstanding interest in

3 Medicare Advantage and how it is felt by beneficiaries, so

4 we have a whole bunch of work to sort of begin to

5 understand different aspects of that that will occur this

6 cycle and next cycle in an ongoing way. We are sort of at

7 the beginning of this whole work stream.

8 But we are going to start with a topic I think of

9 great interest, which is Medicare insurance agents, which

10 is going to focus on how the beneficiaries deal with the

11 enrollment process and the choices that they make, which is

12 obviously an extremely important part of the Medicare

13 Advantage program. And I think Pamina is going to kick us

14 off. Pamina.

15 MS. MEJIA: Good afternoon. The audience can

16 download a PDF version of these slides in the handout

17 section of the control panel on the right-hand side of the

18 screen.

19 Increasingly, beneficiaries have reported working

20 with insurance agents and brokers to select their Medicare

21 coverage. Agents and brokers can play an important role in

22 advising beneficiaries, but some stakeholders have voiced

1 concern that, because agents and brokers receive
2 compensation from insurers, they may have incentives to
3 steer beneficiary decision-making appropriately.
4 At meetings over the past analytic cycle,
5 Commissioners have asked for more information to better
6 understand the role of Medicare insurance agents. In this
7 presentation, we present background information on this
8 topic for your discussion. This is preliminary work, and
9 we plan to continue to work on this topic in the upcoming
10 meeting cycle.
11 During today's presentation, I will first be
12 reviewing the role of insurance agents in the Medicare
13 enrollment process.
14 Next, Jen and Ledia will walk through the ways in
15 which agents market to Medicare beneficiaries, agent
16 compensation and financial incentives, as well as existing
17 concerns regarding agent practices and data limitations
18 surrounding the use of agents.
19 The Commissioners will then discuss the material
20 presented and provide guidance on potential future work on
21 Medicare insurance agents.
22 Note that in this presentation we refer to agents

1 and brokers as one entity, agents, because the distinction
2 is not relevant for most of the topics presented as CMS
3 rules apply to both parties
4 Once an individual becomes eligible for Medicare,
5 and during certain times of the year, they must make
6 several complex enrollment decisions.
7 First, beneficiaries must choose between
8 receiving benefits from fee-for-service Medicare or from
9 private plans through the Medicare Advantage program.
10 Beneficiaries who enroll in fee-for-service Medicare may
11 obtain Medigap insurance to help cover cost-sharing.
12 Beneficiaries selecting Medigap chose from 10 standardized
13 Medigap plan types, and typically there are multiple
14 insurers offering each plan type.
15 Beneficiaries enrolling in fee-for-service
16 Medicare may also select a standalone Part D plan for
17 prescription drug coverage. These beneficiaries choose
18 from an average of 14 PDPs in their regions with differing
19 formularies and benefit structures.
20 Within MA, plans vary on cost-sharing,
21 supplemental benefits and provider networks. Most MA plans
22 offer prescription drug coverage. Beneficiaries, on

1 average, have 41 plans, offered by an average of 8
2 insurers, available in their area.
3 To navigate these complex Medicare enrollment
4 decisions, beneficiaries may rely on resources such as
5 insurance agents, brokers, Medicare's PlanFinder website,
6 and State Health Insurance Assistance Programs, or SHIPs.
7 This presentation focuses on agents and brokers,
8 because they are the resource most commonly cited by
9 beneficiaries. Agents are licensed individuals who enroll
10 people into insurance products, while brokers work as an
11 intermediary between potential enrollees and insurance
12 companies. Both agents and brokers are compensated by
13 insurers.
14 Future work could examine other aspects of
15 beneficiaries' plan choices, depending on Commissioner
16 interest.
17 SHIPs, or State Health Insurance Assistance
18 Programs, are the main federal source of individual-level
19 counseling for Medicare beneficiaries. Created in the
20 1990s, SHIPs are state-based organizations that receive
21 federal funds to provide counseling and information
22 assistance regarding Medicare to beneficiaries and their

1 caregivers. SHIPs can provide assistance on questions
2 related to Medicare, Medigap, Part D coverage, Medicare
3 Advantage, and other health insurance issues. SHIPs also
4 receive federal funding to specifically assist low-income
5 Medicare beneficiaries. They do not receive compensation
6 from insurers.
7 SHIPs provide personalized assistance in a range
8 of settings, including in person, by telephone, on the
9 internet, or through email. Counselors aid beneficiaries
10 on either a paid or volunteer basis.
11 A 2022 Commonwealth Fund survey found that about
12 one in three Medicare beneficiaries, regardless of
13 coverage, used insurance agents to choose a plan. This is
14 indicated by the bars on left-hand side of the slide. Note
15 that respondents could select more than one option, so the
16 sum of percentages will exceed 100 percent.
17 Some other points from the Commonwealth Fund
18 survey are that about 5 percent of fee-for-service
19 beneficiaries and 9 percent of MA enrollees reported using
20 the Medicare hotline or Medicare.gov. Also 4 to 5 percent
21 of beneficiaries reported using the SHIP program.
22 Medicare insurance agents can help beneficiaries

1 navigate their Medicare decisions.
2 In our annual focus groups with beneficiaries,
3 many beneficiaries reported that they had worked with
4 agents to determine out-of-pocket costs, premiums, and
5 prescription costs of individual plans when selecting their
6 Medicare coverage. Beneficiaries in our focus groups found
7 the agents to be helpful, and ultimately selected their
8 plan after discussing options with their agent.
9 I will now turn it over to Jen.
10 MS. DRUCKMAN: Thanks Pamina. I will now present
11 some background on the various ways in which agents market
12 to Medicare beneficiaries.
13 Virtually all Medicare insurance companies
14 contract with agents to reach and enroll beneficiaries. We
15 have heard that agents identify potential Medicare
16 enrollees through various sources such as referrals from
17 financial advisors, banks, and medical offices, or
18 purchasing "lead lists" with contact information, such as a
19 list of people who are turning 65 in the next three to six
20 months. Agents often work with or for larger marketing
21 organizations that perform lead generation, marketing,
22 sales, and enrollment-related functions.

1 Agents who represent MA and Part D organizations
2 by selling their plans must follow various federal
3 requirements, a few of which are highlighted here.
4 Agents must be licensed in the state in which
5 they do business. Each state's licensing requirements
6 vary. Generally, licensing requirements involve
7 specialized coursework and training, as well as passing
8 one's respective state licensing exam.
9 Agents must train and be tested annually on their
10 knowledge of Medicare and health and prescription drug
11 plans and they must achieve an 85 percent or higher on all
12 forms of testing.
13 Agents must use marketing materials that have
14 been approved by CMS.
15 In conducting marketing activities, health care
16 related products may not be marketed during a marketing
17 appointment beyond the scope agreed upon by the
18 beneficiary, and documented prior to any face-to-face
19 individual marketing appointment. This is known as the
20 scope of appointment.
21 Agents can document the scope of appointment in
22 writing via a scope of appointment form or by recording a

1 phone call in advance of the appointment. The salesperson
2 is bound to only discuss those products that have been
3 agreed upon by the beneficiary during that appointment.
4 In contrast, Medigap is mainly regulated at the
5 state-level, so rules may vary.
6 Agents typically sell plans from multiple
7 insurance companies, but they are not required to sell
8 every plan in the area. In this way, the agent is
9 filtering plan options by not presenting the full picture.
10 This filtering is not always apparent to the beneficiary
11 even if the agents and agencies disclose it in their
12 communications.
13 We don't know the average number of plans a
14 particular agent may sell. However, the Commonwealth Fund
15 compared the MA and PDP plans listed on the Medicare
16 PlanFinder tool to the plans listed on three large online
17 agent tools across five metropolitan areas. They found
18 that, on average, the tools included less than half of MA
19 plans and less than two-thirds of Part D plans.
20 Next, I will turn to agent compensation and
21 financial incentives.
22 Agents are compensated for selling plans in

1 varying and complex ways. Agents commonly contract with
2 multiple insurance carriers that pay commissions tied to
3 initial plan enrollment and plan retention in the MA,
4 Medigap, or Part D plans they sell.
5 In addition to commissions, there are often
6 opportunities for supplemental compensation, such as a
7 bonus for meeting enrollment benchmarks, administrative
8 payments for marketing, or payments for carrying out other
9 activities for plans such as beneficiary health risk
10 assessments.
11 Some agents have also highlighted the opportunity
12 for additional compensation from selling other health-
13 related insurance products such as hospital indemnity
14 insurance which can be sold along with other Medicare
15 products.
16 In general, actions of agents when marketing
17 Medigap plans are governed by state law and regulation, so
18 there are no federal compensation requirements.
19 For selling Medigap plans, an agent typically
20 receives a percentage of the annual Medigap plan premium.
21 The percentage is set, and the commission is paid by the
22 insurer.

1 Multiple industry sources report that first-year
2 commissions for enrollments in Medigap are about 20 percent
3 of annual premiums but can vary based on the state or plan
4 type. The commission for subsequent years is generally set
5 at 10 percent of the premium.
6 In 2023, the average annual premium among Medigap
7 policyholders was $2,604. Based on this national average
8 premium and the industry reports cited previously, an agent
9 selling Medigap plans could be paid about $521 for initial
10 enrollment and $260 for subsequent years of enrollment.
11 Note that these are general estimates because premiums and
12 rate adjustments for policies can vary.
13 There are federal requirements for MA and Part D
14 organizations surrounding the compensation of agents they
15 use to sell their plans.
16 There are two general categories of compensation
17 payments that MA and Part D organizations provide to
18 agents. First, plan enrollment. For each enrollment in an
19 initial enrollment year, MA and Part D plans may pay agent
20 compensation at or below a maximum amount known as the fair
21 market value, or FMV. Once a beneficiary is enrolled in an
22 MA or Part D plan, agents can earn a maximum renewal

1 compensation of up to 50 percent of the FMV when the
2 beneficiary switches to a new "like plan type" or stays
3 with the original plan.
4 Second, administrative payments are made for
5 services other than enrollment of beneficiaries, for
6 example, training, customer service, agent recruitment, or
7 conducting health risk assessments. For contract year
8 2025, CMS finalized a policy that would require these
9 additional administrative payments to be included in the
10 FMV and not paid separately, however, that policy is on
11 hold due to litigation.
12 CMS determines fair market value amounts each
13 year, which is the maximum compensation that may be paid.
14 Plans can pay less or even zero compensation.
15 FMV amounts are updated annually by adding the
16 current year FMV and the product of the current year FMV
17 and the MA growth percentage for aged and disabled
18 beneficiaries, which is published each year in the annual
19 MA rate notice.
20 For example, in 2025, the maximum fair market
21 value for initial enrollment in an MA plan is $626, with
22 exceptions for certain states and territories.

1 While there is no requirement for MA and Part D
2 organizations to report the exact amount they compensate
3 agents, organizations must annually report to CMS the
4 minimum and maximum compensation amounts they pay
5 independent agents. Generally, MA and Part D
6 organizations pay the FMV maximum compensation amount to
7 their agents.
8 I will now turn it over to Ledia to discuss the
9 financial incentives.
10 MS. TABOR: In focus groups held by the
11 Commonwealth Fund in 2022, most agents recalled receiving
12 higher commissions for enrolling people in MA plans.
13 This slide is an illustrative example of the
14 financial incentives that agents may have to enroll
15 beneficiaries in MA-PD plans over a Medigap and standalone
16 Part D plan. This is illustrative because it looks at one
17 market and we know that Medigap premiums vary by market.
18 The example also does not include data on administrative
19 and bonus payments that insurers may pay agents.
20 Starting at the left-hand side of the chart, in
21 2025, an agent selling an MA-PD product to a beneficiary
22 that aged into Medicare could make $626 in compensation,

1 which is the CMS set fair market value. If an agent instead
2 enrolled that beneficiary into a median-priced Medigap Plan
3 G and a standalone Part D plan in that market they could
4 make a total of $450 as their initial enrollment
5 compensation. On that initial enrollment, the agent would
6 therefore make $176 more for enrolling the beneficiary in
7 MA over Medigap and PDP policies.
8 In the subsequent years, if that enrollee stayed
9 in the initial MA plan or a "like" MA plan, the agent could
10 receive $313 as compensation. If the enrollee stayed in
11 the same Medigap and PDP policy for a subsequent year, the
12 agent would receive $225 total as compensation, which is
13 $88 lower than the renewal fee for an MA plan. Assuming
14 that a beneficiary were to stay in the same plan in this
15 example over a 5-year period, an agent would make $528 more
16 for enrolling a beneficiary into an MA plan rather than a
17 Medigap or PDP plan.
18 Now for a second illustrative example, since the
19 agent compensation structure for Medigap is a percentage of
20 the premium, agents may have an incentive to enroll
21 beneficiaries in Medigap plan types with higher premiums,
22 for example a Plan G over a Plan N. This is a teaser for

1 the next presentation on Medigap.
2 Starting on the left-hand side of the chart, if
3 an agent enrolled a beneficiary in a median-priced Plan G
4 Medigap plan they could make $341 as an initial
5 compensation amount. If the agent instead enrolled the
6 beneficiary in a median-priced Plan N policy they could
7 make $254 as an initial compensation amount. On that
8 initial enrollment, the agent would therefore make $87 more
9 for enrolling the beneficiary in Plan G over Plan N.
10 In the subsequent years, if that beneficiary
11 stayed in the initial Plan G policy, the agent could
12 receive $170 as a plan renewal fee each year. If that
13 beneficiary stayed in the initial Plan N policy, the agent
14 could receive $127, which is $43 higher than the renewal
15 fee for a Plan G policy. Assuming that a beneficiary were
16 to stay in the same plan in this example over a 5-year
17 period, an agent would make $259 more by enrolling a
18 beneficiary in a higher-premium Plan G Medigap policy.
19 Zero-dollar commissions for enrollment in certain
20 Medicare plans can be used as a disincentive for agents to
21 enroll beneficiaries in those plans. Insurance companies
22 do not have to pay agent commissions for enrolling

1 beneficiaries in plans. There are reports that some
2 insurers are providing zero-dollar commissions, or non-
3 commissionable plans, for enrollment in certain MA, Medigap
4 and standalone Part D plans.
5 Now, switching topics to concerns regarding agent
6 practices and data limitations.
7 CMS has noted increased complaints about agents
8 and marketing organizations. In rulemaking, CMS said its
9 "experience in reviewing beneficiary complaints and
10 listening to recorded calls between agents and brokers and
11 beneficiaries revealed many instances during which
12 agents/brokers failed to provide enough information" or
13 "provided inaccurate information about plan benefits."
14 Examples highlighted by CMS included
15 beneficiaries being told that if their medication was not
16 on the formulary the doctor could tell the plan, and the
17 plan would simply add it; or stating that "nothing would
18 change" when beneficiaries asked if their current health
19 coverage would stay the same.
20 As we think about future analytic work, we want
21 to note that CMS does not collect data on whether a
22 beneficiary used an agent in making their coverage choice,

1 nor does the program collect data on MA payments to agents.
2 Publicly available data on agents and agencies that sell
3 Medicare insurance products is limited.
4 We have just gone through a lot of information on
5 Medicare insurance agents. So to summarize, many
6 beneficiaries turn to agents to help them navigate complex
7 enrollment.
8 Federal law and regulations require MA and Part D
9 organizations to ensure agents appropriately communicate
10 with beneficiaries.
11 Agents typically sell plans from multiple
12 insurance companies, but they are not required to sell all
13 available plans in the area.
14 Agent compensation is tied to initial enrollment
15 and enrollment retention in the plans they sell. Agents
16 may also receive additional payments, such as a bonus for
17 meeting enrollment benchmarks.
18 Some stakeholders have voiced concern that agents
19 may have financial incentives to steer beneficiary
20 decision-making. Incentives may include greater
21 compensation when enrolling beneficiaries in MA over
22 Medigap plans, in higher-premium Medigap plans over lower

1 premium plans, and in plans that offer bonuses for reaching
2 enrollment benchmarks, as well as zero-dollar commissions
3 for enrolling beneficiaries in certain plans. Our ability
4 to analyze the impact of agents on beneficiary enrollment
5 decisions is limited due to a lack of data.
6 For Commissioner discussion, we welcome your
7 questions and feedback about the materials, as well as
8 ideas for potential future work. Some possibilities are
9 that in this summer's focus groups we could ask
10 beneficiaries more about their experiences working with
11 agents. We could also interview SHIP counselors about a
12 variety of topics including choosing a Medicare plan. We
13 can also continue to track changes in federal regulations
14 around agent compensation. We could also examine other
15 features of the broader plan choice environment facing
16 beneficiaries, such as the Medicare PlanFinder website.
17 As a reminder, this is not planned for a
18 publication this year. And with that, I'll turn it back to
19 Mike.
20 DR. CHERNEW: That was really spectacular, all
21 three of you. I will speak less and let the Commissioners
22 speak more. Brian, you are first. Is that right, Dana? I

1 had Brian first in the Round 1 queue.

2 MS. KELLEY: Sure. Go ahead, Brian.

3 DR. MILLER: A really short Round 1 question. I
4 saw that on page 2 of the chapter we denote that 30 percent
5 of the fee-for-service and MA benes use brokers and agents
6 to facilitate choice. What is the breakdown of other
7 information sources and advisory mechanisms that
8 beneficiaries use, and can we include a table?

9 MS. TABOR: Thanks for the question, Brian. Are
10 you referring to the Commonwealth Fund study, the survey?

11 DR. MILLER: Let me --

12 MS. TABOR: I believe so. Yes, it is. I would
13 actually refer back to Slide 6, if you don't mind, because
14 the results are really interesting to look at. I will say
15 Commonwealth Funds did the survey for beneficiaries, and
16 includes beneficiaries over age 65. And they asked those
17 beneficiaries who made a decision between MA and fee-for-
18 service what data sources they used. And they could use
19 multiple ones, and so those are the results for them right
20 here.

21 DR. MILLER: So that's what I thought this was
22 referring to. So we should actually include this in the

1 text, because this is really helpful. Especially note that
2 almost a third to half didn't receive any help, and a very
3 small fraction received help from the State Assistance
4 Program, a similar fraction from TV or Medicare.gov, the
5 friends and family, not an investment round but an advising
6 round, and then, of course, insurance agent.
7 MS. TABOR: Yes, it is interesting. We'll add it
8 to the chapter, or future chapters.
9 DR. MILLER: Thanks.
10 MS. KELLEY: Lynn.
11 MS. BARR: I love this chapter. Thank you so
12 much. Or it's a paper, not a chapter. I apologize.
13 [Laughter.]
14 MS. BARR: So when you're going through your
15 examples of the difference in payment, I was wondering if
16 you could actually put that into the context of what
17 typical insurance agent's revenue looks like. You know,
18 could you do like that curve, you know, what's the average
19 amount of enrollment per year, and then they've got this
20 tail. I think the numbers look small, but if you actually
21 laid it out, it would be much more impressive. So I love
22 that.

1 On the data limitations, what bothers me is we
2 don't know what options they looked at and what they chose.
3 And I'm jumping ahead to the Medigap study, and also my
4 experience, where it was like, there were premiums that
5 were $1,000 a month and there were premiums that were $100
6 a month for the exact same plan. And as a consumer I'm
7 like, well, I don't want the cheapest one, but probably
8 it's fine. You know, I just wouldn't know that going in,
9 as a Medicare beneficiary, but now I actually walk into a
10 doctor's office and I don't have to do anything, and I just
11 walk out and it's awesome. So I'm pretty sure it wouldn't
12 have affected me to have bought the cheaper plan, but I
13 just assumed there was something wrong with it.
14 So we really, I mean, for the beneficiaries'
15 sake, I think it would be really interesting to understand,
16 and they have such an incentive, from the broker's
17 perspective. Because they are getting a percentage, and it
18 would be like, "Oh yeah, you don't want that cheap one,"
19 and they're going to go, "Yeah, of course, you know, bad
20 service." But now I realized that as a beneficiary it
21 probably doesn't make any different whatsoever what plan
22 you choose. You should pick the cheapest one, because

1 you're not even involved with it. That's your provider's
2 problem, not yours.
3 So I think that's actually the most important
4 parts of my comments. Thank you very much.
5 MS. KELLEY: Okay. I have a comment from -- I'm
6 sorry. Go ahead, Wayne.
7 DR. RILEY: Yeah, thank you. Go back to --
8 Angie, could you go to Slide 17? I just want to make sure
9 I understand this. So specifically, if an agent sells a
10 Medigap policy and a Part D policy, is that additive 450
11 plus 313?
12 MS. TABOR: Thanks. So this is an illustrative
13 example, because it does vary by geography.
14 DR. RILEY: Sure.
15 MS. TABOR: And the geography we selected for the
16 example, the 450 is additive. It includes the compensation
17 for the standalone, which would be $109, designated by CMS.
18 DR. RILEY: Okay.
19 MS. TABOR: And then 20 percent of the Medigap
20 premium. I don't have the numbers at hand, but the 450 is
21 additive, Part D plus Medigap.
22 DR. RILEY: So the 450 is inclusive. The first

1 time you went through I thought it was plus the 313 for the
2 Part D.
3 MS. TABOR: Uh --
4 DR. RILEY: Ah, the renewal. Okay.
5 MS. TABOR: And we can, in future editions, add
6 more information about the additive.
7 DR. RILEY: And the second question is, does CMS
8 issue any detail about the 10 plans and the frequency
9 distribution, in other words, how many beneficiaries use N,
10 choose --
11 MS. TABOR: That's a great teaser. Can I ask you
12 to hold that thought for my presentation?
13 DR. RILEY: Oh, sure.
14 MS. TABOR: Thank you. I appreciate it.
15 MS. KELLEY: Okay. I have a Round 1 question
16 from Larry. He says thanks, as always, for your -- oh,
17 sorry. That was a note to me. Okay.
18 [Laughter.]
19 MS. KELLEY: He thanks me for reading these. His
20 first question is this: His understanding is that annual
21 renewal commissions for MA go on forever, if the
22 beneficiary remains in the same or similar plan, whereas in

1 Medigap the annual renewal fees often decrease rapidly and
2 may disappear by year 5 or so. Have you heard this?
3 MS. TABOR: We have seen that, as well. It is
4 hard to confirm that, because Medigap does have so much
5 variation -- I'm responding to you, Dana -- it does have so
6 much variation, but that is what we understand from
7 industry sources, and I see Gina also confirming that that
8 is common.
9 MS. KELLEY: And his second question is, do you
10 know whether discussing the potential difficulties
11 switching from MA to traditional Medicare is one of the
12 topics that CMS requires brokers to discuss with
13 beneficiaries?
14 MS. TABOR: I believe that was proposed to be
15 added, but the rule is still proposed, so we do not know
16 yet, whether CMS is going to require there.
17 MS. KELLEY: Go ahead, Wayne.
18 DR. RILEY: That just triggered something. So in
19 other words, if I buy a Medigap policy, does the broker who
20 sold me that Medigap policy -- I'm sorry, Medicare
21 Advantage. I'm flipping back to Medicare Advantage. If I
22 choose a Medicare Advantage policy, does the broker a

1 renewal fee until death do us part?

2 MS. TABOR: That is our understanding.

3 DR. RILEY: Really?

4 MS. TABOR: But that is not true -- we have seen

5 examples from Medigap, for example, that the renewal fee

6 will be the same for the first six years, then it titrates

7 down to 1 to 2 percent of the premium, and then after 10

8 years, no. But our understanding is --

9 DR. RILEY: [Inaudible.]

10 MS. TABOR: Yes, yes, as long as the beneficiary

11 stays in that plan, yes. Yes, yes.

12 DR. RILEY: Or changes brokers.

13 MS. TABOR: Or changes brokers. Exactly. Thank

14 you.

15 MS. KELLEY: Gina.

16 MS. UPCHURCH: I love this work. Thank you very

17 much for doing this, and you did a terrific job of pulling

18 lots of it together.

19 I'm happy for the paper to become a chapter and

20 to become real recommendations from this group, and you'll

21 hear some of those in Round 2.

22 Where does paying the agent and/or broker go in

1 the medical loss ratio? Is that an admin fee, do we think?
2
3 MS. TABOR: That's a very good question, and
4 we'll get back to you.
5 MS. UPCHURCH: Okay.
6 And the second one, it's just more clarifying.
7 I know in North Carolina, brokers can actually enroll
8 people in Medigap policies or -- so they can actually sell
9 people policies, not just agents. So I think it's sort of
10 unclear, the broker agent, and I don't know that it needs
11 to be clear for us. And maybe every state's different. I
12 think of captive agents working for maybe one company.
13 Some agents can work for multiple companies, and brokers
14 tend to work for multiple companies, but maybe they're not
15 employees. But I don't quite get all the differences, and
16 maybe it's by state that they're different. But I know
17 agents and brokers just in the state of North Carolina.
18 And full disclosure, I'm with the SHIP
19 Coordinating site, and we do SHIP counseling in North
20 Carolina, so just to be clear about that. It's a little
21 fuzzy, agent versus broker.
22 MS. TABOR: Yeah. This is interesting. We

1 hadn't heard about the state variation in that. So we'll
2 look into that.
3 MS. UPCHURCH: Okay. Thanks.
4 MS. TABOR: Thanks.
5 MS. KELLEY: Paul.
6 DR. CASALE: Thanks. Great chapter.
7 I may have missed this, so I apologize. But are
8 agents required to disclose to the beneficiary the plans
9 that they represent when they speak to the beneficiary, or
10 is that --
11 MS. DRUCKMAN: So I believe in the Medicare
12 Advantage context, they have to say that we are talking to
13 you about so many. It may not be all. It's very limited
14 what they have to say. They don't have to say how many
15 they're not talking about. They could just indicate it may
16 not be all that are available to the beneficiary.
17 DR. CASALE: I was also thinking Medigap where,
18 some of them may represent UnitedHealthcare or Humana. Do
19 they need to disclose that? No, not --
20 MS. DRUCKMAN: No.
21 DR. CASALE: No. Okay. Thank you.
22 MS. KELLEY: Amol.

1 DR. NAVATHE: Thank you. Hopefully, you can hear
2 me.
3 So thanks for this important work. I had three
4 questions.
5 One question is, I just want to make sure I
6 understand it correctly. So if a beneficiary is enrolled
7 in MA through an agent or broker, can you just give us a
8 sense? So if they switch to a different plan, then the
9 agent or broker gets that larger commission again? Is that
10 right? Or are there certain bounds when that happens or
11 doesn't happen?
12 MS. TABOR: So if I enroll in a MA plan, the
13 broker will get that initial enrollment, and then if next
14 year I switch to a like-MA plan but by a different issuer,
15 I as a broker would get the renewal fee. I wouldn't get a
16 brand-new initial.
17 DR. NAVATHE: So I guess that's the substance of
18 my question is, how do they define "like" plan?
19 MS. TABOR: We can add more definition to the --
20 I think we have a footnote on it in the paper. We can add
21 more detail on that, but I think, in general, it's like an
22 MA-PD plan to an MA-PD plan.

1 DR. NAVATHE: I see. So it's a pretty general
2 thing.
3 MS. TABOR: Yes.
4 DR. NAVATHE: It's not specific to plan
5 attributes per se.
6 MS. TABOR: No. Right. Exactly. It is MA-PD to
7 MA-PD, not MA-PD with this exact benefit.
8 MS. UPCHURCH: Yeah. And I think you have to
9 have stayed in there for the rest of the year. Like, if
10 you go one month and then had a special enrollment period
11 to switch to another, you wouldn't get paid that full
12 amount if they didn't stay in it for the rest of that year.
13 DR. NAVATHE: I see. Okay. Great. That's
14 helpful.
15 My second question, I guess, is in part related
16 to Lynn's question is, do we have a sense at all of how
17 large the admin payments can be relative to the --
18 MS. TABOR: We don't. We kind of have heard from
19 some brokers, and there's the Commonwealth Fund study that
20 is cited in the paper that they talked to br`okers and
21 focus groups. And we just don't have the data to really
22 say. We just have anecdotes.

1 DR. NAVATHE: Okay. My third question is, are
2 there any organizations that employ agents or brokers that
3 are either publicly traded or that are non-profit?
4 MS. TABOR: I don't believe so, but we can look
5 into it to verify.
6 DR. NAVATHE: Okay. Just thinking that those are
7 organizations that have reporting requirements. So there
8 might be some more interesting information that we could
9 get from public filings.
10 DR. RILEY: [Speaking off microphone.]
11 DR. NAVATHE: Thanks, Wayne. That's another good
12 add.
13 MS. KELLEY: Betty?
14 DR. RAMBUR: Thank you.
15 I'm very enthusiastic about this work, and thank
16 you for your great work.
17 Some of it's still murky to me, so I'm working on
18 it. But my understanding is that agents do health risk
19 adjustment, and I'm not clear how that is different or if
20 it is different than medical underwriting.
21 MS. TABOR: The health risk assessments are not
22 used to determine the premium amounts, whereas underwriting

1 is used to determine the premium amount. So the health
2 risk assessments are separate assessments that the agents
3 can do to provide information to the insurers. But it's
4 not -- again, it doesn't determine premiums. That's the
5 big difference.

6 DR. RAMBUR: I'm just curious what they do with
7 them. I'm not -- maybe just, you know, a little
8 description.

9 MS. BARR: [Speaking off microphone.]

10 DR. RAMBUR: Yeah. I mean, yeah. Because, you
11 know, we've talked about the coding and Medicare Advantage.
12 Could that be a source of it? So, anyway, it would help me
13 to just have a little bit more information around that.

14 MR. POULSEN: So, when you say premium, you're
15 meaning the premium to the enrollee, not to the federal
16 government? I mean, that can be confusing. So the risk
17 adjustment, the risk work that you do could definitely
18 change the amount that the insurance company is being paid.

19 MS. TABOR: Right. So we have heard that
20 insurers may work with brokers to do the health risk
21 assessments that could identify beneficiaries that would
22 need further clinical review to identify conditions that

1 could be used to affect future premiums. Yes.

2 DR. RAMBUR: Election Advantage, we talked about

3 in Medicare Advantage, seems linked to this. It might be

4 good to just flesh that out.

5 MR. MASI: And just to underline one thing Ledia

6 said there, the health risk assessments as collected by a

7 broker, that alone is not necessarily going to be eligible

8 for purposes of risk adjustment for Medicare Advantage. It

9 may serve as information to prompt further clinical

10 diagnoses. But, at this point, we don't know very much

11 about actually how they're being used, and so, we want to

12 tread cautiously.

13 MS. KELLEY: Brian?

14 DR. MILLER: A quick on-point. If we're talking

15 about HRAs gathering diagnoses, we're actually undermining

16 our previous -- or the -- I should say the written

17 chapter's position that there is favorable selection,

18 because this would suggest that there's adverse selection

19 and they're harvesting potentially less healthy

20 beneficiaries.

21 DR. CASALE: That's an assumption of what they're

22 -- Brian, that would be an assumption of what they're doing

1 with the data, though, right? So I think it's hard to make
2 that conclusion.
3 DR. CHERNEW: I think we should probably move on
4 to Round 2, which I think is -- am I right about that, or
5 is there someone else in Round 1?
6 MS. KELLEY: Yes. Round 2, I think we're ready
7 for it. And Lynn is first.
8 MS. BARR: Thank you. I'm really hot on the
9 button today, I guess.
10 So I just -- I love this work, and it seems to me
11 that we're really not doing the beneficiaries justice by
12 putting them through this process. It is not in their best
13 -- and it's just too slanted against them, and I would be
14 very much in favor of a public system to help
15 beneficiaries, because it's super complicated and they need
16 -- I mean, I wish I had somebody that could have told me,
17 you know, now I know I could have bought the cheap Medigap
18 plan, and it would have been fine. You know, but there's
19 nobody that's going to tell me that because nobody's going
20 to get paid for that, right?
21 So I think we should take the money that's being
22 used for brokers and pay employees of the government to

1 actually do this work. That's my opinion.
2 MS. KELLEY: Tamara.
3 DR. KONETZKA: A couple of main points, but
4 first, thank you for this great analysis.
5 I mean, we know that there's not a lot of data on
6 it. So you did a lot of work in pulling together what you
7 could, and we appreciate that.
8 Two main points. One is when people are asked in
9 these surveys whether or not they used an agent, I think
10 it's important to note that they may not actually know
11 they're using an agent. I think there was a line about
12 that in the mailing materials, but I think it probably
13 deserves a little bit more attention.
14 I know that every time I go to Florida to visit
15 my mother, we are bombarded with ads that say, "Are you
16 confused about Medicare? Do you need somebody to help you
17 make your choices?" And it's really hard to figure out
18 that that's not Medicare, and in fact, in a story I have
19 told many of my fellow Commissioners, after I spent hours,
20 hours every year, figuring out my mother's plans, I had
21 another family member swoop in. My mom was, like,
22 complaining about something about her plan, and this family

1 member decided, "Oh. Well, I called Medicare, and they
2 said this other plan would be great for her, and so I
3 switched her in to an MA plan," right? And it was not the
4 best plan for her, and it took me weeks to unravel. But,
5 you know, this family member has an MBA, and this -- you
6 know, it was not like, you know, uneducated or, you know,
7 kind of should know better, and yet these ads, I think,
8 were really deceptive to him.
9 So even when people say they used an agent or are
10 asked whether or not they used an agent, I'm not sure they
11 know they're using an agent. They think they've called
12 Medicare, right? And so my sense is, even though this was
13 anecdotal, that this probably happens a lot more than we
14 think. So that's one point.
15 The other point is, you know, totally in
16 agreement with Lynn about finding an alternative. I think
17 we have a system here that we've created or let be created
18 that is inherently flawed. This will never be a good
19 system for beneficiaries, and we can regulate it to death,
20 and it looks like we are between the state and the federal
21 laws. We are trying to regulate the situation to death,
22 and it can't be fixed, right, because agents are going to,

1 you know, recommend things in their own interest and in the
2 interest of the companies they work for.
3 And so, you know, I say, like, blow it all up.
4 We need a new system that actually works for beneficiaries,
5 and I think, you know, this could be an expansion of SHIP
6 counselors. This could be, you know, a separate effort. It
7 could be financed through a provider tax. There's many
8 options, and I would love to see us, as part of this work,
9 sort of think through what some of those options might be.
10 And maybe that would be also sort of as part of a
11 broader piece of work that I think was mentioned maybe by
12 Paul this morning, that just looking generally at how
13 beneficiaries make these choices, what's working, what's
14 not working, this could be part of the broader conversation
15 on sort of standardization of benefits, on tools to help
16 people make these decisions, but certainly, I think a
17 better help system than this inherently flawed agency
18 system we have.
19 Thanks.
20 MS. KELLEY: Cheryl.
21 DR. DAMBERG: I was really excited about this
22 chapter. I think there's just such great content in here,

1 and it was really illuminating for those of us who aren't
2 really deep in this space.
3 So I kind of want to step back, because I feel
4 like this broker issue is symptomatic of sort of the
5 underlying root problem, which is complexity in this
6 market, and the number of choices, which kind of
7 necessitates some kind of intermediary to help you sort
8 through what's going on. So I think this is my plug for I
9 think the Commission needs to really continue to think
10 through the issue of standardization of benefits and kind
11 of working to simplify choices for beneficiaries, sort of
12 absent standardization, we're really undermining
13 competition in the marketplace and achieving the
14 efficiencies that we think Medicare Advantage is supposed
15 to offer.
16 And I think even before you get to choosing
17 Medicare Advantage Plan A over B, I think there's this
18 basic problem that most people entering Medicare don't even
19 understand the difference between fee-for-service and
20 Medicare Advantage. So this strikes me that there's a lot
21 of education to do with people long before they get to age
22 65.

1 So when you sort of talk about some of the future
2 analytic work, I think it would be helpful to think of
3 other ways we could think about educating people besides
4 things like Plan Finder.
5 And I guess the other thing that I would call out
6 is, you know, the way this is structured now, the
7 incentives are wrong on so many different levels. So
8 there's incentives to enroll in MA over fee-for-service.
9 There's incentives to enroll in higher-premium Medigap
10 plans. There's a disincentive to revisit the plan that we
11 chose last year due to the retention bonus and suggested
12 change in the next year. And there's this problem that
13 insurers -- and by extension, their agents -- are steering
14 beneficiaries away from PDPs into MA, contributing to, you
15 know, the downward spiral in fee-for-service. So there's
16 sort of a larger set of problems that we need to think
17 about trying to solve for.
18 You know, SHIPs, I think, you know, we know
19 they're underfunded, they're understaffed. $55 million in
20 payments to them is, I think, small potatoes in the big
21 scheme of things, given how much money we're spending in
22 the Medicare program, and yet they're really the only

1 unbiased source of information in the marketplace that can
2 present all of the options.
3 So I want to sort of plus-one on Lynn and Tamara
4 in terms of rethinking what are the alternative options,
5 and how do we support them, and is it a public kind of
6 sector activity, rather than leaving it to the plans?
7 I do think we need to request from the plans,
8 information on the administrative and bonus payments they
9 pay to their agents, and I certainly support the different
10 items you've laid out for future analytic work.
11 But one thing I would note -- and this appeared
12 earlier in the chapter -- is that you don't know about
13 whether they used an agent, and I think there's an
14 opportunity -- so Medicare runs the annual Medicare
15 Advantage and Part D Disenrollment Survey. So I think
16 there's an opportunity to potentially add a question on
17 that survey that would provide the Commission and others
18 information in terms of whether agents are actively used.
19 MS. KELLEY: Stacie?
20 DR. DUSETZINA: Like all of the others before me,
21 I really appreciate this work in this chapter.
22 I'm going to echo some of the prior comments that

1 this system does seem fundamentally broken, and it does
2 feel like we need to rethink.
3 I think some of the areas you highlight in the
4 chapter, for example, the CMS audits and the percentage
5 with incorrect information given to people, it's like this
6 is a really hard space for a broker or agent, anybody to
7 have all of the information. So you could imagine, it's
8 really easy to say the wrong thing. But that makes a huge
9 difference on how people experience their health insurance
10 benefits and whether they can access care. So it's a
11 really big deal to have incorrect information, in addition
12 to all the not-so-great incentives for people to buy a
13 higher-priced plan and others that folks have mentioned.
14 I fully agree with Cheryl's comment on having a
15 report of how much spending there is on broker payments.
16 One of the things that the chapter has good information
17 about, how much money is going towards SHIP counseling, and
18 it feels like without that other side of the coin, you
19 don't really have an understanding of that being a pretty
20 small amount of money relative to how much spending goes on
21 to try to help people pick plans.
22 And I was just kind of thinking, how do we get

1 more information? Because this is such a, like, poor
2 information area, you know? And I was wondering a couple
3 of things. If I had a wish list, one might be that we
4 actually had an indicator of who was enrolled by a broker.
5 That has to be generated somewhere, right? So there has to
6 be, like, this beneficiary in this plan that has to go to
7 get people their payment, right? You would think. So
8 somewhere, it's tracked, like, where we know the
9 beneficiary and that there was a broker payment that was
10 associated with enrolling that person or keeping them in
11 their plan.
12 If I were trying to do a wish for data to include
13 in our claims, it would be something like that, to think
14 about how those individuals maybe have plans that are
15 different in their prices, their coverage, something like
16 that, or even geographic area.
17 I think the other one would be -- the piece that
18 bothered me the most was the, like, narrowness of the
19 options that were presented to you. So I fully understand
20 people being supported by brokers and agents to help make
21 these important decisions, but if you are being given a
22 really limited number of plans. So if we do proceed down

1 this path and wanted to collect more information, it seems
2 like understanding from an agent by agent or, like, how
3 many plans do you represent? Are we talking about most of
4 them or just a few? Those might be my wish list for
5 digging in further.
6 But phenomenal work, really good paper.
7 MS. KELLEY: Brian.
8 DR. MILLER: So I have a couple of questions.
9 One, I'd also encourage us not to make policy decisions for
10 60 million beneficiaries, based upon anecdotes.
11 I do agree with some of the comments that the
12 SHIPs do appear to be underfunded, given that they have $55
13 million and address 1.8 million beneficiaries. I think
14 that is worthy of more examination and support.
15 I also agree that there are problems in this
16 marketplace, how beneficiaries are able to procure
17 information and make decisions about their coverage.
18 In thinking about this I have a couple of simple
19 yes-or-no questions for you guys that I think might help us
20 get to a better place, if that's all right.
21 First is, have we reviewed any of the business
22 marketing literature on how consumers make choices about

1 other insurance products that they purchase, such as auto,
2 life, or disability insurance?
3 MS. TABOR: We are just starting out on this
4 work, and that is something we can look into if the
5 Commission so chooses it.
6 DR. MILLER: So we haven't yet.
7 MS. TABOR: No.
8 DR. MILLER: Okay. Thank you. Have we looked at
9 the literature on how consumers, ages 18 to 65, make
10 decisions about purchasing health insurance?
11 MS. TABOR: We haven't. We are just starting out
12 on this work, and it is something we can look at if the
13 Commissioners want us to.
14 DR. MILLER: Okay. A few other questions. Have
15 we looked at the literature on how consumers make other
16 large purchases of complex tradeoffs assisted by
17 financially interested, third-party intermediaries, for
18 example, home purchases or new or used cars, both of which
19 are areas that I believe have been studied by the Federal
20 Trade Commission?
21 MS. TABOR: That too is something we can look
22 into if the Commissioners would like us to.

1 DR. MILLER: Okay. A few more questions. Have
2 we looked at the distribution of captive, employed, or
3 independent agents in any of those other markets, or how
4 they are compensated?
5 MS. TABOR: I don't know if we could do that, but
6 we can look into that if the Commissioners would like us
7 to.
8 DR. MILLER: Okay. And then, to me at least, all
9 of these are other complex markets that people make
10 purchases throughout their entire life before the age of
11 65, in the case of all these other insurance markets, and
12 then after the age of 65. And beneficiaries are aware that
13 their real estate agent is biased, a car salesman is
14 biased. I have an insurance agent who sells me homeowner's
15 insurance, and I know he's biased. And I don't know what
16 his compensation is but I suspect he has an incentive to
17 sell me higher-priced insurance.
18 So I think that we really need to be careful in
19 our conversation here, because we are incorrectly assuming
20 that Medicare beneficiaries have no agency and need a
21 paternalistic central authority to help them make
22 decisions, when, in contrast, for the entire rest of their

1 life they have purchased health insurance, auto insurance,
2 homeowner's or renter's insurance, some life and disability
3 insurance, and also have purchased other things -- cars,
4 boats, jet skis, barbecues, homes. And in every part of
5 the rest of the economy we interact with sales agents who
6 definitely don't have our best interests at heart, and we
7 are able to make decisions. And sometimes we make good
8 decisions, and sometimes we make poor decisions, thinking
9 of several poor purchasing decisions I have made, for
10 example.

11 But we should not assume that once people turn 65
12 and enroll in Medicare that they are unable to make
13 decisions about how they spend their money and what sorts
14 of products that they choose. I think the big problem that
15 I have with this discussion is that is the premise behind
16 this entire chapter. I agree with everyone else that there
17 are challenges about brokers and how they are paid, but I
18 think we need to step back and be realistic, and realize
19 that beneficiaries have agency -- many beneficiaries have
20 agency -- and those who struggle often have, as we saw from
21 that Commonwealth Fund chart, other people who assist them,
22 whether it the SHIP or whether it's their family members,

1 whomever it is.

2 And I would also caution us, because looking back
3 over the past couple of years here at MedPAC I haven't seen
4 a discussion involving private industry that doesn't
5 involve a broad-spread suggestion of new reporting burdens,
6 regulations, or the creation of publicly run organizations,
7 and this is a space that already has these and they are not
8 working.

9 So I think we would be better served, and
10 Congress would be better served, if we answered some of
11 those questions, so that way we could give more targeted
12 suggestions about how to help beneficiaries make better
13 choices. Thank you.

14 MS. KELLEY: Greg, did you have something on this
15 point?

16 MR. POULSEN: Yeah, I did. I guess I think that
17 it's pretty fundamentally different when we are selling a
18 product that is highly related to the federal government.
19 I think that is a big difference from a used car. I think
20 that our expectations are different. And my experience has
21 been the same as some of the other people who have spoken
22 up, which is in some instances you have an expectation that

1 the broker is actually a representative of the government.
2 That may be incorrect, it may not be allowed by law, but it
3 happens.
4 The other thing is, I think there is an
5 expectation that they are there to help you navigate a very
6 tricky problem and that your interest is their interest.
7 And that is not clearly always true, as well.
8 I don't disagree with your premise that it could
9 work. I disagree with your premise that it does work. I
10 think that what we find is that the brokers, in many cases,
11 are not doing what the people that are using them think
12 they are doing. If they were, if they were here to say
13 "I'm here to represent Insurance Company X and here's why
14 that would be a good choice for you," that's very different
15 than coming in and saying, "I'm here to help you make the
16 wisest decision that you can. I have information that you
17 don't have. I have years of experience and have done a lot
18 of research that you haven't been able to do, and here's
19 what's best for you." And that's a misrepresentation of
20 the service that they're providing. I'm not saying that
21 that is what is envisioned, but it's certainly what
22 happens.

1 DR. MILLER: Greg, I'm not necessarily a huge fan
2 of brokers, so apologies if I sound that way. I don't
3 think we have any evidence to say that that happens at the
4 systematic, mass-produced scale. I'm sure it definitely
5 does happen. But my point is that beneficiaries are
6 purchasing things that are very important, some of which
7 are probably funded and some of which are not, whether it's
8 Section 8 housing voucher, whether it's a Fannie Mae-backed
9 home loan, whether it's Medicaid managed care. Whatever it
10 is, people make complex decisions, and they manage to make
11 them frequently. You know, people make good decisions, and
12 frequently also people make terrible decisions.
13 And so I don't think that we should be operating
14 with the assumption that people cannot make decisions and
15 that they don't know that brokers are biased.
16 MR. POULSEN: I don't fully disagree. I know we
17 don't want to get into a discussion --
18 DR. CHERNEW: We just need to keep going, because
19 we've got a lot of people in the queue. We have limited
20 time. So I know there are a few on points, but I wanted
21 them to be, and I hate to say this, really on point.
22 MS. KELLEY: Lynn.

1 MS. BARR: Thank you. I just think that Medicare
2 is so complex. I'm buying a car, I can look at the car, I
3 can look at the price, I can compare myself. I cannot
4 compare these plans without help, as a Medicare
5 commissioner, right, who has recently enrolled in Medicare.
6 So this is a whole different thing. It is not
7 obvious, as we all know, and it is not a simple consumer
8 decision, and we need help. And if the people we are
9 getting help from aren't giving us unbiased help, then we
10 are likely to go down the wrong direction, and it just
11 makes sense.
12 DR. CHERNEW: So let's save the broad debate
13 until we get to a point where we should have a broad
14 debate. We will have a broad debate, but right now let's
15 just get everybody's comments on where we are. So thank
16 you. I think, Stacie, you passed, right? So where are we,
17 Dana?
18 MS. KELLEY: Larry has a comment. He says thank
19 you for the very clearly written material that explains an
20 important area that few people understand and about which
21 it is not easy to find information. He agrees with Tamara
22 and Lynn that the broker system cannot be fixed. It would

1 be better to adequately fund SHIPs.

2 One further point about incentives. In focus
3 groups done with agents by the Commonwealth Fund, brokers
4 reported earning much more for enrolling beneficiaries in
5 MA, with one broker saying, "It seems like CMS wants to
6 push people into MA."

7 He feels very strongly that we should include a
8 discussion of the difficulty of switching from MA to
9 traditional Medicare. In most states, 46, it can be very
10 difficult or, unless you are very wealthy, impossible to
11 switch to traditional Medicare once a beneficiary is
12 enrolled in Medicare Advantage. His impression is that not
13 many beneficiaries, or anyone for that matter, really
14 understands this.

15 One might think that a major thing that brokers
16 should do is explain the potential Medicare trap to
17 beneficiaries, but it's not clear that they do, and as you
18 point out, they have strong financial incentives to enroll
19 people into MA.

20 We should probably include switching in our work
21 on agents. It is so important that an agent may steer
22 someone into MA, and that for most people this will be a

1 lifetime choice.

2 So he asks, did you consider asking beneficiaries
3 in focus groups about their knowledge of the switching
4 issue and whether their broker explained this issue to them
5 before they chose between MA and traditional Medicare? He
6 thinks it would be useful to find out more about whether
7 brokers discuss switching and whey they are supposed to
8 discuss switching.

9 And then on page 28, we see that some insurers
10 are not paying commissions for enrolling beneficiaries in a
11 PDP plan. This is, intentionally or not, a way to kill
12 traditional Medicare. Without PDP plans, traditional
13 Medicare will cease to exist. Maybe we should look a bit
14 more closely, if possible, into brokers' incentives or lack
15 of them for enrolling people in PDP plans. Enrolling
16 people in Part D is time-consuming if done right, because
17 you need to look closely into which plans cover which of a
18 beneficiary's drugs, and at what price.

19 And now I have Gina.

20 MS. UPCHURCH: First of all, yes, thank you again
21 for all this, and I have appreciated all the Commissioners'
22 comments. Mine is a little long.

1 Medicare is a very complex system, and these are
2 crucial and lifelong decisions that mean access or no
3 access to life-sustaining and enhancing care, or bankruptcy
4 or no bankruptcy, frankly. We have seen that.
5 We have created SHIPs and the agent/broker
6 business as being necessary, and we have added costs to the
7 system because we allow all of this variance. So we need
8 to simplify coverage options as a top priority. So I just
9 want to reiterate what Cheryl's point is. We have created
10 ways to try to help people navigate a system we have
11 allowed to be too complex. Medicare coverage decisions,
12 enrollment in A, B, C, or D, is way more complex than
13 enrollment in any employer group health plan that I have
14 ever seen, and we see a lot of them.
15 Right now, helping Medicare beneficiaries with
16 coverage decisions is Healthcare Jobs Program, and
17 understanding Medicare is not easy, especially over the
18 phone, because we are helping to improve health insurance
19 literacy, and it is challenging.
20 There is a need, right now, in our system, for
21 agents and brokers. SHIP cannot handle it all, unless they
22 get significant investment of funds, which I hope we will

1 think about. But agents and brokers, some of them are very
2 good, and though they are limited in what they discuss, and
3 there needs to be full transparency about that.
4 So SHIP, just in North Carolina, just so you
5 know, we do have 30 percent of funding for our state SHIP
6 program comes from the state government, so not everybody
7 relies totally on federal funding. But there are
8 significant concerns about federal funding for SHIPs right
9 now, just to put it out there. And SHIP is woefully
10 underfunded. Senior PharmAssist is an example. Every year
11 we get maybe 10 to 25 percent of funding for what we do is
12 covered by the SHIP. We raise money to do all the rest.
13 It is very underfunded.
14 Volunteer SHIP programs were fine when you were
15 just looking at Medigap policies. But in 2003, with the
16 Medicare Modernization Act, you an explosion of Medicare
17 Advantage plans and Part D plans, and it got way more
18 complex for volunteers. So now volunteers have to be
19 regularly trained, and need consistent experience or they
20 don't feel comfortable doing it -- and a lot of them are
21 quitting because it's gotten so complex -- to stay up to
22 date, because they know that it can be life-altering if

1 they make some mistakes, and there are so many nuances.
2 At Senior PharmAssist we have paid and volunteer
3 staff, and it is like matchmaking. We have some people who
4 know about our state health plan really well. We have some
5 people who know really a lot about Duke retiree coverage.
6 We have some people who are really good at understanding
7 end-stage renal disease and coverage issues. They are all
8 so nuanced. It takes years to have somebody be able to
9 understand all of this, in terms of enrollment. So I just
10 want to put out there how serious it is.
11 Local knowledge is critical. You can have the 1-
12 800 Medicare number, you can have the state SHIP offices,
13 but they don't know about local networks. And every
14 Medicare Advantage plan is sold by county, right, so what's
15 in one county may be different what's in the next county.
16 So local help from SHIPs is really critical.
17 But SHIP has serious administrative burden right
18 now. For those of you who don't know, CMS supports the
19 PlanFinder, but ACL supports something called the STARS
20 Data Entry System. So after you help somebody in the
21 PlanFinder, if you're a SHIP site, you are required to go
22 enter much of the same information, and more, in a separate

1 federal government system, to justify what you just did in
2 the SHIP system, so that SHIP can keep getting funded.
3 We need to connect it into one platform so
4 there's less redundancy and less work for SHIP volunteers,
5 who again, quitting because it's a lot of responsibility,
6 and it's a lot of administrative burden.
7 We should focus on helping individuals navigate
8 their choices versus documenting that help.
9 When we used to start Medicare, we'd also start
10 Social Security, but that doesn't happen anymore, right.
11 So Social Security starts at 66; it's going to 67. So the
12 way that people know that they have to make a decision
13 about Medicare is what? Their mailbox is jammed full, from
14 insurance companies. That is how they know they've got to
15 make a decision, usually.
16 So when I have suggested, when we are about to
17 turn 65, we know they do not get the Medicare And You
18 handbook until they enroll in Medicare. So before that
19 time, we need to make sure -- and I think some states do
20 this; we don't do it in North Carolina yet -- we need to
21 say there are four critical things you need to know.
22 First, you need to be in touch with Social Security about

1 when you want to start B. That is a critical decision, to
2 B or not to B. When do you start B? It can mess you up
3 for lifelong penalties. So that's the first one. And you
4 have to be in touch with Social Security, not Medicare, to
5 start A and B.
6 Number two, then you move to Medicare and CMS,
7 and by the way, they're the same thing. CMS runs Medicare.
8 A lot of people are confused about that. And then you say
9 you go to Medicare to make the decision about fee-for-
10 service versus Medicare Advantage decision.
11 Then if you want fee-for-service, SHIPs, brokers,
12 we can get you in Part D, but we cannot enroll you in a
13 Medigap policy. You have to be in touch with that
14 insurance company or agents or brokers. We cannot walk
15 them through enrollment in a Medigap policy. So that adds
16 another level of complexity.
17 And four, we have the share that agents and
18 brokers don't cost you more, directly, to get the coverage,
19 but they are being paid, and they may be steering you to
20 certain things. That just needs to be super transparent.
21 So those four things. You start with Social
22 Security to get you’re a and B going. Then you move to

1 Medicare to make a decision about fee-for-service versus
2 Medicare Advantage. If you're in fee-for-service you need
3 a Medigap, and you need to be in touch with an agent or the
4 insurance company itself directly. And then lastly, agents
5 and brokers are not going to charge you more, but they are
6 being paid, and they have some incentives to steer you to
7 certain plans.
8 Marketing problems. This is currently happening,
9 and it's allowed, and it's very concerning. I'm not sure
10 how it's related to the scope of the appointment that you
11 covered with us, but when Medicare beneficiaries sign up
12 for Part D, or a Medigap policy from Company X, that
13 company can then be in touch with them with mailings, lots
14 of calls, to tell them about your preferred pharmacy, that
15 may cost you more but they're not telling you that, and
16 they can try and sell you a Medicare Advantage plan. They
17 say it's a better fit for you. You've got Medigap -- what
18 about this? It has a cash card that comes with it.
19 There are no marketing restrictions, as far as I
20 know, once you have signed onto one of their products. It
21 opens up Pandora's Box for their other products.
22 We often hear that, our beneficiaries will tell

1 us that agents focused heavily on the cash cards, the OTC
2 benefits, and other supplemental benefits versus the
3 medical benefits, including are they covering max out-of-
4 pocket. With fee-for-service Medicare there is no max out-
5 of-pocket. Medicare Advantage limits it, but some of them
6 are huge. I'm not even sure if that's being covered by
7 agents and brokers, and it's really critical part of
8 decision-making.
9 So, just summarizing, yes to the lines of work
10 that you suggested. I like all of them, and I have five
11 other things. I'll just summarize what I just went over:
12 Consolidation of the PlanFinder with the STARS
13 system, so that you can capture who enrolled them -- was it
14 an agent, a SHIP person, and the details about the
15 enrollment. What were the topics covered? You know, a
16 checkbox. Could be one system that we could all use.
17 Preemptive and unbiased information about how to
18 understand Medicare enrollment choices several months
19 before they turn 65. It should be a no-brainer to get that
20 out to people.
21 And we need to more professionalize the SHIP
22 program because it is too complex. That means they need

1 more money.

2 And we need to encourage transparency at the
3 point of sale with the agents and brokers, as many people
4 have spoken to.

5 And lastly, we need some limits on marketing from
6 insurance companies. One somebody has a product from a
7 company, it shouldn't unleash a free-for-all, try to shove
8 them to certain pharmacies or trying to sell other products
9 to them. Thanks.

10 MS. KELLEY: Betty.

11 DR. RAMBUR: Thank you.

12 This is extremely important work, and I really
13 value the work you've done in the comments.

14 I'll be very brief. This conversation has
15 illustrated the complexity of the market, and as Cheryl
16 pointed out, the complexity.

17 But I just wanted to say what's important to me
18 is the lack of transparency. That is really the heart of
19 the issue for me, and if people know what they're getting
20 and what they're giving up and it's clear, then I'm
21 completely fine, because that's what it takes to make a
22 market work.

1 I share Larry's concern about people not
2 understanding that it's very difficult to get to
3 traditional Medicare or very expensive if you've been on
4 Medicare Advantage first. If they understand that, what
5 they're getting and giving up, that's fine.
6 Standardization of benefits came up, and I
7 respectfully have to say, I think that auto insurance is
8 actually quite different than this. Auto insurance is
9 pretty easy to understand. You've got a $500 deductible or
10 $1,000 or collision only, and if something really bad
11 happens, your car is ruined. This is life and death for
12 people, and so I think we have a really important
13 obligation, and I'm happy we're taking it on.
14 In the interest of time, I won't go over other
15 comments I was going to make, except for one. I don't
16 understand what agencies own the agents. Now, what am I
17 saying by that?
18 Recently, a little fender bender in my family,
19 and we have this local automobile insurance company, we
20 thought, but it's actually part of an enormous
21 conglomeration. Now, that maybe wouldn't change anything,
22 but I think it's not clear who really is owning all of

1 this. I have some guesses.
2 So anything we can do to make this more
3 transparent, I think is important, and I think over time,
4 the -- what's it called? The paper could become a set of
5 recommendations, but a lot of work to do, and I appreciate
6 all you've done.
7 MS. KELLEY: Scott?
8 DR. SARRAN: Yeah, excellent work. Thanks.
9 And I know others have made excellent comments.
10 So I'll try to be really pointed and as brief as I can.
11 First, in terms of ongoing focus groups, to the
12 extent possible, I think it will be really important to
13 segment the focus groups or at least the information we
14 gain.
15 I think I want to particularly understand what
16 low-income beneficiaries and beneficiaries with low health
17 literacy have to say, because I think that's where we do
18 need to be particularly concerned about how well they're
19 served by the current system.
20 And I would also try to tease out particularly
21 the point around someone who has been in MA and then wanted
22 to go back into fee-for-service and what that experience

1 was like, because that is so darn critical.

2 Secondly, the transparency point, I just want to

3 reinforce -- we start sort of teeing up, as I know we're

4 thinking about a chapter at some point in the future,

5 transparency about payments, about the various incentives

6 that are alongside payments. And the point I think Larry

7 and others made about the zero commission and because

8 that's steering people away, people might think zero

9 commission, that's fine if they don't want to incent

10 something, but it really can be an active steerage away and

11 have all sorts of implications.

12 And in terms of the big picture, I think as we

13 start thinking about what a chapter might look like down

14 the road, we probably should have some kind of text box

15 around how is this similar and how is this different in

16 terms of the choice architecture and the implications of

17 choice versus other buying decisions people make, because

18 legitimately, there's a spectrum, right? And at one end,

19 it's complete laissez-faire, people can buy what they want

20 and buyer beware, and the other spectrum is complete

21 paternalism. And we live for a variety of good reasons in

22 a society where there's going to be tension along there.

1 But I think calling out why this is very
2 different for sure from buying a car and even from buying a
3 car, as I was pointing out, insurance for your car -- and I
4 would tick off at first, it's a necessity. It's not an
5 optional. I don't have to buy a car, right? I have to do
6 something with my Medicare benefit.
7 The complexity, you know, including, of course,
8 lack of standardized benefits in MA.
9 The information asymmetry, right, and the
10 opaqueness, you know, is huge.
11 And the sequelae of this decision. I buy a car I
12 don't like, you know, put it for sale the next day,
13 whatever. I may lose some money, but, you know, that's
14 okay. And the sequelae -- and I would list out. You know,
15 the sequelae, you may not have access to get back into fee-
16 for-service Medicare. Your costs may be higher for a
17 lifetime, Gina mentioned, depending on decisions you make
18 in terms of timing.
19 The access cost, which is hard to calculate if
20 you've purchased something that doesn't give you access for
21 your cancer treatment at a cancer center.
22 And then this is also -- as other people have

1 pointed out, this is so different than any other purchase,
2 because this is the front-end purchasing to a government
3 product, right? GM, Ford, they're not the government
4 making a car, right? So I'm making a very different buying
5 decision.
6 Lastly -- and this is a pure editorial comment --
7 I'd just remind us all that the biggest single difference
8 between the U.S. and the Western world in terms of our
9 spend and our value from health care relates to the admin
10 spend. And, on one hand, transparency and simplicity
11 versus, on the other hand, complexity and lack of
12 transparency are big drivers of the unnecessary admin
13 spend. So acknowledging that last one was pure editorial.
14 Thanks.
15 MS. KELLEY: Robert.
16 DR. CHERRY: Well, thank you very much for
17 bringing this to our attention. It's really fascinating.
18 I wish it was a little more approximate to our discussions
19 on benefit redesign and all of the different choices and
20 options that patients have out there.
21 It may have also crystallized our discussion a
22 little bit more on the complexity of choices that are out

1 there. Certainly, when we were talking about this, I had
2 said this publicly. What problem are we actually trying to
3 solve? And can you create online algorithm-driven tools
4 that would allow for potential enrollees to make better
5 decisions about what type of plan choice they might make?
6 But I was unaware of this cottage industry around
7 insurance agents, which is actually quite fascinating, and
8 I'm not saying whether it's a good thing or a bad thing.
9 But I think it's definitely worth looking into in the
10 future.
11 I do have a series of questions. They're just
12 rhetorical, so that as you start thinking about future
13 work, maybe bringing some of this into context could be
14 helpful.
15 So it was mentioned that CMS does have
16 compensation rules around the insurance agents, but it's
17 held up in litigation. It would be good to know a little
18 bit more about what those rules are and what maybe some of
19 the pain points are where it's held up in litigation.
20 I'm also interested in the disclosure forms that
21 these agents have. What's in them? What's required. If
22 we could see an example, that would be great. I'm also

1 wondering whether they're easy to understand or not in
2 terms of how they're written.
3 The other thing is that maybe some states have
4 websites like this where the agents are actually listed,
5 including who they're contracted with. I doubt it, but
6 that's something to kind of look at, because the better the
7 transparency and the disclosure information, then more
8 likely the beneficiary would be able to make informed
9 decisions.
10 And I was also curious, too, if whether or not
11 plans that are not contracted with an agent should be
12 required to pay some sort of base commission anyway,
13 because if everybody has skin in the game, then maybe
14 there's no conflict of interest or you can at least reduce
15 the conflicts of interest.
16 And then, finally, should there be surveys that
17 enrollees actually take so that we have more information
18 about their experiences?
19 So, again, these are just rhetorical questions,
20 but just something to think about in the next iterative
21 phase of this paper.
22 Thank you.

1 MS. KELLEY: Amol.
2 DR. NAVATHE: Thanks for this very important
3 work.
4 I'll try to be brief, given Mike's comments about
5 us being over time, but there are a couple of pieces I did
6 want to try to elevate.
7 So I think, first off, this is obviously an
8 important area. I think there's a lot of complexity, and I
9 think getting benes information is certainly very important
10 for them to be able to make choices.
11 And I think we should at least very conceptually
12 or generally acknowledge that the brokers, while there may
13 be incentive problems and there may be issues around it,
14 the agents and brokers are actually still delivering some
15 information.
16 To some extent, I know there's a vigorous debate
17 and there's different national regimes that think about
18 direct consumer for things like pharmaceuticals, but
19 there's a lot of information that still gets out there
20 through that mechanism. So I think we should acknowledge
21 that there is that information that is flowing through the
22 system. And so it's not - I don't think it's a priori

1 clear that we can say that it's good or bad. I think we
2 should be careful as a Commission from pre-judging that
3 point, while recognizing that they are clearly playing an
4 important role one way or another in delivering that
5 information.
6 I do want to kind of plus-one Betty's point
7 around the transparency point, however. I think that's
8 critically true.
9 And I think there's also -- Larry and others have
10 mentioned a symmetry point here, which is if both are
11 essentially government-sponsored options being MA or fee-
12 for-service with supplemental and Part D, I think ideally
13 the government would have some symmetry. And I think the
14 point that -- I don't remember which Commissioner made that
15 -- a broker sort of or agent reflected that, hey, you know,
16 the government must want us push more people into MA
17 because the incentives are aligned in that way kind of
18 makes really rational sense that you would think that way.
19 And if that's not the intent of CMS and of the government,
20 then that lack of symmetry is certainly misaligned
21 potentially.
22 So, given that as kind of backdrop, I wanted to

1 try to be helpful to the team in terms of thinking about
2 things that we can do. I do think it would be helpful
3 certainly to talk to more brokers beyond what the
4 Commonwealth Fund has done.
5 Again, I know a lot of us are relying on our
6 anecdotal experiences here, but anecdotally having spent
7 time with some of them, I think they oftentimes do have
8 frameworks or approaches or heuristics in terms of how
9 they're trying to help beneficiaries accomplish their
10 goals, whether that's focusing on vision- and dental-type
11 coverage or if it's focused on something else, network, et
12 cetera. So it would be good to try to understand a little
13 bit more about -- beyond the pure financial incentive part
14 that I think we understand at least at a macro level what
15 the policies are, try to understand kind of how they're
16 empowered with tools and how they're actually driving some
17 of that decision-making.
18 I do think it would be good alongside that to at
19 least bring in the literature that does exist, because I
20 think there is some around just insurance, health insurance
21 choice, as well as beneficiary choice specifically within
22 MA plans. I think that would be helpful.

1 The other point that I would make here is that I
2 think it's also really helpful if we can talk to some
3 plans, and the reason that I say that is -- so paying
4 agents or brokers is certainly not a trivial expense for
5 plans, and as technology, you know, the internet is
6 evolving, as the population that is actually aging into
7 Medicare has been more exposed to technology, I think
8 there's a lot more -- my understanding at least is at a
9 high level, there's a lot more direct enrollment even
10 that's happening through other options that are other
11 vehicles or mechanisms that plans are making available that
12 are essentially broker commission-less ways, which is
13 obviously good for plans. But that's another part of the
14 kind of milieu of choices, and so I think we should be
15 mindful of that. And I think talking to plans, if we can,
16 about how they're thinking strategically about using the
17 agents and brokers versus these other mechanisms would help
18 fill in the picture for us a little bit.
19 And the last point I was going to ask is if we
20 can look into this piece around the zero commission plans.
21 I think that's actually potentially really interesting and
22 helpful, especially because since we don't really know on

1 an individual level, somebody use an agent or not use an
2 agent. It's very hard for us to get a sense other than
3 through surveys, what the kind of empirical impact is, if
4 you will.
5 But when plans go from being a commissioned plan
6 to a non-commissioned plan, that potentially gives us an
7 option, an opportunity to see what the impact is on
8 enrollment or exit from those plans in different markets.
9 And that might be a little event study kind of way for us
10 to do some empirical work that might help understand a
11 little bit about how important these commissions are and,
12 therefore, these agent-broker relationships are.
13 So thank you so much for this fantastic work. I
14 think it's, as you pointed out, Ledia, we're just embarking
15 upon it. So there's a lot of questions, probably a lot
16 more questions than we have data and answers, but I think
17 critically important. So thank you so much for taking it
18 on.
19 MS. KELLEY: Kenny.
20 MR. KAN: Thank you very much for an excellent
21 chapter.
22 This is a very complicated topic, and I just want

1 to really emphasize to all my fellow Commissioners, this is
2 an initial exploratory paper. We need to crawl first
3 before we can run. So I think I want to credit the team
4 here for really doing a good job at highlighting many of
5 the issues.
6 I hear the concerns that some of my fellow
7 Commissioners have brought up, potentially a non-level
8 playing field, potential lack of transparency, biased
9 incentives, but I don't think we know enough about the
10 issue.
11 And I also definitely -- it was an eye-opener for
12 me to find out that SHIP was really vastly underfunded, and
13 I think we should definitely explore more about funding,
14 how we can possibly mitigate some of that.
15 And again, this is an initial exploratory paper,
16 which Amol actually mentioned, and as Gina has clearly
17 indicated, there is a need for brokers, unless you
18 substantially expand the SHIP funding. And some brokers
19 are very good, Gin, as you noted. So I would caution us
20 from -- I worry when I hear statements like, "Oh, the
21 system is broken. Let's discard the whole thing." For me,
22 that appears to be way more than an overreaction. It's

1 like dropping an atom bomb to kill a fly.
2 So I would definitely suggest doubling down on
3 Amol's ideas. We should talk more to brokers instead of
4 relying on anecdotes. We should talk to health plans. We
5 should explore some consumer literature and buying
6 behavior, some of the ideas that Brian has suggested, and
7 perhaps in the next paper, possibly begin to tee up some of
8 the unintended consequences if we were to do some of these
9 options.
10 Thank you.
11 DR. CHERNEW: All right. Okay. So that was
12 wonderful. I can just feel the energy in the room.
13 I will say nothing more broadly about it, besides
14 we have a lot to think about it, and we will hear about
15 this again in the future.
16 Let's take -- can we go with a seven-minute
17 break? I know we have -- we are a bit behind. We have a
18 lot we want to do. We will start at 3:07 promptly. If
19 you're here, great. If you're not, so sorry. We're going
20 to be talking about a related topic on Medigap. So thanks
21 so much.
22 [Recess.]

1 DR. CHERNEW: Hello, everybody. Welcome back.
2 We're in some ways going to continue our
3 conversation about the choices that Medicare beneficiaries
4 face. In this session, we're going to be focusing on the
5 Medigap market, which is obviously a crucial market for all
6 the Medicare beneficiaries.
7 So I think -- now Jen, this is your second
8 presentation, right? So I'm going to call that out as a
9 thank-you. But Jen and Ledia are going to go through this.
10 So, Jen, go ahead.
11 MS. DRUCKMAN: Today we're going to discuss
12 Medicare supplement policies known as Medigap.
13 We'd like to remind the audience that they can
14 download a PDF version of these slides in the control panel
15 on the right-hand side of the screen.
16 We would like to thank our colleague, Pamina
17 Mejia, for her assistance with this work.
18 As background, beneficiaries selecting fee-for-
19 service Medicare can obtain Medigap insurance to protect
20 themselves against certain cost-sharing and coinsurance.
21 Commissioners have asked for information about Medigap
22 availability and coverage. This material is for

1 Commissioner information only, and it is not intended for
2 publication at this time. The next steps may include
3 additional work on Medigap into the 2025-2026 analytics
4 cycle.
5 In this presentation, we will cover four topics.
6 First, I will provide an overview of Medigap. Then we will
7 review the following Medigap topics: Medigap plan types
8 and how they are standardized; Medigap enrollment,
9 including discussion of guaranteed issue and qualifying
10 events; Medigap premium data; and minimum loss ratios for
11 Medigap policies. We will conclude with discussion and
12 potential future work.
13 As you heard in the earlier insurance agent
14 overview presentation, Medicare beneficiaries have many
15 complex enrollment choices to make. This afternoon, we are
16 focusing on one part of the enrollment choices, as
17 indicated in the orange box. Beneficiaries can choose a
18 Medigap plan to help cover cost sharing and coinsurance in
19 Medicare fee-for-service. They can choose from 10
20 standardized plan types.
21 There are several sources of supplemental
22 coverage for beneficiaries in fee-for-service Medicare,

1 including Medigap, employer-sponsored insurance, and
2 Medicaid. This figure shows the sources of supplemental
3 coverage among non-institutionalized Medicare beneficiaries
4 in 2021. The most common supplementary coverage is
5 Medigap, as about 23 percent of all Medicare beneficiaries
6 had a Medigap policy in 2021.
7 This figure shows the trends in supplemental
8 insurance from 2017 through 2021. From 2017 to 2021, the
9 share of fee-for-service beneficiaries who had Medigap
10 supplemental coverage rose from 35 to 45 percent.
11 Over the same period, the share who had Medicaid
12 coverage decreased from 17 percent to 12 percent, and the
13 share who had no supplemental coverage, indicated on this
14 figure as Medicare-only, dropped from 18 percent to 12
15 percent. The share that had employer-sponsored
16 supplemental coverage stayed nearly constant at around 30
17 percent.
18 These trends in fee-for-service supplemental
19 coverage could be due in part to beneficiaries with
20 Medicaid coverage or no supplemental coverage opting to
21 enroll in MA over fee-for-service.
22 Medigap plans are private plans that wrap around

1 fee-for-service Medicare. Medicare fee-for-service does
2 not have an out-of-pocket cap on beneficiary cost sharing,
3 which is a concern for beneficiaries.
4 Many beneficiaries select supplemental coverage
5 to fill the gap by reducing or eliminating cost sharing.
6 In fee-for-service Medicare, beneficiaries make
7 cost-sharing payments when using most services. For
8 example, there is a coinsurance rate of 20 percent for Part
9 B outpatient services.
10 Depending on the plan and the extent of the
11 wraparound coverage, a beneficiary with Medigap may not
12 have out-of-pocket costs for a particular service but would
13 have to pay a monthly Medigap premium. These plans are
14 largely regulated at the state level, which can lead to
15 premium variation.
16 The Medigap premium is in addition to the Part A,
17 if applicable, Part B, and Part D premiums. There is no
18 federal contribution towards the Medigap premium.
19 Medigap enrollment varies widely by state, from 9
20 percent of fee-for-service Medicare beneficiaries in Hawaii
21 to 67 percent in Iowa. In 11 Midwest and Plains states,
22 where relatively fewer beneficiaries are enrolled in MA

1 plans, more than 50 percent of Medicare beneficiaries in
2 fee-for-service Medicare have a Medigap policy.
3 Medigap was the most common source of
4 supplemental coverage among all fee-for-service
5 beneficiaries who are age 65 or older, have income higher
6 than 1.25 times the poverty level, are rural dwelling, and
7 report excellent or very good health.
8 Unlike other insurance policies, all Medigap
9 policies are standardized, which means policies with the
10 same letter offer the same basic benefits, no matter where
11 the beneficiary or the insurance company are located.
12 Medigap plans are named in most states by letters
13 A through D, F, G, and K through N. These plans must
14 include the same basic benefits, but the premiums can vary.
15 This standardization facilitates an apples-to-apples
16 comparison between policies.
17 This figure shows the covered benefits in Medigap
18 plans for 2025. Columns with a checkmark indicate the
19 benefit is covered, and columns that are blank indicate the
20 benefit is not covered.
21 In response to concerns about higher service use
22 associated with first-dollar coverage, the Medicare Access

1 and CHIP Reauthorization Act of 2015 changed the law to
2 prohibit the sale of Medigap policies that cover the Part B
3 deductible to individuals newly eligible for Medicare on or
4 after January 1, 2020. This change in law means that
5 Medigap Plans C or F may only be issued to individuals
6 newly eligible for Medicare prior to January 1, 2020.
7 This figure demonstrates the shares of
8 beneficiary enrollment in standardized Medigap plans in
9 2023. Medigap Plans F and G, the light orange and purple
10 segments in the figure, were the most popular plans, with
11 about 41 percent of beneficiaries with Medigap in each of
12 these plans.
13 In 2023, Plan N, the black segment of the figure,
14 had the third largest share of Medigap enrollment, covering
15 around 11 percent of policyholders. About 6 percent of
16 beneficiaries were enrolled in A, B, C, and D Medigap plans
17 combined.
18 Companies issuing Medigap policies must follow
19 federal and state laws.
20 Federal law establishes standards for Medicare
21 supplemental policies, including beneficiary protections,
22 like disclosure statements describing the type of insurance

1 and prohibitions against collecting or using genetic
2 information.
3 State law sets the type of rating that occurs
4 when insurers set premiums. State laws can provide
5 additional beneficiary protections, including more
6 enrollment periods with guaranteed issue.
7 In general, the National Association of Insurance
8 Commissioners, or NAIC, develops model regulations for
9 states to adopt, especially when there has been a change in
10 federal law. The NAIC consults with a working group of
11 representatives of Medigap insurers, consumer groups, and
12 Medicare beneficiaries when developing regulations.
13 In general, states adopt the model regulations or
14 more stringent regulations.
15 Switching now to the Medigap open enrollment
16 period, which is a federal requirement. Beginning with the
17 first day of the first month on which an individual is 65
18 years of age or older and enrolled in Medicare Part B, an
19 individual may obtain any Medigap policies sold in their
20 state without medical underwriting known as "guaranteed
21 issue."
22 Aside from the open enrollment period and certain

1 qualifying events, beneficiaries are subject to medical
2 underwriting. This means they may have to pay a higher
3 premium due to their health conditions.
4 During the Medigap open enrollment period, an
5 insurance company cannot make beneficiaries wait for
6 coverage to start except for coverage related to a pre-
7 existing condition.
8 In some cases, the insurance company can delay
9 coverage of out-of-pocket costs for certain pre-existing
10 conditions for up to six months called a "pre-existing
11 condition waiting period." However, if a beneficiary is
12 buying a Medigap policy to replace certain kinds of health
13 coverage that counts as credible coverage, such as
14 employer-sponsored insurance or a commercial plan, the
15 beneficiary can avoid or shorten the waiting period for
16 pre-existing conditions.
17 After six months, the Medigap policy will cover
18 the out-of-pocket costs for services related to the
19 beneficiary's pre-existing condition.
20 There's no guarantee that an insurance company
21 will sell a beneficiary a Medigap policy if they don't meet
22 their medical underwriting requirements unless the

1 beneficiary has a guaranteed issue right. This could
2 affect a beneficiary's choice between MA and fee-for-
3 service Medicare.
4 In addition to the Medicare open enrollment
5 period, there are other qualifying events that permit an
6 individual to purchase a Medigap policy with guaranteed
7 issue.
8 This slide includes a few examples of qualifying
9 events and is not an exhaustive list. We will highlight a
10 few Medicare Advantage examples first.
11 Medicare beneficiaries have what is known as a
12 "trial right." This trial right is for beneficiaries who
13 joined MA when they were first eligible for Medicare at 65
14 and then, within the first year of joining the MA plan, the
15 beneficiary decided to switch to fee-for-service Medicare.
16 In that case, the beneficiary is eligible for a guaranteed-
17 issue Medigap policy.
18 Another example is if the beneficiary enrolled in
19 MA plan and the individual moves out of the MA plan service
20 area.
21 The next example is when the beneficiary leaves
22 an MA plan or drops a Medigap policy because the company

1 hasn't followed the rules as determined by CMS or it or its
2 agents misled the beneficiary.
3 Another example is if the Medigap company goes
4 bankrupt or the Medigap policy ends through no fault of the
5 individual. States may also determine qualifying events.
6 States can choose to establish Medigap consumer
7 protections that go farther than the minimum federal
8 standards. Four states -- Connecticut, Massachusetts,
9 Maine, and New York -- require Medigap insurers to offer
10 policies either continuously throughout the year or once
11 per year to Medicare beneficiaries aged 65 and older
12 without regard to their medical conditions. Thirty-five
13 states require Medigap insurers to issue policies to
14 Medicare beneficiaries ages 65 and older due to certain
15 qualifying events, such as when an applicant has a change
16 in their employer retiree coverage, 29 states, or when
17 beneficiaries lose their Medicaid eligibility in 10 states.
18 Now I will turn it over to my colleague, Ledia,
19 to discuss Medigap premiums.
20 MS. TABOR: In general, Medigap premiums are set
21 to cover cost sharing for beneficiaries enrolling in the
22 plan. Premiums may be based on factors, such as a

1 policyholder's age, tobacco use, status, sex, and
2 residential area, even during open enrollment and
3 guaranteed-issue periods. States can impose regulations on
4 how Medigap insurers can price or rate premiums. However,
5 37 states allow insurers to use any rating system.
6 There are three different pricing or rating
7 systems that can affect how Medigap insurers determine
8 premiums. First is a community rating in which the same
9 premium is generally charged to everyone in a residential
10 area, regardless of age or sex. Premiums may go up because
11 of inflation and other factors, such as tobacco use status,
12 but does not change due to age.
13 Second is issue age rating, where the premium is
14 based on the age of the beneficiary when they purchase the
15 Medigap policy. Premiums are lower for people who buy at a
16 younger age and will not change as they get older. Like
17 community rating, there may be some changes to premiums but
18 not due to age.
19 Third is attained age rating where the premium is
20 based on a beneficiary's current age. So the premium goes
21 up as they get older.
22 Medigap premiums varied across states in 2023.

1 The Kaiser Family Foundation, using NAIC data, found that
2 the average monthly Medigap premium across all current
3 Medigap policyholders in 2023 was $217, which ranged from
4 $191 in Alaska to $267 in New York.
5 Average premiums varied considerably depending on
6 the policy type.
7 For Plan G, the most popular and comprehensive
8 plan available to new enrollees, the average monthly
9 premium among current policyholders in 2023 was $164 and
10 ranged from about $140 in Hawaii and New Mexico to $236 in
11 New York.
12 Within the standardized Medigap plan types and by
13 residential area, there can be a number of policies offered
14 by insurance companies with a range of premiums. This
15 slide is an illustrative example of a search for Medigap
16 policies on the Medicare Plan Finder website in a zip code
17 in Northern Virginia. We highlight results for select
18 standardized plan types, each of which offered between 40
19 and 48 policies in our search.
20 The orange box plot in the top left corner of the
21 slide demonstrates the range of premiums for Medigap Plan A
22 policies. Medigap Plan A is the least comprehensive

1 Medigap plan type. All insurers who sell Medigap plans
2 must offer Plan A, leading to a wide range in monthly
3 premiums. Monthly premiums ranged from $82 to $1,330, and
4 the medium premium was $133.
5 The remaining box plots demonstrate the range of
6 monthly premiums for popular Medigap plan types, where
7 there is also a trend of a range of monthly premiums. For
8 example, the green box plot in the upper right corner
9 demonstrates monthly premiums for Plan F policies, which
10 cover all cost sharing. Plan F policy monthly premiums
11 range from $132 to $435, and the median premium was
12 $176.50.
13 Switching now to Medigap minimum loss ratios.
14 When insurers set premiums, they include the cost of a set
15 package of medical benefits, as well as other costs,
16 including administrative expenses and profits. A minimum
17 loss ratio measures the share of enrollee premiums that
18 health insurance companies spend on medical claims and
19 certain other closely related expenses, as opposed to other
20 non-claims expenses, such as administration and profits. A
21 higher percentage means a larger share of the premiums are
22 paid as claims for medical care.

1 In general, the higher the loss ratio, the more
2 benefits a consumer receives for each dollar of paid
3 premium.
4 In aggregate, Medigap loss ratios are higher than
5 the federal loss ratio requirements. Medigap policies must
6 maintain loss ratios of at least 75 percent for group
7 policies and at least 65% for individual policies.
8 Individual states may set more stringent requirements.
9 NAIC reports a total Medigap policy loss ratio of
10 83.6 percent in 2023, which broken out as 83.6 for group
11 policies and 84.7 for individual policies. In general,
12 Medigap loss ratios have steadily increased over the past
13 decade.
14 For a Commissioner discussion, we welcome your
15 questions and feedback about the material as well as ideas
16 for potential future work. Some possibilities for future
17 work include in our annual focus groups. With
18 beneficiaries, we can ask more about the role of Medigap in
19 plan choice. We could explore trends in the Medigap market
20 over time. We could also examine the role of state
21 guaranteed issue policy on the Medigap market.
22 As a reminder, this is not planned for

1 publication this year.

2 With that, I'll turn it back to Mike.

3 DR. CHERNEW: Jen and Ledia, thank you so much.

4 That variation in premium for standardized products is

5 astounding, and we will let Cheryl ask her Round 1

6 question. I think she's first.

7 DR. DAMBERG: Thanks.

8 Great work. Super interesting chapter.

9 I had two questions. I was hoping you could

10 clarify on page 9.

11 It says there's a lack of Medigap-guaranteed

12 issue protections under federal law for those under age 65,

13 and I don't really understand what happens to that

14 population. So can they get a Medigap policy?

15 MS. DRUCKMAN: So they can, but it's varied as to

16 whether they're able to get it, and they're often subject

17 to underwriting.

18 DR. DAMBERG: Okay.

19 And then the second question I had is if people

20 switch, say, from Medigap policy A to G, do they have to

21 undergo underwriting to do that?

22 MS. DRUCKMAN: It depends on the time period and

1 whether it's any qualifying events, but in general, yes.
2 DR. DAMBERG: So if they do it during the third
3 annual open enrollment period for Medigap plans?
4 MS. DRUCKMAN: Right. When they first come into
5 Medicare, they have a guaranteed-issue right --
6 DR. DAMBERG: Yeah.
7 MS. DRUCKMAN: -- and then it depends on state,
8 additional state offerings or if one of the qualifying
9 events apply.
10 MS. TABOR: And I think also to your point,
11 Cheryl, is one that we can look into. The idea of
12 switching, it can -- like how easily can you switch between
13 policies is an interesting question that we'll look into.
14 DR. DAMBERG: Yeah. And this will be my Round 2
15 comment is I am interested to what extent people actually
16 do switch and their ability to switch.
17 Thanks.
18 MS. KELLEY: Tamara.
19 DR. KONETZKA: Thanks for this great work. Just
20 like the last one, I feel like you dug up the data you
21 needed to look at that, and appreciate it.
22 My first question was very similar to Cheryl's

1 about the under-65. It just seems like most of these rules
2 and guaranteed issue rules don't apply to them. And this
3 is obviously a high-cost, high-need population, and it
4 seems like even when they turn 65, they don't have
5 guaranteed issue. It's just like in those states when they
6 first sign up for Medicare, it seems.
7 My question is, I'd like to know more about them,
8 and how does their picture of whether or not they have any
9 supplemental coverage, how does that differ from the over-
10 65?
11 MS. DRUCKMAN: There is some information about
12 the paper. Beneficiaries under 65, 7 percent have a
13 Medigap policy, versus 46 percent of Medicare fee-for-
14 service overall. But we can look into more details in the
15 under-65 population.
16 DR. DUSETZINA: Yeah, that would be great to just
17 break that out a little bit, because it's a population of
18 concern.
19 My other question, something I prob ably should
20 know after all these years, but it has boggled my mind for
21 years that we don't have better data on who has Medigap
22 policy, given that you can go on Medicare.gov and shop for

1 one of these. You know, even if it's not sort of
2 subsidized, Medicare is involved. Why can't we have, in
3 the Medicare enrollment file, why was there never an
4 indicator for whether somebody has a Medigap?
5 MS. TABOR: I can't answer kind of the root of
6 the problem, but I think we are exploring possible other
7 data sources that we could look at. But it would likely
8 not be complete. But we can kind of talk more about the
9 data in the next round.
10 DR. KONETZKA: Yeah. It just seems like we
11 shouldn't have to go do other data sources. It's hampered
12 decades of research on Medigap but also on everything else.
13 So it seems like if there's any headway, we could make to
14 try to get that included in the enrollment files, that
15 would be helpful. Thanks.
16 MS. KELLEY: Stacie.
17 DR. DUSETZINA: You caught me off-guard. I was
18 just making notes about my dream list for the enrollment
19 file in Medicare data.
20 I'm going to pile on the comment around the
21 under-65, and in particular, I was really shocked when I
22 read the part, on page 15, about the 36 states requiring,

1 like at least one Medigap policy without medical
2 underwriting. It's shocking to me, then, that so many
3 people in this group are still not enrolled, because
4 typically if you are getting Medicare under 65 it's because
5 of a disability, which is likely due to health-related
6 issues. So it is just baffling to me, and it feels like
7 something else going on that is preventing people from
8 getting into the plans, despite what it looks like from
9 this statement. So doubling down on that. I'm baffled and
10 I'm really worried about the under-65 access to these
11 policies. I think it's a huge gap.
12 The other question I had was about, on page 14,
13 you mentioned that if CMS determines a provider termination
14 represents a significant change in the plan's network, you
15 can have another period of guaranteed issue for Medigap.
16 And I was curious if they define what a "significant
17 change" is.
18 MS. DRUCKMAN: So they look at those
19 circumstances individually under the network adequacy
20 requirements and the beneficiary's needs, is our
21 understanding.
22 DR. DUSETZINA: It might be good if there's a way

1 to give an example. That feels very squishy, right. And
2 also, I don't know if we have any information on how often
3 that then does open up another chance for people. That
4 feels hard to judge. Like how hard do you fight to get an
5 open enrollment period, sort of what that comes down to.
6 MS. KELLEY: Lynn.
7 MS. BARR: Thank you. I really learned so much
8 from this chapter, and was just so joyous to read it.
9 Thank you very much for the work.
10 A couple of things jumped out on the page for me.
11 One of them was that the ranges that you saw in your graph
12 for that market, the ranges I saw in my market recently are
13 much wider. So I'm wondering if you happened to pick a
14 narrow market. I'm just looking at like my choices right
15 here for Hawaii, and it would go from, for a G plan, it
16 ranges from $115 for issue-age plan, right, then there's a
17 $277 for an attain-age plan, and then there's $415 for a
18 community plan, a month. But there is no difference to the
19 consumer, as far as I can tell, which isn't really well
20 explained.
21 So one of the things that maybe I don't
22 understand is, are there differences in here I just don't

1 understand, or is there nothing that affects the
2 beneficiary? Like I say, when I enrolled, my concern was
3 don't go for the cheap plan because you'll never get them
4 on the phone. I didn't realize as a Medicare beneficiary I
5 never, ever get involved in coinsurance. I just walk out.
6 It's amazing. And I don't get a bill or anything, and I
7 don't even see it. So if somebody has a problem, it's not
8 me, you know.
9 So just again, coming around, like how do we even
10 understand this? Why are the prices so different for the
11 same thing? The pricing doesn't make sense.
12 MS. TABOR: I think this something we really want
13 to keep looking into. I can't speak to the narrowness of
14 the market that we picked for our illustrative example. It
15 was just a random market. There's potential for us to get
16 additional data sources, to be able to look more broadly at
17 the nation.
18 MS. BARR: Well, when you did that, were you
19 looking at it and saying, oh, this is all community rating?
20 No.
21 MS. TABOR: In Virginia, all three rating types
22 were allowed.

1 MS. BARR: Okay, yeah, same with Hawaii. All
2 three. And that makes it much more confusing, because it
3 seems like they're charging the most for the ones that
4 should be charged the least, and I don't really understand
5 why. It's very, very confusing.
6 My other question was, I was shocked. Thank you
7 for sharing the information about Hawaii only having 9
8 percent penetration of Medigap. And now they are a high
9 MA. They are 62 percent, but that's not, okay, that's,
10 what, 20 percent higher. I mean, 50 percent is the
11 average, so it's not like they're wildly higher. But only
12 9 percent.
13 And then the second state that is remarkably low
14 is Alaska at 18 percent. I believe those are our two
15 newest states, right. So I'm just curious. What is the
16 mechanism there that people actually aren't enrolling?
17 Maybe, Amol, you might know more about this than other
18 people because you work in Hawaii. Why aren't people in
19 traditional Medicare enrolling in those states?
20 MS. TABOR: I think you're asking really good
21 questions.
22 DR. CHERNEW: I'm not sure they're clarifying.

1 They're a little complicated.

2 MS. BARR: Well, I figured they're clarifying

3 future work.

4 MS. KELLEY: Brian.

5 DR. MILLER: I really love this chapter. I had

6 three suggestions of sort of tables or charts to add that

7 might make it more accessible to those who are less

8 familiar with this space.

9 The first one I would think is laying out the

10 cost-sharing requirements for Medicare, and I know for us

11 that sounds sort of stupid. But I always forget all the

12 details, because they keep changing. The $1,676 Part A

13 deductible, and then your inpatient stay is $419 per day,

14 for days 61 through 90, and then $838 per day, for days 91

15 to 150. You get the idea. You guys know this stuff cold.

16 It's sort of nutty. So having a table there for the

17 reasons, because whether they are a policy analyst or

18 researcher or a Hill staff, whomever, having that all in

19 one spot would probably really help folks across A, B, and

20 D.

21 I really liked the pie chart about the sources of

22 Medigap coverage. I think that is really important to

1 have, and frankly, a lot of people don't realize the
2 uncovered population, and they often don't realize the
3 importance of Medicaid.
4 I think adding either another pie chart or
5 turning it into a table and including one that has the fee-
6 for-service population only, and what their source of
7 supplemental coverage is would be really helpful. Because
8 we have it for the broader population, and it is
9 particularly relevant for fee-for-service, because then
10 that carves out MA.
11 And then I think a table of cost-sharing across,
12 say, bare fee-for-service Medicare, fee-for-service plus,
13 you know, pick a Medigap plan or two, fee-for-service plus
14 Medicaid, and then maybe a typical general MA plan,
15 excluding SNPs, that might help, again, the readers
16 understand the role of Medigap and how it fills in that
17 space, relative Medicaid or Medicare Advantage. Because I
18 know I have talked to many people -- and it took me
19 probably five years to figure all these relationships out
20 myself -- but I've talked to many people who often don't
21 understand that market and the important role that Medigap
22 plays.

1 And then I think on page 3 there was a very small
2 typo about millions, that should have been billions.
3 But this is a great chapter. Thank you.
4 MS. KELLEY: Amol.
5 DR. NAVATHE: Thank you for this great work. My
6 first question, I think, was asked earlier, which was I
7 just wanted to plus-one the question about the ability to
8 switch between Medigap plans and how that relates to
9 guaranteed issue.
10 The other question I think was partly touched
11 upon also, which was related that price variation that we
12 see, and if we can get more information regarding what
13 might be happening there. In particular, I was also
14 curious if we do have information, or if there is
15 information about how enrollment correlates with that price
16 variation, and also what other information consumers,
17 beneficiaries might be using, and trying to make decisions
18 when there is a standardized product. But we obviously
19 don't see, at least I don't think we see, from what I
20 understand, uniform choice of the lowest product, and
21 hence, we do see this variation.
22 In part, I ask because I think I've seen some

1 data that suggests that benes end up using consumer rating
2 agencies and other ways to try to supplement in making more
3 informed choices. So I was curious if we could explore
4 that a little further in the Round 1 question way, would be
5 to say, do we have information about that at this current
6 time?
7 MS. TABOR: We are hopeful that we can get a data
8 source that would have this information and allow us to do
9 such analysis.
10 DR. NAVATHE: Okay, great. And then my last
11 question is, do we have a sense of how much higher premiums
12 are in the guaranteed issue states versus the others?
13 MS. TABOR: We would like to look into that more.
14 DR. CHERNEW: I actually have a paper under
15 review on that point, so I will send it around. I sent it
16 to the team.
17 MS. TABOR: I didn't want to steal your thunder
18 on that, Mike.
19 DR. CHERNEW: Some of it depends on what rating
20 is being used in the non-guaranteed issue part.
21 I'm saying let's stick with clarifying questions.
22 There are so many ways that Amol can talk with me.

1 Spending time on my paper is probably not worth the time.
2 MS. KELLEY: Gina.
3 MS. UPCHURCH: Thank you. One of the problems
4 with me is I know too much about Medigap policies, so just
5 a couple of things here.
6 Just to clarify a few things, maybe, and then a
7 couple of questions for you. Many states don't require
8 plans to offer Medigap policies to people less than 65, so
9 that's why they don't have them. They're not required by
10 their state. And if they are required, they can be really
11 high cost, so they're unaffordable to a lot of people.
12 So one of the key things for someone who is less
13 than 65 on Medicare, we have to remind people, if they have
14 the good fortune of living to 65, they go on to a whole new
15 bucket and can get a supplement. They have a short period
16 of time where they can get a supplement for much less cost.
17 So that's like a trigger for us, if somebody is turning 65
18 that have been on Medicare before then, they can get a much
19 more affordable Medigap policy, just FYI. But they have to
20 be proactive. The insurance company just doesn't all of a
21 sudden just drop the price on the Medigap you have. You
22 have to ask for the 65-year-old bundle, kind of thing.

1 Medigap switching can happen at any time, if
2 you're going from plan to plan. There's no open enrollment
3 period, like during the year you can switch. But there is
4 underwriting, unless that insurance company has a plan-to-
5 plan policy that allows you to switch, and they can still
6 charge you more for different plans.
7 SHIPs can look and see, well, in North Carolina
8 anyway, we can actually see the ratings of these company,
9 AB rating, you know, those ratings, and we also can see the
10 price increases over the last few years. So we have a
11 little more data that we can give to consumers about the
12 past few years of ratings from the different companies.
13 Here are my questions. Several states, in
14 addition to having the four states that have either the
15 annual or continuous enrollment in Medigap, I think it's
16 seven states have birthday -- it's your birthday; you can
17 change your Medigap. It's like an annual birthday, so I
18 think we should put that in there. When it's your birthday
19 month you have an opportunity to get guaranteed issue
20 rights to a Medigap policy. I've never understood it, but
21 I hear it happens.
22 Slide 8, you said there are folks enrolling in C

1 and F. There are folks enrolling in C and F, even now. So
2 if somebody is still working but they turn 65 before 2020,
3 they have guaranteed issue right to C and F, not D and G.
4 So we've got new people joining C and F, if they're just
5 retiring from work, just to make that clear. And you say
6 that in one place but not in that slide.
7 And then lastly, Slide 11, there's another reason
8 people have trial right to Medicare Advantage. If you're
9 in a Medigap supplement and you cancel it -- not suspend
10 it, because if you have Medicaid you suspend yourself on
11 that, or your Medigap -- but if you cancel it, you can, for
12 12 months, if it's the first time you're trying a Medicare
13 Advantage plan, not if you were young or disabled and had a
14 Medicare Advantage, but if it's the first time you're
15 trying a Medicare Advantage, you've got 12 months to try
16 it, and you can get that supplement back if they still sell
17 it, the Medigap. So there's another trial right to
18 Medicare Advantage. If you drop a supplement, you have 12
19 months after that trial right, for the Medigap. You have
20 to drop your Medigap and you have a 12-month trial on the
21 Medicare Advantage plan, and then you can go back, yeah, if
22 it's their first time doing it.

1 Those really weren't questions. The clarifying
2 question, I guess, was could we add that piece about the
3 birthday month, for certain states. Thanks.
4 DR. CHERNEW: We're learning about the clarifying
5 questions. At least now we're self-conscious about it.
6 Awareness is the first step.
7 MS. UPCHURCH: Sorry.
8 MS. KELLEY: Larry has a Round 1 question. He
9 asks, within the first year of eligibility in enrollment in
10 MA, the individual switches to fee-for-service Medicare, by
11 trial, right, is this the federal rule binding in all
12 states, or does it vary by state?
13 MS. DRUCKMAN: That example is a federal rule.
14 MS. KELLEY: Okay. Thank you. And I have Kenny
15 next.
16 MR. KAN: On page 21 of the deck you noted that
17 medical loss ratios have increased daily over time. I know
18 this is an initial paper, but I'm just curious if you know
19 why.
20 MS. TABOR: We can look more into it. That's a
21 good question. We'll think about it.
22 DR. SARRAN: Great work. And building a little

1 bit off of Amol and Mike's comments and questions, I think
2 any information we have on how the markets work for Medigap
3 in the four states where people can switch MA back into
4 Medigap, versus the other 46, I think that will be really
5 helpful.
6 DR. CASALE: Thanks. Terrific report and
7 exciting to see the information. Well, just adding on, I'm
8 curious, also about the renewal that occurs around Medigap
9 and how that impacts costs.
10 But the one question was, my understanding is
11 that some states allow physicians to balance bill, even if
12 you have a Medigap policy. Some will cover that; some
13 won't. And I don't know the scope of that issue or not, or
14 how big that is, but I was just curious.
15 MS. TABOR: I bet some of our colleagues behind
16 us know about this, so we'll talk to them and add to the
17 future.
18 MS. KELLEY: Okay. That's all I have for Round
19 1, so I'll move to Round 2, and I have Stacie first.
20 DR. DUSETZINA: Okay. Thank you again.
21 Just a couple of, like -- really great work on
22 your figures in your chapter. There were a couple of times

1 where I got to a figure and was like, can you break this by
2 the facility? And then I, like, flipped the page, and it
3 was, like, on the next page exactly how I wanted it. So
4 thank you for anticipating all of my data breakout needs.
5 It was great. I think it will be really helpful to move
6 forward into a chapter.
7 There was one part around -- so first, the
8 variability in the premiums is just -- that's unbelievable.
9 You know, it's just too much for the same standardized plan
10 to have such a variety of premiums. So I just want to say
11 that's crazy. That shouldn't be happening.
12 I didn't know about whether there were limits on
13 the ways that premiums could go up. I felt like I was
14 reading the chapter, that wasn't clear to me, and that was
15 just kind of a lingering question I had. Once you're in,
16 are there limits on how much your premium could go up to,
17 like, over time? And I don't know the answer to that.
18 Maybe you know the answer to that already.
19 MS. TABOR: No, but again, this data source has
20 the potential to help us answer that.
21 DR. DUSETZINA: Great. Okay. So that would be
22 super important for people's ability to still afford their

1 plan over time.

2 And then I'll throw in that my ongoing wish list
3 for our Medicare enrollment data would be to have an
4 indicator for having supplemental coverage. It seems like
5 that should be easy to capture, maybe not necessarily what
6 form of supplemental coverage, but just that something else
7 is responsible for paying part of this claim. It feels
8 like part of the claims processing that should be
9 available. So to whatever extent we could just say, hey,
10 it would be great to just have this included in an
11 enrollment file so we understand who has supplemental
12 coverage versus not.

13 And then I wanted to throw out, like, we've done
14 some work around trying to identify people who have Medigap
15 using the Health and Retirement Study. It's not perfect
16 because it asks a question like do you also have private
17 insurance, which, you know, the extent to which people
18 reporting that might not be always correct that you're
19 looking at Medigap, but should you want to go farther down
20 this route, that is like one place where you can get
21 information on people who have enrolled in what we believe
22 to be, you know, like having Medigap as one example.

1 Great work, really enjoyable chapter, and very
2 good presentation of data.
3 MS. KELLEY: Brian.
4 DR. MILLER: Love this chapter.
5 A couple thoughts. Question first. It's okay if
6 you don't know this. Do you know the -- did you guys run
7 into the study about exploring effects of secondary
8 coverage on Medicare spending for the elderly?
9 MS. TABOR: It's not ringing a bell. We may
10 have.
11 DR. MILLER: That is a very old -- I went
12 fishing. It was an ancient MedPAC study from when I was in
13 graduate school, which was not that recently, sadly,
14 anymore. Great study. MedPAC oversaw and commissioned
15 this many, many, many terms ago, and it showed that
16 secondary coverage increased utilization by 33 percent,
17 driven primarily by specialist visits and elective
18 inpatient hospitalization. I know that that study is based
19 on data that's two decades old, embarrassed to say. We
20 should probably revisit that or find a way to revisit that.
21 I realize that in terms of staff capacity, we can't do
22 that, but maybe that's something a contractor could do for

1 us.

2 And that gets back to, I think, the excellent
3 work that MedPAC did almost 15 years ago on Medigap and
4 induced demand, and I say this for a couple reasons. One,
5 whenever I visit my in-laws, my mother-in-law always asks
6 me why she can't buy Plan F, and I wonder why. And then I
7 look at this chart, and I see the benefits for Plan F and
8 now Plan G. They cover 82 percent of Medigap
9 beneficiaries, and I'm glad that Medicare beneficiaries
10 have rich coverage. But I also recognize that there's a
11 tradeoff, and that drives a lot of induced demand in fee-
12 for-service.

13 That induced demand in fee-for-service also
14 increases MA benchmarks. So that, I think -- is in
15 addition to induced demand from the various types of
16 Medigap plans, I think it would be helpful if we looked at
17 then how that affects MA benchmarks. So it's not just fee-
18 for-service impact. It's an MA impact because both
19 programs are intertwined.

20 Some interesting tidbits that you had in there
21 that I think are worth pulling out a little bit more is I
22 saw on page 11 that we mentioned that an insurer must offer

1 Plans F or G if they're offering a second plan, if I read
2 that correctly, which, I mean, first of all, kudos to you.
3 Incredible regulatory find. I would have not been able to
4 find that in the probably 1,800-page rule or thousands of
5 pages of regs in the CFR.
6 I think that there's something there that's worth
7 considering around induced demand. I don't exactly know
8 what that is, but I thought that that was really
9 interesting.
10 I also went -- and your work inspired me to go
11 digging a little bit. I pulled out the original RAND
12 Health Insurance experiment from 1988 and then also a 2010
13 study by Gruber and Chandra, which, you know, the RAND
14 Health Insurance experiment showed us that going from a
15 zero-dollar coverage to 25 percent co-insurance resulted in
16 21 percent higher expenditures. That's a 1988 study. Then
17 we had the 2009 MedPAC contracted study, and then the 2010
18 Gruber and Chandra study showed that co-payment increases
19 reduced office visits by 13 percent, so going the other
20 way. So I think there's something there for us.
21 One other thing that is interesting that I
22 remember reading in regs -- and I apologize for not

1 remembering specifically exactly where it was -- is that I
2 believe there was a change that allowed Medigap plans to
3 start to implement a network, recognizing that -- and,
4 Jennifer, you probably know the reg I've been talking
5 about. Ledia, you probably do too. I'm forgetting the
6 exact reg, but it allowed Medigap plans to implement a
7 network. I think like a PPO network, not an HMO network,
8 obviously, because that would be pretty restrictive. And
9 so looking at the impacts of that reg on the induced demand
10 and the Medigap marketplace and whether we should look to
11 update the Medigap plan standardization model to include a
12 network model, because any willing provider fee-for-service
13 network from 1965 is probably due for an update. And that
14 might help address some of the richness from the Medigap
15 plans.
16 As Lynn mentioned, beneficiaries can walk in and
17 walk out and not worry about any bill, which is great from
18 a beneficiary perspective, but from a payment level and
19 fiscal responsibility perspective, we have to balance that.
20 Thank you. Wonderful chapter.
21 MS. KELLEY: Gina.
22 MS. UPCHURCH: Thanks so much for this work and

1 really happy that we're looking into this.
2 So I have two recommendations for us to think
3 about moving forward, because we see this a lot with folks
4 who come into counseling at Senior PharmAssist. The first
5 one is -- we have two. One is focused on people who are
6 over 65, but they're still working. Okay. So they have
7 active employer group coverage. Okay. And the second one
8 is focused on someone who has retiree coverage. Okay.
9 So the first one, someone who's still actively
10 working and has an employer group health plan, many of them
11 mistakenly start B. They are never told to delay B. They
12 start paying the premium. Sometimes they even pay IRMAA
13 because they or their spouse are still working. They pay
14 IRMAA the higher amount. And they're shocked when a few
15 years later, they go to retire, and they're told, "You
16 don't have" -- and they're sick.
17 So I'm just giving an example of a couple. The
18 woman had rheumatoid arthritis. The husband was working.
19 They paid IRMAA all these years, even though the employer
20 coverage was primary. They were getting no benefit from
21 Medicare, but they were paying, paying, paying. And then
22 when he was ready to retire at 70, I said, "Your wife does

1 not have guarantee issue rights. They're going to do
2 underwriting because you accidentally started B earlier."
3 These are smart people, and they were furious and upset
4 because she could not get a good Medicare Medigap policy
5 without underwriting.
6 So I would like for us to think about tying the
7 guarantee-issue rights to retirement from active work, not
8 to when you start B, because the employer and other people
9 are not telling people. They don't understand. People
10 think that more insurance is better. So they are hurt when
11 they come. They're overinsured, and it ends up hurting
12 them, and they don't have access to a good supplement. So
13 that's the first thing I hope we plan to make some
14 recommendations to correct.
15 The other one is real confusion if you have
16 retiree group health plan. I'm just going to give an
17 example in Durham. So say I worked at Duke, and I retired,
18 and I have Duke's retiree health coverage. I understand
19 the law says if that is terminated, you have Medigap -- no
20 Medigap underwriting. You can get a policy, guarantee-
21 issue right.
22 The question is, we have some insurance companies

1 that think that means the employer had to terminate you,
2 and some people think it means if you as the employee
3 terminate it. You choose to leave, that you have
4 guarantee-issue rights, and it's clear as mud. So I feel
5 like we need to clarify that, that either the employer ends
6 the coverage or the employee ends the retiree coverage. I
7 think that should trigger guarantee-issue rights to a
8 Medigap supplement.
9 So I just think two things for us to consider to
10 make it better for consumers to be able to have access to
11 supplements in Medigap. Thanks.
12 MS. KELLEY: Brian?
13 DR. MILLER: A quick on-point response for Gina.
14 I agree. I think what you're saying is that that confusion
15 of those transitions across different types of coverage --
16 and we could make the chapter clearer by saying with the
17 employer example, which I think is the one that I wish I
18 had mentioned. Oops. That when they transition, there's
19 no guaranteed issue for Medigap. There's medical
20 underwriting with Medigap. There's probably going to be
21 individual age-adjusted premiums for Medigap. So then they
22 can go into MA, which has guaranteed issuance, no medical

1 underwriting, no age-adjusted premiums. So then they get -
2 - they have a bunch of MA options, and they get stuck in
3 MA, which maybe they want MA, maybe they don't, but they
4 don't have the equal opportunity to get into Medigap.
5 MS. UPCHURCH: And I'm sorry. I meant to say one
6 other thing.
7 And I do worry about the disparity with younger
8 people not being able to afford or even access a Medigap
9 policy. I mean, they're just basically being told that's
10 not really an option for you, and I think we need to think
11 about that.
12 Thanks.
13 MS. KELLEY: Kenny.
14 MR. KAN: I just want to respond to Gina's on
15 this point about the -- you know, a member probably buying
16 too much insurance when they have employer coverage. I
17 think before we formulate any policy, it would be good to
18 get a sense of like how prevalent this is first. That
19 would be very helpful. It's one thing if it's 5 percent.
20 It's another thing if it's 95 percent.
21 Thank you.
22 MS. KELLEY: I have a Round 2 comment from Larry.

1 He says he supports each of the proposed areas of study.
2 He has two questions. First is, might it be
3 worthwhile for MedPAC to examine a potential unraveling
4 death/death spiral of the Medigap and Part D markets? What
5 would it take to occur? How could it be recognized early
6 in the process? What could prevent it?
7 Second question, would it be possible to model
8 the impact on Medigap enrollment if the $83 billion in
9 overpayments to Medicare Advantage plans went away at once
10 or over, say, five years?
11 And I have Greg next.
12 MR. POULSEN: Thanks.
13 I had a number of issues that have already been
14 covered, so I'll skip those.
15 I do think that the points that Brian was making
16 were really interesting, and I think those deserve some
17 additional thought.
18 But the primary one that I wanted to mention was
19 I really think that the final bullet on the discussion
20 items, examine the role of state-guaranteed issue, I think
21 is really, really valuable. If Mike's already done the
22 work, that's great. But to the extent that we can

1 understand that, I think it would also help to answer
2 Larry's death spiral concern.
3 If what we have is a guaranteed issue that really
4 works because people's needs change and it allows them to
5 get into something that's wonderful for them, that's
6 terrific. If what it is, is that people wait until it
7 becomes apparent that something terrible is going to happen
8 to them and then they get coverage, that creates
9 unsustainable insurance markets. And understanding the
10 difference between those, it seems like we have a really
11 nice example of states that have pretty much across the
12 board guaranteed issue, some that have guaranteed issue
13 with constraints, and some that have no guaranteed issue at
14 all. That seems like a fertile area to do some work, which
15 may have already been done.
16 DR. CHERNEW: Let me just say one quick thing as
17 we try and move through is the states that have guaranteed
18 issue all have community rating, the four states. And the
19 community rating decision -- there are some states that
20 have community rating but not guaranteed issue. And the
21 community rating decision seems to be -- there's a lot of
22 problems. Ask the referees. The community rating decision

1 seems to be a bigger thing than actually the guaranteed
2 issue portion of things. In other words, if you can get in
3 at the community rating price, they seem to then -- there's
4 not that many people who let you in. And when you have
5 guaranteed issue versus -- when you have issue with age
6 attained versus age at issue, that seems to matter a lot.
7 So it's very complicated to sort out because, despite the
8 states being the laboratories of democracy, they haven't
9 done all the right experiments.
10 MR. POULSEN: Thanks.
11 DR. CHERNEW: So anyway --
12 MR. POULSEN: So I just wanted to say I think
13 that's interesting and important, not just because of what
14 it tells us about Medigap, but it tells us stuff about
15 other things and people's behavior and so forth. So
16 thanks.
17 MS. KELLEY: Cheryl.
18 DR. DAMBERG: Thanks.
19 I want to say that I support the different areas
20 outlined in the future analytic work plan.
21 One of the things that I was wondering whether
22 you might be able to explore with beneficiaries -- and this

1 gets to Lynn's point about the price variation and like if
2 you're looking at the same plan type, what is that
3 difference by you -- it would be interesting to get some
4 understanding of what consumers understand about like if
5 they pick Plan G and they're comparing two different G
6 plans, are they offering the same benefits, if you will? I
7 don't know if there's some confusion about that.
8 I want to plus-one to Stacie's suggestion on
9 adding an indicator for whether they have Medigap coverage
10 versus not, and I would also add to that if we could get
11 the plan type that they're enrolled in, I think that would
12 be really helpful.
13 And I think the other thing, as I mentioned
14 earlier, it would be interesting to not only examine trends
15 in the market, but any potential switching that's going on
16 between plan types. You know, I don't know whether that
17 happens like zero percent of the time or 50 percent of the
18 time.
19 And then, lastly, I was kind of curious. Do we
20 know what factors are associated with the choice of plan
21 type and whether there's any opportunity to do some
22 modeling to look at that?

1 MS. KELLEY: Scott.
2 DR. SARRAN: Yeah, just a brief comment. So
3 notwithstanding the concerns around seemingly unexplained
4 variation in price that Lynn mentioned and concerns about
5 how the availability and frequency of zero-dollar out-of-
6 pocket products may incent overutilization -- flip side, by
7 the way, of that, of course, as other Commissioners have
8 noted, it doesn't take in a low-income individual a lot
9 out-of-pocket cost to dissuade from high-value clinical
10 care. So notwithstanding those concerns, I think there are
11 some positive take-homes from your analysis of the Medigap
12 market, particularly in terms of the virtue of
13 standardization of benefits into discrete categories that
14 are -- not comparable. They're identical, right? And I
15 think it enables good buying decisions, and that's really,
16 I think, a profoundly important take-home as we talk about
17 standardization potentially in the Medicare supplemental
18 benefit space.
19 Also, I think, in terms of financially, the fact
20 that the MLRs in Medigap are significantly -- if I read
21 things right, are significantly higher than required and
22 actually have risen over time suggests that free market

1 competition, when it occurs, with some important
2 correlates, such as standardized benefits, and they -- you
3 know, that enable good choice architecture actually does
4 work.
5 MS. KELLEY: Betty?
6 DR. RAMBUR: Thank you.
7 This is really, really interesting. I just have
8 a few comments.
9 I'm also interested in this induced demand and
10 moral hazard potential issue and then also very aware of
11 the opposite of when costs prices people out of needed
12 care. Both over-treatment and under-treatment are a form
13 of mistreatment, and to the extent that we can explore
14 that, I think it would be great.
15 The other question I have -- or sort of a wish,
16 but I don't know. Maybe it's more work than it's worth --
17 would be almost like a flow chart. So here's what I'm
18 envisioning. So a person turns 65, but they're still
19 working. So they can go on Part A without paying anything,
20 but they shouldn't go on Part B, if I understand you
21 correctly, right?
22 MS. UPCHURCH: If they're working for a large

1 employer. If they're working for a smaller employer.

2 DR. RAMBUR: Yeah, right.

3 And then in only 28 states, is there a guaranteed
4 issue for them? So they would -- person could be -- and
5 then you've got the birthday thing and all that. So it
6 would really help to have a visual because I think it's
7 really confusing and complicated. So I kind of have this
8 vision of like a Candyland little thing, if it's possible.

9 Thank you. Excellent work.

10 MS. KELLEY: Lynn.

11 MS. BARR: Great work, team.

12 So I'm still a little uncomfortable that we've
13 thrown a 30 percent number out there of overutilization. I
14 just want to make sure that, you know, for those listening
15 at home, maybe we need a little bit more -- a little bit
16 more color on that. I don't want to see that get quoted
17 from MedPAC too much.

18 The thing that stands out that's missing in this
19 report that concerns me is that almost half of the fee-for-
20 service beneficiaries are covered by the Medigap plans, but
21 another half are covered by the employer plans, right? And
22 we really don't know much about the employer Medigap plans.

1 And I know this because the coinsurance issue
2 that came up in rural first came up because my local school
3 district's employer plan wouldn't cover the excess
4 coinsurance, but the Medigap plans did, right? So they
5 don't have the same rules, and I don't know what their
6 rules are. And I don't know how it affects beneficiaries.
7 So can you -- I know this is like a whole other
8 body of work you may not be able to get at, but what is
9 that whole other thing out there that's covering -- what is
10 it? Sixteen percent of all beneficiaries, so 32 percent of
11 our fee-for-service beneficiaries. What is that?
12 MS. TABOR: You're right. It's a whole different
13 body of work.
14 MS. BARR: I know you were hoping nobody would
15 bring this up.
16 MS. TABOR: So yeah. Talk amongst yourselves,
17 and we can decide if that's the kind of work that we want
18 to proceed with. Okay.
19 MS. BARR: But I don't think it's really like we
20 can understand this without understanding Medigap as a
21 whole, and I'll look to other Commissioners to vote.
22 MS. KELLEY: Robert?

1 DR. CHERRY: Yeah. This is really good work.
2 You know, I've had questions about Medigap, and this
3 chapter does answer many of them, so thank you.
4 I'm not going to repeat what a lot of people
5 said. I think that overall Medigap is probably a good
6 option for a lot of people out there.
7 I do agree the employee-sponsored piece of it is
8 curious, but I don't want to throw out any extra work at
9 you. But I just sort of mentioned as an aside.
10 I am concerned, though, about people potentially
11 getting priced out of Medigap over time, and I don't quite
12 understand what the trends are, the inflation on the
13 premiums. But if there's an iterative process to this
14 paper, it would be nice to kind of trend that out and see
15 if there's kind of a price point where it's starting to
16 look more expensive and then becomes counterproductive over
17 time.
18 The other thing, if you're doing surveys, I would
19 really be curious how dental, vision, and hearing is being
20 handled by some of these beneficiaries. Are they getting
21 even additional plans outside of Medigap for that coverage,
22 or they just don't need the extra benefits, and they're

1 perfectly fine with it?

2 And then you mentioned long-term market trends,

3 and as MA is starting, again, it continuously creeps up in

4 terms of the percentage of beneficiaries that chooses it.

5 I do wonder over time, with Medigap in particular, as you

6 have a smaller pool of patients, perhaps, higher acuity and

7 unfavorable selection, whether or not Medigap will be

8 sustainable in the future. So it may be something to also

9 consider in future reports.

10 Otherwise, really great work, so thank you.

11 MS. KELLEY: Josh.

12 DR. LIAO: I add my thanks to everyone else's.

13 Recognizing where we are on the clock and in light of prior

14 Commissioner comments, I'll be brief and just say I support

15 the areas of future work here.

16 I think it's mentioned in the paper, not in the

17 slides, but I think as we think about trends in Medigap

18 market, I would be very interested in looking at that

19 relationship with MA penetration for some of the reasons

20 that were mentioned today.

21 I really like the idea of talking to

22 beneficiaries in the focus groups and just plus-one

1 Cheryl's idea that if there were a way to quantitatively
2 model some of the relationships between factors and plan
3 choice, that would be really nice to kind of mix methods
4 way to approach that.
5 And then the final thing is I found myself kind
6 of grappling with my mind. I was actually drawing it here,
7 Table 2 in some of those cases. So to the extent that
8 Chutes and Ladders is the model, having a few emblematic
9 examples, which has helped me with other chapters and
10 papers where you've given us illustrative examples that are
11 not exhaustive, that would be very helpful to me
12 personally.
13 MS. KELLEY: Kenny, did you jump in here?
14 MR. KAN: Yeah. Just a great chapter. I support
15 doing the future analytic work that's indicated in the
16 deck.
17 I would also suggest that to the extent that we
18 have any bandwidth, we also explore the potential impact of
19 induced demand on any benchmarks.
20 Thank you.
21 DR. CHERNEW: So a little bit with regard to the
22 point of added demand. I had the privilege of being on the

1 Commission back many, many years ago -- and apparently,
2 Brian might have been in graduate school. I'm not sure.
3 But that was a long time ago, and I was part of the
4 Commission. We did a lot of benefit design work, and we
5 can think about how much benefit design work to do.
6 But quick summaries before we move on, because
7 we'll take a quick break and get on to ambulances. So one
8 is we're approaching a half century of work on the impacts
9 of benefit design from just a gazillion amount of studies
10 that all shows that people don't respond particularly well
11 to benefit design if you look at things clinically, but the
12 health consequences of charging them more is really not as
13 big as you would think, and we could talk about why.
14 The second thing I'll say is, as I said at the
15 beginning, the wide variation in prices for standard plans
16 combined with literature that shows people choose dominated
17 plans suggests there's a lot going on with consumer choice
18 here that suggests that while I understand the appeal of
19 standardization, it is not like if you standardize,
20 everybody then makes the right choice or everything gets
21 priced more competitively. So there's a lot of work to do
22 there on information.

1 The other thing I will say, just in general, is
2 when there's not guaranteed issue, what you tend to see, at
3 least for people that have new serious illnesses, if
4 they're in MA, is they don't move back to fee-for-service.
5 They move to another MA plan. So having MA competition
6 matters, because you can choose a different plan or a
7 broader network or a whole bunch of other things.
8 But there's a lot to unpack. I appreciate
9 everybody's passion.
10 Let's take a five-minute break and come back at
11 4:20 to talk about ambulances. So thank you all.
12 [Recess.]
13 DR. CHERNEW: Welcome, everybody. We are now
14 back, and you'll see that as soon as my camera turns on.
15 Now I am officially back.
16 It's been a great day. We've had a terrific set
17 of discussions. And now we get to finish it off with a
18 topic that is going to feed into a mandated report on
19 ambulances. And I think Dan is going to kick us off. So,
20 Dan.
21 DR. ZABINSKI: Thanks, Mike. Okay to start, for
22 the audience, a copy of the slides can be accessed through

1 the Control Panel on the right side of your screen.
2 Today, Jeff and I will be covering a mandate in
3 the Bipartisan Budget Act of 2018 that directs MedPAC to
4 use data that's been collected by CMS to produce a report
5 on the cost of Medicare ambulance services. This is our
6 first presentation of this material, and over the next
7 MedPAC production cycle, we will return with more in-depth
8 analyses and produce a report that has a due date of June
9 15, 2026.
10 Our plan for this presentation is to discuss the
11 report mandated by the BBA of 2018; provide background
12 information and a description of the Medicare ambulance fee
13 schedule; describe the ground ambulance data collection
14 system, or GADCS, that the BBA of 2018 required CMS to
15 develop; discuss our results from an early analysis of the
16 GADCS data; cover our workplan for meeting the requirements
17 of the mandated report; and close with a discussion.
18 Datasets that include data on ground ambulance
19 costs and revenues do exist, but there is a concern that
20 they are small samples that include only a few hundred
21 ambulance organizations.
22 The BBA of 2018 required CMS to develop and

1 implement a comprehensive ground ambulance data collection
2 system. CMS is fulfilling this requirement and has
3 provided us with about half their sample.
4 The BBA of 2018 also mandates MedPAC to produce a
5 report on ground ambulance organizations. This mandate
6 requires MedPAC to analyze the GADCS data collected by CMS.
7 The statute specifies that we evaluate the adequacy of AFS
8 payments for ground ambulance services and evaluate
9 geographic variations in the cost of furnishing ground
10 ambulance services.
11 The statute also specifies that we analyze the
12 burden on ground ambulance organizations associated with
13 data collection and provide a recommendation to determine
14 whether ambulance organizations should continue to submit
15 data or if the data collection system should be revised.
16 And once again, the report is due June 15, 2026.
17 Before we dive into the mandated report, we'll
18 provide some background on the Medicare ambulance fee
19 schedule, the AFS. In 2023, about 10,500 ground ambulance
20 organizations provided ambulance services paid under the
21 AFS. These organizations provided 11.4 million ambulance
22 transports to Medicare beneficiaries that resulted in $5.3

1 billion in payments under the AFS.
2 It's also important to understand that the AFS
3 pays only for ambulance transports.
4 On the next two slides, we'll talk about fee-for-
5 service Medicare payments under the AFS, which have two
6 parts: one payment for mileage and one payment for the
7 services provided during a transport.
8 AFS payments for mileage are a function of a
9 conversion factor, which is $8.97 in 2025; the location
10 where the patient is picked up, urban, rural, or super
11 rural; and an add-on payment for the first 17 miles of a
12 transport that occurs in a rural or super rural area, where
13 super rural are the lowest 25 percent of rural ZIP codes by
14 population density.
15 This table shows the differences between the
16 payments for mileage between transports in rural areas
17 versus transports in urban areas.
18 The overarching point is that organizations
19 receive lower mileage payments for urban pickups than for
20 rural pickups. The first row shows that payments for urban
21 pickups receive a 2 percent add-on. The second row shows
22 that rural pickups receive a 3 percent add-on plus an

1 additional 50 percent add-on for the first 17 miles, and
2 the third row shows that rural pickups receive only a 3
3 percent add-on for each mile beyond 17 miles. An important
4 fact is that mileage payments apply only to the transport
5 of the patient.
6 Payments for services provided during a transport
7 are a function of a conversion factor of $278.98 in 2025; a
8 relative value unit, or RVU, that represents the complexity
9 of the services provided; the location of the pickup, again
10 super rural, rural, or urban; and a practice expense, or
11 PE, GPCI from the Medicare physician fee schedule that
12 adjusts for geographic differences in labor costs.
13 This table shows the differences between the
14 payments for services between transport services in urban,
15 rural, and super rural areas.
16 The overarching point is that transports from
17 urban areas have an adjustment of 2 percent, and transports
18 from rural areas have an adjustment of 3 percent.
19 Transports from super rural areas have the rural adjustment
20 of 3 percent plus an additional adjustment of 22.6 percent.
21 However, these adjustments for urban, rural, and super
22 rural areas are temporary and are set to expire on March

1 31, 2025.

2 Next, we'll talk about the ground ambulance data

3 collection system, the GADCS, which CMS created in response

4 to a BBA of 2018 mandate to collect data from ground

5 ambulance organizations. These data include information

6 about the organizations' characteristics, service area,

7 service volume, service mix, staffing, costs, and revenues.

8 CMS is creating this dataset in two steps. In

9 the first step, CMS surveyed about half the ambulance

10 organizations that provided services in 2017 and 2018,

11 which was about 5,300 organizations. CMS ultimately

12 collected 2022 data from 3,852 of these organizations, as

13 about 800 organizations no longer billed Medicare in 2022,

14 and an additional 700 chose not to participate in the

15 survey.

16 In the second part of the data collection, CMS is

17 currently surveying about half the organizations that were

18 providing ground ambulance services in 2020, again about

19 5,300 organizations. None of these organizations were in

20 the 2017/2018 group that CMS already surveyed, and provided

21 us with data.

22 A fact about the GADCS dataset is that it is the

1 most comprehensive dataset on ground ambulance operations.
2 But we have some concern about the accuracy of the data.
3 Many ambulance organizations share costs and
4 revenues with other emergency responders such as fire
5 departments and police departments or hospitals. Also,
6 these organizations previously have not been required to
7 submit data about their operations.
8 Therefore, we are concerned that some
9 organizations were not able to fully separate their
10 ambulance costs and revenues from other parts of their
11 parent organization, and they do not have much experience
12 collecting and submitting cost data. And CMS has the same
13 concern.
14 An additional issue we have with the GADCS data
15 is that the transport and cost data for each organization
16 are reported for all patients, and there is no separate
17 variables for transports of Medicare patients or costs for
18 Medicare patients. We have been able to get Medicare
19 transports using Medicare claims, but we haven't been able
20 to get Medicare costs.
21 Based on these concerns, we have made two edits
22 to the GADCS data. The first edit drops the organizations

1 that share costs and revenues with fire departments, police
2 departments, or hospitals. This edit is consistent with
3 the analytic method used by GAO in its ambulance report in
4 2012. Also, CMS discusses how to make this edit in its
5 GADCS documentation.
6 For the second edit, due to our concerns about
7 very high cost levels for some organizations, we dropped
8 organizations that have cost per response that are more
9 than 3 standard deviations from the mean.
10 After making these edits, plus elimination of
11 some missing responses, we have an analytic sample of 1,710
12 organizations. We have found that these edits do increase
13 the share of organizations that are for-profit and decrease
14 the share that are government-owned and urban.
15 So Jeff and I dipped our toes a little bit into
16 the data, and we emphasize that our results so far are very
17 preliminary.
18 Thus far, the most striking finding has been the
19 effect that organization size has on their cost per
20 response. We sorted the organizations by number of
21 responses and collected them into quartiles. In the lowest
22 quartile, the cost per response was $1,730, while in the

1 highest quartile it was $425, a ratio of 4-to-1.

2 We also found differences in cost per response by

3 type of ownership and whether the organization has an

4 urban, rural, or super rural service area. That is, for-

5 profit organizations have lower cost per response than

6 government-owned and nonprofit organizations. Also, urban

7 organizations have lower cost per response than rural

8 organizations, and rural organizations have lower cost per

9 response than super rural organizations.

10 Now earlier we said that the BBA of 2018 directs

11 MedPAC to produce a study in which we analyze the GADCS

12 data to evaluate the adequacy of AFS payments and to

13 analyze the burden on ground ambulance organizations

14 associated with data collection.

15 In our workplan for analyzing the GADCS data to

16 determine the adequacy of AFS payments, we intend to

17 address the following issues: first, compare organization

18 fee-for-service Medicare payments with organization costs;

19 second, identify what factors affect an organization's

20 costs; and third, how do costs vary by geography, as

21 geography can affect costs through population density and

22 differences in labor costs.

1 And then to analyze the burden on ambulance
2 organizations associated with data collection, we intend to
3 have discussions with organizations, trade association, and
4 CMS. The topics we could cover in those discussions
5 include the resources that the organizations and CMS devote
6 to data collection; whether the data collection could be
7 streamlined; and identification of questions that require
8 the most administrative effort and how those questions
9 could be modified to ease the burden. We also seek other
10 ideas from Commissioners.
11 So we've reached the end of this presentation.
12 For discussion, we will address your questions on the paper
13 and the presentation. We also seek Commissioners' feedback
14 on our workplan and your ideas for future work on this
15 report. Thank you.
16 DR. CHERNEW: Terrific. I have to admit this is
17 an area I don't know enough about, so thank you for doing
18 this work. And I think Tamara is going to lead off Round
19 1.
20 DR. KONETZKA: First of all, thank you. Really
21 interesting paper.
22 I was really surprised by the fact that they

1 don't get paid for responses that don't result in a
2 transport. Do you know the original motivation for that
3 omission, and what usually happens in those? I mean, I can
4 sort of guess. I think you said it was like a third of
5 them, a third of these responses that don't result in a
6 transport. Do we know what the typical reason is for that,
7 and what was the motivation for not paying them?
8 DR. ZABINSKI: Neither of us knows why, and just
9 backing up, I know the payment system was developed in
10 2002, at which time CMS used some information from a survey
11 to set the payment rates, including the RVUs. And the
12 strange this is the RVUs have not changed since them. They
13 have been fixed.
14 What I'm getting at is this has been a very
15 static payment system, and I think a lot of why things were
16 done, and that sort of thing, have been forgotten.
17 What happens? Well, my understanding -- I can't
18 be certain about this, but my understanding is most of the
19 time, not much, but in a minority of the cases there is
20 medical treatment provided. I can speak from my own
21 experience. A few years ago I was in a really bad car
22 accident. I was unscathed, but ambulances were called. It

1 was a four-car crack-up. Fortunately, nobody had to go to
2 the hospital, but they did do treatment on one of the
3 individuals in the accident.
4 So it does happen, is what I'm getting at. But
5 in that case, you know, the ambulance provider did not get
6 paid, because that's pretty much standard operating
7 procedure in all payment systems, only pay for the
8 transport rather than paying for a response.
9 DR. KONETZKA: Yeah. Okay. It just seems like a
10 very odd incentive. Like if you can provide medical care
11 and not transport the person, you don't get paid. Just
12 very mysterious.
13 MS. KELLEY: Brian.
14 DR. MILLER: I was going to say, this is a
15 record. This is the most concise MedPAC chapter ever, and
16 we have two Ph.D. economists. So I would say it's in
17 competition with the Medigap chapter to be the shortest
18 ever. So that's excellent, non-price competition.
19 Competition policy jokes aside, a few minor
20 details. The chapter denoted that response time was
21 reported as not varying by ownership type. It probably
22 would be helpful for us to put some response time

1 statistics in there. It could even be in a tiny footnote,
2 table, text.
3 And then I had a clarification question. It's
4 not a disagreement with the methodology, to be clear. I
5 think that because we are excluding 54 percent of
6 ambulance providers, and I completely understand the
7 challenges with municipal and local governmental accounting
8 -- they have a completely different set of rules and
9 sometimes it can be a little squishy to figure out what
10 those costs are and where they go -- it would be probably
11 helpful for us to include a tabular breakdown of the
12 features of the government-run providers that were included
13 versus the ones that were excluded, just to support the
14 validity of our analysis and the exclusion. Again, not a
15 criticism of that exclusion because I'm very familiar with
16 accounting challenges at the local and municipal level for
17 governmental finance.
18 On page 11, there was an impressive computation
19 that the cost per response, net of local tax revenue, was
20 $483. I would include a footnote for how we got there. I
21 imagine it's a pretty lengthy explanation so I'm not going
22 to consume everyone's time with that.

1 And then on page 13, we noted that the difference
2 in cost per response between the proprietary organizations,
3 the nonprofits, and governmental organizations is much
4 smaller in urban locations than in either rural or super
5 rural locations. That was true on an absolute scale, but I
6 did a little math, and on a relative scale it looked
7 similar. So we may want to adjust that.
8 Great chapter, and I loved the conciseness.
9 MS. KELLEY: Gina.
10 MS. UPCHURCH: Thank you so much for this
11 information. I, too, was very surprised that there's no
12 payment if you're not transporting somebody. So one of my
13 questions was what's happening in the home, and it sounds
14 like we're not sure about that, and sometimes it's not in
15 the home. It could be on the side of the road.
16 But do we have any idea of nonprofits and
17 governmental entities as opposed to proprietary entities?
18 You know, it's costing more for the nonprofits and the
19 government. Do we have some sense -- I know in Durham they
20 often link people to paramedics, to community paramedics,
21 that then come in and can do other things with people in
22 the home. Do we know if governmental and nonprofits are

1 often connecting to people to services? You know, they
2 call them -- you know, people that are calling the
3 ambulances a lot or something. Do we know if they're
4 getting extra services that don't come with proprietary
5 ambulance showing up?
6 DR. ZABINSKI: This dataset, I do admire it for
7 its comprehensiveness, but it is not that comprehensive.
8 MS. UPCHURCH: Yeah, I was trying to think of why
9 it was so much more, but I know we have community
10 paramedics, but they're not in ambulances, but they do get
11 called in when ambulances come and somebody needs some
12 help.
13 Anyway, thanks.
14 MS. KELLEY: Lynn.
15 MS. BARR: Really nice work. Thank you so much,
16 Dan.
17 So just a couple of questions. When you have
18 chart on the quartiles, I was wondering if you could expand
19 that chart a little bit to talk about kind of rural versus
20 urban, or is there any more characterization of those
21 quartiles other than just the price?
22 The other analysis that I'm curious about is this

1 designation of rural, super rural -- what the heck is that?
2 It doesn't really track with anything else in Medicare that
3 I know of. So is there a way to translate that into our
4 normal categories for rural, so that we could see maybe
5 what that would look like? Because if we're going to come
6 to a recommendation on payment, I think we're going to
7 probably want to use definitions that are more tested than
8 super rural, which isn't sometimes urban, right, and it's a
9 little strange. Thank you.
10 MS. KELLEY: I have a comment from Larry here.
11 He says, I am sure you know this already, but it seems that
12 cost per response would be more useful if adjusted for the
13 type or level of response; for example, BLS non-emergency,
14 ALS non-emergency. Without this, Table 5 in the reading
15 and Slide 11 in the presentation are perhaps less useful.
16 Could you do this type of stratified response going
17 forward?
18 DR. ZABINSKI: Yes. Let's see what to say. I
19 mean, just keep in mind, everything here, I really want to
20 emphasize, it's really preliminary. Jeff and I have full
21 intention of getting a lot deeper into this. I mean, we
22 have actually done some deeper work already, just not ready

1 for daylight yet.
2 MR. MASI: That's a great teaser, Dan.
3 [Laughter.]
4 DR. ZABINSKI: So, yes, more in-depth things will
5 be coming.
6 DR. MILLER: Medigap folks are beating you with
7 more charts and tables.
8 MS. KELLEY: Amol.
9 DR. NAVATHE: Thank you.
10 On the bottom of Page 9, when you're talking
11 about revenues, it says, "We found that the aggregate fee-
12 for-service Medicare payments reported on the GADCS was
13 about 40 percent higher than the payments indicated on the
14 fee-for-service Medicare claims," and I was curious if you
15 have any speculation of what accounts for that difference.
16 DR. ZABINSKI: I have two. One is, I think --
17 I'm almost certain of this first point. I don't want to
18 say this was really common, but I did run across situations
19 where it was pretty evident that the organization recorded
20 their revenue without putting a decimal point for cents.
21 Basically, it was off by a factor of 100.
22 I say that -- when I say that, I just try to --

1 you know, we ran claims to get what the claims say the
2 revenue was, the Medicare revenue was. And you just
3 compare them, the two columns, and they almost match up,
4 except for the fact that they're off by a factor of 100 and
5 maybe 1 percent of the observation. I don't know. In sum,
6 that's one. But that's going to throw you off quite a bit
7 right there.
8 And I think there's also an issue of -- you know,
9 you have Medicare fee-for-service and you have Medicare
10 Advantage, and we were asked to tease out both those and
11 report on both those sources of payment. And I'm going to
12 guess that some had -- you know, they sometimes put
13 Medicare fee-for-service and Medicare Advantage and vice
14 versa. So I think those two things are at least
15 contributing to this, but 40 percent is a lot.
16 I will say, also, the editing we did down to the
17 1,710 that we're using to produce these tables, the
18 reported Medicare revenue and the Medicare revenue from the
19 claims matches up quite well in aggregate. It's pretty
20 close, a couple of percentage points off. So, maybe
21 there's something about the really small -- most of the --
22 I shouldn't say most. A good chunk of the organizations

1 that we edited out were smaller organizations that probably
2 have -- they don't have the resources to do the data
3 collection and submission. I don't want to beat them down
4 or anything like that, but I think that's their situation.
5 DR. NAVATHE: I see. So I guess a follow-up
6 suggestion, because it will be more efficient to do it now
7 than in Round 2, would just be it might be interesting to
8 look at repeating some of the analyses that you've done
9 about where the numbers do align. That would just give us
10 like a subsample that maybe the data seems like it's -- the
11 data integrity is higher, essentially.
12 Thank you.
13 MS. KELLEY: Robert.
14 DR. CHERRY: Yeah. I can appreciate the fact
15 that this is very preliminary. I'm a trauma surgeon by
16 background. Trying to get data out of EMS systems is
17 really, really difficult, a lot of it for good reasons.
18 There's some paper-based information, and things get lost,
19 and there's emergency situations. Things are just not
20 documented like you would like.
21 Just regarding Gina and Larry's points, it is, at
22 first, striking that non-profits and governmental seem more

1 expensive, but if you stop to think about it -- and Larry's
2 on the right track here -- is that, yeah, there are ALS
3 units too that may be driving the cost. But if you think
4 about not-for-profits, there are specialty ambulance units
5 too. There's critical care, there's pediatric, there's
6 stroke, there's ECMO, and so these specialized ambulance
7 transport units are very expensive to actually operate.
8 That could also be driving up some of the costs as well.
9 If you think about government-related ambulances,
10 sometimes they come with other support, fire and police,
11 which also drives up the expense as well.
12 When you think about it, it's not surprising
13 compared with, let's say, for-profit ambulance companies,
14 which are doing, I think for the most part, basic transport
15 that you would expect.
16 I do have one question about the 700 ambulance
17 organizations that opted out. Did they opt out because
18 they didn't meet certain criteria that CMS was looking for,
19 or did they opt out of the survey because they just didn't
20 want to do it? Do you have any sense as to the why behind
21 that?
22 DR. ZABINSKI: It was in -- CMS did a pretty --

1 they have this documentation, and it's pretty thorough,
2 like 150 pages long. I'm trying to remember what they
3 said.
4 I do know -- okay. There was a 10 percent
5 penalty on their Medicare payment rates for not submitting
6 the data. I think my recollection is something to the
7 effect that they just didn't feel it was worth the effort.
8 They were willing to take the penalty because the cost of
9 doing a submission was even higher than --
10 DR. CHERRY: Interesting.
11 DR. ZABINSKI: -- not doing it.
12 DR. CHERRY: Than all the resource intensity it
13 would take to actually try to --
14 DR. ZABINSKI: That's the sense I got out of it.
15 DR. CHERRY: Yeah. Particularly, if it's all
16 paper-based, it could be really hard to do.
17 DR. ZABINSKI: Yeah.
18 DR. CHERRY: Okay. All right. Thank you.
19 MS. KELLEY: Kenny.
20 MR. KAN: Great chapter. Thank you. It's much
21 more complex than I thought on the whole issue.
22 So two quick things. One, on page 11 of the

1 deck, would it be possible -- where you show the quartile
2 ranking per response, would it be possible just have the
3 same chart for urban, rural, and super rural? That would
4 be helpful. I'm just trying to figure out how much of the
5 impact of scale and population density really impacts those
6 numbers, because the difference between Q1 and Q4, it's
7 like a 4x delta. So I'm just really curious. That's one.
8 And then, secondly, I do like the analytical
9 plan.
10 Thank you.
11 MS. KELLEY: Josh.
12 DR. LIAO: Great presentation.
13 I guess at the risk of drawing Mike's ire, I'll
14 just put everything together in the interest of time.
15 You mentioned there's detail in here, I presume,
16 about the type of personnel, so EMR, EMT, AMT, paramedics.
17 I think about prior work, including evaluation we did with
18 Washington State around some of this work, very
19 complicated, but they tend to track with ALS, BLS, ILS. So
20 I think that would be a fruitful thing to do in the work
21 plan.
22 And then it occurs to me -- and Robert kind of

1 got to this, but the specialty care transport, inter-
2 facility to a higher level, to jail, mental health, those I
3 would imagine have staffing differences as well. So, to
4 the extent you have that granularity and confidence in
5 those data, it might be nice to look at kind of type of
6 personnel. Kind of cross with type of transport, I guess
7 I'll call it. And I believe that we'd have some of that
8 data in the data set.
9 MS. KELLEY: Okay. I think that's the end of
10 Round 1. I'll go to Round 2, and I have Stacie first.
11 DR. DUSETZINA: Great. Thank you very much for
12 this work. It's very interesting, and I feel like I
13 learned a lot reading the paper.
14 Knowing that this is very preliminary, I'll just
15 say the things that I'd love to see in the next iteration
16 that you may or may not already have gotten to.
17 So same as Larry's comment, I felt like things
18 like response time and also the Table 4 on the size and
19 costs could be stratified by emergency and non-emergency.
20 Partly because I wonder when you showed that the for-profit
21 or proprietary had, like, half of their transports were
22 non-emergency, it seems like that's really driving down,

1 like, their average costs. And so any chance to stratify
2 by emergency, non-emergency throughout would be very
3 helpful, I think.
4 One other thing, I totally understand your
5 rationale for dropping the organizations that you do
6 because of the quality of the data and those concerns, but
7 I thought it would be helpful to have a table comparing,
8 like, everybody and then everybody you kept in the sample,
9 just to make sure that you're still reflecting, largely, a
10 similar population because these are smaller groups, or
11 either just tell us like a little bit more about those that
12 were excluded.
13 I think the one other thing that was just kind of
14 lingering in my mind, and I'm not exactly sure how to state
15 this well, but Brian had brought up the point on the
16 government-owned organizations and the net cost after you
17 subtract out local tax revenue. And one of the things that
18 struck me was I was struggling a little bit about the
19 Medicare payment, like how are we paying for this, what are
20 we paying for this, but also how many people need ambulance
21 services that maybe don't have insurance. And so how you
22 start to weigh in the tax revenue and the government role,

1 like, it just gets complicated fast. So that's more of a
2 broader thinking about how far down that rabbit hole do you
3 go taking out the local tax revenue piece.
4 And then to Tamara's original point on her Round
5 1 about, like, the going and not getting paid for services,
6 it feels like that's an area where you could actually have
7 -- be inducing, like, more transports than necessary when
8 maybe someone could actually receive services and be
9 stabilized. And so I think that it is odd that we don't
10 pay anything for that, but figuring out like what is a
11 reasonable way to pay for that, so that we don't overuse
12 services would be a really nice way to think about moving
13 forward with this work.
14 But very interesting and looking forward to
15 seeing future iterations.
16 MS. KELLEY: Lynn.
17 MS. BARR: Plus-one on Stacie's comments. I'm
18 also -- you know, the not-paying-for-transport seems
19 absolutely crazy, and so any analysis we can do that would
20 show, like, you know, how that might affect, you know,
21 people getting transported. And, you know, I don't know if
22 there's any way to get at that, but it does seem like that

1 would be important.

2 I was also very much struck by the difference in

3 cost for rural versus urban and, like, the 1 percent

4 difference, you know, in payment rate and, like, double the

5 cost. And so I don't know if there's anything more, you

6 know -- like, is there more we can dig into around there to

7 -- you know, is it really that bad? I mean, people have

8 been saying it is, and we have these ambulance extenders,

9 which do expire at the end of this month, and we continue

10 to extend them. But, you know, there's never a sense that

11 we're actually -- well, there's enough compensation for

12 many rural ambulance providers. And a lot of it's

13 volunteer or the hospital does it, or, you know, there's

14 all kinds of ways people are trying to get this done. But

15 maybe if we paid them enough, we'd have, you know, better

16 access, or is there an impact on access? I don't really

17 know.

18 But thanks. Great work and looking forward to

19 this developing. Learned a lot.

20 DR. CHERNEW: Let me just say one thing before we

21 go on. I think Tamara might be next, but I might be wrong

22 about that.

1 But this issue about paying when they don't
2 transport somebody, I think -- Dan, Jeff, you can correct
3 me -- is sort of a crude way to prevent them from sending
4 ambulances to a whole bunch of places and just getting paid
5 and getting it right. So I think that that's what they're
6 worried about.
7 And so I believe -- you guys can correct me if
8 I'm wrong -- the problem is, as sort of Stacie said, you
9 don't want -- there's times when they want to go out there
10 and treat them, and then you don't want to not -- they
11 really need to go. So it's just very hard to know when you
12 really need to send the ambulance and what you're paying
13 for, and so there's just a lot of policies that sort of
14 aren't exactly right, but fixing them is also kind of hard.
15 So that's my sense of how -- why this is sent
16 out, because a lot of times -- the thing about ambulances
17 is you need a lot of reserve capacity. So a lot of time,
18 you're not actually doing something, but when something
19 happens, you really need them to be there, and you really
20 need to be there quickly. And so how you pay for that
21 capacity and how it plays out is just a very complicated
22 economics problem.

1 But, in any case, since I don't know this area
2 tremendously well, I'll defer to Jeff and Dan to correct
3 me.
4 DR. ZABINSKI: One thing I'll add to what you
5 just said, Mike, you have to have these guys available at
6 all times, and I think one thing that seems -- this is one
7 thing we've already done, though you didn't see and we
8 haven't shown yet, but I'll give a little more teaser on it
9 -- is that, okay, these organizations will -- if they're
10 able to, they'll basically -- say they have, like, 10
11 ambulances, and they know, though, that some period of time
12 is going to be very low use. They're not going to need all
13 10 of them available. So they'll just only have a crew for
14 five ambulances available.
15 But if you're in a rural area where you only need
16 one ambulance, you need a crew there all the time. So
17 there's no flexibility in terms of cutting back for low
18 periods and ramping up during when you think it's going to
19 be busy, and I think that's one thing, an additional driver
20 of the higher costs for rural areas. But we need to dig
21 more into that. That's just something that could be
22 happening.

1 DR. CHERNEW: Ambulances, as it turns out, are
2 very important.
3 MS. KELLEY: Tamara.
4 DR. KONETZKA: Okay. Clearly, I support looking
5 into a little more, maybe thinking about options that might
6 balance those incentives in terms of paying for trips that
7 don't end up in a transport.
8 My other comment is maybe a couple steps down the
9 road, but we got into this discussion about ALS versus BLS
10 and the different costs, and there's a really, I think,
11 fascinating, maybe small literature, but I think a pretty
12 solid literature, comparing outcomes for ALS and BLS, and
13 showing that basically for most trauma patients, it's
14 actually much better to just have BLS and get to the
15 hospital. It's the "stay and play" versus "scoop and run,"
16 right? And that if you're at the scene getting stuff done,
17 then it's being done by people who may do this procedure
18 once a year, right? There's just many reasons. If they
19 just get you to stabilize and get you to the hospital,
20 you're much better off because then you have all the
21 resources of the hospital and people who do these things on
22 a daily basis.

1 And so what I know about this situation from this
2 literature is that whether somebody gets ALS or BLS is not
3 necessarily according to need, but there are sort of very -
4 - and there was some conversation about this and the
5 paramedics, et cetera, but there are, like, very entrenched
6 local political forces that really favor ALS in some
7 places, right?
8 So I guess I say that all to say, as we embark in
9 this work, we should be aware of -- if we're just
10 calculating costs and thinking about whether or not payment
11 is adequate, we shouldn't just assume that when ALS
12 happens, that ALS was necessary and that we should pay them
13 more, right?
14 So that's why I said it's a couple of steps down
15 the road, and it's a hard problem, but I think some of the
16 descriptive work should kind of -- as Larry suggested in
17 his Round 1 comment, like, start separating out the BLS and
18 ALS and, you know, you could sort of look at that
19 geographically and then just keep that, like, unknown
20 appropriateness of ALS in mind when we think about the next
21 step of thinking about whether payments are adequate.
22 Thanks.

1 MS. KELLEY: Brian.
2 DR. MILLER: I have more comments now.
3 First, I want to say as a practicing physician
4 who just completed his BLS and ACLS retraining the other
5 week, I'm thankful for the EMS staff out there doing hard
6 work pre-hospital. That's pretty important. By
7 comparison, I'm sheltered up in the hospital tower.
8 I want to -- before I share my brief comments, I
9 do want to respond about to the BLS and ACLS. One, it's
10 hard to tell if you're calling -- if you're getting called
11 to a patient's house and you're an ambulance company. Do
12 you necessarily want to send the BLS? Do you want to send
13 the ACLS? Are you sure? And if you're transporting a
14 patient from a hospital to a skilled nursing facility or a
15 hospital to a LTCH or a skilled nursing facility to an
16 outpatient visit, again, that BLS or ACLS is a clinical
17 judgment, and people have different levels of comfort.
18 I can tell you that if you ask a patient,
19 patients will always want more. They'll want more
20 security, and that's not necessarily wrong. But I'd be
21 very cautious about us collectively as a group making
22 clinical judgments about the appropriateness of BLS versus

1 ACLS transport for what is functionally a highly localized
2 and specialized decision. It doesn't mean that people
3 locally aren't making the wrong decision for the wrong
4 reasons, but I would be very cautious about us wading into
5 that sort of clinical decision-making.
6 I also wanted to say something that's going to
7 sound really stupid, but I do think it needs to be said,
8 which is I think people should be paid for their work. So
9 we're paying for ambulance transport, but we're not paying
10 for response, which is one third of events. And I
11 understand we don't just want, you know, Auntie May down
12 the street to call the ambulance 400 times a year for
13 transport, but Auntie May or Uncle John or whomever it is
14 is a specific person who does that, who has other medical
15 and social needs that we need to address. So I would set
16 that aside.
17 I don't think that people should work for free,
18 and I especially don't think that frontline workers
19 shouldn't be paid. I do think they should be paid. And if
20 you ask Joe Lunchpail, the hypothetical average American,
21 he'd probably agree.
22 Most importantly, when we think about downstream

1 effects, Uncle John, Auntie May, whomever, if we are not
2 paying for treat in place and we're only paying for
3 transport and Uncle Bob has heart failure with reduced EF,
4 COPD, maybe CKD 3b -- they see a pillbox with a bunch of
5 pills scattered all over the place, house looks a little
6 messy, he's out of breath, they give him, you know,
7 nebulizer treatment, EKG looks fine, vitals are okay --
8 well, if someone has a lot of medical problems, they're
9 still a little uncomfortable. They'll probably end up in
10 the ER, and then they end up in the ER and they get triage
11 and they get labs and they get imaging. And then they call
12 the hospital medicine physician, and the ER doc calls you
13 and says, "Well, I have this old guy downstairs. He has
14 all these problems. He has a little short of breath. I
15 did a CT scan. He doesn't have pneumonia. He doesn't have
16 a pulmonary embolus. Trop is slightly elevated but
17 nonspecific. Maybe we should do a 24-hour, you know,
18 observation stay." And then that turns into a couple-day
19 hospital stay, and then they become weaker, and then they
20 get discharged to subacute rehab.
21 And you think I'm joking, but this happens all
22 the time. So I'm really cautious about us saying that we

1 shouldn't pay to treat in place. It seems clinically
2 prudent.
3 I also realize we need to have controls in place
4 to make sure people aren't using ambulance for basic
5 primary care, because that's not good either.
6 So I think -- in summary, you know, I think
7 people should be paid for the work that they're doing. If
8 they're treating someone in place, they should be paid, and
9 we should have appropriate controls to prevent over-
10 utilization -- or policy -- it doesn't have to be control -
11 - policy to prevent inappropriate over-utilization and also
12 try and prevent that sort of downstream trip to the
13 hospital, which then will invariably result in admission.
14 As for data collection, I understand the instinct
15 to go for more data. I'm really hesitant to go for more
16 data in this marketplace, namely because a lot of the
17 people aren't submitting data. As you point out, that if
18 they're avoiding a 10 percent penalty, that means the cost
19 of data collection for their organization is pretty high.
20 Those are probably very small businesses or their local and
21 municipal governments, and do we want to crush local and
22 municipal governments or small businesses or businesses in

1 rural areas that don't have enough staff to begin with,
2 with an additional data-reporting burden? I would say
3 probably not.
4 Great work in this space.
5 MS. KELLEY: The last comment is from Larry, at
6 least last in my list. He says, as in other sectors, it
7 would be very useful for Medicare to collect correct
8 current ownership data.
9 Responding to the issue of should the AFS cover
10 ambulance responses that include medical treatment but do
11 not result in transport, he says it seems to him there are
12 three questions to explore. Does lack of payment if no
13 transport lead to cherry-picking by ambulance organizations
14 with possible delay in arrival of the ambulance for
15 patients for whom it seems likely that transport will not
16 be needed? Secondly, does lack of payment if no transport
17 lead to transports that may not be necessary? And three,
18 if there were to be payment for ambulance calls that do not
19 result in transport, would this be abused?
20 That's all I have for right now.
21 DR. CHERNEW: Josh had a comment.
22 MS. KELLEY: Oh, Josh, I'm sorry. Go ahead.

1 DR. LIAO: That's okay. I stuck in pretty late
2 here. I'll be very brief.
3 Two things. As I think about what other
4 Commissioners are talking about, kind of basically
5 uncompensated work, treat, no transport, I just want to
6 highlight two other things when I think about riveting
7 conversations I've had with fire chiefs or hospital-based
8 providers.
9 So highlight things related to throughput delays.
10 So you transport a patient somewhere, but then the facility
11 is not able to take them. So all that time waiting is not
12 compensated. If you have to turn around and go back to the
13 facility, it's also not compensated. So whether there's
14 quantitative data or not, maybe putting that into a chapter
15 of paper would be good.
16 The second is loaded versus unloaded miles. So
17 you get compensated for miles. You have a loaded patient.
18 When you go home, when you go back, and they're unloaded,
19 you don't get price for that. So that may kind of get to
20 some of the things around rural. But I would say loaded,
21 unloaded, throughput delays, and then treat, no transport
22 kind of in one bucket.

1 And then, finally, as a clinician, I also respect
2 this idea of clinical nuance. I would say I don't think
3 there's going to be quantitative data here, but if you can
4 spotlight the idea of dispatch algorithms, protocols,
5 training as things maybe to focus on were there to be
6 future work, I think that would be helpful because that
7 will help kind of detail that.
8 And then my prior comment about the personnel
9 types, you know, these are nationally standardized, and
10 EMRs can give oxygen and EpiPen, but they can't give nitro,
11 can't put a collar on, et cetera. So don't want to
12 overstate it, but I think you can get a little bit closer
13 with some of those analyses.
14 Thanks.
15 DR. CHERNEW: Okay. So terrific job.
16 A few quick summary comments. The first one is
17 there's a lot of important payment issues.
18 Another one, I think figuring out the unit of
19 payment is hard, because say that there's actually no
20 accident, you're not necessarily transporting or not
21 transporting, but you still got to be there. So knowing
22 what the right unit of payment is is hard. It turns out

1 that that's -- although hard and important, that's actually
2 not the main part of this mandate. The main part of this
3 mandate is actually closer to what Brian said, which is
4 what should we recommend about the data gathering exercise?
5 Should it be continued? Should it be modified?
6 And I'm going to paraphrase what Brian said at my
7 own peril. So, Brian, feel free to correct me. When we
8 think about the merits of collecting the data, we not only
9 have to think about the value of the data, but we have to
10 think about the cost of imposing the data collection
11 activity. And so that would be easy to do if we knew both
12 of the merits of the data and the cost of the data
13 collection activity, but I think we're on our way to
14 beginning to understand at least what some of the flaws in
15 the data are. And since we're mandated to say something
16 about that, it turns out we will, and we will do our best
17 to make sure that that conversation is balanced between not
18 simply saying, "Oh, it would be nice to have this data.
19 Therefore they should provide it." We really have to think
20 about how that influences the way things operate and the
21 cost of doing it.
22 And so I don't know if I've ever paraphrased

1 Brian correctly, but that's my general sense.
2 All right. So that's where we are on this.
3 Now, fortunately, I'm hoping that there's a bunch
4 of people at home that have thoughts on this topic, and
5 they should reach out to us at MeetingComments@MedPAC.gov.
6 I do think learning a lot from the industry is valuable,
7 certainly in this case, about the costs of the data, for
8 example, and stuff like that. So we are very interested in
9 hearing comments from folks. We are at the beginning of
10 doing this for a report that is mandated, so we will be
11 doing that next cycle.
12 Okay. And if you want to comment about any of
13 the other things we've talked about this afternoon,
14 including agents in Medicare or the Medigap market, also,
15 please reach out to us at MeetingComments@MedPAC.gov or by
16 email or send letters or any of the many ways you can reach
17 out to us.
18 So I think it was a really good day. If I think
19 back to the stuff that we did this morning around the
20 physician fee schedule, it seemed ages ago, and there was a
21 lot of really interesting, really important work. So I
22 want to thank all of you for your time and your comments.

1 I want to thank the staff, as always, for an unbelievable
2 job. Half the time, if you're watching at home and you see
3 me lean over to Paul, what I'm saying is "It's unbelievable
4 what they know." That's sort of the modal comment.
5 Anyway, so thank you all. We will be back
6 tomorrow. We're going to talk about home health and I-
7 SNPs, and for those of you at home, thank you for joining
8 us, and please join us tomorrow.
9 MR. MASI: And that's with one minute to spare.
10 [Whereupon, at 5:14 p.m., the meeting was
11 recessed, to reconvene at 9:00 a.m., Friday, March 7,
12 2025.]
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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, March 7, 2025
9:00 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
AMOL S. NAVATHE, MD, PhD, Vice Chair
LYNN BARR, MPH
PAUL CASALE, MD, PhD
LAWRENCE P. CASALINO, MD, PhD
ROBERT CHERRY, MD, MS, FACS, FACHE
CHERYL DAMBERG, PhD, MPH
STACIE B. DUSETZINA, PhD
KENNY KAN, FSA, CPA, CFA, MAAA
R. TAMARA KONETZKA, PhD
JOSHUA LIAO, MD, MSc
BRIAN MILLER, MD, MBA, MPH
GREGORY POULSON, MBA
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AGENDA PAGE

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

2 [9:00 a.m.]

3 DR. CHERNEW: Hello, everybody, and welcome to
4 our Friday morning meeting of MedPAC. We have two
5 important sessions. The first one is on a topic --
6 actually two topics of great interest. So it's home
7 health, great interest; Medicare Advantage, great interest.
8 And that's just going to leave us to Betty to talk about
9 home health care use among MA enrollees.

10 Betty.

11 DR. FOUT: All right. Good morning.

12 In this session, we will present ongoing work
13 examining home health care use among Medicare Advantage
14 enrollees.

15 During our October 2024 meeting, we presented
16 preliminary results, and Commissioners were interested in
17 continuing to refine those analyses.

18 The audience can download a PDF version of these
19 slides on the handout section of the control panel on the
20 right-hand side of your screen.

21 This presentation is organized as follows:
22 background, the data and analytic methods we used, our

1 findings, limitations of our study, and then our discussion
2 and next steps.
3 Commissioners have expressed interest in
4 understanding post-acute care use among MA enrollees, given
5 their large share of the population. Medicare home health
6 is the most frequently used post-acute care setting among
7 fee-for-service beneficiaries. The benefit covers
8 treatment, for beneficiaries needing skilled care in their
9 home. It may be used after an acute inpatient
10 hospitalization, or SNF stay, or without a prior
11 institutional stay.
12 In our October 2024 presentation, we assessed the
13 completeness of MA home health data sources and presented
14 initial unadjusted estimates of health care among MA and
15 fee-for-service beneficiaries.
16 We previously showed that home health encounter
17 data combined with OASIS data is necessary to obtain a more
18 complete view of nationwide home health care use among MA
19 enrollees.
20 Among MA enrollees with a home health encounter
21 record or OASIS record in 2021, we found that 87 percent
22 had both types of data, 7 percent had only MA Home health

1 encounter records, and 6 percent had only OASIS records.
2 This indicates that reporting was not complete in either
3 the encounter or OASIS data, and by combining the two data
4 sources, we would identify more MA users of home health
5 care than using either data source alone.
6 These match rates also suggest that studies that
7 rely solely on OASIS data may understate use for MA
8 enrollees.
9 In contrast, the match rate was 98 percent for
10 fee-for-service beneficiaries with home health records, and
11 as we discussed in October, differences in data
12 completeness was not surprising giving differences in data
13 collection and claims processing between MA and fee-for-
14 service.
15 Combining data sources also serves as a method
16 for validating them. MedPAC regularly assesses the
17 completeness of MA encounter data by comparing them with
18 external benchmarks, and as we have shown in prior reports,
19 the match rates have improved over time.
20 Today we expand upon our October presentation by
21 incorporating beneficiary, plan, and provider
22 characteristics into our analysis.

1 We estimate differences in home health care use
2 by MA plan types and for MA enrollees compared to fee-for-
3 service beneficiaries, adjusting for beneficiary
4 characteristics.
5 We examined the overall home health care use rate
6 in the population and the number of home health visits
7 received by beneficiaries who used home health care during
8 the year.
9 Where relevant, we incorporate information from a
10 small number of interviews we conducted with home health
11 agencies.
12 We now describe the data and methods we used in
13 our analysis. Among MA enrollees, the home health
14 encounter and OASIS data match rates varied by county.
15 This variation and the lower match rates for MA compared to
16 fee-for-service were concerning for drawing conclusions on
17 nationwide home health care use. We addressed this by
18 applying a county-level minimum match rate of 85 percent to
19 our analytic sample. This still allowed us to include
20 about 80 percent of counties and 70 percent of Medicare
21 beneficiaries.
22 After applying these restrictions and others

1 detailed in your reading materials, we had 35 million MA
2 and fee-for-service beneficiaries in our analytic sample.
3 Of these, 2.9 million used home health care, and 2.3
4 million matched by having both encounter or fee-for-service
5 claims and OASIS records.
6 We incorporated beneficiary, plan, and provider
7 characteristics that could affect home health care use.
8 These included demographics such as age, race, disability,
9 low-income status, and geography for the Medicare
10 enrollment file.
11 For health status, we used inpatient encounter
12 and claims data to identify acute care hospitalizations.
13 SNF and IRF encounter data could be incorporated in future
14 work. We identified hospitalizations that occurred during
15 the year as well as those that occurred in the 14 days
16 prior to the start of home health care. We also included a
17 large set of functional and clinical items from the OASIS
18 for beneficiaries that used home health care.
19 We assessed certain MA plan types that could
20 affect home health care use. These include HMO versus PPO
21 plans, provider-sponsored plans, and plans with home health
22 cost sharing. These are discussed in a slide later in this

1 presentation.

2 Finally, we assessed the types of home health
3 agencies treating MA enrollees, including information such
4 as ownership and type, size, and star ratings. More detail
5 on these characteristics are in your mailing materials.

6 We used multivariate regressions to adjust for
7 beneficiary characteristics and two main regressions, the
8 probability of any home health care use or the home health
9 care use rate, and for those who received home health care,
10 the number of visits per beneficiary. For examining visits
11 per home health user, we were able to include OASIS items
12 in the regression to control for differences in health
13 status, along with other beneficiary characteristics.

14 For all regressions, we controlled for geographic
15 location using county-level fixed effects. The results we
16 present show regression-adjusted differences in home health
17 care use by plan attributes and separately by payer. We
18 also present results stratified by the presence of acute
19 care hospitalizations.

20 We now turn to our findings on home health care
21 use by MA enrollees.

22 We first provide some descriptive information.

1 As shown in the far left bar of this figure, overall, 8.5
2 percent of MA enrollees received home health care. The
3 home health care use rate was higher among MA enrollees who
4 were older, had low income, and was substantially higher
5 among those who had an acute care hospitalization during
6 the year.

7 As shown in the far right bar, 41.7 percent of MA
8 enrollees with a hospitalization in the year also used home
9 health care during the year. 3.8 percent of MA enrollees
10 who did not have a hospital stay in the year received home
11 health care.

12 The number of visits per home health user also
13 varied. These data are not shown in this figure but are in
14 your mailing materials. On average, MA home health users
15 received 18.2 visits during the year. Visits per user were
16 higher for those who were older, had low incomes, or had a
17 prior hospital stay. They were also higher for those with
18 greater impairment or severity, as indicated on OASIS
19 functional and clinical items.

20 We found similar patterns among fee-for-service
21 beneficiary subgroups. These findings show the importance
22 of adjusting for beneficiary characteristics and examining

1 home health care use.

2 Your mailing materials contain information on

3 other beneficiary characteristics we examined.

4 We identified several MA plan attributes that

5 could affect home health care use. Compared to PPO plans,

6 HMO plans generally require enrollees to receive care from

7 in-network providers with whom the plan has negotiated

8 contracts. Under PPOs, enrollees can seek care outside of

9 the specified network, though frequently with higher cost

10 sharing. Forty-six percent of beneficiaries in our sample

11 were enrolled in PPOs and 54 percent in HMOs, as shown in

12 the top set of bars on this chart.

13 Provider-sponsored plans are affiliated with

14 hospitals, physicians, health systems, or other providers,

15 and this can facilitate better understanding of patients

16 and their clinical needs that can improve quality of care.

17 About 15 percent of MA enrollees were in a provider-

18 sponsored plan, as shown in the middle set of bars.

19 Finally, some plans require cost sharing on home

20 health care, through, for example, deductibles or per-visit

21 co-pays. This may affect the probability of any use and

22 the number of visits, depending on how the cost sharing is

1 implemented, particularly in comparison to fee-for-service,
2 which has no home health cost sharing. As shown in the
3 bottom set of bars, 24 percent of MA enrollees were in a
4 plan with some home health cost sharing.
5 Almost all plans required some sort of prior
6 authorization for home health care. So there was too
7 little variation for us to assess its association with home
8 health care use. Information on the type of prior
9 authorization, which can vary by plan and can play an
10 important role in home health care use, was not available.
11 We now turn to our regression results. This
12 table shows the regression-adjusted use of home health care
13 by beneficiaries enrolled in PPO and HMO plans. As the top
14 row shows, the probability of home health care use was
15 almost the same among enrollees on PPO and HMO plans. 8.5
16 percent of enrollees on PPO plans used home health care
17 compared to 8.4 percent of enrollees on HMO plans. The
18 difference between the two rates was less than 1 percent
19 and was not statistically significant at standard levels of
20 significance.
21 The bottom row shows that the average estimated
22 number of visits per home health user was higher for those

1 enrolled in PPO plans compared to HMO plans. Beneficiaries
2 enrolled in PPO plans received 0.85 more visits than
3 beneficiaries in HMO plans, a difference of 4.6 percent
4 that was statistically significant at the 1 percent level.
5 This table shows the results by enrollment in
6 provider-sponsored plans.
7 As shown in the first row, the probability of
8 home health care use did not differ by whether the
9 beneficiary was enrolled on a provider-sponsored plan or
10 not. However, as shown in the second row, beneficiaries
11 enrolled in these plans received 1.75 fewer visits than
12 beneficiaries not on these plans, a difference of 9.5
13 percent that was statistically significant at the 1 percent
14 level.
15 It is not clear why provider-sponsored plans were
16 associated with fewer visits per user. One possibility is
17 that some provider-sponsored plans are part of integrated
18 health systems where data reporting may be less complete,
19 because the home health agency only treats beneficiaries on
20 that plan, for example, even after applying our high match-
21 rate criterion.
22 Lastly, we found that enrollees on plans with

1 home health cost sharing had both a lower probability of
2 home health care use and fewer visits per home health care
3 user.
4 As shown in the first row of the table,
5 enrollment in plans with home health cost sharing was
6 associated with a 6.7 percent lower probability of home
7 health care use.
8 The second row shows that home health cost
9 sharing was associated with a 3 percent reduction in visits
10 per beneficiary, or about half a visit. This finding was
11 supported by the home health agencies we interviewed, who
12 indicated that some of the MA patients with per-visit co-
13 pays would limit the number of visits they were willing to
14 receive from the agencies.
15 We now present findings on home health care use
16 by MA and fee-for-service beneficiaries.
17 This figure depicts the home health care use rate
18 among MA and fee-for-service beneficiaries adjusted for
19 beneficiary characteristics.
20 As shown in the top set of bars, overall, 8.4
21 percent of MA enrollees used home health care compared with
22 8.5 percent among fee-for-service beneficiaries. These

1 rates were not statistically significantly different from
2 each other at standard levels of significance.
3 However, the differences were larger and in
4 opposite directions when we estimated home health care use
5 rates by whether the beneficiary had a hospital stay in the
6 year. Among those without a hospital stay, the middle set
7 of bars, the home health care use rate was 11.6 percent
8 lower among MA enrollees than fee-for-service
9 beneficiaries.
10 On the other hand, among those with a hospital
11 stay, the probability of home health care use was 6.2
12 percent higher among MA enrollees than among fee-for-
13 service beneficiaries.
14 Lower home health care use in MA compared to fee-
15 for-service for those without a hospital stay could be
16 explained by MA plans managing the home health care use of
17 their enrollees through prior authorization or cost-
18 sharing, both of which are not used for home health care
19 and fee-for-service.
20 In addition, some home health agencies may prefer
21 seeing fee-for-service patients over MA patients. In fact,
22 home health agencies we interviewed said that payment for

1 MA patients was frequently lower than the cost of providing
2 care, and all else equal, they favored admitting fee-for-
3 service patients over MA enrollees.
4 The higher use of home health care among MA
5 enrollees with a hospital stay could be explained by plans
6 encouraging substitution away from more costly SNF care
7 following a hospitalization. Home health agencies we
8 interviewed stated that despite lower MA payments, they
9 continue to admit post-hospital MA enrollees to maintain
10 hospital referral relationships.
11 Next, we compare visits per home health user
12 among MA and fee-for-service beneficiaries adjusted for
13 beneficiary characteristics.
14 Overall, as indicated in the top set of bars, MA
15 enrollees using home health care received, on average, 18.7
16 visits during the year, and fee-for-service beneficiaries
17 received 20.7 visits. That is, MA enrollees received two
18 fewer visits than fee-for-service beneficiaries or about 10
19 percent fewer on average. This difference was
20 statistically significant at the 1 percent level.
21 As indicated by the second and third set of bars,
22 when stratifying by having a prior hospital stay, the

1 average number of visits per user was still lower among MA
2 enrollees compared to fee-for-service beneficiaries by
3 about two visits.
4 Some of the home health agencies we interviewed
5 said that their MA patients tended to receive fewer visits
6 than fee-for-service patients with similar conditions.
7 Although there is variation in details, generally, the
8 plans with which the home health agencies contract require
9 prior authorization for home health care up to a certain
10 number of visits with additional authorization required for
11 more visits. But they noted that prior authorization for
12 more visits could be difficult to obtain, even if their
13 clinicians assess that the patient needed more visits.
14 The home health agencies treating MA and fee-for-
15 service beneficiaries differed. A fewer number of home
16 health agencies treated MA enrollees than fee-for-service
17 beneficiaries.
18 In 2021, about 7,000 home health agencies treated
19 at least 20 fee-for-service beneficiaries, while 4,600 home
20 health agencies treated at least 20 MA enrollees. About
21 4,300 home health agencies treated both types of
22 beneficiaries.

1 Home health agencies with high MA shares tended
2 to be large in terms of the total number of Medicare
3 beneficiaries treated, urban, and more likely to be
4 freestanding and nonprofit.
5 When we controlled for the home health agency
6 providing treatment in our regression model of visits per
7 home health user, meaning we estimated the variation in
8 visits per beneficiary within a provider, we still
9 estimated 1.8 fewer visits among MA enrollees, or 9.2
10 percent fewer. This estimate was very similar to what we
11 showed on the prior slide, and this means that on average,
12 MA enrollees received fewer visits than fee-for-service
13 beneficiaries within the same home health agency.
14 There are some important limitations of our work.
15 First, we included beneficiaries residing in higher data
16 match-rate counties only in order to use more complete
17 data. But this required a tradeoff with the
18 representativeness of our study population.
19 Second, MA enrollees could receive in-home visits
20 similar to some types of home health care visits through
21 their plan's supplemental benefits that were not included
22 in the Medicare home health benefit we examined.

1 Third, it's important to keep in mind that based
2 on the information we have, we cannot determine what the
3 appropriate level of home health care is.
4 And then, lastly, the broader acute and post-
5 acute care landscape, such as SNFs and IRFs, affect home
6 health care use and would be important to study in future
7 work if Commissioners decide to continue this work.
8 Other limitations and areas for future work are
9 discussed in your mailing materials.
10 We'll now answer any questions you have and take
11 your feedback for future work in this area, and these
12 findings will form an informational chapter in the June
13 2025 report to the Congress.
14 And I turn it back to you, Mike.
15 DR. CHERNEW: So, Betty, thank you for -- and
16 Andy and Evan. I think this is very interesting work.
17 I do want to emphasize a point that you made that
18 may have slipped by. We don't have a sense of what is
19 optimal or appropriate now. So, when you see differences
20 in use between MA and TM, you shouldn't draw the conclusion
21 that MA is too little or TM is too much or anything should
22 happen.

1 Right now, we are doing an informational chapter
2 about the use differences, but we're not trying to draw
3 conclusions about which level of use and for which patients
4 is correct or not correct -- or that's probably the wrong
5 word -- appropriate or not appropriate or whatever it is.
6 There's a complicated issue about how we think about
7 quality and utilization and efficiency, but the analysis
8 now, I think, is at the informational stage. And I thank
9 you for raising that in the bullet point you had in the
10 slide. It was the last one, maybe the one before that.
11 Anyway, sorry. That was a longer intro than
12 normal. I think we should jump in with Round 1 questions,
13 and so we're going to start. And if I have this right,
14 Stacie had the first Round 1 question. Is that right,
15 Dana?
16 Stacie.
17 DR. DUSETZINA: I'm not on the button this
18 morning. Thank you for this great work. I just have two
19 quick questions about data and what we have available to
20 us. One is, could you use more current than 2021? I kept
21 thinking, that still feels like it was a little bit of an
22 odd time, especially for having people coming into your

1 home, and I just was curious if there is more recent data
2 that could be used.
3 DR. FOUT: I think the 2022 encounter data has
4 just become available to use. We probably won't be able to
5 use it for our June report, but in future analysis we
6 would, moving forward.
7 DR. DUSETZINA: Okay, great. And then the other
8 thing that I just kept kind of wondering is getting maybe a
9 little bit closer to the appropriateness question, of can
10 we learn more about the reason for home health use, like
11 the indications, like why people have been in the hospital
12 or even why they're receiving care even outside of the
13 hospital. Like what conditions they have, for example.
14 DR. FOUT: We could look at the DRG of the
15 hospitalizations, if it was following a hospitalization,
16 and we do have, for the matched group, all the OASIS items
17 available to us. I mean, we could look at their -- yeah.
18 DR. DUSETZINA: It might just be nice to have a
19 little bit more information on what people are getting.
20 And I wondered especially for people getting home health
21 that didn't have the prior hospitalizations, what exactly
22 are those services that people are getting. It would just

1 be nice for context.

2 MS. KELLEY: Lynn.

3 MS. BARR: Thanks, team. Great work. I really
4 enjoyed the chapter. So I just have a couple of quick
5 questions. For the patients that aren't in the OASIS data,
6 is it possible that they're self-pay? I mean, I'm curious.
7 Because if you got denied home health, you know, you might
8 pay for it yourself because you needed it. And I was just
9 curious, is there a way to capture whether or not that's
10 being shifted onto the beneficiaries.

11 DR. FOUT: The ones who are not in OASIS are in
12 the encounter data, so whether or not they were denied
13 payment I am going to give to Andy.

14 DR. JOHNSON: Encounter data comes from the
15 claims that are submitted to the plans, so they are in the
16 encounter data and not in the OASIS data. They are not
17 likely to be self-pay. It's a little unclear whether or
18 not the self-pay situations might show up in denied claims
19 or just not show up at all if no claim was submitted. But
20 that's something we can look a little bit more into. We
21 are still working on using the encounter data and looking
22 at some of the denials. It's a tricky area.

1 MS. BARR: Okay, great, great. That would be
2 really interesting.
3 So I'm so fascinated by yesterday's report on the
4 ambulance. We all knew that it was more expensive to do
5 ambulances in rural, but we didn't know it was twice. I
6 think we'd give them like 1 percent more, so I thought it
7 was a really big gap between the payment and the actuality.
8 I was wondering, do you have the ability to get
9 cost data -- and this may be out of scope, but I'm curious
10 -- do you have cost data on rural versus urban home health
11 facilities?
12 MR. CHRISTMAN: I mean, yes, that's available on
13 the cost report, and that's certainly something we can
14 think about. Certainly there may be some differences
15 across urban and rural. I think, in general, the size of
16 an agency is one of the most powerful predictors of an
17 agency's cost per visit. I guess what I'm saying is you
18 can find high-cost facilities in both urban and rural areas
19 because of that.
20 MS. BARR: Got it. Yeah. Maybe you could match
21 up, because the rural-only ones are going to be small, so
22 maybe you can match them on size or something. I mean, I

1 hear it all the time. It's like the cost of getting to
2 those patients, the cost of getting the nurse to those
3 patients is prohibitive, and it's the same with the
4 ambulance. You've got a bunch of fixed costs, going long
5 distances, and not getting paid for it.
6 So I don't know if it's in this scope or
7 whatever, but I feel like we probably, after seeing that
8 ambulance data, we are probably really underpaying for
9 rural home health, as well, compared to cost, and I just
10 would love to see if we could get at that.
11 And is there any difference in the other data
12 that you looked at, between rural and urban populations?
13 Have you looked at there? Is there a difference there?
14 DR. FOUT: In the paper we have broken down by
15 rural and urban visits and probability of use.
16 MS. BARR: Okay.
17 DR. FOUT: I don't recall, off the top of my
18 head, I don't think. There might have been some
19 differences.
20 MS. BARR: Thank you. And are you going to add
21 outcomes data later, at some point?
22 DR. FOUT: You can certainly discuss what kind of

1 outcomes data you think could be useful in looking at this.
2 MS. BARR: Okay. Thank you.
3 MS. KELLEY: Cheryl.
4 DR. DAMBERG: Thanks for this chapter. Really
5 interesting work. I had two quick questions. Related to
6 prior authorizations, is that a required data field that
7 they are supposed to submit?
8 DR. FOUT: Yes.
9 DR. DAMBERG: And as part of that, are they
10 supposed to signal whether it was denied or not? I don't
11 know what the data look like, but can you tell that from
12 the data?
13 DR. FOUT: I don't think that they are required
14 to say whether they have a prior authorization, and there
15 is a field for them to describe the type of prior
16 authorization, although that is not filled out well. I
17 don't think that would be where the information would be,
18 if they denied it or not.
19 DR. JOHNSON: And the information we have on
20 prior authorization is not at the service level, so it's
21 not like we can track what happened to a given beneficiary
22 as reported by plans.

1 DR. DAMBERG: Okay. Thanks. And then my second
2 question relates to something on page 11. It says,
3 "provider-sponsored plans, many of them were HMOs." And
4 I'm just trying to connect the provider-sponsored plans
5 having lower utilization and the connection to more of them
6 being HMOs, and trying to understand what you did in your
7 modeling and whether you're controlling for HMOs.
8 DR. FOUT: In the results where we showed you the
9 regression-adjusted mean by the plan attributes, those
10 models were run with each plan attribute separately. So
11 the provider-sponsored plan coefficients would have been
12 estimated without the HMO and cost-sharing plan types in
13 the regression. I mean, we did it both ways, but those are
14 the versions we showed you. So there could be some effect
15 of HMO in there too, although we did run models where they
16 all were all included, and the patterns were about the
17 same.
18 DR. DAMBERG: Okay. Thanks for clarifying.
19 MS. KELLEY: Kenny.
20 MR. KAN: Great chapter. Thank you. It is a
21 very difficult operating environment for many MA plans
22 currently as the economics are upside down. Rates are

1 inadequate to cover very high medical costs. So one way to
2 manage the high medical costs are for MA plans is to foster
3 greater home care use in clinically appropriate settings.
4 So I believe that the publicly traded MA plans --
5 I have a hypothesis, that the publicly traded MA plans are
6 likely to be more at the forefront of enabling this greater
7 home care use. You know, this would be consistent with the
8 site neutrality framework that MedPAC has championed.
9 So with that, would it be possible, you know, to
10 have sort of like future iterations of the analysis to
11 show, for example, on the slide deck pages 11, 13, 17, and
12 18, how those measures would change between publicly traded
13 MA plans and the rest of the MA plans. It could actually
14 sort of give a sense of efficiency and a sense of the art
15 of the possible, in terms of outcomes and quality, to the
16 extent we can see how behaviors actually could vary between
17 two different cohorts.
18 DR. JOHNSON: It's certainly feasible to break
19 that out. I think we will have to talk about the timing of
20 when we can get that analysis done.
21 MR. MASI: Yeah, and thanks for that suggestion,
22 Kenny. The only thing I would emphasize is that at this

1 stage of the work we are not trying to draw conclusions
2 about what is appropriate, what is effective. We are
3 really just trying to provide information to Commissioners
4 into the environment, based on what is out so far.
5 MR. KAN: I agree, Paul, and that's why I say in
6 future iterations of the work. Thank you.
7 MS. KELLEY: Okay. I have a Round 1 question
8 from Larry. He says this is important work and very
9 clearly presented. It's very good that you showed absolute
10 differences, percentage differences, and statistical
11 significance. It seem to him, though, that by and large
12 the differences are quite small. So in the text he
13 suggests being careful when using language like "more" or
14 "less," "had fewer," et cetera. We might want to modify,
15 as appropriate, by softening the language, for example,
16 "slightly more," "slightly less." The similarity of the
17 results in most comparisons generally seems to him more
18 striking than the small differences.
19 And next I have Brian.
20 DR. MILLER: Thank you for this chapter. It was
21 fun to read. And I agree with Larry's comments that
22 perhaps making the language more clear, because a lot of

1 these differences looked very small.

2 Building off Kenny's question, do we have, and we
3 might not be able to do this, descriptive statistics
4 perhaps by not just publicly traded or privately
5 held/nonprofit or tax exempt? Do we have it by plan or by
6 plan size? You don't have to say, like, this is plan is
7 good and this plan is bad, just to show that there's
8 distribution.

9 Because one of the comments that Greg has brought
10 up in literally every single MA discussion, which is right,
11 is that there is a range of behaviors and a range of plans.
12 So when I look at these summary statistics, I look at this
13 and think this is relatively boring, and reassuringly
14 boring, I recognize that there may be outliers. So that
15 would be, I think, helpful for us to have.

16 And then a second question is, do we have any
17 evidence that MA plans are inappropriately shunting skilled
18 nursing facility-appropriate patients to home health?

19 DR. FOUT: Not in this work we don't.

20 DR. MILLER: Okay. So then in our language we
21 should be careful not to say anything overtly negative or
22 overtly positive, because most of the time when I was

1 reading this chapter, when there was a difference, the
2 assumption was plans are doing something inappropriate.
3 They might be doing something inappropriate, but if we
4 don't have clear clinical evidence that they are doing
5 that, then instead of saying that they are inappropriately
6 shunting folks to home health, we should also say that it
7 is equally likely that they are appropriately directing
8 beneficiaries to the right post-acute care. Or we should
9 not have any judgment whatsoever. And I'm completely aware
10 that some plans are probably behaving poorly, just that we
11 should make sure that our language is neutral.
12 MS. KELLEY: Paul.
13 DR. CASALE: Great chapter. Thank you. My
14 question was sort of on a similar vein. The subacute
15 rehab, in particular, SNF use post-acute hospital, have we
16 looked at that before in terms of if there is difference in
17 MA versus fee-for-service? I saw it also on the future
18 plan potentially, so I wasn't sure if we knew if there were
19 differences there or not, in general.
20 DR. FOUT: We in the middle of taking a look at
21 that.
22 DR. CASALE: Great. Okay. That would be really

1 helpful. Thanks.

2 MS. KELLEY: Gina.

3 MS. UPCHURCH: Yeah, thanks so much for this
4 information. Just two quick questions. One is building
5 off Stacie's comment earlier. In addition to being able to
6 find out what conditions are potentially being treated, who
7 are the people going into the homes? And that might an
8 easier way to get some of the stuff, too. Is it social
9 work more likely going to the home for fee-for-service, or
10 is it in-home aides that are going more for Medicare
11 Advantage? It would just be interesting to see that mix of
12 who is helping.

13 And then another CAHPS survey for people. I
14 don't know how long you have to be with home health to
15 receive the CAHPS survey, but does the CAHPS survey, is
16 that for people with Medicare Advantage? I know OASIS is,
17 but is CAHPS also?

18 DR. JOHNSON: Yes.

19 MS. UPCHURCH: Okay. So do we know anything from
20 the CAHPS survey about quality or perceived quality of
21 care.

22 DR. FOUT: In the last table in your mailing

1 materials we took a look at home health agencies survey
2 star ratings, and that's sort of the only thing we have in
3 there. We just kind of stratified by MA share, the star
4 ratings of the agencies.
5 MS. UPCHURCH: Okay, and I should know this, but
6 the stars rating comes partially from the CAHPS.
7 DR. FOUT: There's a CAHPS star rating and
8 there's an OASIS claims data star rating. Both of them are
9 shown there.
10 MS. UPCHURCH: Great. Thank you.
11 MS. KELLEY: Amol.
12 DR. NAVATHE: Thanks. I have probably what is a
13 very basic question that goes back to the last
14 presentation. Can you just remind us why we might be
15 seeing discrepancies between the OASIS data and the
16 encounter claims? In particular, why would we see
17 situations where we see an encounter but don't see data in
18 OASIS?
19 DR. FOUT: I will start, and Evan might want to
20 add. I'll just start with fee-for-service. There is, as
21 you saw, very little discrepancy between fee-for-service
22 claims data and OASIS data. But there is an edit in the

1 payment system in which they only pay for claims with which
2 they can find an OASIS that matches.
3 There is no such edit for MA. I mean, home
4 health agencies are supposed to send in their OASIS for all
5 their Medicare patients. But there is no check to make
6 sure that an encounter record is being matched with an
7 OASIS record. There is a quality reporting program penalty
8 if they cannot fully find your start-of-care assessment and
9 end-of-care assessment and match it for quality reporting
10 purposes. But if you don't have any assessment for your MA
11 patients there is not really a good way to find out if you
12 did or did not submit them.
13 And Evan, go ahead.
14 MR. CHRISTMAN: Yeah. I think Betty captured it.
15 I think there are a variety of checks that are done to the
16 OASIS data when it comes in, but because there is nothing
17 really to cross-check until the existence of the encounter
18 data, which trails considerably, there is nothing to really
19 cross-check the OASIS and say, you know, for MA patients.
20 I think there are 10,000 agencies, and they vary
21 in their administrative practices, and I'm sure many work
22 very hard to be complete and thorough. But I would also

1 say that as far as I can tell, there aren't any
2 consequences if an agency fails to submit an OASIS for a
3 Medicare Advantage patient. They will catch it if it is a
4 fee-for-service. And again, I think clearly a lot of
5 agencies are submitting, but like anything in home health
6 there is probably some variation, and that explains why I
7 would expect some of this data to be missing.
8 DR. NAVATHE: So just to follow up there, so if
9 they don't submit it, if the OASIS record doesn't come
10 through in fee-for-service, they would have an opportunity
11 effective -- they would realize if they're not paid, they
12 would have an opportunity to amend that record. And
13 therefore, there's kind of a mechanism to ensure alignment
14 that may not or does not exist on the MA side?
15 MR. CHRISTMAN: Right, because the federal
16 government is making the payment on the fee-for-service
17 side, they can say "You’ve told me that this claim
18 happened. I can look for the OASIS." In the MA side,
19 obviously, the federal government is not making the payment
20 to the agency. They're just getting the OASIS. And so we
21 have a separate stream through which the encounter data
22 comes but that's in a much -- it's relatively new and it’s

1 a much longer time lag. Obviously, the claim and the OASIS
2 on the fee-for-service side should come in pretty close to
3 each other. Where, you know, it's 2025 and we're just
4 getting the 2022 encounter data.
5 So there's a lot of -- I recognize this is a lot
6 of minutiae but it does lead to this phenomenon I think
7 you're honing in on which is, you know, why are some of
8 these things missing from the OASIS?
9 DR. NAVATHE: Okay, that's helpful.
10 So the second part of my question was going to
11 be, is it idiosyncratic? Or in other words, why do we see
12 county-level variation? It seems like that county-level
13 variation may heavily be correlated with MA share or MA
14 penetration in a county. One, does that sound right? Have
15 we looked at that before? And the second question is are
16 there other dimensions that might be correlated with county
17 such that we see this relationship that it varies by
18 county? Or is it otherwise idiosyncratic outside of that
19 MA penetration point?
20 DR. FOUT: I think some of the county-level
21 variation has to do with which plans are in the county, and
22 some plans have lower match rates than other plans. The

1 match rates are lower in the West, where I think there are
2 a lot more HMOs. So I don't think it's necessarily
3 correlated with MA penetration because that's pretty high
4 across a lot of counties. But it is definitely some
5 regional variation and probably related to which plans are
6 operating there.
7 DR. NAVATHE: Thanks.
8 MS. KELLEY: Scott.
9 DR. SARRAN: Very nice work. Just a quick
10 process question. Are we planning on going beyond the June
11 report in our work plan?
12 MR. MASI: Great question. I think that's
13 something for you all to consider. As Betty talked about,
14 there is additional work that could be done in other post-
15 acute settings. You know, as you all know, just looking at
16 one means you're just looking at one, and there's a lot of
17 overlap and substitution potential across these different
18 settings. So I think that's an issue for Commissioners to
19 discuss.
20 Betty or Evan or Andy, do you want to add
21 anything to that?
22 DR. CHERNEW: I'll just add, there's trade-offs.

1 MS. BARR: As ever.

2 [Laughter.]

3 MS. KELLEY: That is all I have for Round 1.

4 DR. CHERNEW: Tamara is first in Round 2.

5 MS. KELLEY: I think, Paul, did you want --

6 MR. MASI: I just have one quick piece of
7 information. So there's the question in the first round
8 about home health agency margins in rural areas and how
9 they compare with overall home health margins. I just
10 wanted to both shamelessly plug our March report, which
11 will be released next week, and then also flag for
12 Commissioners that, as we talked about earlier in the
13 cycle, we found 2023 margins for home health to be roughly
14 20 percent across both majority urban and rural areas. And
15 so that's our most recent finding.

16 DR. CHERNEW: Tamara.

17 DR. KONETZKA: Great. Thank you for such a great
18 chapter.

19 I want to start by just saying, you know, this is
20 an area I do work in, so I have a few comments here. But
21 I'll just start by saying, you know, I think this is such
22 an important area. I really appreciate your digging into

1 this work in such detail. It's such an important area
2 because I think post-acute care in general is just really
3 at the sort of frontier of everything that's happening in
4 alternative payment models and in managed care and
5 capitation, and that, you know, this is sort of the low-
6 hanging fruit where, you know, across all of these
7 different kinds of models, insurers have been able to
8 reduce use of post-acute care, often, you know, without any
9 apparent adverse consequences, right?
10 And so it could either be, like, a great model
11 for improved efficiency or, you know, on, the other hand,
12 in post-acute care, we hear, you know, lots of anecdotes
13 and grumblings. And, you know, I think those anecdotes are
14 actually very important because they lead to sort of
15 recognition that there might be a bigger problem that we
16 want to investigate, and a lot of those anecdotes are about
17 being denied care and being denied post-acute care.
18 If I could just, you know, give you my view of
19 the literature in this area up until this point, it is that
20 study after study, quite a number of them has found lower
21 home health use in managed care, in Medicare Advantage than
22 in fee-for-service. A few studies looked at outcomes and

1 found -- oh, and I'd say that's also combined with sort of
2 lower intensity post-acute care use in general, so kind of
3 lower use of IRFs, lower use of SNFs, lower use of home
4 health, you know, more sort of going straight home after
5 the hospital. And a few studies that looked at outcomes
6 really found no differences, right? And so the conclusion
7 is sort of leaning toward, you know, maybe this is good
8 utilization.

9 And it also -- those studies sort of make sense
10 in that, you know, with prior authorization, utilization
11 management, and sometimes cost sharing, you know, we expect
12 MA utilization to be lower.

13 So all that to say, I think this is super
14 important work, because you're basically coming to, you
15 know, a different kind of conclusion that these are more
16 similar rates than we might have thought, especially it
17 seems in the post-acute side, not so much on the community-
18 initiated side.

19 And, you know, I think there might be a number of
20 reasons. You know, there's also, like, the '21 data that
21 might be a little bit different. But I think the main
22 reason is probably that you use these encounter claims,

1 right?

2 So I've given a lot of thought to some of, you

3 know, the same questions that Amol was raising, and I think

4 you make a really good case that we're missing -- you know,

5 we're missing instances of MA use of home health if we

6 don't use the encounter data, because that whole other

7 literature that I was just talking about basically just

8 relies on OASIS.

9 So I guess my ask here is that this is not a

10 geeky detail, right? This is actually really important to

11 know whether using these encounter claims where you don't

12 have an OASIS is valid, right? And so I guess my ask would

13 be, can we just really dig into that? Right? Like, so for

14 those people who don't have an OASIS -- first of all, there

15 are, you know, reasons why we might not have an OASIS.

16 It's not required if there's a single visit, for example.

17 And maybe MA -- and I think you guys have looked into this

18 a little bit already, but, you know, maybe MA just has more

19 single-visit home health stays, and therefore, they have

20 fewer OASIS, and yet they still have the encounter claim --

21 or the encounter record.

22 So those kinds of issues, the geographic issues,

1 the beneficiary issues, I think people have been
2 comfortable using OASIS for a long time because they've
3 been filling out OASIS for a long time, right? And I think
4 people who are filling out those forms, just like the MDS
5 in nursing homes, are sort of just used to doing that for
6 everybody. And so I just really want to know why some of
7 these places might not submit an OASIS, even though they're
8 supposed to, so just like more detective work about the
9 beneficiaries, about the plans, about those counties, and
10 about the characteristics of the home health stays, right,
11 because, again, it's just really important to know why
12 these results are a little bit different. Okay. So that's
13 the first main point.
14 Just a couple more. One is that as we saw in the
15 last meeting, I think increasingly we might think about the
16 community-initiated home health and the post-acute care
17 home health as almost different services, right? Like, I
18 know they're both under the home health benefit, but the
19 people using the community-initiated home health tend to be
20 more cognitively impaired, older, more chronic conditions.
21 And they're kind of using it to sort of stay in the
22 community and preventability, et cetera.

1 And the post-acute care use is different in a
2 couple of ways. One, these are often like, you know,
3 people who had a joint replacement or whatever and are
4 getting -- or a stroke and are getting their post-acute
5 care, but it's also much more affected by shifts across the
6 acute care spectrum, right? And so I guess my ask there
7 would be, you know, sort of in future work for this,
8 instead of overall rates, wherever possible, can we break
9 it down by post-acute care use versus community-initiated?
10 And then I guess the final point is -- and you
11 didn't raise this in the presentation, but I want to note
12 it because it was in the mailing materials. In Table 11,
13 when you look at the different characteristics by an HHA
14 share of MA enrollees, I think the conclusion you were
15 drawing in the text was that you don't see big quality
16 differences between the HHAs that MA enrollees go to and
17 that fee-for-service enrollees go to.
18 And I think two things. One, I interpret this
19 very differently. Like, if we look at the -- if we look at
20 where the bulk of beneficiaries are in those, like, third
21 and fourth columns and compare sort of lower MA enrollment
22 to higher MA enrollment in those HHAs, I actually see big

1 quality differences, right? So, you know, in the more MA,
2 they're much more likely -- they're 16 percent versus 10
3 percent more likely to go to a one- or two-star home health
4 agency. And they're -- even in the survey star ratings,
5 the HCAHPS ones, you know, 13 percent versus 7 percent to
6 be in the lowest-quality group.
7 And so I would love to see there more of a
8 within-county person-level comparison. So if I'm MA versus
9 fee-for-service within a county, given the same choices as
10 my fee-for-service counterpart, am I more likely to go to a
11 low-quality or be served by a low-quality HHA? So I'd love
12 to see more work on that quality.
13 Great work. I'm just so happy we're embarking on
14 this. I would put a plug in for actually, you know,
15 looking at post-acute care broadly and trying to tie these
16 different pieces together as an important piece of future
17 work, but I very much appreciate this great start. Thank
18 you.
19 MS. KELLEY: Stacie?
20 DR. DUSETZINA: Thank you. That's a really tough
21 act to follow.
22 So this is excellent work, and I agree with

1 others that it is a complicated area, especially thinking
2 about this, you know, like what site of care you might have
3 been most appropriate in. And there are lots of ways to
4 deliver really efficient and great care to people in their
5 homes, so very happy we're digging into this more.
6 A couple minor things. One is that you mentioned
7 in the chapter, cost-sharing for beneficiaries, and I think
8 it would be really helpful to give a sense of what that
9 typically looks like for people, just to know the magnitude
10 of cost-sharing when it exists for a beneficiary. It's
11 just like a little informational piece that I think would
12 help.
13 I kept wanting to know, like, especially for
14 Table 8 in the mailing materials where you showed the
15 different levels of impairment -- I thought it would be
16 really helpful to have that broken out by whether or not
17 they had a hospitalization before, because it feels like
18 it's counter to what I expected when reading the chapter,
19 that, you know, I would have expected that if you're more
20 likely to get home health instead of going into school
21 nursing or in MA, for example, I would have expected that
22 those measures would look worse. But maybe if stratified

1 by prior hospitalization or not, you would see something
2 different. I just think that that would give more context.
3 My last comment was I kept kind of wondering
4 about bringing in more about patient and caregiver
5 satisfaction with home health services and, again,
6 stratified by whether or not you had been hospitalized
7 before, and part of it being that, you know, if you are
8 sent -- if you were hospitalized and then instead of going
9 into a skilled nursing facility or you get home health
10 services, it's likely that your caregivers might need to
11 take on more responsibilities or you might have to fill in
12 other gaps in care. And I don't know whether that would
13 show up on just a patient satisfaction measure or patient
14 or caregiver, so having some information about that, along
15 with things like, you know, did you have to go back to the
16 hospital. So, again, it's around that group that came out
17 of the hospital, I think, where I'm curious about digging
18 in a little bit more on outcomes.
19 But really fantastic work and well done with the
20 chapter.
21 MR. KAN: Yeah. I just want to make a -- I just
22 want to make a plug for Tamara's ideas. I think that is

1 definitely worth exploring, setting aside the trade-offs
2 and priorities issue. I do think we actually should
3 explore this, because I think long term, we should really
4 do more work on post-acute site neutrality and especially
5 since I believe that longer term, you know, care could be
6 migrating to the home if clinically appropriate. So I
7 think, you know, Tamara is right on.
8 The one thing that I -- the one thing that's not
9 clear to me, if I'm recalling correctly, Betty and Andy and
10 Evan, I believe that the encounter data for home health is
11 the least complete, right, of all the various providers
12 we've looked at. Is that fair? That's my recollection.
13 DR. JOHNSON: It has been in the past but has
14 gotten dramatically better for 2021. So it is improving
15 over time.
16 MR. KAN: Okay. Thank you.
17 MS. KELLEY: Robert.
18 DR. CHERRY: Yeah. Thank you.
19 Great work. And, you know, home health is
20 definitely part of the secret sauce with managing care, so
21 really appreciate the focus and the effort on all of this.
22 A couple of the findings caught my attention.

1 One of them is around patients that are hospitalized, that
2 the MA patients have a 6 percent higher utilization rate
3 for home health compared with fee-for-service.
4 The reason that you cited was that they may be
5 using home health as an alternative, a more cost-effective
6 alternative to, let's say, SNFs. And I do agree with that.
7 I think there may be other reasons driving that
8 utilization as well, namely managing the patients so that
9 the MA patients have reduced ED visits and reduction in
10 unplanned readmissions as well.
11 I don't think ED visits and unplanned
12 readmissions was part of the metrics in the report, but it
13 may be something to actually consider, because that could
14 be one of the reasons why MA patients are being managed in
15 that way, just to make sure that they stay at home, they're
16 managed well at home, and that the total cost of care lines
17 up well.
18 The other finding was around those that do not
19 have a hospital stay, and there with the MA patients, the
20 utilization with home health was 11.6 lower compared with
21 fee-for-service. The reasons that were cited is because
22 there may be barriers associated with that, such as prior

1 authorization and cost sharing. And I agree with that.
2 I think, in addition, it's very possible that the
3 higher utilization among the fee-for-service patients that
4 don't have hospitalization could because those patients
5 might have higher acuity as well, and therefore, their need
6 for home health might be greater than MA patients.
7 One way of looking at that is to see if there's
8 any risk adjustments applied to see whether or not the fee-
9 for-service patients actually have a higher acuity and
10 therefore perhaps a higher utilization. And I do realize
11 you're utilizing adjustments already, but they're mainly
12 around functional status and demographics.
13 So if there is a risk model that's sort of easily
14 available to you, it's something to consider, and I totally
15 understand if it's not something that's doable by the June
16 report.
17 Otherwise, the work is very well done, and thanks
18 to all of you for your efforts
19 MS. KELLEY: Cheryl.
20 DR. DAMBERG: I'm not going to echo some of the
21 comments made by Tamara and Stacie and Robert, but I would
22 be in agreement with those.

1 I find myself wondering or -- maybe this plays to
2 what Tamara was raising in some of her comments of wanting
3 to see like the full picture of acute care, post-acute
4 care, to try to understand, you know, differences in
5 utilization and whether that's lower for MA. And I realize
6 this is just one piece of the larger puzzle and trying to
7 figure out sort of how -- if we stitch all these different
8 pieces together, what does that picture look like?
9 And I guess I'm also hopeful that in future work
10 that we could look at some of the health outcomes. So what
11 -- do we see differences in re-hospitalizations, or are we
12 seeing greater shifting into skilled nursing facilities?
13 So I would encourage the team to the extent we're able to
14 do that to try to start looking at some of the outcomes.
15 MS. KELLEY: Brian.
16 DR. MILLER: Again, thank you for doing this
17 chapter.
18 I know that you've gotten lots of nitpicks from
19 all of us, but this really came together quite nicely.
20 I think that some of that granularity that all of
21 us have asked for around the various market participants or
22 segments will be helpful.

1 Wanted to throw out some stats from the chapter
2 and then a thought about them. On page 3, we noted that we
3 found that home health agencies that treated a higher share
4 of MA enrollees in 2021 tend to be larger and less likely
5 to be freestanding for profit.
6 We noted that HMOs had a 0.5 percent absolute
7 increase in home health utilization compared to PPOs on
8 page 14.
9 Then we noted also on page 17 that MA benes who
10 didn't have a hospital stay were 0.5 percent absolute share
11 less likely to have a home health use, while those who did
12 have a hospitalization were 2.4 percent absolute share more
13 likely to use home health. That's page 17.
14 So this sort of -- when I look at this
15 granularity of some things increasing, some things
16 decreasing, not necessarily following a consistent story
17 that tighter networks, because an HMO is tighter than a PPO
18 -- tighter networks sometimes had more utilization in some
19 populations and some in less, and the differences are
20 relatively small on an absolute scale. This tells me that
21 at the macro level, the programs at the macro level, at the
22 programmatic level, that there's not a lot of difference.

1 This doesn't mean that at the firm or segment or the micro
2 individual level that there aren't differences that are
3 meaningful.
4 I think the thing that everyone is asking when
5 they get to this is they say, "Oh, I looked at this high-
6 level data. This is reassuring. Nothing bad happening.
7 Can you give us some segmentation and scoping just to make
8 sure that there aren't segment or firm differences?" And
9 determining individual differences at the beneficiary level
10 is probably outside of everyone's analytical ability.
11 So I guess I would say from looking at this, I
12 feel better about both programs at the programmatic level
13 and then look forward to seeing the next set of data at the
14 segment and/or firm level.
15 So really great work. Know that that is a big
16 ask and that you guys will do with that what you can, but I
17 appreciate you all.
18 MS. KELLEY: Scott.
19 DR. SARRAN: Yeah, just a series of very brief
20 points, most of which are reinforcements of other
21 Commissioners' points.
22 First, I do think it is worthwhile for us to keep

1 going in this space. We should always remind ourselves
2 this is, by definition, a vulnerable population. They've
3 either experienced a medical or surgical issue, or they're
4 about to experience one. And so we owe that population a
5 particularly high degree of scrutiny.
6 I'd also reinforce that although -- as Brian and
7 others have noted, there's no evidence in what we've seen
8 so far to suggest that MA plans are inappropriately
9 reducing care, and that certainly is reassuring. That
10 said, speaking as a clinician who's made decisions
11 regarding post-acute care in terms of which sector to use
12 and length of time in that sector, as well as a managed
13 care chief medical officer, the decision-making is
14 oftentimes remarkably gray. It just is. It's not always
15 clear-cut, and so that leads it open potentially for
16 inappropriate reductions in utilization. Again, reassuring
17 we've not seen that so far, I think we should continue to
18 reinforce that that's encouraging, but there is that
19 potential out there.
20 All right. So, with that, second point, I think
21 reinforce the need for complete data from MA plans, to the
22 extent that we can continue to bang on the drum about what

1 MA plans could and/or should do to match up complete OASIS
2 data with claims they've paid, I think that's a point worth
3 mentioning, as well as are using the data we have to try to
4 link outcomes and denials data. Again, that's important in
5 terms of the context we just discussed to utilization. So
6 that paints a fuller picture: outcomes, denials,
7 utilization.
8 And, in utilization, I think as others have
9 reinforced, I think there probably are some good visuals we
10 could put together that show sort of the landscape pie
11 chart of post-acute utilization by site, right, because we
12 all know that not inappropriately necessarily, there is a
13 shift from most acute high-severity settings downward,
14 right, from LTCH down to SNF down to home health to home
15 without that. And so I kind of think there are probably
16 some good visual ways to show that to our audience and to
17 keep an eye on that over time and also reinforce.
18 I think that the differentiation between post-
19 acute home health use and, call it, prehabilitation or
20 proactive home health use for a beneficiary living in the
21 community, I think it's a valid distinction because it's
22 really two different kinds of populations clinically. One

1 is, again, you're trying to rehab somebody or help ensure
2 their uninterrupted recovery from an issue and versus, on
3 the other hand, somebody is beginning to incur an issue and
4 you're trying to prevent hospitalizations, clinically very
5 different, and so I think that's a worthwhile distinction.
6 The last point I make that we haven't seen yet is
7 it may be worthwhile as we do continued work in this space
8 to look out for workforce issues. As we realistically
9 anticipate a reduction in largely or the immigrant portion
10 of the workforce that's available for this space as well as
11 nursing facility space in particular, I think we will see
12 more challenges. And we know that this is a space as well
13 as nursing facility space where there are current
14 challenges in terms of securing and maintaining an adequate
15 workforce. So I just think, particularly as we do any
16 further exploratory work and if there are any ongoing focus
17 groups or so forth, we should be alert to that and looking
18 out for that.
19 Thanks.
20 MS. KELLEY: Betty.
21 DR. RAMBUR: Thank you so much. I appreciate
22 this great work and the comments of my colleagues. So I'll

1 try not to repeat but to just maybe pile on.

2 I do support the broader look at post-acute care,

3 depending on what we're trading off for it. I want to be

4 clear on that. But I think it's really important.

5 And if I remember correctly, in bundle payment

6 models -- and Amol would know this better than I do -- some

7 of the biggest differences in cost was in differential use

8 of post-acute care. So I think there's some important

9 things there.

10 And I think about, for example, acute care

11 hospital at home, if that gets reauthorized, I would expect

12 that they might have shorter length of stays but longer

13 home health. That seems logical. So I think there's a lot

14 of important work here, especially as remote monitoring

15 becomes more the norm.

16 I just have to pile on a little bit on Lynn's

17 comments on rural, and I know this is an n-of-1, but having

18 delivered home health in frontier counties, I can tell you,

19 you can drive for a very, very long time in very inclement

20 weather, seeing people who could not have possibly gotten

21 themselves to the big city. So I would actually expect

22 that it might be more expensive in frontier counties and

1 appropriately so. So I think that that's a really
2 important thing to further flesh out.
3 We've talked about outcome data, and Cheryl and
4 others have talked about outcome data. The ones I would be
5 most interested in as first step is what happens after.
6 Are they readmitted to the hospital -- this was mentioned
7 by Cheryl and others -- to a long-term care facility or
8 transferred to hospice or palliative care or readmitted to
9 home health? Like, what happens afterwards?
10 And Stacie mentioned caregiver burden, and I
11 think that's really important, and I think it goes two
12 ways. There's a caregiver burden of family caring at home.
13 There's also the burden of having somebody hospitalized or
14 in a long-term care facility not at home that you need to
15 travel to or whatever. So I know that's complex to
16 measure.
17 I wanted to pile on the comments about the
18 community initiative that initiated Gina's comments on the
19 providers and Stacie's on the diagnoses. I would add also
20 to what Scott had said about the different community
21 initiatives. I think about the post-acute has different
22 nuances, too. For example, there's sort of an acute self-

1 limiting of a person, 35-year-old who's in a bad ski
2 accident. The PT comes in. They make sure that there
3 isn't environmental hazards, get them set up to be on their
4 own. And then there's a person with multiple chronic
5 conditions who you're really trying to provide some
6 capacity for them to remain at home. And I don't know how
7 you get at that analytically, but they're very different
8 populations. And, you know, over time, if that can be
9 disaggregated, it would be helpful.
10 As Scott mentioned, the workforce, I have to pile
11 on, on that. At least in the nursing world, the salaries
12 have been much lower, and it has been assumed that it is
13 less difficult work than, for example, working in a
14 hospital. And that is simply not true. If you are going
15 into somebody's home and you're really adapting to their
16 environment, it's very complex work.
17 So I really support going forward with this, and
18 I think it's a really important contribution. Thank you.
19 MS. KELLEY: Greg.
20 MR. POULSEN: Thanks. It was in stereo.
21 Yeah, I really like this report, and it added to
22 the great work that we saw in October of last year. I

1 think both were at a technically high level. Kudos. I
2 certainly have, as many others have said, a hugely high
3 regard for the value of home health and all that it can and
4 should do, both in fee-for-service and in MA. I thought
5 the results were useful and interesting.
6 I really wondered, going into this, whether we'd
7 see anything that was more surprising or concerning, and as
8 others have said, the variation was maybe a little both
9 less and more reassuring than I had anticipated that we
10 might see. Not huge variation between plan types, as Brian
11 mentioned. That's a pet area of mine. But also, between
12 MA and fee-for-service and the differences between groups
13 seemed to me to be both reasonable and explicable. So I
14 thought that was really useful.
15 And I do look forward to the June chapter, where
16 we synthesize some of the things that we've already done.
17 And like others, I can think of a dozen
18 interesting analyses that we could undertake going forward
19 from here, but recognizing that we don't have unlimited
20 resources, I think that the best use of our resources going
21 forward would be a broader, as opposed to a deeper look
22 into the post-acute care, which we've all agreed is the

1 wrong terminology. I mean, care that is outside of an
2 acute setting, whether it's pre-acute care or post-acute
3 care or avoidance of acute care, all of those things, I
4 think, are really, really interesting alternatives that can
5 yield higher quality at lower costs. So I think that it's
6 a broad look that might be of our greatest value at this
7 point.
8 Scott's point regarding the gray areas
9 surrounding the different technologies and capabilities and
10 services that are available to meet the needs of people in
11 need, I think, are really worthwhile. And I recognize that
12 trying to integrate that, we've done great work in each of
13 these areas, whether it's home health or rehab facilities
14 or nursing facilities, et cetera. And other capabilities,
15 trying to synthesize that, I recognize is far from a
16 trivial undertaking, but it seems to me that a look at that
17 in a broader as opposed to a more focused way would be the
18 greatest area of additional value for us going forward.
19 MS. KELLEY: Paul.
20 DR. CASALE: Thank you again for great reporting.
21 I'll be relatively brief.
22 I just want to add my support to what others have

1 said about continuing this work, and in particular, as
2 Tamara mentioned and Betty around alternative payment
3 models, we've already seen shifts, such as for lower
4 extremity joint replacement, shift from subacute rehab to
5 home.
6 But then more broadly, around ACOs, which is not
7 an insignificant amount of fee-for-service beneficiaries
8 are in ACOs -- and having led a large ACO for a number of
9 years, there's a lot of interesting data that we have seen.
10 And also, we have -- you'd be viewing it from a clinically
11 driven as opposed to a coverage approach to use of post-
12 acute services. So, again, just encourage the ongoing
13 evaluation.
14 MS. KELLEY: That's all I have for Round 2,
15 unless I've missed anyone.
16 DR. CHERNEW: That's actually all I had as well.
17 So, first, let me do a quick wrap-up and just say
18 where I am. I appreciate the discussion. I'll say a few
19 quick themes, but first, thank you to Betty, Andrew, and
20 Evan -- Andy and Evan for the work.
21 So here's where I am on this. It is challenging
22 to understand what to do with analyses where it's hard to

1 draw normative conclusions. It's just difficult to know
2 what to do. So I appreciate the interest in sort of moving
3 ahead and expanding and broadening, but if we end up doing
4 that without the ability to actually draw normative
5 conclusions, that just is a factor that has to be taken
6 into account when we think about the trade-offs of what to
7 do. So we will ponder that.
8 So one approach is to try and do some of the --
9 more outcomes, more understanding, which I agree. That's
10 sort of rigorously challenging in a bunch of ways, but I do
11 sort of empathize with that direction.
12 It's particularly challenging if you then take
13 another set of comments, which is, well, be more granular.
14 We recognize there's heterogeneity. So now you're trying
15 to draw more complicated analytic conclusions on a more
16 granular heterogeneous way. That's actually a big task.
17 So we will ponder all of that.
18 I think there's another area, which is not
19 actually this area, but is actually particularly
20 interesting to me, which I do think there'll be some trade-
21 off on -- and, again, I'm not drawing any conclusions about
22 what we will do; I'm just letting you and the folks at home

1 know -- is the impact of MA on the finances of the
2 provider. So a lot of this is about beneficiary and care,
3 and that matters. I really don't want to imply that it
4 doesn't. In fact, I think all of your comments
5 consistently said it did. But I think there's also an
6 important question about what is going on in terms of
7 providers as MA grows, which is a slightly different take.
8 So I'm not sure where we will go or what we will
9 do. I think this will show up in our chapter. I really
10 appreciate the work. I appreciate the enthusiasm around
11 the table for this, and I think the information was quite
12 useful.
13 So I really think, to Tamara's point, if we end
14 up showing that the encounter-only people are really
15 important, if that ends up being true, that actually has
16 really broad consequences for how we think about just
17 general analysis of what's going on outside of what MedPAC
18 does, and I think that matters. So we will check into some
19 of those things, and we'll take all of these comments under
20 advisement and move on.
21 But for now, apart from all the thanks, let's
22 take a five-minute break. We'll come back a little bit

1 before 10:20. Please be on time because we want to end on
2 time.
3 But to the staff, thanks tons, and to folks at
4 home, we're going to come back after about a five-minute
5 break.
6 [Recess.]
7 DR. CHERNEW: Hello, everybody, and welcome back.
8 We are going to do our last session of our March meeting,
9 and it's going to focus on a related topic, I-SNPs, which
10 is fitting into our broader work on beneficiaries that are
11 residing in institutions. So without further ado we are
12 going to turn it over to Eric.
13 MR. ROLLINS: Thanks Mike. Good morning. For
14 our last presentation we're going to take a look at
15 institutional special needs plans, or I-SNPs. I'd like to
16 remind the audience that they can download these slides in
17 the handout section on the right-hand side of the screen.
18 In response to Commissioner interest, we have
19 been taking a look this year at beneficiaries living in
20 nursing homes. In October, we provided background on long-
21 stay residents, described the nursing home industry, and
22 reviewed longstanding concerns about the care these

1 beneficiaries receive. Today we'll look at Medicare's
2 experience with private health plans that serve long-stay
3 residents, since those plans could potentially be a more
4 effective way to deliver care than traditional Medicare.
5 We'll primarily focus on one specific type of plan, the I-
6 SNP, but also review the experience with other types of
7 plans.
8 I-SNPs are specialized MA plans that target
9 beneficiaries who either live in a nursing home or live in
10 the community but need a nursing home level of care. Most
11 of their enrollees, about 85 percent, live in nursing
12 homes. I-SNPs provide Medicare-covered services only; they
13 don't provide any Medicaid benefits such as custodial
14 nursing home care.
15 Aside from the limits on who can enroll, I-SNPs
16 are largely subject to the same rules and requirements as
17 other MA plans. For example, they are paid using the same
18 payment system and must meet similar network adequacy
19 standards. The I-SNP market is relatively small and has
20 about 125,000 enrollees, including those living in the
21 community. I-SNPs cover about 12 percent of long-stay
22 nursing home residents.

1 The I-SNP model is based on the premise that
2 plans can improve the quality of care for long-stay
3 residents by delivering more care in the nursing home and
4 reducing the use of services such as inpatient care and ED
5 visits. Our interviews with stakeholders suggest that I-
6 SNPs largely use the same basic approach to try to meet
7 this goal. This approach relies on nurse practitioners to
8 deliver more care within the nursing home, with NPs
9 typically visiting the facility 2 or 3 times per week.
10 Since NPs are more cost-effective when they can see a large
11 number of enrollees, plans aim to generate sufficient
12 enrollment in their participating nursing homes.
13 I-SNPs also pay for care in ways that give
14 nursing homes incentives to provide more care onsite
15 instead of sending residents to the hospital. We'll talk
16 more about this later. Finally, I-SNPs seek to minimize
17 any revenue losses for nursing homes stemming from their
18 efforts to reduce the use of inpatient care.
19 This scatterplot shows the insurers that offered
20 I-SNPs in 2024. Each dot is a different company. The
21 horizontal axis shows the company's I-SNP enrollment, while
22 the vertical axis shows its I-SNP enrollment as a share of

1 its overall MA enrollment. These insurers can be divided
2 into 3 major groups. The first is UnitedHealth. As shown
3 in the lower right, its enrollment is so much larger than
4 other insurers that we couldn't fit it into this graphic,
5 but I-SNPs are still a small share of its overall MA
6 business.
7 The second group are provider-sponsored plans,
8 which for I-SNPs means the nursing homes in the plan's
9 provider network have an ownership stake in the plan.
10 These insurers are largely in the red box at the top. They
11 have relatively few enrollees and the I-SNP is often their
12 only MA line of business. A few provider-sponsored plans,
13 shown in the blue box, have more enrollment in other MA
14 plans and are less reliant on I-SNPs. The third group, in
15 the green box at the bottom, are traditional health
16 insurers like Humana and CVS. Their I-SNPs have low
17 enrollment and represent a very small share of their
18 overall MA enrollment.
19 The number of companies that offer I-SNPs more
20 than doubled between 2015 and 2021, largely due to the
21 entry of new provider-sponsored plans, and the enrollment
22 and market share for those plans climbed rapidly. However,

1 the number of new entrants has fallen in the last few years
2 and the number of companies that offer I-SNPs has declined.
3 Total enrollment in provider-sponsored plans has
4 continued to grow, albeit at a somewhat slower rate, and
5 the market shares for I-SNPs have stabilized at around 55
6 percent for UnitedHealth, 35 percent for provider-sponsored
7 plans, and 10 percent for other insurer-sponsored plans.
8 Several interviewees said the entry of new provider-
9 sponsored plans had temporarily declined due to the
10 pandemic and that they expected more provider-sponsored
11 plans to enter the market in the future.
12 Nursing homes play a key role in determining
13 whether long-stay residents have access to I-SNPs because
14 residents cannot enroll in an I-SNP unless they live in a
15 facility that participates in the plan's provider network.
16 In 2023, we estimate that 26 percent of nursing homes
17 participated in an I-SNP and that 33 percent of long-stay
18 residents lived in those facilities. Both of those figures
19 have grown steadily in recent years.
20 Nearly all nursing homes that participate work
21 with a single insurer, which means that long-stay residents
22 who have access to an I-SNP typically have one plan

1 available and aren't choosing among different insurers.
2 Our interviewees said nursing home participation in I-SNPs
3 is often tied to concerns about broader developments that
4 are considered unfavorable for nursing homes, such as the
5 shift to value-based payment, where nursing homes feel they
6 have limited ability to earn shared savings, and MA
7 penetration, where plans pay less for skilled care and
8 approve fewer days of care. Given these concerns, some
9 nursing homes see I-SNPs as a way to generate additional
10 revenue and gain more control over their reimbursement.
11 Some types of nursing homes are more likely to
12 participate in an I-SNP than others. Larger facilities are
13 more likely to participate. In 2023, about 15 percent of
14 facilities with 50 or fewer long-stay residents
15 participated, compared to over 60 percent of facilities
16 with more than 150 residents.
17 Insurers may be less interested in smaller
18 nursing homes because it is harder to generate enough
19 enrollment to operate in a cost-effective manner. In terms
20 of ownership, for-profit facilities were more likely to
21 participate than nonprofits, but the difference in their
22 participation rates was relatively small, about 5

1 percentage points.
2 As for location, nursing homes in urban areas
3 were almost twice as likely to participate as those in
4 rural areas. Nursing homes in urban areas may be more
5 attractive to insurers because they tend to be larger and
6 the distances between them tend to be shorter, which may
7 make the use of NPs more cost-effective.
8 We asked interviewees to describe how I-SNPs
9 reimburse nursing homes for care. They said the most
10 common approach is a combination of capitated payments and
11 incentive payments.
12 The capitated payments are paid on a per member
13 per month basis and usually cover Part A skilled care and
14 Part B therapy services, the primary Medicare services that
15 nursing homes provide onsite. The capitation rate is based
16 on historical utilization but includes an allowance for
17 additional skilled care that facilities are expected to
18 provide instead of sending residents to the hospital, a
19 practice known as "skilling in place."
20 The incentive payments can take a variety of
21 forms but are often tied to performance on certain quality
22 metrics and/or spending metrics. The spending-based

1 incentives are often set up as "shared savings"
2 arrangements where facilities keep a portion of the savings
3 if overall spending for enrollees is lower than a target
4 amount.
5 Compared to fee-for-service Medicare, this
6 payment approach aims to remove the financial incentive
7 that nursing homes have to send residents to the hospital
8 so they can qualify for skilled care and to encourage
9 nursing homes to deliver more care onsite, where
10 appropriate.
11 The limited availability of I-SNPs means that
12 enrollment patterns for long-stay residents differ
13 depending on whether their nursing home participates in an
14 I-SNP. The left column shows the overall pattern for long-
15 stay residents, with 62 percent in fee-for-service and 38
16 percent -- that's the sum of all the other colored bars --
17 enrolled in private health plans, including 12 percent in
18 I-SNPs. The second column shows nursing homes without I-
19 SNPs; you can see that a higher share of these residents
20 were in fee-for-service.
21 The third and fourth columns show nursing homes
22 with I-SNPs, presented in two ways. The third column

1 estimates what enrollment would look like without I-SNPs;
2 by assigning I-SNP enrollees to the coverage they had
3 before joining the I-SNP. Without I-SNPs, we estimate
4 these facilities would have higher MA penetration than
5 facilities without I-SNPs (37 percent versus 28 percent).
6 As we noted earlier, concern about rising MA
7 enrollment is one factor that leads nursing homes to
8 participate in I-SNPs. The last column shows the actual
9 enrollment in these facilities, with 41 percent of
10 residents in fee-for-service, 36 percent in I-SNPs, and 23
11 percent in other plans. These figures suggest that I-SNPs
12 attract enrollment from both fee-for-service and other
13 plans. The share of residents who enroll in I-SNPs varies
14 widely across nursing homes, as discussed in your mailing
15 materials.
16 The residents of nursing homes that participate
17 in I-SNPs differ in some respects from residents of
18 facilities that do not participate. Residents of
19 participating nursing homes are more likely to be Black,
20 have Medicaid, and live in an urban area.
21 Within participating nursing homes, I-SNP
22 enrollees had longer lengths of stay, a median of 42 months

1 versus 20 months, and lower mortality rates, 20 percent
2 versus 25 percent, than residents who did not enroll.
3 These differences suggest that some long-stay residents are
4 more likely than others to enroll in I-SNPs. It is unclear
5 whether this selection is favorable or unfavorable for I-
6 SNPs in the sense that we use "favorable selection" to
7 describe how MA enrollees, on average, have lower spending
8 than their risk scores predict. More research would be
9 needed to understand the relationship between nursing home
10 length of stay, beneficiary risk scores, and MA payments.
11 We also examined the impact that I-SNPs have on
12 quality and outcomes using a subset of the HEDIS quality
13 measures that MA plans must report. One analysis looked at
14 three risk-adjusted measures of service use related to
15 hospitals: acute discharges, all-cause readmissions, and
16 ED visits. We identified MA enrollees who were long-stay
17 residents and stratified them based on whether they lived
18 in nursing homes that participated in an I-SNP. We found
19 that the nursing homes that participated in I-SNPs
20 performed better on all three measures.
21 These results should be treated with some caution
22 for several reasons. First, there could be unmeasured

1 differences between the two groups of nursing homes that
2 influence the differences we observed. Second, the risk-
3 adjustment models for these measures are calibrated on a
4 broader sample of MA enrollees and may not be as accurate
5 for long-stay residents. And third, the specifications for
6 these measures exclude a substantial amount of service use.
7 We performed a separate analysis using clinical
8 quality measures and found that I-SNPs had mixed
9 performance compared to conventional MA plans and dual-
10 eligible special needs plans.
11 We also reviewed the relatively limited research
12 literature on I-SNPs. Two older studies, one of which
13 looked at the demonstration that predated I-SNPs, found
14 that I-SNPs reduced inpatient use and shifted some care
15 into the nursing home setting.
16 A recent study by Chen and Grabowski compared
17 nursing homes with "mature" I-SNPs to nursing homes without
18 I-SNPs and used a difference-in-differences design to
19 estimate changes in hospitalizations and quality measures
20 once the I-SNPs reached maturity. The study found that
21 nursing homes with I-SNPs had hospitalization rates that
22 were 4 percentage points lower than nursing homes without

1 I-SNPs, and that those reductions occurred in the three
2 years after the I-SNP reached maturity. The impact of I-
3 SNPs on other quality measures was mixed, including no
4 change in mortality rates.
5 Overall, these studies are consistent in finding
6 that I-SNPs reduce the use of inpatient care but do not
7 appear to have a clear effect on other quality measures.
8 One caveat to keep in mind is that they may overstate the
9 impact of using I-SNPs on a broader scale because they
10 focus on a subset of nursing homes with relatively well-
11 developed I-SNPs.
12 Turning now to plan payments, we compared I-SNPs
13 to conventional plans and D-SNPs, the two other types of MA
14 plans that cover a significant number of long-stay
15 residents. This table shows the average benchmark, plan
16 bid, rebate, and payment amount for each type of plan. In
17 the MA payment system, plans submit bids that reflect their
18 estimate of the cost of providing the Part A and Part B
19 benefit package. Those bids are compared to benchmarks
20 that are based on local fee-for-service costs, and plans
21 that bid below the benchmark receive part of the difference
22 as a rebate that they use to finance extra benefits to

1 enrollees. The figures for I-SNPs are much higher in
2 dollar terms because they only serve beneficiaries who need
3 a nursing home level of care, a group that has high average
4 medical costs.
5 Relative to their benchmarks, I-SNPs have much
6 higher bids, on average, than both conventional plans and
7 D-SNPs, 91 percent versus 77 percent and 79 percent,
8 respectively. The higher bids could indicate that I-SNPs
9 have relatively higher costs or face less competitive
10 pressure than the other plan types, perhaps due to the
11 practice of nursing homes contracting with a single
12 insurer. The higher bids also mean that I-SNPs receive
13 relatively low rebates.
14 Stepping back a bit now, while I-SNPs have grown
15 over time, they still cover a small share of the long-stay
16 population, about 12 percent, and there are several factors
17 that may limit their ultimate reach. First, our
18 interviewees said some nursing homes aren't interested in
19 participating in an I-SNP because they don't want to give
20 up their fee-for-service revenue or don't want to accept
21 the financial risk.
22 Second, insurers may not be interested in

1 contracting with facilities where the I-SNP model of care
2 is unprofitable, such as smaller facilities where it is
3 more difficult to generate sufficient enrollment. Finally,
4 even when beneficiaries have access to an I-SNP, the share
5 who actually enroll has, in aggregate, consistently ranged
6 between 35 percent and 40 percent in recent years.
7 While this presentation has focused on I-SNPs,
8 Medicare has three other types of plans that, to varying
9 degrees, target beneficiaries who live in facilities or
10 need a nursing home level of care. The first two types of
11 plans are dual-eligible special needs plan, or D-SNPs, and
12 Medicare-Medicaid Plans, or MMPs. Both plans serve people
13 who have both Medicare and Medicaid.
14 D-SNPs are part of the MA program while MMPs are
15 part of a demonstration that ends later this year. The
16 level of integration between D-SNPs and Medicaid varies,
17 while MMPs have a high level of integration.
18 The third type of plan is the Program of All-
19 Inclusive Care for the Elderly or PACE, which serves
20 beneficiaries who are 55 or older and need the level of
21 care provided in a nursing home. PACE plans aim to keep
22 people living in the community instead of going into

1 nursing homes and provide all Medicare and Medicaid
2 services.
3 Since these plans all provide Medicaid services
4 or coordinate with Medicaid, they have the potential to
5 improve care for long-stay residents, who in most cases are
6 dually eligible. Some observers have criticized I-SNPs
7 because they only provide Medicare services, and argued
8 that I-SNPs have no incentive to look for ways to return
9 enrollees in nursing homes to the community. However,
10 long-stay residents are a very small share of the
11 enrollment in these other types of plans, and they may not
12 focus on long-stay residents to the same extent that I-SNPs
13 do.
14 Relatively little research has looked at the
15 impact of D-SNPs on long-stay residents or nursing home
16 admissions. One study of plans in Minnesota found that
17 enrollees were more likely to receive community-based forms
18 of long-term care but didn't have a lower likelihood of
19 nursing home admission, while a study of plans in
20 Massachusetts found that enrollees had lower rates of
21 nursing home use and lower mortality. Evaluations of MMPs
22 have examined whether they change the likelihood that

1 enrollees will have a long nursing home stay, but results
2 have been mixed. However, the strength of these findings
3 is limited because the participation rates in many MMP
4 demonstrations have been low.
5 As for PACE, studies have found that it reduces
6 inpatient use and there is some evidence that PACE
7 enrollees have lower mortality rates. The program also
8 appears to delay long nursing home stays but not ultimately
9 prevent them.
10 In terms of next steps, we will come back to you
11 in April with a companion presentation that looks at other
12 Medicare efforts, besides those that use private health
13 plans, to improve care for long-stay nursing home
14 residents. We will discuss such topics as nursing home
15 inspections, the star ratings for nursing homes, and
16 initiatives in traditional Medicare.
17 The material from all three of our presentations
18 on beneficiaries in nursing homes, the one from October,
19 today's presentation, and the one we'll give next month,
20 will lead to an informational chapter in our June 2025
21 report to Congress.
22 That brings us to the discussion. First, I'll be

1 happy to answer any questions about the material in this
2 presentation. Second, we'd like to know if there are
3 additional analyses related to I-SNPs that you think might
4 be worth pursuing. Finally, we'd like to know if there are
5 potential policies related to private health plans and
6 nursing home residents that you might be interested in
7 exploring in the future.
8 That concludes the presentation, and I'll now
9 turn it back to Mike.
10 DR. CHERNEW: Great. This is a really important
11 issue. It's part of a much broader agenda that we are
12 working through. So I think we should just jump into the
13 Round 1 questions, and I think Cheryl is first.
14 DR. DAMBERG: Eric and Carol, thanks for a great
15 chapter. Super interesting to read this, and I learned a
16 lot.
17 I have two questions. I was wondering if you
18 know how the patients enrolled in I-SNPs versus other types
19 of plans differ in term of their diagnoses.
20 MR. ROLLINS: That is not something that we
21 specifically looked at. That is probably something we
22 could try to look at.

1 DR. DAMBERG: Yeah, because I was trying to
2 figure out whether, are plans trying to recruit certain
3 types of patients that they think would be more suitable
4 for I-SNPs, and do they differ from other types of
5 patients. I just don't really know kind of what the mix of
6 patients are and whether that would vary. So I think that
7 would be something worth looking at.
8 And then the other thing I was wondering is, have
9 you looked at transitions out of I-SNPs, like how often
10 that happens and where do people tend to do once they
11 transition out. Do they go back into another MA plan? Do
12 they go to fee-for-service? I feel like there was an
13 article -- I don't know whether it was by the folks at
14 Brown -- that referenced this, but I think it would be
15 interesting to know that.
16 MR. ROLLINS: Okay. We can generate firmer
17 numbers. My anecdotal impression is once you go into an I-
18 SNP you largely stay enrolled in the I-SNP. Now, you could
19 disenroll at some point, for example, if your nursing home
20 decides it's no longer going to participate in the I-SNP.
21 Then you will have to get a different form of coverage.
22 But I think that's somewhat different than what you're

1 talking about.

2 MS. KELLEY: Gina.

3 MS. UPCHURCH: Thank you.

4 I thought that -- really enjoyed the chapter. I

5 also learned a lot, and it reads really well. So thank you

6 so much.

7 So people that live in institutions can make

8 monthly choices about their coverage. So I was a little

9 concerned about coercion. So, say, a skilled nursing

10 facility has an institutional special needs plan, you know,

11 and you've got a lot of people that live in institutions

12 that may not be as cognitively with it, so how -- you know,

13 how are they making those decisions? So if you could talk

14 a little bit about that.

15 And my other concern -- I know there's a smaller

16 rebate, but I think you said somewhere in the chapter that

17 often it goes to help with medication. So one of my

18 concerns was, are the medications often covered well with

19 the I-SNPs?

20 MR. ROLLINS: In terms of the enrollment process,

21 as you noted, they can switch plans on a month-to-month

22 basis. For the I-SNP, the rules are supposed to be that

1 basically if you are in a nursing home that participates in
2 a provider-sponsored I-SNP, the nursing home staff can
3 leave out information about the I-SNP that they work with,
4 but they're not supposed to have a direct sales meeting or
5 anything like that with you to the extent a resident is
6 enrolled.
7 Our interviewees would say things like, you know,
8 during a teen clinical meeting to discuss a resident's
9 care, someone might mention, oh, this person expressed some
10 interest in the I-SNP. At that point, they would forward
11 their name on to sort of kind of the -- for lack of a
12 better term, kind of the plan side to then schedule an
13 appointment with the sales agent to meet with them.
14 MS. UPCHURCH: Okay. Just a little concerning.
15 So I think one of the things that you mentioned
16 here and that I've come to learn is that having the nurse
17 practitioner come regularly is a huge advantage with the I-
18 SNP that's not available with other plans, and it would be
19 a lure to a lot of people wanting to stay well in that
20 facility or in the community-based setting that would
21 otherwise be eligible for institution. How is the nurse
22 practitioner that's not employed by the nursing home viewed

1 coming in there? You're coming into our skilled nursing
2 facility. You're not an employee here. You're ordering
3 things. Did you get any perception of that?
4 MR. ROLLINS: We did. And I think there's a lot
5 of -- there's a lot of concern about the nature and the
6 quality of that relationship. Both sides emphasize that
7 you need a good relationship between the plans, NP, and the
8 clinical staff for the nursing home. And so when it works
9 well, everything goes more smoothly.
10 MS. UPCHURCH: Okay.
11 MR. ROLLINS: But there's going to be variation
12 in the quality of the nurse practitioners.
13 MS. UPCHURCH: Yes.
14 MR. ROLLINS: There's going to be variation in
15 the quality of the nursing home clinical staff.
16 MS. UPCHURCH: Right.
17 MR. ROLLINS: For example, we talked to one
18 nursing home where the concern had been that the plan kept
19 changing the nurse practitioner that was assigned to the
20 nursing home. And so, there was some instability there,
21 and it was hard to sort of generate that kind of
22 relationship.

1 MS. UPCHURCH: And last question related. So for
2 the people who are still in the community but would be
3 eligible for institutional care -- and by the way, I helped
4 somebody in a hospital recently that should have gone to
5 institution but needed a liver transplant, but because they
6 would have likely been in an institution, we used a special
7 enrollment period to get them a drug plan so they could
8 have a liver transplant. It's very confusing, but having
9 this special enrollment period for people who are in
10 institutions or could potentially be in institutions is a
11 huge real benefit to some people.
12 But is the nurse practitioner going into
13 community home -- going into homes in instances where the
14 people are community-based?
15 MR. ROLLINS: So this is -- you know, the I-SNP
16 enrollees who live in the community is like a niche part of
17 a niche market.
18 MS. UPCHURCH: Right.
19 MR. ROLLINS: So we only talked to sort of one
20 interview that sort of was with a plan that focused on this
21 model.
22 To some extent, they will try and focus on sort

1 of assisted living facilities, settings like that where
2 they can hopefully generate a certain density of
3 enrollment.
4 MS. UPCHURCH: Economies of scale, yeah.
5 MR. ROLLINS: One challenge there is the assisted
6 living facility, by and large, doesn't have the clinical
7 staff that like a nursing home does. But there will also
8 be cases where they will do like small group homes or
9 individual homes.
10 So it is a more -- our impression is it's a more
11 spread out model. Probably, the visits from the nurse
12 practitioner are less frequent than you would see in the
13 nursing home setting that we described in the paper.
14 And another barrier that sort of was identified
15 is the requirement is if you're going to -- if you live in
16 a community and you want to enroll in the I-SNP, you have
17 to need a nursing home level of care, and so you have to go
18 through the determination process to get that sort of -- to
19 meet that requirement. And I think the one company we
20 spoke with said that can often take more than 30 days. So
21 that is something of a barrier. And to some extent, they
22 tried to focus on people who are already in like a Medicaid

1 home- and community-based waiver program. They already
2 know that requirement has been met.
3 MS. UPCHURCH: Right, right. Good. Okay.
4 Thank you so much.
5 MS. KELLEY: Tamara?
6 DR. KONETZKA: Thanks for this great work. I'll
7 preface this by saying I'm really excited by this model. I
8 was excited by EverCare when it came out, you know, almost
9 30 years ago.
10 I have a bunch of questions that are kind of on
11 the cusp of Round 1 and Round 2. So I'm somewhat
12 arbitrarily dividing them.
13 So the first question is -- one thing I had no
14 idea about until I read the chapter and learned that how
15 much UnitedHealthcare dominates this -- do you have any
16 insights as to why they've been able to maintain this model
17 and do it successfully for so long, where it seems like,
18 you know, enrollment in other companies is not that high
19 or, you know, whatever, it's a much smaller market share?
20 MR. ROLLINS: Yeah. I don't have a great answer
21 for that.
22 EverCare was the company that was the progenitor

1 of the original EverCare demonstration United -- since
2 acquired them. It has simply been a business line that
3 they have kept and nurtured.
4 I think for some of the other larger insurers --
5 and I think we kind of note this in the paper -- it's a
6 hard market to work into. It's sort of nursing home by
7 nursing home, and then within each nursing home, it's, you
8 know, finding enough enrollment.
9 I think some other companies may decide that
10 relative to the other types of MA products they offer, an
11 I-SNP is just not something they really want to prioritize.
12 DR. KONETZKA: Yeah.
13 MR. ROLLINS: So, for example, if you're a
14 company that really focuses heavily on D-SNPs, given the
15 potential overlap between those two product lines, you
16 might decide, you know, I'm going to focus on the D-SNP
17 over the I-SNP.
18 DR. KONETZKA: Yeah. It would just be
19 interesting to keep thinking about whether there's -- you
20 know, why do they look at those same nursing homes and make
21 a different decision being UnitedHealthcare?
22 The other question is related to what you just

1 said about the D-SNPs. You know, I think of the D-SNPs as
2 really focusing on people in the community, as you also say
3 in the chapter, and trying to keep people out of nursing
4 homes. And this I-SNP model is really focused on people in
5 nursing homes already.
6 For people who are in D-SNPs and end up in an
7 institution, do we know anything? I know these are niche,
8 as you said, small parts of niche markets, but is there any
9 benefit to being in a D-SNP in the institution versus in an
10 I-SNP or vice versa? Like, has anybody looked at comparing
11 those outcomes?
12 MR. ROLLINS: In terms of outcomes, I mean, we
13 talked a little bit about D-SNPs versus I-SNPs for some of
14 the HEDIS quality measures, where I think in a lot of
15 cases, there weren't large differences between them.
16 In terms of the appeal for beneficiaries, as you
17 know, the D-SNP is going to offer a different package of
18 extra benefits in a lot of cases, tailored more towards a
19 sort of community population. Whether or not some
20 residents see particular things about a D-SNP package that
21 appeal to them versus an I-SNP model, I think is kind of,
22 you know, beyond what we know.

1 DR. KONETZKA: Okay. Yeah, it just seems to me
2 there might be advantages for D-SNP people who end up in
3 institutions that, like the I-SNP, it might be a natural
4 transition, right? It might actually be better once
5 they're in the institution, since the D-SNPs are so focused
6 on community.
7 Okay.
8 MR. ROLLINS: And we do see switching. So, I
9 mean, you see in the before and after of what the
10 enrollment pattern looks like for nursing homes that have
11 I-SNPs.
12 DR. KONETZKA: Right.
13 MR. ROLLINS: There are some people who were in
14 the D-SNP who do switch it to I-SNP.
15 DR. KONETZKA: Right. Okay. Thanks. I'll save
16 the rest for Round 2.
17 MS. KELLEY: Brian.
18 DR. MILLER: I really wanted to thank you for
19 this work. The frail long-term care beneficiaries and
20 their families, I'm sure, are glad that we are focusing on
21 this.
22 I remember three or four years ago, a Senate

1 office asked me about this population and what to do, and I
2 stared blankly at them and blinked. And I was silent
3 because I didn't have an answer. This is not just an
4 answer; this is actually a very good answer. So I
5 appreciate us diving into this.
6 A couple questions. Do we know what percentage
7 of care is provided on-site at long-term care facilities
8 for I-SNPs?
9 MR. ROLLINS: No, we don't know that.
10 DR. MILLER: So I went digging through the
11 Federal Register, which is a fun weekend hobby.
12 MR. ROLLINS: It's lots of fun.
13 DR. MILLER: Yeah, it's a fun weekend hobby. My
14 wife is going to address that with me at some point.
15 I found a comment letter from the American Health
16 Care Association, which noted for that 85 percent of -- it
17 was a 2022 comment letter -- that 85 percent of care is
18 provided on-site. So we might want to dig that out and
19 take a look.
20 And I know that beneficiary groups and consumer
21 advocates often have questions about managed care. It
22 sounds like you talked with I-SNPs and skilled nursing

1 facility operators. Did you talk with any of the consumer
2 advocate or beneficiary groups in preparing this?
3 MR. ROLLINS: No, we did not, but we could try
4 that. I think it would be somewhat challenging. Gina
5 might chime in here. I think it is such a niche market
6 that they may just not have a lot of interaction with I-
7 SNPs and nursing homes.
8 DR. MILLER: Or perhaps talking with some of the
9 beneficiaries and their families, because knowing some
10 folks and also having heard from those groups historically
11 years ago when I started to dig into this space, they often
12 have very specific operational questions that I think could
13 probably add to our conversation.
14 And then I noted in the introduction that we
15 denoted that positive I-SNP findings may not be
16 generalizable. I don't think that we have enough evidence
17 to say that they're generalizable or not, because the
18 preponderance of factors and studies that we have doesn't
19 suggest whether that's true or false. So I think that that
20 is an opinion that we should eliminate from the text.
21 Thank you.
22 MS. KELLEY: Betty.

1 DR. RAMBUR: Thank you very much. I'm very
2 excited about this chapter, and I'll have more to say in
3 the next round, including to some of Gina's questions.
4 I have one question. My understanding is that
5 CMS currently requires physicians to alternate regulatory
6 visits to advanced practice registered nurses, of which
7 nurse practitioners are the ones we'd be talking about
8 here, to long-term care facilities. Is that true in this
9 group as well, or are they somehow carved out from that?
10 And if you don't know, I would just be curious down the
11 line. I know it borders on Round 2, but I think it's a
12 necessary regulatory barrier. But I'd be curious.
13 MR. ROLLINS: Not off the top of our heads.
14 DR. RAMBUR: Okay. Thanks.
15 MS. KELLEY: That's all I have for Round 1, Mike,
16 unless I've missed anyone.
17 DR. CHERNEW: Yeah. And I think Scott is first
18 in Round 2.
19 MS. KELLEY: Yes.
20 DR. SARRAN: Yeah, thanks. Again, I'm very
21 excited about this work, and kudos, Eric and Carol, for
22 going up your learning curve so quickly. I mean, you guys

1 have become experts in a short amount of time, and that's
2 greatly appreciated.
3 I particularly appreciate that we've sort of
4 taken three big bites of the elephant here, right? First,
5 last October, describing the population, now describing I-
6 SNPs, and then a presentation next month, because it's a
7 big elephant, right? And so appreciate all the time and
8 attention.
9 Here's how I frame the big picture of the
10 combined bodies of work that you've been digging into. I'm
11 going to list them and then very quickly try to tease each
12 of them out.
13 The first is I think we have an imperative to
14 better serve the population and taxpayers.
15 Second is, by and large -- and this is a little
16 preface I think on next month -- I think in general we
17 continue to do the same things and expect different
18 results, and that's, of course, the definition of insanity.
19 Third is that, as you pointed out, there's at
20 least some sort of teaser results about I-SNPs perhaps
21 being a vehicle for generating some needed improvements,
22 and I'll flesh that out a little bit.

1 And then fourth is that I think in the category
2 of continuing to do the same things but expect different
3 results, we're not really seeing the volumes in I-SNPs that
4 will allow us to draw adequate conclusions, and so that
5 tees up some potential different actions.
6 All right. So the imperative -- and we've
7 discussed this before. I'll be very brief. This is among
8 the most frail segment of beneficiaries, and they also have
9 low-health literacy and very little ability to effectively
10 navigate the health system. Everyone acknowledges that.
11 So we really owe this population of beneficiaries that are
12 better than they're getting. There are longstanding and
13 widespread quality issues that's been discussed.
14 Second point around continuing to do the same
15 thing and expect different results. For many, many years
16 now, nursing facilities have been the recipient of well-
17 intentioned but unfunded mandates. It's a classic example
18 of that. They get more and more regulations imposed on
19 them, and most of the regulatory engagement with nursing
20 facilities has been in the punitive realm, and again,
21 unfunded mandates, punitive regulation, and it's not
22 helpful.

1 There have been small -- and I know this is a
2 preface of April or something. There have been a lot of
3 maybe small- to medium-sized quality collaborative kind of
4 efforts, and those have achieved small and impermanent
5 results.
6 MA, community-based MA, D-SNPs, as we teed up,
7 they're generally not meaningful players in this space
8 because they recognize, reasonably so, that it's a very
9 specialized space. It's small compared to their achievable
10 populations in the community, and so they reasonably look
11 at this segment of beneficiaries as being not worth their
12 attention and maybe prudently so from a management of their
13 bottom line, because it's a risky population if you don't
14 go into it with a real focus.
15 Next point, in terms of I-SNPs being potentially
16 a solution that deserves further exploration. First,
17 overwhelming logic on that. What's -- I've always said
18 what's been missing in all the efforts to improve care for
19 this population previously has been we don't have the right
20 party to hold accountable, and the beauty of I-SNPs is it
21 gives CMS the ability to hold one entity accountable,
22 right? And that's, of course, the I-SNP.

1 It also is the I-SNPs have the upside, if you
2 will, or the opportunity, but to do well when held
3 accountable for what we want as taxpayers and regulators,
4 because the incentives are all nearly perfectly aligned,
5 meaning that essentially the business plan for an I-SNP,
6 the integration of the clinical and financial aspects of
7 that, is to take the high amount of revenue that you get --
8 and you pointed out the risk scores are quite high without
9 any inappropriate coding. The risk scores are quite high.
10 Therefore, the revenue is quite high, and the substantial
11 spend is in fee-for-services on largely avoidable ED and
12 hospitalizations. So that, in and of itself -- that so
13 tightly aligns the incentives between the financial side
14 and the clinical side of the house. So there's a lot of
15 logic in why I-SNPs can, when held accountable, deliver
16 what we want, again, as both regulators and policymakers
17 and taxpayers.
18 The point -- and you made it -- about the
19 penetration of I-SNPs growing slowly, it's a very
20 meaningful one, both within facility and across facilities,
21 within facility, because it's well known in the I-SNP space
22 that unless you achieve a critical mass within a particular

1 facility, you will not be able to sufficiently change both
2 the culture and the processes of care to get the results
3 you need. And there's a general rule of thumb that until
4 you get to the least 30 to 40-ish percent penetration of
5 achievable residents in a facility being enrolled and
6 whether that's in one I-SNP or among three different I-
7 SNPs, perhaps, it's really the total population and a high
8 percent of that -- or a significant percent of that needs
9 to be enrolled in order, again, to change the culture and
10 the care processes, and those are what need to be changed.
11 Side comment on workforce is that, as we all
12 know, this is a setting where there are a lot of workforce
13 challenges, and I-SNPs can help address that. And the most
14 successful I-SNPs do help address that by augmenting and
15 collaborating with and integrating with facility staff, and
16 you mentioned some of that, so thanks.
17 And in terms of I-SNP penetration nationally, I
18 think seeing that the growth is slow also doesn't give us
19 the ability, again, as policymakers, regulators, taxpayers,
20 to really make a solid judgment yet, right? Part of where
21 I think you've gone in this is saying, well, you know, the
22 data kind of looks okay, maybe a little positive, but

1 there's not enough data. Well, we're not going to get
2 enough data without bigger sample size, et cetera.
3 So it behooves us, then, to understand why the
4 growth is so slow when actually the incentives are aligned,
5 you know, the dollars are there, I-SNPs can deliver on both
6 their financial return or sustainable financial return as
7 well as quality, and that's probably worth continuing to
8 tease out, right? And it's well known in the I-SNP
9 community that there are challenges related to current
10 regulations around sales and marketing.
11 And the last point I make, where a lot of this
12 comes together at the integration of quality and cost, is
13 that the quality program writ large -- not just stars, but
14 how CMS looks at the requirements around model of care
15 submission -- is really not sufficient for either us
16 regulators and policymakers, on one hand, or for I-SNP
17 operators, on the other hand.
18 You mentioned -- and kudos for mentioning it --
19 that there's a lot -- the overlap between the current stars
20 measures and other quality measures that are appropriate
21 for community-based beneficiaries, there's just not much
22 overlap between those and what are really appropriate

1 quality and outcome measures for beneficiaries living in
2 facilities.
3 And so one of the things that has to happen, I
4 think, at a policy level is there has to be a specific
5 quality and stars measure set for these beneficiaries.
6 And fortunately, there are a lot of thought leaders who --
7 American Geriatric Society, et cetera -- who can, you know,
8 with a lot of credibility and knowledge, opine on that.
9 So, again, thanks for the work. I really
10 appreciate how we're starting to go down a road where I
11 think we can get some better information about I-SNPs and
12 ideally see where those potentially could impact us in a
13 greater way. Thanks.
14 MS. KELLEY: Stacie.
15 DR. DUSETZINA: I just wanted to align myself
16 after such a great set of comments from Scott. And mine is
17 going to be fairly simple, but really a request for a
18 little bit more information in the chapter around the
19 economics of this and also what Medicare tends to cover in
20 nursing home care. I found myself, throughout the whole
21 reading, struggling with what Medicare actually pays for
22 and covers here. So I kept going back to who can get in

1 this, and when, and how, and even trying to go through some
2 of the documentation through CMS, like who's eligible for
3 an I-SNP. It was really murky.
4 So I think even if it's a callout box that just
5 walks through what's typically covered. You do a good job
6 of explaining this as a very small subset of the population
7 who actually is in these plans, but I think giving a little
8 bit more broader context to the economics around what is
9 covered and how this fits into that puzzle would be super
10 helpful.
11 MS. KELLEY: Tamara.
12 DR. KONETZKA: Great. I'll try to focus on
13 things that haven't been raised already. I agree with
14 Stacie and Scott in their comments so far.
15 As I said, I'm pretty excited about this model,
16 and Scott alluded to this a little bit, as well. After all
17 of these decades of thinking about this cycle of nursing
18 homes being incentivized to not deal with problems in the
19 nursing home and hospitalize people instead, and then bring
20 them back for the higher post-acute care rate before they
21 go back to their sort of Medicaid long stay, as you explain
22 in the materials, as well, there's just been so few times

1 that we've come up with a plan that seems to actually
2 address those incentives.
3 This is why I'm very excited about this model and
4 why, since the EverCare demonstration so long ago, I just
5 keep wondering why I feel the same way about PACE, for a
6 different population. But I keep wondering why it hasn't
7 proliferated more and what we can do to make this model
8 more population.
9 So all of the questions that were just raised
10 about why certain things are happening or what the
11 economics of it are that might be preventing greater
12 proliferation I think are really important.
13 There are a couple of areas I'm interested in
14 digging into more in our current data. And Gina raised
15 this in some of her questions, but I think the interactions
16 with existing staff to me are really important. And part
17 of that is, in Figure 4 when you look at the types of
18 facilities that do have I-SNPs, versus don't have I-SNPs,
19 and you see that for-profit, larger facilities tend to have
20 I-SNPs, I'd be really interested to see there the staffing
21 ratios, breaking that down by staffing ratios, or even the
22 staffing star rating for the nursing home, and the overall

1 quality level of the nursing home.

2 Because one can imagine what might be happening

3 is that sort of lower-quality places that are lower staffed

4 to begin with are sort of more likely to welcome this nurse

5 practitioner in, because that sort of relieves their

6 existing staff of taking care of some of the issues of

7 those patients. And that may be a good or bad thing, but I

8 think these issues sort of quantitatively around which

9 facilities and their existing staffing engage in I-SNPs

10 would be important to know.

11 And then qualitatively, you mentioned this in

12 response to Gina, but, yeah, I'd love to know more, if we

13 can know more through future focus groups or surveys or

14 something, about how those interactions play out with

15 existing staff. Do people think they're helpful? Is it

16 antagonistic? Is that a big factor in how successful these

17 models are?

18 And then I guess the other thing I'd love to see

19 in Figure 4 is broken down by percent Medicaid and payer

20 mix. You do, later in the chapter I think, compare

21 residents in and out of the I-SNPs and facilities that have

22 I-SNPs and not by the percent Medicaid, but it would be

1 nice to see that in that same sort of comparison, for
2 similar reasons as the staffing statistics.
3 And then finally, and this may be a little bit
4 down the line, and it's related to these staffing issues as
5 well, but I'd love to hear about spillovers, just in
6 general. Like having an I-SNP in the facility, how does
7 that affect their overall staffing. After they sign onto
8 the I-SNP do they actually lower their staffing or
9 whatever, and how does it affect the residents who are not
10 in the I-SNP. Are there tradeoffs, or do they actually see
11 some benefit from having this model in the facility too?
12 I could probably list 100 more things that I
13 would love to see, but I will stop there. Thank you. And
14 I love this work, so thank you for engaging in it and for
15 all the detailed knowledge you put into it.
16 MS. KELLEY: Brian.
17 DR. MILLER: So I'm going to structure my
18 comments into categories. I was organizing it as I was
19 coming up with more thoughts.
20 First, administrative thoughts. I think that
21 collectively on highly specialized issues like this we'd
22 benefit from feedback, from either consumer advocates,

1 people who are in nursing homes, or people who run I-SNPs,
2 or even CMS staff who regulate I-SNPs. While we don't
3 follow the Robert's Rules of Order. I'd actually move that
4 we restore the 10- to 15-minute open comment period that
5 used to exist at the end of every MedPAC session, to allow
6 people in person to participate. Because getting a comment
7 letter a month or two later, while it is helpful, it is not
8 the same.
9 I also wish that we had more business operators
10 in the room with us. Again, I might not necessarily agree
11 with them, but I think we'd benefit from their experience.
12 And then I noted that we had the risk-coding
13 discussion on page 38, and I'd note that our MedPAC model
14 is based fundamentally on the AAPPC model, which only
15 predicts 1 percent of spending, and CMS doesn't use it.
16 So comments on I-SNPs, in particular, I think
17 that we should have user perspectives in here, and that
18 might be a good way to frame it. What do I mean by user
19 perspectives? One is the beneficiary, obviously, on-site
20 care, nurse practitioners, coordination, integration, the
21 skilled nursing facility perspective. The skilled nursing
22 facilities understandably like fee-for-service Medicare.

1 They generally don't like Medicare Advantage, for pretty
2 clear reasons. And so I-SNPs are a middle-of-the-road
3 alternative for them between fee-for-service, which is
4 shrinking, and general MA plans, which are growing.
5 And then plans have varying perspectives. As you
6 can imagine, some plans are not interested in this space.
7 Other plans see this as a growth opportunity. And then, of
8 course, the perspective of taxpayers and regulators.
9 So I think including that framing will help us a
10 lot.
11 In terms of market structure for I-SNPs, I feel
12 like we're a bit schizophrenic as a commission. When we
13 look at a market and if we think there are large companies,
14 we get concerned about concentration. Then, if we see lots
15 of small companies, we get concerned about cherry-picking
16 or favorable selection. I don't think we can have it both
17 ways.
18 I think that a healthy, competitive market is
19 something that we should want. As for cherry-picking and
20 favorable selection, as a physician I don't know who the
21 healthy, long-term care beneficiary is, and I would welcome
22 someone to point that out to me, who it is.

1 One more thought on market structure. On page
2 40, we denote that many plans are small, with 20 percent of
3 contracts having less than 1,000 enrollees, and 70 percent
4 of contracts have 1,000 to 2,000 enrollees. This sounds
5 small when you think about a general Medicare Advantage
6 plan with 50,000, or several hundred thousand enrollees.
7 This is a small, highly customized, highly structured
8 marketplace, so I don't actually find that concerning. I
9 find it reassuring that the plans are focusing on small
10 markets, constructed nursing home by nursing home.
11 I'd also note that provider-sponsored plans are
12 even smaller, and if I recall correctly from my notes, it
13 was 63 percent of plans without star ratings because
14 they're newer, small, or provider-sponsored plans. We
15 actually want payer-provider integration in this space,
16 because that's what's going to actually help drive changes
17 in care delivery. And from a marketplace structure
18 perspective, lots of competition is a good thing.
19 I think one thing we also need to remember is
20 that long-term care is a distinct clinical need in a
21 distinct population, and I know my fellow colleague, Scott
22 Sarran, has mentioned this. There seems to be a

1 fundamental misunderstanding of what an I-SNP is. Everyone
2 is thinking about it as a financing model. An I-SNP is
3 actually an integrated clinical model, but it's facilitated
4 by the risk-adjusted capitation of Medicare Advantage.
5 The car guys -- I think of everything in terms of
6 cars, for better or worse -- this is like buying a Jeep if
7 you want to go off-roading. General MA is like taking a
8 Honda Accord up on a mountain road with giant boulders --
9 not a good idea. So it has a specific purpose.
10 When we look at the data presented, and we talked
11 about other alternative plans that beneficiaries who are in
12 long-term care can enroll in -- D-SNPs, MMPs, and PACE --
13 those aren't built for the long-term care nursing home
14 population. Yes, I realize that PACE is for benes who need
15 long-term care that are community-based, but there are many
16 beneficiaries who simply cannot reside in the community.
17 Everyone wants to live in the community when we all get old
18 and we have medical problems and have increasing debility.
19 We'd really like to live in the community, and I want to
20 live in the community, but I also realize that at some
21 point in my life that might not be possible.
22 If I have difficulty putting on my blazer, if I

1 can't toilet myself, if I can't feed myself, if I have a
2 pillbox with 10, 15 medications in it, I see four or five
3 doctors, I can't walk up stairs, I can barely walk across
4 the room, it becomes harder.

5 And the staff actually referenced this. There
6 was a 2015 Ghosh study which noted that many patients can't
7 live in the community in the long term, and that PACE seems
8 to delay but not ultimately prevent long-term nursing home
9 stays. So this is a population that is going to end up in
10 the nursing home, so having a different care model
11 facilitated by financing I think is really important.

12 Other folks mentioned concerns about decisions
13 and who is making decisions. I agree, this is an extremely
14 vulnerable population, many of whom have significant
15 cognitive impairments, and that's why they have either a
16 family member or a court-appointed legal guardian who is
17 helping them make decisions.

18 There was another question about why these plans
19 aren't growing, if they're so great, because that's the
20 natural question we all think about. And I would say part
21 of this is again the specialization issue. The special
22 needs plans, whether you're a D-SNP, an I-SNP, or a C-SNP,

1 are, by definition, special. Not a snarky comment. They
2 are special, right. They are targeting a specific
3 population. And they are targeting a specific population
4 who could either be in a general MA plan or in fee-for-
5 service.
6 And the inherent problem is if you are going to
7 construct an I-SNP, a D-SNP, a C-SNP, CMS does not have
8 specialized network adequacy regulations. CMS does not
9 have specialized marketing regulations. CMS does not have a
10 specialized quality regulation in oversight. States do not
11 have specialized capitalization requirements.
12 And then on top of that, the regulatory policy is
13 not customized for the marketplace. So if you think about
14 the skilled nursing facility staffing ratio, which I know
15 many of my colleagues disagree on with myself, which is
16 fine, but you could imagine that if you have an I-SNP plan
17 that's dumping a lot of staff into the facility, in a good
18 way, and organizing care, that's something that should
19 count towards the nurse staffing ratio, just from a
20 practical perspective.
21 So the reason that I-SNP plans, and frankly a lot
22 of SNP plans, have not processed in the marketplace is we

1 have a customized plan, and hopefully a customized care
2 model that goes with that, but no customized regulatory
3 oversight.
4 So think about it. If you say, "I want you to
5 create a Medicare Advantage plan, with a care model, in a
6 skilled nursing facility, which is a hard population to
7 care for, and by the way, your network adequacy regulations
8 require X number of plastic surgeons within so many miles."
9 And you say, "None of my beneficiaries in the last five
10 years of claim data have seen a plastic surgeon," and CMS
11 says, "I'm sorry, your plan does not meet network adequacy
12 requirements," That's just patently nonsensical.
13 Or if you have marketing and advertising
14 regulations around, say, billboards and TV ads, but most of
15 the beneficiaries enroll because of a conversation or
16 awareness from a health care proxy with a case manager.
17 So we're not designing the regulation and
18 oversight to provide appropriate beneficiary protections
19 while also facilitating the growth of this marketplace. So
20 I think the big opportunity here is actually regulatory
21 policy, and that we should go in and talk with
22 beneficiaries, talk with their family members or court-

1 appointed guardians, get that input, talk with skilled
2 nursing facilities, and talk with plans. Because I think,
3 as I said, many, many years ago a Senate office asked me
4 about what to do for this population, and I didn't have an
5 answer. I think this is a very good answer, and it's an
6 answer that can help this population, which is 1.1 million
7 beneficiaries are folks who live in long-term care
8 facilities, who don't have a lot of good options right now.
9 Thank you.
10 MS. KELLEY: Robert.
11 DR. CHERRY: Yes. Thank you for a really
12 excellent chapter. The I-SNPs model is rather intriguing
13 in terms of how it's developing and evolving over time.
14 The potential to reduce inpatient care and emergency
15 department visits and improve the overall quality of care,
16 you know, is quite promising.
17 You've mentioned in the literature that it has
18 some mixed results, and that may be because ones that are
19 showing positive results are those that are much more
20 mature in their journey and they may also have favorable
21 selection. Nevertheless, I like the whole concept, as
22 Brian has mentioned, of an integrated care model, which is

1 what they're trying to do.

2 I think one thing that could be improved upon

3 with the chapter, because it feels a little bit like a

4 cliffhanger. I know it's an informational item, but in

5 terms of what are the potential next steps. And I know

6 we're not voting on any type of next steps, but just an

7 acknowledgement that we want to explore certain types of

8 options.

9 I think, in particular, how do we incentivize

10 those nursing homes that are not participating but have the

11 potential to participate, how do we make sure that there

12 are new payment models that allows them to enter this type

13 of model more comfortably? Or maybe they seem to be

14 disincentivized because the value-based payment models are

15 a little bit, maybe, intimidating for certain nursing

16 homes. The MA penetration, and you have mentioned this in

17 the chapter, as well, as low payment rates.

18 So perhaps developing a budget-neutral model for

19 them that allows for new entry, and then, over time, taking

20 on more risk, while demonstrating that they can reduce

21 inpatient services and ED visits and improve the overall

22 quality of care could be something to explore. How to put

1 that in a chapter, because like I said, it's nuanced
2 because it's informational, but it's nice to actually be
3 able to acknowledge that there are some next steps here and
4 that the chapter is not just informational.
5 The other thing, just to pick on something that
6 you had said earlier, Eric, regarding the quality and
7 relationship with the nurse practitioner model. I can see
8 there being variability from one nursing home experience to
9 the other, particularly in the I-SNP model. One potential
10 way around this, too, is how do we incentivize those sites
11 to potentially open up their facilities as training sites
12 for potential nurse practitioners, because there's no
13 better way to recruit and retain really good people than to
14 be a part of the training process themselves. Whether that
15 is a viable option for some of these facilities is an open
16 question, but that could help strengthen the quality and
17 the relationship of the NP model.
18 Otherwise, I really like the chapter. There is a
19 lot of good information here. Like Brian, I'm not
20 necessarily intimidated by the fact that UnitedHealth is
21 taking advantage of this, and maybe there's something that
22 we could learn from their integrative model that's scalable

1 to others that are involved in this space or that want to
2 be involved in this space.
3 So thanks again.
4 MS. KELLEY: Gina.
5 MS. UPCHURCH: Yeah. Thanks so much again for
6 this work, and I've appreciated everybody's comments.
7 You know, early on, after joining the MedPAC, we
8 talked about we're focused a lot on fee-for-service
9 Medicare and skilled nursing facilities. Well, that's just
10 after three-day hospitalization for up to 100 days, if
11 you're lucky, and we're really not having much to do with
12 skilled nursing facilities in terms of Medicare payment.
13 But this really does dip into skilled nursing
14 facilities and how people are treated as a care model with
15 institutional I-SNPs.
16 But I agree with Stacie that it would be good for
17 us to know what are people getting beyond coverage of A and
18 B benefits? Like, what is it that Medicare is investing in
19 and paying for with the I-SNP? Obviously, nurse
20 practitioner being there regularly, I think, is part of it,
21 but are there other things? It would be good to know.
22 And I remember early on, also, the stunning

1 revelation that we don't get the perspective of the
2 beneficiaries and family members of people in skilled
3 nursing facilities, and I know it's difficult. Many of
4 them may have dementia. You know, there are lots of things.
5 You're asking them questions, but they're there, and they
6 may stay there. Are they being honest with the surveys and
7 so on? But I do think we need to prioritize the
8 beneficiaries living there and their family members in
9 terms of the quality of care that they're giving and how
10 it's working for them.
11 But thanks again for this work.
12 MS. KELLEY: Betty.
13 DR. RAMBUR: Thank you. This is a very exciting
14 chapter to me, and I really appreciate it, and I appreciate
15 the comments.
16 I just want to make a few additional points.
17 There's a fairly long body of information about the value
18 of geriatric nurse practitioners in long-term care
19 settings, including decreased hospitalization, decreased
20 turnover. But what I've never thought about when we're
21 placing students is which one is an I-SNP versus not, and
22 that might be interesting. I never thought about that.

1 And Robert mentioned the issue of training sites.
2 I have been advocating that GME funding should include
3 long-term care facilities for geriatricians as well as
4 geriatric nurse practitioners. When we place students in
5 these sites with preceptors, they love it, but they don't
6 see it as a career option. And that's unfortunate. And so
7 I think the culture issues you talked about is very
8 different if this person's a fabric of a long-term care
9 facility or several versus coming in from the outside as an
10 expert. So I'm really excited about this line of work.
11 I wanted to mention -- you mentioned PACE, and
12 whenever I travel, I try to visit a PACE setting. I'm so
13 impressed by the model, and many of them are at 300 people.
14 They're trying to get to 500, but these people are all
15 nursing home-eligible. So, even though it's only a delay,
16 potentially, I'd rather be at home longer.
17 And the models are so team-based, and the most
18 important person might be the pharmacist in the team or the
19 physician or the social worker, and so because they're
20 unshackled from fee-for-service, they can really do things
21 differently.
22 But I also wanted to mention supports and

1 services at home, and as a disclaimer, I was actually in
2 Vermont when we started the first program as seniors aging
3 safely at home in Vermont at affordable housing
4 communities. And this is really a nurse-, nurse
5 practitioner-, social worker-led model that's aimed at
6 making sure people can stay in their homes, and it's now
7 scaled all across Vermont. Rhode Island and Minnesota are
8 adapting it, and my understanding is that seven states are
9 demonstrating it through a HUD model, but those are also
10 Medicare beneficiaries. So just to find -- and, you know,
11 I'm obviously too close to that, but when you can see the
12 difference it can make of helping people stay in their
13 homes.
14 So, in summary, I support the kind of things
15 Tamara mentioned, really understanding what's happening
16 underneath the hood. But I really think there's an
17 opportunity to really look at this model and see how it can
18 really serve our society.
19 One last thing, much of what individuals in these
20 settings need is care, not cure, and nurse practitioners
21 can attend to when they need that cure model but really
22 think about creating systems of care. So I'm very

1 enthusiastic.

2 Thank you.

3 MS. KELLEY: Lynn.

4 MS. BARR: Thanks for the great work. I can't --
5 like, I feel bad for you because I feel like you've been,
6 like, dumped, like, 100 years of work, you know, from
7 everybody's ideas of what we could do, and I'm going to
8 make that even worse. So I apologize in advance.

9 I'm working actually on a plan right now for the
10 state of Hawaii that's looking at PACE, I-SNPs, and D-SNPs
11 together as how do you really sort of have an integrated
12 post-acute care model. And so this work is very relevant
13 to the planning we're doing.

14 And I was wondering as you -- like, one of the
15 things that I'm learning through this process is each of
16 these programs have like untenable regulatory barriers,
17 right? And I think that part of -- you know, if there
18 could be sort of a -- again, I, you know -- someday. I
19 know you guys are really busy, but looking at I-SNPs, D-
20 SNPs, and PACE, you know, and what are the sort of the key
21 attributes of those different programs, you know, from the
22 patient's perspective and the provider's perspective, and

1 I'm not saying you need to go out and do surveys or
2 anything, but just, like, what does the patient look like?
3 What does the provider look like? What does the payment
4 model look like? You know, what are the real world
5 economics, you know? What are people making on these
6 programs? You know, are they -- is anybody making any
7 money on these programs, or some of them, just everybody
8 losing money.
9 You know, having some sort of -- I think, like,
10 we need to understand -- like, none of these models are
11 actually working, but if you put them all together, it
12 works, is kind of what I'm seeing. And I'm wondering if
13 there isn't some way to sort of tease that out and go, oh,
14 if we just made this little regulatory change, we could
15 have two models instead of three, you know? Or maybe this
16 one model will work here and -- but I see this as a
17 spectrum, right?
18 I mean, you've got your -- I mean, PACE is
19 basically for, you know, helping people stay in their home,
20 regardless of payer, right, and can be sold to other
21 payers, right? But it's Medicaid and Medicare. And then
22 you look at D-SNPs, and it's really around the duals,

1 right? And so that's a very vulnerable population, but it
2 excludes everyone else, right? And so, you know, it kind
3 of ties your hands to some extent.
4 And then you -- and then the I-SNPs are people
5 that are just in the institution and probably aren't coming
6 out. So they're different, but people could actually go
7 from one to the other quite easily, and I see a lot of
8 overlap in D-SNPs and PACE particularly.
9 One of the issues with PACE is that, for example,
10 like when you're talking about barriers, you really can't
11 enroll Medicare-only people in PACE, right, because there's
12 no drug coverage. And the PACE program has to have its own
13 drug plan, right? You can't put them in a regular, you
14 know, prescription drug plan. You have to have your own
15 drug plan, which is ridiculously expensive, and so it just
16 blows up the model, so nobody can use PACE on Medicare --
17 on Medicare-only patients.
18 And so there's -- I know I'm getting way too into
19 the weeds, but if you could help identify sort of some of
20 the big regulatory barriers -- I'll be happy to send you
21 the ones that have been identified on the PACE program,
22 because that's sort of like I started this as PACE, but

1 then I went, well, maybe it should be a D-SNP. And then
2 it's like, oh, but I need I-SNPs too, and so this is what
3 I'm working on.
4 Really love this chapter. Happy to engage with
5 you guys and share anything I'm learning, but I would love
6 it if you could help us that are trying to figure out what
7 is a good plan for our states. You know, how do we apply
8 these programs and what -- you know, as an integrate --
9 sort of a holistic.
10 Thanks.
11 MS. KELLEY: Mike, that's all I have for Round 2.
12 DR. CHERNEW: And that's what I had too.
13 So, again, Eric and Carol, thank you. There's a
14 lot here. I'll say a few things, and then I'll let Paul
15 say something, and then I'll do a final wrap-up, because I
16 know Paul wants to say one thing.
17 MR. MASI: That sounds great.
18 DR. CHERNEW: Actually, why don't you go first.
19 MR. MASI: Great.
20 Well, I want to thank you all for this
21 conversation. I heard a lot of interest in this work, and
22 I heard a lot of job security for Eric and Carol, so thank

1 you.

2 I did want to say thank you very much to Eric and
3 Carol for all of this work. This is really terrific, and
4 in particular, thank you for all of your hard work in
5 interviewing stakeholders from the SNP world, the I-SNP
6 world specifically, as well as the nursing home world, and
7 all of the other several other stakeholders along the way.
8 I know that really took a lot of work.

9 And then I wanted to emphasize -- and this will
10 come up in the next slide -- that MedPAC takes engagement
11 with stakeholders very seriously, and last year, we met
12 with more than 125 different stakeholder groups, and it's
13 really an important part of what we do and definitely an
14 area where we learn a lot. So we encourage and look
15 forward to those continued conversations.

16 DR. CHERNEW: All right. Now I'll do my wrap-up.

17 I think the big conceptual challenge is when to
18 split separate populations off into separate programs and
19 how to adjust the regulations for those separate programs.
20 So the problem with having a bunch of different, separate
21 programs is you end up -- how do they work together? How
22 do the regulations work together? How do you make sure

1 that things are harmonious between the different programs?
2 And the problem with having one program is then you end up
3 in a situation where the regulations don't work well for a
4 whole bunch of other reasons, and you want to sort it out.
5 And so when you try and figure out what the right
6 connections are, we have D-SNPs. We have segmented it by
7 duals, right? We have I-SNPs. We have segmented by where
8 you live. And these segmentations don't always work well
9 together in a bunch of ways, and it's very hard to figure
10 out what to do.
11 Going forward, we are going to continue this
12 work. So I will, in that context, say our perspective has
13 really been thinking about beneficiaries that live in
14 institutions and what happens there, and I think the nice
15 thing about that segmentation is you can identify who those
16 people are, understand their needs, and potentially try and
17 tailor some regulations around that particular type of
18 population.
19 And I realize that that is not completely on an
20 island, that you want to keep them out of the institution
21 and a whole bunch of other things, but understand there's
22 not going to be a perfect way to get this right.

1 And so what I took -- I took a lot from this, but
2 I'll say one of the things I think is most important is
3 this sort of drumbeat of questions about what are the
4 barriers to expanding this type of model and providing
5 better care in terms of costs and outcomes for this
6 particular population? Remember, this is sort of a
7 population-focused orientation of where we're going, and we
8 will really give some thought to that. But it is going to
9 be hard to do all of those things, certainly, by the time
10 we get through this cycle, but this is sort of a body of
11 work that we'll be continuing next cycle. And so stay
12 tuned as we sort out these sort of many difficulties,
13 issues, and how they interrelate to each other and come
14 together in sort of a coherent frame. So you've given us a
15 lot to think about, and I do appreciate that.
16 For those of you at home, please reach out to us
17 at MeetingComments@MedPAC.gov or in any other way that you
18 want to reach out to us. We really do want to hear your
19 comments, and as Paul said, we do appreciate them. And
20 there's a lot of attention paid to them at a lot of
21 meetings that arise because of that, and we do appreciate
22 that.

1 And, again, I will echo the thanks to Eric and
2 Carol and to all the staff that presented during the March
3 meeting and even those that didn't because they're working
4 very hard doing a whole bunch of other things. So we
5 really do appreciate all the staff time and effort for what
6 happens here.
7 And thanks to all the Commissioners for the time
8 and the comments. It really was, I think, a good meeting
9 this month, and we will see you all again in April. So,
10 again, thank you. Travel safely.
11 [Whereupon, at 11:36 a.m., the meeting was
12 adjourned.]
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