CHAMBER HILL

INSIGHTS

MedPAC Discusses Nursing Homes and Medicare Advantage

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On October 10, 2024, the Medicare Payment Advisory Commission (MedPAC) discussed issues related to Medicare beneficiaries in nursing homes, findings from MedPAC's annual beneficiary and provider focus group, and supplemental benefits in Medicare Advantage (MA). The presentations from MedPAC staff on these topics and the subsequent discussion by commissioners will be used to inform chapters in MedPAC's June 2025 Report to Congress.

MEDICARE BENEFICIARIES IN NURSING HOMES

The first session focused on Medicare beneficiaries in nursing homes and began with a discussion around patients and the industry. MedPAC staff shared information on the differences between long-stay beneficiaries and other beneficiaries. Specifically, they noted that long-stay nursing home residents make up only a small share of the Medicare population (1.7% in 2022). However, Part A&B spending per capita for long-stay residents was about two times higher than other beneficiaries. They also noted that long- stay residents were more likely to be older, to be female, to be eligible for Medicaid, to live in a rural area, and to have died during the previous year. Staff also explained how Medicaid, assisted-living facilities, and long-term care insurance plans provide care to Medicare-eligible individuals who need nursing home care. They also touched on the shrinking share of long-stay residents with fee-for-service Medicare vs. Medicare Advantage (MA) - 86% in 2012, 65% in 2022. MedPAC staff also gave an overview of the breakdown of the nursing home industry, including those in urban vs. rural areas.

Staff next identified challenges to improving care in nursing homes. They include certain financial incentives that encourage hospitalization, low Medicaid payment rates, how racial and ethnic minority groups are more likely to live in areas where nursing homes have fewer staff and lower quality, and concerns about quality reporting. MedPAC staff identified next steps the Commission tends to take in this area, including examining managed care-based approaches with a focus on Institutional Special Needs Plans (I-SNPS) and FFS-based approaches. Additionally, MedPAC will continue to monitor the recent nursing home staffing rule as they work on the nursing home payment adequacy work for December 2024 and January 2025.

Commissioner discussion focused on ways that MedPAC could improve the quality of care for beneficiaries in nursing homes. Commissioners expressed concerns about incentives to hospitalize patients. There was also an agreement among Commissioners that access and affordability to nursing home care are important goals along with quality of care, especially as MedPAC monitors the implementation of the

staffing rule. Another concern for Commissioners was how quickly MedPAC analysis showed nursing home residents becoming eligible for Medicaid after entering a facility and how that comes with spend-down requirements. One Commissioner noted that MedPAC should be careful not to step outside its lane by delving too far into areas outside of Medicare policy. Commissioners also expressed support for where the Commission plans to go in this area, especially regarding I-SNPs.

FINDINGS FROM MEDPAC'S ANNUAL BENEFICIARY AND PROVIDER FOCUS GROUP

The second session featured an overview of MedPAC's annual beneficiary and provider focus group findings. This annual focus group is designed to hear directly from beneficiaries and clinicians about their experiences with both MA and traditional Medicare. Overall, MedPAC staff reported general satisfaction among both MA and traditional Medicare beneficiaries when it comes to the quality of their care and access to primary care providers. That being said, there were reports of provider access issues for new patients, patients looking to see a specialty provider, and patients in rural communities. Beneficiaries also raised concerns about the accuracy of MA plan networks.

Among clinicians, concerns were raised about prior authorization requirements in MA and that MA plans were making coding decisions to get higher reimbursement levels. Clinicians also raised concerns about the effectiveness of certain quality reporting metrics and said they had little direct interaction with accountable care organizations. There were also concerns raised by physician practices about being acquired by health systems or private equity firms and how that might impact patient care.

Commissioners expressed their thoughts on the limitations of these findings. Specifically, they discussed concerns about the sample size of the focus groups, how focus groups may favor those who are more likely to know where to find care, interest in ensuring the voices of those with disabilities are heard, and how MedPAC might improve the language it uses to get a sense of how prevalent a viewpoint is among beneficiaries or clinicians. There were also concerns about certain findings from the focus group related to issues such as wait times for specialty care, the need for better care coordination, addressing the apparent lack of direct clinician experience with ACOs, and concerns about the impact of inaccurate network information and prior authorization requirements under MA.

It's important to note that MedPAC staff acknowledged there are limitations on the use of focus groups and that they are just one tool to measure beneficiary and clinician experiences. Additionally, it was noted that MedPAC would not decide policy solely based on findings from the focus group.

SUPPLEMENTAL BENEFITS IN MA

The third session focused on the supplement benefits available to MA beneficiaries and understanding how those benefits are used. MedPAC staff first focused on the rapid growth of MA rebates, which have more than doubled since 2018. MedPAC estimates that Medicare will pay MA plans $39 billion in rebates in 2024. MedPAC staff also stated that MA plans have generally shifted from using rebates to reduce cost- sharing to using rebates to pay for supplemental benefits. Staff then shifted to a discussion of other supplemental benefits – where they said little is known and little data is available about the use of MA supplement benefits. However, staff highlighted the implementation of new policies by the Centers for Medicare and Medicaid Services (CMS) to better collect and understand data on the use of supplemental services.

Overall, there was an agreement among Commissioners that there is value in supplemental benefits for beneficiaries and improved transparency is needed regarding details of what different MA Plans offer.

However, Commissioners also debated the cost of providing MA supplemental benefits to taxpayers and FFS beneficiaries and expressed concerns regarding whether Medicare should be paying for services that are not primarily healthcare-related.

We trust you found this summary useful. Please reach out to us with any questions.