MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

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10:18 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[10:18 a.m.]

DR. CHERNEW: Hello, everybody, and welcome to our December MedPAC meeting.

As I'm sure everybody knows, we now begin the arduous process of making update recommendations. I want to say two things, emphasize two particular things.

The first one is I want to publicly thank the staff for all the work they've done. That's a general statement.

But I think the second thing I want to say is this is a particularly challenging period in which to do update recommendations. We have to deal with both the past and future ramifications of COVID and all the responses to COVID. And that, of course, makes this analysis complicated, and we're dealing with inflation that has been running at a higher rate than it had in the past times we've been doing -- at least that I've been involved in doing this. So all those things put us in very turbulent times, and I think the staff has done an outstanding job of navigating this sort of difficult period.

So without further ado, I think I'm turning it

over to Jared to start with our analysis that will support the hospital recommendation. Jared.

DR. MAEDA: Good morning. The audience can download a PDF version of these slides in the handout section of the control panel on the right-hand side of the screen. In addition to the staff listed on the slide, we would like to thank Corrina Cline and Lauren Stubbs for their assistant.

This presentation is in two main sections:

First, we will assess the adequacy of fee-for-service Medicare payments for hospital inpatient and outpatient services and, based on this assessment, present the Chair's draft recommendation for fiscal year 2024 updates to base payment rates for general acute care hospitals.

Second, we'll present the Chair's draft recommendation for fiscal year 2024 to support Medicare's safety-net hospitals.

Each year MedPAC assesses the adequacy of fee-for-service Medicare payments by looking at four categories of payment adequacy indicators: beneficiaries' access to care, the quality of that care, providers' access to

capital, and Medicare payments and providers' costs.

The specific set of indicators used for acute care hospitals are enumerated on this slide.

To assess the adequacy of Medicare payments, we start with the most recent available and complete data, which this year is generally fiscal year 2021, and include preliminary data for 2022 when possible. We also project a Medicare margin for the upcoming year, fiscal year 2023, using current law and other expected changes.

Based on these indicators, the Chair developed a draft update recommendation for Medicare's base payment rates to general acute care hospitals, which for this year will be 2024.

Before turning to our assessment of the adequacy of fee-for-service Medicare payments to generate acute care hospitals, we first provide some context.

To reimburse general acute care hospitals for their facility costs, fee-for-service Medicare generally sets prospective payment rates under the inpatient prospective payment systems and the outpatient prospective payment system.

In 2021, the fee-for-service Medicare program and

its beneficiaries paid IPPS hospitals $107.9 billion for inpatient stays, as well as an additional $8.3 billion in uncompensated care payments.

The fee-for-service Medicare program and its beneficiaries also paid hospitals $49.9 billion for outpatient services, as well as an additional $16.4 billion for separately payable drugs.

Our first category of payment adequacy indicators is fee-for-service Medicare beneficiaries' access to hospital care. One indicator of access to hospital care is changes in the supply of hospitals.

After the unusually high number of closures in 2019 where the most financially weak hospitals closed, the number of closures in 2021 returned to pre-pandemic levels. In both fiscal years 2021 and 2022, the number of general acute care hospitals that closed was the same as the number that opened: 11 in 2021 and 16 in 2022. Of the 16 hospitals that closed and opened in fiscal year 2022, most shared several characteristics. All were IPPS hospitals, most were in metropolitan areas, and the majority had 100 or fewer beds.

A second measure of beneficiaries' access to

hospital care is hospital capacity.

One component of capacity is hospitals' occupancy rates. As shown in the left figure, general acute care hospitals continued to have excess inpatient capacity in aggregate, with about 65 percent of all bed-days occupied during fiscal year 2021, slightly higher than in prior years. However, inpatient capacity continued to vary significantly across hospitals, with some hospitals nearing capacity at times.

Another component of hospitals' capacity is their staffing levels. As shown in the right figure, throughout fiscal year 2021, hospitals reported a critical staffing shortage for over 10 percent of all hospital days, despite a modest increase in hospital employment. Reported staffing shortages declined in 2022 to about 5 percent of all hospital days.

A related measure of access to hospital services is hospitals' marginal profit on inpatient and outpatient services provided to fee-for-service Medicare beneficiaries. Hospitals with excess capacity continued to have a financial incentive to provide inpatient and outpatient services to fee-for-service beneficiaries in

2021: IPPS hospitals' marginal profit on IPPS and OPPS services was about 8 percent -- similar to pre-pandemic levels.

As we noted last year, hospitals' rapid response to the coronavirus pandemic has demonstrated that many hospitals can substantially lower their costs in response to declining volume over a matter of months.

A third indicator of fee-for-service Medicare beneficiaries' access to hospital care is the volume of hospital services per fee-for-service beneficiary.

Hospital services continued to shift from inpatient to outpatient settings.

In 2021, inpatient stays per beneficiary declined by 1.8 percent, remaining below the pre-pandemic trend. While inpatient stays declined, the fee-for-service beneficiaries' average length of stay increased in 2021, driven by accelerated decline in lower-resource-intensive inpatient stays and musculoskeletal stays, which can increasingly be provided in hospital outpatient settings.

In contrast, outpatient services per beneficiary increased by 18.1 percent, reaching pre-pandemic levels. The increase in outpatient services was driven by COVID-19-

related services, such as specimen collection and vaccine administration, as well as an increase in clinic services.

Shifting gears to the second category of hospital payment adequacy indicators, the quality of hospital care in 2021 was mixed compared to 2019.

In assessing the quality of hospital care in 2021, we are comparing to 2019 as the quality of care in 2020 was difficult to assess due to the effects of the coronavirus pandemic on beneficiaries and providers and data limitations. For 2021, we updated the hospital mortality and readmission risk-adjustment models to include the COVID-19 diagnosis and have a full year of patient experience measures.

Relative to 2019, fee-for-service Medicare beneficiaries' risk-adjusted hospital mortality rate increased slightly in 2021; risk-adjusted hospital readmission rates improved; and patient experiences measures remained high, with 70 percent of patients saying they would definitely recommend the hospital, but the share of patients rating their hospital highly slightly declined by a percentage point or two.

And with that, I will turn it over to Alison to

discuss hospitals' access to capital.

MS. BINKOWSKI: Turning to our third category of hospital payment adequacy indicators, hospitals' access to capital strengthened in 2021.

As shown in the figure, in 2021 IPPS hospitals' aggregate all-payer operating margin increased to 8.7 percent -- or 7.2 percent without federal relief funds -- both of which were higher than the prior all-time high in 2019. Within this aggregate, there continued to be significant variation.

In addition, hospitals continued to have strong access to bond markets. Throughout 2021 and 2022, hospitals' risk premium to access bonds decreased, falling to one percentage point above the yield on 10-year treasury bonds by the end of fiscal year 2022.

Turning to our fourth category of hospital payment adequacy indicators, Medicare's payments to IPPS hospitals increased in fiscal year 2021 while they held their costs steady.

As a result, in 2021 IPPS hospitals' Medicare margin across hospital service lines remained negative but increased to minus 8.2 percent prior to the inclusion of

any federal relief funds. As with the all-payer margin, there continued to be significant variation.

Underlying this Medicare margin, IPPS payments per stay increased 10.3 percent in 2021, in part due to a rapid growth in case-mix, and OPPS payments per beneficiary increased 16.5 percent. Inpatient and outpatient payments grew faster than costs in part due to Medicare payment changes, such as the suspension of the 2 percent sequestration on Medicare program payments and the 20 percent increase for COVID-19 inpatient stays.

Because hospitals vary in the extent to which they control costs and provide quality care, the Commission also examines the Medicare margin among relatively efficient hospitals -- those with consistently high performance on quality and cost metrics.

For 2021, we identified these relatively efficient hospitals based on their performance in 2017 to 2019 and then analyzed their performance in 2021.

Among the 15 percent of IPPS hospitals we identified as relatively efficient, the median Medicare margin was 1 percent in 2021 when including Medicare's share of relief funds. Even when excluding relief funds,

the median Medicare margin was approximately zero, indicating that Medicare payments were near relatively efficient hospitals' costs.

The relatively efficient hospitals also continued to have better quality measures (lower mortality and readmission rates and higher patient experience scores) than other hospitals.

We project that hospitals' Medicare margin for 2023 will decline relative to 2021. Specifically, we project that IPPS hospitals' aggregate Medicare margin in 2023 will be approximately minus 10 percent, similar to the level in 2017. Among relatively efficient IPPS hospitals, we project the median Medicare margin in 2023 will be modestly below break-even, near the pre-pandemic levels. These projections are based on actual payments and costs from the most recent year of complete data (2021) as well as preliminary data from 2022, and policy and environmental changes that took place in 2022 and are anticipated in 2023.

The key drivers of our projected lower Medicare margin in 2023 relative to 2021 are:

Hospitals' input prices growing faster than CMS'

forecasts;

The expected expiration of pandemic federal relief funds and Medicare payment changes, which were higher than hospitals' additional pandemic-related costs;

And declines in Medicare's uncompensated care payments, partly in response to a decline in the uninsured.

In summary, despite the coronavirus pandemic, our four categories of payment adequacy indicators for hospitals were generally positive in 2021.

First, fee-for-service Medicare beneficiaries maintained good access to care: the number of general acute care hospitals that closed was the same as the number that opened, hospitals continued to have excess capacity in aggregate (though some hospitals' capacity and staffing was stressed at times), and hospitals with excess capacity continued to have a financial incentive to serve FFS Medicare beneficiaries. Hospital care also accelerated its shift from inpatient to outpatient settings.

Second, quality was mixed relative to 2019. While fee-for-service beneficiaries' risk-adjusted mortality rate remained higher than 2019, the hospital readmission rate improved. Patient experience measures

remained high, but most measures declined by a percentage point or two.

Third, hospitals maintained strong access to capital. IPPS hospitals' aggregate all-payer operating margin reached a record high in 2021, and hospitals maintained strong access to bond markets.

Fourth, IPPS hospitals' aggregate Medicare margin increased in 2021 to pre-pandemic levels, and the relatively efficient hospitals' median Medicare margin prior to relief funds increased to near break-even. However, there continued to be substantial variation across hospitals, and we project hospitals' aggregate Medicare margin will decline in 2023.

In considering these payment adequacy indicators and their implications for the Chair's draft recommendation to update 2024 hospital payment rates, the Chair's draft recommendation seeks to balance several objectives. These include: to maintain Medicare payments high enough to ensure beneficiaries' access to care; to maintain payments close to hospitals' costs of efficiently providing high-quality care; to maintain fiscal pressure on hospitals to constrain costs; to minimize differences in payment rates

across sites of care, consistent with our site-neutral work; and to avoid implementing large, across-the-board payment rate increases to support a subset of hospitals with specific needs.

With that, the Chair's draft recommendation reads: For fiscal year 2024, the Congress should update the 2023 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1 percent.

The implication of the Chair's draft recommendation is an increase in spending above current law.

We expect this recommendation will help maintain general acute care hospitals' willingness to treat Medicare beneficiaries and their access to care.

However, this update may not be sufficient for Medicare safety-net hospitals with a poor payer mix.

I will now turn it over to Jeff to discuss an option to support Medicare safety-net hospitals.

DR. STENSLAND: All right. The Chair's draft recommendation that Alison just read applies to all hospitals.

However, some hospitals have unique challenges, such as high shares of low-income Medicare patients. These hospitals may need additional assistance. However, as we discussed last month, the current system of disproportionate share and uncompensated care payments do not adequately address issues associated with low-income Medicare beneficiaries.

A new Medicare safety-net payment system could improve the financial security for hospitals with these types of challenging patient mixes.

Low-income Medicare patients can be financially challenging for several reasons.

First, hospitals with high shares of low-income Medicare patients tend to receive less cost sharing. For example, in many states Medicaid does not pay for dual-eligible patients' outpatient cost sharing. Thus, those hospitals will not receive the full statutory rate for those patients.

In addition, studies have found low-income beneficiaries cost hospitals more to treat than higher-income patients admitted to the same hospital with the same principal diagnosis.

This combination of lower revenue and higher costs can be challenging. In addition, there is a certain amount of uncertainty regarding the future profitability of treating Medicare patients. Hospitals with a large share of Medicare beneficiaries and few commercial patients are vulnerable to unforeseen reductions in the profitability of Medicare patients. They often do not have a high enough volume of commercial patients or a large enough endowment to offset reductions in Medicare profitability.

To recap our November discussion, I want to remind you about hospitals' current safety-net payments. In 2019, IPPS hospitals received about $11.7 billion of Medicare DSH and uncompensated care payments in aggregate.

There are five potential concerns we discussed with the mechanisms used to distribute the $11.7 billion.

First, DSH indirectly subsidizes Medicaid. Higher shares of Medicaid patients result in higher Medicare inpatient payment rates.

Second, DSH shares are negatively correlated with Medicare shares. This means that hospitals with high shares of Medicare patients tend to receive a lower DSH add-on payment.

Third, DSH payments are inpatient-only.

Fourth, last month the Commission discussed focusing Medicare payments on care for Medicare beneficiaries. Large uncompensated care payments violate this principle when they are not tied to the volume of Medicare patients served.

Fifth, current uncompensated care payments are distorted to paying greater amounts to hospitals with few fee-for-service patients and more Medicare Advantage patients, as we discussed last month.

To address these concerns, we developed the safety-net index that we discussed earlier. The safety-net index is computed as the sum of three factors:

First, hospitals' LIS share, meaning the share of inpatient and outpatient Medicare claims that are for beneficiaries receiving the low-income subsidy;

Second, uncompensated care costs as a share of revenue;

And, third, one-half of the Medicare share of inpatient days.

The rationale for this particular formulation of the SNI is discussed in our June 2022 report to the

Congress.

The purpose of adding Medicare shares is to acknowledge that the Medicare profitability is substantially below where it was when the DSH program was enacted in 1985. It also eliminates the Medicare subsidy of Medicaid and aligns Medicare funds more directly with the costs of serving Medicare beneficiaries.

There are some important mechanisms with respect to how the SNI add-on would be distributed to providers.

First, the SNI add-on would apply to inpatient and outpatient payments.

Second, CMS would directly make safety-net payments for MA patients rather than just adding those funds to MA benchmarks. This differs from current product. Currently, CMS distributes safety-net funds for fee-for-service patients only. Those fee-for-service DSH and uncompensated care payments then result in higher MA benchmarks. However, it is not clear these higher payments to MA plans will always reach the hospitals. For example, an MA plan could leave a safety-net providers out of its network if it deemed the Medicare rates too high for that hospital. By directly sending MA safety-net payments to

hospitals, CMS could assure the providers serving like Medicare beneficiaries receive those funds. There is a precedent for this method. Currently, CMS generally sends medical education payments directly to hospitals for MA patients rather than including those medical education payments in the MA benchmarks.

Now, in this slide, we remind you of the simulation we showed last month, and it shows what would happen if DSH and uncompensated care payments were replaced with safety-net payments determined by the SNI. We examined 2019 margins to avoid the influence of the pandemic on margins. But 2021 margins are similar.

First, we simulated what would happen to fee-for-service Medicare margins if we redistributed those payments using the SNI and added an additional $1 billion in fee-for-service payments to the SNI pool. The last column on the right shows that the redistribution plus the extra funds would result in the Medicare margins for high SNI hospitals increasing from a negative 0.9 percent under the DSH/uncompensated care policy to 4.2 percent under the new policy with the additional funds.

In the bottom two rows, I simulated what would

happen if the $1 billion was added to the fee-for-service SNI pool of dollars and a commensurate amount, which was about $0.5 billion, was added to the Medicare Advantage payments. The total SNI pool would then be about $1.5 billion larger than the current DSH/uncompensated care funds distributed. Under this new SNI policy, the last row shows that the all-payer margin for the high-SNI hospitals which increase from about 3.1 percent to 4.4 percent.

Now, while the $1.5 billion would have been enough to achieve these percentage increases in 2019, to achieve approximately the same percentage point increase in the Medicare margins and total margins in 2024, the total increase in the combined fee-for-service and MA SNI pools would have to be about $2. billion.

And that brings us to the Chair's draft safety-net recommendation. It reads: In fiscal year 2024, the Congress should: begin a transition to redistribute DSH and uncompensated care payments through the safety-net index; add an additional $2 billion to the safety-net pool, with the add-on percentages scaled in proportion to each hospital's SNI; the fee-for-service share of SNI funds should be distributed via a percentage add-on to IPPS and

OPPS claims; and the commensurate amounts paid for MA should be made directly to hospitals and excluded from the MA benchmarks.

Now, adding the $2 billion of funding will increase Medicare spending relative to current law.

We expect the recommendation to improve the financial somebody of some safety-net providers.

And I want to mention also, as we said in our June 2022 report, the SNI add-on should not affect beneficiary cost sharing. The idea is that beneficiaries going to safety-net hospitals should not pay more in outpatient cost sharing than patients going to hospitals with few low-income patients. This would mean the cost sharing would be computed on the amount that's paid to the hospital prior to the SNI.

And with that, I turn it back to Mike to discuss his two draft recommendations.

DR. CHERNEW: I am not going to discuss them. You guys have discussed them. We're all going to discuss them, and so I think we're going to start with Round 1 questions.

Dana, you're going to run the queue.

MS. KELLEY: Jonathan is first.

DR. JAFFERY: Thanks, Dana. Thanks, Mike. So great presentation, great chapter. It's obviously a very complicated time to be trying to work through these recommendations.

Just a quick question. When you talk about capacity, is this -- how is this measured and defined? Is it licensed beds or staffed beds?

MS. BINKOWSKI: Yes, it's in the cost reports, and it is supposed to be staffed beds, and it includes also swing and observation.

DR. JAFFERY: Okay. Thank you. That's all.

MS. KELLEY: Stacie?

DR. DUSETZINA: Thank you. This is an excellent chapter and a great amount of work. So I just had a couple of quick questions.

One was about the decline in inpatient stays and the increase in the length of stay, and I was just curious if there was any way to tell if that might be due to greater use for observation stays among Medicare

beneficiaries. I know it's something that had been talked about publicly a little bit, was this concern of more observation stays, because that hits a different part of the benefit. I wasn't sure if there was any way for you all to look into it.

MS. BINKOWSKI: Observation stays have not increased in this time period substantively. We'll have updated data for that specifically in the data book. It's not in this hospital chapter right now, but it does appear that it is not a shift from inpatient observation but, rather, a shift from inpatient to outpatient, as well as some hospital -- as well as some patients delaying or forgoing care.

DR. DUSETZINA: Great. It might be worth just adding a little note there because I think that might trigger for other people.

Two more, real quick. One is about the intensity of use and the shift in what types of services and shift from musculoskeletal, like joint replacements, and I wondered -- I know there was a note about it might be something that is more likely to be taken care of in other care settings versus maybe a pent-up demand question. And

I just wasn't sure how much to anticipate this was delayed care because of the pandemic versus people were still getting those services but somewhere else. And I wondered if you'd had a chance to look at were these services still happening around the same rate in 2021 across all the care settings or was it just -- does it look like a pause, and especially for things that could be scheduled later.

MS. BINKOWSKI: So I think it looks like it's a mix of both, and there were some additional services that got added or removed from the inpatient-only list. And so there were definite changes in the types of services that could be provided in different settings, including ASCs. We'll talk more specifically about what happened in the ASC context later today.

DR. DUSETZINA: Great. Okay. And the last one is just about the increase in the 9.8 percent for separately payable drugs, which I think has been shown in some other contexts as well. That doesn't include, I would assume, any potential paybacks. So this is with the lower payment rate for the 340B payments? So it might just be worth adding a note in that piece that these payments are lower than what might likely have to be paid back.

MS. TABOR: Correct. What is said in this chapter is what was actually paid during 2021, and it is still unclear what, if anything, CMS will do in response to the recent Supreme Court ruling.

MS. KELLEY: Betty?

DR. RAMBUR: Thank you. Again, I echo the previous Commissioners' comments about this wonderful chapter.

I have a question that's really pedestrian, and it's probably in here and I'm just not seeing it, but it relates to some Round 2 questions I'll have. How is "relatively efficient" operationally defined?

DR. STENSLAND: So that is in our -- I think we have a discussion of that in the chapter, maybe in a text box. Essentially, we look at two things. The main thing we say is efficient doesn't mean just low-cost. Efficient means you have to -- it looks at cost and quality. So you can be relatively efficient if you have low cost and at least okay or good quality. You can also be efficient if you have good quality and low or okay costs. So you might have somebody that has a little bit above average costs but has really good quality. They're called efficient. Or

somebody that has average quality but low costs, they're also called efficient.

MS. KELLEY: Marge?

MS. GINSBURG: I didn't see in your report here, and I'm not sure it's in the chapter that we read in advance, and that is distinguishing between for-profit from not-for-profit hospitals. It isn't in the chapter, is it? If it is -- anyway, I guess my question or comment is really should it be. At least in every other domain of Medicare, there's always pretty profound differences in how for-profit and nonprofit providers perform. And so I'm concerned about the status of not-for-profit hospitals, and I wonder if you might discuss that at all or talk at all about whether you think it could be or should be included in some fashion.

MS. BINKOWSKI: Yes, we can consider adding more information on that. As with past years, the all-payer operating margin continued to vary across groups, and it was higher at for-profit hospitals. And, meanwhile, the Medicare margin also was higher at for-profit hospitals, so we can put some more details into the paper.

MS. KELLEY: Cheryl?

DR. DAMBERG: Thanks for a great chapter and all the work of the staff to pull it together.

I had a quick question about the shift from inpatient to outpatient, which I found really interesting, and I'm trying to sort through how much of that was driven by COVID, and I think probably a lot of it. But I think as we kind of move into 2022, '23, and beyond, the question is whether that will be sustained. And I don't know kind of how to think about that in terms of assumptions and related to whether we're going to continue to see maybe sicker patients in the hospital, longer lengths of stay. And I don't know if you are able to look at the 2022 data yet to see whether that is continuing.

DR. MAEDA: We do know that before the pandemic, there was this shift from inpatient to outpatient going on. But as to whether that trend will continue --

MS. BINKOWSKI: Yes, we have preliminary data from 2022. As you know, the claims are not complete yet. There's still more run-out, but it does look like the average length of stay increased slightly between 2021 and 2022 as opposed to the much larger increase that happened between 2020 and 2021. So we'll have more specific numbers

next year.

DR. DAMBERG: Yeah, thanks. I was trying to figure out how much COVID – it's like force and function to maybe move this in a direction we'd like to see happen. So thanks.

MS. KELLEY: Okay, and I have a Round 1 question from Scott. Is there more we can or should do to call out in a granular fashion the characteristics of the more efficient hospitals, especially given that this subset of hospitals performed better on both their Medicare margins and their quality in order to highlight that better financial performance is, in fact, achievable and is not inconsistent with improved quality?

DR. STENSLAND: We can maybe add a little bit to the text, and maybe I'll send something to Scott also discussing some in the past years when we had more of an expansive discussion of who was in the relatively efficient group and who wasn't and why some get in one group and some get in another. But there is a wide group of hospitals that get in there, some smaller, some larger, some teaching, some non-teaching, some for-profit, some not-for-profit. But I'll get back to Scott and see how much more

we need to add to the chapter.

MS. KELLEY: Kenny?

MR. KAN: Yes, in terms of the proposed update recommendation of current law plus 1 percent, regarding the hospital market basket, while fully cognizant that we need to stay empirically focused on the data, one of the things that in trying to echo Cheryl's earlier comments on COVID, how do we -- have we taken a look at prior periods where there have been high inflation -- you know, because this recommendation would impact 2024, how do we think about the lags, you know, in terms of what have we come up with, to the extent that, you know, it's already starting to turn, how do I think about how the recommendation in the past would interacts with the lags in the data? Have we taken a look at that?

DR. STENSLAND: What we're discussing recommending here is a 1 percent over current law, and current law would be the market basket minus productivity, and that market basket would be the market basket that CMS projects in August of 2023 for 2024. So this is a forward-looking projection and a projection that will take into account more data than we even have today.

So I think we're okay theoretically on that. And then in the next year, there will be another projection, you know, for the following year that will be taking into account the new information that's there. So I don't see a clear problem with that.

DR. CHERNEW: I think just the clarifying version of this is the reason why the recommendation is framed in terms of current law is the current law portion of it adjusts as newer inflation comes back. There have historically been mistakes, so I'm going to ask another Chair prerogative clarifying question.

In the past, the errors, the forecast errors, have actually probably been in providers' favor, if I understand correctly. Can you just clarify that point briefly? Because I want to make sure we have enough time for Round 2.

MS. BINKOWSKI: Yes, I think the really briefest answer is the cumulative error over the past 10 years was positive 2.6 percent.

DR. CHERNEW: Current law framing is supposed to deal with the projection of how it plays out. Okay. I want to go quickly through. I think we have Robert and

Amol next. Is that right?

MS. KELLEY: Yes. Robert?

DR. CHERRY: Thank you. I just had a clarifying question regarding operating margin and how it's calculated among teaching hospitals, specifically academic medical centers. AMCs tend to report out two different types of operating margins, one before academic support payments, one after. Academic support payment is where -- it's a common model where academic medical centers actually transfer dollars from their margin to their medical school to help support the research and educational mission. And then they report out an adjusted operating margin after that academic support payment.

Do we know which one we're pulling for purposes of these calculations?

MS. BINKOWSKI: I'll need to follow up with you offline. I know which cost report lines we're pulling, but maybe we can talk about how different hospitals may or may not vary in what they report on that line.

DR. CHERRY: Yeah, I think it would be important to clarify that, because the academic support payments are pretty substantial among many academic medical centers. So

if you pull it before that academic support payment, your margin is going to look very, very different than after that payment is actually made.

MS. BINKOWSKI: I understand, and we'll talk more later, but I'll say that the operating margin is still patient revenues divided by patient costs and how different hospitals choose to use those patient revenues for different things, whether it's expanding in various areas or supporting other aspects. It is not unique to teaching hospitals.

MS. KELLEY: Amol.

DR. NAVATHE: Yes, I have what I hope is a very quick question. So when we're noting that there's a shift in case-mix towards more severe conditions, I was curious, do we have a sense of how much of that is a change in the composition? So the examples that were given, for example, away from musculoskeletal towards respiratory, that's a change in the mix of the conditions, versus within a DRG family or within a particular condition, a shift towards higher severity within that family.

MS. BINKOWSKI: There's both. So, yes, I think the graph you're referring to in the paper was talking kind

of within a major diagnostic category, but we also did look within certain DRGs, and there was, in general, a shift towards – or rather, away from no CCs to with CCs or MCCs.

MS. KELLEY: That's all I have for Round 1, Mike, unless someone has jumped in in the last minute. Oh, I'm sorry. Larry, go ahead -- oh, no, now you're off. Okay. I think we're done.

DR. CHERNEW: Then we're going to start Round 2, and just so everybody knows, there's a queue which we're going to go through. But if you're not in the queue, you will be in the queue. I'm going to make sure that everyone says something before we finish this round, but let's start. I think Greg was first, if I'm right.

MR. POULSEN: I'm more than willing to say something on this topic.

I guess maybe I'd start with Kenny's point, which is, you know, what have we done in the past when we've seen these kind of inflation rates, and the fact is we haven't seen these kind of inflation rates. This is totally new territory since MedPAC was created.

I guess things that jumped out at me is what great work the team has done to bring this recommendation

together, an amazing amount of in-depth work, very thoughtfully put together. I think it's just remarkable.

But I would add that the times that we are in are so odd compared to the past that it makes it really difficult. I mean, we've obviously got the general COVID challenges and the ongoing turbulence related to that. But we also have some dynamics we haven't ever seen before. We're seeing people step away from work, which has never happened in my lifetime. We're seeing effectively in many parts of the country a doubling of the minimum wage, not through law but through market forces, and that clearly impacts the health care sector.

We've seen here just in the last little while the Social Security cost-of-living adjustment allowance or adjustment was triple what it has been in the last 15 years and higher than at any time since 1981, which, if I recall, was the year that the namesake of this building, Ronald Reagan, first entered office.

Similarly, general CPI is also at the highest rate in 41 years, and those are remarkable changes. Certainly it's much easier to do these kinds of projections when things are stable. And I'd just note, I went back and

looked at the last 10 years, and during that time CPI, medical CPI, the recommendation that we made, and the Social Security COLA all drifted -- in fact, interest rates all sort of drifted between 1 percent and 3 percent, and they were up a little bit, down a little bit, but they never really deviated from that relatively narrow band. And now we're seeing something where we're seeing those numbers that were historic are simply gone.

So for those of us who are sort of living this day to day, I think we've seen a remarkable change. We've seen costs explode in the last year. Nurses', tech, and therapists' salaries have gone up remarkably. We've seen that certainly the pandemic has had an impact on that, as we've seen organizations bring in agency traveler nurses at rates that were sometimes three and even four times what they had been paying their local folks. And in order to retain the local talent, they've had to make increases, and that has been pretty universal across the United States. And my neighbor to the left may have more data than I have in terms of the specific numbers, but certainly we've seen dramatic increases, basically among all the hourly caregivers within the hospitals.

So as we look at those dramatic increases, we also see dramatic increases in some supplies fueled by shortages, and I think it's worthy to note that since the pandemic came, all three of the rating agencies have lowered their outlook for the health care sector broadly and the hospital sector specifically. That's Standard & Poor's, Moody's, and Fitch all have negative outlooks on that. So I think that, you know, there's certainly cause for alarm and cause for concern.

With that said, all of this has some pretty profound impact on input costs for the sector that we're talking about today -- hospitals. And I recognize that we're constrained and certainly the staff team is constrained in terms of what we can look at and how we can approach this. So in some ways, maybe I'm just wanting to be putting us forward that, as policymakers and others consider these recommendations, that there may be some things that we need to consider in addition to what we're putting in right now. So the market basket that is used in current law I think is probably reactive rather than proactive in the current strange environment that we're in. I think it's probably fine when things go up and down a

little bit, but when things go from 3 percent or 2.5 percent to 8.7 percent in a matter of months, you know that things are volatile.

So I think that we may want to recognize that some of those market basket items are recursive as well in the sense that what the final rule is will impact what happens to those as well. So there's an element of recursion there that I think is interesting. But I think it's also worth noting that, at least in experience that organizations like mine have had, the cost increases are much more akin to what we see in the broad CPI sector, the input costs are reflective of the general world, maybe with some additions related to shortages of key staff rather than just the specifics of what we historically think of as medical components.

So, with that in mind, I think that I would encourage us to be grateful for the work that has been done, but also if we can to look even more broadly at some of the other things that impact the cost inputs to the health sector broadly. And we're going to talk about other sectors than just hospitals, and the same dynamics tend to be active there. So it's a challenging time. I'm grateful

for the good work that has been done, and I'll leave it at that.

DR. CHERNEW: So I just want to respond quickly, because I think this is going to be a theme as we go through this. So let me just say -- and I'll let the staff respond quickly, and please correct me if I say anything that's incorrect.

It is challenging for us to live in a world which starts with "this is the inflation index of the hospital market basket but we don't believe that it should be X." So we will work off of the hospital market basket. But it should be clear -- and if you look in the chapter there are two stages of that. The one is what was going from '21 to '22, what happened, and in addition to -- we have some preliminary data on that that suggests, and it's in the chapter, for some of the organizations that reported, that some organizations did better, some did worse, but it's not necessarily dire for 2022 per se.

And then the key issue about the market basket is when this actually gets to 2024, there will be updating of the inflation index that will take into account information that is being used by CMS to come up with the number.

So again, I don't mean to repeat this, but the framing in terms of current law provides us some protection. The danger we have if we move away from that to a world in which we say, "Well, I know that's the official number but we think it should be X," that just becomes very hard for, you know, the people who professionally come up with what the numbers are.

And again, historically, as Alison pointed out, to the extent that they have erred historically, they have actually erred historically cumulatively on the side -- the inflation hasn't been as high as they thought it would be so the hospitals got more than you otherwise would have thought. I think I got that cumulative 2.4 percent was the number that I think Alison mentioned in Round 1.

So that's kind of where we are, and I think, as I said at the beginning, this is an unbelievably turbulent time, so the recommendation for 2024 is going to inherently be uncertain. In some sense, some of you may know that this is probably -- I can't remember the last time a hospital recommendation was net current law plus, and this is effectively taking the two recommendations into account, current law plus 1.5. And a lot of that was done to

acknowledge the points you said, so that's kind of where we are.

I had meant to speak less and let everybody else talk.

DR. CASALINO: Mike, a quick clarifying question?

DR. CHERNEW: Yes.

DR. CASALINO: Is there typically much difference between the CPI and the hospital market basket?

DR. CHERNEW: I am going to defer to staff, but there are different components of things in the different ones.

DR. STENSLAND: So there are differences in what's in there. Like the hospital market basket has a lot for nurses, aides, techs, their salaries. That's a lot of what goes into there. The CPI is a lot of housing, food, transportation, cost of used cars and gasoline. So what's in there is different, but when you actually look at it for the last year, ending in October, the CPI, excluding food and energy, which kind of bounce around, was, I think, 6.3. The latest data that Mike just talked about, which influenced this latest recommendation that Mike had, was 5.7 for the hospital market basket for the same period of

time, so they weren't dramatically different.

DR. CASALINO: Traditionally do they track pretty closely?

DR. STENSLAND: I don't --

MR. POULSEN: Could I actually jump in, because I actually did go back and look at this for the last 30 years. And for the last decade and a half they have been pretty close. They have been more or less chugging along together.

Prior to that period, the hospital market basket was consistently and significantly higher. So that's been a real change. There have been a lot of things that really stabilized over the last 15 years that now have destabilized, so it's an interesting time.

DR. CHERNEW: Important that we get everyone to get to out to where we are, so I'm going to try to be quieter, and I think we're going to have to try and be concise. So I think, if I have this right, Jonathan is next.

DR. JAFFERY: Great. Thanks, Mike. And again, I really appreciate all this work. You know, I won't echo a lot of the things Greg -- Greg pointed out a lot of the

constraints and pressures. I want to say I appreciate the approach to trying to add to current law the recommendation. I'm supportive of that piece.

And again, I won't reiterate those constraints and pressures, other than I guess I will emphasize that one thing that really does seem particularly unprecedented is some of the consistent labor costs as a result of the agency. Greg mentioned it, but I'm hearing that a lot of people's concerns. It doesn't seem to have decreased. Maybe it's plateaued a bit, but it's certainly not gone. So that's a significant pressure.

I do want to speak a minute or two about the safety net index recommendation. I very agree with the principle of focusing Medicare payments on Medicare beneficiaries, but I have some concerns that the current proposal may have some unintended consequences.

I think about, for one thing, capacity. We've talked a lot in the chapter about aggregate capacity, and I'm not sure how great a measure that is of things. I'm not sure that we can really be comfortable saying that global capacity really speaks to global access when there's so much variation. When I think about some of the

constraints, the capacity constraints that we see increasing in certain areas, another part of the chapter talks about rural beneficiaries are increasingly bypassing their local hospitals, and we're seeing that a lot of areas are starting to see outlying hospitals close, they close programs, and there's quite a bit of capacity constraint on other sectors, or subsectors within the hospital sector.

And when I think about Medicare beneficiary access -- and this starts to get to be maybe parsing out the definition of safety net -- but thinking about what are some of those other hospitals doing to support Medicare beneficiaries in places that we're not capturing here, things like burn and trauma and transplant and some of those other areas.

And when we look at the recommendation for the proposal, you know, we've seen in the chapter and we talked about this a little bit in November, there's a pretty significant impact on that 5th percentile in some categories -- the government hospitals and the teaching hospitals and the urban hospitals and some others -- where we're seeing negative 2 or 2.5 percent negative total all-payer margin impacts. And in an environment where a lot of

them may be having 1.5 percent total margin to start with, that may be a really significant problem.

So I guess at the end of the day I'm not sure I fully understand what that 5 percent looks like, who they are, where they are, what the impact will be on them. And we speak about a transition period and adding $2 billion, and I'm not sure -- again, as talked about in November -- it's not clear to me what those organizations will do in that transition period. We spoke a lot about how there are other areas like state and local governments that may need to step in, but that's kind of out of their control, unlike some other policies that we talk about like site neutral, where perhaps hospitals can take a transition period and adjust their operating models. That's not clearly the case here.

So I guess to me, before I felt really comfortable with this part of the proposal, I would love to have a little bit more understanding about what that group looks like and thinking about rather than just adding $2 billion, and another, I guess, it's 0.5 percent, to this pool overall, perhaps there's a way to take that money and target it towards some of those areas of need, whether

that's in transition or something else.

And so I'll stop there, but again, thank you for a great chapter and a lot of hard work.

MS. KELLEY: Stacie.

DR. DUSETZINA: Great. Thank you. So first of all I do support the update recommendation and the Chair's recommendations here.

I also just want to follow up on the safety net recommendations and say that I fully support moving in this direction. I think that it is more consistent with paying for Medicare beneficiaries and it addresses some longstanding problems with the DSH formula, so I think it's an excellent way to go.

And then following up a little bit on Jonathan Jaffery's comments is I also would like to see a little bit more about how the $2 billion would be used in this situation, and I do like the idea, especially of while in transition using it to maybe limit losses for those that Jonathan kind of was mentioning, that we're not exactly sure who they are that would be losing under this formulation, but maybe a little bit more detail there about how those dollars could be used to maybe also be a safety

net while we're transitioning.

Thank you for an excellent chapter and great work.

MS. KELLEY: Dana?

DR. SAFRAN: Yeah. Thank you. I'll start by saying I am supportive of the draft recommendation, and I have just a couple of comments.

The first is that I want to call attention to the information that you share about the quality changes, and in particular the patient experience change scores, which you characterize as mostly modest, a point or two. Having spent decades working with patient experience data, I can tell you a point or two as an average change is a massive change, and seeing in the chapter that several items changed by an average of 4 points, this is more than a canary in the coal mine, and we really have to be paying attention to what's going on there.

And related to that, I think that something that could help the reader understand the context of the changes, not just for patient experience but for mortality, for readmission, is finding whatever metric of choice you want to use that shows that amount of change in context of

the effective range of the measure.

So for example, patient experience scores are on a basis of 100 points, but the score's effective range is typically, you know, 10, 15, 20 points, between the 25th percentile and 75th percentile, in this case facilities. So that helps to put that 1, 2, 4 points in context when you look at standard error, or standard deviations, however you want to do it.

So I would really urge you to do that, but also just to stay in the context of this conversation, that we have to keep an eye on what's happening here because for the changes that we know and the strain that we know hospitals are under to be experienced now by patients in a way that they're showing up in measures that, frankly, all of us have worried are just always to topped out, is really something that should be getting our attention. And so that's one point.

And then the other is just to underscore what others have said and my support for the redistribution, the special handling of increases for the facilities that are serving those with -- what's our SNI stand for? -- safety net. I am supportive, though. I think it's really

important for us to keep reiterating that our nomenclature for safety net refers to safety net for Medicare beneficiaries. And I know there's been some concern about that publicly, and I think that's well-founded concern, because the nomenclature we use does get out into the broader ecosystem. And so the fact that we are focused on Medicare beneficiaries, that's appropriate. That's our job. But I think somehow reflecting that, but nonetheless.

The last thing I'll say is, in my sixth and final year on the Commission it does feel much better that we are creating that kind of differentiation here because the old aphorism of the statistician who drowned by walking across the lake, that was, on average, only one foot deep, always has struck me as we're doing average increases and we've got so much variation. So I really appreciate this, and thanks for the great work.

MS. KELLEY: Jaewon.

DR. RYU: Yeah, thank you. I echo many of the comments already made, but just a few points. One, I really like the approach of incorporating the safety net and index component. I think that allows us to take another step towards being more targeted with the

interventions, along the lines of what we've discussed in prior sessions.

The second point is around capacity. There are a couple of mentions in the materials around capacity as a reflection of there's adequate access, and if hospitals have -- I think in the aggregate there was 68 percent, and so there's still a lot of available capacity. I think this gets to Dana's comment, in the average, in the aggregate. And I would caution just a little bit on that, both from a hospital-by-hospital, geography-by-geography, market-by-market, but also in terms of programmatically, not all capacity is created equal.

And so you may have capacity in a med-surg kind of capability but are we seeing programmatic closures -- and we talked a little bit about this, I think in the last sessions -- around programs that just simply are no longer sustainable. The economics have fundamentally changed. And I do worry that you have access challenges there, it would be proverbially a person drowning in the one-foot-deep lake, on average, and I think we've got to be careful there.

Number three, I get that we need to base our

recommendations on the empiric evidence and the data, and I'm all in favor, but I do think there is -- and we've mentioned this and discussed this in prior years -- there is this notion of the leading versus lagging indicators. And this exercise always strikes me, in the payment updates, that we're stuck dealing with very lagging indicators and information. And I think the imperfection of that information is especially pronounced in a time when you had all sorts of tectonic changes happening, especially for hospitals. I think Greg mentioned many of those points.

I think 2022, very, very different than 2021, and here we are dealing with mostly 2021 information. I don't think we've seen or appreciated the full extent of the challenges that are in the industry right now, today, as we sit, because of this awkward dynamic between leading and lagging.

I think there are many other indicators from throughout the sector and the industry that would portend a much worse outlook than what's being represented in this recommendation or in the reading materials. You know, Greg mentioned the rating agencies. That outlook, that's an

industry. That's a business. That's solely in the business of projecting financial outlook of sectors of the industry, and their outlook has turned markedly different and negative between this year and last.

I think another is the public markets. You could look at hospitals versus other segments or sectors within the health care industry and just what that's done on a relative basis. Very different this year versus last year or previous. There are probably many other data points as well, and I think that's what gives me a little bit of discomfort.

But based on all the imperfections of our information construct -- I don't even know what to call it -- maybe this is the best landing spot, because we do need to stay disciplined around being empirically based. But at least it still makes me very uncomfortable because of all these other data points and information inputs that, to me, feels like there's a disconnect between what we're painting a picture of in this recommendation and in these materials versus everything that's going on everywhere else, that's a very different picture.

So that's where I have a little bit of

discomfort, understanding that yes, the recommendation, I get it. Historically we have not had current law plus anything in hospitals, so I think that's good recognition there. But it still makes me a little uncomfortable.

MS. KELLEY: Robert.

DR. CHERRY: Yes. Thank you. You know, first of all I just want to reiterate some of my prior statements in support of the SNI, the safety net index. I think it's directionally correct and a very important model for helping us to problem solve around vulnerable populations and making sure that our hospitals are fiscally sound in those vulnerable populations, that we're able to have commissions like physicians, nurse practitioners, et cetera, be able to serve as those populations as well.

There's one hesitancy that I do have around the model, and it picks up on Jonathan's points, which is that the way that the dollars are redistributed it does create some winners and losers. And there are a couple of categories that I do have concerns about. One is the governmental category, which is state and county and city facilities that are caring for patients. Even though some of those governmental facilities may not meet our SNI

definition for a safety net facility, they largely exist as safety net hospitals, and therefore, there may be some cost shifting that might need to occur if there's loss of Medicare funding, and then the cities and counties would have to pick up or compensate for that in some sort of way.

Now I realize that is probably a bit out of our scope and is probably a local government policy decision that need to be developed to address that, but nevertheless, it is a concern.

The other category is within teaching hospitals, where the bottom 5th percentiles seem to have an operating margin that's quite negatively impacted. We don't even know yet what the bottom decile or bottom quartile looks like as well. And the teaching hospitals are really critically important right to expand primary care, nurse practitioners, physician assistants. That education and training is essential to make sure that we have a highly functional health care system within this country.

And I'm concerned that the negative margins around some of those teaching hospitals may adversely affect our ability to actually be able to train the best and brightest within our country.

My hope is that this model be tweaked a bit so that those losses are either minimized or not created in the short or long term, but that's the hesitancy that I have right now with the SNI.

MS. KELLEY: David.

DR. GRABOWSKI: Great. Thanks. And first, thanks to the staff for this great work, and I'll start by saying I'm supportive of the Chair's draft recommendations. I also wanted to focus my comment around the safety net index recommendation. I believe this is a real positive targeted step forward. This issue is going to come up a lot over the next day and a half. Medicare lives in a multi-payer environment, which includes, obviously, uncompensated care.

I like the idea of targeting more dollars to those hospitals that are treating a larger share of low-income Medicare beneficiaries. I don't believe adding, to Dana's point, you know, increasing the entire water in the lake is going to solve this issue, and I don't think putting more money into a flawed DSH system is going to fix this issue. So I like this approach.

I do recognize, with Jonathan and others, and

Robert and Stacie are worried about, with unintended consequences. I do like their idea of kind of studying a little bit more the winners and losers. But I think this issue of cross-subsidies comes up a fair amount in our discussions. It will come up obviously tomorrow with skilled nursing facilities. I don't think we can just put more dollars in to SNF, for example, and expect those to go to the right kinds of facilities.

And so I think we're not going to solve this overall safety net index problem in our health care system through Medicare, and I think, Dana, you said that really well. I think we can solve the Medicare problem. So I want to understand better the winners and losers but I don't want to lose sight of how we can impact Medicare beneficiaries. Thanks.

DR. CHERNEW: I just want to jump and say one important thing. It's important to understand why winners and losers are winners and losers. And in the case where our goal -- although in my broad life I care a lot about the all-of-population safety net writ large, our goals here is much more targeted, which is supporting the portion of the safety net that would be sort of the Medicare portion,

and that does indeed make it more limited. So there will be some losers, and it may be appropriate for us to call that out, simply because of how the Medicare part is working as opposed to the all-payer part. I liked your line that we live in an all-payer world.

I'm sorry. That was probably more time that was needed. We should keep going ahead. Dana.

MS. KELLEY: Marge.

MS. GINSBURG: So one area that I struggle with was the inclusion of hospitals whose patients are being paid for by MA plans. And Medicare's role, obviously, pays directly those hospitals for Medicare beneficiaries. MA plans' role is to pay those hospital bills for their clients, and even though the proposal says the money would go directly to the hospital and not through MAs, could divert it to other reasons, other places, I still struggle with the fact that we should, in any way, subsidize MA patients in the hospitals where they are, that that is the role for MA plans. And if we do that, if we help those hospitals, then basically it's saying to MA plans, "Don't worry. You don't have to raise rates of what you're paying because we're here in the background and we'll pick it up."

So this is a struggle for me. It feels not right to be doing that, and to me it sends the wrong message to MA plans that they can get away with underpaying. We know MA plans are doing well. We don't need further evidence of that. And maybe it's time they spend some of that money on hospital care for their clients.

And I would appreciate hearing a counter view if somehow I've missed something on this.

DR. STENSLAND: I would just say that they're not -- what we're going to do is when the money goes directly from the MA plan to the hospital, the MA plans will then lose a certain amount of money off their benchmarks. So their benchmarks will go down. The amount of money that CMS pays to the MA play will go down because we're saying, "Look, MA plan, you don't have to pay those DSH and uncompensated care payments anymore. We're paying those directly." So they're not getting like a free ride here.

MS. GINSBURG: I guess maybe that's it. If you're telling me they're not going to get a free ride, then I get it. So thank you.

MS. KELLEY: Lynn.

MS. BARR: Great. Thank you, guys, so much for

this work. I think it's a huge improvement over the current DSH system, and I love the fact that we're not giving money to MA plans that isn't actually getting to the hospitals that need it. So, you know, there are huge improvements here.

I do agree with Dana's comments and the America's Essential Hospitals letter, that this is a Medicare safety net index and we should call it the MSNI and not the SNI, because this will be adopted by people and say, "Oh, there's a new safety net index and everyone should just follow that." And this is really very focused on Medicare, and I do strongly support that idea.

I am impressed, honestly, well our whole system of paying hospitals is working. We've gone through a pandemic, we've got inflation, and it actually seems to be holding together. I know we did some extra payments and things like that 2021, but 2022 seems to be holding together, and I find that absolutely shocking. So, you know, I think the system is working and I do support current law, and I think the 1 percent is generous, and I am fully supportive of that as well.

I think that we need to be careful that because

we are going to be paying certain sectors more than the national average, so we are going to basically say we're going to take money away from these hospitals and we're going to give it to these hospitals, those hospitals that are going to get those extra payments are going to get penalized in advanced payment models because we're going to be looking at a national -- you know, nationally things didn't change, right, but you're getting paid more. So I think we need to account for that in the advanced payment models and make sure that those are backed out of the benchmark somehow.

I am highly concerned about government hospitals in this scenario. I have been in many, many of those facilities, I have been patients in those facilities, and they are held together with duct tape. There is no extra money for them, and I'm thinking, Highland General, SF General, these large, urban, county hospitals that spend every single dollar they can on patient care, and don't have the ability to absorb this loss.

And so I do feel like if we are going to add money to the system, it should go towards those clear -- I mean, these organizations that have this clear mission to

exist to serve the poor, because I am concerned that they will no longer exist. And I support Jonathan's comments that even if they do exist, they are going to cut things like burn programs and maternity and things like that, that we cannot afford to lose.

And don't forget that Medicare does support the disabled, and this is where they get care, and it's the only place they get care.

And so I do feel like it's very, very important that we support particularly the government institutions and that we take care of that in this process.

And I'm also struck by, just on Dana's comment on the CAHPS data, that we're still at a point here now where half the patients discharged don't understand their discharge instructions. I realize that's not a payment issue, but it is certainly a beneficiary issue that we need to pay attention to.

Thank you very much for fantastic work from the staff, very innovative thinking, very creative, and solving a lot of problems at once.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks. I also wanted to commend

the staff for really fantastic work here. It's obviously fundamentally very important.

First off, I just wanted to support the Chairman's draft recommendation, both components, and I'll touch on each briefly.

In general, I think it's important for us to remember that there is a balance here that we, as a Commission, have to strike between -- especially so if we start with the first part of the Chairman's draft recommendation with the uncertainty that is facing society right now, with what empirical data says. And I think it's hard to find a perfect answer here.

I think the role that MedPAC plays in the broader ecosystem of the legislative process, et cetera, I think it's fundamentally important that we stick with a consistent set of MedPAC principles so that it's very interpretable what MedPAC is saying, year after year after year, based on what the economic indicators that we do observe are. And if we stray away from that, I think it starts to make it very difficult to interpret what MedPAC recommendations mean in the shifting landscape. So I think that consistency is really paramount for us to be effective

and for the recommendations that we have to actually stand for something that is interpretable over time.

In that context, I think the Chairman's draft recommendation of adding the 1 percent to current law for hospitals makes sense, and I certainly support it in that context, notwithstanding the fact that Greg and others have pointed out, that there is a moving target here, and there is a lot of uncertainty, and that's something that we should obviously keep track of as we go forward, cycle after cycle after cycle.

The next big bucket, of course, is the safety net work. Again, I want to reiterate that I support the direction that we're going here very strongly. I think it makes a lot of sense from the perspective of really understanding that MedPAC is looking through the purview of the Medicare program.

That being said, I think there are a couple of things that are worth pointing out. I strongly agree with Dana and Lynn that we should be very explicit, maybe even add a footnote, that this is a Medicare safety net index. This is not necessarily a redefinition of what safety net hospitals are in the broader ecosystem, across multiple

payers. And it's worth pointing that out very clearly because MedPAC reports get cited by academic researchers, policymakers all over the place, and it could be potentially misinterpreted. And I think that's really, really important that we proactively try to get ahead of any potential misinterpretation or misuse of that notion of what we should call a Medicare safety net index.

I think there are a few different aspects of the policy that are worth highlighting, and I think that are really fundamentally great in the way that the staff has designed it. The add-on structure of how this works, I think, is really important. It means that every low-income beneficiary effectively, that a provider decides to care for, there is an additional payment, there is an additional increment to the rate. That is the type of incentive that we want to create. It doesn't matter if you're at the low proportion of the safety net index or the high proportion. You always get that benefit of taking care of a patient who would qualify effectively for the safety net index, and that's really very, very fundamentally important that the policy is designed in that way, which I should note is not the way that the DSH system is currently designed. So

that's a really fundamentally huge improvement, I would say.

The payments directly to the hospitals and the fact that these payments don't count in the MA benchmarks also are two other features, I think, that are really worth highlighting, that make a lot of sense.

At the same time, I definitely agree with some of the concerns that Lynn and Jonathan and others, and Stacie, have highlighted, in that it's important for us to understand what the puts and takes are, if you will, around this transition that we would be recommending, and at least quantifying the number of hospitals, for example, makes sense, perhaps understanding some of their characteristics, whether it's regionality or others, certainly makes sense. It makes sense for us to make recommendations with eyes wide open, in some sense, understanding that there will be these puts and takes. So I support trying to get additional information around that.

And in the same breath I would say I support exploring ideas around, even if it's more text-based in terms of how the implementation can happen in terms of a transition or looking at sort of a stop-loss type of system

where we don't create large shocks over short time periods for hospitals, as Lynn has highlighted, that probably don't have a lot of capacity to absorb those shocks. And the broader policy ecosystem needs some time to be able to actually step in and make adjustments as it might need. So I would support that kind of articulation of a transition supporting transitional pieces.

At the same time, all said and done, I'm every supportive of this because I think it does move us in the right direction, and we should be careful for making policy design for small numbers of entities that kind of hold back the broader system from moving in the right direction. So for that reason I strongly support the safety net work and the approach that we're taking. Thank you.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you very much. I really appreciated the innovation and the precision in this chapter.

A couple of thoughts that are perhaps a bit different than some of the things that have been on the table. I want to follow up on Scott's comment about relatively efficient, and I do think some explication is

needed, and it doesn't need to be long.

But as I read this, when I think about efficient, that means getting rid of cost, and getting rid of cost usually means getting rid of people, and the greatest labor cost, of course, is nurses. And yet we have the quality metric, which metrics are largely nurse-sensitive or nurse-driven. So I just think some explication around that is really important.

And the reason I think it's so important relates to something in the narrative but also on Slide 6, that the rapid response of the current virus pandemic stems through the many hospitals could substantially lower their costs in response to declining volumes over a matter of months, and that's absolutely true. But, of course, they did that by furloughing nurses and others. And of course, you've all heard and read about, oh, you're heroes and you're heroes, and then, oh, you're actually laid off.

And then there were opportunities for facilities to use some of their funding, federally, to really help stabilize their workforce rather than lay them off, and many did not. And then there was a great surprise that people are chasing the money to become travelers.

So the reason I think this is so important is I support these recommendations. I probably would've supported a 0.5 versus a 1 percent. But I could go with 1 percent because I really would like to see that this revenue goes to the people at the working surface. And we know that traditionally that has not been the case. And we think about the quality metrics discharge planning. That is all about a person -- a social worker, a nurse, somebody translating the medical culture to the person's culture, understanding their living circumstance, their health beliefs.

So if we want these metrics to look better it has to end up in the hands of people. So I could live with a 0.5. I really hope we can see that we can see that organizations really take the opportunity to change the patient experience. And just very briefly, other states have found that that has not been the case. When there has been more revenue, not increase staffing, not new service lines, et cetera, not investing in the expensive services that don't bring a lot of revenue. So I can certainly support that, but I will be watching, of course.

I strongly support the Medicare safety net index.

I think it's absolutely the right thing. I think it would be important to understand more dynamics of it, but I strongly support it, so I support the recommendations.

DR. CHERNEW: Thanks, Betty. And just one comment on the service line. There is a relative price issue, which we are not dealing with here, which is how to make sure that services are relatively priced. But let's move on because we're getting towards the end of the session and we still have a lot of people that need to talk.

MS. KELLEY: Okay. I have a comment from Scott. He says that he agrees with the recommended current law plus one update, given particularly the challenging labor inflation environment and the need to build and maintain resiliency in this sector as we continue to face public health challenges that unfortunately often fall heavily on hospitals. He applauds the rigor with which the staff has iteratively developed the SNI approach herein articulated, and agrees with its underlying logic and recommendation.

I strongly agrees with the proposal to directly distribute rather than leave it up to the MA plans to distribute the MA portion of the SNI money, for several

important reasons.

And I have Kenny next.

MR. KAN: I would like to commend the staff on an excellent chapter. I just have three points to convey.

First, I do like the framing of the draft recommendation as a current law plus an adjustment, point number one. Point number two, regarding the adjustment, as to whether it should be a higher or lower number, I continue to struggle with the lagging or leading indicator issue while trying to strike a balance consistent with MACPAC principles. So I'm wondering if it would be possible to see how the 10-year forecast error of 2.4 percent could change, or be mitigated.

While I've not studied anywhere close to what Greg has studied regarding 30 years of history on that, I would be really curious to see how that could be mitigated if we took a look at how that would compare with the unemployment rate in the health care services sector and also the yield curve. I mean, the yield curve has been actually declining. It's an inverted yield curve for the past six months, so the yield curve tends to be a very, very accurate indicator of recessions, which could

eventually probably lead to a softening in the labor market. So I would be very curious to see how that could affect it. I mean, I realize there's a bit of a hindsight bias analysis, but I'd be very curious.

Point number three, I applaud the rigor of the safety net index. I really like Lynn's idea of calling it a Medicare safety net index, MSNI. That said, while I support the targeted approach, I am cognizant of the imperfections, especially, and probably want to study a little bit more and think through some of the cost shifting, unintended consequences in an all-payer world, though perfectly cognizant that we need to stick to our Medicare limited scope.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thank you. I want to start -- and I recognize we're short on time -- by expressing support for the Chair's recommendation. I think current law plus 1 percent helps deal with a lot of the uncertainty out there, particularly in the context of new inflation data, and I think consistent with our objectives we want to try to ensure that we can address declining Medicare margins to ensure access for Medicare beneficiaries.

I want to reinforce a comment that Dana made around the patient experience quality measures. I agree that there could be some additional text added to help folks understand the interpretation of those measures and also paying attention to those declines.

One of the ones that struck me in particular was the 3-point change, negative 3-point change in cleanliness, and I think this aligns with emerging information about increases in infection rates that hospitals have been reporting. So again, I think we need to really pay attention to those indicators.

With respect to the safety net index, I'm all in favor of relabeling it to the Medicare safety net index. I'm very supportive of a move in this direction. I think it's a much better targeting of resources. I like the fact that the payments will move directly to providers, that it will be excluded from the MA benchmarks, and the fact that it includes both inpatient and outpatient.

And I recognize that the DSH payments have been subsidizing non-Medicare patients for many years, and I think we all struggle with how to think about that since we are operating in this multipayer world.

You know, I am supportive of some of the comments made by the other Commissioners that it would be helpful to get some additional information on those organizations that are going to be most heavily impacted, and I think while we don't get into the implementation process per se, I think maybe signaling sort of a more gradual transition to this may allow the other sectors that will need to step in and try to help some of these hospitals that are going to be adversely affected, you know, step up to the plate, given the absence of these cross-subsidies.

MS. KELLEY: That's all I have in the queue.

DR. CHERNEW: I do want to hear, if I got this correct, I would like to hear from Wayne and from Larry. Did I miss something I shouldn't have missed? So Wayne.

DR. RILEY: Yes. I support the Chair's recommendation, mindful of the discomfiture that many of us have expressed around the macro environment of health care, inflation pressure, workforce, supply chain, et cetera. But I think it's the right direction.

In terms of the Medicare SNI, I agree with it. I do have a second point of discomfiture around the possible impact to state, local, and municipal hospitals. I'm a

proud product of Ben Taub General Hospital, where I did my residency and began my career, and I just know the tremendous impact that places like that make in the lives of Medicare beneficiaries. So just something we need to monitor going forward, but otherwise supportive of the recommendation as outlined.

DR. CASALINO: Yeah. I mean, really, as usually, great work by the staff and an extremely interesting discussion today. I'm glad I'm going last, actually, because I learned a lot.

So I'm very supportive of the SNI work. I agree with changing the name, both because of the general concern that Dana mentioned but also because I think it actually does play into the concern about the hospitals that might get hurt, and I'll come back to that in a minute.

I think it's also different than the physician safety net index that we proposed, in terms of -- which does actually capture more of what most people think of a safety net, to avoid confusion with the physician safety net. And I think this has practical importance. It's not just a trivial issue.

You know, I think in terms of the hospitals that

may get hurt, Michael's comment about why might they get hurt. And so if you're a government hospital, I mean, some are run better than others, but it's not really their fault. And so I do think we may want to call out, at the very least, call out more in the discussion this issue. And when you think about it, is kind of a -- well, I won't editorialize. We should probably give some consideration to whether some of the $2 billion should be directed directly to some of these hospitals, at least for a time.

And to Michael's comment about the why, I am more concerned about the government hospitals that would be losers than teaching hospitals would be the losers, because I think the why may be different there, as to why some teaching hospitals might get hurt as opposed to why a lot of government hospitals would be hurt.

So at least call the issue out, change the name to Medicare hospital safety net index, and think about whether there should be some of the $2 billion put into helping those hospitals.

And then just the last thing I have to say about Jaewon's comment. I do support half a percent, 1 percent increase over current law. And, you know, the fact that

there's some inflation update baked into current law is somewhat reassuring in terms of the more volatile environment that we've been in.

But I do just want to highlight Jaewon's comment about empirically based. I think we all agree that our recommendations have to be empirically based, but Jaewon pointed out that there are other sources of data. This is going to come up for me, I think, for the physician discussion. But there are other sources of data, and I think it would be just good to think carefully about some of the ones that Jaewon mentioned. And I'm not suggesting a revision in the current recommendation, but just going forward thinking about sources and whether they also are empirical, and more or less quantitative sources that could be considered in next year's work.

DR. CHERNEW: Larry, thank you. If I have this right, and I might not, Robert, there was something you wanted to say. So you actually are going to get the last -- well, actually, I'm going to say something after you. You're going to get the second-to-last word.

DR. CHERRY: Sounds good. Thank you, Mike, and I'll be brief so you can have the very last word. You

know, listening to the context of the ongoing discussion I also wanted to reiterate sort of three points.

One, I totally agree with renaming this to the Medicare SNI, and I think we should be very explicit about the problem we're trying to solve. We should be leading with the statement that we're trying to replace a flawed DSH payment model with a Medicare SNI model. Because, you know, we're talking about a lot of different things, but simply speaking, that's the problem we're trying to solve, and it's a talking point that we should really lead with, because that will decrease some of the angst.

Regarding one of the unintended consequences, which is around government facilities, both at the state, county, and city level, maybe we should just rerun the model and take into consideration that they are all safety net hospitals, because these state and local governments have created these facilities for a specific purpose in mind, and see what the numbers look like, running them as safety net facilities. That might solve at least one or more unintended consequences.

And then in terms of teaching hospitals, I do agree that it needs to have further study. I would like to

see not just the bottom 5th percentile but how far this goes in terms of the bottom decile and the quartile as well.

So those are the three sort of explicit points that I wanted to make. Thank you.

DR. CHERNEW: Okay. So let's see. I'll start with the consensus, which is that we should rename the safety net index to the Medicare safety net index. And I think that is important for a whole – well --

[Laughter.]

DR. CHERNEW: Thank you all for coming. If you have comments about my eloquence, please send them to meetingcomments@medpac.gov, and any other things you may want to comment on.

But I do think, to this point -- and we will take this back. So there is clear concern on at least two levels. One is we're in a very turbulent, uncertain time, so there is just a question about what the right level is. And in the update recommendations we have come up with 1. I think there's been some notion that, well, you know, putting more money in doesn't solve all of the problems that you have. I think saw that for how COVID relief went.

If there's a tendency with, you're in turbulent times to put in a lot of money, maybe too much sometimes, I'm not going to argue. How we came up with the 1 was very specific related to some very specific criteria about where we thought the efficient hospitals would be in 2024, knowing it's, to use Jim's word, "squishy," and understanding that some of the parts of the squishiness will be adjusted for in the current law portion of it. But that's how we ended up with that.

And so one problem we were trying to solve was, frankly, there was just a gap between the input cost growth and where the update had been in 2022, and we have to try and get back to somewhere where we are sort of that notion, understanding we're not targeting a particular margin of efficient hospitals as our only indicator, but in this case it's a particularly important one. That's how we ended up there. So while I think there's angst, I think there seemed to be relative comfort that we're ballpark right, and honestly, if we can end the day ballpark right, I'm going to take that.

There was a lot of other concern, and I heard this back and forth, and I've heard, actually, a span of

opinions about the unintended consequences associated with the Medicare hospital safety net index. I'm sure that means something to someone. In any case, understand that the problem we are not trying to solve -- and this is really important to say -- we are not trying to solve the underfunding of general safety net hospitals by other payers. That's just not a problem we're trying to solve.

We aren't trying to intentionally pull money away from them. In fact, I think in some sense we're trying to put more money broadly. Many of those hospitals do serve Medicare patients, and we are actually sort of makes sense that they're serving low-income Medicare beneficiaries. We are, in fact, trying to give them more money, to the extent to which that is true. But it is true that one of the things we're trying to adjust for is the poor targeting of DSH. And so while it would be tempting to try and undo some of this, to get back to some more of the poor targeting, I'm actually kind of hesitant to get into that world.

Because I don't want to get into a world where we have a recommendation which says we want to support Medicare hospital safety with the safety net index, and oh,

by the way, there are some other hospitals that aren't quite Medicare safety net hospitals, but they're really important hospitals, which, by the way, they are. And I will say they are very important hospitals to Medicare beneficiaries. I'm fully aware that they're important hospitals to Medicare beneficiaries. But I don't want to get into a world where they are having a separate subsidy system for hospitals that are facing a series of other challenge.

And that doesn't mean that in my other hat I don't believe there should be other subsidies to those people, but we have a very prescribed set of activities that we're doing now. So we will take the different views we have heard today on that point back. I will be speaking with you about this all one-on-one between now and the time when we come back in January, so we can delve into your views more than the four minutes or three minutes that you got to talk.

So I will close with two points. The first one is -- and I mean this part, generally -- please, if you've joined us online and you have comments about this discussion, send them. There are many ways you can send

them -- meetingcomments@medpac.gov is one way. You can reach out other ways. We have gotten letters from a lot of organizations, and we really do appreciate them, and we have looked and discussed them. And if you're listening, we discussed them in Executive Session as well. So understand that we are aware of the comments.

And the last thing I will say, and I started with this so I want to end with this, and I probably won't do this for every session so this is just important. I really do want to thank the staff. I think it should be clear from the answers from Round 1 questions, the answers from Round 2 questions, the amount of work they have done, how knowledgeable they are about the details of what's going on in this sector, and I really appreciate all the effort and leadership the staff has given to developing these recommendations and where we are. They really do provide the continuity that Amol was talking about, over time, and how we do this, and that is actually really important.

So in any case, we are not going to take -- what we are going to do, I think we should move just straight into the ASC. We had a five-minute break scheduled but I think we should move into the ambulatory surgery center

discussion. And if people need to step out for a second, you know, I understand.

But again, to Jeff, Alison, and Jared, thank you very much.

I will say, as we do the switchover, this is a somewhat different treatment of ambulatory surgery centers in that we are not going to have recommendations in the way we have in the past. Much of what we've said in the past still stands. And so this is a little bit more of a status presentation as opposed to a draft recommendation presentation.

So maybe we just should have taken the break. Dan, I'm going to wait for you to give me the sign that you're ready to go, and then we're going to start.

DR. ZABINSKI: I'm a lot older than I used to be, so I'm a lot slower.

DR. CHERNEW: That is a common problem.

[Laughter.]

DR. CASALINO: You have little sympathy from this group.

[Laughter.]

DR. ZABINSKI: Okay.

DR. CHERNEW: All right. So we are now going to turn it over to Dan, who is going to discuss where we are on ASCs. Dan, thank you so much.

DR. ZABINSKI: All right. Okay. In this presentation, we'll provide a status report on ambulatory surgical centers, or ASCs. For the broader audience, a PDF version of the slides is available on the webinar control panel on the right side of your screen.

Since 2010, MedPAC has provided standard payment adequacy analyses for ASCs. But this year, as Mike mentioned, we're instead providing a status report.

We have made this change for several reasons.

One is that the ASC sector is only a small part of Medicare spending. In 2021, for example, Medicare spending on ASC services provided to fee-for-service beneficiaries was just 0.5 percent of total Medicare outlays.

Also, since 2010, ASC payment adequacy measures have steadily improved. During that period, the Commission made similar update recommendations for ASCs each year.

Third, ASCs don't submit cost data to CMS, so we're not able to evaluate the financial performance of

ASCs.

Finally, we have issues with the quality data for ASCs. Currently, there are few measures for evaluating ASC quality, and we feel that these measures do not provide a full representation of ASC quality.

Because of these issues regarding ASCs, we're providing a status report rather than an update chapter. In this report, we'll restate one of the recommendations from the March 2022 report, and we'll display that recommendation on a slide later in this presentation.

Again, the fact that ASCs don't submit cost data has been an issue that the Commission has long focused on. We've emphasized that cost data are needed to evaluate the financial performance of ASCs and for developing an appropriate price index for that sector.

The Commission has annually recommended since 2010 that ASCs collect and submit cost data. Collection and submission of cost data should not be overly burdensome to ASCs, as other small providers such as hospice, HHAs, and RHCs all submit cost data.

CMS has shown some interest in requiring ASCs to submit cost data, but the agency hasn't acted. Also, the

ASC industry has argued against submitting cost data, saying that it's not needed for setting ASC payment rates.

We also have issues with the ASC Quality Reporting Program, or the ASCQR, as the ASCQR currently has only four measures, and these measures don't effectively represent the quality of care in ASCs. In your meeting material, we discuss four types of measures that CMS could add to improve the ASCQR.

First, CMS could add claims-based outcomes measures that in some way represent all ASCs. Currently, the ASCQR measures only have outcomes measures for colonoscopy and cataract procedures.

CMS could also add measures that apply to both the ASCQR and the Hospital Outpatient Quality Reporting Program because there's a lot of overlap between ASCs and the hospital outpatient departments. Several measures that could be used in both the quality programs are currently used in only one of them.

Third, CMS could add a measure for the rate of surgical site infections. And, finally, CMS could add measures that reflect specialty-specific guidelines. For example, the American Cancer Society produced a guideline

in 2018 that patients aged 85 or older should not receive colorectal cancer screening. A measure reflecting that guideline could be applied to ASCs that provide gastrointestinal procedures.

On this slide, we present some background on ASCs to provide some context for the rest of the presentation.

The general purpose of ASCs is simply to provide outpatient surgical procedures.

The most common types of procedures include cataract, gastroenterology, and pain management.

For most services covered under the ASC system, CMS bases the payment rate on the payment rates from the outpatient prospective payment system, or OPPS, which is the payment system used to set payment rates for most services provided in hospital outpatient departments. And the general process of setting payment rate for a service under the ASC system is to multiply the relative weight for that services from the OPPS by a conversion factor from the ASC system. And that ASC conversion factor is much smaller than the OPPS conversion factor, so, consequently, the ASC payment rate for most services is only about 50 percent of the OPPS payment rate for the same service.

Now, an overview of the status of ASCs in 2021 includes that: Medicare fee-for-service payments to ASCs were $5.7 billion; the number of fee-for-service beneficiaries served was 3.3 million; and the number of Medicare-certified ASCs was about 6,100.

Also, the ASC payment rates will receive an update of 3.8 percent in 2023, which is the same update that hospitals will receive under the OPPS.

For 2021, we found that the number of ASCs increased at an average annual rate of 2.3 percent since 2019.

In addition, in 2021 volume of services in ASCs rebounded to pre-pandemic levels. From 2019 to 2021, the share of fee-for-service beneficiaries served in ASCs increased at an average annual rate of 1 percent, and the volume of ASC services per fee-for-service beneficiary rose at an average annual rate of 0.6 percent.

Even though the number of ASCs has been steadily increasing, the geographic location of ASCs is uneven. Among the states, the number of ASCs per Part B beneficiary, which includes both MA and fee-for-service, varies from a high of 38 ASCs per 100,000 beneficiaries in

Maryland to a low of only 1.5 ASCs per 100,000 beneficiaries in Vermont. A factor that affects the number of ASCs in a state is whether the state has a certificate-of-need law.

There is also a difference in ASC concentration between urban and rural locations, where urban areas are defined as being in a metropolitan statistical area.

In 2021, 93 percent of ASCs were in urban locations, while only 7 percent were in rural areas. This difference between urban and rural concentration of ASCs has resulted in a fairly large difference between urban and rural beneficiaries in the extent to which they receive care in ASCs.

An underlying reason for this discrepancy between urban and rural areas is that rural areas often lack the surgical specialists and population density to support the ASC payment model.

Now, regarding revenue, ASC Medicare revenue in 2021 was well above the pre-pandemic level after dropping in 2020.

From 2016 to 2019, Medicare revenue per fee-for-service beneficiary grew at an average annual rate of 7.7

percent, and from 2019 to 2021, it rose at an average annual rate of 8.7 percent.

Much of this growth in ASC Medicare revenue was from increased provision of relatively complex services such as implant of spinal neurostimulators and knee arthroplasty.

A summary of the status of ASCs is that they have largely rebounded from the effects of the pandemic. In 2021, the number of ASCs increased. Also, the volume of services and Medicare revenue were above pre-pandemic levels.

Finally, an overall concern about ASCs is that the concentration varies widely among geographic areas. Therefore, access to ASCs might be difficult in some areas.

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

As I mentioned earlier in this presentation, we intend to republish one of the ASC recommendations from the March 2022 report in the status report that will be in the

March 2023 report. This recommendation reads: The Secretary should require ambulatory surgical centers to report cost data.

As we mentioned on Slide 2, our reasons for republishing this recommendation rather than providing a new update recommendation include: ASCs are a very small part of Medicare spending, only about 0.5 percent of total Medicare outlays; MedPAC has made similar update recommendations for ASCs each year since 2010; ASCs do not submit cost data, which limits our ability to evaluate the financial performance of ASCs; and the measures in the ASC Quality Reporting Program need to be improved so that we can effectively evaluate ASC quality.

So, for today's discussion, we'll address the Commissioners' questions and comments. Also, we want to determine the Commissioners' support for republishing the March 2022 recommendation listed on the previous slide.

Finally, if anyone has fresh ideas on how to encourage the collection of cost data from ASCs, we would like to hear them.

Thank you, and now I turn it back to Mike for questions and discussion.

DR. CHERNEW: I didn't know that was coming.

So given the sort of uniqueness of how this chapter is fitting in, we're going to go with one round. So if you're in the Round 1 queue, you're now just in the queue. If you're in the Round 2 queue, you're now just in the queue. If you want to be in both queues, you should say what you're going to say in your one chance to say it. We may get to do a Round 3, which will then be Round 2, but that's just not a good way to chair a meeting.

In any case, Dana, do you want to start? I think Scott was first, but he had two sets of comments, and so it gets a little complicated, Dana.

MS. KELLEY: Yes, Scott has a question and a comment, so I'll start with the question.

Do we understand Congress' or CMS' reluctance to require relevant cost data?

DR. ZABINSKI: Not really. Like I said, CMS has shown some interest, and right no they're in a process for over a five-year span they said they wanted to pay ASCs or update the ASC payment rates at the same rate as HOPDs. In previous years, they used the CPIU rather than the hospital market basket. They wanted to put the two on the same

footing for a while, and during that time frame where, you know, they're paying the ASCs based on the market basket, they wanted to assess the situation of the feasibility and the appropriateness of collecting cost data.

So it's not like CMS is reluctant. It's just like they're not -- I don't know. I guess maybe -- but they're not sure what they want to do. I guess that sums it up.

DR. CHERNEW: Let me just give one other comment, although I have no insight, so -- CMS has a lot on its plate. Sometimes when things don't get done, it's not because they don't agree or not. Sometimes things don't get done just because there's a lot of things to get done. So, in any case, Kenny's comment.

MS. KELLEY: I have Scott's comment first.

DR. CHERNEW: Scott's comment. I'm sorry.

MS. KELLEY: His comment is: Given the understandable and significant concern around appropriateness and, therefore, potentially the value of many procedures performed in ASCs -- see, for example, the Dartmouth Atlas, et cetera, data on practice pattern variation -- as well as the reality of more than adequate

payments, as just described, Scott would like to see the development and implementation of measures around: one, the appropriateness of high-volume procedures with documented high practice pattern variation; and, two, development and implementation of at least a pilot set of measures around long-term functional clinical outcomes for procedures that are performed explicitly to create clinical and/or functional improvements, for example, cataracts and visual and QOL outcomes, THA/TKAs and long-term function/QOLs, and perhaps most critically of all, interventional pain procedures and long-term function/QOL/opioid use, et cetera.

DR. CHERNEW: That wasn't a question, but we're going to treat it as such. One of the key issues in ASCs that has come out in the past is a site-neutral aspect of it. Many of those types of comments would pertain to those same procedures had they been done in a different setting, in an HOPD, for example. So I think we'll keep the site-neutral aspect of this in mind.

Okay. And am I right that Stacie's next?

MS. KELLEY: Yes.

DR. DUSETZINA: Great. Thank you. So I wish I

had new fresh ideas about how to get this information, but I do support the idea of republishing and reemphasizing that cost reports should be required from these centers.

I did want to say I think the chapter does a really nice job of kind of talking about the good and the bad; you know, the good that we have some lower-cost services that people are able to receive, that's a more efficient care setting, and, you know, that it saves beneficiaries money. I think that's all excellent.

The pieces around the low-value services did raise a lot of red flags, and I think, you know, much like Scott's comment, I completely agree with the suggestion of having better measures here that actually relate -- quality measures that relate to the types of services that are high volume around the eye procedures and pain management in particular, which were flagged in the chapter. So I think that really emphasizing that the quality measures, it would be nice to be able to compare across care settings in some cases and have consistent measurement, but also for things that are high volume, I think we really need to think about what's the best quality measure there.

And I guess one last comment is just something

that I've been sort of thinking about this in some of the other chapters is the increase in private equity ownership of these sites of care. I don't know -- you know, to me that strikes me as an important area to be monitoring for thinking about how are we measuring and thinking about quality for beneficiaries given maybe different incentives.

Thank you again for a fantastic chapter.

MS. KELLEY: David.

DR. GRABOWSKI: Thanks, Dan, first for this great work. I'm also supportive of republishing the annual recommendation to show us your cost reports. I found this ridiculous when we first joined six years ago that this sector wasn't submitting cost reports. It's done in the State of Pennsylvania, as mentioned in the chapter. It's done for smaller sectors like hospice and home health. There's no reason they can't do it.

I've said this in the past. If ASCs won't provide their cost reports, we won't provide them with a payment update. I wonder if we might switch from no recommendation to no update in the language, but that may be a minor point and not a relevant one.

In terms of ideas, I don't know if this is a

fresh idea or not, so that's a high bar. But I wonder -- in other sectors, we've been very negative about pay for reporting, but could you actually incentivize this through the payment system, not with new dollars but with a withhold of some type in their rates, that if you don't sort of provide cost reports, you're subject to this payment withhold. But I appreciate the challenges with that type of approach.

Once again, Dan, great work, and I would just strengthen the language once again about how do we get these cost reports provided. Thanks.

MS. KELLEY: Lynn.

MS. BARR: Thank you. I also support the republishing of recommendations and the kind of saying, look, we're not even going to do this anymore if you don't give us the information. I think that's smart. And I would go with the zero update until we find out more, you know, because I think the private equity interest in this is a clear indicator of high -- all right, they don't go where the money isn't. And so that is a red flag.

I have a Round 1 question about Maryland and the number of ASCs in Maryland, and I'm wondering, is this

related to their all-payer model? And are they gaming the system somehow? Is that what's going on here? And is there any discussion around that?

DR. ZABINSKI: I'm actually looking at Jaewon because I think he can probably answer this more eloquently than me. I'm going to give it a shot, though. The answer is yes, apparently, and "gaming," I'm not sure that's a fair word. It's -- okay. You know, the way it's set up that allow them, you know, the providers, to shift things out of the hospital outpatient departments into another setting that does essentially the same thing, which is in this case ASCs. And they can -- you know, they lower their spending, consequently, and the ASC spending is outside the budget. I think that's the way it works. Does that sound right?

DR. RYU: Yeah, and I'm definitely not the expert, and Kenny probably knows, but I believe -- I was going to say it has to do with moving things out of what's within the scope of the waiver.

DR. ZABINSKI: Yeah.

MS. BARR: Right, but what's to be -- I mean, it seems to me there needs to be a fair amount of discussion

around that, because what is actually being done there and are we double-paying -- you know, I mean, or is this out of the scope of --

DR. CHERNEW: This is out of the -- so

MS. BARR: Out of scope.

DR. CHERNEW: Maryland is an interesting model. It is in some ways an alternative payment model that is quite unique to Maryland. Unlike all of the work we've done on alternative payment models that are sort of, for example, population-based, the money's with the person and you're responsible for everything, Maryland is a very site-based system, which leads to this other type of problem. But we're not going to really weigh in on the Maryland model and what it does or doesn't need for ASCs, so I think it's actually for the reasons that were said, pretty unique to where we're going. So let's keep going.

MS. KELLEY: Larry?

DR. CASALINO: Then do I remember correctly that we have made recommendations in past years, or am I imagining that?

DR. ZABINSKI: We essentially made the same recommendation --

DR. CASALINO: No, I'm sorry. We've recommended the -- sorry to interrupt. We've recommended the cost reports, but --

DR. ZABINSKI: Yeah

DR. CASALINO: -- have we recommended -- I think we have --

DR. CHERNEW: We have made update recommendations.

DR. ZABINSKI: Yes, zero

DR. CASALINO: And they've been -- yeah, they've been quite strident. So what has changed that we aren't making a recommendation this year on the payment increase?

DR. ZABINSKI: Jim, do you want to handle that one?

DR. MATHEWS: Again, as Dan said at the outset, the overall circumstances of the payment system or the sector haven't changed. The few indicators that we have suggest, you know, it is -- that Medicare payments are adequate, and given that it makes up a relatively small share of Medicare fee-for-service spending, we have decided that there is diminishing return on investment to just saying the same thing over and over and over again.

DR. CASALINO: Okay. Well, that was my Round 1 question. My Round 2 comment is, first of all, I think ASCs are, you know, in general a good thing for the reasons that the report says, although there is a risk of overuse for sure. But there's that in HOPDs as well, maybe not with quite as strong incentives for overuse.

But it does feel like a win to me for the ASCs and not producing cost reports for us to not make a payment recommendation. It almost feels a little bit like, you know, taking our ball and going home; you guys aren't going to play right, so we're not going to play with you. They'll said, fine, we don't really want you to play with us; we'll just take our current lay payment increases.

So it's been zero percent the last few years. Is that right, Dan?

DR. ZABINSKI: Yes.

DR. CASALINO: I mean, I actually -- I mean, I would feel better with 0 percent and I would feel even better doing something along the lines of what David suggested, which is not -- well, you can frame it as pay for reporting, but practically speaking, it would be you get paid less if you don't -- than the other guys if you

don't submit cost reports. This would favor, unfortunately, actually better capitalized and bigger ASCs. But the idea of saying, okay, we give up, we'll say you should submit cost reports, but we're not going to try to put teeth behind that, it doesn't feel good to me.

MS. KELLEY: Cheryl?

DR. DAMBERG: Thank you. So I agree with supporting republishing the recommendations from previous reports, and I'm going to pile on to David's recommendation about no payment update if they don't provide their cost data. And I firmly agree that it's hard to understand what's an appropriate payment in terms of payment adequacy in the context of Medicare absent having those cost data. And I agree with Lynn's comment, you know, there's a lot of private equity investment in this space, and they clearly go where the profits are. So I think that's sort of telling us something.

And then in terms of quality measurement, I concur with the comments about trying to beef up what is measured. It seems to me that there are probably some measures of appropriateness that can be measured today using claims data. Others may require some additional

data. Always the challenge here. But it struck me that I didn't see a whole lot in there around indicators of poor quality such as infections or complications that develop as a function of people undergoing procedures in this setting. So maybe there's an opportunity there.

And then I think additionally we also need to get at measures of functional status improvement in outcomes for patients. And I guess the one thing that I would say here is I know CMS has been investing some resources in trying to develop outcome measures. I think in terms of the mix in their portfolio of what they pay for in terms of measure development, I think they're underinvesting in outcomes measure development relative to just general process measures and continuing to maintain process measures in their queue. And so I think there could be some recommendations about CMS kind of rethinking their measure development investment strategy.

MS. KELLEY: Kenny?

MR. KAN: Thank you for a fantastic chapter. So, one, I support republishing the March 2022 recommendation. It would be great if we can also like insert as part of the republishing any learnings that we may glean from the

Pennsylvania work that would be helpful. And I actually agree with both Mike and Jaewon. I think the Maryland 38 per 100,000 beneficiaries is really very unique, possibly due to the all-payer and the Medicare waiver model.

MS. KELLEY: Robert?

DR. CHERRY: Yes, thank you. This is a great report. I definitely appreciate all the work that has been put into it.

Just a couple of comments, one on the cost data. I think as a new Commissioner I'm a little bit -- maybe somebody can educate me offline on why this is so difficult to get, because it just seems as though it could be a force function by creating a 2 or 4 percent penalty if you're not submitting the cost data. Obviously, there's something else going on because this has been requested in the past and has not been successful.

The other thing I wanted to discuss was, you know, the more robust quality measures, but specifically appropriateness criteria. It's subtle, but there's a difference between indications for surgery and appropriateness for surgery. So an indication for surgery, somebody has had, you know, a colonoscopy, a biopsy;

there's positive cancer, so they're going to get, you know, a colon resection.

There's appropriateness, which is a little bit different, and one of the examples mentioned is, you know, you should probably not get colorectal screening over the age of 85. So oversimplify this, an 84-year-old, let's say, comes into a doctor's office a month before their 85th birthday. They get a FIT test as a screening for possible colorectal cancer. It comes back positive, which would be an indication to get a colonoscopy.

Now, this 85-year-old, who's now a month from turning 85, is otherwise healthy, no serious co-morbidities, probably expected to live another seven years, should you go ahead and get that colonoscopy and perhaps treat, you know, early Stage 1 colon cancer in an otherwise healthy individual that's expected to outlive any potential complications from their colorectal surgery? That is a question where, if that surgeon proceeded, despite the recommendations, would undergo a clinical review to see whether or not the decisionmaking was appropriate. And it's likely that many would find it to be appropriate in the context of the way this was just presented.

So appropriateness really requires clinical review and, you know, by appropriate peers and to make sure that the clinical judgment was in line with, you know, evidence-based approach. So I think the difficulty with ASCs is that unless they're hospital-based, it's very difficult, I think, to do appropriateness standards. So I would favor more, you know, sort of traditional quality measures until they're more mature and can do, you know, true appropriateness standards.

Otherwise, you know, great report and I support the recommendations.

DR. RAMBUR: Thank you. I really appreciate this chapter, and I just want to pile on the comments on appropriateness. The other piece is all the complications that can happen with a procedure, et cetera, et cetera, where you turn a person into a patient. So I do support reiterating the recommendations, and why now is specifically is that is an era of greater transparency. Every organization and service is really having to do a lot with cost and outcomes, so why one particular group should be exempt does not make sense to me.

In terms of measures, appropriateness,

infections, and unplanned admissions to a hospital would be of most interest to me as a consumer of health care, and the potential to link quality to payment I think is really important. So I definitely think we need to be very forceful on making strong recommendations, that they're included in the contemporary cost and outcome systems.

MS. KELLEY: Greg.

MR. POULSEN: Thanks. I would also support republishing. I think it's great. I appreciate the good comments here.

I do think in terms of policymakers, there is a potential to take some of the ideas that we've talked about here and make them a reason to support the extra effort that it takes to get the reports from ASCs, and that would be to look at whether we can identify differences based on ownership in terms of the way that the ASCs are utilized.

There were a number of studies -- I don't have them at my fingertips, but they certainly were out in the '80s and '90s -- looking at the potential for overtreatment based on the ownership status of the organization. And what we saw is essentially from one extreme where it would be owned by, say, Kaiser Permanente or the motivation would

simply be to identify a low-cost setting for services that would be provided anyway somewhere else, to neutral organizations where you may have some modest incentive for overtreatment based on the income of the providers participating but not getting any of the facility fee, to the other extreme, which is what we're seeing with a lot of the PE examples today where there's almost always provider equity also in those and has the potential, a greater potential to create an incentive to treat and to look for mechanisms that would identify the difference between those, would I think become more apparent when we had the cost data. So I think that would be another reason, maybe to your third point, of a reason to collect.

DR. NAVATHE: Thanks. Great work, and really quickly, I just wanted to say I support republishing the March 2022 recommendation and also support Larry and David's idea that I think a lot of Commissioners have supported around potentially considering still publishing a payment update recommendation around 0 percent and linking that to, if you want to be eligible for the higher update, that you have to support the cost report data, because that ends up providing a lot of information for us to do our job

correctly.

MS. KELLEY: Dana?

DR. SAFRAN: Yeah, thank you. Really great work. And I'll just pile on on a couple of things. This suggestion that has come up here around the negative update for not submitting cost reports, you know, just seems like a strong idea, and I'll put my support behind that.

Mostly I wanted to comment on the issues around quality and outcome measurement and appropriateness measurement. One or two times in past cycles where we've talked about ASCs, I've made the point that a service that you don't need at a low cost is not a bargain. And I feel like that is getting worse with the private equity engagement here, so the issue of appropriateness measurement feels like it's gotten urgent in this space. So really, I'd just double down on the previous Commissioners' comments supporting that.

And then, in addition, Scott I think started the ball rolling on quality-of-life measurement, and Cheryl backed that up about the importance of outcomes. I'll just say I agree 100 percent again that there's a connection between those and appropriateness, because in some work

that I was involved in earlier, when I was still at Blue Cross Mass, we were using measures of patient-reported outcomes longitudinally collected for patients that had procedures, and saw some really important patterns that it turns out, you know, have been picked up at facilities that use PROMs routinely in both deciding treatment and monitoring outcomes of treatment. And what it showed in those patterns was that there are functional status scores, if done at baseline, that tell you whether a procedure is likely to improve a patient's functional status or likely to make it worse. And not every patient falls, you know, above the threshold where it's a bad idea or below the threshold where it's a good idea. There are some gray zones where you need more than just that functional status score.

But the fact that that has been shown over and over for different body parts and that we're still not routinely collecting those data I think is problematic. I'll just add once it becomes high stakes, it's very game-able, so we have to really think about that, because, otherwise, you know, you have those who have an incentive to perform a procedure telling patients how to answer so

that I can get this taken care of for you.

But, nonetheless, I just wanted to emphasize my support for the comments about outcomes measurement and connect the dots between how that could help us with the appropriateness measurement.

Thanks.

MS. KELLEY: Marge.

MS. GINSBURG: I guess I wanted to go one step further and propose one option is that Medicare quit funding ASCs. We don't get information that we get from everybody else -- well, almost everybody else. Not MAs. Almost everybody else. It seems illogical. Why are we continuing to fund a particular service that does not provide the information we need to determine whether this service is both worthwhile and cost-effective.

Now, Congress isn't paying any attention to our other recommendations about requiring the information, so I don't necessarily think they will pay any attention to this one. But it proposes that as a new level of our frustration and unhappiness with what we're seeing. So I just wanted to throw that option into the mix.

DR. CHERNEW: Marge, thank you. If I've got this

right, Dana, that was the last person in the queue, so let me try and summarize what I think is a --

DR. CASALINO: Michael, could I have like 45 seconds? Seriously, only 45.

DR. CHERNEW: Seriously only 45? That's so precise, like why didn't you got -- I'm going to give you 50 seconds. Go.

DR. CASALINO: Amol, go ahead and set your stopwatch.

Number one, I think that recommending a withhold or some kind of direct difference between if you support cost reports or not is a much better idea than what we've done in the past, which is a zero update for everybody. That's number one.

Number two is I just want to draw attention to Jaewon's comment earlier about what empirical data we use to make recommendations and that private equity interest is something that possibly should be looked at when we look at our empirical implications.

DR. CHERNEW: Wow. You now all have to announce how long you're going to speak in advance.

[Laughter.]

DR. CHERNEW: You should know that my first time around the Commission, I was often sitting next to Jim, and he actually was timing everybody all the time. And I think I was seated next to him just to be aware of how long I was talking. They have never admitted that to me.

So a few things in a session that I think there's widespread agreement. First, this did not come up; there's actually widespread academic work now on ASCs. It's actually one of a hotter set of academic topics.

Two, I think there's universal agreement that the more we can understand quality and appropriateness, recognizing they're different -- one of them is how good a job are you doing what you're doing, and then are you doing what you're doing to the right people; those are important. And that, of course, will be a broad area of interest. You should know that's a lot of what the academic work is looking at, and they do it broadly from a patient-centered point of view, because I think we would acknowledge that there's a lot of volume that you would want to move from an HOPD to an ASC if you can do it with adequate quality. And so I think continuing to think about how we can measure both the quality and the appropriateness of what goes on in

ASCs is important.

With regards to the cost reports, there seems wide consensus, with some verging to outrage, that we don't have the cost reports. So as you might imagine, I'm supportive of that generally, we're going to republish it.

That being said, I am very far from outrage for some of the reasons you said. I have a pretty good idea what direction the updates should go in ASCs without actually having the cost reports. And while I think that we could get the cost reports with relatively little effort -- as pointed out, they do do that in other cases, and I think if we had the cost reports it would help. I don't think in the ASC space we are running blind as to what we need to do with the updates. And, in fact, the concern -- and I wish Brian DeBusk were here. Brian, I hope you're listening. Brian probably is. There's a lot of value in ASCs, right? And it is not the case that we would be better off without them. I think they can do a lot of things efficiently. They can do a lot of things I can think of better potentially because they're more focused on specific things. They can do a lot of things at lower cost. I think -- beneficiaries love. They can do a bunch

of things.

I think there's real, real value in the ASC sector, and simply because they don't give us cost reports doesn't negate that there's that value. So there's a question about in some sense how much do you want to -- I don't want to use this word -- it has been and will continue to be a long day. We don't want to punish them per se because we want cost -- we want cost reports. That's clear. We don't -- there's a question about how much you would really want to punish them until we get them. I think the right thing to do would be for CMS to just ask them to have them, which is what we have said.

I wouldn't want to shrink a sector that's providing a lot of value because we're not getting cost reports. That doesn't negate that I want the cost reports. So we will continue to think through how we play that out.

To your point, Larry, about private equity. I didn't say this as explicitly. Entry in a sector is an indicator we look at. Entry by for-profits is a particular indicator that matters. Whether it's for-profit or private equity I think becomes a little bit of a nuance. We had a private equity chapter. Larry here is sort of a national

expert on private equity. I'm not going to say anything about the distinction, but I think broadly entry into a sector by organizations that have an incentive to make money is an indicator that we're probably paying enough. It is important to make sure that when they enter, they're providing good quality. We very, very much don't want to encourage entry of for-profit providers that are providing bad quality and that we're driving out providers that are providing good quality. So there's some nuance across sectors. But that is an indicator that effectively gets captured in some of the things that we do, and I agree with your point on that 100 percent.

The last point, so this is harder. There seems to be a desire potentially to also rerun the update recommendation or some version of that, just to say again we think this should be a 0 update. And I think there's some logistical, production, staffing issues with how we make all of that really come to pass. So we will -- again, I think to paraphrase Jim, and I'm going to let Jim actually speak for Jim -- it's not that we disagree. I don't think that -- a version of a 0 update would be justified if we went down that path. It's really a

question about how important is that to say given the time and the effort it is to say it. And what I hear from this meeting is, in effect -- all of you pretty much said it, so in our calls I wouldn't have to focus on it. There didn't seem to be much dispute there.

SO we will ponder just logistically how that all plays out, but in that sense, I think that's where -- I do want to, given the tone of how this was, I do want to at least emphasize -- and the chapter I think does this -- the importance of ASCs in our system, the importance of the ability for both convenience, safety, and otherwise, to enable folks to do that. And I think I would have argued in, for example, an alternative payment model world where you could have a group -- this is exactly why I think some version of population-based type models work, is because that's where you have an incentive to do this type of allocation of patients and where your quality metrics are sort of more in a population-based level in all those things, and I think it is much better and we are just hamstrung by these silos of models, and certainly the Maryland example kind of shows where, if you pay one sector one way and another sector, you get different things.

Anyway, I won't belabor the distortions. I will just say again thanks to the staff, in this case thanks to Dan but more broadly, and if you have comments on this, please reach out. We can be reached at meetingcomments@medpac.gov, and we really do want to hear input from the public.

So, that being said, we are now going to take a break for lunch. Jim, do you want to correct anything I said before we do? That's a no.

So, again, thank you all, and we are going to return to have what will be a surely fascinating discussion about the physician update. We'll see you all after lunch. Thank you.

[Whereupon, at 12:47 p.m., the meeting was recessed, to reconvene at 2:00 p.m. this same day.]

AFTERNOON SESSION

[2:02 p.m.]

DR. CHERNEW: Hello, everybody. Welcome to the afternoon of our update meeting in December. We have a lot to do right now, and I think we're going to start with

Rachel and Ariel, who are going to talk about updating the physician fee schedule, and our station and recommendation related to that.

So Rachel, take it away.

MS. BURTON: Good afternoon. In this session, my colleagues and I will present our assessment of the adequacy of Medicare's payment rates for physicians' and other health professionals' services. We'll also discuss a way to support Medicare's safety-net clinicians.

The audience can download a PDF of these slides in the "Handout" section of the webinar's control panel, on the right side of the screen. I would like to thank Corinna Cline and Lauren Stubbs for their research assistance.

Medicare's physician fee schedule pays for about 8,000 different clinician services, delivered in a wide variety of settings, such as hospitals, nursing homes, and doctors' offices. Spending by the Medicare program and its beneficiaries on clinician services totaled $92.8 billion in 2021, which is $8.1 billion more than in 2020, but less than was spent in 2019.

To ensure clinicians remained viable sources of

care during the pandemic, Congress paid clinicians an estimated $40 billion in relief funds in 2020, which more than offset their losses from Medicare and other payers. An estimate of the amount of relief funds clinicians received in 2021 should be forthcoming in a few weeks.

This graph shows that over time, statutory updates to clinicians' Medicare payment rates have varied in size. We only reflect updates to payment rates that are specified in law here, and not the additional adjustments that CMS makes to maintain budget neutrality when payment rates for individual codes are increased or decreased.

Over the past few years, we see a sharp increase in the size of statutory updates, due to several temporary increases that are now expiring. First, to boost payments during the pandemic, Congress suspended the 2 percent sequester that normally reduces Medicare payment rates. Second, Congress temporarily increased payment rates to offset a reduction to many codes' payment rates caused when CMS revalued office and outpatient evaluation and management visits in 2021.

In 2023, these temporary increases will have expired.

The circle shows that in 2024, which is the year we are focused on today, current law calls for no increase to payment rates.

Most of today's presentation will cover our assessment of the adequacy of Medicare's payment rates for clinician services, using the indicators listed on this slide. Indicators of beneficiaries' access to care tell us if the supply of clinicians accepting Medicare is sufficient to meet beneficiaries' care needs. Quality of care indicators help us understand the outcomes and experiences of Medicare beneficiaries.

Examining clinicians' revenue and costs helps us understand how the changes in clinicians' Medicare payments, total compensation, and input costs compare to each other. Our assessment of these indicators informs the Chair's draft update recommendation for Medicare physician fee schedule payment rates in 2024.

Starting with access to care, one of the ways we assess whether Medicare beneficiaries are able to obtain needed care is through our annual survey of beneficiaries ages 65 and over and privately insured people ages 50 to 64. This year, we changed our survey mode, switching from

an interviewer-administered telephone survey to a self-administered survey fielded online and by mail.

We found that higher shares of both Medicare beneficiaries and privately insured people reported problems obtaining care this year. In many cases, the difference between these two groups' experiences were larger than prior years, due to privately insured people reporting problems at notably higher rates.

The changes we observed this year could be due to real changes in the environment, and/or due to changes in our survey mode. We won't know until subsequent years how to interpret this year's change in findings. But a broader finding this year was consistent with prior years: across the various questions in our survey, Medicare beneficiaries reported access to care that was equal to, or better than, that of privately insured people.

A few findings I'll highlight from this year's survey, which was fielded in August, include the fact that among the 11 percent of beneficiaries who looked for a new primary care provider, half did so because their PCP had retired or stopped practicing, which is equivalent to 5 percent of all beneficiaries. Among beneficiaries looking

for a new PCP, about half reported problems finding a new one, equivalent to 6 percent of all beneficiaries.

Twenty-six percent of beneficiaries looked for a new specialist this year, but only a third of these beneficiaries had problems finding a new one, equivalent to 8 percent of all beneficiaries. And this year 18 percent of beneficiaries reported foregoing care in the past year. A fifth of these care foregoers said they did so because they couldn't get an appointment soon enough, which was equivalent to 4 percent of all beneficiaries. More common reasons for foregoing care were because a beneficiary didn't think their medical problem was serious or they just put it off, which about half of care foregoers reported.

Another way we assess beneficiaries' access to care is by looking at the supply of clinicians billing Medicare's fee schedule. From 2016 to 2021, the total number of clinicians billing the fee schedule grew by an average of 2.5 percent per year, outpacing growth in the number of all beneficiaries enrolled in Medicare. In 2020, the number of clinicians billing Medicare dropped slightly, but picked up again in 2021, as the effects of the pandemic began to subside.

From 2016 to 2021, changes in the number of clinicians varied by the type and specialty of clinician. We saw rapid growth in the number of advanced practice registered nurses and physician assistants. There was also growth in the number of specialists, who now make up over three-quarters of the physicians billing Medicare. And there was a modest decline in the number of primary care physicians.

Finally, consistent with past years, in 2021 nearly all clinicians who billed the fee schedule accepted Medicare rates as payment in full, and did not balance-bill beneficiaries for higher cost sharing.

This year, we developed a new indicator to assess whether the supply of clinicians is adequate to ensure beneficiaries have good access to care, by comparing the number of clinicians entering and exiting the Medicare program. We identified the number of clinicians who start billing the physician fee schedule in a given year, and the number who stop billing the fee schedule in a given year. If the number of entering clinicians were less than the number of exiting clinicians, or if there were a large increase in exiting clinicians, this could signal future

access problems for beneficiaries.

But for each year between 2016 and 2021, we found that the share of all clinicians who were entering, shown in green, exceeded the share of clinicians who were exiting shown in red. We also found that the number of clinicians exiting Medicare did not sharply increase during this period. Net growth in the number of clinicians suggests that there is an adequate supply of clinicians to treat beneficiaries. That said, as we describe in your paper, trends in clinician exit and entry did vary by clinician type and specialty.

Our next measure of beneficiary access to care is the number of clinician encounters per beneficiary, which has been almost flat from 2016 to 2021, growing by an average of 0.2 percent per year. Encounters per beneficiary declined by 11.1 percent in 2020, as beneficiaries delayed or put off care, especially in the early months of the pandemic, but then increased by 9.4 percent in 2021, as the volume of services picked back up.

Changes in the number of encounters per beneficiary varied by the type and specialty of clinician. From 2016 to 2021, encounters with primary care physicians

decreased by an average of 3.5 percent per year, while encounters with APRNs and PAs increased by an average of 8.7 percent per year. We are concerned about the decline in encounters with primary care physicians and continue to monitor the situation.

Moving to quality, we first caution that it's particularly challenging to assess clinician quality because Medicare does not collect beneficiary-level clinical information or data on patient-reported outcomes. Quality of care is also difficult to assess in 2021 due to the effects of the pandemic. While we report 2021 results for our quality measures, we have not used these to inform our payment adequacy assessment this year.

Although the risk-adjusted rates of ambulatory care sensitive hospital use went down in 2021, we still see geographic variation in these rates, which signals opportunities to improve, Rates of ambulatory care-sensitive hospitalizations and ED visits are about twice as high in some hospital service areas than others.

Patient experience scores remain relatively high with CAHPS scores of 83 out of 100 for beneficiaries' rating of their health plan, and 87 out of 100 for their

rating of their health care quality.

I'll now turn things over to Ariel to talk about our third category of payment adequacy indicators clinicians' revenue and costs.

MR. WINTER: I will be start by discussing clinicians' input costs. The Medicare Economic Index, or MEI, measures clinicians' input costs and is adjusted for economy-wide productivity. Before 2021, the MEI typically grew by 1 to 2 percent per year. It increased by 2.6 in 2021, and it is projected to increase by 4.4 percent in 2022, 3.5 percent in 2023, and 2.5 percent in 2024. The projected acceleration of the MEI reflects the rise of input costs during the pandemic.

This chart shows that the MEI has been growing, and is projected to continue growing, faster than annual updates to PFS payment rates. Between 2010 and 2024, the MEI, as shown in the orange line, is projected to increase cumulatively by 27 percent, far exceeding the 3 percent cumulative increase in annual updates, which are shown by the green line.

We are concerned about the ability of clinicians to cover their input costs given the widening gap between

the MEI and updates to fee schedule rates.

However, other indicators are more positive. This chart shows that physician fee schedule spending per fee-for-service beneficiary has largely kept pace with MEI growth, although it is projected to grow more slowly than the MEI after 2022. This chart shows that clinicians have been able to increase the volume and/or intensity of the services they deliver, which has helped offset the gap between the MEI and annual updates that we saw on the previous slide.

Another indicator we look at the ratio of commercial PPO rates to Medicare fee-for-service rates for clinician services. The ratio was 134 percent in 2021, down from 138 percent in 2020.

This decline was driven by a drop in the ratio for E&M office/outpatient visits, which fell from 127 percent in 2020 to 114 percent in 2021. This change was probably due to CMS's substantial increase in Medicare payment rates for E&M office and outpatient visits in 2021, which appears to have not yet been followed by commercial plans.

Despite the decline in 2021, the overall ratio

has grown since 2011 as commercial payment rates have risen, due in part to greater consolidation of physician practices.

Finally, we look at the growth in physician compensation from all payers. Between 2017 and 2021, median compensation from all payers across all specialties increased by 3 percent per year, on average, and reached $315,000 in 2021. But median compensation continues to be much lower for primary care physicians than for many specialists.

Compensation from all payers reflects Medicare's physician fee schedule, because many private insurers base their payment rates on Medicare's fee schedule. Therefore, the differences in compensation among specialties probably reflect Medicare's historic underpricing of E&M office and outpatient visits, relative to other services.

As I noted on the last slide, CMS substantially increased the RVUs for these visits in 2021, but the long-term impact of this change on total compensation is unclear.

Some have said that relatively low Medicare payments have motivated physicians to sell their practices

to hospitals, in order to increase their compensation. So new for this year, we examined data on whether physicians in hospital-owned practices earn more or less than physicians in physician-owned practices. We did not find evidence of a consistent relationship between physician compensation and practice ownership.

To summarize our analysis, most indicators suggest that payments have been adequate, but rising input costs are a concern. Beneficiaries report access to care that is comparable to, or better than, the privately insured. The total number of clinicians billing Medicare is stable, although the number of primary care physicians is declining.

Clinician encounters per beneficiary declined in 2020, but partially rebounded in 2021. It is difficult to assess quality of care in 2021, partly due to the effects of the pandemic.

In terms of clinicians' revenue and costs, the MEI grew at a faster rate in 2021, than in previous years, and is projected to continue rising through 2024. Aggregate Medicare physician fee schedule payments fell in 2020, but increased by $8 billion in 2021. On a per

beneficiary basis, fee schedule payments declined in 2020 but fully rebounded in 2021.

Commercial payment rates for clinician services are higher than Medicare rates, but the gap decreased in 2021 and physician compensation from all payers grew by 3 percent per year, on average, from 2017 to 2021.

This leads us to the Chair's first draft rec, which reads:

For calendar year 2024, the Congress should update the 2023 Medicare base payment rate for physician and other health professional services by 50 percent of the projected increase in the Medicare Economic Index.

This draft recommendation is motivated by our concern that clinicians may not be able to absorb projected increases in input costs at current payment levels. On the other hand, our indicators suggest that payments are currently adequate, and current law calls for no update for 2024.

Therefore, we're proposing to recommend that payments be raised by half of the projected increase in the MEI.

CMS currently forecasts a 2.5 percent increase in

the MEI for 2024. If this forecast stays the same, the update would be 1.25 percent. Because clinicians' practice expenses account for about half of the MEI, this draft recommendation would ensure that payment rates keep pace with the growth of clinicians' practice costs.

In terms of implications, this draft recommendation would increase spending relative to current law, and it should maintain beneficiaries' access to care and providers' willingness and ability to furnish care.

Now I will turn things back over to Rachel to discuss safety net providers.

MS. BURTON: Filling in for Geoff Gerhardt, I am now going to change gears to talk about safety net clinicians.

In its June 2022 report to the Congress, the Commission laid out a framework for identifying providers that furnish care to low-income beneficiaries and determining whether Medicare should provide targeted funding to support those providers. In the report, the safety net framework was applied to inpatient hospitals, and at your meeting in late September Commissioners discussed applying the framework to physicians and other

health professionals.

In applying the framework to clinicians, we found that some clinicians are furnishing care to a disproportionate number of low-income beneficiaries. For example, 15 percent of clinicians had more than 60 percent of their fee schedule claims associated with lower-income beneficiaries.

We also noted that clinicians are prohibited from collecting the 20 percent in Part B cost sharing from most beneficiaries who are dually enrolled in the Medicaid program.

In addition, almost all state Medicaid programs make reduced cost-sharing payments, or do not make any cost sharing payments, for services furnished to dually enrolled beneficiaries. We estimate that the combination of these two policies results in clinicians not collecting $3.6 billion in revenue that they would have otherwise received.

While we cannot measure profitability directly because clinicians do not submit cost reports, we know that treating low-income beneficiaries tends to generate less revenue than other Medicare beneficiaries because of the Medicaid interaction I talked about on the previous slide.

Since there is no reason to believe that clinicians' costs when treating low-income beneficiaries are lower than when they treat other beneficiaries, we infer that low-income beneficiaries are less profitable than other beneficiaries.

Because they are less profitable, treating low-income beneficiaries may put a financial burden on clinicians. This could cause some clinicians to cut back on the number of low-income beneficiaries they treat, or avoid them entirely, thus hindering access to care. This may help explain why surveys of Medicare beneficiaries show that lower-income beneficiaries report having significantly more difficulty accessing needed care compared to other beneficiaries.

Finally, it's worth noting that although the physician fee schedule does have some add-on payments, targeted financial support for safety-net clinicians does not currently exist.

At the meeting in late September, Commissioners agreed that Medicare should provide additional support for safety net clinicians and discussed a number of options for doing so. Based on guidance provided at that meeting, Commissioners expressed support for several important

features of a clinician safety net policy.

First, most commissioners thought safety net add-on payments should be available to all clinicians for all fee schedule services furnished to qualified lower-income beneficiaries who are in traditional Medicare. This means that clinicians who treat a higher proportion of low-income beneficiaries, and are therefore at greater financial risk from unpaid cost sharing, would tend to receive higher add-on payments than clinicians who treat a smaller share of low-income beneficiaries. This approach also avoids complex formulas, cliffs or cut-offs that could be confusing for clinicians and difficult for CMS to administer.

Most Commissioners also thought because they receive less in total compensation than specialists and serve as the primary point of contact with the health care system, that primary care clinicians should receive higher add-on payments than non-primary care clinicians. In September, the option that most Commissioners expressed support for was a 15 percent add-on for primary care clinicians and 5 percent add-on for non-primary care clinicians.

Most commissioners did not support making safety net payments available to Medicare Advantage plans, either through direct payments made by Medicare or by including the cost of fee-for-service add-on payments in MA benchmarks. The thinking here is that MA plans are free to make up for any lost cost sharing revenue when they contract with clinicians, and we don't have good information about the size or distribution of any revenue shortfall that might exist.

Finally, Commissioners agreed that budget neutrality should not apply to the safety net add-on policy, which is to say the cost of the add-on payments should not be offset by reducing payment rates elsewhere.

This leads me to the Chair's second draft recommendation.

The Congress should enact a non-budget neutral add-on payment, not subject to beneficiary cost sharing, under the physician fee schedule for services provided to low-income Medicare beneficiaries. These add-on payments should equal a clinician's allowed charges for these beneficiaries multiplied by 15 percent for primary care clinicians, or 5 percent for non-primary care clinicians.

In terms of implications, the draft recommendation would increase total Medicare spending relative to current law. We also expect that the draft recommendation will maintain or improve access for beneficiaries with lower income. And we expect that the safety net payments should increase clinicians' willingness to treat low-income beneficiaries.

That concludes our presentation. I'll leave you with a summary of the Chair's two draft recommendations and hand things back to Mike.

DR. CHERNEW: Rachel and Ariel, thank you so much for that, and I think this is obviously a complicated topic. I think we're just going to jump right into the queue, and if I have this right, the first person in the queue is going to be Greg. Is that right, Dana? You can take it from there.

MR. POULSEN: So in order to make this complicated topic simple I've got a very simple question. On Slide 9, we talked about the number of encounters per beneficiary, and it seems to me I get two different thoughts based on your answer to the question I'm about to ask, and that is the encounters with primary care

physicians are lower, the encounters with advanced practice practitioners are higher. Are those primary care encounters in the second bullet or are they all encounter across all?

MS. BURTON: They are all.

MR. POULSEN: Okay. So we could be seeing a decrease in total primary care activity or we may not. Okay, thanks. That's what I needed to know.

MS. KELLEY: Lynn.

MS. BARR: Thank you guys. Great report. I'm excited about this.

So on page 13, as I'm looking at your graph of the MEI versus spending per beneficiary, we see that between 2022 and 2024, it looks like a 7.5 percent difference, or an increase, a 7.5 percent increase in the MEI. And we didn't adjust for that in 2023, right? So this would be the cumulative impact to our physicians.

So I'm curious as to why the recommendation is 50 percent of 2.5 percent as opposed to trying to address the 7.5 percent increase in MEI that's gone to the physicians. Can you help me understand?

MR. WINTER: So is this a question about the

Chair's draft recommendation?

MS. BARR: Yes.

MR. WINTER: I'm going to defer to the Chair.

DR. CHERNEW: A lot of the recommendations are a function of art, not science, in a range of ways. I think the core thing is the indicators that we work off of have to do with indicators of access and things like, not simply, oh, you didn't get paid enough and now we're going to make up. So what's basically happening is if you look at the indicators now for access -- I was going to say something probably between Round 1 and 2 on this -- but if you look at indicators of access and other things there are issues that are concerning about access, but my view is it's unlikely those are fundamentally due to payment issues. And, for example, you see the same parallels in commercial. They're paying substantially higher, just to give you an example.

So the thinking was to try and find a way to balance what is genuine concern about the trajectory of physician payment, which is clear, with sort of evidence that suggests that if we were just going to follow our indicators the way we normally would follow our indicators

we would have ended up with current law. So we needed to just come up with a number that was in between.

The concise version of that is -- the goal is not to come up with a recommendation that just mimics MEI. The indicator that we're looking at is much more indicators of access and quality and things of that nature. And I think that's essentially what we're balancing.

And there are other indicators you could look like the one on Slide -- I'm not sure my slide numbers are right, but the one I have is 13, that looks at fee schedules pending per beneficiary. So there's volume things. There are a lot of other things, volume things that are going on.

We're going to continue to have to look at physician fee schedule, but at least in terms of the exercise we're doing now, which is the update recommendation, we're trying to balance our, what I would say, standard approach, which probably would've, frankly, led us to current law, with what I think is a genuine concern that this is not a sustainable, long-term situation. So we tried to both add money across the board. We added other money through the safety net, so that also

helps people. We shifted towards primary care. So taken holistically, that was the thinking of where we ended up.

MS. BARR: I'll reserve my comments for Round 2.

DR. CHERNEW: Well restrained.

MS. KELLEY: Larry.

DR. CASALINO: So one question. You didn't actually show a slide on this, but there's a very, I think, important table in the chapter, showing the anticipated effects of the SNI increase on physicians. So for example, I think there like about a $2,700, $2,900 mean increase in what would be paid to primary care physicians, about a $983 or something like that for specialists. And I -- well, I won't do a Round 2 now, but I think those numbers would be -- those are great, but it would be informative to have a sense of if you were really to take care of a lot of SNI patients, how much would it be then. Because the mean amounts shown aren't going to mean much, even to poor primary care physicians.

So I think if you can do that -- but just off the cuff now, could you give any kind of crude estimate of if you were in the top 10 percent or so of the most disadvantaged patients, how much more would you likely be

paid as a primary care physician?

DR. MATHEWS: Yes. So Larry, just rough numbers here, and we'll come back to you with something more definitive in January, but for primary care physicians in the top 20 percent of the distribution in terms of treating low-income beneficiaries, we think the add-on would result in additional payments north of $10,000 per clinician per year. That's based on 2019 numbers, and so we're finessing how we would talk about this more specifically in January.

DR. CASALINO: That's great. I think that's very helpful, and I think that is a big enough number to make some difference to primary care physicians. Most specialists might not care about it that much, but that's great.

And then two quick suggestions. One is, the bullet points about why it's disadvantageous to physicians right now to take care of low SDOH patients, let's just say, low-income patients, are good. There is also a set of bullet points in the hospital chapter and presentation about why it's tough for hospitals financially to do that. And I think the reasons are the same for hospitals and physicians, like it's harder to take care of low-income

patients, on average. And that bullet, for example, isn't here. So might just do some work to parallel the hospital reasons and the physician reasons.

And then the last suggestion I have is, I think it's great that you looked at compensation for hospital-employed physicians versus independent physicians. I think the feedback you'll get is, because this is the general wisdom -- I don't know if it's true or not -- but a lot of people believe that hospital-employed physicians don't see as many patients per day, don't work as hard as independent physicians. So if that's true, then equal compensation wouldn't be equal compensation per unit of work, if you see what I mean.

It's a minor point, but if you really care about pushing that, you might have to do that extra bit of work to try to figure out, is it equal pay per unit of work. Thanks.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks for a great chapter. I had what may be a very quick question. In Table 12 of the mailing materials, on page 50, there's a distribution of clinicians, all clinicians across the different buckets of

share of clinician fee schedule claims associated with LIS beneficiaries. And below that we have the add-on broken out by primary care and non-primary care.

And my question essentially is, how does that top row, which is the distribution across the buckets of LIS, how does that actually look for primary care clinicians?

DR. MATHEWS: I think we would have to come back to you with that. I do not have that off the top of my head.

DR. NAVATHE: Okay. Thanks.

MS. KELLEY: Dana.

DR. SAFRAN: I had put a note to withdraw my Round 1 and add me to Round 2, please.

MS. KELLEY: All right then. We'll go Wayne.

DR. RILEY: Yes. Rachel, Ariel, and Geoff in absentia, good work. Thank you.

Quick question on Slide 7. You characterized that there was a modest decline in number of primary care physicians. Can you quantify roughly do you recall the quantification of that?

MS. BURTON: Give me one second. It's in our paper.

DR. RILEY: I thought I saw it but I can't remember.

MS. BURTON: Okay. It looks like, in 2016, there was 142,000 primary care physicians, and in 2021, there was 135,000. So we've lost 7,000 from 2016 to 2021.

DR. RILEY: Yeah. Okay. Thank you. I just couldn't remember, and I do think that's not an insignificant number. That's what I'm driving at here. And then when you tie it to Slide 9, that the encounters dropped by 3.5 percent, when you marry those two factoids together it presents a compelling argument that we need to do this in terms of adjusting. Thank you.

DR. CHERNEW: Dana, if I'm right that was the end of Round 1.

MS. KELLEY: That is all I have.

DR. CHERNEW: So let me make a comment. We're about to go into Round 2, and because we're going to go to recommendations, everyone is going to speak in Round 2. You guys can pick your order or not.

But let me say a reaction I have to some of this. There are some issues in the access data. You're having a hard time finding a new primary care physician, for

example, having a hard time finding a new specialist. It's better than a primary care physician but I wouldn't call it good. Fortunately, not a lot of people are looking for new physicians, which makes the numbers look smaller, but if you find yourself in that bin it really does seem to be an issue, and it's a concern.

My feeling, and this is a little bit of a comment and a little bit of a question for the staff, is a lot of that has to do with the number of physicians in the different primary care and specialties, for example, as opposed to having the right number of physicians, and physicians deciding to just work less, right? We're going to adjust what we're doing, and a whole range of things. I'm not sure that's true but that's my sense. The same, by the way, in terms of the exists. You know, they're very careful because of the data we have, we measure exits from Medicare, but I think a lot of what's happening is not physicians deciding they're no long going to take Medicare but they're going to keep practicing, but they're just retiring, particularly most primary care physicians, where I think there's an age distribution that's problematic.

UNIDENTIFIED SPEAKER: [Inaudible.]

DR. CHERNEW: Yeah, although I don't think so. That's right. I think there's less of a shift to concierge and more of a just a general issue with the supply, and I think this fits into the advanced practice nurses and stuff, because they're filling in for a lot of this.

And so a few general comments as we go through this. One challenge with a common update factor, if we were just to do a common update factor, is dollarwise that rewards the higher versus the lower paid specialties, and it suggests that a lot of the issues that we're facing, that we're seeing here, are dealt with through workforce discussions, which people, broadly speaking, have, as opposed to do update discussions.

So I think the update stuff is important, and I feel that we need to make sure that we can support the provider community, but understand that this is a bigger issue. A lot of the issues we see are a bigger issue than the solutions that we're actually dealing with now. So this is sort of one step on a broader agenda to think about how we might solve, I think, what a general issue has been.

So that's sort of my overall take. This is for Rachel and Arial, and to some extent Jim. Did I say

anything that seems to contradict what you might think facts would be?

MS. BURTON: Jim is shaking no, so I think no is the answer.

DR. CHERNEW: Jim is shaking no because he thinks that you think the answer is no. He's reflecting that. Maybe he's getting Geoff commenting to him on the side.

But good. So I think that's going to end up being important, because one of the challenges, it's easy to say, "Oh, there's an issue we need to do X," and that is not necessarily always the case. But I do think, as I said in response to the other question about -- and I'll say this again in a minute -- we are trying to strike a balance between where we think we need access to be in supply, acknowledging that if the core problem here is supply of different type of physicians, we're going to need to do a lot more than just work through where the update recommendation is.

So I'm going to leave it at that, and then when we go through the queue if I have this right, and this is a perfect segue, it's going to go to Lynn. So Lynn.

MS. BARR: I'll keep it brief. I support the

recommendations on the clinician safety net recommendation wholeheartedly and without qualification. I think it's excellent and awesome and well overdue.

I feel like the 2.5 percent, or the half of one year of the MEI probably isn't going to move the needle, and so I question whether or not that's even worth doing, as a recommendation, or whether it should be more targeted. And I would propose that we look at the two years of cost and we give more of a lift to primary care. And I understand that -- you know, because primary care is the whole basis of the entire APM model and how we're working today on reducing costs and improving quality. And I can't tell you how many times physicians said to me, "Do more. Pay me less. Do more. Pay me less." And that's what we're doing because we're not compensating them for inflation.

So I would be more inclined to give any and all increases to primary care. That's just my comments.

DR. CHERNEW: I promise I won't interrupt every time. I just want to point out another point. We are sort of working through the period post the E&M rule, so while it wasn't targeted to primary care per se, the E&M rule for

services commonly delivered by primary care physicians increased their payments by 20 percent, for example. So there is a question of waiting to see how all of that plays out, and while it is clear from our recommendations that we care a lot and are trying to support the area of supply that we think we're most worried about, which is primary care, I don't want to make it sound as if we don't acknowledge the challenges that specialists face in general.

And so the view of the across-the-board part I understand and we can have a discussion about whether there should be more or less or targeted or not, does acknowledge that there's a broader physician community that is facing the same type of inflationary pressures that other folks are facing.

So that's sort of a justification for why some combination of we have an E&M rule, we have to continue to evaluate. So if you look in the chapter, you'll see E&M, primary care docs. Maybe it was E&M -- I can't remember now -- actually did relatively better, and I think they might continue to do so as this plays out, depending on what happens with the transition parts of the E&M rule.

So we'll see how that goes, but I just didn't want to us to forget that the E&M rule, which was, by the way, very consistent with past MedPAC recommendations, actually resulted in a pretty significant revaluating of E&M services.

MS. BARR: Could you show us that data so that we understand that? That would be very helpful, I mean, for our January meeting, to see, okay, well, they're good, because they're making up that lost ground.

DR. CHERNEW: -- say they were good, just to be clear. If I thought they were good, whatever that means. Well, first of all, let me just be clear for those at home. They're wonderful. And as an aside, I think we should acknowledge that they're being asked to do a lot more in a bunch of other ways -- text messages, chart message exchanges, and the workload that they have because of the new communications is much harder. That's not a solution we're going to solve here, but I do think there are a lot of issues related to that.

The reason we have aspects of the safety net, things skewed the way we do, is that I'm not completely sure that they're good, but I'm not yet sure that we should

then triple down on that particular point. And I also don't want to make it seem like we're oblivious to the challenges that other physicians face or in any way don't appreciate the services that specialists provide, because sometimes I fear that if we listen to this discussion, we would make it sound like primary care physicians are all we really need, and that's just simply not true. I think there is a lot of care, a lot of important care, where really the specialists are needed, and we want to make sure that they are supported in a way that we can maintain that access.

Although if you look, for example, at the supply numbers, people going into medicine are still more likely to choose to be a specialist, in general, as opposed to primary care. So we still have some issues in the specialty choice, that I think we'd like to keep working on, and we're going to have to kind of get there. But it is not the case that, for example, I would say we've done all we could do in primary care, hence parts of the recommendation.

Anyway, sorry. I wish there was a Chair to tell me to be quiet.

MS. BURTON: Mike, just in response to what you said. In the November meeting, in our presentation about primary care payment, we did have a graph that showed income for primary care physicians compared to specialists, and we did see a bit uptick going from 2020 to 2021. So you could refer back to that.

DR. NAVATHE: And can I, just on this point, a quick clarification? So in terms of the two draft recommendations kind of added together, if you will, there is a 1.25 percent from the 50 percent of the MEI piece of it, and then the safety net piece of this adds approximately another 2 percent. Is that correct? Distributed, allocated, to your point, in a targeted fashion towards clinicians that are taking care of safety net. But I'm just saying in aggregate, the amount of new dollars being put in is 1.5 percent plus 2 percent, something like that. Is that right?

DR. MATHEWS: I think it might be a little more. I think the total might be closer to 4 percent. I would have to double-check the math.

DR. NAVATHE: Okay. Thanks.

MS. BURTON: I think the safety net add-on was

$1.7 billion, if that helps.

DR. NAVATHE: Total spending was around $90 million, or something like that.

DR. CHERNEW: This is where it's good to know that we actually have the calculators out in real time. But with that said we're going to go to Stacie. I think she's next, Dana. I'm sorry if I mess up.

DR. DUSETZINA: Thank you, and thanks for the excellent chapter and presentation. I very much support both recommendations. I'm really excited about the safety net piece in particular. I think that moving payments in that way is excellent.

One issue I did want to bring up was on the section talking about finding a new physician, primary care physician, and I know I brought this up last year, same sort of thing. It's like in the scope of things it doesn't seem like a very high percentage across all beneficiaries, but there were a couple of pieces that stood out to me. One is that, you know, it's 11 percent of people reported needing to get a new primary care physician because their physician had either retired or had left the workforce. And I worry a lot about what that's going to look like in

the coming years. We hear a lot about burnout, so there's potential of a lot more people leaving the workforce. But also, I think there will probably be more retirements in the near future.

So I think probably having a little bit of a sense of how much more of this, when we see are we kind of coming up to a peak or are we thinking we're going to see a lot more of that exit.

Because I think the other statistic you have there was that half of those people had a hard time finding a new doctor, and that seems really concerning if we think this is going to be more likely to be happening in the near future and people have a really hard time replacing their PCPs when that happens.

The only other thing I wanted to ask, for the chapter, is that on Table 10 on page 47, there are the categories of beneficiary by low-income subsidy status that just breaks out people who are full dual, partial, and LIS only versus non. And it would be really helpful to know from the data what percent are in each of those categories because their reports look pretty different from each other, especially the LIS only, and I always struggle with

that category. Like I think that's a small, small category who is not dual, not partial, but has only LIS. And so just seeing the percentage of beneficiaries would probably be helpful for interpreting that table.

MS. BURTON: Sure. I think the paper we mentioned that 85 percent of the low-income beneficiaries are in some kind of Medicaid, so I think that leaves 15 percent that are just LIS.

MS. KELLEY: Kenny.

MR. KAN: Yes. I commend the staff for a fantastic chapter. So I have a couple of points to convey. Number one, given the high inflationary environment I support a positive adjustment above current law.

Point number two, regarding the safety net recommendation, I applaud the creativity of the targeted proposal to help mitigate pay disparities for such safety net physicians.

Point number three, I recommend that we do not have this be applied to MA, commercial, or Medicaid members. I realize that it will Medicare fee-for-service, but there are many health plans physicians fee schedule reimbursements are actually tied to Medicare fee schedule.

So it's important to actually note that in the chapter.

And as part of that chapter, regarding the add-on, I also highly recommend that we include in the chapter some ideas of how to implement this to minimize administrative burden for physicians and health plans. Inclusion of such ideas should actually help allay some of my concerns.

An example of such an idea could be in quarterly lump-sum payments which CMS or HHS currently administer under the HPSA, which would not impact the regular base physician fee schedule, as noted on page 48 of the pre-reading material.

So all said, this is great work, and I look forward to further discussion.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thank you. Thanks to the staff for a really informative chapter. There is a lot of information in here to digest.

I am in support of the Chair's recommendation. I think we are living in a very uncertain space right now in terms of changes in input costs, so I think the suggested bump works to address that uncertainty, and hopefully

allows physicians to stay in practice and continue offering services to Medicare beneficiaries.

I particularly like the targeted payments for safety net providers, particularly given some of the access metrics among that subgroup of the population and the fact that their ability to access care results in delays in care, presenting to the emergency room for things that could have been prevented had they been seen in an ambulatory setting. So I think there's a real sort of net win there for both patients as well as kind of what we see oftentimes as unnecessary spending in the system. So I think that those additional payments and the way they are targeted are a real bonus.

MS. KELLEY: Robert.

DR. CHERRY: Yes, thank you. you know, I think there are a lot of positive metrics within the report, especially regarding overall access to care. I think we all agree it's not great but it's not all doom and gloom either. So it is encouraging somewhat.

I do agree with Mike's earlier comments about the patients' perceptions of what the drivers are regarding access to care, you know, whether it's a supply issue or

not. It's probably complicated related to whether it's an urban issue or a rural issue, and what specialties are impacted or not in those particular areas. But it's still an issue of concern.

I do support the physician payment update as presented in the presentation.

Regarding SNI, and I'm largely supportive of that, and the main reason why is because even though overall access is good, among LIS beneficiaries, in particular, they do have difficulty accessing physicians of various types, and that's problematic.

I think consistent with the concerns that I had during the prior meeting, I do think the 15 percent split for primary care and the 5 percent for specialty care is a little bit large. I do support the 15 percent for primary care, that bump, for all the reasons that we've talked about previously over the last couple of meetings. I do think, though that primary care physicians don't work in isolation. They work in teams. They do need specialists in order to coordinate and manage the care successfully. So helping to incentivize specialists to work in those areas over longer periods of time I think is also helpful.

I would support a larger bump than 5 percent, perhaps 7.5 percent, but overall this is a directionally correct and certainly a step in the right direction.

MS. KELLEY: Jaewon.

DR. RYU: Yeah, there are a lot of things I like about this approach. I like that there's a component that addresses primary care versus other, you know, the 15 versus the 5. I like that there's a low-income add-on component. And I also agree that current law was not sufficient. So I like all of those aspects.

I was actually going to say that similar to the hospital thing I still had a little bit of discomfort because it felt like we were relying on lagging versus leading indicators and so forth, understanding that that's the constraint that we're under. But I actually kind of shifted that based on Amol's clarification. I didn't realize that the two were additive. So you put those together and it sounds like this amount would overcome the MEI estimate or projection for 2024. That gets me a lot more comfortable, although even before that I thought it was at least in the right ballpark.

And then the last comment, I just want to go back

to Stacie's point, because I think that 11 percent that is shopping for new a new primary care doc, that is one year, and if you follow that through over time, I think it adds up pretty quickly. And I know that primary care is just one component of the overall payment update recommendation, but I think it's something we, in some other setting somewhere, we should be diving into that.

The same demographic forces that are creating tremendous growth in Medicare beneficiaries are those same forces that are pushing many physicians into retirement, specifically in primary care where those entering the profession are disproportionately less likely to enter primary care versus those leaving the profession. And so I worry about the compounding effect of that over many years, and I think it deserves some deeper diving.

MS. KELLEY: Okay, I have a comment from Scott. Scott supports both Recommendation 1 and 2. Both of those recommendations thread the important needle of responsibly spending some more money to support a critical sector that is challenged now in many ways, through labor and supply costs and ongoing PHE, continuously increasing expectations from all payers, things that are not yet reflected in our

indicators around access and quality.

In addition, he recognizes that access to capital and ability to absorb operational cost challenges year to year is bifurcated in this space. That is, practices owned by hospitals, private equity, health plans, have those funds available, PCP groups who are self-owned do not, and specialty groups are in between. Given that, he would recommend there begin a discussion of whether and how we could differentially allocate more increases over time to self-owned PCPs.

And I have Dana next.

DR. SAFRAN: Thanks. So adding my appreciation for this great work, and also my support for the safety net recommendation. I feel really good about that and just want to call out that I appreciate the way you've structured this so that there aren't cliffs, you know, for a certain percentage of your population. That really sets up the right kind of incentive, so I appreciate that very much.

I was really drawn to -- now I'm trying to remember who made the point. Was it you, Robert? I think it was Robert making the point, on the first

recommendation, about potentially having a differential for primary care versus specialty care. And I'm not sure where to take that yet because of a question I had or a recommendation I have about the way you've presented quality data in the chapter. It's different from how you presented quality data in the chapters we discussed this morning in that there is no benchmarking against historical quality measures, and I think that would be helpful, both for the ambulatory-sensitive conditions that you present and for the CAHPS scores.

It was noteworthy -- I just want to pull them up here so I can remember the specifics -- but it was noteworthy on CAHPS, two declines from 2020 to 2021, again in line with my comments earlier today that a point or definitely 2 or 3 change, on average, on patient experience measures is a big change. We see a 2-point decline in getting needed care and seeing specialists, and we see a 3-point decline in getting appointments and care quickly.

I think it would be very, very helpful on that one to see commercial data as a benchmark, because it would just be good to know whether, is this something Medicare beneficiaries are experiencing or is this sort of more the

state of ambulatory care? And if it's the latter, I feel less strongly about trying to split out, in Recommendation 1, a differential increase for primary care versus specialty care. But if we're seeing some evidence based on the commercial scores being different from the patterns that we see here, I think that would give us some pause.

So those are just a couple of my comments. Overall, I'm really pleased and support the recommendations. Thanks.

MS. TABOR: And if I could just add, Dana, so we can definitely take a look at the average CAHPS scores for commercial plans and consider adding that to the paper. I am hesitant, though, on the avoidable hospital use measures, because we haven't been able to account for COVID yet. So in the future we can perhaps do historical benchmarking, but this year we kind of stuck to just using 2021 results across the country.

DR. SAFRAN: But could you -- okay, so go pre-COVID.

MS. TABOR: Well, we can, and --

DR. SAFRAN: It's very hard to not have any context for the numbers that we're looking at.

MS. TABOR: There are, I think, a few sentences in the paper about this, but the rates are definitely lower because overall hospitalizations went down this year. And it's really hard to detangle how much of it is just a drop in utilization versus less people got the flu, which is an avoidable hospital use. So, you know, that aspect of quality improved.

So that's something we can keep looking into, but I guess I would say that we're hesitant to do it because it's really complicated, and so we can really take into account COVID.

DR. SAFRAN: Actually, if I could just make one other comment. I doubt this is possible for this chapter this year, but one of the things I've been struggling with, and I don't have an answer to this but I'll just put it out there, is, you know, this Commission, I think, made some very important comments and recommendations about MIPS, and particularly about some of the inadequacies of the way that MIPS is handled today. And this chapter does strike me as our opportunity to talk about sort of robust ways to look at ambulatory quality that CMS maybe should be thinking about as it thinks about outside of the APMs how does it

want to evaluate and create accountability for quality.

So like I said, I don't have a simple answer to that, but I think this is our place to make that point again and again. So I just wanted to raise that. Thanks.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. I really appreciate the chapter and the Commissioners' comments and I support the recommendations. I have five points or comments.

First, on page 34, you detail out the compensation between specialists, primary care MDs, nurse practitioners, and physician assistants, and I really appreciate that. I think that's just a really important case of data.

Second, on page 22, you note that in 2019, the Commission called for more detailed information on where NPs and PAs practice, and this goes a little bit to Greg's Round 1 question, when things are in aggregate. I would really like us to underscore that recommendation that the Secretary need more information.

Right now, the bulk of nurse practitioners are educationally prepared and intend to work in primary care, over 85 percent. Family nurse practitioners the most

common, at roughly 70, adult geriatric primary care 9 percent if you include psych mental health as primary care, which I would, at 6.5. And yet roughly half work in primary care. So these are people going to advanced education intending to work in primary care. So I just think it's a really important piece of demonstrating how strong that pull is, and it's not all money. It's the complexity of the work, et cetera. So I think underscoring that recommendation would have some value.

Third point, the loss of primary care physicians, unless I'm misunderstanding, is even more pronounced than what's it's showing because encounters that are billed as Incident 2 billing will look like physician encounters when, in fact, the care is deliver by an NP or a PA. And I know you've made a recommendation previously, before I was on here, about that, but the tentacles of the problems that Incident 2 billing creates are everywhere in terms of understanding what's going on, although I'm sure some groups enjoy the additional 15 percent.

Fourth point, on page 42, you illustrate that overall primary care providers see more LIS beneficiaries than specialists, and on average, nurse practitioners, the

largest share of LIS beneficiaries. And it is for that reason I strongly support this 15 percent. I hear Lynn saying maybe it should be zero, and Robert saying maybe 7.5. But I think this is reasonable because we really do need access to specialty providers. At the same time, it's such a very different environment than primary care so I'm comfortable with this 15.5.

And finally, Dana mentioned MIPS, and I just would have to say that as we open up a conversation about MIPS, I would just say that one thing that I was very positive about in MACRA is that one way or another people are going to be taking on financial risk, and I still think that's a very important premise. So I would just like to have that in the mix as well.

But overall I'm very impressed with the work and pleased to give my recommendation, or my support.

MS. KELLEY: Jonathan.

DR. JAFFERY: Thanks. I'm going to join others. This is just a great chapter and I'm very supportive of the recommendations. And it really does, it ties together so many different things in one collective that it's great.

Just a couple of things that other people have

called out already and I'll just emphasize. Stacie, you brought up the 11 percent, and Jaewon, you talked about it as well. I definitely agree that's a concern. It's likely a leading indicator, and as we think about that 11 percent growing to 12 percent and 15, and so on, it's not going to be still continue to be just half of those people having trouble finding primary care doctors. It's going to be more than half because the supply is not going to be there.

So I think this is a great move in the right direction for a lot of reasons, but I do want to emphasize what others have, in that as we think about the supply issue it's more than just money. It's clearly more than just money. There is a whole work-life balance aspect to this. And so that's not the point of the annual update here. We are focused on the payment policy. But we definitely want to keep this front and center of how we think about other ways to try and support an increased supply of providers across the board but, in particular, primary care physicians.

And I think one other thing I would say is the surveys talked about the differences between access between primary care and specialists. One thing that's not teased

out is mental health providers, and I don't know if we could get to that with existing data or future surveys. But I think that's a really important piece too, and where that would fall in here -- again, payment increases are not going to solve that problem, but I think we want to be thinking more and more about how do we support the supply of mental health providers as well as primary care physicians and other providers in different kinds of creative ways. I think this has come up before in some recent meetings. Licensed counselors are categorically not Medicare-eligible providers, for reasons that I'm not totally clear about, but there may be some ways that we can start to get at how do we increase access for our beneficiaries. And so that's my last pitch on the mental health workforce, but thank you. I am very supportive.

DR. CHERNEW: So two quick things. The mental health part is very important. There are some other specialists as well. In fact, I've been told nephrology, just to name one. I don't know if that's true.

DR. JAFFERY: I've never heard of it.

DR. CHERNEW: Yeah. But I will say not all specialties are the same, which we acknowledge. Sometimes

we treat it like there's primary care and not. I think that's sort of an unfortunate just ease of speaking as opposed to something else, but I do think it matters. And certainly that is true of mental health. Mental health has benefitted from the E&M rule, by the way, I think, because they provide a lot of E&M services.

But that part aside, the other thing that I just want to remind people, particularly those listening at home, is this has been a concern, and we've launched the beginning of this workforce cycle. So I think this year, most things, like APMs, they take two years to come to fruition.

So this has been our first year of our workforce work, and hopefully next year we'll begin to think about workforce with some recommendations. And the issues that you're raising now I think are spot on, and the acknowledgment that we need another stream besides our sort of annual update stream to deal with the supply, because I agree, in fact in some ways, I worry that if we were to say this is just money and we just give more of an across-the-board update, we would actually exacerbate, not solve the problem, because of the differential across the different

groups.

Anyway, hopefully we will say a lot more about this, and we will come back to do more workforce work this cycle, but not in the update part.

Jim, do you want to add anything to that?

DR. MATHEWS: Just one reminder. This cycle we have embarked on a fairly comprehensive overview of Medicare's coverage of and payment for behavioral health. We started out with some work on inpatient psychiatric facilities earlier in the fall. I believe we are coming back with a work on ambulatory care as early as next month. So we'll have some more baseline information there that will be relevant to this question.

MS. KELLEY: Greg?

MR. POULSEN: Thanks. I agree with all of the positive comments about the work that has been done. I agree with the recommendations as well.

Stacie started the discussion about the huge demographic challenges that we're going to face. You know, at the same time we're having the baby boomers continue to join the Medicare population. We're also having the same group with hiring. So I worry that by the time I and my

time on the Commission, our discussions will be different in terms of access. I think that they will become dramatically more acute in a relatively short period of time.

The other one that's related to that is I think the concern that access to specialists, the ability to get access to specialists, is listed comprehensively now, and at least within the communities that I'm aware of the access to surgical specialists is very different than the access to medical specialists. And that, I think, is going to become exacerbated as well in the near future.

I understand that we can't fix it with money, but I do think that the recommendation will at least send a message that care and are paying attention and that they're valued. So I think that's helpful.

I agree with the primary care focus. I would remind us that we talked about both E&M but also about re-evaluating specialty waits over time, since one of the concerns was that at least some specialties, surgical mainly, can become more efficient over time and that that isn't reflected in the waits, and that we talk about doing that. So I think that makes lots of sense.

I will register one concern. I'm slightly concerned about the recommendation to not provide the updates to MA. I understand the reasons for doing that. I understand why we wouldn't want to do it either directly or in the benchmarks. But there is just, in the back of my mind, this concern that these patients are often perceived already as being more challenging to work with if you're in an MA plan, and we may actually discourage plans from focusing on this population in their marketing, in their encouragement, where they sign people up, how they focus on people.

And yet I think it's this population that maybe more than any other can benefit from the coordination that MA, done in its best way, can actually deliver on. And I'm just a little bit concerned that we may be discouraging MA plans from going after these more difficult populations, and yet I think there at a place where the huge benefit could come from.

I can't articulate exactly how I would do it differently, but I think that it's something we ought to continue to think about. Because I love the success of the best MA plans when they are dealing with low-income

populations. They can deal with social determinants of health in a way that we simply aren't doing in fee-for-service, and I don't think we'll do in most of the advanced payment models. I think MA is by far the more capable approach there, and I'm a little worried that we may be discouraging MA plans from going after this population.

MS. KELLEY: David.

DR. GRABOWSKI: Great. Thanks. First, great work by the team. I'm really supportive of both of the Chair's draft recommendations here.

I wanted to make two points. The first is one the clinician safety net recommendation. A lot of my research outside of post-acute care is focused on the dials. Obviously, there is overlap there. But with the duals, there are so many areas where Medicare and Medicaid don't work very well together, and this is just another one of those classic examples where you think, okay, Medicare is the primary payer and Medicaid is kind of paying the cost-sharing, and it turns out -- and you really do a nice job in the chapter of walking us through this -- they don't pay full cost-sharing. And then there's a lot of great MedPAC work and academic work suggesting duals aren't able

to get the same access to clinical care that non-duals are.

So I really like this, and I think that this recommendation can help kind of level the playing field.

I wasn't going to make this point but I just wanted to react to Greg. We know there are a lot of mechanisms for duals within MA, the special needs plans. Some of those, I think, are really quite good, like the FIDE-SNPs. Other, I think, are still not as integrated as we might like. So I think there is a lot of variability there, but I do agree with you in theory, MA is a nice way to bridge this, but in practice it hasn't always gotten there.

The final point I wanted to make, I'm really glad, Dana, that you raised MIPS and sort of quality measurement. I was going to make the same point. Dana and I, I guess, both went through that cycle where it was like MIPS all the time. I know a few others, Jonathan and others, were on the Commission then. And it was like ACOs were last year, that was MIPS that year, we went at it, and we were really critical of it. Obviously, the policy is now in place, and it's really timely.

Larry and his colleagues just had a piece come

out in JAMA three days ago, suggesting your MIPS score is completely uncorrelated with a series of process and outcome-based measures of quality. Really strong work, and basically validating a lot of the work that Jim and the staff did several years ago, in establishing that MIPS wasn't going to be very strong.

So I love the idea of going back at this, and maybe it's because I have all those scars from five years ago. But I still think there is value in trying to fix that. Thanks.

MS. KELLEY: Larry.

DR. CASALINO: So I strongly agree with the SNI work and the recommendations to increase payments proportional to the extent to which clinicians provide care to long-term patients. Can you guys hear me okay with this mask on? And I agree that this should be new money.

Probably we should rename it too, for the same two reasons as we talked about with the hospitals. It should probably be Medicare clinician safety net index, because there are physicians who take care of primarily Medicaid patients, and those are certainly safety net physicians, but they wouldn't be affected by this.

I also, with less enthusiasm -- so I have a lot of enthusiasm for that -- with less enthusiasm I appreciate the recommended increase above current law for all physicians, and I realize it took the Commission, the staff, and the leadership to take quite a bit of effort to get there.

It is worth nothing that the recommendation is lower than current and predicted inflammation. Putting another billion into the SNI payments would help a lot, probably. The $10,000 for the 20 percent of physicians who take care of the highest proportion of SNI patients is good. As I said earlier, I think it would be noticed. But it still only comes out to about $200 a week, and believe me, it's a lot more than $200 of effort from clinicians and their staff a week to take care of low-income patients. So still it is a pretty small amount.

So with that said I just wanted to emphasize a few concerns and get a little bit of context going forward in our future work. And forgive me if I say physicians rather than clinicians. My remarks are really meant to apply to all clinicians who Medicare pays.

I agree with the chapter -- well, I don't think

it's just for the last few years that we can't measure quality that well. Our quality measures are just not that good, and that's not our fault. That's just what you can do with claims data. The ones that we have are okay, but really, if what clinicians do for quality is like this, a big circle, you know, what those measures, even the best ones, can measure is like a tiny little circle within it. So I don't want to put too much emphasis on quality measures and I'll say why in just a second.

So I don't think that we should wait until there is an access problem because the supply of clinicians takes a long time to change, especially physicians. And by the time there is a clear access problem it means there's going to be an access problem for some years to come.

And I do want to mention clinician burnout. I think this is a topic that can be exaggerated, and you'll see estimates that are all over the place, and to me some of the high end are not that credible. But there's no question that there's high levels of physician burnout, and there is some evidence to suggest that that's increased quite a lot. Now some of that is probably because of the pandemic. But the burnout measures, I would argue --

again, I said this morning that there are other more or less quantitative measures that can be used as an empirical basis for our recommendations. Jaewon mentioned is private equity interested in whatever.

Burnout levels for clinicians probably matter, and that is a number. And I would argue that burnout measures are actually better than the quality measures we have now, again, because the quality measures measure such a limited area of quality.

I recognize my response here is not to represent physicians but to think about what's best for Medicaid beneficiaries and the Medicare program. But I don't think it's face value good for beneficiaries or the program to have a lot of burnt-out physicians. That's what we have now, and it's increasing. My primary care physician, who is terrific, hard worker, just retired, and it's because he was burned out. Now it wasn't primarily because of payment. I don't think payment is the major factor. There are other things, some of which Medicare and Medicare Advantage and MIPS, especially, are the cause of, and the Commission could address in the future and I hope we will.

But I do want to emphasize, and I'm not going to

on much longer, I do want to mention a few things that I think are different for physicians than for any of the other sectors for which we recommend payment updates. One is physicians are individuals, and that is who we are recommending an update for, not for nursing homes or hospitals or whatever. So clinicians take the recommendations very personally, and the recommendations are a sign of the value that the program places on physicians, and are taken that way.

And as Greg said a few minutes ago, certain things -- they may be small but they are a token that people actually care, which I think actually makes a difference. If you feel like you're working harder than ever and you're doing more things that you don't get paid for, and then you feel like you're not being respected, that, I think, is a cause of burnout.

So we're not really that interested in cross-sector comparisons, I realize, but it is worth saying that there's a JAMA Health Forum article recently by Melinda Buntin and others, and these are the Medicare payment rate changes over 11 years, from 2007 to 2018. The CPI in those years, inflation, was 21 percent. Inpatient updates for

hospitals was 25 percent, home health agencies 24 percent, skilled nursing facilities 24 percent -- these are over these 11 years -- inpatient rehab facilities 20 percent, physicians 7 percent. So that kind of thing gets noticed, I think.

And just to finish up then, this hasn't really come up yet but if the hospital-employed physicians -- the physicians may not get it, and they may all go to the hospitals, but with our current recommendations if you're a hospital-employed physician you're going to get the updates we recommend plus the MEI increase that the hospital will get, through your own PPS, whereas physicians who aren't employed by hospitals are not going to get that.

So there will be quite a bit higher increase for physicians employed by hospitals. And physicians, again, or clinicians, are the only sector in which there is no automatic inflation updater, as there is in the other sectors, and I think that's something that needs to be thought about in the future. If I could wave a magic wand and make a policy change this year, it would eliminate the difference in that inflation updater between independent physicians and physicians working for hospitals.

And then last point, very briefly, Paul Ginsburg, who, before Amol was our Vice Chair, Health Affairs Blog, October 25th, well worth a look, talking specifically about the things we're talking about this afternoon. And he recommends basically a temporary fix in physician payment for 2024, which I would like to think is what we're talking about. And then, really, much broader reforms in the physician payment methodology. What Paul recommends, an inflation gesture as in other sectors, but I think we really do need to rethink MIPS and the whole way that physicians are paid. Obviously a broad, controversial area. But we're going to be having the same discussion -- I won't be here -- but 10 years from now, as we are having now, if there aren't some pretty broad reforms.

DR. MATHEWS: Larry, if I could ask a question, and you know we are always combing the landscape for additional indicators of payment adequacy, can you say a little bit more about how one objectively measures and quantifies burnout on an empirical scale, in a way that could be used as a payment adequacy indicator?

DR. CASALINO: Yeah. So there are two questions, I think, really, Jim. One is if you could measure it

accurately is it a good indicator? And to the extent that burnout is connected to payment and not to other factors, then it probably is a good indicator. But to the extent it's not connected to other factors but factors that MedPAC or Medicare could influence, it's also a good indicator, like MIPS or prior authorization, whatever. So that didn't answer your question directly.

But to answer your question, I think there is a huge literature now developed over the last decade really, and kind of increasing fast in content, physician burnout, and the estimates do vary a lot. But I think trying to look at the most credible research and see, in any given year, what the estimates are, but also change over time, would be worthwhile. Quite a bit of effort has gone into measuring physician burnout, typically measured by surveys. But there are instruments that been quasi-validated.

There actually isn't such good evidence that physician burnout affects quality. In fact, we published an article earlier this year that did not show that. But again, I think that our measures of quality are so crude that I don't take too much -- I don't rely on that too much because I think it's face value. Who wants to have a

burned-out nurse practitioner or physician as their clinician? I don't think anybody wants that, right? Actually, I had one recently, for one visit, and it was pretty unpleasant.

So did that answer your question, Jim?

DR. MATHEWS: I guess I'm still having a first-order hiccup on what the thing is. I understand, as a general concept, the notion of burnout. Ask me on any given day of the working week and I can give you --

DR. CHERNEW: That's so true.

DR. MATHEWS: -- a sense of where I am on that scale. But in terms of Jonathan versus Jaewon reporting some degree of burnout, you know, the definition that is in any given clinician's mind and how they think of themselves on a given burnout scale and how you can take something that is collected even on a survey basis and use that as an assessment of payment adequacy, that's what I'm struggling with.

DR. CHERNEW: Robert, do you want to say something.

DR. CHERRY: Yeah. I was going to try to answer your question succinctly. There are a number of burnout

surveys, and many physicians are taking them. The problem is that there's not one consistent survey, like with HCAHPS or CG-CAHPS. So there are a number of very good, validated surveys. The National Academy of Medicine has an inventory of them. But they all measure different types of outcomes related to burnout, so depending on what it is you're trying to accomplish, you should pick the appropriate survey tool.

So to answer your question, it is very difficult, I think, from your perspective, to try to pull survey data for physicians to answer the question, because we're using different instruments.

DR. CASALINO: I think that's well said, and it's working looking at the National Academy of Medicine report.

But again, I would say using one of these validated instruments, and you could pick one of a number, if the rates seem high, like 60 percent, in the recent article from the main team that studies burnout, I don't believe that myself that 60 percent of physicians are truly burned out in a meaningful. But nevertheless, if the rates seem high, and especially if they are getting higher over time, I would be concerned by that, and I would want to

then figure out how much of it is due to payment, if any, and then how much of it is due to other things, if any, that we could affect.

DR. CHERNEW: So I think that broadly speaking is spot on, your last statement, and I will say this is something that better fits into the workforce work stream, as opposed to the update work stream. Because as you said, it would be interesting to know how much, if any, is due to payment. My bias, I think, is where yours is, which is that's probably not the main thing, certainly not within the realm of the payment that we're talking about.

And I think it is a particularly complicated thing. I think some of it could be solved if we just had more physicians or more clinicians, more broadly, so there was just less of this pressure in a whole range of ways. I think some of it is due to things that we basically like a lot. Like the ability to contact your clinicians is a lot easier now. That is, broadly speaking, a good thing. But it does create a lot more challenges.

I've heard from my colleagues, a lot of them have to, after dinner, then do the rest of their job because their job is no longer limited by the time that they're

actually seeing patients. I think that's a big issue. I think there is a lot of stuff that goes on with aspects of documentation, broadly, in that space, and a lot of other pressures.

It may be true, I think, Greg, you said that this type of recommendation above current law sends a signal. That maybe the case. That was sort of not the intent. The intent was to acknowledge that there is, particularly amongst physicians practicing independently, underlying inflation in their expenses that for clinicians practicing in a system they have the OPPS part going for them, and we don't really have that going in the physician fee schedule part.

So again, you know, arguing half a percent point one way or another here I think is really not a core issue, and again, our goals was not to signal that clinicians are important. I mean, just to go on record, if anyone is tweeting, the core value of the American health care system is the clinicians and all the other non-clinicians that actually provide care to patients, where the real value is created, and that should sort of be acknowledged.

That being said, there's a lot of different

moving pieces that we have to support, only some of which will be done through the update recommendations. And so our intent was to try and get some balance between the portion of the practice expense side that is being played out in the OPPS and the portion that is in the physician fee schedule and the clinician fee schedule, which doesn't have that.

So I'm not sure if that was a sort of eloquent explanation of where we are, but that's kind of the intent of what we wanted to do. And I think we need to think really broadly about the issue of both the burnout and the, for lack of a better word, the specialty selection issues that go on in med school and a bunch of other training issues. And the training, as Betty knows, extends well beyond just physicians. We have a whole bunch of training issues for nurse practitioners, advanced practice nurses, PAs, and a bunch of things. So we need to think through that with the tools that we have.

I guess I will stop there. I think we have one more -- were you done, Larry? I don't want to stop you.

DR. CASALINO: You've probably heard enough.

[Laughter.]

DR. CHERNEW: You know, Larry. I have a sense I will hear more. But I think Amol is probably -- which is good, by the way -- I think Amol is probably next, and if no one has jumped in, Amol is last in this round.

DR. NAVATHE: Thanks, Mike. So I also think this is great work and very important. I support both recommendations. I really wanted to make three or four points, some of which I think really touch upon what many of the other Commissioners have said and, in part, kind of respond to some of the things that Commissioners have said.

So I support the recommendation in terms of the payment update being 1 point above current law, which is, of course nothing. But recognizing that the MEI piece obviously is, as Larry was pointing out, you know, is not just a one-year issue, is a trend over time and has been building in some sense. So I think it's something that we need to keep track of, and I would kind of put that in the parking lot for a second, because I'm going to come back to it in another moment.

I think the broader piece that we struggle with as part of this work is that we do have a workforce issue, and I think Mike pointed out that there's a lot of work

that we need to do around the workforce issues. Wayne pointed out that we have a declining primary care physician workforce at a time when we're probably creating more and more accountability that requires more primary care physicians. I think there are a number of different factors that are very challenging that we need to work through, and I think it's not part of a payment update set of work but it's a separate set of work that needs to have many different dimensions.

That being said, I think the work on the safety net side is critical, because it does create this clear incentive that benefits clinicians when they care for low-income Medicare beneficiaries. And looking at how the work that MedPAC has done and others have done shows that there is this concentration of clinicians who are taking care, that comprise this kind of safety net on the clinician side, I think the staff should be commended and applauded for taking this one, because I think we have had, for good reason, a lot of work on hospital safety nets, both at MedPAC and not, for a number of years.

I think this is a much more recent development, and MedPAC, in some sense, is really driving some of this

recognition around the clinical ambulatory safety net. And it's a really fundamentally important contribution, and I think it's fundamentally important for the Medicare program and the beneficiaries. And the way we're structuring it in the context of this incentive of the add-on payment also makes a lot of sense. And so I wanted to make sure to highlight that point.

At the same time, we recognize that the dollars here are not going to solve the problem. I think a number of people have said that. There is a broader workforce trend. There are broader demographic trends that need to be addressed. And that is, I think, certainly a subject of broader workforce stuff, which I'll still come back to in a second.

In terms of the way that incentive is being paid, if you will, the add-on, I agree with Kenny's point that we should recognize that the way the fee schedule is actually used, broadly speaking, it is used for a variety of different stakeholders. But I think, Kenny, as you pointed out, it's actually mentioned in the text of the chapter that it follows the HPSA mechanism. And so there are ways to structure this that would not be disruptive to other

payers, for example. So I think that is a point well made by Kenny and already well made by the staff as well.

I think Larry's points around the site of service piece are really fundamentally important, and this point is potentially driving, at least it's certainly an incentive for more consolidation between hospitals and independent physicians. Again, I would weave this back, and to some extent, site of service but also workforce. So there are a number of different pieces that I think we need to think about from the workforce perspective that don't really fit into this payment update.

The last point I wanted to touch on is Greg's point around is how should we think about MA in this context of the safety net. And I think we should be careful here in terms of the principles and how we're thinking about this. A major part of the rationale, the way that the chapter is laid out from a logical perspective, does center around this point that low-income beneficiaries are reimbursed less, in part because of the way that Medicaid policies work, and they're more costly to care for. And there's a portion of that that applies to MA, meaning the more costly part, but the cost-sharing part

1 does not apply in the context of MA.
2 So I think we should just be careful about how we
3 think about that, and recognize that the greater
4 opportunity that exists on these populations probably
5 exists at a financial level as well. And so the way that
6 SNP benchmarks are also set probably allow for a lot of the
7 flexibility that would be needed perhaps for this
8 population. So I think Greg made a great point there.
9 That being said, I have very little consternation
10 because of the reasons that I just outlined around that.
11 But I'm really broadly supportive of this work, and hope
12 that we can tackle some of the workforce issues, and as
13 David and Dana have highlighted, and Larry, some work
14 around broad physician payment reform, and it's nice that
15 David and Dana are leaving that in our laps as they decide
16 to ride off into the sunset. Thanks.
17 DR. CHERNEW: That was such a good wrap-up, I'm
18 not going to wrap up. What we should do, I think, is we
19 have a five-minute break scheduled. What I hear, broadly,
20 is reasonably strong support for the direction we're going.
21 So we'll debrief based on all of these comments. But I
22 really do appreciate all of the input there. And we're

going to come back in five minutes and discuss dialysis.

So I want to give a particular thanks to Geoff Gerhardt, who has done a lot of the work in this area. It's really been outstanding. And to Rachel and Ariel for the presentation. And I think Ledia gets some thanks too, who I can barely see but I know she's back there. There she is.

So again, thank you all for this terrific, terrific job.

[Pause.]

DR. CHERNEW: All right. Welcome back. We are continuing our march through the different fee schedules, and next up we're going to be talking about dialysis services, and we're starting with Nancy or -- Nancy. Okay. Go ahead, Nancy.

MS. RAY: Good afternoon. The audience can download a PDF version of these slides in the handout section of the control panel on the right-hand side of the screen.

Today we are going to talk about the outpatient dialysis payment update for calendar year 2024. First, we will discuss some background on this payment system. Then

we'll walk through the payment adequacy analysis. We'll end with the Chair's draft recommendation.

Outpatient dialysis services are used to treat most patients with end-stage renal disease. Since 2011, Medicare has paid dialysis facilities for each treatment they furnish using a defined "ESRD bundle" that includes drugs and labs that in prior years were billed separately. Medicare also pays an add-on payment for certain new qualifying drugs, supplies, and equipment. In 2021, there were roughly 332,000 fee-for-service dialysis beneficiaries, treated at roughly 7,880 facilities. Total fee-for-service spending was about $10 billion for dialysis services.

Moving to our payment adequacy analysis, as you have seen, we look at the factors listed on this slide which include examining beneficiaries' access to care, changes in the quality of care, providers' access to capital, and an analysis of Medicare's payments and providers' costs.

We look at beneficiaries' access to care by examining industry's capacity to furnish care as measured by the growth in dialysis treatment stations. Between 2020

and 2021, growth of in-center treatment stations grew faster than the growth in all dialysis beneficiaries; that is, those enrolled in either fee-for-service or Medicare Advantage.

The last point about capacity: in 2021, more facilities opened than closed; there was a net increase of roughly 120 facilities. And the 20 percent marginal profit suggests that providers have a financial incentive to continue to serve Medicare beneficiaries.

Another indicator of access to care is the growth in the volume of services -- trends in the number of dialysis fee-for-service covered treatments. Between 2020 and 2021, the total number of fee-for-service dialysis treatments declined by 20 percent. However, during this period, the number of dialysis treatments per fee-for-service dialysis beneficiary remained steady, averaging 2.9 treatments per beneficiary per week. The decline in total number of fee-for-service dialysis treatments is largely attributable to the change in the statute that permits, as of January 2021, ESRD beneficiaries to enroll in MA plans. For example, between December 2020 and January 2021, the share of dialysis beneficiaries enrolled in MA increased

from 27 percent to 36 percent. By December 2021, the share increased to 41 percent. The Commission's analysis found that in 2018, Medicare Advantage contracts paid 14 percent more per dialysis treatment on average than fee-for-service.

We also look at volume changes by measuring changes in the volume of ESRD drugs that are furnished to beneficiaries. This chart measures the volume of drugs furnished by holding price constant. Since the prospective payment system, the PPS, was implemented in 2011 and these drugs were included in the payment bundle, providers' incentive to furnish them, particularly erythropoietin stimulating agents, ESAs -- the blue bar -- has changed. Between 2010 and 2021, use of ESAs -- the blue bar -- declined by roughly 60 percent with some positive changes to beneficiaries' health status.

Now let's focus on the green bar. This represents the bone and mineral metabolism ESRD drug group. Moving from 2011 to 2019 and 2020, the green bar increases because in 2019 and 2020, two new bone and mineral metabolism drugs -- called "calcimimetics" -- were paid using a transitional drug add-on payment adjustment -- a

TDAPA -- to the ESRD PPS base rate. That accounts for the increase in the use of bone and mineral metabolism drugs -- the green bar.

In 2021, the two calcimimetics were included in the PPS bundle and paid under the base rate -- that is, providers no longer received an add-on payment. And so the decline in the green bar between 2020 and 2021 is largely attributable to providers shifting to the less costly calcimimetic in 2021 compared with 2020. So including drugs in the payment bundle is an example of how Medicare can use payment policy to promote efficiency.

It is difficult to assess quality in 2021 because of the pandemic. Let's talk about some differences in quality compared to the prior year.

Between 2020 and 2021, rate of hospital admissions and mortality modestly increased. The rate of blood transfusion, an anemia quality measure, increased. However, other quality metrics are either holding steady or improving. Outpatient emergency department visits and hospital readmissions remained steady.

One indicator that measures how well the dialysis treatment removes waste from the blood -- dialysis adequacy

-- remains high in 2021. And the rate of home dialysis among fee-for-service dialysis beneficiaries and the number of kidney transplants across all patients increased.

Regarding access to capital, indicators suggest it is positive. A growing number of facilities are for-profit and freestanding. Private capital appears to be available to the large and smaller-sized multi-facility organizations. The two largest dialysis organizations have had sufficient capital to each purchase mid-sized dialysis organizations. In addition, both large dialysis organizations are vertically integrated, suggesting good access to capital. The 2021 all-payer margin was 17 percent.

So now let's talk about providers' financial performance under fee-for-service Medicare. The add-on payment for calcimimetics that began in 2018 contributed to the increase in the margin during this period. In 2021, the add-on payment for calcimimetics ended, which might have contributed to the modest decline in the aggregate Medicare margin.

In 2021, the Medicare margin is 2.3 percent. As you can see, the Medicare margin varies by treatment

volume. Smaller facilities have substantially higher cost per treatment than larger ones, particularly overhead and capital costs. The lower Medicare margin for rural facilities is related to their capacity and treatment volume. Rural facilities are on average smaller than urban ones, having fewer in-center stations and providing fewer treatments. In your mailing materials, we highlight that cost per treatment is highly correlated with treatment volume.

The 2023 projected Medicare margin is negative 0.4 percent. The 2023 margin is lower than the 2021 margin because the increase in payments based on net updates in 2022 and 2023 is lower than estimated cost growth. It also reflects the estimated reduction in total payments due to the ESRD Quality Incentive Program. And it reflects the estimated reduction in total payments due to CMMI's mandatory ESRD Treatment Choices model.

This is a conservative projection. For example, this projection does not take into account the effect of the new add-on payment for a home dialysis machine and a new ESRD drug that might improve providers' financial performance; each add-on begins in 2022 and will be paid

for two years. Given the experience that we have seen, the financial performance of providers improves due to the profitability of items paid under the TDAPA policy.

So here is a quick summary of the payment adequacy findings. Access to care indicators are generally favorable. The decline we see in treatment volume is largely attributable to dialysis beneficiaries' Medicare Advantage enrollment. Quality is difficult to assess. In 2021, emergency department visits remained steady and home dialysis increases. Those are good trends. On the other hand, hospital admissions and mortality modestly increased. The 2023 Medicare margin is projected at negative 0.4 percent.

The Chair's draft recommendation is: For calendar year 2024, the Congress should update the calendar year 2023 Medicare end-stage renal disease prospective payment system base rate by the amount determined under current law.

In terms of spending implications, this draft recommendation will have no impact relative to the statutory update. Based on current estimates, this would increase the base payment rate by 1.5 percent.

We expect beneficiaries to continue to have good access to outpatient dialysis care, and we also expect continued provider willingness and ability to care for Medicare beneficiaries.

That concludes this presentation, and we look forward to your discussion.

DR. CHERNEW: Great. I think we're going to start our Round 1. Thank you, Nancy and Andy. Stacie, I think you're number one in Round 1.

DR. DUSETZINA: Great. Thanks. This was a really interesting chapter and great presentation. I guess I just has one question. I hadn't been familiar with the MA coverage issue around dialysis, but it does seem like a really shockingly growth in the MA program, and I just wondered if you all had thought about that. Was there a particular marketing and outreach to this population or something that drove that? And should we be worried?

DR. JOHNSON: I think the primary change is that the law changed in 2021 to allow dialysis patients to enroll in MA, and one of the features of MA coverage is a cap on out-of-pocket expenses. It's somewhere in the $8,000 range now. It's somewhere in the $8,000 range for

the maximum out-of-pocket cap. And there's a phase-in currently happening. It's going to be $9,100 in 2024. So it's somewhere in that range, but that's an important cap for dialysis patients. They might really be interested in it.

MS. RAY: Yeah, particularly younger patients might be interested because they may not have access to Medigap in certain states.

DR. DUSETZINA: Just as a quickly follow-up, it might be really nice to add a little bit of that detail for the context, because I think that point of, you know, the cap and the exposure to coinsurance for that younger group is really an important piece. And I would imagine we'd potentially see even more people moving to MA given that circumstance.

DR. CHERNEW: I want to say two things about MA actually. The first one is to follow up on what Andy said. I think the appeal of MA to dialysis patients is similar to the appeal to MA for everybody. It's just before, it was harder to get in, and now they can. And I think in some cases it's particularly appealing to them. That's one thing.

The other thing I want to say -- and I think I'm going to get this right -- is when we look at the Medicare margins, that's not including the MA portion of it. I think that's correct. So you could think of the all-payer margin as capturing the fee-for-service Medicare and the MA portion, unlike our sort of stylized fact everywhere else, as was said on the slide, the MA plans are paying more in this. So, collectively, you're seeing Medicare -- if you were to do sort of an all-Medicare -- anyway, perfect.

DR. JOHNSON: This is actually just another broader clarification since maybe some of this is news, and correct me, Nancy, if I get this wrong. So people with MA could get dialysis and stay on MA. They just had to already be on MA. So you had to have MA, and then you would develop a need for dialysis, you have end-stage kidney disease, as opposed to choosing it after you -- after the fact. And I think the reason that's also important is that we're going into the hospice chapter next -- right? -- and that's a distinction where -- and there's a lot of -- in hospice they were excluded from it or under -- for the most part.

There's also an important dynamic here in terms

of, you know, market power that will play out differently between MA and hospice and MA and dialysis providers.

DR. CHERNEW: I think that has been, because of the consolidation in the dialysis industry, the bargaining between the dialysis providers and the MA plans is different.

So next I think we have Cheryl -- were you done, Stacie?

DR. DUSETZINA: It just strikes me with the comment that you made about the MA paying more is whether there's some kind of encouragement of beneficiaries into that market who are already getting dialysis, and I just -- it seems like such staggering growth to me. I definitely hear the benefits are very clear, especially for the people who can't get a supplement. But that is really, really fast growth, and we know that, at least in like Part D, people don't go and shop for plans routinely. So it seems like there's something that's spurring -- could be spurring that interest. And maybe that's totally fine. It just was surprising to me.

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

DR. NAVATHE: Yes, this is my Round 1 question, but it kind of relates to this point about the margins, the all-payer margin and the Medicare margin. So what I'm trying to make sense of is, in general, for Medicare, for these dialysis facilities, the vast majority of their payments are going to come from Medicare, either fee-for-service or MA. And so what I was trying to reconcile is that the Medicare margins we're reporting as something in the ballpark of 2 percent. We're saying that the MA margin -- the MA payments are 14 percent -- not percentage points but 14 percent more. And then the all-payer margin is 17 percent. And so I was trying to figure out how that could be. If the Medicare margins are close to 2 percent, there's a relative 14 percent increase in payment -- not increase, but higher payments from MA, but then the all-payer margin is considerably higher.

MS. RAY: So a small share of providers' patients are from commercial plans, and commercial plans on average pay more per treatment. And that is from publicly available information.

DR. CHERNEW: Correct me if I'm wrong. You can't get on on Day 1, right? So if you have a -- there's a

waiting period for you to --

DR. NAVATHE: [off microphone.]

DR. CHERNEW: Yeah, okay. So I think there's some portion --

DR. NAVATHE: That's a pretty striking difference then in terms of what commercial payers must be paying, though.

MS. RAY: Right, right. For Medicare eligibility, there is a three-month waiting period. That is true. Now, if you're working and you're in a group health insurance plan, that group health insurance plan, you can stay in that plan for the first 30 months, and that plan is the primary payer.

DR. NAVATHE: Right, I see. So I guess the interpretation in some sense is, one, commercial plans are paying a lot; and, two, that is just in the same way we're saying that MA piece of it where the default is a fee-for-service rate, but it's really a reflection of dialysis provider market power that they're able to get higher rates, similarly in the commercial side they're getting a lot, lot higher rates because of the market power. Okay. Thanks.

DR. CHERNEW: And now we get to Cheryl.

DR. DAMBERG: Okay. You guys are already talking about a lot of what I was going to ask, but I want to underscore Stacie's point. That growth was really stunning to me, and some better understanding of what some of those drivers might be would be helpful, to the extent that you know them. But I was also confused why MA would be paying 14 percent more and whether you have any insights on that. That sort of surprised me.

DR. JOHNSON: I think the best understanding is this relative leverage between the dialysis organizations, particularly the two largest, and the health plans. There are a number of counties in the country where -- and county is the level of geographic unit that plans have to say we're going to meet this network adequacy, which has been in place up until recently, that the only dialysis providers, one of those two large organizations, and they might be stuck saying, you know, we've got to contract with you in order to operate in this county, basically. And so there's a lot of leverage that they can -- especially I think for the national insurers.

There is, by the way, another paper looking at

the MA payment rate for dialysis, looking at a little bit earlier data from only the large insurers, and their estimate is 27 percent of fee-for-service rates. So there's some differences between the data and what they're looking at, but there's some --

DR. DAMBERG: Thank you.

DR. CHERNEW: Correct me if I'm wrong, because last cycle, maybe the cycle before, we actually had a particular analysis, and maybe even a recommendation. I can't remember if we just talked about it or policy option or we did actually a recommendation -- I just don't know -- on this exact point.

DR. JOHNSON: We did. We did not have a recommendation, but the March 2021 MA chapter had a section on this, and so I think it's -- we're hearing that it would be helpful to pull some of that information into this chapter now.

MS. KELLEY: That's all I have for Round 1 unless someone else would like to jump in.

DR. CHERNEW: I think we're going to go to Robert in Round 2.

DR. CHERRY: Well, thank you. It's a very

thorough report and nicely done. I want to shift gears a little bit away from MA for a moment. By the way, I'm supportive of the draft recommendations.

The report astutely mentioned that dialysis is pretty much dominated by two different companies. Sometimes these companies or others may actually provide acute dialysis for hospitals, and just like post-acute care facilities, I think some of these dialysis companies are also impacted by staffing issues as well, which could lead to potential delays in inpatient services for those hospitals that have contracts with them.

So I think in addition to looking at timely access to home dialysis as well as kidney transplantation, it may be a good idea to also as a quality measure, particularly for those hospitals that have contracts with some of these dialysis companies, to see whether or not, you know, access to inpatient dialysis services is actually timely as well, because I think that's something that's probably a missing component that may not have been previously considered.

DR. JOHNSON: Are you asking specifically about the acute dialysis treatment or hospital access in general?

DR. CHERRY: Not general hospital, but in terms of, you know, hospitals that have contracts with dialysis companies in order for those dialysis companies to come in and provide acute dialysis for inpatients. And so if there are staffing shortages with these dialysis companies, the hospitals may be calling them, but there may be delays in potential treatment if they're having staffing shortages or other issues.

So monitoring, you know, timely access to inpatient dialysis that's provided by a third party is probably worthwhile doing.

DR. CASALINO: How could they find that information? How could they tell if there was a delay?

DR. CHERRY: You know, I probably would defer to MedPAC staff, but either through -- well, you know, one thing is -- well, one way of doing it is through the hospitals. The hospitals could provide that data if there was a quality metric that they were required to report out or the dialysis companies could potentially report it, too, or in some combination.

MS. RAY: Yeah, we will think about that. I know that -- I mean, we do give the annual spending -- the

chapter includes the annual spending for AKI beneficiaries, but that's not a -- I mean, that's just spending. That's, of course, not an access measure. We'll get back to you.

DR. CHERRY: Yeah, and like I said, the hospitals could report it out pretty easily. Thank you.

MS. KELLEY: I have a Round 2 comment from Scott. He says: Given that the all-payer margins in this space are and will continue to be more than satisfactory and those margins well may increase as business moves from fee-for-service to MA, where, as discussed, the plans often pay more than Medicare fee-for-service, is there anything we could or should be doing as the largest payer in this space to further incent world-class outcomes, more payment based on measures -- for example, more payment based on measures such as avoidable ER and hospital utilization, mortality, quality of life, use of home methods, receiving a transplant, et cetera?

MS. RAY: Okay. So I think that's a good question, and I just wanted to highlight what CMS is doing right now with CMMI's model. They have a mandatory model that is looking to increase the use of home dialysis and kidney transplantation. And we can provide a little bit

more text in the paper on that. There's also another CMMI voluntary model that is looking for improved outcomes for both pre-ESRD beneficiaries as well as dialysis beneficiaries. So CMMI does have models in place. Prior to the current ones, they did have a model that did result in improved quality outcomes, lowered admissions. It was essentially the first chronic disease alternative payment model, essentially, the ESRD ETC model.

That's it.

MS. KELLEY: Lynn?

MS. BARR: I'm really curious. Stacie's got me going on the MA track here. So are we subsidizing this increase? I mean, so -- I mean, I've never seen like Medicare Advantage paying a lot more than Medicare, so is this a new world that we're in? Because don't they just -- isn't that passed on through the benchmark? So if they pay more, it goes into the benchmark, right? Is that wrong or -- is it --

DR. CHERNEW: Based on the fee-for-service. MA plans, relatively speaking, ignoring a broader set of MA issues -- and I want to point out a subtle thing that may have been missed by folks. The discussion of this issue

that we had before actually appeared in the MA chapter, not in the dialysis -- there's a part of this discussion which is a bit outside of the dialysis update topic and is in the what's going on in MA topic. But if you're an MA plan, there's this tension between the risk adjustment that you get and how that plays out and that's based on a calibration on the fee-for-service side, and then what you have to pay for -- again, I haven't followed exactly how -- I'll defer to the staff on this. But I don't think we're subsidizing it in the way that you're talking about, but I think per the back and forth with Stacie, there is a concern program-wise that the MA plans are paying a lot more and that the all-payer margin is very high, and it's a weird all-payer margin because, unlike when we talk about the all-payer margin in hospitals, we're looking at the Medicare or typically blending it with commercial, which is good; Medicaid, it is not, and a bunch of things. Here it is -- although a lot of the beneficiaries are Medicare beneficiaries, MA or fee-for-service, there is this other portion of dollars that is flowing in on the commercial side, which is very generously paid for some of the same reason that the Medicare Advantage plans are paying more.

So I think that this issue about MA, as important as it is, is probably a little more suited for what we think about in the MA chapter and how we feel about it as opposed to what we're doing in the update, because now we happen to be just talking about the dialysis-only update. Just to be clear, we went with current law -- I probably should have said this earlier. In general, I'm going to have a basic default towards current law. If you notice, there was a negative 0.4 margin. That wasn't efficient providers. That's a whole separate concept. But we had a negative 0.4 in 2023 and we're not sure what's going to happen in 2022. But given all the other things that are going on that were sort of discussed, it doesn't strike me going above current law is justified. But I'm not completely comfortable going too far below current law given we're making a fee-for-service update and where the fee-for-service margin is. So that's kind of how we ended up where we were.

The other thing I'll say -- and this is just a theme from Larry's point. There's an entry of -- there's entry of for-profit providers, I think, in the grand scheme of how this is playing out. So --

MS. BARR: It's a little scary. But I do -- yeah, so I support the Chair's recommendation, but I can't believe that the MA plans are just rolling over for that kind of money, unless there's some other way that they're getting it somewhere else.

DR. CHERNEW: Well, no, I think the MA plans -- well, I'm not sure the MA plans -- maybe I should just stop. I'm not sure "rolling over" is -- I think there's just issues with the network adequacy rules and some of the other pressures I think in some sense they're saddled with.

I don't know. Jaewon, do you want to comment on this?

DR. RYU: Yeah, so I think it gets to what Andrew mentioned earlier. There are a lot of counties, depending on how dense the county is population-wise, where, yes, there are two large dialysis organizations, but in many counties across the country, certainly in rural, functionally in any given county there's one. And so it's the choice for an MA plan between being able to sell a product in that county versus taking whatever that one dialysis provider is going to give you as far as a contract. And so the negotiating relative strength is just

very different in this space.

DR. CHERNEW: And, remember, dialysis is a service that you get roughly three times a week. So depending on your county, you're not driving -- you know, there's an issue about proximity. You can't substitute people -- you can't substitute providers quite as easily as you might give travel. I mean -- so I think there's just a lot of constraints there. And, again, I think this is a topic that comes up and came up in the Medicare Advantage chapter about how we think through this.

I'm actually going to do -- let me just say another thing. Lynn, were you done? Okay.

DR. JAFFERY: Could I have one response to Lynn's question? In the MA chapter, we did compare the MA bids for the ESRD population to the costs for the ESRD population, and on average, they were similar. So I don't think there's a big disconnect there. In part, I think it's because the dialysis spending is 30 percent or a third, roughly, of the total spending. So there might be some other ways in which MA plans are not paying as much overall even they're spending more on average for dialysis.

DR. CHERNEW: Thank you, Jonathan.

If I have this right, Lynn was the last person in the queue for Round 2. So we're going to go around in some sense, and I was sitting here wondering who's going to start when we go around, because I do want to get people's view. And it turns out now I know. It's going to be Greg. So we're just going to go around, but the reason I stopped you, Greg, is I don't want you just to stay on this point. You can say something at least about your view of the recommendation, and then we're just going to go around, and I guess we're going to end with you, David.

MR. POULSEN: Perfect. So on this point, I think Slide 10 is really important on this. This is one where volume is huge. You guys pointed that out, and it clearly is. And so this isn't one where, if the rate that you're getting as an MA plan is unacceptable, you can go talk somebody else into starting up a program and doing it in your medium-sized community. It won't work.

So, anyway, I think that this really is one that lends itself to natural monopolies in relatively even medium-size communities, not just tiny communities. So I think that's the issue that the MA plans are facing.

And, obviously, to Amol's point, it's faced by

commercial plans outside of MA as well, and apparently to a very large degree. So those numbers are striking.

That said, to the general point, I like this recommendation very much. I think it finds the right middle ground on this, and so I support it.

DR. RAMBUR: Thank you. I appreciate this chapter very much and support the recommendation. Just a few comments.

I do think some of the things Stacie raised, and others, about fleshing out some of the feeding factors, it was helpful to the reader because, otherwise, the numbers look really glaring. And I do want to not lose Scott's earlier point about the issue of are there things that we could do or should we illustrate what CMS or CMMI is doing around things patients value, like home dialysis. I know there's a fair amount of literature about patients really preferring home dialysis, I understand, if I am correct. So I think a bit of context around that.

So either to be clear, things that we can incent or recommend we incent or what others are doing would be helpful. And I very much support the recommendation. Thanks.

DR. RYU: I'm also supportive of the recommendation. I like the chapter. I do think there's interface areas with MA, but as far as the recommendation, I'm fully supportive.

DR. NAVATHE: I too am fully supportive of the recommendation. I think Nancy point out, I think this is an area that Medicare has been doing a bunch of experimentation with a variety of different payment approaches, voluntary and mandatory.

As a clarification, the ESRD treatment choice as a model, the ETC model is mandatory, but I think it's mandatory in a sixth of markets or something. I think a third of the market's got randomized or something like that.

MS. RAY: Yes.

DR. NAVATHE: So it's not a nationwide mandatory model yet.

MS. RAY: That's correct.

DR. NAVATHE: Okay. But, nevertheless, I very much support the recommendation.

DR. RILEY: I support it for all the reasons that have been articulated. This is, again, one of those areas

where we always worry about Medicare beneficiaries, because someone put in the chat there it's sort of a theme of the afternoon, hospice, dialysis, in terms of these two sectors take care of the most frail Medicare beneficiaries. So I support it.

DR. DUSETZINA: I also support the recommendation and the update.

UNIDENTIFIED SPEAKER: I support the recommendation. I think a couple comments to make to respond to Betty's comment about home dialysis. Yeah, there's a fair bit of data about some improved outcomes and patient preference. It's not always suitable for everybody, but I think the other point to make is that there have been payment policies to incent movement towards home-based dialysis methodologies, and there's both peritoneal dialysis, which has always been done in the home, and then a lot more movement towards home hemodialysis as opposed to in-center hemodialysis, not always suitable for everybody based on a number of factors. But there is some movement that way.

I think, you know, this difference in margin, I mean, I don't have all the formulas in front of me, but as

Nancy pointed out, you know, it's not just the three months to get on Medicare. It's 30 months or more that people have their private insurance, and so when we think, unfortunately, about the mortality rate in this population, that's a pretty sizable percentage of how long people often will be on dialysis. Thirty months can be, depending on the demographic. And so, again, the differences -- the differential in the all-payer margin versus the Medicare versus MA is less surprising when you sort of factor all those things in.

And then, finally, I think, you know, what this conversation really drives home, I'm not at all surprised by actually that MA pays greater here for the reasons that people have pointed out. I think it really drives home just how much market power drives everything. And, you know, we're seeing this play out where payers consolidate, where providers consolidate. And as I mentioned earlier, what would be very interesting to think about this as we start to talk about hospice and track over time how that plays out there, where, you know, margins are not exactly as robust as always, and certainly hospice does not have the market power that the LDOs so.

So, anyway, thanks.

DR. DAMBERG: I also support the Chair's draft recommendation. Two other comments I'll make.

One, I thought the slides you had in the slide deck about changes in payment policy and the effect it had in changing behavior, those were particularly illuminating and a reminder of the role that payment policy can play in driving the kinds of behaviors we want.

And then I guess particularly given the shift these patients into Medicare Advantage, I would hope that both MedPAC and CMS would sort of double down in terms of measuring the quality of care for this population in that setting.

DR. SAFRAN: I am not yet sure if I support this recommendation, and here's why. I think we would all agree that the consolidations that exist in this market or the duopoly power that exists in this market is not good for beneficiaries, and I just am curious -- and I'm sorry I wasn't in the room to raise this before we were going around, because this would have been a topic for discussion -- if there is something we could do with payment updates that would differentiate between, you know, those who are

the duopoly and other smaller entrants. And I know we probably can't do that based on a certain percentage of Medicare beneficiaries served, but are there other aspects, like are they the smaller providers disproportionately serving safety-net beneficiaries, something along those lines. But that's where I'm struggling, is that I would love to use this moment in payment policy as a way to start to drive a little bit of a wedge so that this begins to be an area where there's less duopoly power.

Thank you.

MR. KAN: I support the recommendation enthusiastically. I do echo Dana's comments of future studies. We should explore doing it in a budget-neutral way, payment updates, you know, differentiating a duopoly from the other operators.

MS. GINSBURG: I also support the recommendation. I have two questions, which you may have already spoken to and I just missed. Are MA plans required now to make this part of their package, or is that optional? That's the first question.

DR. JOHNSON: They're required all except for the costs of organ acquisitions for kidney transplants.

MS. GINSBURG: So the answer is, yes, they are?

DR. JOHNSON: Yes. There's one very small sliver that is the acquisition costs for kidney transplants. Those are covered under fee-for-service, but MA plans are --

MS. GINSBURG: Okay. And another question about the availability of Medigap plans for this. I assume most people who need dialysis are usually under the age of 65, so, you know, they're not on Medicare yet. If you get on Medicare disabled and then you turn 65, you get theoretically a clean slate. Are they then able to purchase a Medigap plan if they wanted to, in fact, be on original? Are they entitled to do that even if they have -- require dialysis?

DR. JOHNSON: If I understand the question, and then I'll ask Nancy because I don't think I know the answer, if somebody becomes eligible for Medicare and they're under 65, they become eligible because of ESRD, at 65 do they have a new opportunity to purchase Medigap?

MS. GINSBURG: [Off microphone.]

MS. RAY: I don't know the answer to that. We can look into that for you. I don't know the answer to

that.

MS. GINSBURG: [Off microphone] anyway, I just think that would be -- seeing the growth of MAs doing this and the rationale that at least they're limited by their out-of-pocket max for MA plans or they don't have an out-of-pocket max for OM, but obviously if they can get on OM with the Medigap that covers all this, that would be a pretty compelling reason for many even to switch back to OM once they're 65. So the question is: Is that available to them?

DR. JOHNSON: We'll have to look into that.

MS. RAY: We'll have to look into that, yeah.

MS. GINSBURG: [off microphone] the recommendation. Thank you.

DR. CHERNEW: I think we're going to loop around to Larry.

DR. CASALINO: Nice work, and I do support the recommendation. One comment and one question. The question is -- well, let me do the comment. The comment is we have here kind of an interesting place study of quality inpatient experience in Medicare Advantage, right, because we've had such a sudden change now compared to traditional

Medicare for dialysis patients who are among the most frail patients, as I think Jonathan said. So quality and patient experience differences should be more likely to show up if there are differences. So what is the impact of MA on that?

The other is, you know, in terms of duopoly, arguments can be made both ways, the likely effect on patient experience and quality of having a duopoly, and so it would be very interesting to track that, and I think important, quality and patient experience for patients of the duopoly versus others.

The question is: We've said in other settings that because of incomplete claims data, we don't feel -- MedPAC doesn't feel like quality can be adequately measured in the Medicare Advantage program. Would that be true in this case as well for dialysis patients?

DR. JOHNSON: I think it depends on the measures. We'd probably have to go measure by measure. Some of the quality measures in the fee-for-service program come through a different data stream that the facilities submit directly for sometimes all Medicare patients, not just fee-for-service patients. Am I right?

MS. RAY: Yeah, I think that's one of the items that is sort of on my to-do list, to share that with you, is to see what we can parse out of the encounter data. For example, can we look at use of home dialysis among MA patients? I think that would be a key quality metric, for example.

DR. CHERNEW: And the MA plans, of course, would have some sort of incentive to promote home dialysis as well.

DR. CASALINO: Incentive for the MA -- dialysis patients -- never mind.

DR. CHERNEW: Okay. Yeah, we should move on. I think one of the issues here is the dialysis patients have a relationship with the dialysis center that is pretty tight, and the notion that the MA would use its standard tools -- it's going to be hard to use network tools for reasons we discussed. And you're not going to prior auth someone getting dialysis in a range of ways. So there are some clinical -- so there might be things that are going on, but I actually don't think this is an area where the -- whatever we think is going on with MA and quality, and there might be some -- I won't claim to know. I'd actually

look to Jonathan since we have our resident nephrologist here now. But I actually wouldn't think this would be an area that if I'm an MA plan, I'm going to decide to go do something to manage the quality of the dialysis. It's just a harder thing, as far as I know, to do.

DR. JAFFERY: I think to your first point that these are individuals who come to -- have a standing relationship with a facility when they come there three times a week and spend half a day a week there on each of those days and just have a very tight relationship, which is a lot tighter than their insurance payer. And so, you know, the influence on, oh, you should do home dialysis instead of in-center -- and there are some incentives already for centers to do that and to -- and for providers to have those conversations. Those don't actually change here. I'm not sure exactly what I would imagine an MA plan would throw up as an incentive or a barrier for those things. And to your point, Mike, you know, there's not prior auth to these things. It's pretty structured.

So, you know, if they are getting those claims, it might be worth looking at as this number grows, and maybe we could see what those differences are at that

point. But, you know, things like readmission rates or referral to transplantation or things like that, those are -- those things, they seem like they're more grounded in the dialysis provider.

DR. CHERNEW: We'll move on. Lynn and Robert, I think you both spoken in Round 2, but I just want to make sure you don't want to add anything.

So, David, you get the last word.

DR. GRABOWSKI: Great. I'm supportive of this recommendation. I really liked Amol's point about the all-payer margin versus the Medicare margin and sort of unpacking that, I think in the chapter potentially giving us more of the data there to see the commercial. It would be nice to be able to put all the parts together. I was also sort of troubled by that, and am I missing something here? You know, 17 percent real, and so just connecting the dots would be great.

The other thought, Jonathan, was your point on market power, and I don't know if this is a reflection on dialysis or MA, maybe both, but in the dialysis space, MA pays a rate above fee-for-service. Mike, you've done work on this, so you can correct me if I'm wrong. Hospitals,

physicians, I think MA and traditional Medicare are pretty similar. Post-acute, however, MA pays below fee-for-service. So this issue of market power really matters, and it's not something we think about a lot, I think, in our -- more and more the Commission has begun to consider it, but I don't think historically we've thought a lot about it in the payment update space.

And so going forward, I think the challenge, as Greg noted, is this is a bit of a natural monopoly, and so it's not as if you can naturally break this up and say, oh, for the sake of market power. So I think there's a lot going on with this, but I did want to raise this issue of market power.

Thanks.

DR. CHERNEW: All right. So I'm going to summarize quickly. We're almost exactly on time, and so we'll take another break while we do the transition and come back with hospice. But with regard to this point, Dana, about consolidation, there's -- it is obviously not impossible for us to build into our update chapter things that go beyond just the numbers, you know, current law plus or minus, that we do that with our safety net stuff. But,

in general, as a matter of course, we don't try and divide up and accomplish a lot of things with the update recommendation stuff. And I think the market power one would be a particularly challenging set of things to write. It would be a whole series of analyses one would have to do about how you define it, how you deal with it if someone -- if the market power changes, what happens when entry happens, do you get a bump up? There would be a lot of complexity trying to build in something along those lines.

So I think as a general point, we've been pretty clear to me in this discussion two things. There's broad support for the recommendation. There's broad concern about both the role of MA and the things that give rise to the MA -- the higher MA payment. I think we're going to have to reserve that part of the discussion to other areas like the MA chapter or other things we do. I think it's very hard in the update chapters to deal with that type of issue.

So that's sort of where I hear we are. I think everyone is --

MS. KELLEY: Actually, I'll speak for Scott. He sends a comment that he, too, supports the recommendation.

DR. CHERNEW: Okay. So Scott gets the last word. We're going to take a break again for a minute, and we'll be back, once we do the transition, to the hospice presentation.

[Recess.]

DR. CHERNEW: Okay. We are now live, just to be clear, and we are going to finish what has been a really thoughtful and useful and constructive day with Kim talking about updates for hospice services. So, Kim, the floor is yours.

MS. NEUMAN: Good afternoon. The slides for this presentation are available on the control panel on the right side of the screen.

So we're now going to talk about hospice and the payment update for fiscal year 2024 and discuss the Commission's prior recommendation to modify the hospice aggregate cap.

First, we'll discuss some background on hospice.

Then we'll walk through the payment adequacy analysis.

And then we'll talk about the hospice aggregate cap.

And we'll conclude with the Chair's draft recommendation.

So we begin with two slides of background on the hospice benefit and the hospice payment system. You've seen these slides before, so I'll just highlight a couple points.

Hospice provides palliative and supportive services for beneficiaries with terminal illnesses who choose to enroll. To qualify, a bene must have a life expectancy of six months of less if the disease runs its normal course. There is no limit on how long a beneficiary can be enrolled in hospice as long as a physician certifies that the patient continues to meet this criterion.

Next, we have background on the hospice payment system. A couple things to highlight.

Medicare pays hospices a daily rate for each day a beneficiary is enrolled regardless of whether services are furnished.

Medicare's payments to hospice providers are wage adjusted, and there's also an aggregate cap that limits the total payments a provider can receive during a year, and we will discuss the cap more later.

This daily rate structure in the hospice payment system, as we've discussed before, makes long stays in hospice quite profitable.

So in 2021, over 1.7 million Medicare beneficiaries, including nearly half of decedents, received hospice care furnished by over 5,300 hospice providers, and Medicare paid those hospices $23.1 billion.

As we consider hospice payment adequacy, we'll use the same framework you've seen today. One difference, though, is that we'll present margin estimates for 2020 instead of 2021. This is because the data needed for the aggregate cap calculation lags.

So moving to our payment adequacy data, first, we have provider supply.

The total number of hospice providers increased about 6 percent in 2021.

For-profit providers account for all of the net growth in provider supply in 2021, and over the last five years, as shown in the orange bars.

Next, we look at hospice use rates among Medicare decedents. In 2021, the share of Medicare decedents who used hospice declined slightly to 47.3 percent, from 47.8

percent in 2020.

With the pandemic, we've seen the share of decedents using hospice decline in 2020 and 2021. And this is a reflection of the effects of the pandemic on death rates and patterns of care, not payment adequacy.

The chart on the right shows the relationship between the number of deaths (represented by the orange bar) and the share of decedents using hospice (represented by the green line) across the months in 2021.

Corresponding to waves of the pandemic, months with the highest number of deaths had the lowest hospice use rates.

And this largely reflects that elderly people who die of COVID-19, similar to those who die of pneumonia and influenza, are much more likely to die in the hospital and less likely to die at home than elderly people who die of other illnesses.

Now looking at additional indicators of access to care. In 2021, the total number of hospice users and the number of days of hospice care was stable.

The site of hospice care continued to shift toward the home and away from nursing facilities.

Among decedents, average length of stay declined in 2021, but was similar to the 2019 level. Median length of stay declined one day in 2021.

The amount of visits furnished to hospice enrollees on average per week increased slightly in 2021, after declining in 2020, but remained below pre-pandemic levels.

Marginal profit, a measure of whether providers have an incentive to treat Medicare beneficiaries, was strong at 18 percent, a positive indicator of patient access.

It remains difficult to assess quality due to the effects of the pandemic on data reporting as well as patterns of care.

The most recent available CMS quality data indicate that hospice CAHPS scores were stable in the most recent period; a composite of seven process measures of care at admission increased slightly in the most recent period but was topped out.

In addition, claims data indicate that in-person visits in the last days of life were stable in 2021, after declining in 2020.

So next we have access to capital. Hospice is less capital intensive than other Medicare sectors.

Overall access to capital appears positive.

We continue to see growth in the number of for-profit providers, which increased about 8 percent in 2021.

Reports from publicly traded companies and private equity analysts indicate that the hospice sector continues to be viewed favorably by the investment community.

We have less information on access to capital for nonprofit freestanding providers, which may be more limited, while provider-based hospices have access to capital through their parent providers.

Next, we have margins, and as I said, different from other sectors, we have historical margin data through 2020.

First, looking at the chart on the left, the aggregate Medicare margin in 2020 was 14.2 percent. That's an increase from 13.4 percent in the prior year. If we had included Medicare's share of COVID relief funds in the margin, it would have been higher, at about 16 percent.

Freestanding hospices had strong margins at 16.7

percent, while provider-based hospices had lower margins.

Margins also vary by ownership. For-profit hospices had substantial margins at 20.5 percent. The overall margin for nonprofits was roughly 5.5 percent.

Urban and rural hospices both had favorable margins -- 14.3 percent and 13.5 percent respectively.

Now looking at the figure on the right, we have margins by providers length of stay quintiles, and that figure shows that margins increase as length of stay increases. The dip in margins in the highest length of stay quintile is because of the effect of the hospice aggregate cap on payments for some providers.

So next we have our margin projection. For 2023 we project a margin of about 8 percent. We arrive at this projection by starting with the 2020 margin and making several assumptions.

First, we assume revenues increase based on net updates of 2.4 percent, 2.0 percent, and 3.8 percent in 2021, 2022, and 2023.

We also assume reinstatement of the 2 percent sequester starting in July 2022.

In terms of cost growth, we use the observed 4.2

percent increase in hospice cost per day that occurred in 2021. For 2022 and 2023, we assume cost growth equal to the projected growth in the market basket for these years, which reflects the most current data available on wage growth.

Taking all these factors together results in the projected margin of 8 percent.

So to summarize, indicators of access to care are generally favorable; the supply of providers continues to grow; the number of hospice users and total days of care were stable; in-person visits per week increased slightly; the share of decedents using hospice and lifetime length of stay declined; marginal profit was 18 percent.

Quality is difficult to assess, but the most recent CAHPS data were stable, and visits at the end of life were stable in 2021, after a decline in 2020.

Access to capital appears positive. The 2020 aggregate Medicare margin was 14.2 percent, and we project a 2023 margin of 8 percent.

So switching gears, let's talk about the hospice aggregate cap.

The cap limits total payments a hospice provider

can receive in a year. The cap is an aggregate limit, not a patient-level limit.

If a provider's total payments exceed the number of patients served by that provider multiplied by the cap amount, the provider must repay the excess to Medicare.

Currently, the cap is over $32,000, and the cap is not wage adjusted.

In 2020, we estimate that about 18.6 percent of hospices exceeded the cap. These providers had margins of 23 percent before the cap and 8 percent after.

Each year since March 2020, the Commission has recommended the hospice cap be wage adjusted and reduced by 20 percent.

Changing the cap in this way would make it more equitable across providers and would reduce aggregate Medicare expenditures by focusing payment reductions on providers with long stays and high margins.

So on this next slide, we summarize the simulated effects of the cap policy. This is similar to what you've seen before. The simulation has just been updated to use 2020 data, and as in the past, we assume no utilization changes.

Under the Commission's recommended cap policy, the share of hospices exceeding the cap is estimated to increase from roughly 19 percent to 34 percent.

Hospices currently below the cap that the simulation estimates would become above the cap under this policy are mostly for-profit, freestanding providers, and these providers had an aggregate 2020 Medicare margin of 25 percent.

The chart on the left shows the estimated effect of the cap policy on total payments to providers.

Our simulation estimates that total 2020 payments would have declined 3.3 percent under the cap policy.

As you can see in this chart, the reduction to payments occurs among hospices with the longest stays -- the last two lines in the chart. Other hospices are unaffected by the policy change.

So turning to the Chair's draft recommendation, our generally positive payment adequacy indicators and the projected margin suggest that aggregate payments could be reduced without hindering quality of care.

Recognizing the variation across providers in margins that likely reflects provider business decisions to

capitalize on certain incentives in the payment system, the Chair offers this draft recommendation that would reduce aggregate payments by bringing payments closer to costs for providers with very long lengths of stay and low costs relative to payments, while allowing a payment update for other providers.

The draft recommendation reads: For fiscal year 2024, the Congress should update the 2023 Medicare base payment rates for hospice by the amount specified in current law and wage adjust and reduce the hospice aggregate cap by 20 percent.

In terms of implications, the recommendation would decrease spending relative to current law.

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

So this concludes the presentation, and I would be happy to answer questions and look forward to your discussion.

DR. CHERNEW: Kim, thank you. Outstanding job.

I think we'll get right to it, and I think Round 1 is going to start with Kenny, if I have that right. Kenny.

MR. KAN: Yes, on page 11 in the slide deck, I was surprised that the margins between urban and rural are pretty much almost the same. I was wondering if you have any -- if you know why.

MS. NEUMAN: So we've seen that the difference in margin between rural and urban providers narrow over time, and rural providers over the last few years through 2020 have had relatively slow cost growth compared to urban providers. That is one factor that's affecting it. And I know when we think about rural providers and potentially lower economies of scale that we might expect potentially lower margins through that mechanism. But another sort of aspect of hospice care is that you don't have a facility kind of fixed cost in the way that you think of hospitals or dialysis providers, and so that may make this sector one where there's more likelihood to have closer margins.

MS. KELLEY: David?

DR. GRABOWSKI: Thanks, Kim. This is terrific work. I wanted to ask -- there's a real push today about paying for quality, and there is, as you mention in the

chapter, this MA-VBID model, and I was just curious. You document sort of the early evidence around that model. Is that the right approach to thinking about innovation in this space? And I obviously want to expand on this in Round 2, but I just want to get your thoughts of kind of is that -- does it have the right outcomes? Is that sort of the right way to be thinking about this? Your thoughts on that model. I know it's a very broad Round 1 question.

MS. NEUMAN: Are you thinking about -- in terms of your question, are you thinking about it in terms of how to measure quality or how to --

DR. GRABOWSKI: How to structure and encourage better quality at a hospice? Is sort of the MA-VBID the right kind of chassis for that sort of approach?

MS. NEUMAN: Well, the MA -- as you know, the Commission made a recommendation in 2014 that hospice care be included in the MA benefits package, and the MA-VBID is sort of a step toward testing that approach that CMMI has undertaken. And the rationale for the Commission's recommendation was that the way it is right now with beneficiaries going from -- being fully in MA to if they elect hospice, getting their hospice care through fee-for-

service, but still being in MA for unrelated services -- well, for certain -- it's complicated. I'm going to sort of not get into the detail there. But there's fragmentation that occurs, and so the idea is that including hospice within the MA benefits package would eliminate the fragmentation, have one entity that's responsible for the beneficiary from when they're in the -- when they're in the MA plan until potentially the end of their life. And so that kind of accountability is seen to be a benefit.

The other thing about the hospice MA carve-in that the Commission discussed was the idea that MA plans could have flexibility in a way that at this point we don't have in the fee-for-service program, so they could have ability to potentially offer palliative care for people with serious illnesses who might be a little bit up in the disease trajectory, or they could test concurrent care. And those are aspects of the MA-VBID design that they're looking at. And it's really early to be able to say, you know, how that's going to turn out. You know, they've had, what, 10,000 beneficiaries in the first year, and we have some information about what's happened. But I think it's

going to take longer to sort of see how that all falls out.

DR. CHERNEW: Let me try and give it -- so I think that's right, but maybe this will help. There's some real logical reasons why the MA-VBID demo was put in place. However, I don't think the MA-VBID demo is intended to solve all the problems with hospice quality, and there's no way that you would think that it would, because, by definition, you're not getting all the people that are not in MA and it really can promote certain types of coordination for people that are in MA. And we had the problem that Kim mentioned. I think that's right.

I think the questions that come up on quality -- and they will come up a lot -- typically have fit into the chapters and the work we've done on our VIP. You know, there's like eight hospital VIP chapters. And those are typically not in the update chapters. So there are questions across all of these sectors about how to promote quality, and hospice is no different in that regard. And I think we'll reserve the comments about how to measure hospice quality, how to, you know, incent hospice quality, how to deal with it in our kind of quality world, to the type of work we do when we get to quality. I think it's

hard to have the update chapters answer the simultaneous questions. How do we set the update? Which is our main question. And, again, we do in other areas, like the TAP, for example, so we do stray in certain things that are very tied to payment. But when we get much beyond payment, then issues get very complicated like measuring quality of hospice, measures of other things. We tend to move those into targeted analyses of quality.

So I think the answer to your question is the MA-VBID demo is certainly not sufficient to guarantee good quality in hospice. It is certainly an important topic. How do we guarantee quality in hospice, some of which may be done through payment incentives. But it's unlikely it will be done through the update payment incentives. It will be done through other versions. And that's kind of the way we'll have to think about sort of where that all fits into the agenda, but, you know, some of that comes up in how we harmonize the post-acute setting things and how we deal about quality across the different settings. So there's a lot of other places where I think it's probably easier for us to get into the quality of hospice topics.

That's in no way meant to dismiss the importance

of hospice quality as much as to try and keep us on the narrow as we can kind of say. Anyway, is that --

DR. GRABOWSKI: Yeah, I don't think I can say anything else without going into Round 2 so I'll wait for --

DR. CHERNEW: I'm not sure I could have answered without going into Round 2, but I did anyway.

Okay. Who's next, Dana?

MS. KELLEY: Jonathan.

DR. JAFFERY: So first, Kim, good chapter. I really appreciate it.

Just a quick question, I guess. You had outlined, I think it was Slide 11, and you don't have to go there, but you outlined the different Medicare hospice margins and freestanding nonprofit, for-profit, and then model some of the other impact in different quartiles or whatnot for the cap and the wage index, and you talk about how the impact would be greatest in freestanding and for-profit. Did you model what those margins look like, how you might redo Table 11 if the cap and wage index were in place?

MS. NEUMAN: So we have, I think not exactly like

that but it's pretty close. I think it's on page 50, we have the payment-to-cost ratios simulated -- it's by length of stay quintile. It's not by the other categories. But we simulate them for all providers, urban and rural. So you can kind of see there what they look like now and what they would look like under the simulation.

DR. JAFFERY: Gotcha. Yeah, I would have to think about the math there too. I mean, that's helpful. I think translating it maybe to those -- I don't know if that's possible to just think about that at a future date, think about what that impact would be and what it might look like on those margins. I'm just trying to think about it the back-and-forth calculations here that I'm not sure that I can translate easily. Thanks.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thank you for such a great chapter. I always learn a lot when I read these.

So I'm trying to make sense or at least dovetail what's on Slide 17 and what's on Slide 16 in terms of the implications, which says "decreased Medicare spending relative to current law." But that's predicated on Congress acting on the wage adjustment and reducing the

aggregate cap. Is that correct?

MS. NEUMAN: Yeah, that is the effect of the text on the prior page, which is hinging entirely on the cap policy.

DR. DAMBERG: And given that Congress didn't act on that in the past, do we have any sense of the likelihood of them doing that, and would we be concerned about overpaying here? I'm trying to think about how to think about this.

DR. CHERNEW: Let me just see if I can get this right, and again, I will turn to Jim. This has been a sort of long-going version of compound recommendations, so we have this sort of compound recommendation here and you're illustrating sort of why I earlier said we tend not to like compound recommendations. But in this particular case the way you could think about it is just separately. Like there's a current law update recommendation, and if that were the recommendation it would have no impact on spending, et cetera. And then there's a cap reduction recommendation, which is part of the same thing in this, which would have an effect of saving money because of the cap reduction.

The congressional likelihood of adopting what we do is really outside of what -- there are a lot of things we're going to do that I'm not sure will happen any time soon, and I think our -- that doesn't mean it's not important, by the way. I think in many cases it certainly contributes to the debate in a range of ways, and there are a lot of other ways in which the staff interact with the Congress to help them think about what they do.

But we try and make the best recommendation we can do that is sort of the most useful to Congress. So will they do it? There are a lot of issues that they face, and I'm not going to hesitate to speculate on how this would all play out.

DR. CASALINO: Mike, on the compound recommendation point, I'm just trying to think back historically. Is it fair to say that there are two kinds of categories of compound recommendations, one like this, where Congress can do one or the other and not both and that's okay. One doesn't depend on the other. Correct? So in this case they could pick and choose or do both or do neither.

But I think sometimes we make a compound

recommendation uncommonly, but I think we've done it where the one depends on the other, and that's more problematic, right? When one doesn't depend on the other, I don't really see much of a problem.

DR. CHERNEW: Well, let's just go with how some of these played out like on the hospital side or various things we've done. The problem with doing it is there is a sequence over time about how all the recommendations stack and whether the recommendations themselves sort of stand. So when we did the recommendation now, say, on the hospital side, we intended that each recommendation would stand. The current law update plus 1 on the hospital side is intended to be -- you know, we think they should do both. We're recommending they do both. The text can talk about how they're tied. But the recommendation itself would stand alone in a way that would sort of, if they didn't do both, you know, we wouldn't go back and say -- it's very hard to say if you do this, then do that.

In this particular case, to give you some sense, if they decided to not lower the cap, I wouldn't come back and say, "Oh, then you should go under current law." If that's the question that Cheryl's asking. That the current

law part of the update, there is a slightly negative Medicare margin. If you look at the Medicare Advantage portion of it, it's slightly positive. And that's why, in some ways, we defer to current law, and this is a really big reason to change.

So I would not come in with a strong negative hospice -- I'm sorry. I was talking about the other one. But in this case still, I wouldn't come in with a strong negative hospice update even if we took out the cap part.

Jim, you might want to say something. Correct me if I'm wrong.

DR. MATHEWS: No. I won't correct anything. But, you know, a different way to think about it would be we try to be equitable in our treatment across the different provider sectors we look at when we make recommendations. And I don't want to get ahead of our agenda, but when we talk about inpatient rehab facilities tomorrow and we talked about skilled nursing facilities tomorrow you will see comparable indicators of the adequacy of Medicare payments, with respect to access, with respect to financial performance, that kind of thing.

And so when we look at hospice and we see

predominantly favorable or positive indicators of payment adequacy, and we have a Medicare margin of, Kim, I want to say around 8 percent is what we're projecting, you know, we could conclude that some money could come out of the hospice payment system without compromising access.

Now over time, including at this session, we have always heard Commissioner interest in making differential updates, based on different types of providers, different types of ownership, different types of policy goals. In most instances, those differential updates are very, very hard to implement. You know, there is a common base payment rate, there is a common conversation factor. And so we can't really easily do things where we say we're going to give the for-profits one update and the nonprofits another update.

This is a unique sector in that we can adjust the payments that Medicare makes to hospices based on the behavior with respect to length of stay. And so here we are taking savings out of the sector in a manner that is targeted towards the hospices that have, you know, the most extreme lengths of stay, at the right-hand tail of the distribution, where they might not be completely adhering

with the Medicare requirements with respect to admitting patients into hospice, keeping them longer than they should be, that kind of thing.

So that's another way of thinking about why we might be saying one thing for IRF and skilled nursing facilities and we might be saying something slightly different for hospice, even though it might have the same financial effects.

MS. KELLEY: Lynn.

MS. BARR: Great report. Thank you. I'm always really interested in this topic.

In Table 11-14 where you discuss the differences of the adjustment in rural versus urban, would you be able to provide numbers of facilities for each group? So, you know, as you can see the impact of this policy would be detrimental into lowest quintile in rural --

I apologize for not having my microphone on. Do you want me to repeat the whole thing.

MS. NEUMAN: Yes, please do. I'm sorry.

MS. BARR: Okay. I apologize. So what I was asking is would you please be able to provide numbers of facilities that fall into each of those quintiles, because

by putting in the wage adjustment is going to differentially hurt people that have low wages, which would be rural, right, typically. So I'm just curious, is it evenly distributed amongst those quintiles in rural and urban, or is there a different pattern that we need to worry about?

MS. NEUMAN: So a couple of thoughts on that. First of all, we do have a sense of what percentage of providers or how much revenue is in the different quintiles, so we should be able to give you a better sense of that.

The second thing is that the policy does not have a negative effect on urban or rural providers that have the lowest margins. So I just want to make sure. The chart is a little complicated and I just want to make sure that the takeaway is clear. The rural in the lowest length-of-stay quintile, their margin is at that level right now, and the policy doesn't change it, doesn't take any money away, and they would get a full update under the recommendation.

MS. BARR: I see. I appreciate it. That makes perfect sense to me. I would be curious to know the distribution in rural versus urban and see if there are

really any difference in that. Thank you, if you could provide that, and I wholeheartedly support the recommendation.

DR. CHERNEW: That is going to be a Round 2 comment, unless you have it on.

So I think now we're moving to Round 2, and I think again we're going to start with Kenny. And as you go around, we'll go through the order of the queue, and be sure to say something about the recommendation, if you say nothing else.

MR. KAN: Outstanding chapter. I support the recommendation as I think it strikes a logical balance in summarizing the various dynamics in the space.

The one thing that I have a slight concern with, you know, is this. I am cognizant that we need to be data driven in striking a consistent balance in terms of a payment update. The thing that I struggle with is that for this cohort of very frail beneficiaries, in the last month of life especially, where hospice total cost could be like half that of a hospital stay, are we, by reducing the cap by 20 percent are we at least sending a different signal in terms of incenting towards the usage of more efficient

care? It's a slight concern but it's kind of a new space for me, but I understand why we actually need to do this in a data-driven and consistent framework.

DR. GRABOWSKI: Great. So I'm also very supportive of the Chair's draft recommendation. I think the idea of the cap -- it's a very blunt instrument and it's going to have the intended effect. I think in the chapter it's also noted it may have an unintended effect, and we've seen some of that with live discharges, and that would be something obviously we want to continue to monitor.

When I talk to folks in the palliative care space about what MedPAC is working on with hospice and end of life they kind of yawn when I talk about the cap. I think it's very effective and I'm supportive but I think they're much more excited about innovative policies around alternative payment models, although we haven't seen a lot of action, as is noted in the chapter, in that space. But they're particularly excited about the MA VBID program.

And so, Kim, your point is really well taken that we're really early in that, but maybe I'm just adding to the to-do list for MedPAC after I leave. But I really

think focusing on that and kind of -- yeah, just this whole-of-meeting, Wayne, I'm going to continue to --

DR. RILEY: You will just be able to mail your thoughts.

DR. GRABOWSKI: That's right, so I can continue to offer comments. But this one I can do here at the meeting. I think we want to continue to think about this payment model. I do think that's where a lot of folks think the innovation, at least on the MA side, is coming, and it will be interesting to following this as the model grows, and I think more as from what's now a hospice benefit to a palliative care benefit. I think that's what a lot of the practitioners in that space really want. Thanks.

MS. KELLEY: I have a comment from Scott. He agrees with the Chair's draft recommendation and thinks it represents a logical take-home to a well laid-out summary of the dynamics of the space.

Similar to our discussion about the dialysis space, Scott has great concerns that are not so much rooted in concerns about potential overpayment but more about how we can be appropriately stronger buyers of the care we want

for our most frail beneficiaries. He is quite upset on behalf of our beneficiaries at what underlies stable cap scores in this space, including, as noted on page 29 of the chapter, that scores were lowest in the areas of providing help for pain and symptoms, providing timely care, and training caregivers.

Scott would like to see us, at some point, discuss and recommend some combination of treating these kinds of failings as never events, calling them out publicly, potentially attaching penalties to them, et cetera; increasing the role that pay-for-performance plays in hospice's compensation; strengthening the requirements for participation in the program; et cetera.

We have no concern about there not being enough players in this space. It is a low barrier to entry space with good margins. We need to become, over time, stronger in demanding the care our beneficiaries deserve and the support their families need at this most challenging time in their life.

And I have Robert next.

DR. CHERRY: Yes, thank you for a great report. You know, I want to discuss a little bit the quality

measurement piece in this space. Maybe it might answer David's question too. I'm not sure. I do recognize that there is probably not enough time to explore this thoroughly relative to the payment update. However, it would be nice in the future if we can talk about these payment updates in the context of quality measurement as well, instead of just talking about the payment updates and then bifurcating the conversation to something else.

But I think there is a need for more robust quality reporting. I like the hospice care index. I think that's a good foray into it. There are other types of measures that were alluded to in the report that could also be explored, including evidence-based pain control therapies, nausea/vomiting treatment, dyspnea management, and also bowel regimens for opioid use.

I do think, though, it's a unique space and we have to carefully think through quality measurements. You know, it's a time of great stress for the patient, for the families, and you don't want to create unintended consequences through the quality measurements as well. So it's a principle of "first do no harm," particularly in hospice care.

But perhaps mandatory reporting of some of these quality measures could be helpful and just to see how they behave, and then to refine the strategy over time. But, you know, I wouldn't have any issue in the future having a mandated quality reporting measurement set with an associate penalty for noncompliance, like 2 percent or something like that.

Otherwise, thank you again for a great report, and I do support the recommendations.

DR. CHERNEW: I think that was the end of where we were, so I think we are going to just go around and get folks' views. I think maybe we'll start -- we had David and Robert spoke in Round 2, so maybe if we start with you, Lynn, and come around this way it will be a nice way of going, because then it turns out Greg will be last, and last time he was first.

This was one of Glenn Hackbarth's great skills.

MS. BARR: I support. Thank you.

DR. CASALINO: I have two questions. Michael, I just wanted to make sure I understood. Did you say that if Congress didn't reduce the aggregate cap and wage adjust that you wouldn't be for the update, or did I

misunderstand?

DR. CHERNEW: I said that -- you did not misunderstand. I probably shouldn't have said that, is the honest answer. I think what would happen is -- I'm going to defer to Kim and Jim on this -- this is an elegant way to achieve two things at once. In other words, we're basically taking money out and we can do a target or we can do one part of the recommendation. If somehow, we were told we couldn't do Part X, what would we do in the update? I'd have to think about that more because I misspoke before. The margin here is 8, so it's not quite as high as you might see in some of the other sectors we're about to talk about, but it's certainly healthier than some of the other sectors we've spoken of.

So I think we'd have to think carefully about what the update would be if we weren't doing the cap part. But by doing the cap part, it gives us sort of this ability to balance where we think the overall sector should be but do it in a way that sort of targets a portion of the sector of long stays, that we think are probably overpaid.

So I wish I could just go retract. Maybe this counts if you're reading the transcripts, go back and just

erase what I said before -- please don't read the transcripts.

DR. CASALINO: Okay.

DR. CHERNEW: But that's sort of where I am.

DR. CASALINO: We'll leave it at that. So we're kind of assuming that ideally Congress would understand the N, that Congress would do X and Y, which is the way we have it worded, rather than we have number 1, number 2, and Congress can pick one. We hope that they would do the N. Okay.

And then, Kim, a question. Do I remember correctly that a lot of the patients with long stays are patients with dementia?

MS. NEUMAN: The patients with long stays are a share of those with dementia, but other conditions as well. It happens across diagnoses with, you know, dementia, heart disease, some other neurological more likely, but it happens across diagnoses.

DR. CASALINO: So I thought I remember from a discussion from years ago now that long-stay dementia patients are particularly profitable because they don't necessarily demand that much medical care. Or I'm sorry.

They don't necessarily demand -- they just kind of -- well, do I remember correctly or is that my imagination?

MS. NEUMAN: Patients who have long stays, regardless of diagnosis, tend to be more profitable. We tend to see similar service patterns in terms of number of visits across diagnoses. And so it's more how long you're in hospice and less about what diagnosis you have.

DR. CASALINO: -- as the question at the beginning than at the end. Okay, so I do support the recommendation.

Just a possible item for future work for MedPAC. I'm saying this because a lot of Commissioners weren't here at the time. I think Karen DeSalvo raised the issue fairly strongly that she thought to some extent hospice was becoming a program for taking care of patients with Alzheimer's disease, basically, and that it wasn't necessarily that well suited for that, and that some attention should be given to that fact and what would be a suitable program for patients with dementia or especially Alzheimer's disease. So just a flag of something to possibly think of for the future. She was quite eloquent about that, actually.

DR. GRABOWSKI: Mike, very, very quickly. I promise. I just can't help myself. Long-term care is not covered under Medicare, and that's the problem, Larry. And so they try to fit it in in places like this. But this would be if you had a long-term care benefit that's Medicaid or private pay, but that's the disconnect of our system. Thanks.

DR. CHERNEW: I think we're going to jump over to Marge.

MS. GINSBURG: I support the recommendation as written. Thank you.

DR. CHERNEW: And Kenny, you spoke so I think we're okay. We're just going to move to Dana.

DR. SAFRAN: Thanks. I do support the draft recommendation. I would just make a couple of points. One is I have been sitting here thinking about that same conversation from a couple of years ago, I guess it was, and the sort of really important differentiation across types of illnesses, and like the stay and what that implies for profitability. So it's again, you know, drowning walking across a lake that's, on average, one foot deep, just does strike as a metaphor here where, you know, I have

to think certain hospices are doing different work from other hospices in terms of their focus. That's nothing we can do for this round, but it does feel like something we should be thinking about for payment policy going forward.

The other comment I want to make is a kind of overarching one about quality, because this is my last December meeting and I am finding myself just so discouraged that quality measurement is one of our important criteria here and every year, for every sector we're saying the same thing, six years now for me. We just don't really have the measures that we need, but based on what we have, and it's like two measures, one measure, three measures, and many of them process measures, not outcome measures, almost all of them other than patient experience.

And so I just call that out as something that I think MedPAC needs to make a statement about. And then there's the lack of data infrastructure needed for measurement where we do have the measures, like in Medicare Advantage and the inability to compare across sectors. It just kind of goes on and on. And it's kind of coming together for me in this moment and feeling that we have to

find the right place in this report or the June report to say something pretty strong about that and the need for the field and for payers, and in this case CMS, the payer for the Medicare population, to take this really seriously and dedicate resources to that next generation of measures.

So thank you.

DR. DAMBERG: I support the recommendation as written, and I'm going to pile onto what Dana just said. I think we have to take a very strong stance around quality measurement, particularly in light of this desire to measure value and what's being delivered from all this payment that's being had. So I'd certainly like to see more discussion of that and really raising the red flag again for CMS to rethink their measurement strategy and where they devote their resources, to try to make more inroads on this front.

DR. JAFFERY: I support the recommendation, and I just want to shine a little light on something that David said, that I think didn't get as much emphasis in your comments, and it was about hospice providers are very interested in moving into that palliative care space. And it has some of the same dynamics we've been talking about

with some of the long-term care, but that actually is a very logical extension of hospice care. They have the same capabilities. A lot of them do it and provide it on an out-of-pocket payment basis.

And sort of coming back to what Kenny said earlier, there is probably a better opportunity there to try and prevent some end-of-life spend than we often see in patients who get pulled into hospice in the last couple of weeks of life, and we're not seeing the impact on cost there. Thanks.

DR. DUSETZINA: I also support the recommendation as written. And just to pile onto the comments that were made previously by Scott and then Robert, the quality measures there are really concerning, especially given when you think about hospice and what a person might need at hospice. Pain and symptom management and timely care seem like the very basic. If you're not meeting that you are not meeting the goals of this service.

So I like the idea of somewhere, somehow emphasizing that more, and especially because we do have a generous margin which we don't often do, so it does seem a place for leverage. But I support the recommendations as

drafted.

DR. RILEY: Yeah, I too support it for all the great reasons. First of all, Kim, thank you very much. Excellent work. You know, having referred patient to hospice, you're right, that's what I want for my patients is that they get good personal care, pain control, and a very fitting, dignified place until their demise.

DR. CHERRY: I also support the recommendation as written. I think a couple of quick comments. I support many of the Commissioners' comments about quality, about measurement, as well as having, as a payer for driving some of the impetus to try to improve quality of care and measurement in this space, as well as David's points around thinking about how the structure of the payments here work, in particular in the context of MA. There may be greater opportunities, but then when a beneficiary is enrolled in hospice, they kind of exit MA and that creates some quirky dynamics, we say. Because there has been actually a lot of innovation that has happened in the palliative care space, and so what could it look like is something I think that may be interesting for us to ponder at a later point.

I also think Jim's point earlier was really

helpful to understand relative to other sectors in the sense that here there is a way to develop a policy recommendation that is maybe not razor-sharp but at least is directionally directed at a set of patterns, basically, that are concerning and that may not be really in keeping with the best interests of the program and the beneficiary. And that is not an opportunity that we oftentimes have. So it's not targeting any type of hospice, per se, but a practice. And if there are certain types of hospices that engage in those practices, of course they may be disproportionally affected. But I think that's kind of a unique situation that's worth calling out, that the policy recommendation here is very rationally designed to address that element of it.

But I strongly support the recommendation. Thanks.

DR. RYU: I'm supportive as well. I especially like the targeting component with the reduction in the aggregate cap.

DR. RAMBUR: I strongly support the recommendation. I have just a couple of burning comments.

When I look at the life expectancy of six months

or less, I think about other countries like Australia that start to sort of care much earlier. But, of course, they don't have the per diem incentive that we have in our current system.

And I really support the notion that was raised by a few of you about the idea of palliative care benefit rather than hospice care. The overtreatment at end of life is very, very painful to providers and to families. So we have this paradox of these real long stays and then people really not getting what they need. And I recall, too, the things about dementia and Alzheimer's.

So I think this is a fine recommendation. I think we have really some work to do to think about quality metrics and how do we design something for the new world of dying, because I think in many ways, we really are in a new world of dying as this enormous group of baby boomers age together.

So I look forward to more conversation and support the current recommendations. Thank you.

MR. POULSEN: I too support the recommendation and share the issues related to quality. I suspect most of us have experienced in our professional and sometimes our

personal lives vast variation in terms of the quality of these kinds of services, in hospice services. And so I think they're probably not measured nearly the way we would all like to see that, but I'll close on that by saying I support the measures here, for sure.

DR. CHERNEW: So thank you, everybody. It is nice to have a session and have a lot of people commenting, prefacing their comments with the phrase, "I'm piling on." And the word "support" is always nice.

So a few things. One, I did hear support for the recommendation. Two, I heard strong concern about our ability to measure quality in a range of ways. I think that's generally true. Where and how we go about doing that is a separate issue, but certainly you would get no argument from me that the current quality measure system, writ large, in hospice or otherwise, needs some rethinking and discussing, and that will transcend what we do in any particular payment recommendation. But that might end up being a discussion for another day.

So I think for now I'm going to close with, first of all, thanking Kim, more broadly thanking all of the staff who once again did an outstanding job, and I probably

express that appreciation from all of the Commissioners. I want to thank all of the Commissioners for sticking with and providing very thoughtful comments across the board on a number of chapters.

And lastly, to the public, please send us your thoughts to meetingcomments@medpac.gov or reach out in any other way. We really are looking forward to hearing from you.

And lastly, before I close, please join us again tomorrow morning. We're going to start a 9:00, and we're going to start with skilled nursing facilities, followed by inpatient rehab.

So again, thank you everybody. We will see you tomorrow, and otherwise have a wonderful evening.

[Whereupon, at 5:41 p.m. the meeting recessed, to reconvene at 9:00 a.m. on Friday, December 9, 2022.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, December 9, 2022
9:01 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
AMOL S. NAVATHE, MD, PhD, Vice Chair
LYNN BARR, MPH
LAWRENCE P. CASALINO, MD, PhD
ROBERT CHERRY, MD, MS, FACS, FACHE
CHERYL DAMBERG, PhD, MPH
STACIE B. DUSETZINA, PhD
MARJORIE E. GINSBURG, BSN, MPH
DAVID GRABOWSKI, PhD
JONATHAN B. JAFFERY, MD, MS, MMM, FACP
KENNY KAN, CPA, CFA, MAAA
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AGENDA PAGE

P R O C E E D I N G S

[9:01 a.m.]

DR. CHERNEW: Hello. Good morning, everybody. Welcome to the second day of our December update discussion. We're going to start this morning with skilled nursing facilities, and so I'm turning it over to you, Kathryn. Take it away.

MS. LINEHAN: Thank you and good morning.

Webinar attendees can download a PDF version of these slides in the handout section of the control panel on the right side of the screen.

Before I start, I want to thank Corinna Cline and Carol Carter for help with this chapter.

In this session, I will present information about the adequacy of Medicare fee-for-service payments to skilled nursing facilities, or skilled nursing facilities. This information falls within four domains in our framework: beneficiaries' access to care, quality of care, providers' access to capital, and Medicare's payments and providers' costs.

The specific indicators are listed on the slide. Based on these indicators, we will present the Chair's

draft update recommendation for Medicare's base payment rates to skilled nursing facilities.

Before diving into the data, I'd like to provide some high-level context about the effects of the pandemic and related policy changes.

As you know, nursing home residents and staff were devastated by COVID-19 and the pandemic. Its starkest effects have been that more than 159,00 residents (so roughly 10 percent) and 2,700 staff deaths were attributable to COVID-19 from May 2020 through October 2022.

Vaccines were made available in the winter of 2020-2021, and nursing home residents and staff were prioritized. As a result, in early 2021 mortality rates from the virus fell.

SNF volume and employment in the sector saw steep reductions in 2020 and 2021. In 2022, volume and employment have begun to return but remain below pre-pandemic levels nationally as detailed in your paper.

Finally, some Medicare coverage policies implemented in 2020 have remained in place and are scheduled to end when the PHE expires. The waived three-

day prior hospital stay requirement allowed facilities to treat residents who required skilled care without a preceding hospitalization. CMS estimates that about a quarter of SNF cases in 2021 were waiver cases.

This slide provides a snapshot of the SNF sector in 2021. That year, the Medicare program spent $28.5 billion on SNF care.

These payments were made to about 15,000 providers, most of which also provide long-term care that makes up the bulk of services this sector provides.

You can see in the third yellow box that Medicare makes up a small share of most nursing facilities' volume (about 10 percent of days) but a larger share of revenue.

And in 2021, about 1.2 million beneficiaries, or 3.4 percent of fee-for-service beneficiaries, used SNF services.

Turning to our measures of access, we see a small decline in supply in 2021, but this rate of decline was consistent with prior years. In 2021, 88 percent of beneficiaries lived in counties with at least three SNFs or swing beds.

SNF occupancy rates have not rebounded to pre-

pandemic levels nationally but have been increasing in 2022. SNFs have faced staffing shortages that could affect access. But these are not the result of Medicare payment rates.

Between 2020 and 2021, covered admissions per beneficiary decreased 2.4 percent and days per beneficiary decreased 3.7 percent. This is the result of fewer SNF referrals, patient avoidance of the setting, and secular trends of lower fee-for-service SNF use observable prior to the pandemic.

The Medicare marginal profit, a measure of whether providers have an incentive to treat Medicare beneficiaries, was very high, 26 percent, which is a positive indicator of patient access.

Shifting now to indicators of the quality of SNF care, we evaluate quality of care in post-acute settings, including SNFs, using two measures: average risk-adjusted rates of successful discharge to the community and all-cause hospitalizations within a stay.

In 2021, the mean facility risk-adjusted rate of successful discharge to the community and hospitalizations improved compared to 2020. We present this finding with

the caveats that changes in these measures since 2019 reflect pandemic conditions, PHE-related policy changes, and SNF payment policy changes described in more detail in your paper. We plan to explore refinements to our measures in the coming year.

Because the vast majority of SNFs are also nursing homes, we assess the adequacy of capital for nursing homes.

The number of SNF deals again fell in 2021 -- the latest full year for which we have data. The number of facilities and beds involved were similar between 2020 and 2021. And the mean price per bed in these deals was a near record high in 2021.

HUD is a key lender in the nursing facility sector, typically financing renovations and improvements rather than new construction. In its data from fiscal year 2022, HUD reported that its financing of nursing home projects (both in value and number of facilities) decreased in 2022.

The total margins in this setting were 3.4 percent compared to 3.1 percent in 2020. This reflects suspension of the sequester, provider relief funds reported

on 2021 cost reports, PHE-related policy waivers, and the temporary increases in many states' Medicaid rates.

Investor interest in the sector is expected to continue due to the aging of the population and the fact that SNFs are lower cost compared with other institutional PAC providers. Government financing is also considered stable.

Next, we will review changes in 2021 to freestanding SNFs' costs and payments. As a reminder, freestanding SNFs make up about 97 percent of facilities. Compared to 2020, average costs per day increased 4 percent. This reflects fewer covered days over which to spread fixed costs, an increase in routine costs per day, and a small decline in ancillary costs per day compared to 2020. Higher routine costs per day reflect an increase in labor costs that may be driven by signing bonuses, hazard pay, and the use of contract labor. The small decrease in ancillary costs are related to less therapy utilization under the new case-mix system.

On the payment side, SNF payments per day increased 3 percent in 2021. Payments reflected continued suspension of the sequester and the overpayments in the new

case-mix system. In addition, there was some shift in payments from Medicaid to Medicare that accompanied the waivers of coverage requirements that I mentioned earlier.

In 2021, the average Medicare margin for freestanding facilities was 17.2 percent, which was the 22nd year in a row that the average was above 10 percent. These Medicare margins illustrate why Medicare is considered a preferred payer.

Across facilities, margins varied substantially, and there is more detail on the variations in the paper. Variations in Medicare margins reflect several factors including differences in economies of scale. For example, nonprofit facilities are typically smaller and have higher costs per day. Nonprofits also have had higher cost growth compared with for-profit SNFs.

We consider the costs associated with relatively efficient providers, as we have in other sectors that we saw yesterday. Relatively efficient providers are those that perform relatively well on both cost and quality measures. The measures we use are: standardized cost per day, and risk-adjusted rates of successful discharge to the community and hospitalization.

In 2021, 9 percent of SNFs included in the analysis were relatively efficient. Compared to other SNFs, relatively efficient SNFs had community discharge rates that were 14 percent higher and hospitalization rates that were 14 percent lower.

Relatively efficient SNFs' standardized costs were 7 percent lower than other SNFs. Payments per day were 10 percent higher.

The combination of lower costs and higher revenues per day resulted in a median Medicare margin of 22 percent, an indication that Medicare's payments are too high relative to the costs to treat beneficiaries.

We also look at the average payment per day that some MA plans pay for SNF care. In a survey of 1,200 SNFs conducted by the National Investment Center for Senior Housing and Care, fee-for-service payments per day average 25 percent higher than MA payments. Evidence from two publicly reported companies are generally consistent with this differential.

While we don't know the characteristics of beneficiaries in the facilities included in the National Investment Center data, our analysis of the age and average

risk scores of MA and fee-for-service SNF users indicates that differences between the two groups would not explain the differences in payments.

The publicly traded PAC companies with SNF holdings report seeking managed care business, suggesting that the MA per day payments, though lower than fee-for-service payments, are attractive.

We project that SNF Medicare margins will decrease in 2023 to 11 percent. This is because costs are expected to increase more than the payment rate increases.

Specifically, in our estimate of costs, we used CMS' most recent estimates of the market baskets for 2022 and 2023. The market baskets consider how labor and other costs will change in both years.

On the payment side, we assumed that payments will increase by the updates included in the final rules for 2022 and 2023. We also accounted for the reapplication of the sequester starting in April 2022 and the adjustment that CMS applied to correct for overpayments resulting from the implementation of the new case-mix system in 2020. Margins could be higher or lower if changes in costs or payments differ from the projections.

In summary, our indicators are generally positive for SNFs. Supply of facilities declined less than 1 percent; declining volume reflects declining demand due to a number of factors and not the adequacy of Medicare's payments. The high marginal profit indicates providers had a strong incentive to treat Medicare beneficiaries.

Our quality measures in 2022 indicate improvement compared to 2020, but the pandemic and PHE-related policy complicate our interpretation of rates and trends.

SNFs have adequate access to capital, and this is expected to continue. The total margin increased compared to 2020.

The average Medicare margin in 2021 was high, and for relatively efficient SNFs was even higher.

The projected margin for 2023 is 11 percent.

Before turning to the Chair's draft recommendation, I want to walk through expected changes to payments in 2024. CMS will revise its estimates before the publication of the final rule.

As you can see on the bottom line, currently we estimate a net update of 3.3 percent in 2024. This is the result of an estimated market basket increase of 2.8

percent minus a productivity adjustment, minus 2.3 percent to correct for overpayments resulting from the implementation of the new case-mix system. In addition, CMS corrects for over- and underestimates of the SNF market basket when it was misestimated by more or less than 0.5 percentage points. The forecast error correction for fiscal year 2022 would be applied in fiscal year 2024. Currently, the correction would result in an increase to account for the 3.2 percentage point underestimate in 2022. These puts and takes result in an estimated net update of 3.3 percent in 2024.

So this brings us to the Chair's draft recommendation. It reads: For fiscal year 2024, the Congress should reduce the 2023 Medicare base payment rates for skilled nursing facilities by 3 percent.

SNF margins in 2023 remain high even with the downward adjustment to capture overpayments resulting from the new case-mix system. A 3 percent reduction to payments in 2024 is needed to more closely align aggregate payments to aggregate costs.

In terms of implications, spending would be lower relative to current law. Given the high level of

Medicare's payments, providers should continue to be willing and able to treat beneficiaries.

And with that, I'll turn things back to Mike and look forward to your discussion.

DR. CHERNEW: Terrific. Kathryn, that was great.

I'm looking forward to folks' comments. I think we can jump right into Round 1, and if I'm right, Dana, that's going to be Dana.

DR. SAFRAN: Thank you. Just a simple question. You noted that in terms of the population mix that 10 percent of patients in SNFs are Medicare. And I'm wondering if that's an artifact of the age mix or the payer mix. So do we know what percent of SNF patients are 65 and over?

MS. LINEHAN: Are you asking what share of Medicare beneficiaries with a Part A SNF stay are 65 or over?

DR. SAFRAN: No. I'm asking in terms of a payer mix for SNFs, a very low percent that's Medicare, I doubt is a low percent of older people. So I'm just trying to understand what percent of SNF patients are age 65 and over.

MS. LINEHAN: Total nursing facility patients?

DR. SAFRAN: Yes.

MS. LINEHAN: I don't know the answer to that off the top of my head, but, yeah, it's high.

DR. SAFRAN: Okay.

DR. GRABOWSKI: Yeah, it's over 90 percent.

DR. SAFRAN: Thank you. That was what I was wondering.

MS. KELLEY: Kenny?

MR. KAN: Yes, on page 9 of the slide deck, I'm curious, in the analysis of margins, were you able to glean any color on urban versus rural?

MS. LINEHAN: Yes, and that's in the paper. Urban margins are 17.3, rural margins are 16.8.

MR. KAN: Okay, so similar, comparable to what we saw in the nursing home where it was relatively comparable between urban and rural -- in the hospice, sorry. That's good to know.

On page 10, were there any learnings in terms of, you know, quality process measures for the relatively efficient SNFs that you were able to glean beyond what's noted on the page?

MS. LINEHAN: Can you say -- I'm not understanding what --

MR. KAN: Were there any -- I'm just curious were there any like qualitative quality measures that you were able to glean from the relatively efficient SNFs?

MS. LINEHAN: We haven't looked at any other quality measures other than the two outcome measures that we have on the slide.

MR. KAN: Okay. Thank you.

MS. KELLEY: That's all I have for Round 1 unless anyone else has a question.

DR. CHERNEW: So as you know, we're all going to talk in a second. I know who's going to talk first. But I do want to say this is a sector that really has faced a lot of challenges, and that just makes thinking about how the updates go challenging. And I want to make sure that people don't interpret the Chair's recommendation in any way as a comment about the importance of the sector, the people it serves. I think we've been through an era where it's just very clear that these institutions have faced a large number of challenges.

The issue that we have, for those listening at

home, is there's a set of criteria that we use that lead to the updates, and we stick to what our mission is in that way. So that's sort of how we got to where we got to. I'm sure you all have comments, but I do want to emphasize broad acknowledgments of the importance of the sector given the Chair's recommendation is for a cut to the update.

DR. CASALINO: Mike, you might want to put your mic a little closer going forward.

DR. CHERNEW: Yeah, I might want to.

[Laughter.]

DR. CHERNEW: I'm not sure I'm going to. Instead -- thank you, Larry. I think I'm just going to turn it over to David, who I think is going to be second -- is first in Round 2, and I'll be he's going to say something similar, so go ahead, David.

DR. GRABOWSKI: Great. I'm so happy you led with that, Mike, because I think there's a huge disconnect. When you talk to folks in the industry, popular press, there's a real perception that things are tough, and things have been tough, yet financially I think this report is great in terms of framing the set of metrics and suggesting that the overall financial health today looks good. So I

am supportive of the Chair's draft recommendation, and thanks, Kathryn and Carol, for this great work.

I did want to kind of take on this issue or this disconnect between why folks think things are so horrible right now and kind of the financial health. Kathryn, you mentioned this in your presentation, but I just wanted to pull it out and highlight it. The reason the help has been, I think, good financially has been the public health emergency, and it's really -- initially, it was all the relief funds, PPP dollars, but more recently -- and we've done some research on this -- it has really been the relaxation of the three-day rule and the ability of nursing homes to skill in place. And MedPAC was on that very early in our work. Carol, you had that in last year's report. That's how kind of Medicare is continuing to support nursing homes right now.

I'm really worried, once the public health emergency ends, we're going to see kind of a bit of a reckoning there where we're not seeing the discharges from the hospital to SNFs that we were pre-pandemic. And so, really, the way Medicare is right now supporting, you know, skilled care in nursing homes is via skilling in place. I

don't think the public health emergency should go on forever. I know we've sort of joked about that at prior meetings, but at some point that's going to end. And then I think we're really going to face this kind of crossroads with the industry. Medicaid does not pay a rate that's commensurate with the cost of care. MACPAC is meeting somewhere else in the building, but yesterday they did a session on Medicaid payments, and they found that in most states, you know, Medicaid is paying below cost. So that's really important work that we should incorporate in future years into our reports, because they've gone out and kind of done the work of looking at the states and --

MS. LINEHAN: We've talked to them about --

DR. GRABOWSKI: Yeah, I -- this is not news to you, but may be to the other Commissioners. There is -- I think there's cross-subsidization that you've written about for a lot of years is present, and I think I just want to double down on a comment I think I make every year, that this way of paying or supporting nursing home care in this country is completely broken. Mike said it well. From a Medicare perspective, it's quite healthy, but from an industry perspective, this is a flawed model with kind of

overpaying with one public payer, underpaying with another, and hoping for the best. In certain facilities, this might work, but to Dana's point yesterday, you know, just because the water is on average a foot deep, you know, some nursing homes are really struggling. They do very little Medicare. They do a lot of Medicaid.

So I know that's not a MedPAC problem per se, but it's an industry problem, and at some point that issue is going to be magnified at the end of the PHE.

A couple of other comments I just wanted to make. We haven't seen -- there's been some media reports of closures. I think that's going to be an important metric over the next several years to watch. I think you even included one, Kathryn, with some kind of local media stories in some market, and I get a lot of calls about these closures. Once again, there's a lot of attention. But I think continuing to document overall supply, as you do in the report, is going to be really important towards sort of countering that argument that once again the sky is falling, because there are some facilities that are really struggling, but those are high Medicaid places, and that's a little different than our payment update.

A final comment. I really like that you looked at sort of financing and transactions, and I've wondered a lot about this. You would be worried, I guess, if you didn't see any sort of entry or transaction or deals. You'd also be worried if everyone was kind of trying to get out and selling and going bankrupt, and so kind of -- I know it's a little bit down, but I think in the coming cycles sort of thinking about what the number of deals means as an indicator of the financial health.

And I'll say finally I'm really glad you flagged HUD. We did a piece recently. It's not private equity that's a big funder of nursing home care. It's HUD. And HUD has kind of been a very -- I don't know -- traditional source of funding, but not very innovative in how they provide dollars. And so we outlined a series of ways that HUD could actually be a little bit more innovative on that front.

Once again, great work, very supportive, but I do worry that even though we're not up against it this year, in the coming cycles there's going to be some real challenges with this sector given the end of the PHE.

Thanks.

DR. CHERNEW: Thanks, Dave. I'm going to -- my sense is there will be some similarities as we go around, so I'll save my comments until the end.

I think next is probably Lynn, and then I'm going to let Dana run the queue.

MS. BARR: Good morning, and thank you for an excellent chapter. I do agree with the Chair's draft recommendation with, you know, lots of trepidation about what's really happening in the real world and how this affects everyone. And, you know, what I wonder, so what seemed to have happened was the three-day SNF waiver really made a difference. And here's where I think Medicare can be a good payer to nursing homes and save money, which is through the APMs and these three-day waivers.

And I wonder whether we should also be recommending to CMS that, you know, right now only risk-bearing APMs, which, of course, there are going to be fewer of because the restrictions have been lifted, that we encourage more APM utilization of SNFs to avoid hospitalizations so that we are continuing to support the SNFs, but at the same time saving Medicare money.

I worry about these facilities, and I worry about

the 2,700 staff members that died and what it was like being in those facilities in the last year, and I can't even imagine -- or through the pandemic. I'm very grateful they exist. But I do support the recommendation. Thank you.

MS. KELLEY: Okay. I have a comment from Scott. He agrees -- I'm sorry. He directionally agrees with the Chair's draft recommendation, but shares David's concerns. He's somewhat concerned that given the lack of adequate Medicaid payments and the low likelihood that many state Medicaid programs will address that, such a steep cut has the potential to further destabilize a sector that is still reeling from the PHE's effects on volumes, costs, and staffing issues.

He would be more comfortable with a somewhat more modest reduction. As fodder for subsequent and ongoing discussions, he reminds us that there will continue to be major imperatives for improvement in the overall clinical and quality of life outcomes for all the 100 beneficiaries residing in a NF on any given day, that is, not just the ten that are there on their Medicare skilled benefit.

We do not today have a truly strong holistic and

coherent approach for dealing with that. Dealing with that will require a beneficiary and setting-centric set of approaches, that is, not just a business approach. We see yet again through how the industry responded in terms of clinical care provided to beneficiaries based on the PDPM changes as well as how effectively large MA players manage skilled spending, how the for-profit players are more than capable of managing to the incented outcomes. That in turn should give us confidence that payment policy can drive the outcome improvements we want for this very frail subset of our beneficiaries.

I have Kenny next.

MR. KAN: I directionally agree with the Chair's draft recommendation. I wish to pile on, you know, with trepidation regarding Scott's, Lynn's, and David's concerns about how such a reduction could actually impact the sector given the inadequate payments that we've seen from Medicaid.

DR. CHERNEW: Okay. So I'm going to say this again. It's challenging to say but I'll say it, nevertheless. I just want to remind us that our mission is to pay for the amount necessary to provide efficient care

to Medicare beneficiaries for the services that Medicare is covering. The comments that the sector is broken, that there's challenges in the way the financing goes in the score, are totally, totally understood, and really very sympathetic, and I think no one speaks more eloquently on that than actually David.

There's this tension between the mission of what we're actually doing, which turns out not to be fixing a broken payment system for SNFs. That's just not -- that is something that should be done, so, again, if you're thinking about -- like how I'm thinking, I fully understand that people much more expert than me need to figure out how to fix aspects of this financing. But we have a much more narrow job across this -- when the recommendation is made, which is if you look at the efficient margin for finding care for efficient hospitals, for SNFs, for Medicare beneficiaries, the margin's like 20 percent. The overall margin has been like 10 percent for Medicare beneficiaries.

So our basic charge is what to do about that. I understand that that does have the potential for a range of deleterious consequences and that those will likely be worse at the PHE ends. I'm completely sympathetic to that

argument. I don't know really how to say that louder, although I guess in Larry's case, I'll move the mic closer to say it. But it remains really clear, and I tried to say at the beginning of this Round 2 to emphasize that we are not signaling anything that one might think we are signaling. We are certainly not signaling that the sector is healthy long term and a whole bunch of other things. We are doing a much more prescribed exercise that we do across the board given what our central mission is when these update recommendations go, and that's essentially where we're going to end up being. And that's true across all of the fee schedules, and I understand -- we had this discussion in the inpatient sector yesterday. It is quite analogous in my mind, and it is -- I don't want to make it to imply that I am comfortable in a broad health policy sense about where all of that is, but we do have the sort of mission of MedPAC, which is not as broad as the mission that some people would like.

So that was maybe ineloquent. I hope it was clear. Jim, will you please say something that's -- you've been here longer than me. You're more knowledgeable about our mission and our statute and stuff, so please.

DR. MATHEWS: Everything you said was spot-on. The only thing I would add is I would refer Commissioners to the materials that we sent out, particularly Figure 3, which does recap the fact that Medicare margins for skilled nursing facilities have exceeded 10 percent for the better part of two decades, and this phenomenon of much lower Medicaid payments has persisted through that same duration.

So while things may have been exacerbated by the pandemic and there may have been some financial relief given through various payment policies, alleviation of the sequester, a relaxation of the three-day rule, the overall trends that we continue to observe have been around for a long, long time. So I would, you know, just ask everyone to focus on those facts as you're contemplating the draft recommendation from the Chair, and also keep in mind, you know, in the past, given the magnitude of the Medicare margins, it has not been uncommon for us to make recommendations of payment reductions of minus 5, minus 7, given the very, very strong financial performance under Medicare.

DR. CHERNEW: And I want to say one more thing. The reason why it is a smaller number, which is one way we

deal with some of this issue, there is a concern about like the speed of transition and the extent to which we get there. So it's not that I think I would say for our mission minus 3 is necessarily right, but I think, you know, Bruce Pyenson always was never a big fan of like transitions, but I think as a general rule there's a lot of turbulence in this sector, and everything that Lynn said I totally understand the challenges of people working in this sector and the people they care for and what they had to go through in the pandemic is really remarkable. And I think it is -- if I were watching from home, it would be frustrating to see us sitting here and talking in a very sort of sterile way about what was actually going on. I totally, totally understand. But that is, in fact, what we're going to do, as uncomfortable as that may be sometimes.

So, anyway, if you look at where we are, I think we have in the past had larger cuts. This is a recommendation for larger cuts. This is a smaller one. And the last thing I will say I do believe the policy sector in taking our recommendation will understand this more holistic view. I think that's true in a range of

ways. And we're playing a very specific role. We are not saying this is the fix. We are saying what you would need to do to support efficient care for Medicare beneficiaries in this very important sector is this. There are other considerations besides that. They're just not particularly our considerations right now. And that is frustrating, but it is, I think, sort of where we are.

David, you were going to add something, and I interrupted you.

DR. GRABOWSKI: No. I was trying to interrupt you. Jim, I would have never believed this before I saw our data, but in 2020 and 2021, the Medicare margin and the all-payer margin are stronger than they were in the pre-pandemic at least six, seven years, which is sort of mind-boggling. I think people don't -- because we hear so much, and everything Mike said, I've been studying this for the last two-plus years. It's been incredibly hard on SNFs, but I think Medicare has been a big part of what's continued to support the sector, not kind of some of the head winds they're facing elsewhere.

MS. KELLEY: Okay. I have Robert next.

DR. CHERRY: All right. Well, thank you for this

report. I will say off the top that I do support the recommendation, but I would say that I don't support it enthusiastically. I would say I support it with some degree of reluctance, and I think the reason why is because of similar comments that I made yesterday. I realize that this exercise around payment updates is rather narrowly defined, but it's one size fits all. We're not really differentiating between high performers and low performers in terms of delivering quality of care.

So, you know, case in point, in our pre-read materials there were a couple of articles that were referenced where, you know, Blacks, Hispanics, and dual-eligible beneficiaries are more likely to use lower-quality facilities. And I think that's something that, you know, MedPAC should look at and confirm if that's actually true or not, at least with the two measures that we have in place, which is, you know, successful discharges and all-condition hospitalizations, because if there are truly disparities in care, I think we're obliged to really look at those root causes and try to correct for those in some sort of form or fashion. It may or may not turn out to be the case, but I think as we get better at getting better

information around, you know, quality of care measures, I think maybe some of us may be more comfortable saying we'll give, you know, a 2 percent reduction to high-performing facilities and a 3 percent reduction to everybody else. But, otherwise, I support it with some degree of hesitation.

Thank you.

DR. CHERNEW: Thank you, Robert, and, again, I agree. I just want to say a few other things to remind folks. This is a narrow -- there's an update in a fee schedule, one number, what should it be? There are things we could think through, safety-net things, for example, but to your particular comment, we have spent a fair bit of time on nursing home quality as a general issue. The current program is not one that I think we're wildly enthusiastic about, and we've had a separate set of recommendations. I don't know if we'd call it SNF -- what's the name of it? The VIP. So we have value incentive programs across the board which are actually -- you know, we have peer groupings to deal with differences by different statuses of people and stuff like that. So that issue is one that actually we're quite concerned

about, but there's the where it slots into how we make those recommendations. And so I think, again, what's coming out in some sense is a frustration with the exercise we're doing, which is slightly different. And so I guess I probably should -- I probably should have led with thank you for your support, I share --

[Laughter.]

DR. CHERNEW: In fact, I'm going to work -- next time -- someone write this down: Thank you for your support. I share your frustration. That would have been a much more concise way to say that.

Anyway, I think we're to Larry next.

DR. CASALINO: Four things pretty quickly.

I think first, David, I'd like to hear a little bit more from you. We've been on the Commission together for about three and a half times. This is the only time that I haven't been clear about, you know, what you were saying. I mean, I was clear about the emotional tone of it, but where do you stand with the Chair's recommendation?

DR. GRABOWSKI: I thought I said -- I'm supportive of the Chair's recommendation. Once again, the overall health of this industry in the longer term I'm

really worried about, but that's not a -- like in terms of our charge here, I think Medicare's paying a strong rate, and I'm fine with this.

DR. CASALINO: Okay. That's good to know. Thanks.

Second -- well, just piling up on what you just said, yeah, I strongly -- I won't repeat what Michael said, but I agree, I don't think we're here to cross-subsidize anybody, including Medicaid. And I say that knowing that there was a time in my career when I had to spend some time taking calls for basically an all-Medicaid nursing home, which had a SNF but was mostly -- you know, people who were there forever. And it was really awful just to walk in the door. It's hard to exaggerate how awful or hard to exaggerate the contrast between that home and the home where an aunt of mine died fairly recently, which was much better funded and was quite nice, actually. But the former -- and I've heard many other physicians say that. If I knew I was going to have to be there for life or for a long time, there's no question in my mind I'd rather be dead. It's awful. Nevertheless, it's not our job to cross-subsidize with Medicaid. Something else needs to be done

about it. That's number two.

Number three is -- and here I'm venturing into grounds that I don't know about as a researcher or as a policy person. From a physician's point of view, I think it's safe to say the three-day rule seems kind of crazy. I remember when I first heard about it, you know, early in practice. What? I can't -- I have to put this patient in the hospital for three days before I -- okay, fine, I'll put him in the hospital for three days. So I don't know if it's within the purview of MedPAC in future years to have some comments on the three-day rule and even a recommendation perhaps, because I'd be interested to hear what other clinical people in the room think, but to me the three-day rule made no sense at all. So it will be a shame when it starts to be enforced again.

Then the fourth thing is -- and you've apparently thought about this a lot, Kathryn. Would it make -- because of the huge gap -- and it is a socioeconomic and racial/ethnic gap, I think -- in the type of SNFs/nursing homes that people go to, have we thought about some kind of SNI for SNFs? Again, for future work.

DR. MATHEWS: Larry, can I address that question?

DR. CASALINO: Yes.

DR. MATHEWS: So we have been doing some work in the post-acute care sector consistent with what we've discussed at this meeting for hospitals and physicians. We'll be rolling that out in the spring.

DR. CASALINO: Excellent. This would actually be a sector where it really would be very useful, I think because the contrasts are so dramatic, I think.

Okay. That's it. Thanks.

DR. CHERNEW: Dana?

MS. KELLEY: Greg.

MR. POULSEN: Thanks. I really agree with everything Larry just said, and I'm tempted to say just "Amen." But I think there is one thing that needs to just be -- I think we all get it, but I think it probably deserves to be said specifically, and that is, I think the broad public assumes that Medicare is the primary payer for SNFs. And, you know, given the age mix of the folks that are there, it's an understandable misinterpretation. But if I'm remembering correctly, we actually are the smallest payer among any of the sectors that we're examining over these two days -- in fact, by quite a big difference, too.

So, you know, with only about 10 percent of the days and even though our revenues are a bigger percentage, our ability to address the concerns that David and others have raised is limited not just by the charge that we have, but also by the fact that were we to try and make a significant difference, it would have to be - in order to make up for sub-payments by 84 percent of the paying group, you'd have to make a huge change to that other 16 percent to make a big difference. And so I think we're limited by reality as well as by charge.

So, with that said, I would support the Chair's recommendation along with all the cautionary language that is in the chapter. And, in fact, I think that some of the commentary in the chapter could even be strengthened a little bit to point out the risk that SNFs are under, but that the correction for that needs to primarily be placed elsewhere and that Medicaid obviously as being the primary issuer there.

DR. CHERNEW: There's actually -- I think it's a text box. I'm not sure. I apologize. But I think there's a specific part of the chapter that explains the number of reasons. It includes issues like if we keep making up for

shortfalls for other payers, the other payers will have a tendency to continue to shortchange what they pay. And so there's a complicated interaction of taking -- you know, of how this plays out, and we have that very specific charge. I won't belabor that.

I think Amol is next, right? Amol.

DR. NAVATHE: Thanks. I'll try to build off of the comments of my fellow Commissioners. I definitely agree with the substance of the comments that have been made previously.

I will also just first start out and say that I do support the Chairman's draft recommendation. I think, to some extent, it might be right that there is a text box that describes this. I think the text box, the content within that text box I think is helpful, but I think it may actually be even more helpful if we could be explicit around why this cross-subsidization is problematic, from a kind of public and population health perspective as well.

I realize that there is an interaction here between Medicare and Medicaid, and so some pieces of this may be less us, including a lot of our own text around this, but at least pointing to MACPAC or other work that

describes this. Particularly in terms of the type of challenges around the responses that we elicit from the industry, from the sector itself, from the facilities, and the implications that has in terms of things like services offered, geographic location, the incentives for quality, to Rob's point around how this might be interacting with disparities that we see in socioeconomic racial minorities, ethnic minorities, et cetera.

Because I think there is a fairly complex interplay here. And the current language in the text box I think is fantastic but it has a bit of an arm's-length feel around those elements, and I think we could do a better job of basically making that more apparent as to why the cross-subsidization is not the best policy vehicle to solve this problem, understanding that, per Mike and Dave and everybody's comments, that obviously the financial health of the sector is fundamentally important.

The other piece I would highlight, and I think David said this earlier in this meeting, yesterday perhaps, is that this is, to some extent, a reflection -- and Scott has made this point as well, that most of the individuals who are in these facilities, while not paid by Medicare,

are still reflective of our beneficiary population. And so it's highlighting that in the Medicare program there is, if we were to think about this conceptually, the comprehensive governing program, there is a bit of a gap in terms of long-term care.

And so I think that's also important in context to keep in mind. Alongside our narrow payment update view, alongside our charter as trying to protect Medicare beneficiaries, there is this important implication here. So I think it's part of the broader work perhaps that the Commission could start to explore in the future around this sector. I know there is a bunch of work, and Rob is talking about disparities. I think there is the value incentive program type stuff. But I would say that this is a really big challenge, and even though from a very payer-centric view, payer-specific view, one could choose to not explore it. I think if we really think about the health of our beneficiaries and managing them, it is incumbent upon us to try to take on some more of that work going forward. Thank you.

MS. KELLEY: David, did you want to jump in here? Oh, okay. All right then. I have Dana next.

DR. SAFRAN: Great. Thanks. I do support the Chairman's draft recommendation, and I guess I'll just make a couple of points. One, I really appreciate, David, the point that you made about post-COVID, that you're really concerned what happens to this sector. And one of the things that struck me from that is it's, at least in my limited exposure and anything pales compared to yours, a combination of changes in payment that incentivize thinking more carefully about where patients need long-term care and how that can most affordably and effectively be provided, and public fear about the setting, and those two things coming together.

And I guess part of what that, and our cross-subsidy conversation, have led me to think about is quite apart from this chapter and this recommendation. MedPAC really, it strikes me, should be putting forward some policy thinking about just how broken this sector is. The fact that we account for 10 percent of the patients, meaning who is the payer, but 90 percent of the population there is 65 and over -- and Scott's points that Amol voiced, that that is a very different form of cross-subsidy. These are still our people -- is really very

striking and makes this different.

Now given that based on how Medicare coverage is provided, I don't think any amount of further cross-subsidization fixes the problem. We can't fix this problem unless we actually fix the way coverage and payment for long-term care are handled.

So I do think it is incumbent on MedPAC to address that, and I think our unified PAC PPS work gives us a perfect platform from which to begin to make those stronger points. In this instance, for this chapter, I would just say I'd like to see us somewhere make that strong point that the cross-subsidization is different here, but that even going further in cross-subsidization can't fix this problem.

So those are my comments. Thanks.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you very much for the chapter and I really appreciate the comments. Many of you said the things that I was going to say much more eloquently. Nevertheless, I will say at least some of them.

I support the recommendation, and like Larry, I've worked in these settings so I've felt it firsthand and

I'm very concerned about the beleaguered staff, the distressed facilities. I also think about students, be they nursing or medical or whatever, coming into these environments. It does not often spur them to want to take on careers in this, and I strongly believe we have to create a world in which any of us would be happy to work in or to live in.

And I also strongly believe that Medicare can't do that. Medicare cannot continue to subsidize and make this work. So the sort of more comprehensive approach and detailing this is absolutely essential because I don't think the public does understand it.

I've often wondered if the cross-subsidization actually kind of almost hinders comprehensive reform, because like maybe there will be more money from the Feds. And so it is absolutely clear, important, essential that this is better delineated.

I agree with Larry on the three-day rule issue. It's always seemed preposterous to me. And I'm also intrigued by the APM comment that I think Lynn mentioned.

So I strongly support the recommendation.

MS. KELLEY: Jonathan.

DR. JAFFERY: Yeah. So first off, Katherine, I also want to give kudos. This is a great chapter and a great presentation, and I too support the draft recommendation. You know, David, of course, put all the points together very eloquently.

I think a couple other things I want to call out, I appreciate Lynn's comments about how, in the long term, or in the near term even, can try to support more use of SNFs through a three-day waiver and APMs, and Larry, you called this out. As another clinician, I absolutely agree it's always been a little bit perplexing. And there may have been very good reasons for it in the past. I think this is a prime time for us to look at it.

I was originally thinking about asking a Round 1 question about lessons we may have learned, but I think that was a little bit off-scope and maybe early. But I think over time that's something we should think about -- what have we learned from the suspension of the three-day waiver during the public health emergency, and what do we know when it comes back, presuming it will be back in place once the PHE ends. There might be an opportunity for us to think about that and think about recommendations going

forward.

And I will say, specific to that, it does feel like that creates a lot of constraints that we don't want to have on extra costs early on, and also when we think about the various capacity constraints we're seeing in a lot of hospitals and the shift from rural to urban, for a lot of hospitalizations, this may just be causing increasing issues.

You know, Amol, you used the words "bit of a gap" in long-term care, and I think that's the understatement of the meeting. Really, it's quite clear that that is a huge issue. And I guess overall I really appreciate -- you know, this is my fifth year doing updates, and they seem like at some point you sort of feel like, oh, here's the chart again and we're going to make some recommendations, and we'll talk about ASCs, and Congress will ignore us, and so on and so forth.

But, you know, I think this meeting has really called out to me how important and how informative it is to have these discussions, and that each of these sectors really plays out so different in terms of the dynamics, you know, the fact that we're 10 percent versus 90 percent.

That's a huge different than other sectors.

And I think the other thing that's really called out in this conversation is how we can stay focused on this narrow charge that Mike and Jim have been keeping us on track about. You know, yesterday we had lots of conversations with compound recommendations, and we're not trying to get to multiple bullet points here.

So with that in mind I very much am supportive of this, and again in this context of having double-digit Medicare margins for over two decades now. So thank you.

MS. KELLEY: Marge.

MS. GINSBURG: Yes. Great. Thank you for the wonderful work you've done.

A couple of things. The discussion about the fact that Medicare theoretically is a small financial player in this and yet we feel tremendously large impact because, as somebody said, these are our people. But I wonder whether it might be useful for the chapter, maybe not, of showing all the various domains that Medicare plays a role in, in terms of nursing homes and hospitals and home care and hospice, and the percent of the costs that Medicare has attached to each one of those.

Because I'm really, I think, maybe even for the first time, fully recognizing that this 10 percent number in an extremely large and meaningful domain of care is, in a way, almost ironic, and seems so different than every other. And I wonder whether that might be useful for the readers of the chapter of seeing how those different domains differ in terms of the percent of Medicare coverage.

And the other thing I wanted to mention, this brought to mind before I retired six or seven years ago that we had done a project. I know staff, Ledia, will remember this. We did a project using a computer program called CHAT, where people get to put their markers where they want Medicare to fund, using the number of markets equivalent to what the costs are and giving them far more options. No surprise, long-term care -- not all of it, maybe the first two years because they couldn't afford to put that many markers -- people really, really want long-term care covered by Medicare, and there are a lot of other things they would be willing to give up. I'm more than happy to share the report with all of you. This was a California-wide project, so, of course, you have to take

that into account.

[Laughter.]

MS. GINSBURG: And I know we do go looking -- that's not our job to look for new ways that we can spend money that we're not already spending now, but this is a biggie, and it really does feel, in some way, that there's more that we should be doing to somehow improve the quality, improve the cost, improve the whole domain in a way that really reflects the type of work we do, I think for every other area that Medicare funds. So thank you.

MS. KELLEY: Jaewon.

DR. RYU: Yeah. I agree with the Chair's draft recommendation as well. I think it's appropriate. Given that the sector is among the highest Medicare margins of any of the sectors we're looking at, I do think it's appropriate. But the appropriateness doesn't do away with a little bit of discomfort, for other reasons that people are talking about. I do worry a little bit about the lowest quartile in that margin, kind of what you reference, and I think it was smaller volume, smaller bed, not-for-profit, you know. That is of some concern.

I am somewhat encouraged and reassured, Jim, your

comment about the fact that we're starting to look at something like an SNI index. I think that feels a little more targeted, which I think would be good.

And then the only other thing I would mention is there are a lot of spillover effects that I'm not sure we've totally unearthed, to the hospital sector in particular, but other places. I mean, you all have read and seen about the longer length of stays in hospitals, and obviously that hits hospital margins. So the two sectors are tied, in some ways, in many ways, and I think the portions of each of those sectors that are at greater risk are probably also tied to the same communities, which I think further augments at least my anxiety and concern.

But I do agree with the recommendation.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks to the staff for a very interesting chapter, and also to David for all the great context setting.

I agree with the Chair's draft recommendation, and, you know, in the context of Medicare margins and overpayment, these margins remain quite high.

I also was encouraged by Jim's comment about the

SNI work that's getting jump-started. I think that work could be very helpful because I think we do need to keep our eye on the ball in terms of differences in quality of care based on patient characteristics, particularly race, ethnicity, and dual status. You know, those differences are really concerning, and I think we need to take a harder look at what we can do to better support those patients who are receiving care.

You know, as I looked at the text box, you know, and listening to the comments of the other Commissioners, right now it sort of reads more like a justification for why we're staying in our lane and we're not cross-subsidizing. I do think there is an opportunity here to expand on it and really draw attention to the fact, you know, for all the different reasons people around the table mentioned, that this is a broken kind of financing system in this sector and that additional work needs to be done to try to rethink that and put us on better footing moving forward. Because as this thing has the potential to tank Medicare beneficiaries, they are going to be at risk.

MS. KELLEY: Do you want me to call on the remaining --

DR. CHERNEW: I think Wayne is left.

MS. KELLEY: Wayne and Stacie.

DR. CHERNEW: Oh, Stacie and Wayne. Yeah.

DR. DUSETZINA: I also agree. Thanks very much for this chapter and the great work and presentation. And also thanks to the fellow Commissioners. I feel like I've learned a lot from everybody's comments. And I will say that I do support the recommendation as written.

I also really appreciated Dana's suggestion to really kind of dive into this. But it sounds like there are some more extremes that touch on a lot of issues brought up around value incentive programs and the safety net-related work. So I think that it sounds like we have a good base there but really need to dig into it more.

You know, I also agree that the payer mix piece is really challenging, and any efforts to fix it do seem like they will be met with potentially other payers cutting back on what they pay. So we remain in this cycle of cross-subsidization. But I still think it's really important to move in that direction, in other streams of our work.

But thanks again for the great work and again, I

support the recommendations.

DR. RILEY: Yes, I too support the Chairman's recommendation, and I appreciate the comments of Dana with regard to somewhat our aspiration as a Commission to have policy heft to try to generate, catalyze, and change and innovation. And then I too share with Robert the objective evidence that there is inequitable care for African American residents of these places at times, and again, it's sort of a sinking feeling. We're delimited in how much we can do, based upon the current law, and you reminded us, Mr. Chairman, and so has Jim, of our task here, which I acknowledge.

DR. CHERNEW: So let me just wrap up by saying I feel great support and frustration and unanimity, and I agree.

I will say a few things related to that. One is I appreciate the acknowledgment that we have a task that we will -- I think this was Cheryl's phrase -- stay in our lane. Understand that we have a role and a process that is bigger than what we do.

I want to call out one other point that I think is clear but I want to emphasize this. Medicare explicitly

covers post-acute care. It does not cover long-term care. That is not a MedPAC decision about how we finance long-term care in this country. I do not claim that we finance it correctly. I'm just saying that is a big challenge. A lot of the reasons why you're seeing what's going on -- it's different than hospitals where there's a commercial payer mix and a Medicare payer mix, and it's basically the same type of services. It's just we have a certain number of people.

As has been pointed out, these are our beneficiaries. Medicare beneficiaries face a number of challenges, some of which are in long-term care but a bunch of other challenges for things that Medicare doesn't cover. There's been a whole debate about, where we talked about standardizing Medicare Advantage benefits, about vision, dental, hearing, transportation, meals, a whole range of things that could benefit Medicare beneficiaries.

In particularly the update sector, we are trying to figure out what to do not just for Medicare beneficiaries but for the services that Medicare explicitly covers, which in this case is post-acute. Because of the connection of the providers that are providing both the

post-acute and the long-term care, we face this connection. If they were somehow separated institutionally, we would not be having this complex problem. But it is clearly a problem that both I share and I feel coming from folks here.

So that leads to the question, and I think it came up and I will just say it again, the question then is what to do given the charge that we have, and the charge that we have is not how should long-term care be financed. But, as was pointed out, we can certainly say more and we can do more. So that's why we have the quality measurement stuff and the VIP stuff.

There's a ton of quality measurement issues, in all the sectors honestly, but certainly in this one, and we do have work on the VIP in the SNF sector, and the safety net stuff we have begun to move through, as you can see where we're going, to try and figure out how to support entities. Those activities come up in separate chapter, in different ways, in a somewhat slower pace, or different pace, whatever it is, and we will continue to do that.

But I guess that was a little bit more therapy than comment, but I do understand sort of where we are and

what we're doing. And so thank you, really, to the staff. And I guess, Kath and Carol, you might want to say something as well. I think the staff really is completely on board with where we are. You guys can say anything you want. I feel like I should give you a chance to say something. But I think there's nothing that's been said that conflicts with my sense of where the staff would be about what's also going on. And you haven't had a chance to express that, but that's my assessment.

MS. LINEHAN: I don't have anything else to express.

DR. CHERNEW: All right then. With that we will take a break, and we're going to come back and talk about home health.

[Recess.]

DR. CHERNEW: Okay. We are back, we are live, and for everybody that wanted more Kathryn, we have more Kathryn. We're now going to talk about home health, so, Kathryn, thank you for doing this because I know this is extra for you.

MS. LINEHAN: Yes, so I'm not Evan, and I will do my best, and we'll make it work. Okay.

So next we're going to review our framework as it related to home health care agencies. Like earlier presentations, a PDF version of these slides is available on the control panel.

As a quick reminder, here is our framework. I don't need to go over all the elements again. I think you've heard it enough at this point.

This slide provides a snapshot of the home health care sector in 2021. That year, the Medicare program spent $16.9 billion on home health care. These payments were made to about 11,400 providers. Home health agencies provided services to three million beneficiaries, or about 8 percent of fee-for-service enrollees.

Beneficiaries received 9.3 million 30-day periods in 2021, and about 93 percent of the services were provided by freestanding home health agencies.

As background, I want to remind us that the home health PPS recently implemented major changes to its payment system in 2020.

The BBA 2018 mandated two changes to the home health PPS be implemented, so in 2020, a new 30-day unit of payment and the elimination of the number of therapy visits

provided during the home health episode as a payment factor were eliminated.

The mandated changes were implemented through a new case-mix system called the Patient Driven Groupings Model, or PDGM.

The Commission produced a mandated report earlier this year concluding that the new policies did not appear to have a negative effect on access or quality of home health care in 2020.

The law requires that these changes be implemented in a budget-neutral manner. In effect, the act requires CMS to ensure that spending does not increase or decrease due to the new payment policies for a seven-year window running from 2020 to 2026.

So far, CMS has identified two overages above the budget-neutral targets that will require it to adjust future payments. First, CMS has indicated it will need to make a one-time reduction to recoup $2 billion for overages that occurred in 2020 and 2021.

Second, CMS has identified that it needs to reduce spending by 3.925 percent in future years to account for spending that is over the target.

While CMS has indicated that the law requires that they take these reductions, it has not said when it will take action. However, under current statute, they must occur by 2026.

Turning to our framework, we begin with supply and access. As in previous years, access to home health appears to be very good. Ninety-eight percent of beneficiaries live in a ZIP code served by two or more home health agencies. About 87 percent of beneficiaries live in a ZIP code served by at least five home health agencies.

Turning to supply, the number of agencies was over 11,400 by the end of 2021. The decline in agency supply of 0.8 percent was actually lower than the average annual decline for recent years, and this suggests that the rate of decline is slowing.

I would note that Medicare payment levels for 2013 to 2020 were well in excess of costs for this period, so the decline in supply we observed is not related to Medicare payments.

The number of 30-day periods declined slightly in 2021, but this decline likely reflects factors other than Medicare payment. For example, the number of IPPS

hospitalizations, which commonly precedes home health use, declined in 2021. In addition, the number of fee-for-service beneficiaries also fell in 2021.

Per capita utilization in 2021 increased slightly to 26 home health periods per 100 fee-for-service beneficiaries, and the share of beneficiaries receiving home health actually increased slightly to 8.3 percent.

In 2021, home health agencies had a marginal profit of 26 percent, indicating that providers had significant incentive to provide home health care.

Turning to visit utilization, in-person visits averaged 8.8 per 30-day period in 2021, a decline of 1.4 visits since 2019, the last year before the BBA 2018 changes were implemented.

About 70 percent of this decline was due to a drop in therapy visits, with a decline in nursing accounting for the balance.

However, the decline in visits should be interpreted carefully. CMS expanded the coverage of telehealth during the PHE, allowing home health agencies for the first time to provide virtual visits. Home health agencies did not report the delivery of telehealth

services, so we have no way of assessing their use.

In 2023, consistent with a recommendation in last year's report to Congress, Medicare will require home health agencies report telehealth services, and this will allow us to see how much virtual visits have offset in-person visits.

Our next indicator is quality. We observed a lower rate of successful discharge to community in 2021, but the rate of hospitalization during a home health stay did not change significantly.

While performance on quality measures in 2021 was mixed, these results should be interpreted cautiously.

The data for 2021, like those we reported last year, reflect the impact of the pandemic on how beneficiaries have used home health care and other Medicare services. For example, the increase in mortality due to the pandemic may have lowered performance for the successful discharge to the community measure because death shortly after discharge is treated as an adverse outcome under this metric.

Also, the hospitalization rate may reflect that some beneficiaries might have been less likely to go to the

hospital during the pandemic.

In addition, the Commission's quality metrics rely on data from pre-pandemic years to predict beneficiary risk. COVID-19 is a new diagnosis and is not included in the current risk-adjustment models, though many associated conditions are.

Finally, I would note that our discharge to community measure was likely affected by the implementation of the 30-day unit of payment in 2020. This measure looks at a window immediately after home health use ends. The implementation of a shorter unit if payment in 2020 caused the window being examined to shift, and as a result, it captures adverse events that previously would have fallen outside this measure.

Next, we look at capital. It is worth noting that home health agencies are less capital intensive than other health care providers; also few are part of publicly traded companies.

Financial analysts have concluded that the publicly traded agencies have adequate access to capital. Several large for-profit companies reported acquiring new home health agencies to expand their operations, and one

large for-profit is being acquired by a major insurer to supplement their operations.

The all-payer margin in 2021 was 11.9 percent

In aggregate, home health spending declined 1.2 percent in 2021. We calculated payment per in-person visit to assess how Medicare's payments have changed since the PDGM was implemented.

Payment per visit in 2021 was $219, or about 22 percent higher relative to 2019, the last year Medicare paid under the predecessor to PDGM.

The rise in payment per visit reflect two factors: first, visits per period have been declining since PDGM was implemented, as I noted a few slides ago; and, second, payments per 30-day period have increased in 2020 and 2021 as home health agencies have received positive updates in both years.

In effect, on a per 30-day period basis, payments have increased while visits have fallen. The decline in visits contributed to the 2.3 percent decline in cost per period we observed in 2021.

Turning to the Medicare margins for 2021, we can see that the margin for this year was 24.9 percent. The

trend by type of provider indicates that for-profits have greater margins than not-for-profits and rural agencies have higher margins than urban.

The margins with provider relief funds equaled 25.9 percent. The 2021 margins are the highest we have observed since the home health PPS was implemented in 2000 and indicate that Medicare continues to pay well in excess of providers' cost.

This year we again examined the performance of relatively efficient home health agencies. We used the same criteria to identify efficient providers as in other sectors, and based on these criteria, about 14 percent of agencies met this standard. Compared to other home health agencies, efficient providers had lower hospitalization rates. They typically had lower standardized costs and served a more severe patient population. The relatively efficient providers had median Medicare margins of 28.4 percent in 2021.

This brings us to our margin projection for 2023.

We project that home health agency margins will decrease in 2023 to 17 percent. This is because we assumed costs will increase more than payment rates.

On the payment side, our estimates include CMS' payment updates for 2022 and 2023 which are detailed in the paper.

On the cost side, our assumption for cost increases in 2022 and 2023 used CMS' most recent estimates of the market basket for these years, which averaged about 5 percent a year.

However, this level of cost increase is well above the recent experience of home health agencies. As I noted earlier, costs per period decreased by 2.3 percent in 2021.

This low level of cost growth is not unusual; for example, in 2011 to 2019, home health agencies averaged a cost growth rate of 0.5 percent a year. As a result, our assumption for 2022 and 2023 of 5 percent growth per year is very high relative to past experience.

Margins for 2023 could be higher than our projection if the actual cost growth is more in line with history than we assumed.

Finally, I turn to the summary. Overall our indicators are positive: 98 percent of beneficiaries live in a ZIP code with two or more home health agencies; total

volume decreased, per capita volume increased; and home health agencies had positive marginal profits of 25.9 percent.

As for quality, under unique circumstances of the pandemic and changes to the unit of payment, our assessment of these measures is confounded. Access to capital we see positive all-payer margins, and large for-profits continue to have access to capital. And Medicare margins in 2021 were 24.9 percent. The efficient provider median margins were over 28 percent, and the projected margin for 2024 is 17 percent.

Next, we turn to the Chair's draft recommendation. For calendar year 2024, the Congress should reduce the 2023 Medicare base payment rate for home health agencies by 7 percent. We expect this will be a decrease in Medicare spending relative to current law, but that access to care should remain adequate and should not affect the willingness of providers to serve beneficiaries, but may increase cost pressure for some providers.

That concludes the home health presentation, and take it away, Mike.

DR. CHERNEW: Kathryn, thank you so much.

I think, again, like all these sectors that have been struggling through the pandemic, it's worth acknowledging. That being said, I think we will jump into Round 1 -- I have to remember to lean forward, Larry -- and I think we're going to do that with Lynn.

MS. BARR: Thank you, Kathryn. First of all, I just really want to appreciate the work that the staff did to address my concerns and questions around home health access in rural communities. You know, there's been probably half a dozen times in my career where statistics and reality don't match, and I always find that when you dig in, you can learn something really important. These still don't match to me, but I feel like you've answered as much as you could. And I will continue to try to find ways to bring other information to the table that can continue to explore. But I do really appreciate all the work you did in the chapter to address my concerns about this. I do support the Chair's recommendation and will continue to explore this topic.

Thank you.

MS. KELLEY: Amol?

DR. NAVATHE: Kathryn, I just had a quick

question, which is: It's oftentimes striking when we look at an industry and we see for-profit entry, when we see that the payments are very profitable. And one thing that's kind of interesting here is that if we look over the past decade, there's actually been a smaller number of HHAs over time, and yet the payments are still very profitable. I was just kind of curious. Do we have a sense of why we see that dynamic playing out here? In other words, why do we see that they're so profitable from a Medicare payment perspective and an all-payer margin perspective, yet we see a declining number of HHAs and what looks like a lack of for-profit entry?

MS. LINEHAN: So I will do my best to answer this question based on conversations Evan and I had about this topic, but Evan did this work and might need to follow up with you.

I think that more recently it might be a labor issue, and I think there's also a potential MA piece here where agencies need to have relationships with MA plans in markets to make a go of it. And so that's hard to do like right out of the gate. And, Jim, you may have something else you want to say here.

DR. MATHEWS: The other thing I would add here -- thank you, Kathryn -- would be recall that this sector has been subject to, you know, quite a few program integrity interventions over the last decade or so, including moratoria on the establishment of new home health agencies in certain parts of the country. So that obviously will have a secular effect on, you know, any drive to expand the supply of home health agencies.

MS. KELLEY: Cheryl?

DR. DAMBERG: I had a question in terms of the recommendation that's being made and its relationship to Slide 5 in these other recoveries that CMS needs to make, and I realize the clock is running out because they have to be implemented by 2026, so there's essentially '24, '25, and '26.

So is it possible that CMS could make those recoveries on top of this recommendation?

MS. LINEHAN: Since we're making a recommendation for 2024, I think so, if that hasn't happened yet.

DR. MATHEWS: CMS has not indicated how and on what timeline they will make these recoveries. So when we project a margin, we stick closely to current law, current

policy. Up to this point in time, they have not signaled through proposed rulemaking when or how these dollars will be taken out.

MS. KELLEY: Marge?

MS. GINSBURG: This is sort of a sidebar question. As I recall, MedPAC doesn't or can't make recommendations to increase funding. We're always looking to maintain an even balance, so if we want to increase funding dramatically for one area, we'll have to find ways to decrease funding for another. Am I misremembering that? No, Mike?

DR. CHERNEW: We're trying to make an update recommendation that will allow Medicare beneficiaries access to efficient -- sort of amass the cost of providing efficient care for the services that Medicare covers.

MS. GINSBURG: Okay, so it doesn't matter for however many areas --

DR. CHERNEW: In the hospital case --

MS. GINSBURG: -- that we're recommending increases --

DR. CHERNEW: We do not have a budget constraint. So if in the hospital case and in the physician case, we

put more money than current law -- In the past, we have actually really tended not to, right? But this year, because of the data, we actually have a set of recommendations in the physician sector and the hospital sector where we're recommending above current law payment. We don't have to fund that from some other sector.

MS. GINSBURG: Okay, good. Thank you. That's all.

MS. KELLEY: That's all I have for Round 1 unless anyone else wants to jump in.

[No response.]

MS. KELLEY: Mike, you have your mic on. Do you want to speak first?

DR. CHERNEW: No, I don't. I want to say, "David?"

[Laughter.]

MS. KELLEY: Okay. Then you said it.

DR. GRABOWSKI: Thanks, Mike. So, first, thanks, Kathryn and Evan, for this great work. I'll start by saying I strongly supported the Chair's draft recommendation.

I think it's once again worth recognizing home

health served a really important role during the pandemic, and I also believe it's going to be a big part of the Medicare post-acute care space going forward. I think Dana said it well in the SNF discussion. There's a real shift in preferences, and folks do not want to go -- beneficiaries do not want to leave the hospital and go to a skilled nursing facility to the extent they did pre-pandemic. They want to use home health.

All of that said, Medicare's currently overpaying for home health care. I'm just going to be very blunt. A 24.9 percent Medicare margin is obscene, so a 7 percent cut I think is very much warranted. This will not harm beneficiary quality or access here.

I did want to make a couple of comments about this sector above and beyond -- that are sort of kind of consistent with this recommendation.

First, the decline in visits is really hard, as you said, Kathryn, to interpret. We have the kind of increase in telehealth. We have the pandemic. And we also have this new payment model that shifted from, you know, paying based on therapy to really paying based on case-mix. And I think that's very consistent with our uniform PAC

recommendation. I think in the long term that's a good thing. But I think in the short term it's unclear if it helps to right-size the amount of therapy being offered or maybe cause some stinting in other places. And so I do think MedPAC will want to keep an eye on sort of what does the quality of care look like in home health and what does the delivery of services look like there.

I also am really glad, Kathryn, you raised, in response to one of the questions, the workforce issues. They're present here as they are in nursing homes.

I'm a little confused, however, why, given this is just a labor-driven sector -- we've seen wage data suggesting nursing homes have increased wages, maybe not commensurate with kind of the needs there, but I'm less clear why home health agencies haven't been able to adjust. I know that there just aren't workers in some markets like rural areas and others, but I would have expected just based on the data to see a greater increase in home health aide wages.

Final issue, back when Mike was on MedPAC for the first time -- and Jim will remember this -- they made a recommendation around cost sharing, and so this is my last

chance to offer this, cost sharing for home health. Home health has no cost sharing right now for beneficiaries, and I think that could really help here. MedPAC recommended it. I offered it at a prior MedPAC meeting. It failed for lack of a second. People glared at me and said, "No, thanks." So I'm going to raise it one last time. I really like this idea. We do have cost sharing, for example, in SNFs. It's not well designed. I realize folks have Medigap and other ways of sort of blunting this. But I really like that idea. It's an old MedPAC idea, Jim, but it's one that I think trying to think about how do we engage beneficiaries in what's high-value home health care.

So I'll stop there and just say once again I'm very supportive of the Chair' draft recommendation. Thanks.

DR. MATHEWS: And, David, you do remember how hard-fought that recommendation was.

DR. GRABOWSKI: Mike has told me that, and I do remember -- or you may remember when I raised it last at a MedPAC meeting, people -- I was -- you know, one of the -- I've had a lot of ideas that haven't been well received. That one may have been the lowest or the worst of the worst

here or something. So thanks.

MS. KELLEY: Stacie?

DR. DUSETZINA: Thank you. I always like following David on these topics. He brings up a lot of great points that I can usually say, "Ditto."

This is a very good chapter. I also agree with the Chairman's recommendations.

I guess one of the things that struck me in that I felt very unsatisfied with many of the measures of access and quality here in a way that I think kind of echoes Lynn's points about the reality doesn't seem to match what we're seeing on the paper or perception of reality in my case. Just anecdotally, I've heard people struggling to get access to home health, and so even the measures of, you know, you have this many agencies in the area, I don't know if there's some way to dig more into like do they have capacity, like if you actually did, you know, calling of agencies, do they have the bandwidth to take on more customers?

And even just like the quality of the services received by beneficiaries, especially as we're moving into telehealth, which I am excited about, but part of home

health is actually having eyes on the patient and being physically able to check in. And so I think that probably this is an area where we need to have more granular information about care quality and care access, especially given what we think will be increased demand over time.

But, in general, I'm very supportive of the recommendations. Thank you so much.

MS. KELLEY: Greg?

MR. POULSEN: Thanks. I support the recommendation strongly. I would note that home health, done well, is our highest-value alternative for many conditions and situations. Used correctly, it contributes to reduced hospitalizations, ER use, SNF use, and even drug spend.

I think we're likely underestimating the cost increases that will actually be incurred in this sector, and for some of the reasons that we mentioned in others, and since we're not making this recommendation tied to a market basket adjustment, we may need to consider that next year if we see that things have moved in a direction beyond what we anticipate here. But that said, the magnitude of the margins I think justify very much going this path for

now.

I would also note -- and other Commissioners have already sort of pushed in this direction -- that maximizing home health performance and quality is much more likely in a prepaid world. The best MA plans use home health dramatically better than fee-for-service, and I emphasize the best MA plans. Not all MA plans. But use it in a really dramatically more effective way that contributes to everything that we'd like to see from that, having people in a safer, happier environment and at a lower cost.

So I'm very supportive of home health. I think it has got huge potential value. That said, I do fully support the Chair's recommendation.

MS. LINEHAN: Can I just have a quick response? I said this and I just want to underscore that in his projections Evan did use the most recent estimate of cost growth from the market basket, and it's higher, much higher than historical work. And I know -- I just wanted to make sure that --

MR. POULSEN: I totally agree with that, and I did read that.

MS. LINEHAN: Okay.

MR. POULSEN: And understand it. I think even that we will be surprised by some of the impacts that we'll see on the specific types of caregivers that are used in home health. We will see. I'm hoping I am incorrect on that.

MS. KELLEY: I have a comment from Scott. He supports the Chair's draft recommendation. He thinks it is consistent with the data laid out in the staff presentation. He believes this sector is capable of continuing to deliver on access and quality under the recommended changes that we're considering here.

I have Cheryl next.

DR. DAMBERG: Again, thank you for this chapter. I agree with the Chair's recommendations. Profit margins are high. I don't see any reason to not go with the Chair's recommendation. And I particularly liked Stacie's comments building on Lynn's about trying to strengthen quality measurement in this space, particularly around access issues.

I kind of know firsthand through various relatives challenges of accessing home health. I don't know whether that's sort of like the moment in time we're

in right now with, you know, staffing shortages just writ large in the economy. But I do think it's something that we need to monitor long term.

MS. KELLEY: Robert?

DR. CHERRY: Yes, thank you. First and foremost, I support the Chair's recommendation [turns microphone off] because I think it's appropriate.

A couple of comments, one regarding other parts of the country. My guess is some of the decline may be due to consolidation because I think for home health it's ripe, you know, for [off microphone] you know, helps to kind of offset some of that. So I do think we need to look at, you know, these various sectors, different types of quality measures so we can do a better -- have better discussions around the care that they're delivering and when we're making decisions around payment updates to feel much more comfortable with the decisions that we're making.

Otherwise, I support the Chair's recommendations. Thank you.

MS. KELLEY: Betty?

DR. RAMBUR: Thank you. Thank you for the great work, and I strongly support the recommendation.

Just a few thoughts or comments. I just want to underscore what Greg said, and I guess David as well, about home care done right can make such a difference, particularly prepaid environments or potentially alternative payment models.

I wanted to comment on my perception on David's question about the labor shortage. One of the things that's always perplexed me is that salaries in home health for nurses, physical therapists, have been lower than acute care because there's sort of this acute-care-centric bias and this belief that it's somehow more difficult. Having done a fair amount of home care, particularly in rural areas, it's not less difficult. It's just different. You're coming into somebody else's environment. And so there's, you know, this drain of people to the higher-salary place. I don't think that that will be able to be continued, so that goes to some of the comments that Greg made.

I have to pile on to be unpopular with David here. I strongly support cost sharing in this and every sector. I think it's always important for people to have skin in the game and prevent moral hazard, and obviously

there's ways around that with, you know, Medigap and whatever. But I think it's actually really important and very valuable.

But I strongly support this recommendation. Thank you.

Oh, could I just say one other thing briefly? People are generalists, so the physical therapist, the registered nurse, they're generalists. They're not -- so the salaries are set by looking at home health agencies, but really their potential opportunities for employment are across the health care setting, and I think sometimes there's this perception in the public that they're not generalists.

Thank you.

MS. KELLEY: Lynn?

MS. BARR: I'm sorry. I already gave my comment.

DR. CHERNEW: Her Round 1 comment included her Round 2 Qs.

MS. BARR: Round 2 comment. However, I will support the cost-sharing idea. I strongly support cost sharing, so maybe it's a new world.

[Laughter.]

MS. KELLEY: Okay. Then I think I have Larry next.

DR. CASALINO: I, too, support the Chair's recommendation. I just want to go back to David's comment about possible stinting and then several other Commissioners, you know, expressed some dissatisfaction with -- not the staff's fault, but with the paucity of quality measures.

Just a question for the Commissioners and for Kathryn. Stinting -- so with the change in the payment method now and not paying for therapy, therapy is expensive to deliver for the home health agency, and so you can imagine there are strong incentives to stint. And if the stinting is like really awful, it might change the hospitalization rate. But there's probably a big area between being that awful that you'd see it in the hospitalization rate and stinting on providing therapy.

So I'm just wondering, is there any way to get at that? There's no -- I'm ignorant about this. There's no equivalent of CAHPS for home health care?

MS. LINEHAN: I think there is a home health CAHPS, but I think what you'd want to look at, ideally you

want function data at admission and discharge from the home health agency, which we have but we don't -- I think we have some concerns about it.

DR. CASALINO: Yeah, the home health agency is providing the functional assessments. If there any kind of survey data that seems reliable, you could imagine that there'd be earlier evidence of stinting in that than there would be in hospitalization rates, I think. So that would be something kind of obvious to look for if there's a way to look for it.

DR. CHERNEW: Yeah, I just want to say one thing. I'm not going to assert this to be true, but I do think it's interesting. Although we're not talking about cost sharing now, it would be interesting to know if people had to pay a little bit, if they would demand a certain level of care that they otherwise might not demand if it's all free. But that's just total speculation by someone who doesn't study this area. But if there's someone who does --

DR. GRABOWSKI: I wasn't going to make that point. I was going to make -- that was a very Chernewian point. I don't know if that's a word.

[Laughter.]

DR. GRABOWSKI: But you'll allow it, maybe?

I was going to react to Larry's question about satisfaction. There's actually a five-star just based on the satisfaction scores already on Home Health Compare. So Medicare does this already. It's out there. Beneficiaries can look at the five stars. So you have a good question about how those have trended since the start of the pandemic.

DR. CASALINO: Would you have any confidence that moderately severe stinting would show up in that?

DR. GRABOWSKI: I think you're right; it would show up there first. Those measures are a bit topped out like other sectors, but that's an opportunity.

MS. KELLEY: Marge.

MS. GINSBURG: Just a quick response to the cost sharing. I was a home care nurse back in the '70s. I was a supervisor back in the '70s. I was very involved, as you know, with public discussion about what they should pay for. I was always very opposed to cost sharing for home care, and my main reason is I was afraid -- and I think I still am; I'm not quite as confident anymore -- that people

will turn it down. They don't turn down going to their doctor's office because they want to. They don't turn down any cost sharing they might have for the hospital, for any other aspect they know they need. But if home care involves a nurse, a PT, maybe even an OT, my concern is they'll say, "Oh, I don't want to pay the 20 bucks," or whatever, "I think I'm fine." Or they'll cut it off earlier than they need to.

So I'm not so opposed. It might be very interesting if there was ever a project that could look at that. But, anyway, with all the enthusiasm for the cost sharing, I just felt like I had to weigh in. Thank you.

MS. KELLEY: Jonathan.

DR. JAFFERY: Great. Thanks, Dana. So, first off, great report. Kudos to Evan and thanks, Kathryn, for pinch hitting on this.

To start off, I am very supportive of the draft recommendation. Just a couple other comments to build on what some of my fellow Commissioners have said. Stacie, I think this question about, you know, are our measures of access adequate has always been something that has nagged at me a bit, and I think it goes beyond home health, and at

least some other sectors, SNF being one obvious one to me.

I think some of the issues around, you know, competition for labor, there's a lot of it. And I think about -- we'll talk about hospice in a few minutes, a lot of home nurse and other home health staff, you know, have some opportunities in those areas as well.

Greg, you talked about maybe top-performing MA plans really utilizing home health agencies in a great way that meets all of our collective needs, and I think that's true. But as I think others have mentioned a little bit, there are some other places as well, particularly in APMs, there's a huge opportunity there.

You know, we saw with some of the hip and knee bundled work, Amol, you may know the evidence -- you certainly know the evidence around this better than I do, and the numbers. But I'm confident that at least for hips and knees, the shift to home health was if not the biggest factor in making that financially successful, then certainly one of them. And in my experience in implementing one of those programs under CJR years ago, that was a relatively painless and simple switch. It was probably the easiest kind of movement in any kind of APM

thing that I've been involved in.

And I think building on that, in population-based payment models in ACOs, this really -- home health agencies really become fundamental in terms of being the backbone for a lot of the home-based care work that we're doing, and that's home-based hospital care that we're seeing tons of now. It's also home-based primary care, and people are starting to explore other things like home-based SNF care or SNF-level care. So it's hugely important for us to think about this going forward, and that said, I would tag onto David's comments about 25 or almost 25 percent margin is -- I think the word used was "obscene." And so, again, fully supportive of the recommendation today.

Thank you.

MS. KELLEY: Kenny.

MR. KAN: Yeah, Kathryn and Evan, thank you very much for a fantastic and insightful chapter. I strongly support the Chairman's draft recommendation.

I do echo what some of my other fellow Commissioners have said about having more robust quality of care and access measures, and I seriously encourage that we explore this in future studies.

I understand Marge's point of view on the cost share, but I do feel that, you know, Medicare beneficiaries need to have more skin in the game, and I strongly support having cost sharing on home care.

DR. CHERNEW: I think that was the queue that we had. There were some people that hadn't spoken, so let's see if I can do this. Wayne?

DR. RILEY: Yes, I fully support for all the reasons the Commissioners have outlined.

DR. RYU: Yeah, I'm fully supportive as well.

DR. NAVATHE: I'm fully supportive as well. I would say also very much agree that there is an importance for home health services and would very much endorse what Jonathan said, that it has played a very important role in the success of some of the alternative payment models, including bundled payments for sure.

I also would echo the comments around ideally having more quality measures and perhaps some harmonization across the functional status type measures that we see in different settings, including home health and SNF and others as well, and would put a plus one on the idea of exploring cost sharing here as well.

Thanks.

DR. CHERNEW: Okay. There was a lot there, but I think directionally we are in the same place. I think, again, we understand the challenges that the sector faced. Its importance -- it is an area, because it's not as capital intensive or labor -- becomes unbelievably important for what happens here, so we will continue to look at this sector. But, again, thank you all very much. And, Kathryn, double thank you to you for doing double duty.

So, again, thanks a lot, and I think we will again -- let's take a five-minute break, and then we're going to come back with rehab facilities, and I think it's going to be Jamila and maybe someone else.

[Recess.]

DR. CHERNEW: Hello, everybody. We are now going to turn to our last session of the December meeting with Jamila and, I think, Betty, and Jamila, I think you're going to start. So first, congratulations. It's wonderful to see you, and we look forward to what you're going to say about IRFs.

DR. TORAIN: Thanks, Mike. Good morning. Before

we start, we would like to give special thanks to Lauren Stubbs for her help with this presentation.

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

As you've seen in earlier presentations today, we continue to use our established framework.

After illness, injury, or surgery, many patients need intensive rehabilitative care including physical, occupational, or speech therapy. Sometimes these services are provided in inpatient rehabilitation facilities.

In 2021, there were 1,181 IRFs, and about 335,000 beneficiaries had 379,000 stays. Medicare spent about $8.5 billion on IRF care provided to fee-for-service beneficiaries, and Medicare accounted for about 52 percent of IRFs' discharges.

Now I'll review our assessment of payment adequacy for IRFs. We'll start by considering access to care.

In 2020, IRFs experienced a reduction in volume due to the coronavirus pandemic, which likely decreased elective acute care hospital services requiring subsequent

IRF care. In 2021, overall volume somewhat rebounded, increasing by about 4 percent.

In terms of the supply of IRFs, in 2021, there was a 2 percent increase in the number of IRFs mainly in freestanding, for-profit IRFs. In 2021, the aggregate occupancy rate was 68 percent, and if we look at the Medicare marginal profit, we see a robust 22 percent for hospital-based IRFs and 41 percent for freestanding IRFs, the highest among all fee-for-service sectors. Overall IRF indicators of access suggest that capacity is more than adequate to meet demand for IRF services.

Shifting now to indicators of the quality of IRF care, as Kathryn and Evan mentioned, in the PAC settings we evaluate average risk-adjusted rates of successful discharge to the community and all-condition hospitalizations within a stay.

In 2021, the mean facility risk-adjusted rate of successful discharge to the community and all-condition hospitalizations improved compared to 2020.

We present these findings with one caveat: some of the Commission's quality metrics rely on standard risk-adjustment models that use performance from previous years

to predict beneficiary risk. COVID-19 is a relatively new diagnosis that is not included in the current risk-adjustment models.

Turning now to access to capital. As I noted in your paper, almost three-quarters of IRFs are hospital-based units, which access needed capital through their parent institutions. As you heard yesterday, hospitals' access to capital strengthened in 2021, with the all-payer operating margin among hospitals paid under the IPPS reaching a record high in 2021, despite a decline in federal relief funds.

As for freestanding IRFs, nearly 45 percent are owned or operated by one large company. Their investor reports indicate that this chain has good access to capital. In 2021, the company opened 8 IRFs and added 117 beds to existing IRFs and has opened 9 new IRFs in 2022. While mergers and acquisition activity was minimal for this company in 2020, it picked back up in 2021, acquiring or opening 25 home health and hospice locations.

Most other freestanding IRFs are independent or local chains with a limited number of facilities. The extent to which these non-chain IRFs have access to capital

is less clear.

Overall, the all-payer total margin for freestanding IRFs is a robust 14 percent.

Moving on, as shown by the blue line, the aggregate IRF Medicare margin has been over 13 percent since 2016. In 2021, the Medicare margin grew nearly 4 percentage points to 17 percent, driven by slow cost growth.

Financial performance continued to vary widely across IRFs. For example, in 2021, the aggregate Medicare margin for freestanding IRFs was about 26 percent, as shown by the white line. In contrast hospital-based IRFs had an aggregate Medicare margin of about 6 percent, shown by the green line. We also see wide differences in margins of for-profit and nonprofit IRFs as most freestanding IRFs tend to be for-profit and most hospital based IRFs are nonprofit. These differences in profit margin by provider type has persisted over time, and we continue to investigate the drivers of these differences.

We found that profitability differs by IRF condition and within a condition. For example, using 2019 data, payments exceeded costs, on average, for stroke cases

by 12 percent and for other neurological conditions by 26 percent. For cases within a condition, we found that the greater the functional impairment of the case mix group, the more payments exceeded costs. Higher profitability for patients with greater impairment promotes selection of them over other types of patients and may also further incentivize coding patients to a lower functional status.

As shown in your reading materials, we also found that in 2021, IRFs with higher case mix tended to have higher profitability. This was not the case in 2007. Also between 2007 and 2021, we observed a large shift in the number of IRFs with high overall case mix. In 2007, case mix was more evenly distributed across IRFs.

We will continue to investigate drivers of these patterns. We are examining the methodology for calculating payment weights as well as IRFs' coding practices and their implications on IRF patients, access to care, and CMS payments.

In 2021, 17 percent of the IRFs included in the analysis were relatively efficient. Compared to other IRFs, relatively efficient providers had hospitalizations rates that were slightly lower and higher rates of

successful discharge to the community. Additionally, while payment rates to all IRFs were similar, if we look at the second-to-last line, their standardized costs per discharge were $14,423, which is 17 percent lower than $17,284, leading to a large difference in the median Medicare margin, which was 20.4 percent for the relatively efficient group compared with 9.5 percent for other IRFs.

With that we will move on to discuss our projected Medicare margin for IRFs. For fiscal year 2023, we project that IRF margins will decrease to 11 percent. This is because costs are expected to increase more than the payment rate increases. Specifically, in our estimate of costs, we used CMS's most recent estimates of the market baskets for 2022 and 2023, which is well above recent actual cost growth.

On the payment side, we assumed that payments will increase by the updates included in the final rules for 2022 and 2023. We also accounted for the re-application of the sequester starting in April 2022. Margins for 2023 could be higher or lower if changes in costs or payments differ from the projections.

In summary, our four categories of payment

adequacy indicators for IRFs are generally positive. First, in terms of fee-for-service Medicare beneficiaries' access to care, IRFs continue to have capacity that appears to be adequate to meet demand. Second, in 2021, our measures of IRF quality of care improved but we present these findings with caution. Third, IRFs maintain good access to capital markets. The all-payer total margin for freestanding IRFs is a robust 14.0 percent. Fourth, Medicare payments and IRFs costs indicators were positive. In 2021 the aggregate Medicare margin was 17.0 percent, 20.4 percent for the relatively efficient provider. We project a margin of 11.0 percent in 2023.

And so that brings us to the update for 2024. The Chair's draft recommendation reads:

For fiscal year 2024, the Congress should reduce the 2023 Medicare base payment rate for inpatient rehabilitation facilities by 3 percent.

To review the implications, on spending, relative to current law, Medicare spending would decrease. Current law would give an update of 2.9 percent. On beneficiaries and providers, we anticipate no adverse effect on Medicare beneficiaries' access to care. The recommendation may

increase financial pressure on some providers.

With that I will close. I am happy to take any questions. Thank you.

DR. CHERNEW: Great. That was wonderful. Greg, you have a Round 1 question, and then I have several Round 1 questions, but maybe they're the same. You go first.

MR. POULSEN: It would be interesting if they are.

I'm concerned about the issues related to coding that you talked about Slide 8, and obviously this isn't unique to this sector but it's an issue here. It does make me wonder to what degree the relatively efficient IRFs on Slide 9 are really relatively efficient or are they better at coding. Do you have any thoughts on that?

DR. FOUT: So it is hard to really distinguish, you know, good coding from bad coding, and certainly we're looking at the pattern by high-margin, low-margin IRFs, which are reported on in your paper. We haven't looked at the efficient providers compared to other efficient providers, but it's something we could do.

MR. POULSEN: Thank you. Yeah, I just note that -- and when I say "good at coding" I should've put that in

air quotes. "Creative at coding" might be the right word. And it's perverse because doing that can make you look better from a cost and quality perspective, and so it's interesting.

That said, I'll get it out of the way and say I support the recommendation. I think it makes lots of sense. Thank you.

DR. CHERNEW: We'll note that is out of the way.

So this is a comment that actually goes across a lot of sectors but it's clear here. In many cases we find hospital-based facilities have much lower margins, and you see that starkly in one of the slides here. It says in the reading materials, but I'd like if you have any other thoughts, on the allocation issue that occurs at hospitals. In other words, how much of what's happening in the low hospital margins is just because they're allocating broader hospital costs, and I might add that is mirror images of the profitability of hospitals.

But if you have any thoughts about how much you think that coding is going on, how easy it is to shift costs between one section of the cost report versus another. For hospital-based, that's something I think is

interesting to note.

MS. KELLEY: That's something we haven't looked at recently, but we did pay a fair bit of attention to this several years back. And I think our conclusion was that allocation from other parts of the hospital actually accounts for a very small share of the difference here. So it doesn't seem to be driven by that.

UNIDENTIFIED SPEAKER: [Unintelligible]

MS. KELLEY: I'm going to say eight years ago, but this has been a pattern, the disparity, if you will, between the hospital-based and the freestanding margins have been an issue across the PAC settings for I think as long as we've looked at the different settings.

DR. CHERNEW: Okay. If I've got this right, I was the last Round 1 question, which means we're going to go on to Round 2. Again, everyone is going to talk, but I think the order is going to be such that I think Stacie is first in this case.

DR. DUSETZINA: Okay. Thanks very much. It's always tough to be the last chapter that people read and also the last presentation, and I will say I was fascinated

reading this paper, so thank you for an excellent, excellent paper.

I fully agree with the Chairman's recommendations. I did want to make a couple of comments about some of the things I found so fascinating, and I think, to Greg's point, good at coding or really lazy at assessment. There are different ways of reading what's going on here, and it strikes me that, you know, we are not forcing them to give us better data so we're getting what we're getting.

Some of the things like the coding of conditions into these very broad categories of other neurologic conditions and debility that it seems like we would want more details than that. Those feel very broad. And also the fact that we're paying more for other neurologic conditions than for stroke, something you all called out in the chapter. And I just think from a, you know, maybe we should ask for more or like you can't give us such a broad definition and get such high payments.

The other thing I just want to applaud you all on is the graphs comparing the case mix from 2007 to 2021, and boy, that really stood out how either just fundamentally

everyone who is being treated in these settings has changed or there is a lot of gaming going on with the coding system. So again, I must appreciate that you're all looking into this and thank you for giving us such a strong chapter.

DR. FOUT: I just wanted to say, for the conditions, those are the groups of diagnoses that are specified by the IRF payment system, and within each condition there are case mix groups that are specified by the motor score and other features, and there are also these tiers of comorbidities. So there is more granularity than that might imply when you just look at the conditions.

MS. KELLEY: And we also do have the information on the underlying conditions that are kind of grouped up into these broader categories of "other neurologic" or "debility" -- maybe not debility as much. But for other neurologic we do know, for example, which patients have ALS, so we do have some more granular detail about their conditions as well.

I have David next.

DR. GRABOWSKI: Thanks, Dana. First, thanks to you both for a great chapter here and a great presentation.

I'm also strongly supportive of the Chair's draft recommendation. I agree with everything Stacie said. And very similar to a comment I made with home health, IRFs can benefit patients when done well, but we are paying a rate in traditional Medicare that is just too high. And so these margins, I guess I can use the word again, are obscene again. These are huge. So I can strongly support the Chair's recommendation to lower those rates.

I wanted to make a couple of other points. I just wanted to read a sentence that really stood out to me in the report, from page 7. It said, "It's not clear when IRF care is necessary or beneficial for a given patient or when another potentially lower-cost PAC provider such as a SNF could provide appropriate care."

This sector is the poster child for the uniform PAC PPS. If SNFs can offer a comparable quality for similar patients at a lower reimbursement, beneficiaries should be receiving services in that setting. MedPAC has been on this issue for a long time about a lot of the similarities between IRFs and SNFs and the different rates paid across the two. So I just wanted to draw that out again, that we're paying a really high rate here, and it's

not always clear that we're getting good value.

The other comment I wanted to make is just to contrast IRFs against LTCHs. LTCHS, we've had, I think, the most successful, or one of the most successful post-acute care policies that Medicare has put forward in the site-neutral policy. That really limited low-value care. We've seen some similar -- I don't know if "similar" is the right word, but at least kind of similar efforts in IRFs to also try to target services to appropriate patients, whether it's the so-called 60 percent rule or the 3-hour rule. These just haven't been as effective.

So I think as an area for future work are there other policies similar to the site neutral payment policy for LTCHs that could be applied here to IRFs, to really maybe encourage greater value here.

Final point, and Greg and Stacie already said it well, but this evidence that higher case mix is more profitable is just really problematic, and I'm really glad that MedPAC is kind of digging into that. I think that's something that we should be looking at and really analyzing.

So once again, I'm very supportive of this work

and thanks for the great chapter.

MS. KELLEY: Scott sent in his comments. He supports the Chair's draft recommendation. He thinks it is well supported by the data, that it's nicely summarized in the concise staff work. He believes this sector is more than capable of delivering on access and outcomes under these proposed rates.

I have Larry next.

DR. CASALINO: Yeah. Jamila, Betty, and Dana, I don't want to put you on the spot, and perhaps this is a question for the Chair, but given the degree of profit in this sector, the 3 percent proposed cut seems quite modest, actually. And if you compare it, for example, to the 7 percent cut that we were just talking about in another sector.

Does someone want to try to explain a little bit? I know it's always hard to say where this specific number comes from, but it does seem like a fairly modest cut, given what you pointed out, Jamila, as maybe the highest profit margins we've looked at.

DR. CHERNEW: So I guess that's on me. In the way past, I think, like when I served before and Glenn was

Chair, there were certain situations where we would make recommendations to rebase things, which would be much more dramatic, and I think our general feeling is that there are certain really big shock recommendations that we would make directionally. So 7 is a pretty big recommendation, and we would see where that would go. It doesn't mean that that would be -- we would then reevaluate where we were should that come to pass. But I think it's difficult to make a recommendation.

DR. CASALINO: It's difficult to do?

DR. CHERNEW: It's hard to know, when you get out of sample, how everything would change. So that's sort of why we go in a direction, but we didn't go, sort of --

DR. CASALINO: I guess the counter argument would be how often is Congress going to make a substantial cut.

DR. CHERNEW: That's a reasonable --

DR. CASALINO: And recommending a 3 percent cut now with the expectation there will be another 5 percent cut if there's still, what some Commissioners have called, obscene profit margins, may not be too realistic.

DR. CHERNEW: Some Commissioners. That's a reasonable view.

Greg, did you want to say something on this point?

MR. POULSEN: Just really quickly. I think that if we were to go with something dramatically more dramatic in terms of a cut, we would want to understand what the implication would be on the hospital-based IRFs and whether we could live without them. Because, you know, the margins there are dramatically different, and with the hospital-based I think they are serving a purpose, and we would want to evaluate whether that purpose could be lost without harm to the overall system. And I'm not saying it couldn't be or shouldn't be, but I would think we'd want to analyze that, because a more dramatic cut would probably get a number of the hospital IRFs out of the business, I'm guessing.

DR. CASALINO: Greg, We are talking the 22 percent margin for the hospital-based IRFs.

MR. POULSEN: No. Look at Slide 7.

DR. CASALINO: I'm looking at Slide 4.

DR. TORAIN: It's 22 percent versus the Medicare marginal profit.

DR. CASALINO: -- patients.

DR. TORAIN: Right. Marginal profit. Right.

DR. CASALINO: Okay.

DR. TORAIN: The margin is about 5 percent.

MS. KELLEY: Yeah. I just also wanted to remind us that in this particular industry, building on Greg's point, the hospital-based providers make up half of the -- no, I'm sorry, 75 percent of the facilities and take care of a little less than half of the patients. Is that right? Yes. So they are a much bigger player here than, for example, in home health or SNF, and that, I think, also weighed into our discussions with Mike.

DR. TORAIN: And I just wanted to add that we, on the for-profit, freestanding side, were able to track one company that owns almost 45 percent of the freestanding share. But on the hospital-based nonprofits we have limited information, so we don't know how they're doing during these times. So that also goes along in our thought process for the projection as well.

DR. CASALINO: It does this really hurt the hospital-based IRF. It might result in handing more of the industry to the single company.

MS. KELLEY: Robert.

DR. CHERRY: Yes, thank you. By the way, I had a very similar question too, the 3 percent versus the 7 percent for home health agencies. I think this discussion helped to clarify that I think quite a bit. I'm comfortable supporting the 3 percent, but certainly if this was reassessed between now and January, and there was something larger, I probably would support that as well.

As a new Commissioner I'm starting to notice things that are probably obvious to those that have been around for a while, but I thought I would just state them. This is the third time today, in our pre-read materials, where I've seen a statement, "Quality of care in 2021 is difficult to assess," unquote, dot-dot-dot. So that's kind of a running theme.

The other theme, too, whether it's skilled nursing facilities, home health, and now with the rehab discussion, we're using the same two measures, you know, which is basically successful discharges and all hospital conditions, without really any customization or consideration about what's specific to the sector. And there are other measures available. Granted, it's not as robust as hospital or physician measures, but there's more

available than just two.

So I think it's something to consider as we start to assess payment adequacy in future meetings.

Personally, I would like to see measurement sets that more closely mirror the IOM domains, so not necessarily two measures but maybe 6, one for each, you know, safe, effective, patient-centered care that's timely and efficient and equitable might be sort of a way to go, just in order to have something more than sort of a two-dimensional view of quality of care.

But otherwise I support the Chair's recommendation and thank you for your time.

MS. KELLEY: I have Cheryl.

DR. DAMBERG: Thanks for a great chapter. It was actually kind of a thrilling read. I'm going to channel Stacie's comment. I just kind of found myself, page after page, circling things and going, "Wow." I kind of share David's comments that these payment rates look more than adequate, and so I support the Chair's recommendation.

You know, I did appreciate the comment that MedPAC is going to continue to investigate the risk coding. I think it's Table or Figure 9.3, which is so striking in

terms of the share of pie, case mix, comparing 2021 to 2007. So clearly some more digging needs to be done there, and thinking about how to restructure that, so that there aren't all these opportunities for gaming and increasing profits. Thank you.

MS. KELLEY: Kenny.

MR. KAN: Thanks, Betty and Jamila, for a fantastic and awesome chapter. As a new Commissioner, I have read the materials in the past but now I read it with a different lens. So I strongly support the Chairman's draft recommendation. And I'm also wondering for future studies, Dana, if we could possibly look at a refresh of the hospital cost allocation issue, for future studies. Thank you.

MS. KELLEY: I think that's all I have, Mike.

DR. CHERNEW: So we're going to start -- I think we'll start with Marge, and I'm going to try and make sure I get this right as we go around. So Marge.

MS. GINSBURG: Fabulous work in putting together an intriguing topic. I do support the recommendation. It also makes me a little uneasy that it's as low as it is, but I can live with it. So thank you.

DR. JAFFERY: So great chapter. Excellent report. I really appreciate the context of what the thinking was behind the 3 percent, and again, this sort of calls out how we can have these consistent discussions but then also dig into the nuances and complexities of an individual sector which isn't obvious, like the fact that hospital-based IRFs are such a large percentage here where they're not in others. So with that I fully support the Chair's draft recommendation.

MR. KAN: I support as well. Excellent work.

DR. NAVATHE: Excellent work. I also support the draft recommendation.

DR. RYU: Nothing further here. I also support it.

DR. RAMBUR: Thank you for the great work. I just to have to comment that my initial reaction was much like Larry and Robert and Marge has, which is, is it enough? But hearing all your comments I'm comfortable, but as Robert said, if some new data emerges between now and the next vote, I'd be happy to have consideration of a deeper cut. Thank you.

DR. CHERNEW: Betty, thank you. I think that

brings us to a close, if anyone wants to say anything else.

DR. CASALINO: Mike, I didn't actually say whether I supported it or not, and I do.

DR. CHERNEW: Oh. Sorry, Larry.

DR. CASALINO: No, that's okay. I had enough to say. But I do support it. It is quite striking, though, the difference between, "obscene profits" on the one hand and the concern that the margins for hospital-based IRFs are low enough that we would worry that a bigger cut would hurt them. That's such a gap in profit among different sectors of this sector. I'm sure you guys have thought about this, but it might be worth even more thought in future years, whether there's anything that could be done about that.

DR. CHERNEW: Yes.

DR. GRABOWSKI: Larry, this gets back to my earlier comment about site neutral, and there may be ways to really rethink how we pay IRFs that could maybe direct dollars differently to hospital-based and freestanding IRFs.

DR. CHERNEW: And so we will continue to give some thought to that broadly.

So let's see. I want to thank both Jamila and Betty for their presentation, to the staff writ large for all the work they've done, even more importantly for all the work they're going to do. That includes Jim. The December meeting is always one of the more challenging meetings because we have a lot to cover, we have a narrower lane that I think people would like to stay in, and we're really getting to sort of where the rubber hits the road on our charge.

So again, thanks to everybody for their comments. For those of you at home, thank you for spending this time with us, or in your offices, wherever you may be. But please send us your comments at meetingcomments@medpac.gov. We do look forward to hearing from you. And I hope everybody has a healthy and happy holidays and New Year's, and we will be back in January to wrap up our recommendation meeting.

So again thank you, and travel safely.

[Whereupon, at 11:40 a.m., the meeting was adjourned.]