MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, NW
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10:48 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[10:48 a.m.]

DR. CHERNEW: Okay. Welcome everybody to our December MedPAC meeting.

One of the core MedPAC activities is to recommend to Congress how the fee schedule should be updated each year, and in doing so, we go through a set of sectors and make recommendations about the appropriate update for those sectors using our standard criteria, acknowledging we have to look at the financial health, the margins, the access, access to capital, quality, and things of that nature. We'll go through all of them.

We are going to start today with the fee schedule for physicians and other health professionals, and am I turning it over to Rachel? Rachel, you're going to start. Take it away.

MS. BURTON: Good morning. In this session, we'll assess the adequacy of payments for physician and other health professional services and present the Chair's draft update recommendation for 2025. To those watching remotely, you can find a copy of these slides in the handout section of the webinar's control panel on the right

side of your screen.

Our presentation will start with some background on the physician fee schedule, including how its payment rates are updated each year and how we assess the adequacy of these payment rates. We'll then describe our findings regarding beneficiaries' access to care, beneficiaries' quality of care, and how clinicians' revenues compared to their costs. We'll end with the Chair's draft recommendation in your discussion.

So to begin with, some background. Medicare's physician fee schedule includes billing codes for about 8,000 services, which are delivered in a wide variety of clinical settings. In 2022, the Medicare program and fee-for-service beneficiaries paid 1.3 million clinicians, a total of $91.7 billion for fee schedule services. Compared to 2021, fee scheduled spending was 1.2 percent lower in 2022. This was largely driven by a 3.9 percent decline in the number of beneficiaries enrolled in fee-for-service, as enrollment in Medicare Advantage continued to grow.

In 2025, current law calls for a zero percent update to fee schedule payment rates. In addition, a one-year-only increase of 1.25 percent that applied in 2024

will expire.

The physician fee schedule's payment rates are updated each year by updating the conversion factor, which is a fixed dollar amount used when converting a service's relative value units to a payment amount. Conversion factor updates usually reflect two things, a percentage specified in law and a percentage calculated by CMS to maintain budget neutrality. The budget neutrality adjustment ensures that any changes CMS has made to values for particular codes in the fee schedule do not, in and of themselves, increase or decrease total spending.

MACRA specified that clinicians' payment rates were to be updated by zero percent from 2020 to 2025, but in 2021, CMS increased the payment rates of office and outpatient evaluation and management visits, which required a minus 6.8 percent budget neutrality adjustment.

To avoid a reduction of this size to payment rates in 2021, Congress passed subsequent laws that provided a series of one-year-only increases that decline in size from 2021 through 2024. These have the effect of phasing in the 6.8 percent reduction to the conversion factor.

As a result, payment rates for E&M visits have increased substantially, shown at left, and the conversion factor has declined, shown at right.

In 2024, part of the decline to the conversion factor, shown at right, is offsetting a new add-on code that will add another $16 to the payment rate for office visits provided by clinicians who have an ongoing relationship with a patient.

In 2025, the prior year's one-year-only increase of 1.25 percent will expire, and the transition to the new lower conversion factor will be complete. As a result, the conversion factor will decline by 1.25 percent in 2025.

To assess the adequacy of Medicare's fee-for-service payment rates, the Commission usually looks at four categories of payment adequacy indicators. The specific measures we use to assess clinician payment adequacy are 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.

We generally do not assess clinicians' access to capital due to data limitations. Examining clinicians' revenues and costs helps us get a sense of whether clinicians' revenues are sufficient to cover their costs of delivering services to Medicare beneficiaries. Our indicators for this last category are different from other sectors, since clinicians do not submit cost reports to CMS. So we are unable to calculate their profit margins.

Our assessment of the various indicators on this slide informs the Chair's draft update recommendation for payment rates in 2025. We begin our assessment with access to care.

In the Commission's 2023 patient survey, Medicare beneficiaries ages 65 and over continue to report access to care that is comparable with or better than that of privately insured people ages 50 to 64.

As we show here, higher shares of Medicare beneficiaries reported being satisfied with their ability to find providers that accepted their insurance and had appointments when they needed them, and higher shares said they never, or only sometimes, had to wait longer than they wanted to get an appointment for routine care or for an

illness or injury. These findings are consistent with several other national surveys and our annual focus groups.

The share of clinicians who report accepting Medicare is relatively high and comparable with the share who accept private health insurance. For example, the 2021 National Ambulatory Medical Care Survey found that among non-pediatric office-based physicians taking new patients, 89 percent accepted new Medicare patients, and 89 percent accepted new privately insured patients.

A 2022 survey by the American Medical Association included physicians who work in other settings besides offices and found that even higher shares accepted Medicare and private insurance.

Another indicator of beneficiaries' access to care is the number of clinicians billing Medicare's fee schedule. From 2017 to 2022, the total number of clinicians billing the fee schedule grew by an average of 2.4 percent per year. The increase in clinicians kept pace with growth in the total number of beneficiaries enrolled in Medicare.

Over the same period, growth varied by the type and specialty of clinician. In particular, we saw rapid

growth in the number of advanced practice nurses and physician assistants. We saw modest growth in the number of specialist physicians, who account for over three-quarters of the physicians billing Medicare. And there was a modest but steady decline in the number of primary care physicians. We are concerned about the decline in primary care physicians and are monitoring this closely.

Consistent with past years, nearly all clinicians who billed the fee schedule did so as participating providers, meaning they accepted Medicare rates as payment in full and did not balance bill beneficiaries.

Our next measure of beneficiary access is the number of encounters per fee-for-service beneficiary in a given year. An encounter represents an interaction between a beneficiary and clinician for which one or more fee schedule services were billed.

For all clinicians, the number of encounters per beneficiary grew by 3.1 percent from 2021 to 2022.

Similar to our analysis of clinicians billing the fee schedule, we found that changes in the number of encounters per beneficiary varied by the type and specialty of clinician. For example, between 2021 and 2022,

encounters per beneficiary with primary care physicians decreased by 0.3 percent, specialist encounters increased by 1.3 percent, and encounters with APRNs and PAs increased by 10.4 percent.

I'll now pass things over to Lydia.

MS. TABOR: Turning to our assessment of quality of care.

The quality of care provided by individual clinicians is difficult for us to assess for two reasons. First, Medicare does not collect much clinical information, like blood pressure and lab results, or patient=reported outcomes, such as improving or maintaining physical and mental health at the fee-for-service beneficiary level. Second, CMS measures the performance of clinicians using MIPS, which in March 2018, the Commission recommended eliminating because it is fundamentally flawed.

For example, clinicians choose which measures to report from a catalog of hundreds of different measures. This makes it harder to compare physicians since only a few clinicians may report a certain measure.

Also, many clinicians are exempt from reporting quality data for MIPS, so there's a portion of clinicians

where CMS has no quality information.

Taking these limitations into account, we will report on the quality of the ambulatory care environment for beneficiaries in fee-for-service Medicare by looking at two sets of measures. We use outcome measures that assess ambulatory care-sensitive hospitalizations and emergency department visits, and we look at patient experience measures from the fee-for-service CAHPS survey. This approach is consistent with the Commission's principles for quality measurement to focus on quality measures tied to clinical outcomes and patient experience.

Although the 2022 risk-adjusted rates of ambulatory care-sensitive hospital use were relatively stable from 2021, we continue to see geographic variation in these rates, which signals opportunities to improve. Rates of ambulatory care sensitive-hospitalizations and ED visits were about twice as high in some hospital service areas than others.

Patient experience scores were also relatively stable from 2021 with CAHPS scores of 83 out of 100 for beneficiaries rating of their health plan and 85 out of 100 for the rating of health care quality.

I'll now turn to Brian.

MR. O'DONNELL: Finally, we turn to clinicians' revenues and costs.

On a per-beneficiary basis, fee schedule payments continue to grow at a steady rate for most types of service. We found that allowed charges per beneficiary for all clinician services grew by 2.8 percent between 2021 and 2022. This was about the same growth rate observed in the years immediately prior to the pandemic.

The growth in payments per beneficiary varied by broad service types. It ranged from minus 0.2 percent for major procedures to an increase of 6.8 percent for tests. Allowed charges for evaluation and management services grew by 2.2 percent.

The 2022 growth rates for most broad service categories were similar to the growth for those services during the pre-pandemic years, 2017 to 2019.

In this slide, we compare private insurance PPO rates with fee-for-service Medicare rates. We compare private insurance rates with Medicare rates because large differences could create an incentive for clinicians to focus on patients with private insurance. We found that

commercial PPO payment rates were 136 percent of fee-for-service Medicare rates in 2022, up from 134 percent in 2021.

The increasing difference between Medicare and private payer rates is part of a longer-term trend. For example, in 2011, private insurance rates were only 122 percent of Medicare rates.

As studies by academic researchers and the Commission have shown, growth in private insurance rates is partially due to increases in the consolidation of physician practices and hospitals acquisition of practices. The trend toward consolidation has enabled physicians to increase their negotiating power with private payers.

In this slide, we discuss all-payer clinician compensation.

As a reminder, we like physician cost reports, so we look at indirect measures of costs and revenues. One of those measures is clinician compensation.

In 2022, we saw strong growth in clinician compensation after slower growth during the pandemic. According to SullivanCotter's latest clinician compensation surveys, from 2021 to 2022, median compensation grew by 9

percent for physicians and by 5 percent for advanced practice providers, such as NPs and PAs.

Over a four-year period from 2018 to 2022, median compensation grew at average annual rates of 3.4 percent per year for physicians and 4 percent per year for advanced practice providers.

In this slide, we shift to the cost clinicians incur to treat patients. The Medicare Economic Index, or MEI, measures clinicians' input costs and is adjusted for economy wide productivity. MEI growth was 1 percent to 2 percent per year for several years before the coronavirus pandemic. MEI growth then increased from 2.1 percent in 2020 to 4.6 percent in 2022. However, MEI growth is projected to moderate in the coming years, increasing 4.1 percent in 2023, 3.0 percent in 2024, and 2.6 percent in 2025.

In this slide, we take a longer-term view of how clinicians input costs compared to fee schedule updates and fee schedule spending per beneficiary.

Over more than two decades, MEI growth consistently exceeded fee schedule updates. From 2000 to 2022, the cumulative increase in fee schedule updates, the

bottom line, totaled 12 percent compared with MEI growth of 48 percent, the middle line. However, as the top line on the figure shows Medicare fee schedule spending per fee-for-service beneficiary grew by 94 percent over the same period, far outpacing MEI growth.

This suggests volume and intensity growth has helped offset the gap between MEI growth and annual updates, and as noted earlier, the Commission's full set of access measures suggest that beneficiary access to care has remained stable and similar to or better than individuals with commercial insurance.

The fact that our beneficiary access measures remain good, while fee schedule payment rates have not kept up with MEI growth, suggests that increasing fee schedule rates to closely reflect inflation has not been necessary to ensure beneficiary access to care. Instead of hindering access, relatively low payment rate updates appear to have been a tool to slow the rapid increase in spending On clinician services, which benefits both taxpayers and beneficiaries.

To summarize our analysis, most indicators suggest that payments have been adequate, but rising input

costs are a concern. In terms of access, beneficiaries report access to care that is comparable to or better than the privately insured. Comparable shares of clinicians accept patients with Medicare and private insurance. The total number of clinicians billing Medicare is increasing, although, the mix of clinicians is changing. Clinician encounters per fee-for-service beneficiary increased.

In terms of quality, it's difficult to assess, but we know wide variation in rates of ambulatory care-sensitive hospitalization and ED visits and stable patient experience scores.

In terms of clinicians' revenues and costs, spending per Medicare fee-for-service beneficiary increased. The ratio of private insurance to Medicare payment rates increased slightly.

Clinician compensation grew rapidly in 2022. MEI growth peaked in 2022 but is expected to slow to 2.6 percent in 2025.

Taking a step back, we note that, in totality, our payment adequacy indicators are similar to, or better than, those that the Commission published in its March 2023 report.

And before we get to the Chair's draft recommendation, we thought it would be useful to review the recommendations from that March 2023 report.

First, the Commission recommended that base payment rates be increased by half of the projected increase in the Medicare Economic Index in 2024.

Second, the Commission recommended that Congress institute a new permanent add-on payment for clinicians who care for Medicare beneficiaries with lower incomes. Specifically, for services provided to Medicare beneficiaries with lower income, primary care clinicians should receive add-on payments equal to 15 percent of fee schedule rates, and nonprimary clinicians should receive add-on payments equal to 5 percent.

We said the proposed safety net payments should not be subject to beneficiary cost sharing and not require offsetting payments elsewhere.

Had this policy been in effect in 2019, we estimate that add-on payments would have averaged $1,340 per clinician and totaled $1.7 billion in additional Medicare spending.

This brings us to the Chair's current draft

recommendation, which reads "For calendar year 2025, the Congress should update the 2024 Medicare-based payment rate for physicians and other health professional services by the amount specified in current law plus 50 percent of the projected increase in the Medicare Economic Index. This draft recommendation is motivated by our concerns that clinicians may not be able to absorb projected increases in input cost at current payment levels. However, our indicators suggest that payments are currently adequate. Therefore, we're proposing to recommend that 2025 payment rates, under current law, be raised by half of the projected increase in the MEI. CMS currently forecast a 2.6 percent increase in the MEI for 2025. If this forecast stays the same, the update would be 1.3 percent over current law."

In addition, the Chair proposes that the Commission reiterate its March 2023 recommendation for additional payments to support Medicare's safety net clinicians.

In terms of implications, this draft recommendation would increase spending relative to current law. It should not have an adverse effect on

beneficiaries' access to care, and we expect continued provider willingness and ability to treat fee-for-service beneficiaries.

And with that, we look forward to your questions, and I'll hand it back to Mike.

DR. CHERNEW: Great. That was a terrific presentation, not just in the content but I think you presented the criteria particular well, and you went through it, I think, in a particularly clear way. But that is just me.

We are now going to move to questions overall, and Cheryl, I think you are out of the queue, so now I think the queue is going to start with, is it Stacie?

MS. KELLEY: Stacie.

DR. DUSETZINA: Great. Thank you. Thanks so much for a great chapter and presentation.

I just had a question about the survey data for the access question, so the people struggling to get primary care appointments. And excellent job on footnotes, very detailed. I appreciated that very much.

I was wondering if, in future iterations, it is possible to get more details to tease apart the fee-for-

service and MA beneficiaries in case there are at least signals of access to care challenge because of MA networks or something like that. So that is part one.

MS. BURTON: In our focus groups, and maybe Ledia will comment here, we have found that beneficiaries often have difficulty knowing if they have fee-for-service versus MA. Like they will say they think they have one and then by the end of the conversation we are like, okay, they clearly have MA. And so the Medicare Current Beneficiary Survey is a much larger survey, and they do tease apart if somebody has fee-for-service or MA. So we use them for supplementary analysis that we include in this chapter, but it is a few years lagged, so there are sort of tradeoffs in using them versus ours. Ours is very current but it is a short survey, and so we can't ask enough questions to figure out accurately if they have fee-for-service or MA.

MS. TABOR: And I will just add that actually we are now thinking of the future, that we are going to try to tease this apart in the focus groups. Now that there are more MA beneficiaries, we may be able to do this. So stay tuned.

DR. DUSETZINA: Yes, and I empathize with the

difficulty in that because we are using some data that tries to ask people this question, and we are also very skeptical of how well people are doing answering it.

The other question I had was about the increase payment for the established patients. And I just wondered if that -- so my understanding is if you are new patient that is usually a higher payment. Will this just kind of make those more equivalent? I will say the background to why I'm asking is that makes me worry it would be even harder to get a new patient an appointment because there is a not a differential in a slightly higher payment for a new patient versus established patient. And I was just trying to figure out like how are they going to be about the same amount of money?

MR. O'DONNELL: So no. We can put in some additional payment rates for context, but the delta between the new and established is greater than that $16 add-on. But for context we can put those numbers in, and it does vary by specific HCPCS. So we can just give you that context.

DR. DUSETZINA: Okay. That would be really helpful. Thank you.

MS. KELLEY: Gina.

MS. UPCHURCH: Great. Thank you. I also really enjoyed the chapter. Just three quick questions. In one of the slides that you showed, but also on page 4 of our reading, it says in 2022, preferred provider organizations' payment rates for clinical services were, on average, 136 percent of fee-for-service Medicare, up from 134.

Is that including Medicare Advantage plans that are PPOs or just non-Medicare PPOs?

MR. O'DONNELL: So the private insurance data we have is non-MA, so it is just commercial.

MS. UPCHURCH: Okay. Maybe just clarify that. I assumed so, but just to put that in there.

The second one, on page 12, the survey with older adults with more limited incomes and talking about lowered expectations potentially of access to care and that kind of thing, do we know what kind of insurance they were coming from? And that may be too difficult to get at. But when somebody joins Medicare, our understanding is if they have come uninsured or really struggle to access care their expectations are lower than somebody that is coming from a Cadillac employer plan.

So is there any way we can easily get that, or is that sort of complicated?

MS. BURTON: We can't easily get that, but we can think about that. Maybe low-income people we can look up stats for what kind of insurance they tend to have pre-Medicare. We will see what we can do.

MS. UPCHURCH: It seems like that would obviously influence expectations. And then lastly, Table 4A, and you also had it in the slide, it is a survey of Medicare beneficiaries 65 and older. So I am just curious if we have an equal slide for younger than 65 that have Medicare.

MS. BURTON: So our survey only includes Medicare beneficiaries age 65 and over, but the Medicare Current Beneficiary Survey is a much larger survey, and they do include non-elderly people, and we include some stats for them in our chapter. It is just a brief paragraph because we are trying to spare you guys and shorten the chapter. But it is briefly in there.

MS. UPCHURCH: That would be great to see. Thank you so much.

MS. KELLEY: Larry.

DR. CASALINO: Yeah, a very well written and

informative chapter, as usual.

Three questions. The first is could you say a little bit about how we arrived at the half of MEI for the update? I mean, why a half? Why not 0.25? Why not 0.75? Why not 1.0 of MEI?

MR. O'DONNELL: Yeah. So I think the balance is -- and I can see Mike itching for it -- I will say that the balance is that all of our access indicators look, actually, quite good, but then we look at inflation costs and it has been higher than historical averages. So this comes to the situation of do we pick somewhere in the middle, and I think the rationale for the half of MEI is that practice costs generally are half of MEI. So the thought is that you are paying sufficient to maintain, you know, pay for kind of nurses, kind of costs to run the practice, things like that. So that is kind of the justification.

DR. CHERNEW: So first, these are chair draft recommendations so I think I take all of the blame for aspects of the recommendations, just so you all know. But I will say, at least in my thinking on this point, very much on what Brian said, we are very concerned with site-

neutral sort of incentive issues, consolidation issues around paying differently across the sectors. We have done some separate work, as you know, on that. And so we were calibrating to make sure that the costs of independent practice, roughly, was not deteriorating relative to the cost of being acquired, and that is essentially where we are thinking.

As you know, this issue is going to rise again in much greater force as we move into the June report because this sort of cross-sector harmonization, or lack thereof, has been a big concern. And so that is where we ended up with the half. It is because half of the fee is a practice expense issue, which we were particularly concerned about. The work part of it, which is a totally legitimate issue to discuss and something I wouldn't say we are unconcerned with, but if you look at some of the other measures -- physicians retiring, physicians applying to med school, things like that -- we didn't see a particular concern in both currently and in pipeline measures on the work side, so it was harder to justify moving away from current law just purely on the work portion. Certainly we could have a discussion about that, but that's the rationale for where

we ended up with the half of MEI.

DR. CASALINO: Mike, just to make sure that I'm clear on the first thing you said, and also that listeners are clear, so current law would not update physician payment, either the practice expense part or the professional service part at all. And we are recommending that the practice expense part be increased by half of MEI. And, Mike, what you were saying is that if you are a hospital-employed physician the facility fee part/practice expense part is updated for inflation because it is paid through the LPPS, basically.

DR. CHERNEW: Yeah. So that, in spirit, is correct. We ar4e going to delve, in more detail, about this as we move through to June because there is variation that practice expenses share across different types of services, and therefore across different physicians or specialties. We have not titrated this granularly to that variation, although the potential to do that is a reasonable thing to investigate, and that is sort of going to work outside of our update chapter exercise. So we are trying to do that. What you said, it was correct, sort of on average, but we acknowledge there are a number of

nuances in what we have done that don't make that necessarily true for specific physicians, practices, or specialties.

DR. CASALINO: Got it. But the overarching kind of simple point is that current law would increase practice expenses, in effect, for hospital-employed physicians but not for independent physicians.

DR. CHERNEW: That is correct.

DR. CASALINO: And that is part of the rationale for the half of MEI.

Okay. Second question is --

MR. MASI: Hold on. I am so sorry to interrupt. I can see Brian wanting to get in here. Brian, do you want to add anything on that first point?

MR. O'DONNELL: Yeah. I just want to say that current law is zero percent for everyone in the physician fee schedule. Our half of MEI is a magnitude, but the application of it is across the board. So even though we are titrating the size of the adjustment based on practice expense, it doesn't get differentially applied to different types of clinicians. It is 1.3 percent estimated across the board for all clinicians.

DR. CASALINO: Okay. That's helpful.

The second point is I'm trying to get clear in my mind how the safety net index payment, or let me put it another way, how the extra payments we have recommended and are going to recommend again, perhaps, for physicians, depending on the percentage or number of safety net patients they take care of, if those recommendations were accepted, the 15 percent add-on for caring for an LIS patient, let's say, for primary care and 5 percent for specialists, what percent would that increase the payment rate or the Medicare revenue for primary care physicians, or specialists, or both, compared to current law? Because the obvious thing to do is add that to the 0.5, and if you're looking at it from a physician's point of view that would give us a sense of how much of an increase are we recommending, really, with the two recommendations, compared to current law of zero?

MR. O'DONNELL: Right. So I will break down the answer into primary care clinicians, which include primary care physicians and primary care NPs and PAs, and then everyone else.

So for the primary care clinicians, the projected

increase for MEI, the half of MEI recommendation, is 1.3 percent, and the safety net recommendation equals 4.4 percent. So when you add those two together the total increase for primary care clinicians is about 5.7 percent. Okay? And for non-primary care clinicians, because they receive the lower 5 percent for the safety net, it equates to 1.3 percent, the same as for primary care, plus the 1.2 percent for the safety net, which totals about 2.5 percent.

So in aggregate, because there's a difference in the 15 percent versus 5 percent for the safety net, primary care clinicians will be receiving the equivalent of about 5.7 percent and specialists about 2.5 percent.

DR. CASALINO: So I've been thinking about this, and I hate to take so much time but I think this is pretty fundamental stuff. I think I've been thinking about this wrongly over the last week, and it's because I don't really have the numbers. And it might be helpful to have those both here and even in the chapter.

So we say, I think, in the draft chapter right now that for the average physicians -- and I understand this merges primary care and specialists -- that the income for the safety net payments would be like $1,344, which I

guess the denominator of that should be compared. It's not physician compensation from all payers. It's physician revenue from Medicare, right?

So what would be the average add-on payment for primary care physicians from the safety net payments as the numerator, and what is the average revenue from Medicare for a primary care physician, say -- and we can do the same thing for specialists, obviously, to get at that? I think you are arriving at almost 4 percent. Well, put another way, the extra income for safety net is 4 percent of Medicare revenue for primary care physicians. Those are numbers that I would like to see play out, but maybe you could give them to us now.

MR. O'DONNELL: Yes. We'll talk to you afterwards, but I think we can add some things to the chapter. We modeled it based on 2019 dollars, so I don't want to throw out raw dollars to compare it to the 2022 figures. But you are right, we can put some of that context in there to help you understand what this means in terms of effect on clinicians.

DR. CHERNEW: One other quick answer, and I do want to move us along because we have a long queue, but

it's Medicare fee-for-service, though. There is this issue that Medicare Advantage is also -- typically the rates are the same, so this notion that the number that you gave is Medicare fee-for-service numbers but there is another Medicare component which is Medicare Advantage. And there is an assumption there that the rate will continue to be the same.

DR. CASALINO: So I'm just about done, Mike. So that would be great to actually see those transparently, and I think that would help physicians, physician lobbyists, and me explain to physicians how things really compare currently.

And I will just say one last thing, and you don't have to respond now, but I like your two points about how to measure quality. You might consider adding a point that measuring quality at the individual physician level, like MIPS does, is probably problematic for a variety of reasons. It might be incomplete with that, so you might just think about that.

So I'll be quiet now.

MR. O'DONNELL: I do want to say one more thing, Larry, that we will try to give you as much kind of data as

we can, but some of this are kind of simulated or estimated, so there will be some of those caveats in some of the data. Some of the numbers that I walked you through are simulations based on old data and we applied them forward. So that's just some context there.

MS. KELLEY: Brian.

DR. MILLER: Thank you for doing this chapter. I know it is definitely a labor of love. And I appreciate the effort to make it shorter.

I was a bit confused about the access and wait time measures because I saw that our assessment was that private pay commercial beneficiary, benes age 50 to 64, have the same access as Medicare benes age 65 and up. I guess I'm confused by that, and the reason I'm confused is -- I'm going to make an assumption here -- most of the commercial benes are employed and have jobs, bearing hours, and if the doctor's office says, "I can see you in one week at 10:30 a.m.," you can't take half the day off necessarily. So the commercial private pay measurement of access might be different than, say, the 65 and up category who doesn't have that employment. I mean, there are older Americans who are definitely working part-time and full-

time, so I'm not discounting that. But a large portion of this population is retired, so if you say, "Come at 11 a.m. in a week or two," they say, "Sure."

So if we asked them if their access to care is good, they may perceive that as good, but it may actually end up being quantitatively different. Because of the low payment rates they may get an appointment later, at a less convenient time. So we might not actually be measuring access in a quantifiable way that's comparable across payer markets.

So I guess my question, instead of asking benes if we feel that they have good access, do we have specific metrics for wait time for, say, seeing a primary care physician, seeing a neurosurgeon, because that might give us a more accurate view of access.

MS. BURTON: Yeah, I hear your concern. We can think about whether to switch from subjective to objective questions. It's a really short survey, though, so we don't have a ton of room, but it's definitely something we could think about.

DR. MILLER: Because even changing it to have one subjective question and then two objective questions, one

saying like, "How many days did you have to wait to get a primary care appointment," "If you saw a specialist last year, what type of specialist was that and how many days did you have to wait to get that appointment that worked for you," that might give us a better idea. And it doesn't have to be an exhaustive table of all specialties, because that would be ridiculous to have 69 or 70 specialties. It probably wouldn't even fit on a page.

And then my other question was about salary, and I agree that looking at margins for industries is important. I guess my question about physician salary is recognizing now that half of physicians are employed, and I mean employed by a hospital physician organization or a hospital corporation directly, that salary includes a lot of other non-PFS components of Medicare. And, in fact, that Medicare, for many specialties, might represent 20 to 40 percent of payer mix, 40 percent if we are being aggressive, 20 percent if we are being a little more conservative. And that, of course, if you are employed by a health system, the health system looks at the integrated view of the types of revenue that you bring in. Recognizing then that most physician salary is not

necessarily related to the PFS, do we think that is a good way to measure the adequacy of PFS?

MS. BURTON: Yeah, the whole category, that fourth category of indicators we look at, they are all indirect. They are all kind of imperfect because we just don't have cost report data. We can't calculate profit margins for delivering Medicare services. So we just use a bunch of imperfect measures.

DR. MILLER: Maybe we should consider eliminating the salary measure given that most of it is probably unrelated to PFS.

MR. O'DONNELL: So I do want to note that, you know, I think that Rachel is right, that kind of our best indicators are some of our survey and our claims data. But I do think, in the past, industry groups have suggested that we are not looking long term enough and that we are undermined to long-term supply. Even if the access right now looks good, they said you are kind of undermining the long-term supply with lower payment rates. And they suggested med school applications' income, these types of things, to add some type of qualitative context.

I take your point. I think it's totally spot on.

But I do think we are trying to be responsive and provide a realistic picture her.

DR. MILLER: Oh, I agree, and I think the med school applications is a good sort of long-term, soft measure. I guess on the salary aspect, given that we are not reporting salary for any other clinical, professional, or executive or administrator across the entire health system, it looks like we are singling out physicians when we do that. So we might want to consider eliminating that salary metric, given that most of it does not come from the PFS. Thank you.

MS. KELLEY: Wayne.

DR. RILEY: Thank you, Rachel, Brian and Lydia.

Further to the access issue that we've sort of been circling around, although our survey showed that our beneficiaries are not, by and large, experiencing delays in access, in looking at page 10, there's mention that the Commission has found that among the beneficiaries looking for a new provider, a higher share report problems finding a new primary care provider than a new specialist. Can you tease that out for us a little bit?

MR. BURTON: It's a finding we've found

consistently for the last 20 years. I'm not sure what else to say.

DR. RILEY: But order of magnitude, when you say "share," I'm thinking, is it 25 percent share, 10 percent of the --

MR. BURTON: It's in the paper. I'm sorry. I don't have it memorized.

DR. RILEY: Okay. Got it.

DR. NAVATHE: On this point, can I ask? Are we differentiating primary care physician from primary care clinician there? Is that including NPs and PAs?

MR. BURTON: It's primary care provider, I believe, is what we're asking about in that question, so including NPs and PAs.

DR. NAVATHE: Thanks.

MS. KELLEY: Amol, you're up next.

DR. NAVATHE: Thanks, Brian, Lydia, and Rachel for this great work as usual.

So on Slide 9, where we have the access measures, I was curious if you could comment on the longitudinal trends here, because I think these are the snapshots from the most recent survey that we've done. And I feel like I

recall that there was some issue potentially with the comparisons of longitudinal trends. I was just wondering if you could remind us about that.

MR. BURTON: Sure. So last year, we switched survey vendors and used totally different survey methods. We can compare this year's survey results versus last year, and they're very similar. But if you try to look for earlier than that, so 2021 and earlier, we are using a totally different survey methodology. So it's dicier to try to compare 2022 and 2023 to earlier years.

DR. NAVATHE: Got it. Okay. That's helpful.

It might be worth just adding something about a footnote around that, because to some extent, if we think about the longitudinal trends, that might help, especially if we are worried about MEI-like inflation factors and how that might be affecting access and supply, et cetera, et cetera. The trends help, but in this particular case, obviously, we have some limitations.

Thanks.

MS. KELLEY: Scott.

DR. SARRAN: Wonderful job of pulling together a tremendous amount of data and making the threads quite

clear.

Are we able to parse the ambulatory care-sensitive hospitalization and ER data by subtype of beneficiaries? But I would ideally like to see, recognizing there's some overlap in these categories, are duals versus non-duals, under versus over 65, institutionalized versus all others, and ideally as well by number of multiple chronic diseases.

MS. TABOR: Yes. We did actually in our last June report to the Congress look at ambulatory care-sensitive hospital use for race/ethnicity groups, as well as for LIS and non-LIS populations. And we did find disparities across those.

We haven't looked at these other groups you mentioned, but we can think about that.

DR. SARRAN: That would be very illuminating.

MS. TABOR: Thank you.

MS. KELLEY: Kenny.

MR. KAN: Great chapter. Thank you.

I have a clarifying question. I know you mentioned something about a 5.7 percent increase for PCPs earlier. Assuming that the CMS projection of a 2.6 percent

and you get 50 percent, that that's 1.3 percent. Rough math, is the safety net spend around $2 billion or so, and then you've divided by $90 billion? So that's another 2 points. So are we looking at an all-in sector increase of 3.3 percent? I'm just trying to clarify that.

MR. O'DONNELL: Yeah, and I apologize. I probably created some confusion doing some quick math, but I think you're basically right. I think the one caveat I would say is that some of those the denominators you listed were 2019 dollars -- or 2022 dollars. When you combine the MEI increase with the safety net, you come out to about 3 percent for the entire sector. And the difference is because the difference in denominators.

DR. CHERNEW: Okay. That was the end of Round 1, if I got that right.

So few things, and I imagine this is going to come up going forward. So I appreciate particularly all the questions about access, how we measure it, what it means. It is actually a crucial topic, and it's one that we think about a lot. I think my take is it's a very difficult concept to measure. We certainly could think about other ways of doing it or trying to do it better, but

at least the information that we've historically had and the ways we've looked at it -- and I think both the focus groups and the surveys, our survey and the MCBS and a whole bunch of others and the total volume measures is such that first-order assessment is probably best suggested that we don't see a clear deterioration in access. And if anything, my read of the data that was in the chapter is it's probably mildly better than it might have been in the past.

That's not said with great confidence in the trend or the measure or the direction, but I think we do spend a lot of time thinking about and trying to measure access. And I do appreciate the comments around that point there. They're well taken.

But we should start. We have a robust Round 2 queue. So please be judicious in your comments. We do want to hear from everybody, and I think this is going to start with Jonathan. Is that right? Jonathan.

DR. JAFFERY: Thanks, Mike, and thanks to you all. This is a great chapter, and I'm really excited about this direction we've taken the last couple years to take into account more than what maybe what we have in the past

about the physician cost of practice, running a practice.

So a few quick things. So first, very specific, on page 4 of the chapter, there's a paragraph in the middle about in '22, what the total spending on clinician services by the Medicare program and benes was and how that's gone down. And I originally had a clarifying question, but I think, Brian, you clarified it for me that that's exclusive of MA. I think maybe we could clarify that in the chapter because I was confused when I read it.

There's been some discussion of -- and actually, Mike, you said this a little bit ago -- typically rates are the same as Medicare fee-for-service and MA, and I think we're seeing that change, at least in some sectors. And I think this is important for us to think about because a lot of this, I think it's a leverage issue.

As MA plans and insurance companies have consolidated and grown larger and larger and as MA has become now half of payments, there's an issue there. And this may, in fact, be driving some of the health care sector consolidation that we talk about a lot as an issue. So I just think we need to think about that in the balance whenever we talk about health care consolidation and

recognize that it's not just the providers. There's also the payers. So when we think about that in the context of these chapters or -- I don't know. If you're writing a New York Times op-ed, think about that.

Related to that, there's lots of discussion in the chapter, and several times this morning, we've already heard about hospitals acquiring physician practices, and yes, this has been a trend. Yes, this has a whole bunch of different ramifications on all sorts of things, but there's not really any mention about where other areas of physician employment have gone.

And in fact, hospitals are not the largest employer of physicians. We're seeing a lot in the payer side and in private equity. Private equity is a huge area, and they're not taking multispecialty practices whole cloth. So it creates a whole bunch of other issues.

I think we talked about this before here. Optum is the largest employer of physicians, and they had an earnings call a couple weeks ago. I don't know what the numbers were, but they've gone up. It was 70,000. It's gone up, I think.

And so the last thing, this sort of builds on, I

think, Wayne's question around the summary around beneficiary access to new providers and primary care versus specialists. And I know we've talked about this for many years. I've seen it for a lot of years, but I have some real concerns about how we interpret that data and what it means for recommendations and policymaker decisions.

So that the section kind of headline is, quote, "Beneficiaries report more problems finding a new primary care provider than a new specialist." I don't know that the data that you then present actually bears that out. So 12 percent of Medicare beneficiaries reported looking for a new primary care provider, and then 23 percent of those had a big problem. That's 7 percent. You laid that out very clearly.

About a third of beneficiaries report looking for a new specialist, and 13 percent of those reported big problems. So that's 11 percent of beneficiaries.

While an individual beneficiary who's looking for a new doctor has more trouble finding a primary care doc than a specialist, in aggregate, it seems to me the data suggests that the problem is not enough specialists, that the access to specialist care is actually a bigger problem.

Now, they're both problems, and so I don't want to lose sight of that, but I think the conclusion that beneficiaries report more problems finding a new PCP than a specialist is misleading here.

Finally I think this has huge policy ramifications. Policymakers, including sometimes MedPAC, we talk about shifting the workforce from specialty to primary care, and I think that's a big issue if we have shortages in both areas.

So again, thanks for a great chapter and look forward to the rest of the conversation.

MS. KELLEY: Gregory.

MR. POULSEN: Thank you. I'd also add my compliments in terms of a terrific chapter.

I would like to focus actually to one, plus on what Jonathan said, and that was going to be a lot of what I was going to talk about as well, because I think that we are all legitimately and reasonably concerned about some of the consolidation. And I'd like to identify that what we're talking about here -- and this is going to apply to some of our other topics as well, but I thought this would be a good place to bring it up.

There's a quote in the chapter. This is compensation survey data suggests that providers are increasingly consolidating into large, complex organizations. And then here's the part that I'm worried about, "to improve their ability to negotiate higher payments with private insurers." And I think that demonstrably that's becoming a less important reason why they're doing that. They're doing it for a lot of reasons, and that may be one of them and in some cases is.

But I think that if we look at that, we need to identify that there are other reasons why that's taking place, that in most cases are more important than that negotiating leverage perspective.

And just to throw out a few, regulatory requirements are crushing private surveys that I've been part of, show that the majority of small practitioners believe themselves to be out of compliance with key requirements, and that the only thing that gives them comfort is that everybody else is out of compliance too, but that they're in very short grass in terms of potentially ending up with major penalties.

Second, resources to deal with. We talked about

this earlier. Utilization management, denials, and the prior authorization games that are incredibly difficult for all organizations but crushing for small unsophisticated practices. They don't have the resources to deal with huge denials. It just isn't there.

The tools to optimize coding are also a big deal. That's really, really a scalable capability, which is not present in many small organizations.

Electronic medical records and other tools are hard to implement without large organizational resources and capabilities. These are increasingly critical to both clinical and financial success of practices.

Telehealth, both ingoing and outgoing telehealth, is a scalable resource that's difficult to do in a small practice.

Looking at all of the quality payments that are being provided and expected and all the quality measurements, simply providing high quality is insufficient. You have to demonstrate that you're providing high quality, and that's a resource-intensive service.

Actuarial skills are increasingly valued in the

current world, and in the future world, they'll be even more important. That's not something that's easy to scale either or to buy on the open market in today's world.

I think that all of these are much bigger than the leverage needed for simply negotiating, and I think that that's the reason that we're seeing over the last few years. We mentioned also -- and I nitpick a little bit talking about hospitals, and Jonathan made this point so well. But over the last three years, the majority of consolidation has not been into hospital systems. It's been into PE. It's been into Optum. It's been into insurance organizations of various types.

So I'm not doing that because I want to nitpick on a paragraph, but rather because I think that if we are concerned -- and we should be -- with consolidation, we need to understand what the underlying causes are and, therefore, what the potential solutions are also, what it is that we're hoping to gain from this. And I think the answer is we'd like to have efficient practices that are able to meet the needs of our Medicare beneficiaries. And that's different, depending on how and where the consolidation takes place as well.

So thank you very much.

MR. BURTON: Sure. I just wanted to mention that we were citing an AMA survey for that finding, but they mentioned some of the stuff that you just mentioned also. So we can add some additional stats from that survey and that paragraph.

MS. KELLEY: Gina.

MS. UPCHURCH: Thank you.

My comments all have to do with page 13, and the things that I'm thinking about, we define individuals with low-income subsidy as a proxy for people with limited incomes. I would just say, add the word "assets." So to be eligible for the low-income subsidy, a lot of people have plenty low income, but they're not eligible because of their assets. If we could just clarify that first.

Second thing, I'm going to just read something briefly. It says the Commission contends that Medicare should provide additional financial support to clinicians who care for low-income beneficiaries. Absolutely agree with that. But the reasons may be a little different than what we say here, because treating those beneficiaries can generate less revenue, even though the cost required to

treat them is about the same.

Revenue for treating LIS population is lower than non-LIS population because clinicians are prohibited from collecting cost sharing amounts, either the annual B deductible or 20 percent coinsurance for most beneficiaries who are dually enrolled in Medicaid and Medicare, and most states do not pay that cost sharing on behalf of beneficiaries.

When I think about this and why we need to support providers that help people with limited incomes, it's not because there's lower revenue, because I don't quite understand those comments -- and it's not my experience -- it's because it's more expensive, potentially, to provide that care. For example, does somebody need transportation assistance to get there? Do they need interpretation services? Are there more no-shows? I don't know that there are, but I would argue that there might be added expenditures from providers trying to help individuals with more limited incomes and asset.

This may be true. It's just not my experience in helping people, because if somebody has -- and there are different levels, obviously. If somebody has full Medicaid

or even MQB, MQB-Q, it pays the cost sharing for B, as far as I know, and the 20 percent. So I'm not sure what that's about.

Now, people that have MQB-E, they just get their Medicare Part B premium paid for them. People with low-income subsidy, they just get help with Part D, unless they have a Medicare savings program. And providers can still come after the 20 percent. They can come after the allowable amounts.

I just don't know. Either I'm missing something or this paragraph maybe in certain states it's true, but as far as I know, people that have Medicaid as a wraparound to Medicare, they are getting paid that 20 percent. I may be wrong.

MR. O'DONNELL: Yes. We can talk offline.

In some states, they are collecting that coinsurance. I think the hitch is in states that set their rates at 80 percent or lower of Medicare payment rates, the Medicaid program considers the 80 percent Medicare payment as payment in full. And we cited some urban research that looked across the country on this, and I actually don't know where North Carolina is, but we can talk more offline.

MS. UPCHURCH: Thank you. That would be good. I just wasn't aware of that. So it sounds like a state issue, and maybe understanding how many states, that's an issue, because that's a tremendous problem if it's a lot of states.

Thanks.

MS. KELLEY: Cheryl.

DR. DAMBERG: Jonathan was distracting me.

I want to plus-one on what Greg said about consolidation and adding bit more information to what is a terrific chapter, so I really appreciate all the work that you have done in this space.

I know Mike mentioned sort of a lot of interest in our measures of access and how that relates to. And I just want to plug that I think we can dig a big deeper in the access space. Some of it may be, per Brian's comments, trying to better understand wait times, because I do observe that the system is slowing down on access. And what I'm not totally clear on is how much that is a function of payment versus a workforce issue. And obviously the two are interconnected, but I think we have seen a lot of losses of physicians, not just due to

retirement but coming off of COVID. So maybe trying to unpack that a bit more would be helpful.

And I think also trying to unpack the access issue for the disabled population of Medicare beneficiaries. And here I'm trying to, once again, disentangle how much of this is related to payment of physicians and that's driving more challenges with access, versus there are other issues that these beneficiaries have, whether it's financial problems that are really sort of driving the access problem.

And then the other thing where I thought the chapter could use a bit more discussion, and you actually covered it in the slide deck, is where you talk about the increase in volume and intensity but not tying it a little more closely to, you know, this is a way of making up for depressed payment rates.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. I have to pile on my appreciation for the chapter and really support my colleagues' comments around access consolidation, and a plus-one on Stacie's appreciation of the footnotes.

So I will limit my three comments to things that

I don't think have been said yet. I really appreciate that this chapter really clearly elucidated the contribution of nurse practitioners and PAs more than I have seen in the past. I mean, that's moved along in the four years I've been serving here. But I appreciate that because that is a reality of the workforce.

You mentioned two limitations to measuring quality, and Larry suggested a third, which is a difficulty at the individual level. I would add a fourth, and that's incident to billing. If you don't know who is doing it, how do you know not only what it costs but the outcomes? And that recommendation, I know, came before I was on the Commission. This is my fourth year. So I think we really have to underscore that. It see it as not only an economic issue but an ethical one. Who benefits from an incident to billing? Not the beneficiary. Not the taxpayer. Not the nurse practitioner or PA. And that is part of the reason, respectfully Brian, I would like to see the salaries in there of the different providers, including the specialists, because it certainly doesn't say everything but it says something. So I would really like us to really push that.

We received a very thoughtful letter from the AANP, and I just to pull out two things that I wasn't aware of, and I'm sort of embarrassed that I didn't know these things. I didn't understand that even with the Medicare Shared Savings Program update that there is still an entry barrier for nurse practitioners and PAs to be the attributed provider. And I don't know if that's in our lane, but they are held accountable for the costs and the outcomes of their work in that model, and so why do we want to have additional barriers to people accessing primary care? So if that's in our lane I think that should be underscored.

And the other thing I didn't know is that nurse practitioners and PAs and health professionals who are in these areas do not receive the 10 percent bonus, meaning that they are receiving 25 percent less than a physician working in that area. And so if we think about low volumes there to begin with, and often the complex not only medical needs but social needs, in my view that should be at the full amount, not the 15 percent reduction, and certainly including the bonus to incentivize people to work in these places, because of the data that suggests that they are

more likely to work there.

In terms of the other 15 percent differential, I am not sure because I feel more comfortable with it on the specialist side, nurse practitioners and PAs working with specialists, than in primary care. But maybe that would be a conversation for another time. So the extent that we could incentivize people who want to work in primary care, go to school to become primary care providers, to actually work in primary care, perhaps that 15 percent should be looked at for primary care.

That said, thank you. Thank you very much.

MS. KELLEY: Brian.

DR. MILLER: Plus one to Jonathan on access for specialty care. I think that -- and I disagree with the Chair -- I think that there is an access issue if 11 percent of beneficiaries cannot get access to specialty care. If you need to see a cardiologist, electrophysiologist, allergist, orthopedist, you know, that's a significant issue because that could imply you have a surgical issue, a procedural issue, significant morbidity that has yet to be discovered, which could vastly impact your functional status. If you have undiagnosed or

potentially diagnosed cancer and you are waiting extra long to see an oncologist or start radiation therapy or get access to chemotherapy, or have a brain tumor removed, all of these things are real and significant. So I would say that that number is actually really concerning if you think about it from the beneficiary perspective.

I strongly disagree on the salary. I think including salaries when most of that does not come from the Medicare program or the physician fee schedule could be perceived, as was said, singling out physicians. If we are going to do that, we should include that for all medical professionals and staff across all chapters, which is not realistic, so I don't think we should include it.

I do think that there is a big equity issue in terms of the differential between nurse practitioners and physicians. I think we should, in the fee schedule, which the American Association of Nurse Practitioners sent that excellent letter noting the 15 percent decrement, so I would suggest that we emphasize that as a problem that should be addressed and solved as opposed to using salaries to paint one profession or another in a certain light.

I also had the same interest in the access

section for low-income beneficiaries that Gina did. I probably read it five times, including several times against last night, which is why I still have terribly scrawled, handwritten notes here instead of my usual typed ones.

And it's really interesting. I think we should note that part of the problem is that there is no out-of-pocket maximum for the Medicare fee-for-service program. You know, that is up to Congress if they are going to address that, but that is because the Medicare fee-for-service program has insurance designed from 1965, before I was born, and that the Medicare Advantage program, with all of its warts, actually has an out-of-pocket maximum, so many of those low-income beneficiaries are being pushed into MA -- it's good and it's bad -- including the dual eligibles, and I know we have spent a lot of time on D-SNPs so we should probably mention that as one of the solutions that is either intentionally or unintentionally happening.

I saw that also there was a mention of physician consolidation into large practices. I don't think that is the right description. I think the description is hospital physician consolidation. There are around 60 to 70

hospital and ambulatory mergers per year, per the FTC data, and I remember, I think it was Marty Gaynor's testimony or a Health Affairs paper from 2016 or 2017, that included the number of 1,412 mergers from 1998 to 2015. And then multiple people have expressed concerns about private equity. It's fine to have concerns about private equity -- we should have questions -- but employing 4.3 or 4.5 percent of physicians -- I was looking at that same survey that you were -- we should include that number. That suggests that is not the driving factor for consolidation in care delivery.

The other thing I wanted to note, which we should probably include, is we should look at, rather than looking at these chapters as individual islands, they are all interrelated, as many other Commissioners have noted, and we should start to take a more integrated approach. If we think about it, for example, the FTC chair, Lina Khan today -- and I realize there are probably a variety of views about the FTC around the table -- has done an excellent job in that they are appointing a Counsel for Health Care. So that might be someone we want to talk with as we look at the competitive impacts of our recommendations for payment

policies. I know that my colleague, Larry Casalino, has long been a promoter of having a competition policy lens to Medicare payment policy and Medicare program policy. So I think that we should include competition impacts in each of these chapters.

Thank you.

MS. KELLEY: Tamara.

DR. KONETZKA: Thanks. I have just three quick points. One, I know we talked a lot about access and the access measures, and I will say despite the limitations of how one can best ask those questions, I am willing to buy into the fact that, on average, access is okay to me. The most interesting part is in the heterogeneity.

So I was really pleased to see in the chapter -- you know, it wasn't in the slides much -- but I was really pleased to see in the chapter that for both quality and access you sort of divided out those numbers by not only low income by also race, ethnicity, and urban/rural. And not surprisingly, all the access measures looked pretty much worse for low income, for minoritized groups, and for rural beneficiaries.

And this goes back to the way we measure it. I

know there are some challenges in trying to get more objective measures, but to me that is well worth trying to do, the next time we do this survey, in part because I think otherwise it really sort of entrenches the subjective differences by group. So if you are low income, you are used to being on Medicaid, or you're in a minoritized group in a low-income neighborhood, you might just have different expectations. And I don't think we can sort of fairly compare people across all of these groups unless we get at least some more objectives measures. So to me that's maybe difficult but well worth trying in the future.

Second point, the ambulatory care-sensitive hospitalizations, it makes total sense to me that you use that given lack of sort of other physician-level measures. There are well known issues with ambulatory care-sensitive hospitalizations. We know that that is just sort of a blunt category. And so my suggestion would be to also look at all hospitalizations, in case we get those categories very wrong, and that would also give us more of a clue whether, when we look at the heterogeneity, if this is just a sort of sicker population that has also more emergency hospitalizations, or all kinds of hospitalizations versus

those that might be more ambulatory care-sensitive, with caveats. But I think that would be an interesting comparison to do, and I think it's always good to look at all hospitalizations as well as these sort of avoidable measures.

And third point, I just wanted to plus-one on what Cheryl said about the volume and intensity growth. I know it is a very complicated relationship that economists have been studying for decades, between sort of payment rates and sort of the supplier-induced demand and how physicians respond to different payment rates. So we may not be able to establish that rigorously, but I think it's worth unpacking that a little bit more in the chapter and talking about that relationship because, you know, it sort of may be endogenous to the payment rates that we recommend. Thanks.

MS. KELLEY: Larry.

DR. CASALINO: So I can be pretty quick. You know, to be very candid, I have had difficulty accepting the recommendation of half of MEI, if that's all we did. So the comparison to current law and the potential addition to the payment rate from the safety net index I'm just

calling it, for shorthand, is really important, I think. So as I said before, I think making the math on that really clear in the chapter is critical, because the recommendations might look much better if those numbers are as good as, Brian, the numbers you were talking about before.

Second point, we focus a lot on access, and it's correct to do that, although there has been a lot of discussion today about the problems with measuring access. But I'd like to say a little bit about access versus quality. So it could be that what Congress does about Medicare payment for physicians doesn't affect access that much, but it could affect quality. And we know that we don't measure quality very well. Almost all the work that physicians do that could contribute to quality, for example, diagnosis, accurate and timely diagnosis, is not measured. So I think it's risky to do things that might affect physician morale, because I think it is plausible, just common sense, that although given the situation, payment rates that don't seem very good might not affect access very much, but they might affect moral a lot, and through that might affect quality. Now we can't measure

morale -- well, we could make some attempts to do that.

So I think the problems with morale -- and I'm almost done -- would be that it's pretty clear that in every other sector Congress factors inflation into account when considering payment updates, but not for physicians, and that's pretty glaring. We can't calculate margins for physicians like we can in other sectors, Medicare margins, but in the absence of the ability to calculate margins it would seem, at face value, that one might reasonably expect payments to keep up with inflation, and that's why I think the half of MEI alone is a problem.

And then in terms of consolidation, several people have mentioned that, I think if the practice expense part gets inflated for inflation, for hospital-employed physicians, whereas it's not going up for other physicians, for better or for worse that will lead to, as an unintended consequence, to more employment of physicians by hospitals.

And then the last point I would make -- and again, this is a morale point -- I think the unpredictability of year-to-year changes in what physicians are going to get paid and how they are going to get paid for their services by Medicare, I think it's more damaging

to morale than many people in this room might realize. It really causes cynicism and bitterness among physicians because they take this personally. It's not like our recommendation for the hospital sector where the CEO doesn't think, "Aha, they are really going after me." Physicians are the sector where it's personal. So I think the combination of unpredictability and MIPS, which is kind of patently not very good, I think really contributes to decreased moral and cynicism.

So more broadly, this is not for the update chapter, but I'll just finish by saying I think more broadly we need to work on helping to create a way of paying physicians that has face value and makes sense and that is predictable. And I think that would do a lot for morale, almost as much as whether physicians get another half a percent or more than if physicians get a percentage more or less on their payment rate, and Greg addressed that as well.

MS. KELLEY: Scott.

DR. SARRAN: Yeah, I'm enthusiastically supportive of the safety net clinician. While respecting and agreeing with Larry's points, I'm only guardedly

supportive of the 50 percent MEI component, and here is the reason. The question, I think, in my mind -- and I think we should express some concerns as a Commission about -- is whether we are getting, whether we have gotten a commensurate increase in value from the continued year-over-year increase in spend per beneficiary. And I use the following three datapoints in your materials to help me reach that or help reinforce that conclusion.

The first is, as you've noted, volume and intensity go up year over year. So even though fee schedule has not kept up, or conversion factor is not kept up, there has been continued growth in volume and intensity driving the increased spend per beneficiary. So we are spending more per beneficiary.

The second point is the noted high variability in the ambulatory care-sensitive hospitalization, ER visits, and by the way, I strongly agree, Tamara, with your point that we should look side-by-side at those and total hospitalizations. I think they run in parallel but would be sort of bilaterally informative.

But that suggests, that high variability in one of the key markers of value, which is keeping beneficiaries

out of needlessly being hospitalized, is one of the best -- again, recognizing there are some challenges in the metrics, but that's a lot of what we expect from our spend. So we know there's a lot of room for improvement in that, as demonstrated by the high variability. Why aren't we all clustered across all geographies towards the superb end of that spectrum? And again, we do need, I believe, to parse that data by beneficiary subtypes because I think we will see significant issues among certain beneficiaries.

Then the third piece of data is the fact that we are seeing decreased PCP volumes and markedly increased NP and PA volumes, and when I put that next to the poor overall, or highly variable performance on ambulatory care-sensitive hospitalizations, I can't help but conclude that we are not, or the provider sector is not efficiently deploying the combined PCP and NP/PA resources to create teams that help manage the care of beneficiaries with multiple chronic diseases, which is the key population that has avoidable hospitalizations. So we are paying more money to more clinicians who are not doing what we want them to do with that money.

And again, that's why I can only be, at best,

guardedly supportive of the MEI piece. I could be more supportive of it if we include our chapter some expressed concerns. I think it's possible to take everything I just said and say it more cogently and pointedly. But I think those concerns have to be there, that we are spending more money and not getting all the value we'd like to see from that.

MS. KELLEY: Robert.

DR. CHERRY: Yes. Thank you, and thank you for the great work on the chapter. It's a heavy lift and not easy pulling data on physician practices, given the limitations.

The bottom line is I'm generally supportive. I think we're going in the right direction here in terms of the recommendation. Nevertheless, I do have some comments.

First of all, the projected clinician costs for 2025 is expected to go up by 2.6 percent, and over the intermediate to long term, it's unlikely that the payment model that's moving forward beyond 2025 will keep up with the costs. I mean, I think over the long term that the gap is going to increase, where there's going to be increased pressure on clinician costs versus the revenue that's

coming in. And that could have an impact on access and quality of care.

So I think we're moving in the right direction and in a sense that we're looking at the MEBI and we're saying 50 percent of that is probably what we can do to help compensate for the difference, but it does feel like both a science and an art to try to get to that number.

If we could develop some sort of more objective indexing methodology based on clinician costs, that won't be for this go-around, but for next year, if we can do that, I think that would be quite helpful. So this way, we could have a validated measure that says that based on inflation, this is how we should index the payment adjustments moving forward.

Not to be a broken record, but last year certainly was a broken record with every payment update session that came along. But I definitely support a primary recommendation based on our charge by Congress to have a single payment, and then a secondary recommendation, if possible, based on performance or something else that's intrinsically of value. So I do like the way this is constructed is that we have a primary recommendation.

Our secondary recommendation is an additional payment adjustment based on participation and low-income Medicare beneficiary. So it could be that metric. It could be the SNI model or other types of performance metrics. But I think, increasingly, throughout the payment updates, whenever possible, I think we should introduce secondary recommendations.

That also brings up the whole issue of performance metrics, particularly for physicians, and it's really challenging. I agree with the comments that have been made. We have a blended payment model, and a myriad of choices that physicians can select from. And it's very difficult to make comparisons. So streamlining this as best as possible and having some sort of single value-based process to compare an individual physician with their own specialty is ideal. So certainly moving forward towards eliminating MIPS, which this body has recommended in the past, and eliminating the annual participation, it starts to streamline the process a bit but doesn't get there completely.

I realize that there is challenges to comparing an individual physician's practice, even within their own

specialty, because there's a lot of nuance to individual physician's practices. But for those that can't fit into a standard model for metrics, this is where perhaps those physicians should report out their clinician costs, because that could be an alternative metric if they can't actually sign on to bona fide metrics.

Now, the problem with doing that is that you have employed positions and you have independent practitioners, and you probably need two different models for cost reporting comparison, based on that. So I'm just talking about future state, because we'll never get to the issue around what is the quality of care being delivered until we actually start to streamline and think about a future process over the long term.

Otherwise, I think great job on the chapter, directionally correct, and looking forward to further comments by the Commissioners. Thank you.

DR. CHERNEW: Okay. We're at time, but I think Brian and Betty wanted to say something. So, Brian, why don't you go first and then Betty.

DR. MILLER: I think Betty was before me.

DR. CHERNEW: Okay.

DR. RAMBUR: I rang the bell actually on Scott's comments. I just want to underscore my support for anything that we have that clarifies that we have to really incentivize team-based care.

I think it was Scott that sent me an article that was RNs, not nurse practitioners, and pharmacists who had excellent outcomes with complex patients, people with diabetes. It's very hard whether you're a nurse practitioner, a PA, a physician. You're thrown in this blender of episodic fee-for-service care. So the payment model shapes that, so anything we can do that talks about teams.

And other studies have found that regardless of physician, nurse practitioner, the outcomes are always better in teams -- or I shouldn't say always, but there is a lot of evidence of teams. So I just want to underscore my support for that.

Thanks for letting me speak.

DR. MILLER: I also want to underscore my support for team-based care and think it's important that we not use incident-to billing as a way to enforce team-based care for NPs, PAs, and physicians. So I think currently our

payment policy methodology does that, and that's why we probably have terrible team-based care, because we have a payment differential that forces it.

Instead, it should be voluntary and constructed, and so I think part of that -- and I can't believe I'm saying this in 2023 -- is equal pay for equal work, I think is sort of something that we should put in, in terms of our fee schedule update, and think about that 15 percent differential, also noting that the majority of nurse practitioners are also women. So we are perpetuating an earning disparity by doing this -- or continuing the policy of the 15 percent differentials. So we should think about readdressing it.

DR. CHERNEW: Okay. That brings us to the end of this session. So first, for those folks at home, we really do want to hear your comments. So please reach out to us. You can get us at meetingcomments@medpac.gov, or reach out in some other venue. I know many stakeholders do. So we appreciate all of that feedback. So that's the first thing.

Second, I want to thank the staff for really exceptional work. You do it so well, it's not clear, I

think, to everybody how much data and analysis goes in and how many different sources you look at. And I want to emphasize the triangulation of what goes on to where we get to.

I very much hear the comments around the table about concerns about measurement. I share concerns about access and measurement of access. I share concerns about a consolidation. I share -- for those listening, we are planning more work on this issue that has come up repeatedly about the lack of an inflation adjuster in the fee schedule.

I will note that it is not the case that whatever starting point you start at, that was the right place, and we should have inflation adjusted from there. But that doesn't mean that I disagree with Robert's point, which is long run, it seems implausible that we're going to have flat nominal, reasonably flat nominal physician fees, and that there is some merit to having a trajectory that seems a little more reasonable. That is a bigger question than an update chapter question, and so we will take it in the standard manner in which we deal with bigger questions and put that in the work that we do going forward. I know the

physician team is doing that.

So that's where we are on the PFS update, and we're going to now take a break, and we'll be back to talk about other sectors, starting with hospitals, right after lunch. And that is going to be at 1:30.

So again, thank you all, and we'll see you back in about a little more than an hour. Thanks.

[Whereupon, at 12:22 p.m., the meeting was recessed, to reconvene at 1:30 p.m. this same day.]

AFTERNOON SESSION

[1:32 p.m.]

DR. CHERNEW: Welcome back to our afternoon session on the update meeting.

As is our norm, we're going to move to another sector. We discussed physicians this morning and other clinicians, and today we are going to talk about -- now we're going to talk about hospitals.

So I think I'm turning it over to you, Allison.

MS. BINKOWSKI: Thank you, Mike, and 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.

In addition to the staff listed on the slide, I'd like to thank Jamila Torain, Stuart Hammond, Corinna Kline, and Pamina Mejia for their assistance.

In today's presentation, we'll cover six topics. First, we'll provide an overview of general acute care hospital use and spending under fee-for-service Medicare. Then, to assess the adequacy, fee-for-service Medicare inpatient and outpatient payments to hospitals, we'll

summarize results from four categories of payment adequacy indicators: beneficiaries' access to hospital care, the quality of hospital care, hospital's access to capital, and the relationship between Medicare payments and hospital costs. Finally, we'll conclude with the Chair's draft recommendation on how to update fee-for-service Medicare inpatient and outpatient hospital payment rates in 2025.

To start with some context, to pay general acute care hospitals for the facility share of providing services, fee-for-service Medicare generally sets prospective payment rates under the inpatient prospective payment systems and the outpatient prospective payment system.

In 2022, over 3,000 hospitals were paid under these payment systems. These hospitals provided $6.6 million inpatient stays to fee-for-service Medicare beneficiaries and the Medicare program and its beneficiaries paid $103.9 billion for these inpatient stays, as well as an additional $7.1 billion in uncompensated care payments.

General acute care hospitals paid under the OPPS provided $127.4 million hospital outpatient services to

Medicare beneficiaries, with $49.7 billion for outpatient services, an additional $19.1 billion for separately payable drugs. Together, these IPPS and OPPS payments totaled about $180 billion.

Each year, MedPAC assesses the adequacy of fee-for-service Medicare payments by looking at four categories of payment adequacy indicators: beneficiary's access to care, the quality of that care, provider's access to capital, and the relationship between fee-for-service Medicare payments and providers' costs.

The goal of this exercise is to determine what update to fee-for-service Medicare payments would achieve access to high-quality care for beneficiaries and good value for taxpayers.

The specific set of indicators used to assess the adequacy of Medicare inpatient and hospital outpatient payments are enumerated in this slide.

For each set of indicators, we start with the most recent available and complete data, which for this year is generally fiscal year 2022, and include preliminary data for 2023, when possible.

We also project a fee-for-service Medicare margin

for the upcoming fiscal year, fiscal year 2024, using current law and other expected changes. Based on these indicators, the Chair develops a draft update recommendation for IPPS and OPPS base payment rates in 2025.

Our first category of hospital payment advocacy indicators is beneficiaries' access to hospital care. We found that hospital capacity remained adequate in 2022 in aggregate but varied across hospitals.

Specifically, general acute care hospitals' inpatient beds remain steady at about 650,000. Hospitals have available capacity in aggregate, with 67 percent of all general ACH beds occupied in 2022. However, some hospitals had much higher or lower occupancy rates, and hospital employment rebounded to above pre-pandemic levels, though some hospitals continued to report staffing shortages.

Another indicator of beneficiaries' access to hospital care is the supply of general acute care hospitals. As shown in the figure, the supply was relatively steady in 2021 and 2022, thanks in part to federal coronavirus relief funds. However, the supply

declined slightly in 2023, as 18 hospitals closed and 11 opened. In addition, 17 hospitals converted to the new rural emergency hospital designation, which we discussed in November.

Of the 18 hospitals that closed in 2023, many cited low patient volume as a driver of the closure. All but two of these hospitals that closed or within 25 miles of the next nearest hospital, suggesting that most beneficiaries served by those facilities continue to have reasonable access to inpatient and emergency services in their region, but some faced longer travel times.

Another indicator of beneficiaries' access to hospital care is fee-for-service Medicare beneficiaries' inpatient stays per capita.

As shown in the top figure, the number of inpatient stays per thousand Medicare beneficiaries continued its pre-pandemic decline. However, there continued to be significant variation by type of inpatient stay.

For example, as shown in the bottom figure, joint replacements rapidly declined since 2018, as both hip and knee replacements were removed from Medicare's inpatient-

only list and subsequently shifted from inpatient to outpatient settings, such as ambulatory surgical centers. In contrast, stays for respiratory infections, such as COVID-19, increased substantially with the pandemic and then began to decline in 2022.

A similar indicator of beneficiaries' access to hospital care is hospital outpatient services per capita. As shown in the top figure, the number of hospital outpatient services per Medicare beneficiary declined substantially in 2020 and then largely rebounded. However, this rebound varied by type of service.

For example, as shown in the bottom figure, emergency department visits remained below the level in 2019. In contrast, COVID-19 care, such as vaccines and tests, peaked in 2021 and then fell in 2022.

Excluding COVID-19 care, the overall number of hospital outpatient services per Medicare beneficiary increased slightly from 2021 to 2022.

Our final indicator of beneficiaries' access to hospital services is whether hospitals with available capacity continue to have a financial incentive to serve fee-for-service Medicare beneficiaries; that is, whether

fee-for-service Medicare payments exceed hospitals' marginal costs of providing those services.

We found hospitals continued to have an incentive to serve Medicare beneficiaries, as evidenced by a 5 percent aggregate marginal profit on IPPS and OPPS services. As with other metrics, this fee-for-service Medicare marginal profit varied across hospitals, including higher at for-profit than nonprofit hospitals and higher at rural than urban hospitals.

Our second category of hospital payment adequacy indicators are those related to the quality of hospital care. In 2022, these hospital quality indicators were mixed relative to pre-pandemic levels. Specifically, after peaking during the pandemic, fee-for-service Medicare beneficiaries' risk-adjusted mortality rate decreased to 8.1 percent, the same level as in 2019. And Medicare beneficiaries' risk-adjusted readmission rate decreased to 14.7 percent, below the level in 2019. However, most patient experience results declined relative to 2019. More details are in your mailing materials.

Our third category of hospital payment adequacy indicators is hospital's access to capital. The primary

way hospitals access capital is through operating profits.

As shown in the orange solid line in the figure, from 2021 to 2022, IPPS hospitals' aggregate all-payer operating margin fell from a record high of 8.8 percent when including federal coronavirus relief funds to 2.7 percent, the lowest level since 2008. This decline was driven by an about 8 percent growth in operating costs, including growth of more than 6 percent in hospital salary per employee.

As in prior years, there was considerable variation around this aggregate margin as shown in the gray band in the figure. While there was variation within each group of hospitals, in 2022, for-profit hospitals' aggregate all-payer operating margin was 12.7 percent when including relief funds, above its level in 2019, while nonprofit hospitals margin was 1.2 percent, below its level in 2019. The aggregate all-payer margin at both urban and rural hospitals fell to below 2019 levels, with metropolitan hospitals' margin remaining higher than rural hospitals.

While we only have complete cost report data through fiscal year 2022, we can gain insight into

hospitals' 2023 all-payer margin by looking at financial statements from large hospital systems and projections from rating agencies. These preliminary data suggest that hospitals' all-payer margin will remain strained but improved.

We analyzed the latest 2023 financial statements from six large hospital systems, three for-profit and three nonprofits. In aggregate across the entire year, this data suggests the hospitals all-payor operating margin remained positive in 2023 but was slightly lower than in 2022. However, looking at only the most recent quarter of 2023 data relative to the prior year, the data suggests that hospitals all-payer margin improved, driven by nonprofit hospitals, which cited improvements in patient volume and declines in contract labor and supply costs. Consistent with this, rating agencies also project that nonprofit hospitals all-payer margin will gradually improve in 2024.

A second way hospitals can access capital is through issuing bonds. As shown in the figure, in fiscal year 2022 and 2023, hospitals' borrowing costs increased, as shown by the orange line, but by less than the general market, as shown by the dotted black line. The smaller gap

between these lines, referred to as a risk premium, suggests that demand for hospital bonds remains strong.

Looking even more recently, since the end of fiscal year 2023, both hospitals and treasury bond yields have started to fall, leading to lower borrowing costs.

I will now pass the microphone to Betty for the rest of the presentation. Thanks.

DR. FOUT: Our fourth and final category of payment adequacy indicators are how Medicare payments compared to hospitals' costs.

As shown in the solid orange line, from 2021 to 2022, IPPS hospitals' overall fee-for-service Medicare margin decline from negative 6.1 percent to a record low of negative 11.6 percent, or negative 12.7 percent as shown with the dotted line when excluding federal coronavirus relief funds. There was considerable variation in this margin across hospitals, as demonstrated by the gray band in the chart.

This decline was driven by higher than expected inflation. When setting payment rates in the summer of 2021 for fiscal year 2022, CMS projected that hospitals' input costs would grow by 2.7 percent in 2022. However,

the hospitals' market basket grew by 5.7 percent, an underestimate of 3 percentage points. Other factors that contributed to the decline in hospitals' Medicare margins included a $1.2 billion decline in uncompensated care payments and the reinstatement of sequestration.

One offsetting factor that led to higher Medicare payments for some hospitals was the start of higher payments for 340B drugs in 2022. This is discussed in more detail in your mailing materials.

Every year, the Commission examines the performance of a set of hospitals identified as relatively efficient, using measures of costs and quality. The goal is to identify a sample of hospitals that consistently perform in the best third on cost or mortality and that always perform reasonably well on all the measures we use, which are costs, mortality, and readmissions.

This year, we reviewed the methods for identifying relatively efficient hospitals and implemented two substantive improvements. First, we incorporated Medicare outpatient costs. To better capture hospitals' overall Medicare costs, we combined standardized costs per inpatient stay with standardized cost per outpatient

service relative to their respective national medians and weighted based on their overall shares of Medicare payments.

Second, we applied more rigorously defined thresholds for quality of care. To determine the thresholds for classifying hospitals on risk-adjusted mortality and remission measures, we considered only the hospitals that met inclusion criteria, such as volume minimums. This led to the removal of small hospitals and resulted in higher quality thresholds.

Because of these refinements, we identified fewer relatively efficient hospitals compared to the past, 7 percent compared to 15 percent. This is discussed further in your mailing materials. This updated method better represents both the costs and quality of hospitals used in this analysis.

Using this updated methodology, we found that the median Medicare margin for relatively efficient hospitals in 2022 continued to be higher than for other hospitals but was still negative. We calculated that relatively efficient hospitals had a median Medicare margin of negative 2 percent when including Medicare's share of

relief funds and negative 3 percent when excluding these funds. These are lower than in prior years but still substantially higher than for other hospitals.

We also calculated that relatively efficient hospitals' median all payer operating margin was slightly higher than among other hospitals, 4 versus 3 percent, but also lower than prior years.

Like previous years, the relatively efficient hospitals had better quality measures, lower mortality and readmission rates and higher patient experience scores and lower costs than other hospitals. Performance on mortality and readmission measures was better than in past years, partially related to the application of more rigorous criteria in identifying relatively efficient hospitals.

The final comparison of Medicare payments with hospital costs is a projection of the fee-for-service Medicare margin in 2024. But first, we discuss a one-time increase in payments that will occur in 2024.

In 2018, CMS reduced Medicare OPPS payments to hospitals for drugs obtained through the 340B drug pricing program. In 2022, the courts decided that this approach CMS used to establish the reduced payment rates violated

parts of the Social Security Act, and CMS reestablished the higher rates. CMS has determined that in 2024, they will provide $9 billion in a lump sum, one-time payments to the hospitals affected by the lower payments between 2018 and 2021.

We project that the IPPS hospitals' fee-for-service Medicare margin will improve in 2024 to about negative 8 percent due to the one-time 340B remedy payments. Excluding these one-time payments, we project the Medicare margin will be about negative 13 percent, which is similar to the level in 2022, exclusive of coronavirus relief funds. We project the median Medicare margin for relatively efficient hospitals to be negative 3 percent, excluding remedy payments.

We project similar margins in fiscal year 2025. Like all projections, these are subject to uncertainty. We will update them with data on actual experience in our next recommendation cycle.

In summary, our hospital payment adequacy indicators were mixed but included a record low Medicare margin in 2022. Beneficiaries' access to care was mostly positive, including available capacity in aggregate and

positive Medicare marginal profit. The quality of hospital care was mixed in 2022 relative to pre-pandemic levels, with improvements in risk-adjusted mortality and readmission rates but a decline in patient experience.

Hospitals' access to care was mixed, with a relative low all-payer operating margin in 2022, but demand for hospital bonds remained strong, and preliminary data suggests slight improvements in hospitals' all-payer margin in 2023.

And fee-for-service Medicare payment indicators were mostly negative, with hospitals' Medicare margin declining to a record low in 2022, including a negative median Medicare margin among relatively efficient hospitals.

While we project an improved margin in 2024 due to the one-time 340B remedy payments, absent these payments, and in 2025, we project hospitals' low fee-for-service Medicare margins to persist.

In considering how to update Medicare IPPS and OPPS payments, the draft recommendation aims to balance several objectives. These include maintaining payments high enough to ensure beneficiaries' access to care,

maintaining payments close to hospitals' costs of providing high-quality care efficiently to ensure value for taxpayers, maintaining fiscal pressure on hospitals to constrain costs, minimizing differences in payment rates for similar services across sites of care, being cautious in how much emphasis is placed on a single year of data, especially in volatile periods, and avoiding implementing large across-the-board payment rate increases to support a subset of hospitals with specific needs.

Last year, when we observed record-high margins for predicted declines, we balanced those objectives by recommending a small across-the-board update above current law to all hospitals with a larger and more targeted increase for Medicare safety net hospitals.

Specifically, last year, we recommended a record-high update in 2024 of current law plus 1 percent for all hospitals, a redistribution of existing Medicare via the Medicare Safety Net Index, or MSNI, developed by the Commission, which better targets hospitals serving large shares of low-income Medicare beneficiaries, and adding an additional $2 billion to the MSNI pool for fee-for-service and Medicare Advantage combined. The Commission's

recommendation was not taken up.

We now turn to the Chair's recommendation. The Chair's draft recommendation reads "For fiscal year 2025, the Congress should update the 2024 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1.5 percent.

In addition, Congress should redistribute existing disproportionate share hospital and uncompensated care payments through the Medicare Safety Net Index, using the mechanism described in our March 2023 report—and add $4 billion to the MSNI pool.

The implications of the Chair's draft recommendation is an increase in spending above current law. We expect this recommendation will help maintain hospitals' willingness to treat fee-for-service Medicare beneficiaries and maintain beneficiaries' access to care by improving the financial stability of hospitals serving large shares of low-income Medicare beneficiaries.

And I now turn it back to Mike.

DR. CHERNEW: I am not sure what the orange screen means when it gets to the chair's draft recommendation, but terrific job. Really comprehensive.

And again, the amount of work behind this is really remarkable.

So we have a lot of people wanting to ask questions and then comments so we will get right to it. I think, Kenny, you are the first one in the Round 1 queue.

MR. KAN: Truly an outstanding chapter. I really appreciate how the team triangulated many different sources of data to arrive at the draft recommendation.

I also especially appreciate page 19, where you attempt to balance many considerations in coming up with the draft recommendation. It's like playing an eight-dimensional chess game in hyperspace.

That said, page 21, my rough map suggests that it may be -- I know that the whole hospital acute sector is not monolithic, but in terms of an aggregate, all-in update, my rough math is around 5.6 percent. Does that seem about right? It's like 2.8, based on the market basket, 1.3 basically for the safety net index, plus 1.5 for the add-ons. Does that seem right?

MS. BINKOWSKI: Yes, with caveats and everything that we do not know what current law will be. Right now it looks like it's going to be 2.8 percent. That could change

by the time it is finalized. As well as when looking at the effect of the MSNI, it is going to depend on what total volume and payments are in 2025, of how far that roughly $2 billion that goes to fee-for-service goes. But in broad brush strokes, yes.

MR. KAN: Thank you.

MS. BINKOWSKI: And there will be additional payments for MA.

MS. KELLEY: Jonathan.

DR. JAFFERY: Thanks. Hyperspace, Kenny? Is that right? Yeah. It's not easy to make a nephrologist think you're geeky.

So great chapter. Just three questions, and I think the first two are sort of yes/no questions. On page 2, you talk about 67 percent of all general acute care hospital beds are occupied, and then next in the chapter talking about that includes odd stays and things like that. But I assume those are licensed beds?

MS. BINKOWSKI: Yes. Technically they are available beds in the cost report, which are not only licensed beds but beds that have been in use for at least once in the last 30 days. So if they are completely taken

offline, they would be out, but if they are just temporarily unstaffed, they would still be in. So closed to licensed beds.

DR. JAFFERY: Okay, great. Thank you.

The relative efficient hospital discussion, you talk about standardized costs and things like that. Is anything adjusted for social risk of patients?

DR. FOUT: For standardized we do adjust for a bunch of factors, and one of them includes low-income or dual eligibility, or the share at the hospital.

DR. JAFFERY: But that's the basis of the social risk adjustment.

DR. FOUT: Mm-hmm.

DR. JAFFERY: It's LIS, dual. Okay. Thank you.

And then the last question is, so there are a couple of things where throughout the chapter you talk about for-profit hospitals reduce the number of employees and constrain the growth in salaries, and somewhere else there was an increased high cost outlier in patient stay.

Do we know more about some of the patient characteristics in there? I guess the most straightforward thing would be to think about case mix index, and if those

are different, say, in the for-profit hospitals or what that means that we are seeing greater case mix in the high-cost outlier patient stays or places that have a lot more of those?

MS. BINKOWSKI: I don't have those numbers off the top of my head. I can follow up with you. But my belief that I will double-check is that as in past years the nonprofits, in aggregate, had a slightly higher case mix, but I will follow up with you.

DR. JAFFERY: Good. Thank you. That's all for now. Thanks.

MS. KELLEY: Betty.

DR. RAMBUR: Kudos as well. One quick question, kind of maybe follows up a little bit with Jonathan, on staffing and employment. On page 9, it says in fiscal year 2023, hospital employment grew an additional 3 percent. Does that include employed physicians, or not?

MS. BINKOWSKI: It does. That data is from the BLS and includes all data, all staff employed by hospitals, which would include physicians.

DR. RAMBUR: Thank you. Quickly, they don't disaggregate that, do they? Or do they?

MS. BINKOWSKI: The BLS data source does not.

DR. RAMBUR: Thank you.

MS. KELLEY: Brian.

DR. MILLER: Thank you. This was a hard chapter because the hospital market is very varied. I had some questions, and I apologize if some of them seem a little silly. It's because I'm a little new at this.

My question, from looking at the Medicare margin, does this include -- I'm not referencing the 340B recompensation as a result of the lawsuit, but does the general margin include the 340B subsidy that nonprofit hospitals get?

MS. BINKOWSKI: If what you mean is does our overall Medicare margin include the different acquisition cost for drugs of nonprofit and for-profit hospitals, the answer is yes.

DR. MILLER: Okay. Thank you. And then did we measure specialty hospitals? And the reason I ask is I know that the hospital industry is, as I said, highly diverse. We have 25-bed CAHs. You also have orthopedic, surgical, specialty factories. There are cardiac hospitals, cancer hospitals. Do we differentiate between

the various hospital sectors?

MS. BINKOWSKI: So partially. A subset of the hospitals that you mentioned are paid under the inpatient prospective payment systems, and the results we present include all of those. So that would include, say, orthopedic hospitals. It does not include critical access hospitals or cancer hospitals, some of the other ones you mentioned.

DR. MILLER: Could we break out the various specialty hospitals, because I know that there are a lot of cardiac and orthopedic specialty hospitals. We may not have an identifier, I realize, in the dataset, and that's always been a challenge in looking at hospital markets. But we can't actually clearly identify them but we know they exist, that might be actually a good recommendation for us to make.

The reason I mention this is if we suggest a small or a large update, recognizing that different services have different profitability, we want to make sure that we are targeting entities that need it most. That's where my question came from.

And then another question I had, on page 16 and

17 I was excited to see HCAHPS used. My question is what is the response rate for HCAHPS?

MS. BINKOWSKI: I'm going to look at my colleague, Ledia.

MS. TABOR: [Inaudible.]

DR. MILLER: So we should --

MS. BINKOWSKI: It is about 30 percent.

DR. MILLER: So we should definitely mention that, and this may be my own personal bias, I think that the angrier, less satisfied patients or beneficiaries are more likely to respond probably than the less satisfied, so we may be either over- or under-estimating hospital patient satisfaction. I would guess we are probably underestimating patient satisfaction.

And then I had another question. We mentioned -- and I like it that we were looking at all-payer margins for six systems -- again, recognizing the diversity of the hospital industry, how did we select those systems? I wouldn't want us to pick only vertically integrated systems or only systems in urban areas. Do we have a good mixture, and how did we make those decisions?

MS. BINKOWSKI: So the short answer is we started

with a list of the top hospital systems, by revenue, so the largest systems, and then certain ones were excluded because, for example, they went through a larger merger and acquisition or there was some other issue with their data. And so we took the largest three that we were confident in their kind of year-over-year comparisons.

DR. MILLER: So we should either describe how we did that and either expand that methodology to expand that measurement, or potentially even enumerate the systems, not to out anybody, but that way we don't want to be accused of cherry-picking systems -- and I don't think anybody did. I'm saying we wouldn't want to --

MS. BINKOWSKI: Specific systems are enumerated in the citations.

DR. MILLER: Okay. I missed that. And then I had a question about the efficient hospital methodology and term. I guess I was concerned about the use of inefficient as a term, given that I saw that the average mortality rate is 8.1 percent. And I realize patients are very sick, obviously, in the hospital, working in one myself. But I was wondering if we should use a term besides "efficient hospital," especially when we are using it in a relative

sense.

MS. BINKOWSKI: Let me say we do refer to it as "relatively efficient hospitals."

DR. MILLER: Right. But I'm saying even that, like with an 8.1 percent mortality, seems like the wrong term.

MS. BINKOWSKI: There are always tradeoffs between getting a large enough sample size of hospitals and identifying the group that you think is the most relatively efficient.

DR. MILLER: And the reason --

DR. CHERNEW: If this is just an issue of the semantics of the term, that's --

DR. MILLER: Well, I think it's important when the Bureau of Labor Statistics has good methodology that shows that the private community hospital sector, writ large, has 25 years of lack of labor productivity growth. So using the term "efficient" or "relatively efficient" is probably economically inaccurate. Thank you.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks for this very comprehensive chapter. I have what is probably a very minor point that I

was just kind of curious about. On Slide 12, or on the top of page 22 of the reading materials, where we looked at the all-payer margins for the subset of large nonprofit hospitals, and there is a comment about using the most recent quarter and saying that that recent quarter was trending up, I think. And I was curious if that is a comparison of the most recent quarter to the same quarter in the previous years, or is a comparison of a quarter with the annual trend?

MS. BINKOWSKI: It is the quarter year over year, so the most recent quarter of 2023 compared to that same quarter in 2022.

DR. NAVATHE: Okay, great. Thank you.

MS. KELLEY: Jaewon.

DR. RYU: Thank you. Just two quick questions. One of them, I think I know the answer, but I just want to clarify. This comes up every year. But when you reference operating margin, you are excluding investment income or loss. Is that correct?

MS. BINKOWSKI: Correct, and even due to a suggestion from you and others that we move towards emphasizing the operating margin versus the total margin.

DR. RYU: And then the second question had to do with the referenced increase in employment. And again, I'm guessing you're not factoring in -- this gets to Betty's question a little bit -- contract labor. Is it normalized at all for that, whether it's physicians or nurses or other contract labor that is now, you know, employed, let's say?

MS. BINKOWSKI: So I will follow up on this, but my understanding is that we report employment two different places. I think the main place you're referring to we use BLS data, and that is not normalized for changes in contract.

DR. RYU: Thank you.

MS. KELLEY: Gina.

MS. UPCHURCH: Thank you, and great job. Just a quick clarifying question, similar to Brian's question about the 340B. Are DSH payments -- when we say uncompensated care, I'm always curious, like does that mean before or after the DSH payments that come to the hospitals?

MS. BINKOWSKI: So currently the Medicare program provides two types of safety net payments to hospitals. One are DSH payments, and those are percentage add-ons to

the inpatient payments. And the other are kind of lump sum, uncompensated care payments. And our overall Medicare margin that we present includes both.

MS. UPCHURCH: Includes both already. Okay. And when people talk about community benefit of hospitals, when they talk about uncompensated care, do we know if that includes DSH payments?

MS. BINKOWSKI: So that gets complicated, and there is also Medicaid DSH which it goes into as well. But I would say generally no.

MS. UPCHURCH: Okay. Thank you.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks. This was a great chapter. I had a quick question. So on page 9 you talk about capacity varying considerably across hospitals. I was curious whether those hospitals that have little in the way of capacity are the hospitals that serve a disproportionate share of Medicare beneficiaries in the country, to know if there is any way you can sort of look at those two factors together. Because I think it relates to the distribution of Medicare beneficiaries where they live and where that capacity is.

MS. BINKOWSKI: That's something I can look into. I don't have the correlations offhand. I can tell you in general the hospitals with the most available capacity are smaller and in rural areas, and conversely, for those with the highest occupancy rates. I can see if I can look at the relationship to Medicare share.

DR. DAMBERG: Yeah, I think that would be helpful because I think sometimes when we're looking at averages, we're not clear on what the picture really is.

MS. KELLEY: Larry.

DR. CASALINO: This is probably quite a minor point in terms of payment updates, but actually a fairly significant point about hospitals, I think. The last two sentences on page 16, they seem to contradict each other. The first sentence says that 86 percent of patients reported that they received discharge information, and then the very next sentence says 51 percent understood their care plan when they left the hospitals. That's a pretty big discrepancy.

I think I can guess what the reason for that is, but do you guys have a sense of that, and do you think this deserves some comment?

MS. BINKOWSKI: I know those are two separate questions under the HCAHPS. I'm seeing if my colleague, Ledia, wants to weigh in. If not, yeah, I don't think we have particular, concrete insight into that.

DR. CASALINO: I will just jump in there. I think when you get discharged from the hospital you get a bunch of papers thrown at you. And so the answer to did you get a bunch of papers thrown at you, discharge instructions, 86 percent say yes. But do you actually get it explained to you what is happening and what you should do next, 51 percent say yes.

So there hasn't been that much trend change in it, so again, I don't know if this is a payment update relevant point, but it's pretty striking, I think, that we should all understand that half the patients leave the hospital without understanding what they are supposed to do next. I'm not sure if it's that much better after outpatient visits.

MS. KELLEY: I think that's all. No, I'm sorry. Greg, did you want to get in here? I'm sorry. Did I miss someone? Okay, Robert.

MR. POULSEN: So I was trying to sneak in on

Round 1 at the very end.

MS. KELLEY: Go ahead.

DR. CHERNEW: I think I just marked off the wrong row on my spreadsheet.

MR. POULSEN: No, that's perfect, and I came in late. I was just looking at the very summary. What would we be looking at if we took current law plus X that included both the $1.5 and the $4 billion? Can we turn that into a percentage so that we just have a global sense for that? And maybe you said it and I missed it.

MS. BINKOWSKI: Yes. That's similar to what Kenny summarized at the beginning. So the current law is currently projected to be about 2.8 percent. There is an additional 1.5 percent that we are recommending, and then about 1.3 percent from the fee-for-service portion of the additional $4 billion at the MSNI pool.

MR. POULSEN: So the --

DR. CHERNEW: I think the answer to your question -- and I say this as a question, not as an answer -- but I think the answer is this loosely would be equivalent to current law plus 2.8.

MR. POULSEN: Is that right? It just seems to me

that probably a lot of people, including myself, wondered how that all totals out, so that's what I was asking. Thank you.

DR. CHERNEW: It has -- there have been a few other pieces of confusion, so let me just try and say one thing to at least give a little bit of history and clear a few things up.

When there was less MA and because our charge is to update the fee-for-service fee schedules, which don't literally apply to MA, correctly, we tend to do our analysis in the fee-for-service space, and so you see a lot of things about fee-for-service. As we have realized that MA has grown, and in some places it is 70, pushing 80 percent share, thinking about what this means for the provider sector and ignoring MA is, I'm going to go, incomplete.

So there are times when you will see things, particularly on the safety net add-on stuff, where you will see the aggregate. So the $4 billion, for example, in the safety net, that's 2 fee-for-service, roughly speaking, and 2 MA, not all running through the fee schedule particularly. That can come up.

But that's basically going to get us to where I believe, if you wanted to ask from a provider perspective how would you look at this update, taking in the fact that it is going to go with the fee-for-service, and if hospitals continue to get paid from MA about the same rate as fee-for-service, I think we would project this to be, loosely speaking, current plus 2.8. And if there's enough noise, but that will ballpark where we are.

It's so rare I get the triple head shake.

MR. POULSEN: Yeah, that's really good. I was surprised at that.

DR. CHERNEW: Yeah, it's good. And that, I think, matches with what Kenny was trying to ask in the beginning. So that's a good bookend to a Round 1 question. Was there anything else, Greg?

MR. POULSEN: No, that was it. It seems to me that that's important for all of us to collectively sort of understand the totality of it, with the recognition that for certain hospitals it's going to be more. You know, they'll get a higher percentage of that $4 billion, and for some it will be less. Thank you.

DR. CHERNEW: And I should just say, as an aside,

it does -- I'll say one other point, that it might not come up that I want to say, and we're about to go to Kenny for Round 2. But there are always these distributional analyses. We use a standard set of rows and distributional analyses -- rural, urban, for-profit, nonprofit. It turns out there's an enormous amount of heterogeneity within those rows. Within-row heterogeneity actually dominates the between-row heterogeneity in often cases, but if you actually look at the underlying numbers, the safety net index does compress, if you will. It helps by construction, but it helps the hospitals that are, say, having the higher Medicare share, which tend to have a lower margin -- that's what we created. It then tends to direct money.

So we could always target better or worse, but it is having the desired effect. Again, you could debate the formulas we use to do these simulations, but for the most part it's having the desired effect of targeting money to the organizations that we consider to be the most financially challenged in terms of their serving of Medicare beneficiaries. And that came up, I think, in our safety net chapter from when we developed the Medicare

safety net index before.

DR. CASALINO: Sorry to hold this up, but I'm still confused about the math on our informal spreadsheet. So the projected current law is a 2.8 percent increase, and then we're recommending an extra 1.5 plus whatever comes through the safety net index. So 2.8 plus 1.5 is 4.3; is that right?

MS. BINKOWSKI: Yes. I think you're missing the additional about 1.3 percent, which is the equivalent, the MSNI $4 billion, about of which $2 billion is for fee-for-service on a percentage basis.

DR. CASALINO: Right. But I think maybe this is a typo, or I'm still not understanding. The spreadsheet says current law plus 1.5 percent and then in parentheses 3.3 percent. Should that be 4.3 percent? This is on the informal spreadsheet.

DR. CHERNEW: I think it's because of the fee-for-service. So I want to go on to the questions. We can sort out the math. I think it's because of the way in which fee-for-service and MA is constructed makes following the spreadsheet sometimes challenging. I think that's what the issue is, but regardless of that, we can sort through

what that is.

Since I got the triple headshake and I want to just emphasize again for those at home that I got the triple headshake, just think of it as current law plus 2.8, which is, ball park, what it is. And that plus 2.8 is partly in the across-the-board portion and partly in the safety net portion. And we're calculating that across MA and fee-for-service. That's the loose number.

I'm only getting one headshake now. I'm going downhill.

If it's okay, I think we should go on to Kenny, and we can sort out what the actual numbers are in a bit.

MS. KELLEY: So starting Round 2.

DR. CHERNEW: I haven't checked if someone else jumped in after Greg, but I don't think so. So yeah, starting round two with you, Kenny.

MR. KAN: Okay. I have two questions. So question one, current law plus 2.8 percent is 5.6 percent. I understand that CMS when they project payment updates in the past has overshot on average. They tend to get a little bit high, especially in the much more recent years -- or maybe over the last 10 years. So as an actuary, I

like to minimize forecast errors when analyzing this payment update.

That said, I'm also aware this is playing dimensional chess in hyperspace, and I've had more than my fair share of hits and misses. So as forecasting is both an art and a science, how can I get comfortable around the two following nuggets? Number one, you mentioned in the slide that results in 2023 have been improving. So how do we get comfortable around that? And especially what Jaewon mentioned, especially this whole demand for contract labor, at the peak of the pandemic, contract labor was like 3 to 4x that of regular labor, but you have that, and you also see that the Fed, who has way more data than any of us have, is projecting that inflation is slowing down. They've paused for two months in a row, and Wall Street is actually betting that the Fed will start to cut rates in Q1.

So given that, inflation is slowing down, inflation is probably going to decrease, how can I get comfortable around this improved performance in hospitals and inflation is actually slowing down and minimize overall forecast error?

DR. STENSLAND: I'll just say that CMS hires economists to try to project what they think the input price growth is going to be, and what they think the input price growth is going to be in 2025 is what this is in the third quarter of 2025. And if you look at their projections, they do expect it to go down. So the CMS economists expect it to be lower in 2025 than it is now, which is kind of consistent with the Fed. And we generally say we are just going to go with the assumption that the CMS economists are going to get this as good as we can.

think what we've always said, what we don't want to start doing is thinking, oh, we think the CMS economists are too tense, too high, so we're going to adjust our recommendation two-tenths. I think that would be way overestimating our ability to out-project inflation by the CMS economists. So we try not to do that game and just take their estimate of future inflation as the best we can do.

I don't know. If Mike has his mic on, he might have something.

DR. CHERNEW: I think there's two things I would say. One is the actual what would happen will depend on

whatever the forecasts are, whatever they decide to do it. So there's a particular issue.

Second, the forecast is -- we had a whole section on inflation, I think. If I remember, it was last year, but my memory's not good. Oftentimes the errors go in the other direction. People don't seem to be as upset when the errors go in the other direction.

But in any case, this year, the myths, if you will, seem big. Our update recommendation, in some sense, is not predicated on any of that particularly anyway. Our update recommendation is -- well, I want to say this exactly right. Our update recommendation is taking that number, as Jeff said, as loosely given, where do we think efficient hospitals are, and where are they going to be? Could they be off by a percent, one way or another? Sure. We're not going to forecast the error that the people who do the forecasting do to change what it is that we want to do. And frankly, when the proposal would go through the actual legislative process, they would have more information in a whole range of ways.

So the way that I would read this is not we've done some mathematical calculation based on all of the

pieces you asked and came up with X. I think I would read this as it seems pretty clear that the gestalt that was laid out of hospitals had faced headwinds. Now they face headwinds that are more we've decided that we think it's appropriate, therefore, to increase our recommendation relative to where it was last year and to particularly worry about the hospitals that would have a lot of Medicare or a lot of low-income patients.

That's kind of what we're signaling, and that's sort of the main message is the math all coming out to a precise number. I wouldn't say it is, but the core point is nothing in the forecasting would change that big-picture summary of where I think we are and where I think motivates the draft recommendation.

I'm not sure if that helped, but it did take a long time to say.

MR. KAN: A second question?

DR. CHERNEW: Okay.

MR. KAN: So early in the morning, we heard a lot of concerns among many Commissioners around provider consolidation, especially doctors selling out the hospitals, because they don't want to deal with the stress

of being in private practice anymore. Three percent, that's our physician payment update recommendation. 5.6 percent is a hospital payment update recommendation. How can I look two of my best friends who are doctors in the eye -- one is in private practice and one is the hospital -- and say how can I get comfortable around the PR and the financial optics that one deserves a higher payment update recommendation versus the other?

DR. CHERNEW: I guess how you get comfortable is between you -- I'll tell you how I get comfortable with it. Our charge is to come up with a recommendation that's appropriate for each sector. The issue of consolidation is, indeed, a very important issue, right?

There's different forces at play in hospitals and physicians. It is not the case that we should, for example, say we need to update them the same in lockstep. That's simply not sensible for a whole range of reasons, right? So we look at all -- our charge and what we do is to come up with update recommendations for each one.

The issue that you raised about consolidation and differential updates leading to consolidation is an issue of great interest and importance, and it motivates some of

our thinking around the physician update. For example, the physician update is higher than it would have been if we weren't worried about the practice expense differential. We had that discussion.

But on the physician side, I would say when you see the access numbers, looking at where the access numbers looked, it's hard to justify substantially higher than we do, which is well higher than current law, and on the hospital side, given the pressures that they're under, it is hard to, in my view, justify considerably less update recommendation. Could we give a little more to physicians? Probably. Could we give a little less to hospitals? Probably. But our criteria is not that we should update them the same, because they're covering fundamentally different things.

In particular, the hospital side isn't covering the work part. So we don't worry about applications to med school and all the criteria that we look at, right? The practice expense stuff, we have tried in that motivation to equalize that portion more. It's not perfect. We have a lot to do in June to get there, but we are not doing an exercise of cross-sector, quote, "fairness." We're doing

an exercise of what update do we think would appropriate given our criteria to ensure Medicare beneficiaries of access to care in each sector. And I think, again, the physician one is suitable to do that for a range of reasons, and I think the hospital one has been designed to accomplish that here.

But last thing I'll say, for example -- I don't want to pick on any one number -- you see hospitals closing in ways you don't see physicians leaving, just to give you an example of something, right? So there's just differences. None, one of these are determinant, but the sectors are different, and so we will have differential updates.

MS. KELLEY: Okay. I have Jonathan next.

DR. JAFFERY: Thanks, Dana, and thanks again to the staff. This is great, guys.

So I'm going to stick on the access issue. The main heading for the access section in the reading is, quote, "Beneficiaries maintain good access to hospital services in 2022." And there are a lot of references throughout the chapter talking about -- and the presentation -- hospitals still have financial incentive to

serve fee-for-service Medicare beneficiaries.

I think you guys do a great job of calling out and emphasizing that that is provided, that there's available capacity.

And in fact, the presentation, you talked about beneficial access to care. Mostly positive, I think is how it's summarized. Available capacity exists in aggregate, positive fee-for-service, median marginal profit, those all go together.

And so my concern here really -- and it's been a concern I've had for a number of years here, but it's really grown. So we're deeming this adequate based on an aggregate bed occupancy rate of 67 percent, and if I recall from previous years, that's sort of hovered in the 63 to 65 percent, so maybe ticked up a little bit, but still it's in the 60s, which if you're an operating hospital, you would say 67 percent is occupancy, you got plenty of room. And in fact, to try and operate -- well, you probably want to hit about 85 percent, right? So the lay person might say you want to get to 100 percent, but you don't want to be at 100 percent. You want to probably be at 85 percent so you can manage things.

And yet we know all these things. We know that hospitals are closing, like Mike just mentioned. We know that other hospitals have taken advantage of the rural emergency hospital classification designation.

We know that more and more patients are leaving areas and coming to bigger centers, especially as more care shifts to outpatient and into the home and inpatient becomes, on average, more complex.

Another point in the chapter states that over the last five or six years, the number of inpatient stays has declined by 20 percent, but length of stay has gone up 13 percent, partially due to complexity, partially actually to talk about this maybe tomorrow because of a lack of availability in the post-acute care space, which is an increasingly big issue for a lot of places.

But I think the key thing I really want to focus on here is that limited capacity is not a minor issue, and I think we're not doing a fair assessment of things to say that is 67 percent an aggregate. It's just a situation where an aggregate number doesn't really give us a picture of it. It feels like we're basing a lot on that.

I have some -- able to get data around at least

AAMC members, and so in 2022 -- this is about 5 percent of hospitals. It's about 20 percent of beds. So it's obviously big places, as you know. So in 2022, actually 30 percent of those places had greater than 85 percent occupancy. So they're already above that kind of comfort space, 13 percent over 90 percent, and a full 5 percent were over 100 percent.

So I think in a lot of areas -- and this kind of gets to Cheryl's question about how does this match up to where the Medicare beneficiaries are. This is a real risk, a real threat to access for a huge number of Medicare beneficiaries and other people and particularly for some of the more complex care.

So I think the bottom line is that access to these hospital services, especially for some of the more complex specialized care, is actually threatened for a lot of Medicare beneficiaries. And I really worry a lot about hanging our hat on this key metric that we put in every year and all the sectors around access and saying it's okay based on this number.

And then the one other thing, which is a different topic, is getting back to the classification of

relatively efficient hospitals. I think people have called that out a little bit here, but I do wonder if there's an opportunity to think a little bit more about what that means and how we measure it and how we define it. There may be more that can be done around the quality, what quality metrics actually matter, and not just one or two things.

And then in particular, I can appreciate that the social risk adjustment is limited currently to LIS and dual status and what you have available. We've talked a lot about adjusting for those factors in payment, and so the same thing should, I think, hold true in terms of what it actually costs to run a place that cares for a more socially complex population that we know isn't just captured by LIS, and that could make a significant difference in a lot of places.

And now that there's a push to have hospitals do more screening for that, we may actually be able to get that data in the not too distant future.

So again, thanks for a great chapter, and I will close my comments there.

MS. BINKOWSKI: Can I make one really brief

counterpoint? I think you had mentioned about the distribution, some of the AAMC numbers in occupancy. On page 9, we do talk a little bit about the spread in occupancy and how among the general acute care hospitals, in aggregate, 5 percent had occupancy rates over 85 percent. So that's still a concern, but I think that helps put it in context.

DR. JAFFERY: Right. No, I get that, and that was actually where -- but I would say that that's true. And so I guess I was trying to bring forth some more granular data that I know that you don't have and say that in this subset, while it may be a smaller number of hospitals, they're big because they represent this more four times a percentage in terms of the number of beds. And they deliver a certain kind of care that patients don't get other places, and it's a problem that is growing and is really, really significant.

DR. CASALINO: But, Jonathan, if they're over capacity, what's the implication for payment rates?

DR. MILLER: And if they're over capacity, maybe we should address certificate of need, which prevents them from expanding capacity.

DR. CHERNEW: We have about eight people in about 20 minutes. I don't mean to drive us to make sure, but everyone needs to get to say their piece, and then we can have a broader exchange, but yes.

Jonathan will be happy to explain his thinking on that later.

All right.

MS. KELLEY: Stacie.

DR. DUSETZINA: Thank you so much. This is a great chapter and a ton of work, so excellent job.

I wanted to just highlight the patient experience measures -- and Larry brought a couple of these up -- that just seem like huge red flags to me. Like, 69 percent said they would definitely recommend the hospital. If I saw a restaurant that 69 percent of people would definitely recommend, I would definitely not go there. So that feels alarming.

And I think some of the others on understanding your care when you're leaving the hospital, half, 51 percent, 62 percent said that they didn't have communication about medications.

So I guess one of the things I wondered when

looking at that was if there was any way to dig into the data and get some sense of how this varies across hospitals or whether those types of reports, hospitals that have lower reports of understanding discharge instructions have higher rates of like readmissions or something else that we are hanging our hats on a little bit more, because those things seem -- of the few measures we have from beneficiaries, those are not good.

I think the other just broader comment I'd have is I definitely agree with the recommendations, but I did feel like I was surprised at the jump in the Medicare safety net index payment from 2- to $4 billion, the add-on piece of that. And it might just help for additional context.

I think when Mike was making his earlier comments, it became a little bit more clear, the rationale behind wanting to do a little bit more and especially targeting additional payments to that group, but it felt like I was kind of surprised and was like, oh, I wonder why that was a big jump from one year to the next.

That is it for me, but great work on this piece of work.

MS. KELLEY: Greg.

MR. POULSEN: Thanks.

Kenny and I bookended the last one. Maybe we'll be in the opposite position this time because I'm in a different place for sure.

I think that it's really important that we all understand that marginal profit doesn't create long-term stability or sustainability. Marginal profit may encourage access, happy to sell a product at a marginal profit, but over time, that won't keep the doors open, especially when the doors need to be replaced, because they're a fixed cost rather than a variable cost.

That leads me to the concern, I think, that when we look at the efficient hospitals essentially being decreased in half in terms of the hospitals that are identified that way, and even among that relatively diminished and small sample, still at a negative total margin, I think that should give us pause. Because what it clearly, at that point, assumes is that we are not only observing but we are expecting that somebody else is going to pick up the difference, into perpetuity, and we need to be thoughtful about doing that.

So the assumption is, gosh, the government can't afford it. We are going to have employers pick that up, or individuals, or states. So we are building that assumption into our expectations, and that's maybe okay, but we should be explicit and understanding that that's part of what we're thinking.

I would very wary -- and people have stated this -- be very wary of assuming that we are going to see improvements coming, based on six large organizations that have, by a significant margin, more tools and capabilities in their toolbox than do small community facilities without that kind of huge backup, without access to enormous resources. And I would note that in past bad years it's far more common for the fourth quarters, and for most hospitals, not all but most of them, that they are on a calendar year, so they will be making year-end adjustments to reflect the bad year that they've had by writing down bad operations and bad assets.

And so I'm anticipating we're going to see the fourth quarter look worse, not better, because of those. Now I may be wrong -- I frequently am -- but that would be my guess. And I'm not arguing that we should reverse

what's in the document, but I certainly would argue that we shouldn't make assumptions that, gosh, it's going to be wonderful now, things have turned a corner, because they haven't. They really haven't.

I would also just like to end my thoughts with a tale of two cities that are within my own organization, because it shows something very, very different that we should be thinking about, not for this chapter but in general. And that is we have one fairly large part of our organization that has more than 60 percent -- it's Utah -- 60 percent of our care is prepaid in Utah. In Colorado, 5 percent of our care is prepaid. Our Utah operations have an enormous lever to pull in terms of finding cost savings that we do not have in Colorado, and if you look at our performance it's radically different in those two communities. The one is doing financially very well. The other one is doing financially badly.

In terms of the operation of the hospitals they are equally well managed, they are effective, or equally effective, and the difference is the payment mechanism. And since we have such an important part in helping to propose beneficial and more payment policies going forward,

I just toss that out, as this is a learning moment to point out the organizations with more capabilities in terms of the payment that we give them are better able to respond to difficult financial times.

So that's really for a different topic but I think one that fits right here in terms of what we're doing.

So I am supportive of what we're proposing. I am certainly not thinking that it's unduly generous.

MS. KELLEY: Brian.

DR. MILLER: I might disagree with unduly generous. But I guess the first thing is I think we need to look at payment policy holistically, like many of my other colleagues have mentioned, thinking about hospital payment in the context of physician payment, because we might not like our system of care but we are in a system, and all of these payment chassis are interrelated, whether we realize it or not, and many organizations straddle and own multiple components.

I think we can actually turn to a competition, which encourages us to think this way. As I mentioned, the FTC Chair, Lina Khan, hired a counsel, or is hiring a

Counsel for Health Care to think about competition holistically. This gets to something that my colleague, Larry, has mentioned, which is that we need to consider the competition impacts of all of Medicare program policy decisions. He has mentioned this time and time again for the now five months I've been here. And I agree with this and I think that we should do that because competition, or lack of competition and consolidation drives increased costs, which hurts beneficiaries because they are responsible for some of the costs. And it hurts taxpayers, so we need to think about that.

I noted that Kaufman Hall, which is a classic hospital industry consulting firm, had a study of 1,300 hospitals that suggested a margin of 1.1 percent, so that is very different than the numbers we're getting, so we should try and explain why that is -- I'm sorry, 1.2 percent.

I think that having a summary of our payment policy recommendations at the beginning of all of this, in a table as Larry was referencing, is an excellent idea.

I think that our recommendations should just be current law, and here is the reason why. One, as I said,

labor productivity in this sector has been flat from 2007 to 2019, and before that it was actually declining, in 2001 to 2007, and that's just the ills of consolidation, where you have an operating choice to either improve clinical operations, lobby for higher funds, seek additional regulatory protections or subsidies. So the industry has made a strategic choice in one way or another.

I'm concerned about the efficient hospital terminology. I don't consider 8.1 percent mortality and 67 percent operating occupancy rate to be evidence of an efficient hospital. If you go to the hotel industry, they consider around 90 percent to be an efficient hospital.

And then the differences between tax-paying and tax-exempt hospitals, yes, it could be due to CMI or different patients, as my colleague, Dr. Jaffery, suggested, but we should also consider the fact that it might just be that they are actually more efficient hospitals treating the same patients because the taxes are several percentage load on operating margin.

And then I think two final thoughts. One is the integration of policy writ large, we should be actually discussing things like site neutral here. That is a

bipartisan idea supported by groups as diverse as Loren Adler at Brookings Institute and then also Charlie Katebi at the America First Policy Institute, which is widely across the political spectrum. That is relevant for payment policy and payment levels, and that should be something that we consider.

I think the other thing we have to consider, which I found concerning, is on page 4, where we noted that it is extremely difficult for hospitals to constrain costs or plan for the future. This is absolutely factually incorrect. I mean, hospitals, just like any other clinic, ASC, or whatever, MA plan, Medicaid MCO plan, they are businesses, they are going concerns, and they do plan for the future every quarter and every year as part of their normal strategic operation cycle. They have an opportunity to reduce costs.

And I pulled some literature from Himmelstein and Woolhandler, the two founders of Physicians For a National Health Program. They wrote four papers on administrative costs in 1991, 1993, 1997, and 2003. Pulling the two papers that specifically look at hospitals, the 1993 noted that administrative costs for hospitals are 24.8 percent,

and in 1997, they noted it had increased to 26 percent. And there has been a lot of work that that organization has done showing the growth of administrators over the growth of clinical labor nurses, physicians, certified nursing assistants, whomever.

So to suggest that it is extremely difficult for hospitals to reduce costs is not true, and I think that we should eliminate that and include those references, noting the high administrative load and the administrative burden that hospitals are directing Medicare funds towards, meaning not the clinical workers and not the beneficiaries.

Thank you. So I would recommend our current law update.

MS. KELLEY: Scott.

DR. SARRAN: You're doing a great job of literally boiling the ocean and coming out with solid takehomes.

Three very brief comments. First, I reluctantly support the recommendation, and I support it because I don't think we have a reasonable alternative given that the present business environment for hospitals, reluctantly, because, again, I think we could get more value out of the

sector.

Second comment is just reinforcing Larry and Stacie's earlier points about the relatively, I think, poor performance around a specific measure on whether patients and families feel adequately instructed about discharge plans. Just think about that in humanistic terms.

It's frequently a terrifying experience for a patient and family to come home from a hospital stay, and the voltage drop between all the staff that's available at 11:59 a.m. in the hospital and then 12:30 p.m., when they get home, again, it's frequently terrifying. And this is just such a core responsibility of the hospital to ensure that patients and families are adequately prepared. I think we should sort of double underline that.

The third brief comment, I think that we should highlight also that we are missing an opportunity, I think, to hold hospitals, which are now essentially hospital systems, right, virtually all of them, accountable for population health measures, even in fee-for-service Medicare. Obviously, Gregory's points are well taken that it is extremely challenging to do that when you're operating in a fee-for-service environment.

Nonetheless, when a hospital is employing the bulk of the physicians in their community and they are providing inpatient and the bulk of the ambulatory services -- outpatient, ancillary, et cetera, et cetera -- I think it is reasonable to view them as accountable, not the sole driver but have an accountability for population health measures, such as avoidable emergency and hospitalizations, overall non-elective hospital admit rates, community health status, et cetera.

And I think we could at least point out that those are sort of unlooked-at measures, and we've not, I think, advanced our measurement, the breadth of our measures to reflect the increasing breadth of a hospital's role in the overall health of their communities.

MS. KELLEY: Jaewon.

DR. RYU: Yeah. I too agree with the recommendation. A few comments. I think it's important in this chapter to have a tone that recognizes the current challenging environments that hospitals are facing, and I think it strikes that tone, so I appreciate that.

I think, point number two, and it's come up in prior years as well and I think this is inherent in the

challenge of these lagging indicators that we rely on, and I say this every year, but I think it's especially challenging to have lagging indicators in a time of major sea change like shifts in the industry, and I think that's exactly what we've had, especially in the hospital sector, over the last few years.

I think it's still the right framework. I get that we have to have empirically kind of justified recommendations. So I think it makes sense, but it's still a recognition that inherent in that lagging indicator approach, I think it's very -- I'm similarly uncomfortable, as Greg mentioned, to forecasting that things are looking better and going to get better, because I'm not sure that's going to be generally true. So that's point number two.

Point number three, I think you had in the summary slide where you had the four categories of how we assess, and the one on access, you know, marginally positive or something like that, was the summary. I think we've got to be careful because there is a lot of diversity within the hospital sector, and having a hospital stay open versus closed, that's a very binary look at access. You know, this has come up in our discussions with the rural

hospital chapter and the safety net chapter. I think what's more concerning is not necessarily closure or opening, but hospitals that stay open but have really skeleton services, because programmatically, they have essentially died on the vine.

And so some of these programs we could say, well, does every hospital need certain programs? Certain programs, of course they don't. But some other programs, would we feel comfortable if a hospital, would we say access is good if the beds are there, the hospital is open, it has not closed, so by our measure it looks like access is great, but that hospital has no ability to take care of cardiac services, strokes. You know, you can go on and on and on.

And so I think there is a little bit of caution that I would exercise in the access assessment, because I think what is, in fact, happening is hospitals may be struggling to stay open and they're barely getting by to do that, but programmatically it's just constant decline. And I think we certainly see that near where we are, where programs are shutting down and hospitals across our service area, I see it and hear of it, in urban markets as well.

But I wish there was some way to recognize and reflect that.

I think the last point gets to Michael's characterization, which I like. I think for all these reasons, current law plus is what I support, and I think that's where the recommendation makes sense to me. And I do think that some portion of that, as the recommendation reflects, should land in a more targeted way around the safety net hospitals.

So I thought you all did a stellar job with a very, very complex sector.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks for this fantastic work. Obviously very complicated and you put a lot of work in to pull this all together, so thank you for that.

I think it is notable how much uncertainty there is, and I think it's challenging at times to look at smaller subgroups to reflect what's happening in the overall industry, and the uncertainty, I think, intrinsically is kind of related to the variability that you all describe. That variability or that uncertainty is most certainly related to the size of the institution. As

well, there are a lot of puts and takes here that are worth noting, that this is a challenging problem, and at the same time we're charged with trying to get it right essentially on average. So I think that's a practical, sensible approach that we've been taking here.

I think several of my co-Commissioners have highlighted the areas where there is opportunity, on the quality side, on the transition side, on the fact there is this interdependence between the different sectors, the hospital, the physician, post-acute care. I think those all totally make sense. At the same time, I think, based on what we're charged to do, in a sense, we all obviously have to provide payment updates for hospitals, and if we try to incorporate all the interdependence it's hard enough to come up with a number for hospitals. It would be almost impossible to do it in a highly interrelated way.

But I don't think that diminishes the importance of that point, and I know this doesn't really belong in this chapter per se but I think it highlights, somewhat akin to what Greg was saying, I think it highlights this need for payment systems and payment models that create accountability and that have a more holistic view around

how we pay for care. And essentially what I'm leading to is we need to find a way to make alternative payment models and the like work for hospital, including hospitals of all sizes, of all geographies, and I think that certainly hasn't happened to date, and hopefully we can find a way to get there.

The more substantive point -- that's sort of me waxing philosophical now -- I have a more concrete point, which is one of the things that's notable in the work -- I really appreciate the methodological enhancements that you've made to the relatively efficient hospital analysis. It is notable, and you put it out there very transparently, that the group essentially halved in size, from 15 percent to 7 percent, which makes it much more of this small group point, which I was making. In essence, it's harder to see how that's reflective of the broader national group.

And so what I was wondering is if there is an opportunity for us, akin to our own recommendations around policymaking, where we shy away from cut points and thresholds, to do something like create a composite across the measures that we're tracking and see how the financial margin and other metrics vary across a spectrum on the

performance of this composite across mortality and standardized costs and the like. Because I think that will help us understand a little bit more, I think, of how much sensitivity there is to these metrics and these definitions, which right now is a little bit harder to get a sense for, and in particular, again, the fact that it changed a lot overnight, in a sense, between 15 percent and 7 percent. I thought that would be helpful to informing the conversations.

And the last point I wanted to make is I just wanted to echo Jaewon's point that I am very supportive of the idea of channeling dollars where beneficiaries who are really in need are going in terms of the safety net.

Think you.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. I share the kudos for this chapter, and I will be brief, but I have a few points I'm rather burning to make.

The first relates to the relatively efficient. I think ever since I've been on the Commission, I've asked about what "efficient" means, because my concern has been if the quality pieces of the composite aren't strong

enough, you're very efficient by getting rid of a bunch of staff, particularly nursing staff who are the largest piece of the labor cost.

And in the conversation we've had I see this play out in many ways. We've talked about hospital beds, but it's not beds we're lacking. It's the staff to serve those beds. When we're talking about a bed it's who is going to take care of the person in the bed.

The point about the people not understanding their plan of plan -- Larry alluded to this -- it is pretty easy to give people materials and then spin them in a merry-go-round and out the door. But to make sure not only that they understand them but that they execute them is a whole other level, because they may understand perfectly that they need to see their primary care provider in a week, but they can't possibly get there. So that takes time on the part of the social worker, a nurse, or someone who can not only understand the medical necessity but the social context of the person. And the more challenges a person has, the more difficult this becomes when you don't have the resources to pull it off.

So I think we really need to look at that metric,

whether it's the term or how we put it together, because it's really important.

The second thing, I won't go into the details on this but I wonder if it's time for us to consider a recommendation about modernizing the Medicare cost report. I know that's a big lift, and that might not be in our lane, there might be technical pieces, but all these pieces that I've been talking about that really relate to the people doing the work are not easily captured, as least as I can see them. Medicare cost report looks to me like houses that have been added on in different years, that made sense when it was added on, and man, what were they thinking? So I know that's a lot of work. There might be other strategies, but I think that's important.

So in conclusion, I'm very reluctant to supporting it with a couple of caveats. If we're having an increase because there's increased labor costs, right, then we should make sure that the resources go there, not more expensive administration. I really like the accountability for population health as well as overall accountability considering the social safety net hospitals.

Io I'm reluctantly supportive, but I think there

is a lot to do in terms of these pillars that rely on both the relatively efficient and the Medicare cost report. Thanks.

MS. KELLEY: Robert.

DR. CHERRY: Thank you. I think this was a really challenging chapter to put together, and so I just want to thank you for keeping it focused and allowing us to have a productive conversation here.

One of the things I like about the recommendation -- I've mentioned it previously in the prior sessions -- that we've broken us out into two parts, our primary recommendation, which we're charged to do, but a secondary recommendation around the SNI that makes it much more productive and fulfilling, I think, for the Commissioners involved.

Like several other Commissioners, there's a little bit of a disconnect between the recommendation and the argument that we're building within either the slide deck or the pre-read material, because my takeaway message is hospitals have a 4 percent all-payer mixed. There's strong investor demand. The bond ratings are going to improve next year. Capacity is good. Even the quality

metrics are getting better. Yet we're asking for more than what we did last year. So I think that some refinement of why we're asking for additional dollars needs to be built into the slide deck and the pre-read materials better.

Taking the risk of oversimplifying the problem. I think one compelling argument for me is that we have hospitals, fee-for-service Medicare margins, where if you exclude the relief funds, it's negative 3 percent. So what does that actually tell me? It tells me that at least there's a perception that commercial plans are cross-subsidizing Medicare. I mean, that's the only reason why you have a 4 percent margin, but Medicare is losing 3 percent. And we historically have had this principle where Medicare doesn't cross-subsidize Medicaid, but there's this impression here in the chapter, I think, anyway, that commercial payers are cross-subsidizing us.

So I think we have to make it as a first principle that we have to float on our own and not have hospitals dependent on commercial payers to make themselves whole, and I think that's part of the challenge here.

And I think, increasingly, commercial payers are listening to their stockholders and their investors, and

they're having much more tense negotiating conversations with hospital systems all throughout the country, because they're accountable to their stakeholders. And so there's people all over the country right now that are in the enrollment period, uncertain if their plan and their providers that they're accustomed to are actually going to be a network or not, because commercial payers are having these challenging discussions, because hospitals are looking for commercial payers to cross-subsidize Medicare and Medicaid.

So I think we need to get out of this sort of cycle here. So I would say one compelling argument is that we're trying to avoid cross-subsidizing and having Medicare stand on its own. I think if we built that argument, that could be helpful.

The other thing, as far as the SNI piece, is that not every hospital is the same, but there's a bell-shaped curve. So you have a group of hospitals that's losing money, but they're not always necessarily losing money because of volume decline. Some of those hospitals are actually facing increased volumes but are distressed.

In California, we have up to 17 hospitals that

could be facing closure next year. That doesn't mean that they're all seeing volume losses. No, not necessarily, because what's happening is that if you have 70 to 80 percent government payer inclusive of Medicare and you don't have enough commercial to cross-subsidize, the more services you provide because of increased demand, the greater your losses are. The only other industry I can think where that happens is the EV market, electric vehicle market.

So the SNI argument has also play on the fact that Medicare has to stand on its own, which is why we have the SNI, and then just in general, we just can't have negative 3 percent margins in Medicare and expect the quality of care and access to care to be sustainable over the long term.

But otherwise, it's a good chapter. But I just think we need to strengthen the argument a little bit better.

Thank you.

DR. CHERNEW: We're at time. Greg wanted to say something in a minute, if he can say it in a minute. That's a challenge.

MR. POULSEN: Yeah, that is a challenge. Okay. Really fast.

We talked about administrative costs being up. They are, but they are absolutely up because of regulatory and insurance expectations that are way up. The demands that -- a lot of you are nodding because you know that what I'm saying is right.

Second, we want hospitals to take accountability for broader population metrics, but at the same time, we're all hesitant to talk about it in vertical integration and physicians and hospitals getting together. Who does that most effectively? It's the docs and hospitals that work collectively as an organization. So we can't really talk out of both sides of our mouth on that one.

Third, hospital costs are largely -- that have impacted them over the last couple of years are largely impacts of external forces. Nursing shortages have led to increased nursing costs. That's not an inappropriate thing, but it's a clear thing, and supply costs, particularly for drugs, are outside of their control as well.

So as we look at this, I don't think that we can

look at a hospital industry that's incapable of management. I think what we're seeing is one that has a lot of external factors that are really important.

And that's as close to a minute as I could get my --

DR. CHERNEW: Thirty seconds by my timing.

MR. POULSEN: Oh, good.

DR. CHERNEW: I discount all the speech.

I won't take the time to summarize, but this is, I think, a clear example of a particularly challenging chapter for a range of reasons.

I appreciate all the comments and certainly all the staff work. We'll review all of this, and we'll consider it. And I will be calling all of you to just get a sense of where folks are.

In any case, I think we should take -- actually, I think, if it's possible, let's just try and transition as quickly as possible. And if folks need a break, just step out for a minute and then come back if you can, because we have two more chapters.

I think we're going to go to hospice now, if I have that right, and these chapters -- just to give

everybody some expectation, we have two chapters left, hospice and dialysis, and these past two we allocated an hour and a half, but these two have just an hour. So there's a lot to get done in all of this work.

We are live, just to my fellow Commissioners. Jonathan, Greg, we are live, just so you know. Same for Kenny and Robert.

Maybe we should wait a second, because now we have three people in the room.

Since enough people have stepped out -- okay. We're going to stop for about two minutes, and then we're going to come back as quickly as possible. My attempt is to keep people here and to move into the next session.

[Recess.]

DR. CHERNEW: I think we're back, and we're now going to continue our update work. Time is tight. So we're jumping to Kim, and we're going to do hospice.

Kim, take it away.

MS. NEUMAN: Good afternoon. The audience can download a PDF version of the slides on the right-hand side of the screen.

Next, we're going to talk about the hospice

payment update for fiscal year 2025. Today's presentation has four parts. First, we'll discuss some background on hospice. Then we'll review our payment adequacy analysis. Then we'll discuss the Chair's draft recommendation, and then we'll turn to a separate topic, nonhospice spending for beneficiaries enrolled in hospice.

So we begin with background on the hospice benefit. Hospice provides palliative and supportive services for beneficiaries with terminal illnesses who choose to enroll. To qualify, a beneficiary must have a life expectancy of six months or less if the disease runs its normal course. There's no limit on how long a beneficiary can be in hospice as long as they continue to meet this criterion.

A second requirement of hospice is that the beneficiary agrees to forego conventional care for the terminal condition and related conditions.

Also, another thing to note, fee-for-service Medicare pays for hospice for both beneficiaries enrolled in fee-for-service and Medicare Advantage.

Next, we have background on the hospice payment system. Medicare pays hospices a daily rate for each day a

beneficiary is enrolled, regardless of whether services are furnished. The daily payment rate depends on the level of care a beneficiary receives on a day. Routine home care is the most common level. There are three other specialized levels of care that receive higher daily rates.

The daily rate structure, as we've discussed before, has made long stays in hospice quite profitable because hospices tend to provide more visits at the beginning and end of the episode and less in the middle.

One other thing to note is that there's a cap on the aggregate payments a provider receives in a year. This is not a patient-level limit. It applies to a provider's total payments across all its patients. If the provider's payments exceed the cap, the hospice must repay the overage to Medicare.

So here's an overview of hospice in 2022. Over 1.7 million Medicare beneficiaries, including nearly half of decedents, received hospice care in 2022.

These beneficiaries received an average of 3.9 visits per week from hospice staff. Length of stay was 18 days at the median and 95 days at the average. There were 5,900 hospice providers, and Medicare paid them about $23.7

billion.

As we consider hospice payment adequacy, we'll use the same general framework as you've seen before in other sectors. One difference, though, is that we'll present margin estimates for 2021 instead of 2022. This is because the data needed for the aggregate cap calculation lags.

So now moving to our payment adequacy data, first, we have data on the supply of providers. The total number of hospice providers increased substantially in 2022 by 10 percent. Growth in total provider supply is driven by growth in the number of for-profit providers, as shown in the orange line.

The number of nonprofit and government providers, represented by the gray and green lines, has been on a slight downward trend.

Next, we look at hospice use rate among Medicare decedents. The share of Medicare decedents who used hospice increased to 49.1 percent in 2022, up from 47.3 percent in 2021.

The use rate among decedents increased in 2022 for all beneficiary subgroups we examined; for example, by

age, race and ethnicity, and rural and urban status.

During the pandemic, we saw the share of decedents using hospice decline between 2019 and 2021, and this largely reflected that patients who died of COVID-19, similar to patients 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.

The 2022 hospice use rate was also affected by the pandemic. In January 2022, there was a surge in deaths, and the hospice use rate was substantially lower that month than the rest of the year.

Now looking at a wider set of indicators of access to care, they are positive. As just discussed, the share of decedents using hospice increased. The number of hospice users and total days of hospice care also increased. Among decedents, average and median length of stay increased. The amount of visits furnished to hospice enrollees was stable, increasing very slightly in 2022, but remaining lower than the pre-pandemic level from 2019.

Our final indicator of beneficiaries' access to hospice services is marginal profit. Marginal profit measures how much the revenue from treating an additional

Medicare patient exceeds the variable cost of treating that patient.

In 2021, Medicare marginal profit for hospice providers was strong at 17 percent, a positive indicator of patient access.

So next, we turn to quality. Overall quality indicators are generally stable. Performance on the hospice CAHPS survey changed little in the most recent period. Of eight CAHPS measures, performance on five was unchanged, and performance on three declined by 1 percentage point.

A composite of seven process measures of care at hospice admission increased slightly in the most recent period but was generally topped out.

How much time hospice staff spend visiting patients at the end of life is also thought to be an indicator of quality. Our analysis of visits in the last week of life found they changed little between 2021 and 2022 but were lower than the 2019 level.

So next, we have access to capital. Hospice is less capital intensive than some other Medicare sectors. Overall, access to capital appears positive. We continue

to see growth in the number of for-profit providers, at least 10 percent in 2022.

Reports from publicly traded companies and financial analysts indicate that the hospice sector continues to be viewed favorably by investors, such as other health care companies and private equity firms.

We have less information on access to capital for nonprofit freestanding providers, which may be more limited.

Provider-based hospices have access to capital through their parent providers, and those organizations appear to have adequate access to capital.

So next, we have margins. Different from other sectors, as I mentioned before, we have historical margin data through 2021.

First, looking at the chart on the left, the fee-for-service Medicare margin in 2021 was 13.3 percent, a slight decrease from 14.2 percent the prior year. If we had included Medicare's share of COVID relief funds in the margin, it would have been higher, about 14.5 percent. Freestanding hospices had strong margins at 15.5 percent, while provider-based hospices had lower margins.

Margins vary by ownership. For-profit hospices had substantial margins at 19 percent. The overall margin for nonprofit hospices was roughly 5 percent. But freestanding nonprofits had a higher margin at 8.5 percent. Urban and rural hospices both had favorable margins at about 13 and 12 percent respectively.

Now looking at the figure on the right, we have margins by provider's length of stay quintiles. This figure shows that margins increased 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 some providers in this quintile.

So next, we have our margin projection. For 2024, we project a margin of about 9 percent, and we arrive at that projection by starting with our 2021 margin and making assumptions. First, we assume revenues increased based on net updates of 2 percent in 2022, 3.8 percent in 2023, and 3.1 percent in 2024. We also assume reinstatement of the sequester.

In terms of cost growth, we use the observed 3.7 percent increase in hospice costs per day that occurred in 2022.

For 2023 and 2024, we assume a rate of cost growth that is between the recent high rates and the historic trend.

Taking all these factors into account results in the 9 percent projected margin.

So to summarize, our indicators of payment adequacy are favorable. In terms of access, the supply of providers continues to grow. The share of decedents using hospice, the number of hospice users, and total days of care increased. Length of stay also increased. In-person visits per week increased slightly, and marginal profit was 17 percent.

On quality, the most recent CAHPS data were generally stable. Visits at the end of life were stable in 2022 but below 2019. Access to capital appears positive. The 2021 aggregate Medicare margin was 13.3 percent, and the 2024 projected margin is about 9 percent.

So based on our positive payment adequacy indicators and the projected margin, the Chair offers the following draft recommendation. It reads "For fiscal year 2025, the Congress should eliminate the update to the 2024 Medicare hospice base payment rates.

In terms of implications, the recommendation would decrease spending relative to current law. In terms of beneficiaries and providers, we expect there would be no adverse effect on beneficiaries' access to care, and we expect that providers would continue to be willing and able to provide appropriate care to Medicare beneficiaries.

So now we're going to switch gears to a different topic. nonhospice spending for beneficiaries enrolled in hospice. We talked about this issue briefly in November, and your December paper has a summary of interviews we conducted on this topic.

As you'll recall, for hospice enrollees, the hospice is responsible for all services that are reasonable and necessary for palliation of the terminal condition and related conditions, while unrelated services are covered by fee-for-service or Part D.

CMS has said it expects virtually all care needed by the terminally ill individual would be provided by the hospice. Despite this, there's significant Medicare spending outside of hospice while beneficiaries are enrolled in hospice.

In fiscal year 2022, CMS estimates that fee-for-

service and Part D spending outside of hospice during a hospice election totaled about $1.5 billion in Medicare spending and about $200 million in beneficiary cost sharing.

It's unknown how much of the spending is truly unrelated and appropriately paid by fee-for-service and Part D.

To understand what is driving spending outside the hospice benefit, we conducted interviews with 12 providers in 2022 and 2023, including hospice providers of different sizes, geographic locations, and ownership status.

So we asked hospices how they determined whether services are related and fall within the hospice benefit. Hospice clinicians make the determination of what services are related for a particular patient. Most hospice respondents described taking a similar approach, classifying treatments for all conditions that contribute to the terminal prognosis as related.

However, hospices' views varied when discussing some specific types of care. For example, hospices we interviewed had differing views about whether diabetes care

was typically related or unrelated. We also asked hospices if there are any treatments that are typically unrelated. Eye and thyroid conditions were the most frequently mentioned conditions as unrelated, but a number of other conditions were cited by at least one respondent as typically unrelated.

We also asked hospices about their efforts to ensure appropriate service use and billing. Hospice respondents said they use a variety of approaches to educate patients and families that the hospice is responsible for their care and that they should call the hospice first before seeking outside care.

They also described efforts to reach out to other providers and pharmacies to inform them when a beneficiary elects hospice and develop relationships with these entities to coordinate care and appropriate billing.

According to hospices we interviewed, a number of factors likely contribute to related services sometimes being billed outside of hospice. In some cases, hospice efforts to educate a patient and family or to reach out to other providers or pharmacies may be unsuccessful.

Information flow and coordination challenges may

also play a role. For example, in some cases, a nonhospice provider may not realize a beneficiary is in hospice, or a hospice provider may not realize a beneficiary has sought outside services.

There may also be unbundling of the hospice benefit by some hospice or nonhospice providers.

Hospices also told us that they generally do not receive Medicare claims information on the nonhospice services that their individual patients receive unless there is an audit. So they are not in a position to know how often billing errors are occurring.

The interview suggests that multiple factors likely contribute to the significant nonhospice spending that we observe for beneficiaries enrolled in hospice. There are a number of policy directions that could potentially be explored to address this issue. For example, administrative approaches could be considered, like creating a more concrete definition of related services or taking administrative steps to facilitate more information flow across providers, pharmacies, and Part D.

Another approach could be bundling where unrelated services are bundled into the hospice benefit

with an increase to the hospice base rate. In interviews, we asked hospices about this potential approach, and reactions were mixed. Some hospices supported bundling and thought it would simplify things, especially for Part D drugs. Other hospices opposed it and were concerned about the ability of small providers to take on the responsibility for a larger bundle, or the potential for stinting of care by some providers.

A third different approach that could be considered is a payment penalty that could apply to hospice providers whose patients have a high nonhospice spending rate compared with other hospices.

Depending on Commissioners' interest, we could pursue further work to explore one or more of these types of approaches.

So this brings us to the end of the presentation and back to the draft recommendation. I turn the microphone back to Mike.

DR. CHERNEW: Kim, that was really terrific. There's a lot of things happening broadly in the hospice space, both in terms of, I think, the delivery of and also in the research examining hospices and some related demos.

It's a particularly important sector.

I'm going to turn it for, the sake of time, over to the queue, and I think the first person in the queue, Round 1 queue, is Gina. Is that right, Dana?

MS. KELLEY: Right.

MS. UPCHURCH: Thank you, Kim. Very well done. Lots of great information.

I do have this one clarifying question, and I'll have several comments in Round 2. But do we know what percentage of people -- what providers hit the ap and had to return money to Medicare, and how much money was that? Or is that -- you'd hit it with one person but not another, and it would equal out, so you never met the cap to have to pay it back?

MS. NEUMAN: So the cap is an aggregate cap, and it applies across all your patients. So you won't hit it. One provider isn't going to hit it for one patient and not for the other. It's either you hit it in the year or you don't.

And we estimate that just under 19 percent of providers reached the cap in 2021, and I think -- we have this in the paper. I think they represent about -- 5

percent of beneficiaries are served by those providers that hit the cap in 2021.

And I think we estimate the amount of the overage on average per provider that exceeds the cap was in the neighborhood of $450,000.

MS. UPCHURCH: Okay. So I'm sorry I missed that.

If there are 10 people served by an agency, you spent more than $343,000 or something. That's when you would give the money back. Okay.

MS. NEUMAN: Exactly.

MS. UPCHURCH: I just want to make sure I understood it.

MS. NEUMAN: Yeah, yeah, yeah.

MS. UPCHURCH: Yeah. Thank you.

MS. KELLEY: Greg, did you have a Round 1 question?

MR. POULSEN: Yes, I did.

For those people, for that money, that $1.5 billion dollars that we talked about that's spent outside of hospice-covered care, what percentage of that occurs when the person or family decides that, okay, we want to step away from hospice because my mom's had a fall and we

need to go to the emergency room?

The CMS literature that's provided says, well, you know, if you ever want to, you can always step away from hospice and go back to the traditional program, and then you can join hospice again. Is that what is happening there, or is this people that are just simply providing care? They're still under the hospice rubric. They've never formally stepped away, and they're getting care, anyway. Is my question making sense? It's a difficult one to ask.

MS. NEUMAN: Yeah, it makes sense.

So I think the way this $1.5 billion is estimated is it's not including the first day in hospice or the last day if you're discharged alive, and so if somebody goes to the hospital and decides that they don't want to be in hospice anymore and they're discharged and they decide to revoke and return to traditional Medicare, then that spending on that day of the live discharge would not be in this $1.5 billion.

MS. KELLEY: That's all I have for Round 1. Should we go to Round 2? Yes. Scott is first.

DR. SARRAN: Thanks for a very concise chapter.

First, I support the recommendation of the eliminating the update, and in terms of dealing with the potentially overlapping hospice, nonhospice spend, I'm comfortable with exploring either the outlier approach -- that was, I think, your third one -- or the administrative approach, the first one.

I think the challenge, as you point out, with the bundling is it will potentially chase away the smaller hospices, and we already have an issue, I think, where the smaller hospices are going away, and they're being taken over by for-profit organizations, which is probably not the direction we want.

Okay. My overall strong impressions, re-reading the material and going through the presentation, is that I am -- and I think we all should be -- deeply troubled by our -- although admittedly incomplete, the picture of quality in hospice. And it's certainly no -- nothing negative against very many, very good players out there, but overall, the quality picture should really be troubling.

First, process measures, we mentioned on page 25 and in the pre-meeting materials. We're still dealing with

penalizing hospices for nonreporting. That just shows how primitive we are, that we're dealing with having to penalize providers, not for can't even get the reports in. That just shows we have a long ways to go.

We then mentioned provision of in-person visits at the end of life is still remaining below 2019 levels. Again that's a process measure, but it's a troubling one.

More troubling are the outcome measures reflected in CAHPS, and I just have to call these out. These are page 26 in the pre-meeting material.

The median hospice, median meaning half or worse, had 10 percent of patients' informal caregivers give the bottom rating on help for pain and symptoms, meaning the patient sometimes or never got the help they needed. So let that sink in, okay?

Page 27 continues that in the median, meaning half or worse, also the same, I think, 10 percent, problems with providing timely help defined as "sometimes or never getting timely help." So again, let that sink in for a minute, right, if that were us or our relative.

So to me, the big picture here is, yes, the industry is doing well financially, but no, we're not doing

well, getting the value we need and the help for, again, obviously our very, most frail beneficiaries at the end of their life.

If you look also at page 28 on the CAHPS, only 75 percent were hospices scored -- or CAHPS survey responders reported, top box, results for help with pain and symptoms, which is unimproved from 2019, and only 77 percent, a slight decrease scored, top box, on providing timely help. Again, just take a moment and think about that picture, right?

Again, I know we're talking about the updates. Again, I appreciate the work. I'm in sync with the recommendation, but I think we have to call out strongly that in terms of value of quality versus payment, it's the quality that's the issue, not the payment, or it's the quality that's the bigger issue.

Last thought on that is I think about how we moved several years ago -- and, Robert, you and I were talking about this in hospitals -- through Medicare to stop paying for the most egregious "never" events, the archetypal, fortunately, extremely rare these days of taking the wrong leg off or the wrong surgery on the wrong

patient or so forth.

Having a beneficiary enrolled in hospice who dies with inadequate symptom relief, in my mind, that's a clinical "never" event, and we should be considering for CMS. We should recommend CMS that they consider using withholding payment for "never" events at the same time they crank up the expectations around incenting positive events or positive outcomes, positive scores.

Thanks.

MS. KELLEY: Cheryl.

DR. DAMBERG: Kim, thanks for a great chapter. This is a really interesting read.

So I think all the indicators sort of align with what the Chair's recommendation is in terms of a zero percent update. So I would be in alignment with that.

In terms of some of the other areas covered in this chapter, I thought the nonhospital spending, especially the large growth, was concerning and was glad to see some recommendations about possible options for addressing that.

I have to confess, I don't know enough about this space to know whether bundling would be a good thing or a

bad thing, would love to learn more about the possible downsides of that.

But it seems to me in the near term, some education or guidance is needed, and while we're waiting to sort out different payment approaches, it seems to me that CMS could move more quickly to provide some guidance to try to tamp down on that.

And then lastly, I would plus-one on Scott's comments about the CAHPS scores. The performance is really lacking on a number of these indicators that you would think you would care deeply about if you were in hospice, and if you look at the hospice's star ratings, half of them are in the 1, 2, and 3 range.

MS. KELLEY: Gina.

MS. UPCHURCH: I appreciate Scott's comments.

I just want to say plus-one to that. If there's ever a time that we need to be person-centered in the way we arrange medical care and health supports, it's in hospice care. So my comments are related to that.

I don't really care if something's related to Medicare A or D, if it's related or unrelated to that bundle of payment, if it's something someone needs. So I

think we have a systems problem of not making it clear necessarily; for example, we say instead of getting this care.

It's not you're taking hospice instead of or in addition to Medicare. I don't think that's clear, your regular Medicare benefits. Is hospice something additional, or it's to replace everything? If we really want it to replace everything, we need to do some clear systems fixing, because obviously it's really fuzzy with the drug benefits. For example, I'm a pharmacist. So if somebody is filling a prescription for Parkinson's medicines, but the reason the person's on hospice is because they had a devastating stroke, do I fill the Parkinson's meds? Don't you want the person to be able to move around a little? So it's too fuzzy. Is that related. Should it be in the bundle? Should it not be in the bundle, but the pharmacist is not going to get in trouble for filling the Parkinson's meds? I just feel like that's a systems problem that shouldn't fall to the patients.

Then I really appreciate the work you all did on looking at long stays, and you mentioned neurological issues and dementia. For the people that I know that have

gone into hospice with dementia, the reason they've gone in, they needed a bed. They needed a comfortable bed. They need a hospital bed. They needed incontinence supplies. They needed someone to come in the home. They were shocked, first of all, that there was no in-home aide services, really, except for when you need help bathing a couple times a week, but they needed that to stay in the home and to be somewhat clean. And they needed a quarterback, so that 24/7 nursing, that you can call 24/7, that can manage the pain was so critical.

So if we're going to say we're going to be real concerned about whether it's related to the hospice bundle or not, if we're going to make it harder to get into hospice care, then we need to have those things available in some other reasonable way, because that's what gives people a quality of life as they're getting sicker and sicker.

And we don't pay for a lot of those things, to get a hospital bed, to get incontinent supplies. I think a lot of people choose hospice to get those basic services, even when they may have more than six months to live, but I think that's why they end up in the hospice benefit, from

our perspective, from what we see in the community.

And lastly, just around the Part D, prior authorization, for certain medicines that should be related to the hospice benefit, again, you have pharmacists that are rotating through these large chains. I'm not sure how they're notified and how they know where's the hard stop that, no, that should be billed to the hospice benefit, not to their SilverScript Part D plan. We need to fix the systems.

And I guess my main comment is I want it to be as person-centered as possible. So whether it's related or unrelated, that becomes less. And I guess I'm wondering, do we think that there's too much money going to unrelated services and we want less of that, or is it okay to have money going to unrelated services? I mean, guess I don't know that.

DR. CHERNEW: Well, let me just say a few things.

MS. UPCHURCH: Yes.

DR. CHERNEW: There's a complicated history of hospice and how it was sold and what it was meant to do in a range of ways. I think there's an acknowledgment that end of life is a particularly important time, and the

regulatory framework around hospice and what it meant has, I think, for a long time been challenged for those reasons. I think it was sold in some sectors as a money-saving activity, we'll give you these extra things, but then you can't -- then people realize, well, that doesn't actually really make clinical sense.

There's been some demonstrations, the MCCM demonstration, for example, in this area. There's been some research in this area about what goes on.

So I think we're planning a broader look about these more holistic hospice issues beyond this, for this reason, both because we acknowledge what these issues are. We acknowledge sort of emerging research about the impact. But again, I think in the particular case of hospice, the history of how it was sold and the way we thought about it is different than the way some of the comments might be, and so we are working through there.

What does seem to be the case is -- this is going to sound so reductionist, and I don't mean it to be -- the margins are high, and so the reason we haven't been more aggressive in some ways is because we need to think through some of these interactions with the rest of the health care

system. So as it's been pointed out, as Brian did, we think about these things in silos. We should think about them holistically.

In that sense, in an update sense, we're bound to do that. I could give you a number of examples where, in fact, in practice, we are aware of specific instances where things are working across sectors, and we do take them into account in how we work through our updates. And I think that's motivating a bit about where we sort of ended up here as a payer, as opposed to where we might end up if we just said, "Oh, it's where the margins are. Let's see something else."

So I'm not sure that's a good answer, but I do think it jumps out of your reading the chapter that the related and unrelated discussion is fraught with challenges.

MS. UPCHURCH: My comment would just be I can understand if we think that hospital providers are trying to skirt their responsibilities to take care of the people they're getting paid to take care of. I get that and that we need to monitor that.

I guess what I'm more concerned about is if that

person still needs other care, that we consider reasonable, even with less than six months to live, that we don't put barriers to getting that care in our systems.

Thanks.

DR. CHERNEW: All right. So given the time, we should move on, but that's a comment that we could probably spend half an hour on just in and of itself.

I think Jonathan is next.

DR. JAFFERY: Yeah, thanks. And, Kim, great chapter. Thanks.

Can you go back to the slide that looks at the margin by quartiles? It's relatively early in the presentation. Just to lay the groundwork, it looked like that fifth quintile was the one where things dropped off considerably where hospices were over the aggregate cap, correct?

I think it's the next one after this, maybe. There it is, on the side. Yeah.

Yeah. So they go up and up, and then you see the highest quintile.

So this is just a -- I'm just going to throw this out there quickly, not related to the recommendation here

but just as a thought. Since it's my last year, I'm just going to start throwing out all sorts of ideas for work for later on.

I think it's a really great example. I've always thought it was a really great example of a really excellent policy that was constructed in a way that really got around the negative consequences of other kinds of payment models that we put in place, whether it's because someone's doing something deliberately or not. It just seemed very effective.

But it's also kind of binary, and I wonder if there's a way to think about that over time, whereas there's some aggregate cap type of policy that could be crafted that smooths out these margins a little bit better. And it's not just the fifth quintile. You're over it and problem solved. So just something to think about.

And then one other comment too to think about is now that they're starting to move towards MA being part of it and given all the other conversations we've had about MA penetration and some of the administrative burden that gets put into place when dealing with Medicare Advantage and what that does for not only providers but beneficiaries,

something really important to keep an eye on, not just the financial outcomes.

But anyway, great chapter, and I look forward to watching from afar.

MS. KELLEY: Brian.

DR. MILLER: A couple of thoughts on point response to the margin smoothing. I don't think we should do margin smoothing. I think we should have broader policies to improve performance in the marketplace.

And one of the things about the increasing MA penetration, I agree that that's a concern, and that's why I think one of the things we should explore further is integrating the hospice benefit into MA and what that would look like, because for an MA plan, you should have to care for the bene from entrance until final departure. You shouldn't be able to skirt that with fee-for-service.

A couple sort of bigger-picture thoughts. One, I am not Catholic, but a lot of Catholic organizations sponsored a lot of the early hospices. I think it would probably behoove us to talk with Catholic Health Leadership Alliance or the Council of Bishops to learn about their early experience in this space.

I agree with Scott on the concerns about quality. I have a slightly different take knowing about the "never" events. There was a 2012 New England Journal paper that showed that that payment policy intervention was not for CLABSIs in particular. It was not particularly effective at changing the rate of change and that "never" event.

I also know that other industries have been tortured with quality regulation, doctors through VIPs, hospitals through the hospital readmissions reduction program, which has been shown to increase mortality in cardiac disease. So I'm cautious about overdoing quality regulations, specifically at our level here.

One of the things that I do think is the one to two star -- the high penetration of one-to-two-star hospice facilities is really concerning. Maybe we should think about an MA-like model, four-star ratings, where if you are below a certain level, you get put on probation, can't have new beneficiaries enter, and then if that poor performance continues, you get ejected, right? Because I don't think any of us want our family members or anybody to be in a one-star hospice and agree that the quality metrics for going into that star rating should probably improve.

But probably our better recommendation for us is to suggest an off ramp for those facilities, because it's scary, right? Because hospice is -- the family members rarely in an inpatient hospice. At-home hospice, you're helping with toileting, you're cleaning them up, you're bathing them, turning them, giving them meds. It's pretty burdensome for a family, and so no one should have a one-star experience with the facility or agency that's helping them with that.

I want to sort of caution people's concern about nonhospital spending. When you are dying, people have doubts. Those doubts are normal, right? Sometimes people make decisions when they're in hospice, and they say, actually, XYZ happened, I'm short of breath. They go to the hospital. They get admitted. They get treated for pneumonia, heart failure, COPD, exacerbation, or whatever. They may leave the hospital and then reenter hospice. They may leave the hospital and not reenter hospice, close but have a level of care that's between that.

So when we look at that nonhospice spending, we shouldn't necessarily look at that as bad spending. Some of it might be, but a lot of it is people having different

thoughts and different paths at the end of their life. And like Gina, I think we should not restrict that, because what we don't want to have happen is have Medicare beneficiaries sign up for hospice and be stuck in there because of a capitated payment that includes all care, and then the hospice says, "Oh, you can't go to the hospital. You can't do all these things." We want beneficiaries -- and part of, I think, the promise and the social contract of hospice is that people get to choose to go into it, and then they can still do other things should they feel that they and their clinician -- doctor, nurse practitioner, whomever -- feel that that's appropriate. So I wouldn't want us to suggest breaking that sacred social contract.

MS. NEUMAN: Can I offer one?

DR. CHERNEW: Yep.

MS. NEUMAN: I know we're short of time.

DR. CHERNEW: Very quickly.

MS. NEUMAN: Yeah.

I just wanted to offer just a very quick clarification that the issue of related services is not in any way driven by the idea that beneficiaries don't have a choice in terms of whether they want to be in hospice or in

conventional care and that they can switch back and forth as they wish to do so.

The spending that is estimated here is for when beneficiaries are in hospice, not for when they left.

DR. MILLER: Right. But --

MS. NEUMAN: And just one last thing, and then I promise I'll stop because I know we have no time. But it's been more about whether you whatever services the beneficiary gets, just making sure the appropriate entity is paying for it, whether it be hospice or fee-for-service or Part D.

DR. MILLER: Right. And I wasn't trying to suggest that you were saying that they can't switch in and out. So just to clarify, I'm saying, like, when people are in hospice and they go and do other things and incur other expenditures, we should be cautious as Commissioners, not you staff, the written document about saying that that is bad spending, because it's not necessarily bad spending.

MR. MASI: I'll be very quick. That's different from the point -- or in addition to the point that I thought Kim might have made.

An historical point, I think the Commission

recommended carving the hospice benefit into MA, And I'm looking at you for the year because I don't recall offhand.

MS. NEUMAN: 2013 or 2014.

MR. MASI: Thank you. Just as a --

DR. CHERNEW: [Off microphone.]

MS. KELLEY: Robert.

DR. CHERRY: Thank you.

This chapter was nicely done. It's an extremely important topic, particularly when you think about the number of patients that benefit from hospice care and the families it touches. So it's really a critical part of the life cycle, if you will.

Just regarding, I think, the very positive sign about trying to shift from process outcomes to really outcome measures -- and it can be difficult, of course, to define what a successful outcome is in this particular space. One of the things that in my travels, I hear about a lot of efforts around redesigning CG-CAHPS and HCAHPS, so that's more patient- and family-focused, and also other types of digital and electronic platforms to get information in real time.

I haven't heard about that kind of momentum

necessarily with hospice CAHPS, and it may in fact be going on. But whether it's in this chapter or maybe another chapter that's related to hospice care, it will be great if maybe a recommendation around -- you know, taking a step back and perhaps redesigning the hospice CAHPS survey in a way that that's meaningful for the families that are completing this.

In an ideal world too, just as a corollary, one thing I would like to see too is -- you know, families and patients come in with goals of care, and it would be nice if maybe their top three or five goals of care was translated into a hospice CAHPS survey so that how well those goals of care were met can actually be captured after hospice care is completed. I think that's another way of kind of putting some sort of measure on outcomes, because outcomes can really only be defined by the patient, the families, in terms of what they want to get out of it. And I think goals of care is one critical way of actually being able to measure that.

But otherwise, I think you laid out the issues very nicely in the chapter. So thank you for that. And no concerns about the recommendation. I'm supportive.

MS. KELLEY: Tamara.

DR. KONETZKA: Thanks, Kim, for a super interesting and careful chapter.

I agree with the payment recommendation. So I'm going to focus my comments on these services outside the bundle, which I find really fascinating. I feel strongly that we should work toward a bundle that includes these services in contrast to what a few other people have expressed but for a couple of reasons.

First of all, I think having services being paid outside the bundle just may be unsustainable. We see the growth now, and even if we try to define it well, I just imagine many unintended consequences and hospice providers finding a way to sort of get around those definitions, because it would have to be a pretty extensive definition, I think, to work well. I'm not sure it can cover all the contingencies.

But I think more importantly than that, to me, having these services outside the bundle is just antithetical to my idea of hospice, regardless of what the history was or how it started. But I think this idea of sort of communication with the hospice team and the

coordination across services and sort of helping a family think through the sort of right bundle of care -- I know there are maybe unintended consequences in that as well, but to me, that's part of hospice, right? It's sort of a different way of looking at care, and that seems to me to be really important.

And we kind of know how to do bundles. We do it in a lot of places, right? So the idea is that, okay, maybe there's a lot of variation. Maybe we're going to need some outlier payments. We're going to need to make sure that hospice providers don't have an incentive to avoid really complex patients if they can't build those things outside. But we've worked through that in many other different bundle payments kind of scenario.

So I guess I just want to express that I think moving toward a bundle is probably the right way to go coupled with an emphasis on quality. That part is important. So just like in other sectors, we don't want hospice providers to just have an incentive to not pay for that other kind of care.

And the other issue that came up in some of the surveys that you did or the interviews about the billing, I

feel like the billing stuff, we can fix, right? We know when people are on Medicare Advantage, and we know who has to pay that, right? We can fix it. If somebody's on a hospice benefit, we can fix who has to -- that everybody knows who pays for that.

Okay. I'll stop there.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you very much. Great chapter. Great comments.

I just have to give a plus-one to what was just shared. When I was reading this, it made total sense to me that there would be an all-inclusive bundle, because from the person's point of view, it's all connected. If they're incontinent at night and they go to the bathroom and fall and break something, it's all connected. So to have that kind of parsing just doesn't make sense to me.

And it seems to me that then there's a real incentive to be much more proactive about managing that incontinence, et cetera, et cetera, whatever it might be. So when I read that, that was my immediate impression, although I haven't studied it deeply. So I might be a little bit more like Cheryl in that point.

I just wanted to mention the very short stays that were talked about on page 32. We haven't mentioned those much, but very short stays are also a huge concern to me as we prolong people's dying in this country and prolong their suffering, and that hadn't come up.

I hadn't thought about the star rating exit plan that Brian mentioned, which is actually very interesting. I want to think about that more, but it seems the best way to change behavior is stop paying for it. What you permit, you promote. So I think that's a very intriguing idea.

And I don't know about this, but it seems to me that benefit designs really have to change as the nature of aging in the United States change. My understanding is initially hospice was directed towards cancer care, which has a certain kind of trajectory, and now if we think about the people with cognitive disorders who may live a very, very long time, how do we think about hospice, palliative care for them? Because the burden on families is huge too, which is a whole other dimension.

Having said that, I really appreciate the work and the conversation, and I support the recommendation.

MS. KELLEY: Stacie.

DR. DUSETZINA: I also support the recommendation, and I just want to say plus-one to Scott and Robert and others who have emphasized the issues around measuring the quality and getting that right because this is such an important area to be patient centered, as Gina referenced.

I also think that, in a separate work stream, so not related to this specific issue, I would love to know much more about the MA versus fee-for-service, how much more time, when are they enrolling.

Also, it's not clear to me if you go back after you've gone into hospice and you go back. Do you always go back to fee-for-service, or could you go back to MA? So maybe additional details in that space for that separate work stream.

I also think that maybe there is something there around this low star ratings or ways we should be thinking about payments and bundles, but as many have pointed out, it's complicated.

But this is really exceptional work, and thank you very much.

MS. KELLEY: Amol?

DR. NAVATHE: Thanks, Kim. Great work. I also support the rec.

I'm going to try to be very brief here as much as I can be. I also support and echo the concerns about quality.

I'm also supportive of the idea of pursuing this work around nonhospice care and alternative approaches, whether they're payment or penalty or exit or what have you.

I have a couple of really quick thoughts on that. So I think there's an element here, which is challenges and program design. I think we should differentiate two different pieces. One part is the ability to take what should be hospice spending and shift it to the nonhospice spending, which I think is essentially more egregious and something that we should probably be much more assertive about in the short run and maybe trying to even point that out to CMS.

I think there's a broader issue of what happens to nonhospice spending when somebody is in hospice, and I think that that's actually sufficiently more complicated and sufficiently requires sufficiently more thought. And I

wonder if from the MA demonstration if we can garner some more insights.

Also, the VA has for a long time not required people to forego curative treatment to be on hospice. So you can be on both hospice and get your curative chemo or surgery or whatever. I think it would be great if we could bring some information about that, because I think -- my very sort of general gist of the evidence there is that there are positive spillovers from being in hospice on nonhospice-related spending. It would be good to know about what we can learn from that.

And I do think we should be careful about thinking about -- as somebody who studies bundles a lot and value-based payments, one of the ideas behind most of these value-based payment models a la bundled payments is that you need to be able to tie it to some notion of value. If we feel that we cannot measure quality in any reasonable or meaningful way, I would be very concerned about that a la concerns that Brian and others have made about stinting and other issues there.

So I think we should definitely pursue this. I just think we have to be very thoughtful and careful, and I

strongly urge just to differentiate this point of kind of gaming of what's in hospice versus not versus the whole total pie, if you will.

Thanks.

DR. CASALINO: I can be quick.

First of all, I do support the recommendation.

Secondly -- this will be very quick -- if we're actually going to get into big-think mode, if that's what you meant, Mike, about hospice, just one idea, and I can throw out two sentences. When Karen DeSalvo was a Commissioner a few years ago, she suggested that hospice is becoming, to a large extent, a dementia program and isn't well suited for that. She thought there should be some thinking about that and should there be a different program for dementia and not make it hospice. So I'll leave it at that. That's a very big think, if we get to that.

The last thing I have to mention --- the last thing I have to mention is the related versus unrelated conditions. It would be really careful -- it would be really easy here to make things worse. So the amount of money we're talking about is actually pretty small, right? Less than $2 billion. I mean, it's true, a billion here, a

billion there. Appreciate you talk about real money, right? But still, by the standards of what we're talking about here, that's small.

I'm actually more concerned about what's not counted in that less than $2 billion is the cost to the hospice of trying to figure it out, the cost of other providers, the cost of Medicare, and probably worst of all, the uncertainty for the families who are trying to figure out, "My God, if I do this, am I going to have to be on the hook for this, and is the hospice screw me here?" and on and on and on.

So that's really kind of intolerable, much more than the $1.9 billion or whatever. Anything that would simplify things a lot, even if it doesn't save money, I think would be extremely valuable. That would make less uncertainty.

All these three approaches here have -- it's easy to see in each one of them how they can introduce unintended consequences that would actually make things -- might or might not have financial effects but would make things worse for everybody involved.

So the bundle payments is conceptually

attractive. Tamara did a good job of talking about that, I think. But it probably would drive small hospices out of business. That might be a good or bad thing. I'd love to see some data on the star rating performance -- I don't think it was in the chapter -- on the star rating performance of small hospices. Maybe I just missed it, but that would be useful.

And just the last comment, which is related to could we do bundles and avoid skimping, for example, on care, I actually think that -- and I'm pretty ignorant really in this area of hospice care, but it seems to me that would be easier to measure quality in hospice care than in hospital care or physician care, whatever, because really the family's experience is huge, right? And so if the family's experience is bad, I think quality is bad, right? You don't have to look at readmissions or any of those things. There would be a problem with different patient populations with different hospices take care, but that could probably be dealt with.

But my main point is I think with the unrelated spending, simpler would be better and simpler in terms of what it really makes families and providers in the hospice

do, and I wouldn't make things more complicated in a way that would introduce consequences that we really don't like in an attempt to save a half a billion dollars or something like that.

DR. CHERNEW: Dana, was that the end of Round 2?

MS. KELLEY: I believe that is, although I think Scott had one more thought. No? Okay. Then we're all set.

DR. CHERNEW: Okay. So what we're going to do, if we can transition quickly to dialysis -- I will wrap up, and then we're going to move right into dialysis because we obviously have a lot to cover.

So yeah, there's a lot going on in the hospice space in part because of the way the program was originally designed and what it was intended to do and the narrative that surrounded it, and I think it's becoming clear as evidence arises. I would have argued a lot of people felt, I think probably appropriately, there was a lot of clinically deleterious, quality of life deleterious, and expensive end-of-life care that wasn't helping anybody. And hospice was a mechanism to allow people to perhaps have a more deliberative end-of-life experience, which I think

is broadly important.

At the time, people felt that in order to get those added services, in order to make it not an add-on, you had to forego care that, again, at the time, I think some people felt might not be appropriate for somebody that was close to the end of life. I think the feeling was if you're close to end of life, why do we need to treat anything? We just have to help manage you.

I think it's become clear in this discussion, what is sort of clinically clear, is there's a lot of other services that people might need. The type of care that people are getting at hospice now is a patient population that's different than I think it was originally. Originally, I think it was a lot of cancer care, and now there's a lot of people with other conditions in the hospice program. And I think we're trying to, in some sense, on the fly think through that narrative.

The evidence, Amol mentioned the VA. There's also the MCCM demonstration. There's some other research that's been going on that suggests that we might be able to do -- we might be able to accomplish the original goals without this incredibly burdensome and administratively

complex system where we require people to decide, well, you have the right to cover something that's related, not unrelated, what is that? That entire way of thinking might actually not be needed to achieve some of the original goals of hospice.

But that is -- as I think I may have said earlier, that is a longer conversation and an update conversation. So I appreciate all of those comments. I think the ones around quality of care, end of life remain an important thing, and we will get to that.

But what we're going to get to now is Nancy.

So go ahead, and we are going to talk about dialysis.

MS. RAY: Thank you, Mike. 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 2025. First, we will discuss some background on this payment system. Then we'll walk through the payment adequacy analysis. And 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, fee-for-service 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 2022, there were roughly 290,000 fee-for-service beneficiaries on dialysis, treated at 7,865 facilities. Total fee-for-service spending was about $8.8 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 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 the industry's capacity to furnish care as measured by the growth in dialysis treatment stations. Between 2021 and 2022, growth of in-center treatment stations was relatively steady while the number of all beneficiaries on dialysis, that is those enrolled in either

fee-for-service or MA, declined. The slowdown in the growth of capacity in 2022 compared to prior years is linked to increased use of home dialysis and the other factors that are listed on the slide.

Another indicator of beneficiaries' access to outpatient dialysis services is providers' fee-for-service Medicare marginal profit. The 18 percent marginal profit suggests that providers have a financial incentive to continue to serve Medicare beneficiaries.

To look at access to care we look at the changes in the volume of services -- trends in the number of dialysis fee-for-service covered treatments. Between 2021 and 2022, the total number of fee-for-service dialysis treatments declined by 14 percent, while the number of fee-for-service beneficiaries on dialysis declined by 13 percent. However, during this period, the number of dialysis treatments per fee-for-service beneficiary per week remained steady, averaging 2.9 treatments. The decline in the number of fee-for-service beneficiaries on dialysis in 2022 is largely attributable to their increased enrollment in Medicare Advantage plans.

Specifically, as of January 2021, the statute

permits beneficiaries with ESRD to enroll in MA plans. Because of this statutory change, the share of beneficiaries on dialysis in MA increased from 27 percent to 47 percent between December 2020 and December 2022. Increasing MA enrollment by beneficiaries on dialysis is likely linked to the factors listed on this slide that affect enrollment among non-ESRD beneficiaries. In addition, the Commission's analysis found that in 2018, MA 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 use of ESRD drugs that are furnished to fee-for-service beneficiaries on dialysis. This chart measures the volume of ESRD drugs furnished by holding price constant. Since 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 black bar -- has changed. Between 2010 and 2022, use of ESAs has declined by 60 percent.

Including drugs in payment bundles is an example of the how Medicare can use payment policy to promote

efficiency. Under the ESRD PPS, providers have become more judicious about the provision of services; we have seen competition for market share among drugs with similar health effects; and, importantly, CMS's monitoring program concluded no sustained negative changes in beneficiary health status from the changes in drug use over the years.

Quality is stable. Between 2021 and 2022, measures of ED visits, admissions, readmissions, and mortality held steady. The rate of blood transfusion, an anemia quality measure, also held steady. An indicator that measures how well the dialysis treatment removes waste from the blood -- dialysis adequacy -- remained high in 2022. And the rate of home dialysis among fee-for-service beneficiaries on dialysis and the number of kidney transplants across all patients increased.

Regarding access to capital, indicators suggest it is positive. Overall growth trends among dialysis providers indicate that the dialysis industry remains attractive to for-profit facilities and investors. The large dialysis organizations have reported positive financial performance related to their dialysis business for 2023, including improvements in productivity and

earnings growth. In addition, both large dialysis organizations are also vertically integrated, suggesting good access to capital. The 2022 all-payer margin was 14 percent.

Moving to providers' financial performance under fee-for-service, dialysis facilities' financial performance under the ESRD PPS has been variable due to statutory and regulatory changes as well as the use and profitability of certain ESRD drugs. For example, between 2018 and 2020, the add-on payment for new drugs contributed to the increase in the aggregate fee-for-service Medicare margin. In 2022, higher labor and capital cost growth than historical norms contributed to a decline in the aggregate fee-for-service Medicare margin

In 2022, the fee-for-service margin is -1.1 percent, and as you can see, the margin varies by treatment volume. Smaller facilities have substantially higher cost per treatment than larger ones. The lower Medicare margin for rural facilities is related to their capacity and treatment volume. Rural facilities are on average smaller than urban ones. They provide fewer treatments. In your mailing materials, we highlight that cost per treatment is

highly correlated with treatment volume.

The 2024 projected Medicare margin is 0 percent. We project the 2024 fee-for-service Medicare margin to modestly improve compared to the 2022 aggregate margin, after considering payment updates, historical cost growth, and the small reductions in total payments due to the ESRD QIP and CMMI's ETC model. Other factors not considered that may have a positive effect on future margins are listed on this slide, including the potential effect of a new add-on payment for an anemia drug in 2023.

Here is a quick summary of the payment adequacy findings. Access to care indicators are generally favorable. The decline in treatment volume is largely attributable to beneficiaries on dialysis enrolling in MA. Quality is stable. For example, in 2022, dialysis adequacy continues to remain high and home dialysis continues to grow. The 2024 Medicare margin is projected at 0 percent.

This brings us to the Chair's draft recommendation that reads,

For calendar year 2025, the Congress should update the calendar year 2024 Medicare end-stage renal disease prospective payment system base rate by the amount

determined under current law.

This draft recommendation will have no impact relative to the statutory update. Based on current estimates, this would increase the base rate by 1.8 percent.

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

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

DR. CHERNEW: Terrific, Nancy. We should jump into Round 1, and I think the first person is Larry.

DR. CASALINO: Yeah. I think a simple question, Nancy, that I should probably know the answer to but I don't. In hospital and physician sector, my understanding is that Medicare Advantage does not pay above Medicare fee-for-service rates to hospitals or physicians. But apparently MA does pay above Medicare fee-for-service rates to dialysis facilities. How does that happen? First of all, is that correct, and secondly, why? How can dialysis facilities do what hospitals and physicians can't, for example?

MS. RAY: So I'm going to have the person who calculated that number answer your question.

DR. JOHNSON: I don't think we know exactly how it happens, but does have to do with the negotiating leverage between the dialysis organizations and MA plans. One factor in that is that generally plans have to participate in, you know, submit bids based on a county basis and meet network adequacy standards. They used to have to meet network adequacy standards which was in place for the years of our analysis for dialysis organizations, and there are a number of counties where the only dialysis provider is from one of the two large dialysis organizations.

DR. CASALINO: And so if the dialysis provider says, "If you are not going to pay us X, we are just not going to see Medicare patients, period," and wind up getting paid fee-for-service rates, then the MA plan is stuck. That's the idea?

DR. JOHNSON: Generally, yes, although they will still continue to see the Medicare patients, but it will not be in network with the plan. The plan has a general responsibility still to provide those services and make

sure that there is access, but they will be not through a contractual agreement.

DR. CASALINO: But if they're not in network with the plan, why don't they just get paid fee-for-service rates, as in other sectors? That's what I don't understand.

MR. MASI: They'll refuse to service that patient.

DR. JOHNSON: If they see that patient, they will be receiving fee-for-service rates, generally.

MR. MASI: And to clarify, even if that patient remains a Medicare Advantage patient?

DR. JOHNSON: Yes. We can get back to you and clarify that situation. I'm not quite sure -- I didn't quite understand the exact question.

DR. JAFFERY: I think at the end of the day it's a balance. It's different factors of, one, the history of network adequacy, but then it's a leverage thing because LDOs are so consolidated, and then it's a capacity thing. So if you don't need to take them, you don't necessarily have to -- they have all the negotiating power in this in a way that hospital sectors and physicians do not.

DR. CASALINO: [Off microphone.]

DR. JAFFERY: Right. And I remember early on, years ago, it was Warner Thomas who would talk about, you know, you take the 50 biggest hospital systems in the country and they don't get anywhere close to the level of consolidation that you have from the two LDOs.

DR. CASALINO: So basically, they have the threat of not taking Medicare patients at all.

MR. POULSEN: Yeah. The leverage is they won't take the Medicare Advantage patients from that Medicare Advantage plan, right.

DR. CHERNEW: And then you can't be a Medicare Advantage plan in that area.

MR. POULSEN: Because you don't have --

DR. CHERNEW: That's a relatively small thing, and your entire ability to operate.

MR. POULSEN: And it's not exclusive to them. I mean, there's nothing unique about this except for the fact that there's so much market power with those two organizations.

DR. CASALINO: I get it.

MR. POULSEN: There's no reason it couldn't

happen in some other sector if they had that market --

DR. CASALINO: Got it. So as Jonathan said. Okay. That's helpful.

DR. JAFFERY: They could absorb if they can't agree in these two counties --

DR. CASALINO: It's nice that --

DR. JAFFERY: -- for a year. They're not going to go under.

DR. CASALINO: It's nice that the antitrust agencies let this happen.

MS. KELLEY: I have Tamara next with a Round 1 question.

DR. KONETZKA: This follows nicely on that. I have two quick questions. One is, first of all, great chapter, very interesting. It's not a sector that I really feel expert in, so I learned a lot. But I was just really astounded by the extent of horizontal and vertical integration. I mean, it's not only very consolidated horizontally but apparently there is all this vertical integration as well.

And one aspect of the chapter you wrote about was these joint ventures with physicians, and in the spirit of

vertical integration I was wondering, is that arrangements between the physician and a particular facility, or a regional facility, or all the facilities with one of these big companies, which affects the market power, then, that they have.

MS. RAY: Yeah. That's a good question. I would think it would be, at least in the, I guess what I would call the MSA, but I would want to go back and double-check that to know if it's even broader than that.

DR. KONETZKA: Okay. Yeah, I just feel like there's tons of consolidation questions here that we may or may not get into.

But anyway, moving on to my other Round 1 question, on a different track, it seems like home dialysis seems like the preferred mode for a lot of people, and in the chapter you said 53 percent of facilities offer in-home dialysis, but only about 16 percent of patients overall end up getting it. Have you done any analysis of the relationship between facility occupancy and the percent of patients getting home dialysis, or why do you think that's so low?

MS. RAY: So making the decision to do in-center

dialysis versus home dialysis is a very patient-specific decision. There are a lot of factors that are going to enter into that. Well, I can start and then you can finish.

DR. KONETZKA: I was concerned, because it said some of the reasons were patients just didn't know about it, so are facilities just not telling them about it, and they have all this in-center capacity?

MS. RAY: It starts with beneficiary education, of course. It also has to do with provider training. For a long while, I think, it did have to do with what I would call the bricks-and-mortar syndrome, which means if you are building a facility of course you're going to want to fill the treatment stations. I think, over the last, gosh, five to ten years, there has been increased emphasis in at least educating patients to dialyze at home. CMMI now has a mandatory model in which I think roughly 30 percent of facilities are required to participate, and their money bonus or withhold is based on their home dialysis rate and getting people on the transplant waiting list.

So it's a very complicated decision. Some patients feel more comfortable in-center than at home.

It's complicated.

DR. JAFFERY: Yeah, I mean, you nailed most of that. Just a couple of things, to put an exclamation point on it. So there are two kinds of home dialysis. There is peritoneal and there is hemodialysis. There are a lot of things that go into having the capabilities to do either of those at home -- space, supplies, things like that. There is the concern over managing your care. If you're doing home hemodialysis then you have to have somebody who can help run it, like put a needle in your arm and be there to manage it.

And I think from a payment policy perspective, I don't know how many years it is now -- COVID screwed everything up in my mind, so it's probably a little bit longer -- but it hasn't been that long that the financial incentives to provide home hemodialysis have really incented that. And so as a result, between the brick-and-mortar piece there hasn't been as much of it except in larger centers, or maybe academic centers would do peritoneal dialysis for an entire state. But then, over time, and Nancy mentioned this, basically there's less training so people didn't really learn about it.

Nephrologists didn't learn about peritoneal dialysis, so you just sort of did what you knew. And home hemodialysis, the technology was not as prevalent.

So all those factors have made it a slower uptake, but it's changing.

MS. RAY: Right. Right. Right. The other thing is researchers have linked the implementation of the ESRD PPS that included the drugs in the bundle, they have linked that to an increase in home dialysis as well.

MS. KELLEY: Gina.

MS. UPCHURCH: Thank you for the chapter. Questions about medication and medication prices and looking at value of how we pay for medications for dialysis patients. I see four ways that we are paying for medications for people with dialysis, if I have it right. So there is a transitional drug add-on payment for certain medications. There is now a post-transitional care add-on payment for Korsuva. Here is the third one. The third one is when it's in the bundle, and then you have the large dialysis units, organizations, I imagine, negotiating with all their power. And then you have Part D, which is all the different standalone plans or Medicare Advantage plans

using PBMs that then get rebates as a way to negotiate prices.

So what is the best way for us to get medications to people that need dialysis with the least expensive costs and less hassle to patient and everybody else? Is there a clear answer to that?

MS. RAY: Well, I mean, in my opinion it would be all included in the bundle. That would be the most seamless for the beneficiary. They wouldn't be having any separate cost sharing.

The Commission made a recommendation in June of 2020, that the transitional drug add-on payment for drugs that are in an existing functional category, that CMS should stop implementing that, essentially. That was the recommendation.

And then just one last part, to answer your question. In 2025, unless Congress acts in the interim, CMS will have the statutory authority to move phosphate binders, which is considered an ESRD drug, into the Part B ESRD PPS.

MS. UPCHURCH: Okay. Thank you for that. So is the payment less, from Medicare's perspective, if it is in

the bundle? Is that a Part B? Is it based on ASP? What is the cost there?

MS. RAY: Okay. So when the ESRD PPS was implemented, let's look at the ESAs, for example. What they did is they took the drug utilization in a prior period and multiplied that by the ASP -- I believe it was the ASP at the time -- and that amount was accounted for in the bundle. And that was done drug by drug. So that's how they originally got the 2011 bundle in place.

So in 2018, calcimimetics, which were being paid under Part D prior to that, they were moved into the ESRD PPS because an injectable form became available in 2018. So this was a -- let me backtrack a moment, and I'm sorry for being long-winded.

When CMS put together the ESRD PPS in 2011, they said the Part D drugs, the calcimimetics, the phosphate binders, should be in a bundle, but we are going to defer it until 2014, so we have more data and such. Congress has delayed that now until 2025. In 2018, however, calcimimetics were eligible to be put into the Part B ESRD bundle because an injectable form was approved by the FDA. They gathered utilization data from a three-year period and

then in 2021, those drugs were put into the bundle and the base rate was increased accordingly.

MS. UPCHURCH: Okay. So first of all your history is amazing and the fact that you know all that. But secondly, is ASP -- and I will look to Stacie here -- is ASP a better price than what the Part D plans have been able to do, in terms of like getting rebates in the end? I guess that's what I'm getting at.

MS. RAY: So for phosphate binders I don't know the answer to that. That's a really good question. I'm not going to try to answer that.

MS. UPCHURCH: All right. Thank you so much.

MS. KELLEY: Greg, do you have a Round 1 question?

MR. POULSEN: Yeah, very quickly. Do we know the average tenure that somebody has once they are identified as ESRD with Medicare? I mean, I was looking at the Table 6.1 of their age, but I was just wondering do we know how long they typically are part of the program?

MS. RAY: So the mortality rate -- I'm trying to bring that number up -- I'm going to say it's roughly between 15 to 18 percent per year.

MR. POULSEN: And that would be across all age groups, I'm assuming?

MS. RAY: Yeah. Yes.

MR. POULSEN: I was just trying to figure out if somebody is identified early it would be interesting to know what kind of length of time we would have to implement cost-saving and health-enhancing things that may be effective within a bundle or within an entire prospective payment approach. But that's probably something that's premature to ask, but thank you.

MR. MASI: And Greg, we can check that and get back to you.

MS. KELLEY: Robert?

DR. CHERRY: Thank you. First of all, I'm also impressed with your history as well. Just to clarify. One part of the pre-read materials mentions the consolidation of the two largest dialysis organizations. Then separate from that is this 6 percent increase in the cost per treatment. Is there a relationship between the two, or not, in terms of the costs that they are incurring in the context of increased consolidation?

MS. RAY: So I'm not sure I can answer your

question. What I can tell you, number one, is the two large dialysis organizations account for roughly 75 percent of all fee-for-service treatments, so clearly, they have an effect on the payments and cost, the results that we see here.

And both in their calls with investors and publicly their available materials, because they are publicly traded, have noted the increased cost pressure from increased labor costs in 2021 and 2022.

DR. CHERRY: Okay. All right. Thank you.

MS. KELLEY: That's all I had for Round 1, unless I missed someone. So we'll go to Round 2, and Stacie is first.

DR. DUSETZINA: So this is excellent work, as always, and I'm not sure how articulate I can be about this because I have just been struggling with the MA uptake in this group, which just seems extremely large to me. And I've been trying to work through, as others are making comments, about payment issues and the network adequacy issues. So it seems like an area where MA plans are not able to -- they are overpaying relative to fee-for-service, so they might not be that interested in bringing a bunch of

beneficiaries over.

When I'm reading through the ones on the materials it sounds like it might be the financial protections that are driving beneficiaries in this direction, but I'm just so shocked at how fast beneficiaries moved to MA, and I worry about why. We know, historically, once people pick something they just stay in it, so this feels a little suspicious to me. So maybe I'll just put a plug for if we're going down the path of looking more into this, and maybe it's MA behavior, this feels like one to look closely at, because this seems suspicious.

Great work. I agree with the chair's recommendations on the update.

MS. UPCHURCH: Can I make a point on that? When we see people that have end-stage renal disease and they don't have guaranteed issue rights to a supplement, they could go absolutely broke, and they would quickly. So that's the drive to Medicare Advantage. And I do know, from one of the large organizations I talked to this past week, trying to get some help, and they create payment plans, because, you know, you have all these dollars up front because you have MOOPs, maximum out-of-pockets, but

they come at the beginning of the year, so they'll work with you on payment plans, so it's spread out through the year, so that smoothing. But a lot of people just can't afford a supplement.

DR. DUSETZINA: So maybe that would be helpful to know if there was any particular outreach that was done related to this or if this is coming from maybe the dialysis providing centers, giving people information about, oh, you could be on this plan and have that out-of-pocket maximum. But that's the part that I'm thinking about.

MS. KELLEY: Brian.

DR. MILLER: Thank you. I think that challenges in this space are best elaborated by saying that the two large dialysis organizations have their own acronym, LDOs. So I was just thinking about that for a moment. Which is a long way of saying I recognize how hard this space is to do in policy, analyze and write about it, so I thought this was a very concise chapter, which is great.

I want to unpack the MA component a little bit more, because it was actually really interesting. I went back and pulled it up in the shifts, like that graph which

you had, which was great. I was trying to find the page. It was the one that showed the number of weekly treatments and the number of -- oh, thank you -- Figure 6.1, which showed the 21st Century CARES Act with that direct policy change, and then the massive drop in fee-for-service benes on dialysis and dialysis treatments, yet the preservation of the number of per-weekly treatments.

I think it is worth maybe have a discussion about the difference in the fee-for-service and MA benefit design, not to say that there's anything wrong, but I'm saying we should emphasize that that's probably a driving factor. As Gina was saying, if you get integrated PDP, Medigap coverage, supplemental benefits, and a MOOP, and you get it at a really low cost, and you know you're going to be consuming a load of medical care, functionally that actually makes MA, for many of these benes, especially given that they probably have a limited financial resources, very limited income, it makes it the only option for them.

And also looking at the share of benes, it looks like it's going to continue to decrease in fee-for-service and increase in MA, so I wonder if this is an example of a

market with potentially less favorable selection than other MA markets, because I don't think that there is a healthy ESRD beneficiary, having cared for many of them.

And then I also wonder, sort of to Scott's comments on not necessarily this section but on other sections, about quality and the need for integrated care, if we should think about having some small section or comment about D-SNPs for the dual eligibles who are ESRD benes and the need to further integrate their benefits.

And I know that we have historically, MedPAC has historically recommended eliminating CCIPs, which I personally disagree with, but that as a potential model to increase customization for care for these benes, many of whom fly in and out of the hospital with complications. Some have heart failure, COPD, and lots of other medical problems, and are arguably the most expensive Medicare population. The policy community is obviously concerned about outcomes, but the beneficiaries themselves are the most concerned, because half of their life is spent in medical care.

This is a long way of saying I love this chapter, loved the graph, can we talk a little bit more about the MA

versus fee-for-service benefit design tradeoff and the potential for more experimentation with C-SNPs and D-SNPs.

MS. RAY: So just to let you know, the ESRD D-SNPs I think care for roughly, what is it, like 4,400 patients in about 15 states. I think that factoid is buried in a footnote, but we can move that up for you.

DR. MILLER: Yeah. That would be great. Thank you.

MS. KELLEY: Scott.

DR. SARRAN: Just a very brief comment. Thanks for the work. I support the current recommendation. And I actually think this space is an example of an area where CMS has, over many years, pursued an agenda that has, by and large, worked, meaning they thought about bundles, they have increased the quality expectations year by year, and some very good things are happening that we might not have anticipated, which is the uptick in home-based dialysis and transplants.

So there may be some things we can learn from this space where I think there have been a lot of good directions happening, and potentially apply those to other spaces.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thank you very much for this chapter. Quite informative. I agree with the chair's recommendation in terms of the payment updates.

One thing, I really like Table 6.1 in the chapter where you lay out the different characteristics of those on dialysis, and I know you have some text right above it. But I think I would be inclined to add to the table the percentages who are LIS duals versus not. Because I think this underlies this question around the shift to MA and trying to avoid all those out-of-pocket costs.

DR. CHERNEW: There's a lot going on here, but that was a really rich discussion. So again, thanks to the staff for all of the work they have done in putting this out. I think we talk a lot about issues of consolidation, and I think here is an area where we haven't, and we can see how that challenges a lot of other things, and there are a lot of issues with how we [inaudible].

As always, there is a range of issues beyond just the update recommendation, but I do appreciate the broader set of comments about this, and in particular I think -- and this is probably true throughout the day -- the

acknowledgment that the beneficiary and what they face in their centrality to how we think about what is going on, and I think a lot of that came out in the themes of the comments that were made, and I very much appreciate that.

So to those at home we had a very rich afternoon, and we really would appreciate hearing your comments about it, so please reach out to us at meetingcomments@Medpac.gov, or in any other way. We will look forward to those comments.

To the staff, both here and from presenting earlier, really appreciate all of the work that you've done. To the Commissioners, thanks for hanging in. Larry is going to give you some special thanks in a minute. Larry, go on.

DR. CASALINO: I'm just looking at the last slide here which says "Please note official public comment letters submitted within 14 days will be posted on MedPAC's website." People might wonder what an official public comment letter is as opposed to public comments that maybe submitted directly too. Is there something special about --

DR. CHERNEW: That's a Paul question?

DR. CASALINO: Is everything that comes in an official comment, or is there something special about official comments?

MR. MASI: Thanks for the question, Larry, and this was in an effort to enhance transparency around our proceedings and our interactions with stakeholders. I think, in general, comments we receive within 14 days will be considered official public comment letters unless there is an obvious reason to consider them not official. For example, if they contain lots of words that I would not say in public, that would be one basis for being unofficial. But I don't anticipate receiving too many of those.

DR. CHERNEW: George Carlin will explain the words you can't use.

DR. CASALINO: So anything that comes in within 14 days. It can just be from any individual. It doesn't have to be from the AMA.

MS. KELLEY: Yes, but it does need to be a letter, not an email or a text or a tweet. It needs to be a letter.

DR. CASALINO: So it has to be mailed.

MS. KELLEY: It can be emailed to us, but it

needs to be a letter.

DR. CASALINO: Okay. In a letter form. Got it.

DR. CHERNEW: This is something we are experimenting with, to allow people to see what we receive.

DR. CASALINO: I think it's a good idea.

DR. CHERNEW: Anyway, we'll see how that plays out.

But in any case, let me get back to the actual job at hand, which was saying thank you to everybody. We will be back for our discussion tomorrow morning. We are going to talk about SNFs, we'll talk about IRFs, and we'll talk about home health.

So again, thank you to the staff, thank you to the Commissioners, thank you, everybody. Have a wonderful night, and get some rest for tomorrow. Thanks.

[Whereupon, at 4:44 p.m. the Commission was recessed, to resume at 9:00 a.m. on Friday, December 8, 2023.]

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 8, 2023
9:01 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
AMOL S. NAVATHE, MD, PhD, Vice Chair
LAWRENCE P. CASALINO, MD, PhD
ROBERT CHERRY, MD, MS, FACS, FACHE
CHERYL DAMBERG, PhD, MPH
STACIE B. DUSETZINA, PhD
JONATHAN B. JAFFERY, MD, MS, MMM, FACP
KENNY KAN, CPA, CFA, MAAA
R. TAMARA KONETZKA, PhD
BRIAN MILLER, MD, MBA, MPH
GREGORY POULSON, MBA
BETTY RAMBUR, PhD, RN, FAAN
WAYNE J. RILEY, MD, MPH, MBA
JAEWON RYU, MD, JD
SCOTT SARRAN, MD
GINA UPCHURCH, RPH, MPH

AGENDA PAGE

P R O C E E D I N G S

[9:01 a.m.]

DR. CHERNEW: Good morning, everybody, and welcome to our Friday MedPAC session, where we're going to continue to work through our update recommendations.

We're going to start. We have a day of post-acute, and we're going to start with SNF. So, Kathryn, you're up.

MS. LINEHAN: Thanks, and good morning, everybody.

I'm here to present our work on skilled nursing facility services, and I'd like to acknowledge Pamina Mejia and Betty Fout's contributions to the paper. And I'd like to remind webinar attendees that they can download a copy of the slide from the control panel on the right-hand side of the screen.

In today's presentation, I will cover six topics, an overview of SNF's use and spending in 2022, then the four domains of payment adequacy indicators, beneficiaries' access to SNF care, quality of care, access to capital, and fee-for-service Medicare payments and SNF's costs. And finally, I will present the Chair's draft recommendation

for your discussion.

This slide provides an overview of the SNF sector in 2022. That year, there were about 14,700 SNFs, most of which also provide long-term care that make up the bulk of the services this sector provides.

For the average SNF, Medicare makes up about 10 percent of total facility days. This contrasts with other PAC settings where fee-for-service Medicare makes up about half of providers' volume.

In 2022, there were 1.8 million fee-for-service Medicare covered stays for SNFs -- covered SNF stays, and the program paid $29 billion for care in SNFs and SNF care provided in swing beds. You can find more detail on the SNF and swing bed spending and utilization breakdown in your paper.

A new payment system for SNFs called the patient-driven payment model, or PDPM, was implemented in fiscal year 2020. Because the changes and effects of PDPM will come up a few times in our discussion, I thought it would be helpful to review the PDPM briefly.

The PDPM made a number of changes to the SNF prospective payment system, including recognizing and

targeting payments for the higher costs associated with medically complex patients and paying for therapy disciplines based on patient characteristics and function, rather than on the volume of services provided as under the old payment system.

Consistent with the PDPM's elimination of incentives to provide more therapy to receive higher payments, minutes of therapy per stay declined when PDPM was implemented.

Another effect of the PDPM was the unintentional 4.6 percent increase in payments to SNFs above the amount intended by CMS starting in 2020. CMS did not correct for this unintentional increase until 2023 and 2024. So payments above the intended amount in 2020 to 2022 were not recouped.

Each year, we assess 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 indicators used for skilled nursing facilities are shown 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 2022, and we include preliminary data for 2023 where possible.

We also project a Medicare margin for the upcoming year, fiscal year 2024, 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 SNFs in 2025.

Turning to our measures of access, the number of SNFs declined about 1 percent from 2022 through October 2023. The number of certified beds declined less than 1 percent.

Staff are also key to ensuring access. After falling during the pandemic, as volume plummeted, employment in the SNF sector has been growing since the spring of 2022. But the number of workers remained below pre-pandemic levels, according to the BLS. We do not have comprehensive data on capacity constraints at SNFs due to staffing, but some facilities have reported staffing challenges as volume returns.

After falling during the pandemic, SNF occupancy into 2023 and per fee-for-service beneficiary utilization rates increased in 2022. Specifically, mean occupancy was 81 percent in September 2023. This is a marked increase compared to the pandemic low of 69 percent in January 2021, though not quite at the pre-pandemic level of 85 percent in 2019.

SNF admissions in days per fee-for-service beneficiary increased to 10 percent in 2022, in part, due to recovering some of the share of acute care hospital discharges lost during the pandemic, as detailed in your paper. Admissions per fee-for-service beneficiary in 2022 were below 2019, but days per beneficiary were higher, owing to longer lengths of stay.

Another indicator of access, the Medicare marginal profit was high in 2022. At 27 percent, SNFs with available capacity have a financial incentive to serve Medicare fee-for-service beneficiaries.

Shifting now to indicators of the quality of SNF care, we assess the quality of care in post-acute care settings, including SNFs, using two claims-based outcome measures, average risk adjusted rates of discharge to the

community and potentially preventable readmissions after discharge. These measures include data for 24 months. More information about these measures is in your paper.

As shown in the top left table, the most recent data from fiscal year 2021 and 2022 show a median facility discharge to the community rate of 50.7 percent and a median rate of potentially preventable readmissions of 10.4 percent. The discharge to community rate is a slight decline compared to 2018 and 2019. Due to a change in the way the measure was calculated, we can't compare the readmission rate to the earlier period.

The amount and continuity of nursing facility staff are also an indicator of quality. In the bottom left table, we see that the median facility total nurse and RN staffing ratios declined slightly between 2019 and 2022. The median 12 month turnover rate was 53 percent in 2022. Turnover was not available for 2019. As discussed in October and detailed in your paper, average staffing rates varied across facilities.

Ideally, we would also present data on other outcomes and the experience of SNF care for Medicare beneficiaries in a Part A stay, but significant gaps in

data persist.

First, patient experience data are not collected for SNFs, as they are for many other sectors that we assess.

Second, restoration and maintenance of patient function is a key outcome in all post-acute care settings, including SNFs. However, because provider-reported function data are used to adjust payment, the Commission has raised concerns about its validity as an outcome measure. In our June 2019 report to the Congress, the Commission discussed strategies to monitor and improve function data.

Monitoring changes in patient function is especially important since the implementation of PDPM. While current provider-reported function information is flawed, beneficiaries and policymakers have a strong interest in objective information about SNFs and other PAC providers' effectiveness in improving or maintaining their patients' function.

Because the vast majority of SNFs are also nursing homes, we assessed the access to capital for nursing homes. The number of nursing facility transactions

fell in 2022, the latest full year for which we have data. While there were fewer transactions, they involved more facilities in 2022 compared to 2021.

In 2022, the average price per SNF bed in these transactions rose to a record high. As debt has become more expensive, however, the average price per bed has dropped for the four quarters ending in June 2023 but still remained high.

HUD is a key lender in the nursing facility sector. It typically finances renovations and improvements rather than new construction. In its data from fiscal year 2023, HUD reported that it financed fewer projects compared to 2022, but the amount of financing was about the same.

In 2022, the all-payer margin for nursing homes, reflecting all lines of business, all payers, and investment income, was minus 1.4 percent, down from 3.4 percent in 2021.

Provider relief funds were reported in 2022, but the amounts in aggregate were about half of what they were in 2020 and 2021, contributing to the reduced total margins.

Because the all-payer margin includes Medicaid-

funded long-term care, the overall financial performance of this setting is heavily influenced by state Medicaid payments to nursing homes, including their base rates and supplemental payments.

In part, because of SNF's all-payer margin, the Commission grapples each year with concerns about the financing of the nursing facility sector broadly, but narrowly making a recommendation to update Medicare SNF fee-for-service payment rates. So I thought it would be useful to spend a slide highlighting work that our fellow Commission, MACPAC, published earlier this year on Medicaid payments relative to nursing home costs.

With the caution that these findings do not include supplemental payments because of data quality problems, MACPAC found a wide range, both within and across states, in Medicaid-based payment rates compared with nursing facilities' acuity-adjusted costs in 2019, as shown in the figure on the left.

In about four-fifths of facilities nationally, in the orange box, Medicaid-based payment rates did not cover their costs. The median nursing facility had base payment amounts that were 86 percent of costs. However, as I

noted, these payments do not include supplemental payments.

Because they found that payment and cost data were incomplete and variable across states, MACPAC recommended that all sources of Medicaid payment to providers be collected and reported consistently for a more complete accounting of how Medicaid payments compare to nursing home costs.

The variability across facilities in Medicaid payment-to-cost ratios illustrates how Medicare fee-for-service SNF payments in excess of cost could result in poorly targeted subsidies, as discussed more in your paper.

Okay. Moving on from the Medicaid rate interlude, we're now going to review changes to freestanding SNFs' Medicare payments and costs per day in 2022. As a reminder, freestanding SNFs made up about 97 percent of facilities.

SNF payments per day increased 2.2 percent in 2022. This change reflects the combined effect of the market basket increase to the base payment rate, an increase in case mix, and the reinstatement of the sequester starting in April 2022.

Compared to 2021, average cost per day increased

1.7 percent. This relatively lower growth in cost per day reflects more covered days over which to spread fixed cost. Total cost growth in 2022 reflects both a higher than historical average growth in routine costs per day, though that growth moderated relative to 2020 and 2021 and partially offsetting reductions in ancillary costs per day, which are reflective of fewer total therapy minutes per say and increased use of group and concurrent therapy.

As a result of changes in cost and payments, the average fee-for-service Medicare margin for freestanding facilities was 18.4 percent in 2022, as shown in the top row of the table.

As shown in the figure on the right, this is the 23rd year in a row that the average fee-for-service Medicare margin for freestanding facilities was above 10 percent. These Medicare margins illustrate why fee-for-service Medicare is a preferred payer.

Across facilities, fee-for-service Medicare margins varied, as they have for years. For example, in 2022, the average margin for nonprofit SNFs was 1.1 percent, and for-profits was 22 percent. As detailed in your paper, variations in Medicare margins reflect several

factors, including economies of scale.

Nonprofit facilities are typically smaller and have higher costs per day. Nonprofits also had higher cost growth compared with for-profit SNFs.

We project that SNF Medicare margins will decrease in 2024 to 16 percent. This is because costs between our base and projection year are expected to increase more than payments. Specifically, in our estimate of costs, we use CMS's most recent estimate of the market basket for 2023 and 2024. On the payment side, we assume that payments will increase by the amounts in the final rules for 2023 and 2024, including positive forecast error corrections in both years.

We also accounted for the reapplication of the sequester starting in April 2022 and the adjustment of the minus 2.3 percent that CMS applied in 2023 and 2024 to correct for excess payment 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 these assumptions.

In summary, our access indicators show that the supply of facilities declined 1 percent. Employment

remains below pre-pandemic levels, but occupancy is rebounding, and fee-for-service Medicare SNF use per beneficiary increased in 2022.

The high Medicare marginal profit indicates providers have a strong incentive to treat fee-for-service Medicare beneficiaries.

Measures of quality show that the risk-adjusted facility rate of discharge to the community declined slightly compared to the pre-pandemic period as to total nurse and RN staffing ratios. Notably, data on patient experience and function are lacking in this sector.

SNFs have adequate access to capital, and the sector remains attractive to investors. The total margin fell compared to 2021, but this is not a function of Medicare's payments.

In continuation of a now decades-long trend, the average Medicare margin in 2022 was high at 18.4 percent. Factoring in expected changes to payments and costs, the projected margin for 2024 is 16 percent.

So this brings us to the Chair's draft recommendation. The recommendation reads "For fiscal year 2025, the Congress should reduce the 2024 Medicare base

payment rates for skilled nursing facilities by 3 percent. We project the SNF margin in 2024 to remain high, even with the downward adjustment to account for excess payment resulting from the new case mix system. A reduction to SNF base rates is needed to more closely align aggregate payments to aggregate costs.

In terms of implications, spending would be lower relative to current law. We do not expect adverse effects on access to care due to continued provider willingness and ability to treat fee-for-service Medicare beneficiaries.

That concludes the presentation, and I'll turn it over to Mike and your discussion.

DR. CHERNEW: Thank you so much. This has always been a very challenging sector because of the interplay between Medicare and Medicaid and other payers, and I think everyone agreed that during the recent pandemic, this was a particularly important and particularly challenging time for the sector that we're still grappling with the hangover from.

But that said, that was an outstanding presentation. So I think we're going to jump into the comments, and I think Tamara is first. Is that right,

Dana?

DR. KONETZKA: Great. Thanks, Kathryn. That was excellent work, super interesting.

My question is -- you know, this is obviously about fee-for-service, but managed -- Medicare Advantage is playing a stronger and stronger role in this sector. And you mentioned in the chapter that we don't have the data really to look at Medicare Advantage, which is true in terms of spending. Have you tried to use the MDS to look at utilization from Medicare Advantage, and does that affect the other conclusions you made?

MS. LINEHAN: Thank you for your question.

We are right now in the process of putting the data together to do that. I don't have that for this chapter, but we've been working across the PAC settings trying to link the assessment data with claims and to try to assess completeness, and we hope next year to bring some data to you, at least on the completeness of what we have. So we'll hopefully have more information on that soon.

MS. KELLEY: Gina?

MS. UPCHURCH: Thank you, Kathryn, so much for this information. I've got three quick questions for you.

On page 14, you noted that some skilled nursing facilities tried to avoid longer stays. Do you know the reasons for that?

MS. LINEHAN: There are a subset of facilities that might prefer and specialize in PAC, post-acute care, and so try to do less long-term care business, and so because the patients are commonly -- their stay is commonly paid for by Medicaid. So --

MS. UPCHURCH: Okay. So longer stays. I thought that meant you want them to stay 10 days, not 40 days.

MS. LINEHAN: Oh, sorry. That could be clearer. So what I meant there was long, long-stay patients, not short-stay SNF patients.

MS. UPCHURCH: Okay. Thank you. That's helpful.

And then the mean and the median for discharge to communities hovers around 50 percent. That's just Part A, right? That's just people in part A of post-acute care? That's not all skilled nursing. That's just --

MS. LINEHAN: That's correct.

MS. UPCHURCH: Okay.

MS. LINEHAN: And in the calculation of that measure, beneficiaries who were nursing home residents

prior to their SNF stay are excluded. So they're not --

MS. UPCHURCH: So truly, it's people that are there for rehab to move on. Okay.

MS. LINEHAN: Yeah.

MS. UPCHURCH: My last question -- and I'll have a comment in Round 2 --is, why don't we gather patient experience for people in skilled nursing facilities that are there for rehab? Is there --

MS. LINEHAN: I don't know. I don't know why we don't have it. I think that it's been developed. CMS proposed it in the 2024 proposed rule, but they didn't implement it. I could go back and look at the language for the rationale. Maybe Tamara knows. But it's --

MS. UPCHURCH: Do we know if states collect it and if there's any distinction between a Part A post-acute versus long-term stay?

MS. LINEHAN: I don't know. Greg is nodding affirmatively, so --

DR. CHERNEW: Tamara?

DR. KONETZKA: Yeah, a couple of things. I mean, CMS has been thinking about the patient experience measures forever, but there was a lot of controversy on two points;

one, which one to use. So they had originally backed the sort of industry-backed one, which is quite short, and then I think there's a lot of pushback about that particular measure. And then the other measure, there's a kind of CAHPS measure for patient experience that I think it would just sort of cost more to implement and would be longer. So there was a lot of pushback from the industry about that one. So maybe that's what led to CMS deciding to not do it now, but there's been pressure for a long time to include it.

MS. UPCHURCH: Okay.

DR. NAVATHE: Tamara, on the first measure, you said there was pushback. Pushback from who on the first one?

DR. KONETZKA: Oh, sorry. Mostly advocates and researchers who just didn't like the industry-backed patient experience measure.

MS. LINEHAN: It's like a four-item question set.

DR. CHERNEW: I think this is a common tension where everybody agrees on a broad direction and then they disagree on the details and then nothing happens. I think that is true. I don't believe we could think through, if

we have a position on match tradeoff, there is obviously a legitimate concern across a lot of things about the administrative costs of doing varying things. But there is also, I think, a legitimate concern to want to get richer information to understand what's going on, and that's a complicated balancing act.

MS. UPCHURCH: Yeah.

MS. LINEHAN: And Gina, what was your second thing?

MS. UPCHURCH: I mean, well, and if there's a distinction between what you asked the long-term stay people versus the Part A in their post-acute care, if it is the same questions or if it's different questions.

But I just want to, getting back to some comments that Scott made yesterday around the quality of care that we provide, I am very concerned about staff turnover, which will be my comment in the next time. But asking the individual -- because we keep hearing, oh, you've been there 20 days; it's time to go, and it's like, what's different about Day 18 than Day 25 here in the skilled nursing facility? So I feel like an exit interview of some sort of, you know, how was your care, do you feel like

you're ready to go?

I'm very concerned, particularly for people, you know, if you're looking at an equity issue, people that are being discharged to home that really can't manage in their home. And I know there's pressure on ACOs and alternative payment models that says they want to save some money by looking at the post-acute care stay. In the long run that would hurt them if they go back to the hospital.

But I'm just concerned about that transition, when people don't feel like they're ready to go, so somehow getting at how was your experience and do you feel that you have been made ready to go back into the community? That seems really critical. So thank you for your work.

MS. KELLEY: Brian.

DR. MILLER: I have a clarification question. I tried to look up the functional status quality measures on the CMS website but unfortunately the link was dead. So can you tell us a little bit more about the functional status measure that CMS uses? We mentioned in the chapter that providers do it. By "providers" do we mean some random staff member in the facility, a registered nurse, LPN, NP, and just sort of what goes into that functional

status measure? One, for my edification, and then we may also want to put that in the chapter too, because most readers probably won't know.

MS. LINEHAN: So in your paper, on page 19, there is some information on the measure. It uses data from the MDS.

DR. MILLER: Right. I'm saying like what goes into assessing functional status? Who --

MS. LINEHAN: Oh, like the instructions on the MDS?

DR. MILLER: Yeah, and who is actually doing the assessment? Like is it a clinical staff member, is it an LPN, is it a nurse practitioner, or is it the front desk staff?

MS. LINEHAN: I can add something to the chapter that explains sort of what the instructions are for those measures and how they are supposed to determine that.

DR. MILLER: The reason I ask about this is when I was an FDA product reviewer there were lots of drugs where the measurement scale sometimes can be, shall we say, adjusted or interpreted differently. And so knowing how that measurement scale is constructed and who is doing the

assessment will give us a better idea of what is the reliability, or lack thereof, from that assessment of functional status. Because for beneficiaries who are in a skilled nursing facility, functional status is arguably probably one of the most important outcomes in addition to beneficiary satisfaction, so having us understand, and having the public understand how that measure is good or not good will make our recommendations more effective. Thank you.

MS. LINEHAN: There are instructions in the MDS that say if you can do this. It's like a range of totally dependent to independent. So I can add that for sure.

DR. MILLER: Thank you.

MS. KELLEY: Brian, you have actually tapped into something that has been a concern of the Commission for several years now across all the PAC settings, where I think there has been general agreement that functional status is perhaps the most important outcome of post-acute care, but particularly because it has been used as a function in payment, the incentives are sometimes not as aligned as we might like them to be.

And we have some interesting findings in our work

in IRFs, in the IRF area, and there has been some research in home health, not so much by us but through some of the demonstrations, that had some really interesting suspicious findings about changes in functional outcomes. And we have also had some interesting findings that you did with your staffing, that Kathryn did with her staffing work in relationships with functional outcomes.

So it's a very fraught area, and I think you are hinting at that very strongly.

DR. MILLER: Yeah. And I guess what I'm saying is I like the idea of us paying for outcomes. I love the idea of us paying for improved functional status. Understanding how that is measured to make sure it is measuring what we think it is measuring and that the people who are doing the measurement are the best people to be doing the measurement will help us make better decisions. Because I don't think we should dump functional status as an outcome but we should make sure that it is a robust and valid measure.

DR. CHERNEW: So this is all at an important point. I agree completely, and this is the worst part of my job. But I want to make sure people get to make their

comments, not just their clarifying questions, and this is a short session as is. I will send a chat message, but let's move.

MS. KELLEY: Amol.

DR. NAVATHE: I should have a hopefully very quick question here. Thanks, Kathryn, for the great work.

On Slide 13 there is a chart that shows the fee-for-service Medicare margins over time, and as I understand it the increase that we see from 2019 to 2020, that is related to the PDPM implementation, and I wanted to confirm that. And then secondly just to ask, between 2011 and 2012, we see this pre-market level drop, and I was curious what happened there, such that we saw that level drop.

MS. LINEHAN: Sure. CMS recalibrated the case mix weights under the RUGs in fiscal year 2012, and that led to that reduction, similar to what -- well, not in magnitude, but in spirit, what CMS is doing in 2023 and 2024 for PDPMs. So when the weights were established because of provide behavior changes the payments were above a budget neutral amount, so CMS had to make an adjustment for that. So this is sort of history repeating itself. It is typical for change to the case mix.

DR. NAVATHE: Great. Thank you.

MS. KELLEY: Larry.

DR. CASALINO: Kathryn, one thing that stands out to me in the slides is the 22 percent Medicare margin for for-profit SNFs and the 1 percent margin for nonprofit SNFs. That's a pretty big difference. Just on the face of it, it's a little hard to believe that the for-profits are that much more efficient. Do you want to comment at all on why you think there might be such a big gap?

MS. LINEHAN: So --

DR. CASALINO: I don't think I've ever seen a 22 versus 1 in margins. It's pretty --

MS. LINEHAN: So we see a gap every year. I think there is some detail in your paper about some of the differences, and it's size, there's also lower costs, lower staffing. So those can be contributing factors.

DR. CASALINO: I know it's in the paper. I just kind of want it on the record and in the public meeting. How about comments on quality or staffing?

MS. LINEHAN: So I presented, in October, the staffing information that showed the variation across facilities and the lower average and lower distribution in

for-profit SNFs for staffing. Quality, well, given our sort of staffing may be one quality measure, our other measures, I think we see lower rates of discharge community in for-profits.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thank you. This was a great chapter. I had a question about one of the sentences on page 27 that talks about the PDPM, and if payments are too high. And I guess I'm trying to think about this in the context of the payment update but also sort of longer term, you know, what is being done to address the fact that payments are set too high.

MS. LINEHAN: Could you say a little bit more about what your question is?

DR. DAMBERG: Sure. I think it sounded like the change to the PDPM -- so it says it better recognized medical complexity, which that sounds like a positive, but then it says it set payments too high. So it feels like there's going to be sort of ongoing higher payments to nursing facilities over the long haul, and what action is CMS or Congress taking to try to address that bigger issue?

MS. LINEHAN: Okay, thank you. Now I can answer

that. So CMS estimated that it overpaid, or it inadvertently set the case mix weights too high, resulting in an estimated 4.6 percent payment above the budget neutral amount, so just switching from RUGs to PDPM. And so CMS, in 2023, adjusted the case mix weights downward, and then in 2024, took another adjustment, so that's supposed to take out the 4.6 percent sort of inadvertent excess payment going forward.

Does that answer your question?

DR. DAMBERG: Thanks for clarifying that.

MS. KELLEY: Jaewon.

DR. RYU: Yeah. I had a quick question on the all-payer margin. I think you reference in 2022 that that was negative 1.4 percent. But in the reading materials I think it also referenced that in addition to all lines of business, all payers, it also included investment income. So I wasn't sure if that is actually in there, or is it possible to tease that out separately?

MS. LINEHAN: It is in there. So I know, in the hospital sector, you have asked to have that taken out, and they report a slightly different figure for this sector. I don't know how much investment income is a factor in SNFs.

That's something I could look into.

DR. RYU: Yeah, because I think it references 2022, with investment income in there, and to your point maybe it's nominal. But it would've artificially made their all-payer margin worse than it probably actually was.

MS. KELLEY: That is all I have for Round 1, unless I've missed someone.

DR. CHERNEW: I'm hoping you didn't.

MS. KELLEY: So we can go to Round 2?

DR. CHERNEW: -- Round 2, and we are now going to turn, I think again we have Tamara to kick off Round 2. Just a reminder for everybody, we have a little more than a half an hour scheduled for this. There are about 10 people in the queue, roughly. Love you all.

DR. KONETZKA: I have a list of fairly brief points. Maybe the most important one is about access and our measures of access. I mean, we had lots of conversations yesterday about our kind of blunt measures of access, and this is, to me, a particular concern in the SNF sector. Because I think, sort of anecdotally, anybody who is sort of aware of the challenges of discharges from hospitals and finding a SNF bed, that isn't really

consistent with the sort of fairly good access we see in our more blunt measures about the supply of SNFs.

And I think that is for a couple of reasons. One is there is sort of competition for certain kinds of SNF beds. They're not all equal in quality or in what they specialize in. So if you really need a stroke SNF bed or a joint replacement SNF bed, there may be only one place you can go to in your market. And then the other reason is that all the capacity is not being used because of staffing shortages, so SNFs may not be staffing all their beds. And so just anecdotally we keep hearing about how people being discharged from the hospital are having trouble finding a SNF bed.

I don't know if this is really possible. I actually have a doctoral student working on this in a much more rigorous -- not more rigorous -- a more elaborate way or detailed way. But I wonder if we can move toward any kinds of measures, if it would be possible to look at measures of excess hospital stay, and look at some other kinds of measures of SNF access. I do have some concerns about access right now. So that is one point.

I think that in terms of quality, the successful

discharge and readmissions, given the data limitations, are exactly the right measures to use because out of all the things we can look at in nursing homes, in SNFs, these are the most specific to the post-acute population.

The staffing levels and turnover, they are extremely important and they are important to Medicare beneficiaries in PAC stays as well as in long-term stays. They are just so much harder to, I think, interpret because they apply to the whole facility. Like you cannot divide out staffing for post-acute and staffing for long-stay patients in a nursing home, and that creates a lot of interpretation issues in using those as quality measures. I'll say a little bit more about that with respect to the for-profit/not-for-profit as well in a second. I do think we want to keep tracking staffing levels, though. I mean, I think that's important.

And, in part, even though it affects the whole facility, it's not necessarily just this cross-subsidization issue. Like we care about staffing for the post-acute care stays, and we want that staffing to be high enough.

So I think it's good to track. There's just a

lot of caveats and interpreting it cross different types of facilities that have different payer mixes.

A couple of other data issues. One, we talked yesterday a lot about the cost reports as well. I think in the SNF sector it may add another problem with the cost reports to the list and that is it doesn't really reflect these related party transactions. It's sort of a well-known problem now that if you sell the real estate to a REIT or to some other entity, and you pay sort of inflated rent back to make your profit margins look lower, and then you recoup that profit because it's a related party, we're not going to find that in the cost reports. So the profit margins also should be taken with a grain of salt in the cost reports.

Another data issue, you talked about the ownership data, and CMS is making good progress in trying to publish more ownership data. But we have found that it's not very accurate. There are facilities that were sold to private equity like three years ago and just don't appear as a change of ownership in that CMS data. And so I think we should encourage more pressure on CMS to continue to improve those data, as well as encourage pressure on CMS

to collect patient experience data.

Back to Larry's point about the for-profits and nonprofits, I really think in one way this may be meaningful. In another way SNFs just have these different patient groups that have very different staffing needs that turn into different costs. So if for-profits have really high margins because they have low costs it goes back to this problem, you can't separate out the staffing across the whole facility or the costs, really. I mean, it's kind of tricky. And so for-profits may just have really high margins because they have a huge Medicaid population that has lower staffing needs than the post-acute care population. So it's not just that they are so much more efficient, it is that their patient mix is inherently different in ways that we can't capture well.

And so I think for the data, moving forward, I think the for-profit/nonprofit comparison is great, but maybe we could also sort of stratify by payer mix and look at sort of similar for-profits and nonprofits that have similar Medicaid populations.

Okay. The only other thing I'd say is I think that, in general, I agree with the recommendations. I

think that we all realize there is always this tension. We don't want to use Medicare to cross-subsidize Medicaid, for all the reasons that you explained really well in the chapter, I think. So we don't want to perpetuate this cross-subsidization system.

At the same time, I feel like this is a time of incredible uncertainty. I think that I have some doubts about the access being sufficient. You know, we're not considering the new staffing proposed regs because they're not final yet, but I think that adds a huge amount of uncertainty to the industry. So I guess I would say I wouldn't want to go farther than the cut that we are recommending because this is a particularly vulnerable time for this industry, and we really should have some concerns about access if we change Medicare rates dramatically.

DR. CHERNEW: So let me just add one quick thing. So I agree with that, so people may ask, well, how come the margins are consistently so large and our recommended cut is particularly modest? And I think that is the reason why we ended up -- there is no mathematical certainty about how to go, but that was certainly in our thinking when we came up with the magnitude of what we recommended.

So next we have --

MS. KELLEY: Jonathan.

DR. JAFFERY: Yeah, thanks. Thanks, Kathryn. It is a great chapter, and echoing Mike's comments being the discussion particularly -- I appreciate this more year after year, a particularly challenging sector to think about because of the connections with Medicaid and the great heterogeneity in terms of states' licensing practice and stuff like that.

I just have one point I want to make, and I'm sort of continuing my drumbeat around the way we assess access. There's a lot of things about -- you talk about a nexus and a key marker in the chapter and things saying how many beneficiaries live in a county with three or more SNFs, and I just want to put out that I don't think that's at all equivalent to adequate access to care.

I live in a county with a dozen or more, and I can tell you it's often very, very challenging to get a patient discharged into a skilled nursing facility. And this is increasingly a big problem, tying this back to the capacity discussions in hospitals we were talking about yesterday, increasingly a big problem for many of our big

centers that are pushed at the 85, 95, 100 percent capacity. If you ask them what they need for relief, they're not looking for changes to CON or things like that. They're looking for more nursing homes and beds.

And I think related to that is -- there's a comment in the presentation that one of the lines was about having incentive to serve Medicaid beneficiaries because the marginal profit, and while I think that's true, based on the statistics, but based on your data, it's not necessarily true for all patients. And that becomes a big issue too, as the patients get complex.

So the PMDP -- is that the right abbreviation? -- that is a great step towards that increased complexity, but it's still a big issue as folks around the table could attest to. You try to get a patient that's extremely complex, try to get a patient that has significant mental health, behavioral health concerns, try to get a patient with morbid obesity, or if you've got somebody who has significant nutritional needs and needs TPN or something like that, there's no way they're going to go to a nursing home. They're just not going to accept them.

So just something to really think about as we

think about our access measures. That is a continuing issue across the sectors, really.

Thank you.

MS. KELLEY: Scott.

DR. SARRAN: Thanks, Kathryn. Great presentation.

Yeah. This space is just highlighting, and the space is unique, not just because the different payers are so widely spread in their lengths of stay and their dollars per day, but because our beneficiaries live there funded by other payers. And so somewhat in that context, it's sort of saying we should stay within our swim lane, as Mike continues to remind us appropriately, but our beneficiaries are living in the lane next to us.

In terms of the recommendation, I agree with it, with one modification that we perhaps could consider, which would be to allow nursing facilities or SNFs to earn back the 3 percent based on defined quality and measures. We've got some quality measures now that I think we all agree are incomplete but useful in and of themselves. So I'd like us to consider that.

And then just very quickly, a couple of

reinforcements of some other comments. The access piece, yeah, absolutely, to Jonathan's point. Access is much more granular in the real world. It's not "Is there a SNF bed in this county? Is there a staffed and capable SNF bed for this particular beneficiary's clinical needs?" I know that's difficult, but it really -- you know, real world is much more granular in terms of access.

Big reinforcement, Tamara's point, about we need MA data. Part of the challenge this sector has, real life has is that now half of their business is -- their skilled business is MA, and the relative equilibrium that today exists between large MA plans on one hand and consolidated physician and hospital entities on the other hand, creating a somewhat level playing field in terms of negotiations and behavior, just does not exist effectively in much of this space, meaning you've got a lot of large national payers with a lot of leverage on the MA side and a lot of relatively small SNFs or SNFs that just cannot afford to say no to an MA plan and walk away.

And as MA has grown and MA has gotten tougher in managing utilization and cost per day at SNFs, which everyone acknowledges is the case, we've got to get MA

data. We have such an incomplete understanding of what's going on in this space because of lack of MA data.

Big reinforcement on continuing to work with MACPAC to understand, state by state, what the reimbursement versus cost dynamics are, and I'd love to see all that be clean and public.

And then huge reinforcement on working forward on patient experience. Our comments yesterday or discussion yesterday on hospital discharges and the relative disappointing 50-ish percent on the CAHPS survey of people leaving the hospital feeling adequately informed and prepared for their post-discharge plan, that's a great question right there to be focused on. There are similarly low-hanging fruit, simple questions: Did you understand what the goals of your SNF stay were, and where those goals met? There's a few sort of obvious low-hanging-fruit kinds of patient experience sort of questions that we desperately need.

Thanks.

MR. MASI: If I could jump in real quick. I'm not sure if I'm allowed to do this, but I wanted to say plus-one on the patient experience conversation that a

number of Commissioners have had.

And just as a historical note, wanted to surface for folks that I think in 2021, the Commission did make a recommendation that there ought to be a patient experience tool to measure that in the SNF sector. So I wanted to surface that, and we can include a reference to that in the chapter.

MS. KELLEY: Gina.

MS. UPCHURCH: Great. Thanks again.

The 3 percent reduction, I really prefer Scott's thought that maybe people could earn back some of that, and one of the ways, I think could be including staff turnover. I know we can't say pay living wages, you know, or maybe we can. I don't know what we can say. But staff turnover is a measure of that. Seems like it would be really, really important. So I just want to say I support that idea of earning it back by focusing on quality and staff.

Thanks.

MS. KELLEY: Brian?

DR. MILLER: I'm becoming very interested in the post-acute care space as we continue to have these discussions. I'm getting more excited.

So one, I really like Scott's idea about earning back any sort of cut tied to quality metrics that are meaningful and we know that are robust and less likely to be manipulated.

I also agree with Jonathan's comments about access. I can tell you there are lots of beneficiaries who sit in the hospital waiting for that bed, providing that highly customized care, and they have applied to nine or ten skilled nursing facilities. And you see the daily progress note, and it says patient awaiting discharge.

And so, one, that's a hospital bed that's not being used for a patient who needs hospital services and hospital-level care, and also, there are harms from being in the hospital and not getting access to the care that you need. Hospitals do a great job with rehabilitative services -- or habilitative services. It's not the same as going to a skilled nursing facility or an IRF. So we should add that emphasis in that we need the beneficiary to get the right care from the right team at the right time, and keeping them in the wrong environment harms the operations of that environment, delays access to other beneficiaries for that environment, and then also, of

course, as I said, is not the right place for that beneficiary.

One thing I think we could also mention -- and I realize this is a sub-population, but we should also talk about the role or at least recognize the role of I-SNPs for those beneficiaries who then go to skilled nursing and transition to long-term care. There are lots of beneficiaries who we discharge from the hospital who we know that their stay in subacute rehab is on a path towards long-term care.

With quality metrics, I think we should be more direct about acknowledging the limitations. I'm obviously -- I've seen preventable readmissions, but I also recognize that preventable readmissions to some degree are in the eye of the beholder, and it's not easy, whether you're a hospital or skilled nursing facility, to prevent readmissions. There are lots of things that we'd like to think that we can do but are hard to operationalize and are outside of the systems control. And I say preventable readmissions here for skilled nursing facilities. I know that in the hospital industry, the hospital readmissions reduction program also has many challenges. I don't want

us to replicate that.

An example of a quality measure that I think we should be cautious about or thinking about as a quality measure is the community discharge rate. That's good, right? We all want to discharge beneficiaries to communities.

We also know that there are many beneficiaries who will never, ever be discharged to a community setting because it's just not possible, and so we do not want to discourage skilled nursing facilities from taking those patients from the hospital who we know are not going to get to the community setting. And so if we unfairly penalize skilled nursing facilities for that, then that population -- they're less likely to take that population. Then that population sits in the hospital, and that's bad for the system writ large.

I think that I just agree with everyone's comments that staff turnover is a great quality measure, because something that has come up in the Veterans Affairs space from Representatives Rosendale and Cherfilus-McCormick has been about the need for -- and this is in the veterans space, which I think is relevant to here -- is

customization and personalization of care that could come from a different skill mix, but often it comes from the staff member who knows you, knows what you need, knows that when you're calling, you need to be turned, you need to use the bathroom, you need your meds, whatever it is. And so staff turnover is a great way of getting at that in a meaningful fashion.

I think staffing ratios are not a good quality measure, and the reason is it's not because I don't think skilled nursing facilities need more staffing. They do need more staffing, but we also don't want to put their current operating model in concrete and make that permanent for the future. And if we do a quality measure based upon a staffing ratio, that discourages innovation and thinking about how we deliver care differently. I think we all recognize that skilled nursing facility care is probably not where we would want it to be, but we also recognize it's just a very challenging operational space.

In terms of emphasizing the specialization, there was a discussion in here on page 24 about the different payer mix and different sort of populations. Again, that can be problematic. It can also be a good thing, right?

So specialization might allow facilities to care for certain populations of beneficiaries that aren't well served if they're thrown in the mix.

And then from an access perspective, I think we should note certificate of need as a barrier to building new facilities and as a challenge to then helping get people out of a hospital, and I think I would put more of an emphasis on a discussion of paying for outcomes. Again, robust quality measures need to not be manipulated. We need to feel comfortable with them, I think, but what we do want to do is we want to encourage systems to innovate to do a better job with the limited funds that they have. I don't think we want to specify what their business operating model is, because even though we have a lot of collective wisdom around the table, I think it'd be hard for us all to come up with a description of what that business model should be.

As for the recommendation, I am generally okay cutting payment. However, with the staffing rule, I'm not really sure how I feel about cutting payment if we are putting them in an operating space where the super majority of facilities currently would be noncompliant with that

rule. So I guess I'd want to see what happens with the CMS rule before, at least personally, making decision about what we should do with their payment rate.

And I really love Scott's idea about earn-backs. I think that would be a great way to transition to paying for outcomes.

Thank you.

MS. KELLEY: Robert.

DR. CHERRY: Yes. Thank you for the report. Even though it's a short chapter, it generates a lot of interesting conversations, so well done.

I also want to weigh in on the patient experience comments as well and strongly supportive of what other Commissioners have said.

Interestingly, with Medicare beneficiaries, they get discharged from a hospital, their short stay. They might be there for ten days or two weeks, and then they get home, and they see an H-CAHPS survey and a CG-CAHPS survey. And their experience within those skilled nursing facilities inevitably can bleed onto those other surveys as well. So it would be nice if the SNFs had their own dedicated survey instrument.

The other thing too is that when those referrals are made to other skilled nursing facilities, case managers are using a number of criteria to give patients choices. Some of it is readmission differences that they're seeing in the SNFs, ED visits, but they also get informal feedback from patients and families around their experience at some of these places. And then case managers are using that to create some context around their choices. So having an objective survey instrument, I think, will be helpful in terms of case managers making referrals for discharge planning.

The other thing is I think, like many others, just a little uncomfortable with the cross-subsidization that occurs in this particular space, but for the reasons that Mike mentioned, I'm going to leave it alone. The first principle is, I think, do no harm in this particular sector.

The other thing -- and this may be a third rail question, but I'll kind of put it out there maybe as more of a Mike question. But if we take this 3 percent savings, it's probably, in terms of the fee-for-service component, nearly $900 million. So I sort of wonder whether or not

the savings here could be potentially applied to the hospital payments. I know we often don't think about that, and we try to compartmentalize those things. But I thought I'd kind of put it out there for consideration or critique.

Otherwise very nicely done, and I appreciate the chapter.

MS. KELLEY: Betty?

DR. RAMBUR: Thank you.

Well, this was a great chapter, and I really appreciated the comments from all of you. It's been very enlightening.

Just a couple of additional points, I want to underscore. The decrease in RN staffing is somewhat subtle, but I think that's actually really important, because if you think about skilled nursing, the one thing you really need is nurses. You need other things, but you need nurses. And there is a lot of data on staffing levels and fluctuations, et cetera.

And the turnover rate has been mentioned, and that's obviously a big concern. But it's not only concern for the patients' experience, but it's also the people working in that setting. Organizations start to

cannibalize themselves as people leave. So I think those two metrics are really important.

To the patient experience, I want to add the family experience. It doesn't seem like it would be altogether that difficult to gather some data about the family experience, and I think that would be really important.

And my comment was going to be that these, I believe, should be linked to payment.

I like the earn-back even better, I think, because it maybe prevents a little bit some of the overt potential for gaming. So I think that that's really an interesting idea that Scott and Gina, I believe, both mentioned.

And I just wanted to mention Brian's comment on functional status. What I heard in there is a question is who's gathering the data, because these organizations can be very hierarchical, and there can be a lot of pressure to sort of the equivalent upcoding. So I think that that's really -- you know, it's a very important measure.

Obviously, not everyone's function is going to improve. So it becomes a complicated measure, but overall

I'm very supportive of this recommendation and really am pleased about the work. So thank you.

DR. CHERNEW: I need to jump in since a lot of people have been talking about the earn-back idea, and I just want to give a sense of where we are so you understand.

We have a standing recommendation of quality payment model in the SNF space, and we could discuss whether we like it, want to modify it, whatever we want to do with it. But it does exist.

So the moving to a new value payment component would have to be integrated with all the other stuff we've said, and there would be a bunch of issues that would arise in doing that. And some of these comments, for example, is "Well, we like the idea of earning back, but we also want to change the quality measures in a bunch of ways, and we want to add some others or do some other sort of things." So all of that is well taken.

I think that the spirit of the conversation is one that is both well appreciated and I think had been acknowledged -- Kathryn, I'll let you jump in, if you want, but acknowledged in a whole body of other work that we've

done on how we try and ensure better quality. But I don't want to get expectations further ahead of where they're going to be on what we can actually do in the update recommendation section of what we want. We have to give a number, if we want to change or modify an existing quality program thing, which we have done in the past. Just to be clear, we have had recommendations where we have incorporated a quality model into the recommendation.

I personally have misgivings with how a lot of that works out in practice as opposed to in theory, but that's a separate issue on measurement. The point is, because we have that standing recommendation now, we would have to think about any changes to our value incentive program, both in the measures and the structure and all the other things, in a setting that is probably more detailed than we would do by just having this recommendation say, oh, and by the way, we're now going to integrate this other thing in some other different way than we've already done.

Those VIP recommendations were developed in a set of principles on quality measurement that happened actually before my chairmanship that we went through sector by

sector on how they all went. They're typically a two-sector kind of thing to figure out. They typically grapple with a bunch of measurement issues, which are complicated.

So I think we're probably further away than some of you may like on building quality into the update recommendation stuff, but I want to -- I took the time which we, by the way, don't have. Someone should send me a message to be quiet. I'd appreciate it, but I want to make sure, given the enthusiasm, that you all understand that it is not for disagreement with the principles that we need better measures and better quality programs. But the expectations of the aspirations of doing that are probably a little ahead of where we are in the process of doing that, given that we have gone through that process already with the SNF VIP. It is more complicated than some of the discussion may allude to.

MS. KELLEY: Cheryl.

DR. DAMBERG: So this is a really important care setting for so many Medicare beneficiaries, and we need to support beneficiary access to and receipt of high-quality care in this space. And I just want to add my support to the different measure issues that folks around the table

have cited. So I definitely support the Commission's work on providing greater transparency in the Medicare Advantage space around utilization of SNF and denials.

I want to echo Tamara's comment around getting better data in this space, so who owns who and how that is playing out in this space through enhanced data collection through PECOS, which is the CMS Provider Enrollment Chain Office System database. And particularly, as Tamara noted, the need for annual updating of those data so that we know what is going on in that space because ownership relationships are changing constantly.

I also support the capture of patient experience measures and hope that that can be fast-tracked.

And then I really appreciated the comments from both Tamara and Jonathan about access. I think we have a fairly limited understanding of access, and I would hope that we could signal that more work needs to be done to develop better measures of access.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks, Kathryn, for this great work. As others have highlighted, this is obviously a very challenging sector that has undergone a lot of challenges

through the pandemic and beyond.

I just wanted to make a few quick comments, some of which are echoing what other Commissioners have said. First off, I just wanted to say that I do support the recommendation.

Second, so I think it's important for us to be clear about the safety net analysis that we have done here because there is a clear interaction between sort of the payer mix issue, if we call it that, you know, how much Medicaid versus how much Medicare, in particular, in long stay versus short stay.

So when we do our analysis to look at whether we need to have a Medicare safety net index or whether there is a need to support through a sort of safety net type of mechanism, we conduct this empirical analysis that basically says higher share of LIS, you know, higher Medicare margin. And it seems like while there's not really a role for safety net support, in a sense. And I think that's clearly "confounded," in quotes here, with what is happening between long stay and short stay.

And so I have no critique of our analysis. I think the analysis and the conclusion is right. I just

think it might be worth adding some additional language to be very clear that we're talking about safety net support through a Medicare type of mechanism for the Medicare type of stay, which is very different than a broader issue around is there a sort of safety net issue around access or quality or other issues that relate to broader nursing home care. So I think we could benefit from just clarifying that a little bit further so that way there is less wiggle room, if you will, for misinterpretation of what we are actually and what we mean by our analysis.

The second thing is wanted to also touch upon the many comments that have been made about access. In part, I guess I would say this is informed by my own clinical practice as well, where I agree with Jonathan, Brian, and others that while short stays, on average, are certainly desirable and more profitable and oftentimes sought after perhaps by skilled nursing facilities, there is a considerable variation or variability by the patient factors that are oftentimes highly non-clinical in nature, and I think Jonathan alluded to many of them. I share that experience and I share that concern.

And that certainly has a ripple effect, also, on

the hospital sector, as it can be very difficult to discharge patients that have behavioral issues, have issues with delirium, have issues with substance abuse, have issues with housing instability. There are a whole bunch of these factors where if the SNF doesn't feel like they are going to be able to discharge the patient in an expeditious way then it's very hard to actually get what should be a short stay patient into a SNF.

And I realize we have data limitations, but I think to the extent that we could, as we did in some sense in the hospice work, where we talked to operators to understand a little bit of what those dynamics look like, within the limited capacity bandwidth and budget and other things that we have, I think if it is something that we could prioritize I think it would be very helpful. Because ultimately our measures of access are clearly limited, and I think to the extent that we can elucidate more of actually what is kind of operationally happening, I think that would be very helpful.

I would also say it's worth noting, however, that since we are in this payment update chapter world right now, I'm not trying to imply that additional payments would

necessarily solve this access problem, because I'm not sure that they would. I just think it's worth just noting since we are measuring access and we are commenting on access from that perspective.

And the last thing I want to say is I also agree with this concern, that I think Brian raised, about the quality measure of discharge to the community, again, in relation to the patient heterogeneity and the patient complexity issue. Because as it is, there are disincentives, if you will, to take on these beneficiaries who might have more challenging social circumstances, or non-clinical circumstances, and I think a measure like this would only kind of double down on that complexity. So I think we should just be careful as we think about this.

So thank you. Great work. I really appreciate it.

MS. KELLEY: Kenny.

MR. KAN: Kathryn, outstanding chapter. I support the recommendation.

I am a plus-one on Tamara's access hospital stay as a quality measure and also further analysis on how the various metrics compare for MA versus fee-for-service. I

also am a plus-one on Paul's reference to including the patient experience tool in the chapter. Thanks.

MS. KELLEY: I think that's it, Mike.

DR. CHERNEW: Larry.

MS. KELLEY: Oh, sorry.

DR. CASALINO: Thanks. So I think the main point I want to make is I strongly support including the patient experience as an important measure. The patient experience is important in any sector of the health care system, but patient and family experience is so important here.

I just went through this with one of my sisters, and it was a nightmare. I mean, I could go on for an hour about it. It was awful. You know, we are spending $29 billion on SNF care. I think the idea that we can't spend some millions on measuring experience is ludicrous, really. I have no sympathy for CMS on this.

So that's probably my strongest comment. I do support the recommendation, but I also support maybe even making the chapter a little sharper, although this is, I realize, sensitive politically, on the bind that Medicare is put in by Medicaid not paying enough and by how that varies across states. We have some states cross-

subsidizing other states, and because of that, beneficiaries in all states get worse care, actually. It's not just a matter of access. It's that SNFs have less money. The quality is also going to be worse.

You know, if you have ever been in a SNF that is predominantly, or in a nursing home with a SNF that is predominantly Medicaid as opposed to one that's not, the difference is like the difference between heaven and hell, and that's not really an exaggeration, I think.

So this is a problem that we can't really fix, and it is really on Medicaid and states to do something about it.

I will leave it at that.

DR. CHERNEW: Okay. So a few things. First, Kathryn, thank you. Second, to the Commissioners, thank you. Third, it is very clear, and I would say most of the conversation has focused around these concerns about the quality, quality measurements, and a range of things like that, and how that plays into things, and as I mentioned, we have spent a lot of time thinking about that. It is complex, for reasons that you all mentioned, and it is complex because of our existing set of recommendations.

So we will continue to discuss where that is going to be, but I will talk again with staff and with Paul. My gut is where we are going to be is to reemphasize the things that we have already said about quality and keep the update recommendation as just an update recommendation, and then we will go from there. But, of course, you are free to reach out and explain how you feel otherwise.

But given the time we are going to jump to home health, and that means we are going to jump to Evan.

MR. CHRISTMAN: Good morning.

Next, we will look at payment adequacy for Medicare home health agencies. The audience can download a PDF version of these slides in the handout section of the control panel on the right-hand section of your screen.

In today's presentation, I will cover our payment adequacy indicators, similar to what you have seen in other sectors, and we will also review the Chair's draft recommendation.

Before turning to our payment adequacy indicators, here is a brief overview of home health care and Medicare fee-for-service. In 2022, there were about 11,300 agencies participating in the program. Those

agencies served 2.8 million fee-for-service beneficiaries and delivered 8.6 million 30-day periods of home health care. Total fee-for-service payments in 2022 equaled $16.1 billion.

As background, I want to remind you that the home health PPS implemented major changes in 2020. The BBA 2018 mandated a new 30-day unit of payment and the elimination of the number of therapy visits provided during home health as a payment factor. These changes were implemented through a new case mix system called the "patient-driven groupings model."

The Commission produced a mandated report in 2021 concluding that the new policies did not appear to have a negative effect on access or quality of home health care in 2020. One important fact to keep in mind is that the number of visits per 30-day period has declined relative to the pre-PDPM period by a total of 15.6 percent. This decline in visits is one factor that has contributed to the high margin since 2020, which have exceeded 20 percent since the changes were implemented.

Now we turn to the payment adequacy indicators, the Commission reviews. They are similar to what you saw

for SNF earlier and in other sectors yesterday. So I will not run through them in detail. But in general, we assess these factors to determine a payment recommendation for the upcoming payment year, 2025.

Our first category of payment adequacy is fee-for-service Medicare beneficiaries' access to care. Similar to past years, over 98 percent of fee-for-service beneficiaries lived in an area served by at least two home health agencies, and 88 percent live in an area served by five or more. We recognize that the number of agencies active in a zip code may not be a complete measure of access but include this as one of our measures because it provides a baseline of how the supply of providers is distributed relative to the Medicare population.

The number of home health agencies declined by about 1.1 percent in 2022, continuing a decline that started about 10 years ago. This decline was preceded by a period of rapid growth, with over 3,000 agencies entering the program between 2002 and 2013. That said, agencies vary widely in size. So the number of agencies is an important but limited indicator of access, and it should be considered with the context of other data.

This year, we also included data on the share of services that were reported by home health agencies as being initiated on a timely basis, which was 95.9 percent in the most recent period. Though this measure has some limitations, as noted in our paper, beginning home health promptly after it has been ordered is important to beneficiaries. The rate has been steady in recent years, indicating that agencies are not reporting significant delays in the initiation of care.

Next, we look at utilization. This table shows utilization since 2020, the first year of PDPM. Per capita utilization increased in 2021 and then declined by 3.5 percent in 2022. Several factors may account for this decline, but an important one may be that the decline and the share of fee-for-service beneficiaries receiving inpatient hospital services, which are a common precursor to home health, inpatient hospital services for fee-for-service beneficiaries have declined on a per capita basis by 5.6 percent since 2020.

I would also note that home health utilization was slightly lower in rural areas in 2022, averaging 22.6 periods per 100 fee-for-service beneficiaries compared to

24.5 in urban areas. While the rural rate is slightly lower, like other health care services, there is significant variation within these categories, and low-use and high-use areas can be found in both urban and rural areas.

As another indicator of access, we also looked at the share of inpatient hospital stays that were followed by a home health or SNF stay. This chart shows the trend since 2020. As you can see from looking -- excuse me -- from 2019. As you can see from looking at the blue line, in 2019, the share of inpatient discharges to home health was less than SNF. However, during the pandemic, the trend reversed, with home health becoming the more frequent destination in 2020.

In 2021 and 2022, there has been a rebound for SNF with its share increasing and home health falling a little bit, but home health in 2022 still remains the most frequent destination.

This graph leads to a few conclusions. First, some of the decline in home health in 2022 noted in the last slide may reflect increased referrals to SNF. From a broader perspective, this graph provides an indicator for

assessing overall access. Though home health utilization has fallen in 2022, it appears that beneficiaries needing post-hospital home health are able to access it at a rate that is actually higher than before the pandemic.

Another indicator of access, the Medicare marginal profit was high in 2022. At 23 percent, home health agencies with available capacity have a financial incentive to serve fee-for-service Medicare beneficiaries.

Next, we turn to quality. In this report, we included two new measures of quality, discharge to community and re-hospitalization for a potentially preventable condition.

The share of patients discharged to the community declined to 74.7 percent in 2021 to 2022, a decline of 3 percentage points. For re-hospitalization, 3.9 percent of patients were re-hospitalized for a potentially preventable condition. Comparable data for this measure is not available for prior years, but this rate did not vary significantly across provider types or ownership categories.

We also reviewed the consumer experience measures reported by beneficiaries through H-CAHPS. The rates

remained high and did not change significantly, with 84 percent of beneficiaries rating their agency highly, 78 percent reporting they would recommend their agency, and 85 percent reported effective communication.

Next, we look at capital. It is worth noting that home health agencies are less capital intensive than other health care providers and fewer publicly traded companies. That said, we see several positive indicators for access.

The all-payer margin in 2022 was 7.9 percent, indicating that agencies yield positive financial results. In recent years, the merger and acquisition activity has been considerable. Three of the largest publicly traded for-profit home health firms have been purchased by Medicare Advantage insurers since 2020. In addition, in recent years, private equity firms have purchased a significant number of home health agencies to build new corporate chains. So this activity has slowed down in 2022. One estimate concluded that about 5.7 percent of agencies are owned by private equity in 2022.

Overall, these indicators suggest that home health remains attractive to investors and providers should

have adequate access to capital.

Next, we look at payment and costs and financial performance. In 2022, the average payment per period for freestanding agencies increased by about 3 percent, while the average cost per period increased by 4 percent. With these changes, Medicare fee-for-service margins for 2022 still remained high, and we can see that the margin for this year was 22.2 percent. The trend by type of provider indicates that for-profits had better margins than nonprofits and urban agencies had slightly higher margins than rural.

The 2022 margins remain above 20 percent, higher than the long-run average of 16.8 percent since 2001. Overall, these margins indicate that Medicare fee-for-service continues to pay well in excess of cost.

This brings us to our margin projection for 2024 for Medicare fee-for-service. We project that margins will decrease to 18 percent. This is because we assumed cost will increase more than the payment rate increases.

On the payment side, our estimate includes CMS's policies for 2023 and 2024, which include the payment updates for those years as well as payment reductions

mandated by BBA 2018.

On the cost side, we assumed a blend of the high rate of cost growth experienced in 2022 and the low rates of cost growth agencies have experienced in the past, and these two factors average out to about 3 percent a year.

However, this level of cost growth is well above the past experience of home health agencies. For example, cost growth averaged about half a percent a year in the 2011 to 2019 period.

Margins in 2024 could be higher than our projection if the actual cost growth is more in line with the low rates of past experience than what we assumed.

This brings us to the summary of our indicators. In terms of beneficiary access to care, 98 percent live in a zip code with two or more agencies. Per capita volume decreased, but the share of hospital discharges to home health was comparable to prior years. And the 2022 fee-for-service Medicare marginal profit was 23 percent.

For quality of care, the risk-adjusted discharge to community rate declined but remained high, and patient experience measures remained high and more stable.

For access to capital, they had an all-payer

margin of 7.9 percent, and we note that the industry has been the focus of acquisition efforts by large insurance companies and private equity in recent years.

For payments and costs, the fee-for-service Medicare margin in 2022 was 22.2 percent, and the projected margin for 2024 is 18 percent.

This brings us to the Chair's draft recommendation. The recommendation reads "For calendar year 2025, the Congress should reduce the 2024 Medicare base payment rates for home health care services by 7 percent. This would decrease spending relative to current law, and we expect that there will be no adverse effect on access to care and continued provider willingness and ability to treat fee-for-service beneficiaries.

This completes my presentation, and I look forward to your discussion.

DR. CHERNEW: Evan, thank you so much. This is another particularly important sector, and it was very thorough presentation.

I think we're going to jump into the Round 1 queue just to keep us moving, and I'm not sure I have this right, because I was having a few computer issues. But I

think it's Robert is the first person in the queue.

DR. CHERRY: Yeah. Thank you. Very good presentation.

Just a question regarding virtual home health care visits, because you're not able to track that. Is there any particular reason why? Because it is a billable service. So you would think you'd be able to kind of pull that information out.

MR. CHRISTMAN: Yes. So CMS did not require reporting of virtual visits on claims until July of 2023. So they basically came in during the pandemic, and they could provide them. But they weren't being reported.

DR. CHERRY: Okay.

MR. CHRISTMAN: So they just weren't visible. Hopefully, we'll get a look at them soon.

DR. CHERRY: At a later date. Okay. Thank you.

The other thing I noticed, that the fee-for-service Medicare margin on page 3 was listed at 23 percent, but on page 4, it's 22.2 percent. I'm not sure if that's --

MR. CHRISTMAN: Well, I'll check the text. I mean, just to be clear, as I like to say, we have margins

for our margins at MedPAC. The overall fee-for-service Medicare margin for freestanding agencies in 2022 is 22.2 percent.

We also report what we call the marginal -- the fee-for-service marginal Medicare profit, and the word "marginals" inserted in there -- and forgive me. I'm not sure if it -- and that is 23 percent, and that is supposed to capture sort of more of a variable cost margin. So I might have messed up the textual.

DR. CHERRY: Yeah. Maybe it needs to be described a little more clearly because they both look like a fee-for-service Medicare margins.

MR. CHRISTMAN: Okay.

DR. CHERRY: So probably just clarifying that one variable, but that's my questions. Thank you.

MS. KELLEY: Tamara.

DR. KONETZKA: Thanks, Evan. Great chapter.

Couple of questions. One, I was confused about whether community-initiated home health was included in these calculations. It seems like the quality measures are really focused and the access measures are really focused on the post-acute part. I'm assuming the margins'

calculations include the community initiated.

MR. CHRISTMAN: Right. So the margins don't pick up the -- what they don't pick up are -- excuse me. The margins include all of them. I was starting with the quality. You asked about the quality. That's what I meant.

The quality measures won't pick up community-initiated home health spells of care, and that's because they're both hospital-focused measures, the CAHPS, and the -- I'll have to check the CAHPS. I'm not sure if the CAHPS is hospital measured. I don't think it is. I think the CAHPS -- I think the CAHPS is everybody, but I'll have to double check that.

But the re-hospitalization measure and I believe the discharge community measure, I think those are post-hospital measures.

MR. CHRISTMAN: Okay. Yeah. Do we have good quality measures that we could adjust, apply to the community-initiated, then?

MR. CHRISTMAN: We can look at that. The ones that are available off the shelf, a lot of them are sort of the OASIS functional measures. Those are generally done

for the whole population, but we can look at that.

I think one thing we might think about is whether there's some possibility of measuring the discharge community for the community population.

DR. KONETZKA: Right. Or a hospitalization measure that's not re-hospitalizations. Yeah.

The other question is sort of related which is, how in these discharge to community measures -- how are recertifications taken into account? Because they can have multiple 30-day --

MR. CHRISTMAN: Right. So my understanding is that that measure is done from -- measures the period from end of care, so after all the recertifications. I call it the "spell." It goes by many names. But, you know, a whole spell, my understanding is it captures the 30 days after the spell.

DR. KONETZKA: All right. Thanks.

MS. KELLEY: Brian.

DR. MILLER: Thank you for this chapter.

A simple question. I liked figure 7-1, and I noted that the number of home health agencies is -- it looks like functionally the same as it was in 2010. So I

was wondering if we could adjust the y-axis scale to make that clearer.

MR. CHRISTMAN: I'll take a look at that.

DR. MILLER: Thank you.

MS. KELLEY: Cheryl?

DR. DAMBERG: Evan, thanks for this chapter.

I had a quick question. At the top of page 23, it says home health agencies do not report payments and costs for MA services on the cost reports, and I was trying to understand why that's the case.

MR. CHRISTMAN: Yeah. I think the -- you would have to really ask CMS. The cost report is a legacy document that has been used for many purposes over the years, and I don't think there has been a policy salience around tracking Medicare Advantage payments and costs. It's much stronger now than maybe it was the last time they revised the cost report.

DR. DAMBERG: Yeah, thanks. I agree. I think the salience is much stronger now.

And then I guess somewhat relatedly is, what do we know about utilization of home health by MA?

MR. CHRISTMAN: Well, that's one of my favorite

topics that I look forward to looking into. There is some literature that suggests that MA utilization is lower, a little bit lower, but the published work that I'm aware of to date mostly relies on the data from OASIS about whether a beneficiary is MA or fee-for-service. And that's clearly not complete, being polite.

And I would, I guess, looking at Stacie -- a former colleague of ours that is now a student of Stacie's published some work relying on other data that suggested they were much more comparable when you -- I forget the exact survey they used, but they used a different one. So that's one of the questions we're thinking about, the work that Betty and others have been doing cleaning up the MA encounter data.

I probably come in and ask about once a month about where it is, because I think this question is really important, and we want to get a better answer for you.

MR. MASI: And if I could jump in for one moment, just to try to clarify. Evan, is it right that the MA payments and costs are not broken out separately on the cost report, but they are reflected in the overall cost report and are reflected in our all-payer margin? Is that

correct?

MR. CHRISTMAN: That's correct.

MR. MASI: Okay. Does that help, Cheryl? Okay.

MS. KELLEY: Gina.

MS. UPCHURCH: Thank, Evan, for this chapter. A couple of quick questions. If I'm somebody in a hospital ready to discharge somebody and I'm worried about needing to free up some beds, deciding home health versus a skilled nursing facility for post-acute care, I know the idea is that if somebody needs skilled nursing they need five days a week therapy, home health maybe three days a week, something like that.

But do we know if other things like household makeup, like I'm sending you home alone versus you've got somebody that can help you, race, income, do any of those things matter in terms of -- I mean, I'm assuming an overall assumption here, well not an assumption. We know that home health is less expensive than SNFs. So that's the first question.

MR. CHRISTMAN: So I think the phrase they sometimes you is a "safe home environment," and it's the first, a beginning, and then depending on the patient,

there is not a requirement that there be a caregiver in the home under Medicare. But I would assume that would be something that people would be weighing about a beneficiary's self-care needs and their self-care deficits and what situation they have at home, and that can be another factor that determines which setting they go to.

I would note that in practice, we recognize that caregiver situation can vary immensely across beneficiaries. From the perspective of the data that we see I'd say well over 90 percent of home health beneficiaries have a caregiver recorded. You know, what that means about ability and things like that is something else, but that's very common.

MS. UPCHURCH: Right. Well, it gets to my second --

DR. MILLER: May I actually provide some input on that? When a beneficiary is leaving the hospital, if they are deemed by the physician seeing them that they potentially need habilitative services, they have a physical therapist, usually an occupational therapist see them, in addition to doing a holistic review of the patient they actually have sort of criteria that they go through

for determining their functional status. There are a variety of scales about independence, functional status, ability to do activities of daily living.

And then they make an assessment, a recommendation, the physical therapist does, for no services, outpatient services, home health services, skilled nursing facility with sub-acute rehab, or IRF inpatient rehab facility. If they go to an IRF, usually they have to be assessed and seen by a PM&R doc or a physiatrist.

The determination of safe at home is usually made with the physical therapist and/or the occupational therapist in conjunction with the physician, considering the ability for people to do those basic activities of daily living. If they are unable to do those basic activities of daily living and that the thought of a couple of days a week for a couple of hours a day of having either a home health aide or a physical therapist, occupational therapist, visiting nurse, et cetera, are deemed to be inadequate, then the patient is recommended to go to sub-acute rehab.

MS. UPCHURCH: Thank you, Brian. Very helpful.

So that leads to my second question, which is, you know, we said there is a slight decline in people getting social services with home care or home health aides, and so that's why I thought it might be rated, is there someone in the home that could help them. So I didn't know if you thought those things were related.

MR. CHRISTMAN: I guess what I would just comment is that this is an area of concern that beneficiary advocates and the industry have had, is that the number of home health aide visits has declined over time, and at different times that's been explained different ways. Some people in the industry have said there are more of a skilled care model and others will say that more of those visits should be provided.

I mean, from a payment perspective, wearing that hat very narrowly for a moment, they are the least expensive visit to provide. And I appreciate that there are workforce dynamics and challenges, but the decline in visits has sort of been a secular trend under PPS for the last 20 years.

MS. UPCHURCH: So just a quick follow-up question. I just want to throw out the capable model as a

way of getting some people care in the home and modifying their home so we can save money, because people can stay safely in their home instead of having to go to a SNF.

But the other thing I was just asking was a concern about staffing challenges. Have we asked -- and this is not for this chapter but just in general -- have we asked if you are a PT/OT nurse, is there a preference for working in a home health agency versus a SNF? I'm just curious, because I would think that influences some of the workforce issues we're concerned about.

And my last question is on page 21 we talked about Medicare Advantage plans buying the three large home health agencies. Does that mean they remove them from being available to fee-for-service --

MR. CHRISTMAN: No.

MS. UPCHURCH: -- or they're still available to people with fee-for-service.

MR. CHRISTMAN: Yes. They're still active in fee-for-service.

MS. UPCHURCH: And so then the last, do we know about the workforce and preference for work, or is it just so dramatically different?

MR. CHRISTMAN: I think that some aspects of the home health workforce there have always been concerns about, like prior to the pandemic there were different things going on with the payment system. But I think I heard more complaints, difficulties in the PT market than skilled nursing. And obviously home health has been affected similar to other health care provides since then. It's nurses and PT.

My impression is that we don't have hard numbers on this, but I feel like the news cycle has been, in the last six months to a year, that the labor market has gotten a little better. Nobody thinks it's back to normal. I think when you look at why picking one setting over another for practicing in, that's an individual choice. I've heard people tell me, you know, nurses go into home health because they like the autonomy, but obviously some will find it isolating or not appreciate the autonomy. So it's those types of things.

MS. UPCHURCH: Thank you.

MS. KELLEY: Greg? Oh, sorry. Go ahead, Betty.

DR. RAMBUR: I wanted to respond very, very briefly on that. In terms of where people choose, the

hospital has always been the highest payer, so that, at one time, was really sort of the preferential draw. But that is mitigating a little bit because of the challenges and all the issues of violence and that type of thing.

People have chosen home health, even though it had lower salaries, because they like the autonomy. They are often working with their community. But in general, unfortunately, skilled nursing facilities and nursing homes have been viewed as sort of having a lot of stigma and where it's less desirable to go, which is something I wish we could help change. But that's sort of the lay of the land. I don't know PT as well. Thanks.

DR. CHERNEW: Am I right that Betty is next in the queue, as well?

DR. RAMBUR: Well, thank you. I really enjoyed this chapter the comments.

I have a brief comment and then a question. Cheryl brought up the issue of the Medicare cost report, which was clarified by Paul, but yesterday I suggested maybe it's time to modernize or think about that differently, and this might be another illustration.

The piece I have a question about, and this is

something I just actually can't lace through, I see the study that you mentioned that talked about how Medicare Advantage enrollees use less post-acute care and had shorter duration of service, but reported fewer functional improvements.

One of the things we're seeing in our area, and I saw it in the news nationally, is we're seeing a lot of home health agencies close because with increasing Medicare Advantage population they can't make the math work in terms of serving relatively smaller populations.

What I can't really lace through is does that affect or influence how we think about this recommendation or not? How does that lace through, and is that a broader national phenomenon?

DR. CHERNEW: I'm going to try and take an answer to that question. I'm not sure I'm going to give a good answer to that question. The growth of Medicare Advantage, broadly, challenges the norms by which we do our work in our updates, and I feel, personally, and I feel, around the table, sort of frustration in trying to go through the update recommendations always had a little bit of a challenge when you're now recognize that half of the people

are enrolled in a program that's actually not affected by our update recommendation, per se. In some sectors, the prices seem to go somewhat in lockstep, although there are others, you say prior auth, and in other sectors, dialysis, the prices don't go in lockstep, and in other sectors there's a bunch of other things that might happen.

I think the short answer -- and I'm just going to give my answer and I'll turn it to Paul in a minute -- is I would like to, I think Evan expressed interest in, really understanding the interaction between MA and each of these sectors and what we might want to do there. That is a big, complicated analytic topic. The update recommendation is a sometimes frustratingly narrow activity, but that is loosely what it is.

So for the most part we go through our criteria the way that you're seeing each chapter in parallel go through the criteria, and we come up with a number that basically has a rule which is if the profits are as high, if the profits seem to be as high, as access seems loosely as good as access seems to be, if capital access seems loosely as good as that is, we try and come up with an update recommendation that meets a bar. And I cannot

emphasis this part enough -- reasonable. That doesn't mean it's going to be preferable to all of you, but one that is reasonable, and then we essentially make that recommendation and the move on to deal with these bigger issues in the context of our broader cycle work, of which MA is clearly an important one, but there is a slew, as all of you know, a bunch of other very pressing issues that we would like to take on.

So that's a longer way than I would like to have done to say, for the most part, no, we don't spend a lot of time trying to figure out, in our criteria, if Medicare Advantage was 80 percent would our recommendation be different. If it was 20 percent, would it be different. If there was in some markets 80 percent and in other markets 20 percent, would it be different. That's just outside of the criteria we have typically used, and requires more analysis than the update work typically is.

So Paul.

MR. MASI: I agree with all that. The only thing I would add is that there are some times when we talk about how we could look at something in the future it's kind of a question of how it stacks with other priorities.

I just wanted to emphasize what I think Kathryn raised in the last session and what Evan spoke to earlier, that this is absolutely an area where we have ongoing analytic work. We hear that this is an important thing, to Commissioners and to the program. And so we are trying to do the data work to glue together the counterdata on the various assessment and other data components of the different PAC sectors.

I think the staff would want me to manage expectations about what the outcome of that is going to be in terms of the quality of the data and what we'll be able to do with it, but this is definitely a place where we agree it's very important what we're trying to move our analytics along.

Evan, do you want to add or subtract anything?

MS. KELLEY: Greg.

MR. POULSEN: I was going to ask the same question that Gina asked regarding the purchase by MA of the plans by MA. But I did want to quickly add in the point that I was going to make, and thanks for answering the question. But it was the point that I think home health clearly functions most effectively in an integrated,

prepaid environment. I just wanted to get that point in, because in our other discussions of home health and some of the worries about home health it's been in the fee-for-service incentive that's caused the challenges.

Anyway, I was trying to sneak in a comment with a question, but you answered the question, so apologies.

DR. CHERNEW: And we got the comment, and I think that was the end of Round 1, or maybe the beginning of Round 2. I'm not sure. Either way. But we are now going to get to the official Round 2, and if I have this right, Cheryl is first.

DR. DAMBERG: Okay. So I just want to go on record that I support the chair's recommendation. And I think the other quick comment I wanted to make is, you know, giving the ongoing changes to the market structure in this sector, with increased ownership through private equity and insurance companies, I think it's really important that we continue to monitor this, and these changes in ownership relationships and what their impacts are on quality and costs. So again, sort of a plug for trying to leverage data that CMS has and working to improve that data source to enable us to do that.

MS. KELLEY: Brian.

DR. MILLER: A couple of comments. One is I know there is a lot of concern about private equity ownership, and I thought it was interesting that only 5.7 percent were owned by private equity firms. From the framing of the media and other things I have heard my estimate was an order of magnitude larger. So I was interested to see that it was so low, and we should probably denote that while policymakers are interested in it that the ownership shares are actually pretty low.

In the notation that Medicare Advantage plans have purchased a lot of the home health agencies, we should denote the historical benefits of vertical integration that are noted across many markets, and that this may allow, through an integrated prepaid environment, as my colleagues noted, to more efficiently target care to the people who need it.

We should also, I think, put some notation of health systems owning home health agencies. We might not have those data, but I know it's very common for health systems, even ones that don't own health plans, to have a large home care footprint for physical therapy, speech,

language, pathology services, occupational therapy, visiting nurse, et cetera. So it's not just Medicare Advantage plans and private equity and independent groups. A lot of health systems are in this space, and it is arguably appropriate that many health systems and Medicare Advantage plans are in this space, to better coordinate care.

One thing that I'm curious if we have ever discussed. I know that there was no co-pay or co-insurance deductible for this service and that historically there have been concerns about overuse and abuse of home health services. Has the Commission ever explored the concept of implementing a co-pay or a deductible for this space? I'm not saying that we should do that. I'm just curious about the historical context.

MR. CHRISTMAN: In 2011, I believe it was, the Commission recommended a co-pay for basically community-admitted services, and there were a couple of other exclusions for like low-income folks, if I recall correctly. But we did that.

DR. MILLER: Do you know what happened with that recommendation? Have we repeated it, or --

MR. CHRISTMAN: Well, I mean, I don't know that we've ever returned to it, I guess. We haven't returned to the issue.

MS. KELLEY: I do think we took it up in discussion subsequently to that, or subsequent to that, but I think there was some disagreement among Commissioners about the merits of reinforcing or repeating that recommendation.

DR. RAMBUR: Marge Ginsberg was very opposed; I remember very specifically. She was concerned about it being an access barrier.

DR. MILLER: The reason I was curious is if we are concerned about be it the health systems, Medicare Advantage plans, private equity firms, or whomever buying this service area and potentially engaging in abuse, of course transparency and heading towards capitation and population-based payment for integrated care is the best policing of that.

Also, as an aside, I was just surprised, I was unaware that there was no co-pay for this space, and was curious about prior discussions. Thank you.

MS. KELLEY: Gina.

MS. UPCHURCH: Now Brian's got me thinking. I would be like Marge, opposed to any cost sharing with that.

My comment is, just looking on page 20, where you have this graphic that's talking about the HCAHPS, and you say "discuss medicines, pain, and home safety with them." And it's 82 percent. How is that possible, that it's not 100 percent? So I guess that question alone, does it mean you have to have spoken about medicines, pain, and home safety? Because one of the things we see often is when somebody is coming home, they're being discharged, you know, what I call possible combustion. They've got the medicines at home, and they're coming to the hospital with some, and you have maybe some people in and out of the house that are helping you, and then they mess up your pillbox. Medication reconciliation is huge post-hospitalization.

So does that mean you have to have asked about all three to get the yes?

MR. CHRISTMAN: I'm not sure. I don't know CAHPS that deeply. I can take a look. I think, you know, obviously I would expect some form of medication reconciliation to happen in virtually all cases. So I can

look at the question. And this is also obviously what the beneficiary recalls when they are filling out the form.

MS. UPCHURCH: Right. Well, that's probably part of it.

But just to get back to the point about cost sharing with home health, if we think it's a very efficient, less expensive way to treat people, I think putting any barrier that would have an equity concern would be something I would be very concerned about. But thank you.

MS. KELLEY: Betty? Larry?

DR. CASALINO: Just a quick question, following up on Brian's 5 percent owned by private equity. To really understand that statistically it would be good to know the size of the home health agencies that private equity or any other entity owns. Is that information available? Because usually the staff will do that, and when they can write, say percent, but it's really 20 percent of blah, blah, blah.

MR. CHRISTMAN: Not easily. That data is -- we don't have that at arm's reach, no.

DR. CASALINO: Just pointing that out. I don't

know myself whether it's bigger agencies that are being purchased or not, but the uncertainty about that would be worthwhile, just so people don't jump to the conclusion that, oh, this is trivial.

MS. KELLEY: Tamara.

DR. KONETZKA: Yeah, a couple of quick suggestions.

In general, I support the recommendation, and so my comments are really about a few suggestions for ongoing analysis.

So following up on my R1 question, I think it's important to look separately and look a little bit more closely at the community-initiated home health. My understanding is that this is a mode that's been used more and more by Medicare Advantage as well. So I think there's lots of interesting stuff to unpack there about access and quality and efficiency of that mode of home health care.

Second point, similar to what I mentioned yesterday, I think in addition to potentially avoidable hospitalizations, it would be nice to look at all hospitalizations, and one could look at re-hospitalizations, all cause for the post-acute, and also

hospitalizations for the community-initiated. For the same reasons as yesterday, I think potentially avoidable is a pretty blunt cutoff.

And then I guess the last point is, following up on something that Betty said earlier, the workforce pressures in home health, just like in SNF, are going to continue to be really severe for a while. And I know that yesterday it was mentioned that you guys just kind of take the CMS estimates of future costs, and I don't really know what goes into those future estimates of cost growth over time. But I think wage pressures might be actually pretty different for hospitals verses this post-acute care sector, right? Because as Betty was mentioning, nurses actually prefer to work in a hospital, right? And I think given all the pressures on workforce in the home health sector and in the SNF sector, we may actually see more wage growth and more costs devoted to workforce in order to staff up in these post-acute care sectors.

So just doesn't probably affect our analyses, but something to keep in mind as we monitor these sectors over time.

MS. KELLEY: Robert?

DR. CHERRY: Thank you. Just a couple of brief comments.

First of all, just supportive of the draft recommendation as written.

The second comment is more about what that translates to, and it's similar to my prior comment on SNFs. So a 7 percent reduction on $16 billion is roughly $1.1 billion. So if you take that 1.1 and you add the $900 million savings for SNFs, that comes out to $2 billion, which could be applied towards the hospital update.

I'm saying all this because I think if we could create a narrative that this is as close to budget neutral as possible, it might be received in a more favorable fashion, just given the overall climate.

So that's my only comments, but thank you.

MS. KELLEY: Scott?

DR. SARRAN: Thanks, Evan, for the great work. I just wanted to go on record saying I support the recommendation.

MS. KELLEY: Kenny?

MR. KAN: Fabulous chapter. I support the recommendation.

I wish to pile on Cheryl's idea of monitoring how private equity involvement and how some MA plans migrating care to the home will impact this space going forward and our future payment updates.

DR. CHERNEW: I'm sorry. We've had -- I think Stacie wants to say something, and Brian wants to say something. But I think, Brian, yours is a loosely on point, one removed, if I understand what you're going -- so why don't you go, and then Stacie. And I think that was it, Dana.

DR. MILLER: I was just going to say I disagree with a comment about rating post-acute care to pay hospitals. I don't think that that is a good idea, because the post-acute care space, be it skilled nursing facilities or home health, regardless of our update recommendations, it's a challenging operational space. And I do not think we want to rob Peter to pay Paul.

DR. DAMBERG: Thank you very much. This is great work, Evan. I just want to say I'm in support of the recommendation and also plus-one to thinking about how MA influences us in future years and also to the quality measurement issues.

DR. CHERNEW: All right. So that was a really good discussion, and I want to thank everybody for their conciseness.

So now we're in a luxurious period of time. We skipped our break before. So now we're going to get a break. Why don't we take ten minutes and try and come back at a quarter after. For those following at home, we're going to start at a quarter after eleven to go into IRFs. Okay? So break time.

[Recess.]

DR. CHERNEW: And now to bring us home on our update session, we're going to talk about rehab facilities, and, Jamila, that is going to be you. So please take it away.

DR. TORAIN: Thank you, Mike. Good morning.

Before we start, I would like to give special thanks to Pamina Mejia 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.

In today's presentation, we will cover six topics. First, we will provide fee-for-service Medicare

context on inpatient rehabilitation facilities. Then to assess the adequacy of fee-for-service Medicare payments to IRFs, we will summarize results from four categories of payment adequacy indicators: beneficiaries' access to care, quality of IRF care, IRF's access to capital, and the relationship between fee-for-service Medicare payments and IRFs' costs. Finally, we will conclude with the Chair's draft recommendation on how to update fee-for-service Medicare IRF payment rates in 2025.

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, also known as IRFs. To pay for providing services, fee-for-service Medicare generally sets prospective payment rates under the inpatient rehabilitation facility prospective payment system.

In 2022, there were 1,181 IRFs and about 383,000 stays. Medicare spent about $8.8 billion on IRF care provided to fee-for-service beneficiaries, and Medicare accounted for about 51 percent of IRF discharges.

Now I'll review our assessment of payment

adequacy for IRFs using our established framework you've seen in earlier presentations today and yesterday. We'll start by considering access to care.

In terms of the supply of IRFs in 2022, there was no increase in the number of IRFs compared to 2021. However, the number of IRF beds slightly increased by 2 percent. The majority of IRFs that opened were freestanding and for-profit, and most closures were hospital-based nonprofits.

In 2022, Medicare stays per 10,000 fee-for-service beneficiaries increased by about 4 percent, and the aggregate occupancy rate was stable at 68 percent.

Overall, our IRF indicators of access suggest that capacity is more than adequate to meet demand for IRF services, meaning that both sets of providers have an incentive to serve additional Medicare beneficiaries.

Regarding the fee-for-service Medicare marginal profit of IRFs, we see a robust 18 percent for hospital-based IRFs and 39 percent for freestanding IRFs, the highest among all fee-for-service sectors.

Our second category of IRF payment adequacy indicators are those related to quality. As shown in the

table, the most recent data from fiscal years 2021 and 2022 show a median facility discharge to the community rate of 67.3 percent and a median rate of potentially preventable remissions of 8.6 percent. The discharge community rate increased compared to the 2018 and 2019 period. Due to a change in the way the measure was calculated, we can't compare the readmission rate to the earlier period.

As mentioned earlier today, ideally, we would also consider measures of other outcomes, but significant gaps in the data persist. Patient experience survey is available to IRFs but not required under the IRF QRP, Quality Reporting Program.

Our third category of IRF payment adequacy indicators is IRF's 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 declined in 2022, with the all-payer operating margin among hospitals paid under the inpatient prospective payment systems reaching 2.7 percent. However, preliminary data suggests hospitals all-payer operating margin will

remain strained but improve.

Access to capital for freestanding IRFs remained strong in 2022. Overall, the all-payer margin for freestanding IRFs is a robust 9 percent, down from 13 percent in 2021, as relief funds and other PHE-related, public health emergency-related payment policies ended, and cost growth increased.

Nearly 45 percent of freestanding IRFs are owned or operated by one large company. Their investor reports indicate that this chain has good access to capital. In 2022, the company added 87 bids to existing IRFs and has opened nine new IRFs. The company has already opened six new IRFs in 2023 and plans to open a total of 18 IRFs between 2024 and 2026.

While costs are still elevated, the company reported a decrease year over year in premium labor costs. Most other freestanding IRFs are independent or local chains with a limited number of facilities. The extent to which these non-chains have access to capital is less clear.

Our fourth and final category of payment adequacy indicators are how fee-for-service payments compare to

IRFs' costs. As shown by the dark blue line, the aggregate IRF fee-for-service Medicare margin has been over 13 percent since 2016. In 2022, the fee-for-service Medicare margin declined from a historic high to 13.7 percent, which is in line with pre-pandemic levels.

Financial performance continued to vary widely across IRFs. For example, in 2022, the aggregate fee-for-service Medicare margin for freestanding IRFs was 23 percent, as shown by the red line. In contrast, hospital-based IRFs have an aggregate Medicare margin of about 1 percent, shown by the gray line.

We also see why differences in margins of for-profit and nonprofit IRFs as most freestanding IRFs tend to be for-profit, and most hospital-based IRFs tend to be nonprofit. These differences in profit margins by provider type have persisted over time, and we continue to investigate the drivers of these differences.

With that, we will move on to discuss our projected fee-for-service Medicare margin for IRFs. For fiscal year 2024, we project that IRF's margins will increase to 14 percent. This is because payments are expected to increase more than growth and costs.

Specifically, in our estimate of costs, we use CMS's most recent estimate of the market basket for 2023 and a three-year historical average of pre-pandemic cost growth for 2024.

On the payment side, we assume that payments will increase by the updates included in the final rules for 2023 and 2024. We also accounted for the reapplication of the sequester starting at 2 percent in July 2022. Margins could be higher or lower in 2024, depending on changes in costs or payments and how they differ from the projections.

In summary, our four categories of payment adequacy indicators for IRFs are 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 2022, the median facility-level risk-adjusted rate of potentially preventable remissions was 8.6 percent, and the median facility risk-adjusted rate of successful discharge to the community increased to 67.3 percent during the fiscal year 2021 and 2022 period.

Third, the all-payer operating margin among hospitals under the IPPS reached a low of 2.7 percent in

2022. Despite this. preliminary data suggests hospitals' access to capital will improve The all-payer margin for freestanding IRFs decreased to 9 percent in 2022 remained strong. Freestanding IRFs maintained good access to capital markets.

Fourth, Medicare payments and IRF cost indicators were positive. In 2022, the aggregate Medicare margin was 13.7 percent. We project a margin of 14 percent in 2024.

And so that brings us to the Chair's draft recommendation. The Chair's draft recommendation reads "For fiscal year 2025, the Congress should reduce the 2024 Medicare base payment rate for inpatient rehabilitation facilities by 5 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, no adverse effect on access to care, continued provider willingness and ability to treat fee-for-service beneficiaries, though financial pressure on some providers may increase.

And with that, I will close. Happy to take any questions. Thank you.

DR. CHERNEW: Great. That was terrific, and we're going to jump in. And I think we're going to go to -- Scott is the first person in Round 1.

DR. SARRAN: Thanks, Jamila, for a very concise presentation.

Two questions. First, on Slide 5, we mention that stays per fee-for-service beneficiary increased 4 percent. Do we have any sense of why that occurred?

DR. TORAIN: I think, in general we're seeing a rebound from the pre-pandemic level. It was actually above pre-pandemic levels. But in general, I think there was a pent-up demand, and we're starting just to see the normalization of that.

DR. SARRAN: So we think reasonably --

DR. TORAIN: Yeah, this is --

DR. SARRAN: -- it could be attributed to --

DR. TORAIN: Yeah.

DR. SARRAN: Okay.

DR. TORAIN: Yeah, exactly.

DR. SARRAN: Thanks.

And then the issue that -- and you mentioned we've been tracking this issue for a while and mentions it

on Slides 8 and 9. Pretty profound differences in margins between, on one hand, freestanding versus, on the other hand, the hospital-based facilities. I'm trying to understand how much of that is due to cost accounting, how much of that might be due to patient mix, how much might be due -- I'm just thinking what are the buckets of causes. Cost accounting is one. Certainly, patients served could be very different, right? That should be easy to tease out. A third could be efficiency, certainly.

DR. TORAIN: Mm-hmm.

DR. SARRAN: So where are we or where have we been in being able -- and there may be other things to put in that bucket. Where have we been in terms of trying to tease those various factors out?

DR. TORAIN: Well, I think you're dead on with the factors. I think you've identified a lot of them. I think it is a combination of case mix differences between the two providers.

We've also looked into like differences in coding, but then they have substantial differences in costs per case as well. So those are the three main issues, but I think that we also have to consider that they are also

very different. Hospital-based providers and freestanding providers have different goals and missions. One, for-profit IRFs, their strategies, their cost strategies are different, you know, because of the intention to have return on investors -- for their investors. And so in actuality, I just think they're different. They have different goals in mind. So I think that's part of it, and that lends to their differences in cost strategies, which contributes to the differences we see in their cost growth.

DR. CASALINO: Jamila, could you move the mic a little bit closer?

DR. TORAIN: Oh, sure.

DR. CASALINO: Thank you.

DR. SARRAN: This borders on Round 2, but perhaps we could -- and I apologize if I missed it in the reading. The text box lays out what we understand of the different drivers and their relative contributions as best as we can semi-quantitatively assess that of those reasons.

MS. KELLEY: Amol.

DR. NAVATHE: Hi, Jamila. Thanks for this great work.

I have a couple of questions which are primarily

related to our theme, I feel like, of this set of sessions around access, and I apologize if I missed this in the reading materials. But in many of the different sectors, we try to characterize what share of beneficiaries have access to one or more of a particular facility type, and I was trying to get a sense. I don't think I found it, but what percent of beneficiaries live in an area where there is an IRF to begin with?

DR. TORAIN: We actually do have access to that information. So if that is something that you would like to see -- and I did not include that in the chapter. You're correct. Then we can think about adding that.

DR. NAVATHE: Okay. I think that'd be helpful. I think, in part, because I was curious how that would vary for areas that have a higher proportion or density of LIS or dual, dually eligible beneficiaries.

DR. TORAIN: Mm-hmm.

DR. NAVATHE: Somewhat related to this -- I guess, correct me if I'm wrong here, but it seems like from an absolute number of IRFs, there's more hospital-based IRFs than freestanding --

DR. TORAIN: Yes. From 71 percent hospital-

based.

DR. NAVATHE: But then from an actual use perspective, there is more IRF discharges in freestanding.

DR. TORAIN: Yes.

DR. NAVATHE: Is that correct?

DR. TORAIN: Yes. And that's related to the capacity, the size of freestanding facilities. They typically are larger than a hospital-based providers.

DR. NAVATHE: Great. Okay. So one of the things I was curious about is in the SNF work and the SNF reading materials, there was a text box that described how swing beds work in SNFs, and I was curious if there is a similar concept of swing beds in IRFs.

DR. TORAIN: I don't believe so. I can double-check, but not that I'm aware of.

DR. NAVATHE: Okay. So for hospital-based IRFs, they're designating certain beds, essentially, or units as IRF units.

DR. TORAIN: Yes, a certain amount of licensed beds.

DR. NAVATHE: And it's not a fungible thing.

DR. TORAIN: Right, exactly.

DR. MILLER: Often the hospital-based IRF is classified as a separate facility, so you have to discharge the patient from the acute care hospital and then readmit them to the -- or admit them to the IRF. Even if it's just a different floor on the hospital, it's classified as a different hospital for Medicare purposes.

DR. CHERNEW: It would be interesting to know how many people at a hospital-based IRF were coming from a pathway that wasn't through the hospital.

DR. TORAIN: Oh, it's very low. Most of them coming from -- over 90 percent of them coming from hospital.

UNIDENTIFIED SPEAKER: The IRF -- the hospital-based IRF must be a distinct part unit. So there isn't it -- I think you said often. I just was clarifying always. An IRF must be a distinct unit.

DR. MILLER: I was saying that it's often even physically in the same building as they --

DR. TORAIN: Oh, yes. Yeah.

DR. MILLER: It could be a separate building on the same campus.

DR. CHERNEW: So apart from the physical plant,

though, I think the broader point is freestanding IRFs -- I don't know this to be true -- are probably drawing from a range of different places, but a hospital-based IRF is drawing from that particular hospital, which affects its size, for example. It affects a whole bunch of other things related to it.

DR. NAVATHE: Well, I think -- sorry.

DR. TORAIN: No, go ahead.

DR. NAVATHE: Yeah. So I think they're all kind of interrelated, but what I'm trying to get an understanding of is when we say that access is good, what do we understand essentially of these different dynamics? And if you have a market where there's, for example, a hospital that has an IRF that primarily is serving its own hospitalized patients and there's a broader community and there's no other freestanding IRF, then how would we interpret that in terms of access?

And so I think some greater information about that, I think, would be helpful.

DR. TORAIN: That's possible. Yeah. And we learned a lot about that in our interviews that we conducted this past summer as well. So I can provide

additional context.

DR. NAVATHE: Perfect. Thank you so much.

MS. KELLEY: Greg.

MR. POULSEN: So one of my questions was answered. Thank you.

The other was since we have patient experience metrics available that are not required, do we know why they haven't been required? It seems like, as we've said in all the other sections, it would be very good to have that information. Do we know why?

DR. TORAIN: I don't disagree with you. We constantly check with CMS and CMS's website, and it's just currently not --

MR. POULSEN: And we don't know --

DR. TORAIN: The tools and the survey are available to our providers to distribute, but they are not collecting on the QRP.

MS. KELLEY: That's all I have for Round 1, unless I've missed someone.

So if you're ready, Mike, we can go to round two?

DR. CHERNEW: Absolutely.

MS. KELLEY: Okay. And I have Stacie first.

DR. DUSETZINA: So this was like a borderline Round 1, Round 2. So I saved it for Round 2.

You mentioned that 51 percent of the discharges are fee-for-service Medicare beneficiaries.

DR. TORAIN: Mm-hmm.

DR. DUSETZINA: And I just wondered if we had the information on the rest of the payer mix there, just thinking about the MA proportion relative to commercial or Medicaid or others.

DR. TORAIN: Yeah. And this goes back to the other PAC sessions with data being limited in regard to MA, but we have looked at stays or days. And we can say that 50, about 50 percent are fee-for-service, and then it's 15 percent are MA, and then there are 24 percent other payers and then about 10 percent Medicaid.

DR. DUSETZINA: Okay. But that really -- it kind of harkens back to your prior presentation, as you mentioned, in a previous meeting about some of the qualitative work you all had done around MA placement here. And it just made me wonder about the long-term sustainability.

I'm fully supportive of the recommendation for

the fee-for-service payment, but it does feel very much like another sector where we really need to know more about MA payments and access here as well for thinking about the long-term sustainability of access.

That was my main comment, but supportive of the recommendation for this year and great work.

DR. TORAIN: Thank you.

MS. KELLEY: Brian?

DR. MILLER: I started with one question but ended up with quite a list. It's a bad habit.

First question, I guess, is what have our IRF recs been for the past five years, and have they been implemented?

DR. TORAIN: So if you want to go back to 2019, 2019 the minus 5, well, actually 2019 through 2022, minus 5. In 2023 it was unique, minus 3. And this year we're at minus 5.

DR. MILLER: And what has been the response to our recommendations?

DR. TORAIN: CMS does not have the authority to implement the recommendation. They use the update, the current law, update.

DR. MILLER: So we have recommended payment cuts for five years, and CMS has ignored our recommendations?

MR. MASI: Well, just to clarify real quick, this is a recommendation to the Congress.

DR. MILLER: Right.

MR. MASI: But everything else you said is correct, Brian, if you just replaced --

DR. CHERNEW: I think the word "ignore" is not correct. "Not implementing" and "ignoring" are different.

DR. MILLER: So we made recommendations in this marketplace for five years and neither Congress nor CMS has picked them up, it sounds like.

MS. KELLEY: CMS doesn't have the authority to, which Jamila said.

DR. MILLER: Right. So we should probably think about the fact that our recommendations have not been implemented by Congress for five years.

Another thing I wanted to, a small point before my next question, I disagree with the distinction between for-profit and nonprofit having different motivations. The Federal Trade Commission and the Department of Justice Antitrust Division and the antitrust community writ large,

in analyzing mergers, have found that these entities economically behaved the same, in hospital markets, physician markets, and others, so we should denote that.

I noted that on page 8 we noted that IRFs and SNFs offer the same or similar clinical services. I do not think that is accurate. They might both offer physical therapy or occupational therapy, but the intensity of services offered by an IRF and the specialization are different than sub-acute rehab or a SNF, a skilled nursing facility. I think that point that IRFs offer different level of service applies to both freestanding and hospital-based IRFs, so we should correct that and denote that.

One of the things that I think was interesting, which other Commissioners have hit on, is that the freestanding and hospital-based markets might potentially be different in terms of the patients that they are serving or the segment of the market that they are occupying. Anything we can do to describe that difference would be good. It doesn't mean that that difference is bad.

And then I think another thing we should note is that the qualifying condition list for IRFs has not been updated in, I think, 10 or 15 years. There are, if my

memory is serving me correctly, 13 qualifying conditions. So we should probably describe that there are -- and I realize this is not part of our update recommendation, but we should probably describe that there are 13 qualifying conditions, and it hasn't been updated in a long time, yet the marketplace has moved.

As to others' comments, just to respond, I think the thought about freestanding and hospital-based IRFs do serve different markets, my understanding, and my colleagues can correct me, is the hospital-based IRF is primarily to serve as a place to discharge acute care hospital patients on that same facility in a good way in that the hospital is offering complex services for tertiary and quaternary care services, and they want to ensure that beneficiaries have access to that, and that the freestanding IRFs largely pull from, yes, those facilities, but mainly from other facilities that don't have IRFs, so that both occupy an important and complementary place in the service marketplace for beneficiaries. Thank you.

MR. MASI: I think Amol had a --

DR. NAVATHE: Yeah. Thanks, Paul, for noticing. I appreciate it.

So on the point that Brian made about the kind of similarity or overlap of the services, I think, in part, some of the questions that I was asking on access are somewhat related, because there is nuance around the qualifying/non-qualifying condition, and what the reason for the patient's need for rehabilitation is. But there is a clinical literature here, and at least part of the clinical literature suggests that patients, for example, I think stroke is probably the best-studied condition, do have better outcomes with intensive rehab at IRFs relative to SNFs.

DR. TORAIN: Yes.

DR. NAVATHE: And you are obviously aware of that. So one, I just wanted to add context for that. That was one of my motivations for trying to understand a little bit more about the access piece. But it might be worth kind of pulling a little bit of that in, just to add the nuance around why we, as a Commission, might care a little bit that even though I think you're absolutely right that SNFs can provide functionally the same exact services, that there may be some nuance in terms of the differences. As Brian notes, intensity of rehab is, in particular, that

one that I guess we would probably call out as the most meaningful clinically.

DR. TORAIN: I agree, and I did add to the chapter this year a bit on IRFs in the health outcomes as it relates to stroke, in particular, and that there is literature to support that health outcomes are better in IRFs when they serve beneficiaries. So that is in the chapter.

DR. NAVATHE: Perfect. Thanks. Sorry for missing that.

DR. TORAIN: That's okay.

MS. KELLEY: Robert.

DR. CHERRY: Yes, thank you. Very nice report, and I am very supportive of the draft recommendation as well. And it looks like the savings on this is probably just over $400 million. So if you look at SNFs, home health, and rehab combined it's probably about $2.5 billion, which could be applied to something else like the hospital update increase.

I find it rather fascinating that the margins are so different between hospital based and other types of freestanding rehabs. I know you're going to be looking

into the drivers of that. I do think part of it is probably related to patient selection, because hospitals, in particular, if there is kind of a gray area around admission, they probably would prefer to free up an acute care bed and admit someone to rehab. I think they're going to have some benefit from it rather than tying them up in an acute care bed and having no potential benefit. So there could be patient selection issues.

The other thing could be the mix with specialty services around traumatic brain injury, spine, stroke, may have differences in margin depending on the facility, and the intensity of services provided, depending on acuity or the type of condition as well. So I'm sure some of those things are already running through your mind, but I thought I would just mention them as well. Otherwise it is a really nice report. Thank you.

DR. TORAIN: Thank you, and I do want to mention, it's not in the chapter this year. I usually report it. Twenty-five percent of hospital-based providers, I think it is important to note that in 2022, 10 percent of them had margins over 22 percent, and 25 percent had margins over 14 percent or greater.

MS. KELLEY: Jaewon.

DR. RYU: Yeah. Many of the points have been made. I am also supportive of the recommendation. Thanks for the chapter. I think it is an interesting are.

I was just going to agree with Scott and Robert. It felt like there is some more unpacking that can be done just around if two pretty wide gaps, hospital versus freestanding, and then for-profit versus not-for-profit, and the margins, I thought the contrast was pretty stark. I think there is some discussion about mix, and specifically low income and higher needs. But also what I thought was interesting was the mix of clinical services, acuity, and stroke, and so forth. It would be good to unpack that a little more, if that's reasonable to do. So that was my only comment.

DR. TORAIN: Thank you for that, and I don't know if we'll see it in this chapter. We do have work coming in January related to case mix profitability for IRFs.

MS. KELLEY: Tamara.

DR. KONETZKA: Great. Thanks for a really interesting chapter. Two quick comments. One, I said this before but this comparison between hospital-based and

freestanding, I'm always a little bit skeptical about because it's based on the cost reports, and I just don't know how hospitals allocate the costs and whether it's really consistent. I know you guys have been doing this forever, so you probably understand that point with much more nuance than I do, but I'm always a little skeptical.

The other point I wanted to make, this kind of goes back to our October meeting, and this is more of a sort of a long-run comment, but it also applies to sort of value and what we get out of payments to IRFs.

To me, that discussion in October, and then also just some of the communications after that, make me sort of realize that I think there's still a big gap in the literature about what we understand in terms of unmeasured selection between people who go to IRFs and people who, for example, go to SNFs. And we just don't know. I mean, there are people we know who go to IRFs because they can benefit from that therapy, and their outcomes may be better from all of that therapy because they are different in ways that made them go to go an IRF. And I just don't think the research is there yet to really tease that out.

So I guess for a sort of long-run goal I would

encourage us to keep working on that issue, and perhaps because IRFs don't exist in every market. You could really try to drill down on the geographic variation and availability of IRFs to try to make some of those comparisons.

DR. TORAIN: Yes. Thanks for that point. I think that with Scott's original question in the beginning, that is what I was trying to say, that freestanding and hospital-based providers are not always an apples-to-apples comparison, and part of that is there are differences in the way we can look at the way that costs are allocated, and that's an issue that has been going on for a while with the cost report.

MS. KELLEY: Greg.

MR. POULSEN: Thanks. I just wanted to follow up and say that I think that we need to be very careful not to handicap our success rate based on how frequently our recommendations are taken up by Congress. I think doing so would embroil us in political situations that would be inappropriate, and I think we need to just give it our best shot, call it the way we see it, and in this one I see the way the recommendation is and would support it.

MS. KELLEY: That is the end of my list for Round 2. I'm sorry, Betty. Do go ahead.

DR. RAMBUR: Thank you. I just wanted to voice my appreciation for the report and my support.

I just have two follow-up comments. I just wanted to pile on a plus-one on Stacie's and others' comments about the importance of lacing in MA. That might be really clear to some of you, but this particular space is something I'm much less familiar with and then when you lace MA on top of it. Maybe that can't happen in this report. I don't know. But even just a text box of information would be very helpful.

I also agree with what Greg just shared. Having served on a regulatory body it took me a while to understand really the difference between a regulatory and advisory body. And I appreciate what you're saying, Brian. I actually feel very comfortable in putting our best thoughts forward, and because our responsibility is not to think about all the political implications but Congress has that complexity. And at least in my experience the recommendations have broad tentacles that seed other kinds of things, and it is a long game.

So I feel less uncomfortable with that. I'm support of this recommendation.

One last thing, and that you have probably heard me hound on incident to billing every time. That was recommended to Congress. It wasn't taken up. I still think it's important, and I still think we need to bring that forward. That's just an example.

So thank you.

DR. MILLER: So I do support the recommendation for IRFs, just to be clear. I'm not saying that we should necessarily recommend anything different. I think that from an organizational performance perspective obviously I agree that we should support or recommend what we think is the best recommendation.

Other organizations, such as the Federal Trade Commission, for example, their Office of Policy Planning makes recommendations on a regular basis for years or decades to state legislatures about laws and policies that state governments implement, and the FTC, for example, provides a competition policy voice across administrations for years if not decades.

One of the things that the FTC does, in addition

to obviously recommending policies that frequently make probably every industry stakeholder upset and angry with them, the joke is working at the FTC is a great way to not make friends outside of the employees. Having worked there myself I understand that experience.

The FTC still grades its performance in terms of the implementation of its recommendations, which are often politically unfeasible, if not unpleasant recommendations that it's making, and not necessarily enjoyed by those who are receiving them. The FTC still grades its performance and looks at are the recommendations implemented by the state legislature that is writing a letter to have it put on a bill, or the recommendation not adopted, or is it adopted at a later date?

So to be clear, I'm not saying that we should change our recommendations. I think more so that we should keep track publicly of how our recommendations are responded to and eventually implemented, because I think that will help shed light on our positive work.

DR. JAFFERY: Yeah, so this is a great chapter. Thank you. I am supportive of the recommendation as well. But I guess I have a macro comment since we have a few

minutes in this conversation for direction. And I am old here, as far as Commissioners go.

DR. CHERNEW: I'm probably older. Go on.

DR. JAFFERY: How older?

MALE VOICE: He means this concept of Commission age.

DR. JAFFERY: Yeah. I'm a six-year-old, and some of you are one-year-olds and two-years olds. Already this comment is going poorly.

[Laughter.]

DR. JAFFERY: It is rapidly descending into chaos here.

DR. CHERNEW: And Jonathan.

DR. JAFFERY: So we do this a lot. We have a tendency to do it a lot, which is to ask for a lot of things from the Commission, and I will say, Brian, I have heard over the years some reports of -- and they are often more informal -- from not Paul but his predecessors, and not Mike but his predecessors around when things get taken up, and it's some informal discussion.

But we have a tendency, whether it's analytic or data searches or things like that, to make a lot of

recommendations about what staff should do, and I guess I really want to remind everybody that they are very, very busy, and it's their day job, and this is a side hustle for the rest of us. And it's an important one and we play an important role, and I think they appreciate -- I hope they do -- our comments and input. But I think we should be careful about what we ask for.

DR. CHERNEW: So thank you. I agree with that. Dana, I think we've made it through the Round 2 queue, so I want to make a broad comment before I wish everybody safe travels.

This is the December update meeting discussion, and I know we've had this discussion before but I will say it again. It is a very stylized activity, and there are a few things that are important.

The first one is that it is evidence based, so we do not shade the recommendations, and we don't expect the Commissioners to shade the recommendations because they have a hunch that something good or bad would happen if you don't do more. You know, otherwise we end up in a world in which people come in and say, "Yeah. I know the evidence suggests this, but in my experience it's that, and you

should give more to this sector or that sector." That's very hard to defend when we stray too far from the evidence. That doesn't mean that those comments are unimportant. They are important, and, in fact, they are actually useful in how we think about things.

I responded to Tamara earlier about the SNF sector, about why we ended up at a minus 3 as opposed to something that you might think maybe you would go lower. It's because we're concerned about some of the things that were raised in the SNF sector. We're concerned about there's a staffing rule, you mentioned. There's what's going on in COVID. There's a bunch of things that have happened.

But that was within a range of what I would consider reasonable based on where things are. I would have said the same in the hospital sector as well. I think it's reasonably clear in the hospital discussion that by the metrics that we use the hospitals are facing a lot of headwinds. Could they be more efficient if we put more pressure on them? Undoubtedly true. Would I like them to be more efficient? Absolutely the case. But I think there is evidence in our analysis, I think it's clear that there

are challenges with hospital closures and other types of things that make assertions about what would happen if you gave them more or less harder.

So we've tried to pick a recommendation we think is, broadly speaking -- and I'm going to emphasize this -- I have tried to pick a recommendation that I say, broadly speaking, is reasonable given the evidence as I see it. I've tried to give recommendations that don't rely on overpayment in one sector to support another sector or underpayment to compensate for underpayment in other sectors, as we've talked about, for example, in the SNF and some of these other ones.

So that's sort of where we are. In terms of this discussion about whether or not Congress does or doesn't take our recommendations, I'll pass on that topic now, but just to say -- and I will defer to Paul -- the way in which we interact with the Hill, the recommendations are one part, and I would actually argue a relatively smaller part of aspects of our influence. The comments that we have on the books recommending quality programs, for example, or improvements in data collection, in telehealth we have no standing recommendations, and it's amazing how impactful,

for example, our telehealth discussion has been.

So how we engage with the Hill, how our comment letters are written reflect all of this conversation. But the update recommendations, the sort of voting on the update recommendations, I think have to maintain the same meaning as we go through, institutionally, what things are so people understand where we are.

So I guess, in closing, I'll start with, as always, thank you to the staff. You guys did a terrific job, Jamila and all that preceded you. To the public, we would love to hear from you at meetingcomments@medpac.gov. Please let us know. To the Commissioners, I will be available for discussion as much as you would like, to the extent that we can, if you have any other concerns or things we didn't get to.

But in the meantime, I would just encourage everybody safe travels, happy holidays, healthy New Year, and I, again, appreciate everybody's time and attention to the materials. I know how much work that it is, so I think it's useful to remind folks at home how much the folks here do, and to take Jonathan's words, in an activity that's not their day job.

So again, thank you all, and we'll be back in January.

[Whereupon at 12:02 p.m., the meeting was adjourned.]