MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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AGENDA PAGE

P R O C E E D I N G S

[11:16 a.m.]

DR. CHERNEW: Hello, everybody, and welcome to our December MedPAC meeting. As is always the case, we are going to be discussing MedPAC recommended updates that will appear in the March report, 2026 report. There's a lot, a lot of things to discuss and a lot, a lot of thanks to go around, but given the time constraints, I think we're going to jump right into the fee schedule for physicians and other health professional services.

And with that, I think, Rachel, you're kicking us off. Go ahead, Rachel.

MS. BURTON: Good morning.

In this session, we'll present our assessment of the adequacy of current payment rates for physician and other health professional services and present the Chair's draft recommendation of how to update payment rates in 2027.

For those watching online, a copy of these slides is available in the handout section of the webinar's control panel on the right side of the screen.

Our presentation will begin with a quick overview

of use and spending under Medicare's physician fee schedule. We'll then give an overview of the indicators we look at when assessing the adequacy of payment rates and then dive into our findings regarding beneficiaries' access to care, the quality of their care, and how clinicians' revenues compare to their costs. We'll end with the Chair's draft recommendation and your discussion.

In 2024, 1.4 million clinicians billed Medicare for 1.1 billion service units provided to 27.5 million beneficiaries in fee-for-service Medicare. The Medicare program and fee-for-service beneficiaries paid $93.8 billion for these fee schedule services in 2024.

This slide shows the four domains the Commission looks at when formulating our recommendations about how to update payment rates each year. These domains can be hard to directly measure. So we look at a number of different types of data to come up with our overall assessment.

In the case of clinicians, we explore beneficiaries' access to care and the quality of their care.

Unlike other presentations you'll see today, we do not assess clinicians' access to capital due to data

limitations, but we do examine growth in clinicians' revenues and costs. Our assessment of the various indicators on this slide informs the Chair's draft update recommendation for physician fee schedule payment rates in 2027.

Now for our findings. One of the main ways MedPAC assesses beneficiaries' access to clinician care is through our annual patient survey, which we have fielded since 2003. Our survey allows us to obtain more recent data than would otherwise be available to us, since our survey results are available within one month of fielding instead of two to three years.

We currently contract with Gallup to conduct our 10-minute survey, which is completed by about 5,000 Medicare beneficiaries ages 65 and over and 5,000 privately insured people ages 50 to 64 as a comparison group.

Gallup statisticians weight the survey data to be nationally representative and identify which results are statistically significant.

In our 2025 survey, Medicare beneficiaries reported access to care that was generally better than that of privately insured people.

As shown here, more Medicare beneficiaries than privately insured people reported being satisfied with their ability to find providers that accepted their insurance and had appointments when they needed them.

Medicare beneficiaries were also more likely to report that they never or only sometimes had to wait longer than they wanted to get an appointment for routine care or to get an appointment for an illness or injury.

In response to special interest in the topic of wait times among Commissioners and Congress, we added new questions about this to our survey starting in 2024.

In 2025, we found that among those who tried to get a new primary care provider in the past year, more Medicare beneficiaries than privately insured people were able to be seen within two weeks for their first appointment, and fewer Medicare beneficiaries reported waiting six weeks or more for their first appointment.

Similarly, among those who tried to get a new specialist, Medicare beneficiaries were more likely than privately insured people to be seen within two weeks for their first appointment and less likely to wait six weeks or more for their first appointment.

Once beneficiaries find a new clinician and establish a care relationship with them, subsequent appointments seem to be easier to schedule, according to our analysis of CMS's 2022 Medicare Current Beneficiary Survey.

CMS's survey groups together appointments with new and existing clinicians and finds that among Medicare beneficiaries who recently had an office visit, 73 percent were seen within two weeks. This is a much shorter wait time than was reported in our survey, which focused only on wait times for a beneficiary's first appointment with a new clinician.

Another key indicator of beneficiaries' access to care is the share of clinicians who accept Medicare. In the American Medical Association's 2024 Survey of Physicians, among those reporting accepting new patients, 95 percent accepted new Medicare patients. More specifically, 85 percent accepted all new Medicare patients and 10 percent accepted some new Medicare patients. Only 3 percent said they only accepted privately insured patients. The AMA's survey also found higher Medicare acceptance rates among physicians in hospital-owned practices and

among specialists.

I'll now hand things off to Geoff.

MR. GERHARDT: Another indicator of beneficiaries' access to care is the number of clinicians billing Medicare's fee schedule. From 2019 through 2024, the total number of clinicians billing the fee schedule grew by an average of 2.2 percent per year. Because the number of beneficiaries in fee-for-service Medicare decreased over this time, the ratio of clinicians per fee-for-service beneficiary also increased.

Growth varied by the type and specialty of clinician. Specifically, we saw rapid growth in the number of advanced practice nurses and physician assistants. There was modest growth in the number of specialist physicians who account for over three-quarters of all physicians billing Medicare. And there has been a decline in the number of primary care physicians up until 2024, when the number stabilized. We're concerned about the decline in primary care physicians and are monitoring the situation closely.

Finally, 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.

Now we'll turn to our assessment of quality of care. The quality of care provided by individual clinicians is difficult to assess for two main 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 select a small set of quality and improvement activities 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 are clinicians where CMS has no quality information.

Taking these limitations into account, we 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.

The 2024 risk-adjusted rates of ambulatory care-sensitive hospital use remained relatively stable from 2023 and remained well below pre-pandemic levels. Patient experience scores were also relatively stable, with CAHPS scores of 84 out of 100 for beneficiaries' rating of fee-for-service Medicare and 86 out of 100 for the rating of their health care quality.

Finally, we'll turn to clinicians' revenues and costs.

We found that allowed charges per beneficiary for all clinician services grew by 4.1 percent from 2023 to 2024. This was higher than the average growth rate from

2019 to 2023, although that period does include the 2020 when aggregate payments for most services declined due to the effects of the pandemic.

The 2024 growth in payments per beneficiary varied by type of service. It ranged from a decline of 0.3 percent for major procedures and anesthesia to an increase of 5.1 percent among evaluation and management services.

For each of the seven types of service we look at, each increased more in 2024 than the average rate for those categories over the 2019-to-'23 period.

In evaluating the growth in service units and spending, one of the things we look for is anomalies in growth rates. On a per-beneficiary basis, the total number of all E&M services grew by 10.9 percent and allowed charges increased by 5.1 percent, which are both higher than normal. We found that these high growth rates are largely driven by the introduction of a new E&M code.

Starting in 2024, clinicians can bill an add-on code, G2211, with certain office visits when a clinician is the primary provider managing care or treating complex health conditions. In 2024, G2211 was successfully billed 25 million times, and Medicare and beneficiaries spent a

total of $400 million. As such, introduction of G2211 accounted for about half of the total volume increase in all E&M and roughly one-fifth of the increase in allowed charges for E&M.

In addition to introduction of the complexity add-on code, in recent years, CMS has taken several steps that have tended to increase aggregate payments for primary care. For instance, CMS increased payment rates for many types of E&M office visits. It created care management codes designed to reimburse clinicians for costs that are not included in E&M visit codes.

Starting this year, CMS is making monthly per-beneficiary payments for advanced primary care management. These payments are higher when a clinician is treating certain patients who are dually enrolled in Medicare and Medicaid programs. This is directionally consistent with the Commission's recommended safety-net add-on payment.

Next year, CMS will recognize efficiency improvements among non-time-based codes by reducing the work portion of their payments by 2.5 percent. Because of the fee schedule's budget neutrality requirement, this will increase payments for other services, including E&M.

I'll now hand things over to Brian.

MR. O'DONNELL: 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 and peaked at 4.3 percent in 2022. MEI growth slowed through 2024 and is projected to moderate further in the coming years, with projected increases of 2.6 percent in 2025, 2.3 percent in 2026, and 2.1 percent in 2027.

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 2024, a cumulative increase in fee schedule updates, the bottom line, totaled 14 percent, compared with MEI growth of 56 percent, the middle line.

We also present Medicare fee schedule spending

per fee-for-service beneficiary, which includes the combined effects of changes in updates, volume of care, intensity of services, and changes in coding practices by clinicians over time.

As you can see in the top line of the figure, Medicare fee schedule spending per fee-for-service beneficiary grew by 104 percent over the same period, far outpacing MEI growth. And as noted earlier, the Commission's full set of access measures suggest that beneficiary access to care has remained similar to or better than individuals with commercial insurance.

The fact that our beneficiary access measures remain similar to the commercially insured population 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.

In this slide, we discuss all-payer clinician compensation. While it's an indirect measure, we use compensation as a rough proxy for all-payer profitability.

In 2024, median annual compensation for physicians increased by 6 percent, reaching $369,000 per

year, with large differences in compensation by specialty. Meanwhile, compensation for nurse practitioners and physician assistants was about $130,000 per year. Over a five-year period from 2019 to 2024, median compensation grew by approximately 3.5 percent per year for physicians, nurse practitioners, and physician assistants.

In this slide, we compare private insurance PPO rates with fee-for-service Medicare rates.

We compare private insurance rates with Medicare rates to gain insight into clinicians' revenues and incomes and because large differences could create an incentive for clinicians to focus on patients with private insurance. We found that commercial PPO payment rates were 140 percent of fee-for-service Medicare rates in 2023, up from 136 in 2022.

Despite lower rates, providers may accept Medicare for several reasons. A substantial share of many clinicians' patients are covered by Medicare, and if these clinicians opted to accept only commercially insured patients, they might not be able to fill their patient panels. And as we've heard in our annual focus groups, many clinicians have a strong desire to treat their

patients regardless of their insurance status.

Medicare fee-for-service is also a prompt payer, as it's required to pay clean claims within 30 days, and private payers generally impose more administrative burdens, such as prior authorization, which can decrease the amount of time clinicians have to see patients.

To summarize our analysis, our indicators suggest that payments have been adequate, but input costs remain slightly elevated.

In terms of access, beneficiaries report access to care that is generally better than that of the privately insured. Similar 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, and services per fee-for-service beneficiary increased substantially.

In terms of quality, it's difficult to assess the quality of clinician care because Medicare does not collect much patient-reported outcomes or clinical information, and CMS currently measures clinician quality using MIPS, which is fundamentally flawed. Having said that, the indicators we track have remained relatively stable over time.

In terms of clinicians' revenues and costs, allowed charges per fee-for-service beneficiary increased by 4.1 percent. MEI growth has moderated and is expected to slow further to 2.1 percent in 2027. And clinician compensation continued to grow in 2024.

Also, the ratio of private insurance rates to Medicare payment rates increased slightly.

Taking a step back, we note that in totality, our payment adequacy indicators are generally similar to or better than those that the Commission published in its March 2025 report.

This brings us to the Chair's draft recommendation for 2027, which reads, "For calendar year 2027, the Congress should increase payment rates for physician and other health professional services by 0.5 percentage points more than current law."

In this slide, I'll walk through the estimated impact of the Chair's draft recommendation. The draft recommendation is to increase payment rates by 0.5 percentage points more than current law, and current law updates are scheduled to be 0.75 percent for AAPM clinicians and 0.25 percent for all other clinicians. As a

result, the combined effect of the Chair's draft recommendation and current law for 2027 are 1.25 percent for AAPM clinicians and 0.75 percent for all other clinicians.

In terms of implications, this draft recommendation would increase spending relative to current law, and it should maintain clinicians' willingness to treat fee-for-service Medicare beneficiaries and maintain beneficiaries' access to care.

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

DR. CHERNEW: Thank you, Brian, and thank you to the rest of the team for some tremendous work.

We're going to go through the queue in a minute, but I just want to -- this is tricky, how the wording goes. So I just want to try and clarify for those at home, I think most of you have heard me say this. A recommendation, which is current law plus 0.5, is essentially a recommendation to pay more than otherwise would have been paid under current law. That's what the plus means.

But because there was a patch in 2026, that the

implications of a recommendation would be such that payment in 2027 would be below payment in 2026, less so than under current law, but still, there's a patch that was explicitly made temporary, and that patch would be going away. And we're making a recommendation relative to a current law baseline.

So that's just -- the numbers I think work out, if you see the math. It's just sometimes in the framing, it's not clear what's going on. So this is an increase in payment relative to current law, and that's the way that I see it. But it does essentially allow the patch to expire as the patch, whatever it's called, was written.

I will just say quickly two things. The first is our analysis is all based on the data for payment before 2026. So all of the access stuff, all the payment stuff, all the acceptance of Medicare stuff, all that stuff was done without the increase that folks are going to get for 2026, for better or worse.

We will see in 2026 as data comes in, if that improved access or whatever it did, but that's right now we're working off data that's before that. So all of our payment adequacy indicators are before that.

And my read of the data is that, you know, access relative to the commercial sector, I would always love access to be better. I frankly think the problems of access involve things that are well beyond a percentage of a payment, but the point is access relative to commercial and other sectors seems reasonable, if not slightly better.

And I think -- I commend the staff for noting that there's added revenue going in because of a lot of the new codes and stuff going on. So the fee schedule isn't the only measure of payment adequacy or money that has been put into the system. We're going to have to see how that all plays out.

But those are the core factors that are driving where the recommendation is. So now I know that there is a queue, and if I have this right, and I might not, I think Lynn was first. But, Dana, you were in charge of managing the queue.

MS. KELLEY: Lynn is first.

MS. BARR: Thank you, and welcome back, everybody, and thank you so much for this great work.

I'm intrigued by Medicare beneficiaries getting better access than other payers that pay more, and I was

wondering if, you know, that struck you as odd. I don't remember us actually having better access.

And so is this -- is this like -- how much of that is associated with APRNs and PAs versus, you know, physicians? Is there any difference in that access?

MS. BURTON: This is a finding we've had for a few years now, and we've been kind of conservative and been reporting it as, you know, better than or comparable, but after a few years of seeing this trend, we decided it was time to just say it's better.

And in terms of APRN and PA usage, we don't see a big discrepancy in terms of fee-for-service and -- sorry -- between Medicare and privately insured people using those types of clinicians.

MS. BARR: And nothing across, you know, disparities or anything? It's just across the board, even though we pay less, we get more access, that just seems surprising to me.

MS. BURTON: Well, I think a lot of payers have narrower networks, whereas, you know, fee-for-service Medicare is accepted very widely.

MS. BARR: Got it. Thank you.

MS. KELLEY: Wayne?

DR. RILEY: Yeah. Good morning, all. Thank you, Rachel and staff, for the wonderful work you've done. Thanks for hanging in there during the shutdown.

Rachel, you mentioned the two-week wait for Medicare beneficiaries. I may have missed it either in the written materials or in your presentation, but is that two-week wait inclusive of specialty access or just primary care access?

MS. BURTON: Yeah, yes. That is combined.

DR. RILEY: That's combined.

Now, what can you tell us about the average wait for a primary care versus specialist?

MS. BURTON: I've run the numbers, but I don't have it memorized. So that's something I could, you know, potentially add to the chat.

DR. RILEY: That would be helpful because, anecdotally, many of us know one of the problems some beneficiaries have -- and I understand it's regional and geographic -- is access to specialists, cardiology, GI, endocrinology, where they get in to see their primary care internist or the family physician, but then there's an

inordinate delay sometime. And again, this is just anecdotally what we hear in New York City. So it'd be interesting to sort of tease out both primary care wait time and specialist wait care.

Thank you.

MS. TABOR: I can add also that in our focus groups with beneficiaries, we do also hear that, Wayne, that wait times do generally tend to be longer for specialists than primary care.

DR. RILEY: Right. And it would be good to quantify, is it three weeks or three and a half weeks for specialists versus two weeks for, you know, primary care access? I think that would be helpful for us to know as Commissioners and also for the general public.

Thank you, both.

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

DR. CHERRY: Yes, I did.

First of all, I just want to thank the staff, not only for this particular session, but all the ones that are coming up for pulling all this data together. I know it's a very heavy lift, you know, coming off the shutdown, and

it doesn't go unnoticed, and it's really greatly appreciated.

I just had a technical question, perhaps, you know, for future work on this. I was just curious whether it was technically possible to see if there's a correlation or relationship between the intensity of E&M coding, including care management codes and ambulatory sensitive hospitalizations and ED visits. In other words, does the intensity of E&M coding actually translate into improved care using those outcomes? Because that would actually be helpful to know.

DR. CHERNEW: Hearing not an answer, I'll say quickly, Robert, I think that's a really good question. I think there's a really broad question. There's a lot going on with coding.

We know we're paying more because of the coding things. We don't yet have a very good sense of what we're getting for all of that, and frankly, we don't even have a sense for how care itself is actually changing as opposed to code changing. We just don't know. I don't know.

DR. CHERRY: Yeah.

DR. CHERNEW: So I'll take from your point -- and

I think it's a reasonable one -- we have a lot more to learn about what's going on. You can see that it is certainly a way that more revenue is moving into the sector. What we're getting for that revenue is less clear. That doesn't mean it's unimportant. It just means it's unknown. So I want to emphasize absence of evidence doesn't mean evidence of absence or some clever thing like that, but it is important at least to acknowledge that that is happening. And I think it's a good point that we should try and understand that better.

DR. CHERRY: Yeah. Because, theoretically, we created these complex codes because there's a resource intensity around certain patients, and so is that actually translating into avoidable ED visits and hospitalizations?

DR. CHERNEW: Yes. And --

DR. CHERRY: And we need to figure that out at some point.

DR. CHERNEW: And as an aside -- so I want to go through the queue, but I will say -- but we've also created a bunch of scribes and other mechanisms for coding things differently. So there's the sort of -- I agree 100 percent with what you said, and we should go on through the code --

through the queue, but there's a real -- a lot of uncertainty about what's happening.

MS. KELLEY: All right. Gina.

MS. UPCHURCH: I'm going to pile on. Thanks so much to the staff for all this great work. I thought this chapter read really beautifully, and this put things in context really well.

A couple of clarifying questions. When we talk about balance billing, I thought providers could bill up to 115 percent, and I see in the chapter it says 109.25. Which is it?

MR. GERHARDT: It's a complicated formula, but in effect, it's the -- when you put all the payments together, it's the 109 number.

MS. UPCHURCH: Okay.

MR. GERHARDT: Again, these are not people that have opted out entirely. Those people just can't bill Medicare at all.

MS. UPCHURCH: Not accepting assignment, yeah. As a SHIP-coordinating site, so we're always trained that it's 115 percent. So I'm not -- I'm not -- but either way, just to make that clear.

And then I've asked this before, but we're seeing more and more concierge care, where people are saying, oh yes, we'll accept Medicare, but by the way, we have this other fee over here if you really want good access. So are we capturing that anywhere, and how does that fit into our CAHPS survey and -- because, obviously, that's, you know, worrisome, if people feel like they have to pay this side payment to get access. Do we have any data about direct care or concierge care?

MS. TABOR: We are asking about concierge care in the focus groups that we do every year in different parts of the country, with beneficiaries as well as with clinicians, and generally, you know, there is a sense that concierge medicine is a thing in some markets, and that some beneficiaries have chosen to do it and some do not because of the cost.

But there is a general sense from clinicians reporting out that they don't think concierge medicine in their area is necessarily affecting access. These are small ends, but that is one way that we are looking at concierge medicine.

MS. UPCHURCH: Okay. If we could quantify that,

that might be helpful, because I'm, you know, just in one market, so it seems like it's growing a lot, quite significantly around here.

You have something about Medicare Advantage-only clinicians. I'm like, what are they? Are they people that are, like, hired by UnitedHealthcare to be clinicians for just United patients? What are Medicare Advantage-only clinicians?

MR. O'DONNELL: So when we track, a lot of our data rely on fee-for-service data, and increasingly, I think we're concerned, and we have some preliminary data suggesting that there are a tranche of clinicians that we don't see in the fee-for-service data. And so -- and these are, we believe, largely going to be contained amongst, kind of, primary care clinicians and certain other types of clinicians.

And so, basically, we don't know precisely, kind of, who these folks are, but you can kind of think of a typology of saying, like, these could be folks who are employed by, kind of, United or Humana and focus on treating, kind of, MA patients for a number of different reasons.

But I think that our goal, as the encounter data become available, is to track this cohort of clinicians that focus on treating MA and to give you more information on that in the future.

MS. UPCHURCH: That would be great. Thank you.

Just two more.

DR. CHERNEW: Gina?

MS. UPCHURCH: Yeah.

DR. CHERNEW: Gina, can I say something? Think of practices like Oak Street.

MS. UPCHURCH: Yep.

DR. CHERNEW: There's certain companies that --

MS. UPCHURCH: Yeah, but Oak Street takes all different insurance, and they take fee-for-service. They don't just take Medicare Advantage.

DR. CHERNEW: I'm not sure that's true, but we'll let the staff answer.

MS. UPCHURCH: I think that's true.

MR. O'DONNELL: I think we've seen a variety of different business models, and I think that's where it becomes great for some quantitative work to fill the gap. And we're, kind of, anxious to put that out there, but we

don't have it quite yet.

MS. UPCHURCH: They do focus on a lot of duals. I know that. But as far as I know, it's not just Medicare Advantage, but it may be.

So the last two questions. You mentioned care coordination as part of, I think, the CAHPS survey, but in that one question of coordinating care, there were very disparate, sort of, questions. Are your meds managed? Are other things that you need coordinated? Is that one question, or is that just a composite measure of multiple questions?

MS. TABOR: It's a composite of multiple questions, yes.

MS. UPCHURCH: Okay, okay. Good. I was like, how would you answer that? Because one thing may be good and one thing -- okay. Thanks.

And last question is about G2211. Who gets to claim that? I mean, I know it's complex care coordinating over time, but say I'm seeing a nephrologist and I have a primary care provider, and they're supposedly working together. Can both of them claim that when I have visits with them, or is it just one gets it for a month? How does

that work?

MR. GERHARDT: So the add-on code goes with whatever the visit code is. So there's no monthly payment aspect to it. It's just billed with the visit code, and it's a little extra money. It's about $15 in extra money.

The definition around it is pretty broad. If you're the focal point of care for someone or you're treating someone who has an inherently complex medical condition, you technically can bill it. Because they're sparse data and we've only had sort of one year of usage, we don't know exactly who is using it quite yet. But suffice it to say, a lot of providers could bill it in a lot of circumstances.

MS. UPCHURCH: So it's not only about one.

Thank you so much. Great, great job.

MR. GERHARDT: The other thing that I mentioned that's coming online, the advanced primary -- or advanced primary care practice payment, that is a monthly payment, and it can only go to one provider at a time.

MS. UPCHURCH: Thanks so much.

MR. MASI: And real quick, Gina, just following up on your question about the importance of quantifying the

phenomenon of concierge care, I want to thank you and Scott and others for surfacing this last year, and just wanted to raise, this is very much on our radar, and we are exploring ways of trying to quantify it.

This came up around your conversation with Ledia just now around the difficulty of measuring something in a survey, the care coordination measuring caps, and it turns out there are some real challenges to crafting a survey question that gets at this information for Medicare beneficiaries, but it's very much on our radar, and we're trying to approach that.

MS. BURTON: And just on that point, I wanted to mention that a study recently came out in Health Affairs that quantified the number of concierge clinicians and direct primary care clinicians as being about 7,000. That's probably a lower bound, but it's like the first number we kind of have, so something.

MS. KELLEY: Okay. Tom, do you have a Round 1 question?

DR. DILLER: Yes. Thanks.

The main thing that I wanted to ask about is the disparity between the compensation for primary care and

specialists, and, I mean, this is an issue that's gone on for decades. And I know that it's being addressed in a variety of different ways, but we are seeing a decrease in primary care physicians, and certainly, there's a disparity in their compensation that's in some of the additional data.

From a quality perspective, I know that the staff -- and I really appreciate what they've attempted to do. I know how hard this is to try to measure quality, but anecdotally, I'm seeing increased referrals to specialists from primary care, access-to-care problems, and when we put out clinical pathways, evidence-based guidelines and things along that line and start to measure those things, it's not as effective as we would like it to be.

So I guess my question is, with the recommendation, is what is the effect of this recommendation on improving compensation for primary care? What's the net of that?

MS. BURTON: It's going to apply uniformly across different types of clinicians. So it's not going to help primary care more than specialists or vice versa.

DR. DILLER: Okay. Is there anything else that

we can do to help to close that gap?

MR. MASI: Yeah. Maybe I can try to -- Mike, do you want to jump in?

DR. CHERNEW: I'm going to say what I think you might say, but we'll see how I do.

MR. MASI: Go for it.

DR. CHERNEW: The first thing is, we have a standing recommendation from before that explicitly targets primary care, and that recommendation -- we're not reputing -- that recommendation is still -- we haven't rerun that recommendation. That recommendation still stands as a MedPAC recommendation.

Part of the issue here is, because of some of these other things that were done, I think our feeling is, let's wait to see how some of these things that have just been put in place are playing out.

I don't know how it will play out, but the core thing, I think, is this particular recommendation, as Rachel said, is across the board, but it's in the context of other standing MedPAC recommendations we have and existing policy, is to address the primary care issue that you're talking about.

Paul, did you want to add anything to that or correct anything from that?

MR. MASI: No. I completely agree with all that, and I would add, from an analytics standpoint, we have top of mind that we're going to be tracking how all of these different payment changes -- Mike mentioned the codes, the efficiency adjustment -- over the next year or two, how are those codes and those changes being taken up, and whether we see that translating through to pay differential, as you talk about, Tom. But very much top of mind, and we'll keep looking at this.

DR. DILLER: Great. Thanks. Appreciate it and appreciate the staff and all their work.

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

DR. METAN: Yes, I do.

So, in the report, I see that the number of clinicians billing Medicare has increased, but the mix has also changed. And I'm also looking at one of the notes on page 22, and it says clinicians who opted out of Medicare were concentrated in the specialties of behavioral and mental health, 61 percent.

So, in terms of the mix, are there any concerning trends in the data that we need to be aware of, and could you maybe give a little bit more details on that?

MR. GERHARDT: So we've always been concerned about the number of primary care providers, which, in our definition, does not encompass mental health. Those are in specialty. That is an area where people -- mental and behavioral health is an area that has traditionally sort of been a cash business, if you will, and it's not surprising to see a lot of the opt-outs focused in that area. That's been very consistent over time.

I don't know whether Rachel has any specific results regarding our surveys of folks asking about mental health access that she wants to chime in on.

MS. BURTON: Yeah. I was just going to say, the share of patients that look for a new mental health professional in any given year is very small. It's something like 3 percent.

But among those looking for a mental health professional, a majority have a problem finding one. So this is definitely a problem, and it's not confined to Medicare. It's also among the privately insured.

MR. GERHARDT: And I'll just mention a couple of new types of mental health providers have come online in the last couple of years. Congress has sort of expanded the types of providers that can bill to marriage and family counselors and a couple of other specialties. So it will be interesting to see how those trends look going forward since they're relatively new to the program.

DR. METAN: Thank you.

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

MS. UPCHURCH: I do. Thank you for bringing that up.

So I think most people know I'm a SHIP person. So we're in the middle or about at the end of Medicare counseling, mercifully, and one of the things that we're seeing is a lot of people that do need behavioral health or mental health counseling will choose to go with fee-for-service Medicare for this very reason, because they cannot find providers that will accept Medicare Advantage. So it's another way that feeds into favorable selection for Medicare Advantage, because people avoid it if they have significant behavioral health issues. Not everybody, but

we're seeing it a lot. Just wanted to share that.

Thanks.

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

[No response.]

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

DR. SARRAN: Yes.

Regarding the monthly per-beneficiary payments for advanced primary care -- and I apologize if I missed it -- when did that go into effect, and what are we seeing as the uptake on that?

MR. GERHARDT: It's set to go into effect 2026, so not on it yet, but at some point, we will.

DR. SARRAN: Broad base, what are the requirements for billing that?

MR. GERHARDT: So there's three different tiers, and basically, there are quite a number of requirements that providers' practices where they need to meet in order to qualify for the payments. They need to have certain infrastructure and other sort of things that will enhance the quality and the access to primary care.

And there are three levels, depending on whether the beneficiary involved has essentially no conditions, whether they have multiple conditions, and whether they have multiple conditions and there's going to be dual enrollment status. And it goes up pretty high. We're talking low 100s per month for the one with the duals, but again, we're just -- we can send you more detailed data about the code descriptors, but in a nutshell, that's sort of it.

Does that answer your question?

DR. SARRAN: Perfect. Thanks.

MS. KELLEY: Okay. That's all I have for Round 1, unless I've missed anyone.

DR. CHERNEW: Okay. I think it's good. We have about 45 minutes to get through Round 2.

But I will say a lot of these questions about MIPS relate to other policies and other work we've done that's probably best done outside of the update recommendations. So things about relative fees we think about, we've done work related to that, for example. And you might think that there's other types like the education work we did, for example. So I think there's a lot of ways

to get at some of these problems, and I do appreciate them.

We do obviously have concerns, and it's a very complicated sector. But now we're thinking about what we're going to do in this sort of relatively limited frame of the update, which is inherently more aggregate and not particularly well suited to meeting some of the other nuanced questions across the spectrum because of how it applies. So there's other things, incident-to billing. There's a whole range of things one can talk about that are worthy of discussion, but, again, I want to focus everybody here on the actual update work and push those other things off to sort of broader work streams, some of which we've done, some of which we can certainly expand or do more of.

But, anyway, let's jump into Round 2, and I think Gina is first, but, again, I'm not sure, Dana. You're in charge.

MS. KELLEY: Yes. Gina is first.

MS. UPCHURCH: I'm talking a lot. Okay. Just three quick comments here.

First of all, I just really appreciate the feedback from the focus group where you identified that people had no idea -- many people, I think you said, didn't

have any idea what sort of Medicare coverage they had. So, as we move forward with coverage choice decisions, let's just identify that, the very basics. Are you in traditional or original Medicare fee-for-service, or are you Medicare Advantage? A lot of people don't even know. So that's really, really telling about how confusing Medicare is for people.

The other thing, as we move forward in access to Medicaid, access to Affordable Care Act plans, employer-sponsored plans with prices going up gets worse, that doesn't mean that Medicare access is getting better. It just means the comparator is getting worse. So I just want us to pay attention to that in future years, to notice that, you know, compared to commercial, it may be worse. And that's because commercial is getting worse, not because Medicare access is necessarily getting better. So that's just a thought.

And then, lastly, we mentioned you have something that says interest in being a clinician remains high, which is fantastic, but we never mention in this chapter foreign-born clinicians. They're a huge part of the backbone of some of the services that we provide in terms of health

care in this country. And I know that's under threat a bit now. So I don't know if we can mention that or at least allude to that. Foreign-born clinicians who come here or emigrate to the country specifically and sometimes specifically to provide health services to our citizenry. I think we need to at least acknowledge that and put that in there as a big part of our workforce, especially maybe for non-providers, but the people who do a lot of the work that make quality of life better for Medicare beneficiaries.

Again, wonderful chapter, but I just wanted to add those comments. Thank you so much.

MS. KELLEY: Betty?

DR. RAMBUR: I'll be very brief.

Thank you so much for this work. I just wanted to make a couple of comments.

One, I'm really happy to see how the language has evolved over the past at least five years when I've been here to really think about the broader range of professional services, physicians, of course, but also physical therapists, nurse practitioners, PAs, and I think it's really important.

I wanted to sort of underscore what Tom had said about primary care, and I ask -- and I know that we will continue to monitor the aggregate payments to primary care because last year -- what was it? -- less than 5 percent of our nearly $5 trillion went to primary care. So that's kind of the heart of it.

In terms of if you could access this data -- and I don't know that you can -- on page 27, you talk about indirect billing, and we have that standing recommendation which is really important that we get rid of indirect billing. But is there any way to dissect the proportion or the number or the dollars, physicians receive in volume bonuses for work that's totally done by PAs and nurse practitioners? I think that's probably a black hole, but I know it happens. And I know there's even companies that help people figure this out, and I don't think it serves Medicare beneficiaries particularly well.

You may not be able to get it, but I support all this. But I just wanted to have those few points out there. But thanks for this great work.

MS. KELLEY: Brian.

DR. MILLER: Thank you, all. I'll try and keep

my comments brief for once, although I know that Amol is unfortunately not here to time me.

I do agree that a diverse physician workforce and non-physician workforce is important. We can mention that without being political, and I think that that's important when we do.

A couple comments on our physician fee schedule update. So I practice medicine, and I agree with the good Dr. Diller that I think the quality of care is declining. And I think we're not measuring it, and this is not me being -- this is not disparaging any hospital, doctor, or nurse or anything. I think that the system is breaking and has been breaking and is continuing to decline. I think our quality metrics, while they are good, don't measure this.

I think the increased volume of specialty referrals is one measure, and I think a lot of that -- and this is something that our good colleague Dr. Larry Casalino talked about -- is that sort of elbow grease that makes the system work has vanished and is vanishing, and so I think that the quality of care is definitely declining, and we're not capturing that.

I also think that clinicians are increasingly becoming employed is not just a cultural shift, although I recognize there is a generational shift with my generation. It also suggests that payment rates are inadequate, and you can't run a small enterprise.

I don't think that as a consequence with rising corporate employment that physician salary is a measure of the Medicare physician fee schedule accuracy, given that physician salaries are supported by a variety of other things in a corporate setting. And I know that many of our colleagues who run large integrated health systems can attest to that.

I do think that there's increasing cost shifting into the commercial market, which I think a lot of private payers are seeing, and that, again, suggests that there's a problem with the widening gap between the Medicare and private market rates.

I also noted that we didn't address the nurse practitioner/physician differential in Part B payment. I think we should include that, and we should actually perhaps make that a formal recommendation on that at some point.

The price volume intensity trade-off drives a lot of the fee-for-service payment challenges. As we acknowledge and have discussed many times before, the volume and intensity is a response to payment and to regulation of payment or low payment. I think that that has not been adequately addressed. We talked to the research side and talked more about relative than absolute price values.

And so just, in summary, our physician fee schedule update last year was a net update of 3 percent. Our update this year is a net update of negative 2.2 percent. So while we are recommending something above the current law, we are still formally recommending a net physician fee schedule decrease or a pay cut for physicians in the setting of rising corporate employment, threats to private practice and small business, declining quality of care, but not adequately captured. And so I don't think that this recommendation, which is a net pay cut of 2.2 percent, is a good recommendation. It is also a change of 5 percent from last year. So I don't think we should be recommending cutting physician pay, which is on aggregate what we're doing.

MS. KELLEY: Okay. Scott?

DR. SARRAN: Three very brief comments.

First, I congratulate the team on excellent work. You've synthesized all the right inputs in a very articulate fashion and drove at a conclusion.

A second comment, I believe your conclusion and the recommendation are evidence-based, and I think we've threaded several needles in order to get there. So I support that.

The third comment -- and I'll be very brief here because it really -- I'll be more long-winded in tomorrow's session about payment approaches. Although I think there's been excellent work done by CMS in terms of addressing one of the round-peg/square-hole issues or some of the round-peg/square-hole issues between, on one hand, population needs and, on the other hand, traditional fee-for-service discrete in time and discrete by providers, payment mechanisms and things like the G2211 and the advanced primary care, I think are excellent steps in the right direction. But we still don't have here -- and again, it's not for this section so much as tomorrow -- is a concept of how we reimburse a team rather than a single provider. So

everything in the fee schedule by definition is down to the level of which provider is billing for the service, whether that service is longitudinal or at a point in time is important.

But it's also we're going to have to get more and more towards holding a team accountable, because it's only a team that is going to be able to deliver on the promise of all the medications and technologies that we have available to meet an aging population with multiple chronic diseases, a mix of behavioral and medical conditions, social determinants of health, et cetera. So none of that takes away from the excellent work and my support of the recommendation.

Thanks.

MS. KELLEY: Tamara.

DR. KONETZKA: Okay. Well, first, thanks, Rachel, Geoff, and Ledia, for this great work, as usual. I have two main comments.

One is about the volume and intensity. I know we've discussed this many times in the past. I'm still just really struck by that graph and really interested in this topic. The fact that we have payment rates that many

people are concerned about in that they don't keep up with inflation and yet we spend dramatically more every year due to these volume and intensity increases, and that, to me, reconciling those may explain why we don't see huge access problems, even though rates aren't keeping up with inflation. And so I'm just really interested in that volume and intensity trend.

I don't want to say exactly response, because I think as the chapter makes very clear, it's really hard to sort of tease out how much of that is a behavioral response, how much of that is coding, for example, and how much of that is just due to sort of increasing intensity and increasing demographics and need for care and better technologies.

The comment I have about that is that in the chapter, I think I appreciate that there was a discussion of the literature around this. I found the kind of tone and implications of the discussion of that literature could use a little more nuance. This was around page 39. I think the discussion in the chapter implies that, you know, people used to be concerned that doctors would make up for low payment rates by increasing the volume of services,

and, you know, more recent literature basically says that's not true. And I think that's just -- doesn't really reflect the sort of complex, long-standing economics literature on this.

I think people generally agree -- although those recent papers, the Gottlieb papers are great. You know, I think it is actually much more complex than that. I think there's agreement that it really depends on, you know, how much of a physician's practice is dominated by Medicare, what their outside options are, you know, whether in their field, private practice or Medicaid, whatever their alternatives are, what those are paying, et cetera. And so, you know, you can see higher income effects or substitution effects depending on all of those factors.

And there are sort of counterexamples. The one I think of immediately is the Mireille Jacobson papers about how in physician practices, when we lowered payments for chemotherapy administration in physician practices, you basically saw more chemotherapy, right? There were some substitutions in terms of drugs too, but there was more chemotherapy. So I think that part of the chapter could just use more nuance, and instead of saying, we don't worry

about this as much, we think doctors basically respond, as you would learn in Econ 101, prices go up, supply increases, instead of kind of concluding that, I'd love to see a little bit more nuance in the conclusion that this is something that we should really keep monitoring.

And to the extent that our workflow allows and that, you know, it's kind of a hard thing to do, but that we should keep trying to sort of tease out how much of that volume and intensity response is sort of warranted and how much is just a behavioral response to payment. So that's my first broad comment.

The other one is very simple, that I wanted to say, I do support this recommendation. I think it -- to me, you know, based on all of our conversations over the past year or two, that led to us coming to some agreement on a kind of MEI minus 1, and the fact that this recommendation loosely aligns with that and to me really balances rising beneficiary costs with preserving access to physician services, makes me support this recommendation.

Thank you.

MS. KELLEY: Josh?

DR. LIAO: Okay. So I really want to echo other

Commissioners in thanking the staff for this work. You know, the primary care-trained general internists, who's had an opportunity to engage and the schedule issues through the RUC and other avenues, I think this is an important discussion.

Just a few comments from me. I think, first, must foundationalize support, kind of updates that anchor to current law rather than kind of incorporating patches that might be year-over-year. I think that introduces uncertainty, and it feels unlikely to provide a durable basis for policy recommendations going forward.

Second, I think starting from current law, I'm supportive of an upward adjustment. As other Commissioners and MedPAC and many other groups have noted, there is a long-term trend about reimbursement against the pace of inflation and underlying practice costs, and in my own experience, I think individual clinician compensation hasn't always kept pace with those pressures, so I'm supportive of that.

I think, third, you know, recognizing the inherent limitations in the data we have, I agree with a comment about how we measure access, and I think Wayne's

example about looking at wait times for primary care versus specialty care is a helpful illustration. I think thinking about things like whether we can assess wait times or access to referral loops between primary and specialty care would be another, but regardless, I support maintaining that type of measurement.

I think, fourth, you know, based on the data we do have and has been presented today, there appears to be reasonable access alongside, you know, stable clinician revenue and cost trends, and I think, taken together, you know, these, to me, don't point to a need for large data adjustments.

Fifth is kind, Tamara, a little before when I did the back-of-the-napkin math on the numbers here. I think what's being proposed here, a half-a-point increase, you know, strikes a reasonable balance and is consistent with our prior work, and in particular, you know, focusing on MEI minus 1 and thinking about whether that adjustment is for APM versus non-APM clinicians, recognizing there's a differential, I think it actually balances that very well.

And then, finally, and very importantly, I appreciate the multiple factors that are outside the fee

schedule that would shape payment adequacy, and other Commissioners have mentioned some today. I think different avenues can and perhaps should be taken to address those, and even outside of payment, you know, how we pay avenues for doing that in Medicare quality of care, et cetera. So I hope I have a chance to discuss that more, including in tomorrow's sessions and beyond.

But in short, I support the draft recommendation, and I look forward to additional discussion on other important topics, including those released today.

Thanks.

MS. KELLEY: Stacie?

DR. DUSETZINA: Great. Thanks so much.

Thanks to the team for excellent work and also to the fellow Commissioners, especially Tamara's points and reminder about the volume and intensity relationship and how that fits with this particular recommendation.

So I'll start by saying I really support the recommendation. I think an increase about current law is appropriate, but also taking into account those broader context around volume and intensity and those trends, I think it's an appropriate recommendation.

I want to go back to one of the points that Gina made about the workforce issues and immigration-related issues, and I recognize that this would be something that we don't want to wade too far into, because there aren't really data yet to support anything. But I did also find myself during several of those chapters, especially ones where we know that immigrants play a larger part of the workforce, that that might be even more impactful there. So I wonder if there's a way to think about, you know, just a need to monitor and think about staffing over time as a way to kind of note that there are a lot of things that are changing right no. And we don't know how consequential that will be for beneficiaries and access and workforce.

The other thing that I noted and really appreciated was on the access piece, I think on page 18 and 19, you talk about the low-income beneficiaries, in particular, and some of the stark differences in access for that group. And so I was incredibly pleased to see, you know, the payment change to try to help to incentivize, like, care of low-income beneficiaries. And so I do think it would be great to, you know, explicitly say we would like to look at this in the future to see if that does

start to close the gap for those beneficiaries. I think that's a great opportunity to understand how much are payment-related, you know, issues for access versus not.

So thanks again for the incredible work and, again, very supportive of this recommendation.

MS. KELLEY: Tom?

DR. DILLER: I have to remember to click the button.

I am very supportive of the Chair's recommendation at this point. I recognize our task is to recommend changes to the fee-of-service system, and I recognize also, as Brian pointed out, that it's below the inflation rate. And I don't think that that's a bad, bad thing.

The issue for me is -- and I guess my comment and where I'm at -- is the health care system is breaking or is already broken, and it's largely due to our reliance on fee-for-service payment model that's been going on for decades.

Our quality is, I believe, decreasing. I think some others on the call here also believe the same, and our access to care is also decreasing.

So there are shifts going on that are not necessarily good for the overall health care system. What I look forward to are shifts in the payment model to value-based approaches, and I know CMS is putting a number of those in place. They seem to be coming out with new ones almost every month, and I'm very supportive of that.

So part of my approach here is that, yeah, we're not giving as great a fee-for-service increase as would keep up with inflation, but hopefully, that money, that differential, is somehow funneled into more advanced payment models that will help resolve some of the issues in the health care system.

Just my comment. Thanks.

MS. KELLEY: Lynn?

MS. BARR: Thank you.

Would you go to slide 22, please?

MS. KELLEY: It might just take a second.

MS. BARR: Okay. Great.

So, again, great work, and I really appreciate everything that's done here and what we're trying to do, and I do agree that the indicators look good. But, you know, I'm not sure, you know, what we're doing here.

Is that 22? I'm sorry. It's the one that had the chart. I was looking in the handout. It was 22, but it's the chart that shows the increases for the physicians versus the -- that's the one.

So I just have to ask myself, what are we doing here? Because, you know, we -- okay. We're squeezing the physicians, and we've got, you know -- but this is our tool to reduce the cost of care, right? This is what we're doing here, and look at what we've done. You know, we've squeezed the physicians. It has had no impact on the total cost of care, right? They're independent.

And so, you know, we can keep squeezing the providers, but we're not solving the problem, and this is not actually reducing costs. And we're bringing it down as much as we can, because we care about cost. So I don't think that these -- what we're doing here is really benefitting the patients, the providers, the taxpayers, or anybody else.

I do agree with the recommendation. I support the Chair's recommendation, because we have to do everything we can to bring down cost, but this isn't working, and we need -- and everything we're doing with

advanced payment models, I mean, just look at the chart. There's nothing that we're doing -- Medicare Advantage now is, you know, two-thirds of our patients. It's not helping. So I think we just have to think differently about this whole thing, and just continuing to squeeze the providers is not helping anything. It's just breaking the system.

And you should look at what we've -- what happened in the UK, where, you know, starting with Margaret Thatcher who says we'll squeeze the providers, we'll squeeze the budget, squeeze the budget, and they went from one of the best health care systems in the world to where they are today, which is shambles. And that's where we're headed as well. So we need to do better, and we need to do something completely different.

Thank you.

MS. KELLEY: Robert?

DR. CHERRY: Yes. I want to thank the staff again for a great report.

I will say that I'm empathetic to both Brian and Lynn's arguments, you know, that an effective cut to the physician payment schedule is really kind of tough to

reconcile.

I think when I look at it and you take a step back and you look at the all-payer compensation, it's probably very unlikely that the Chair's recommendation is going to have a material impact on the quality of care, at least in the coming year, if this gets adopted.

So I am supportive of the Chair's recommendation, which is the current law plus 0.5 percent.

I do think that looking at clinician or physician compensation, though, is a poor marker for Medicare profitability. I just want to kind of, you know, state that and emphasize that. I think if you've seen one physician practice, you've seen one physician practice, and we have to be very cautious in interpreting that metric.

There's a growth in concierge services and subscription services that some patients are paying into that kind of offsets some of the Medicare losses. There are physician practices that, you know, target, you know, commercial payers to try to offset, you know, governmental payers. There's hospitals that's cross-subsidizing, you know, physician practices to retain certain clinical services.

And I do agree with Tamara that the volume and coding intensity is not the sole factor in sort of keeping physician compensation, you know, propped up, and that there's a lot of other factors going into this.

So I do think it's a bit presumptuous to think that physician compensation is strongly correlated with Medicare profitability. However, it does have utility, you know, in tracking what drives specialty choice and practice location, and I think we also need to keep an eye on it because, you know, physicians that work in vulnerable areas, for example, have limited ability to offset potential Medicare losses, and that that could lead to access issues over time, including the expansion of medical deserts as well.

So I do favor tracking the old payer compensation, but I think we should not emphasize or even really kind of state that the reason is really to derive some sort of indirect marker for Medicare profitability.

But thank you for, you know, the work and the recommendation, which I'm supportive of.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks And sorry to be late to the

party here.

So, first of all, thank you to the team for such excellent work. It's always a pleasure to read this chapter and then sit there and puzzle a bit about what it all means and how to make sense. Particularly, I think, to echo Tamara's comment, making sense of the growth in volume and intensity.

And I've been trying to figure out, you know, how do we get at whether patients are truly sicker or whether there's some amount of upcoding, likely some combination thereof. But I think in the future, if there's some mechanism for getting at, you know, really what's driving the intensity, I think that would be informative to the Commission.

I generally support the Chair's recommendation, but I do, I think, share some of the concerns about -- the system, I think, is really struggling. And I think physicians are sort of front and center, especially primary care physicians, and they are struggling to meet the demand. And yet, at the same time, I realize in the chapter, it talks about how physician compensation increased by 6 percent while input or inflation was at 3

percent. So, again, I think the Chair's recommendation is directionally correct.

But, as I read the chapter, one of the things that really stood out for me -- and I very much appreciated the inclusion of Table 4.6 in terms of all these new codes that disproportionately are used by primary care physicians -- this, for me, was kind of a dizzying array of codes that looked like a kind of a bunch of patches. And so I look forward to the Commission's future work on redesigning payment, because I think to Lynn's point, you know, kind of what we're currently doing doesn't seem to be working.

And, you know, I kind of wonder across all these codes -- and I did not see this in the chapter, and perhaps the staff have this information is -- you know, how often are these codes actually used?

I know I worked on a study looking at transitional care management codes, and they're frequently not used. I mean, there has been increased uptake, but I think physicians may not be deploying all these codes, just in part due to the complexity.

The other point that I would make related to the chapter, I really was very pleased to see Table 4.4, the

data display, where you present on low-income beneficiaries and the challenges they face with accessing care. I thought that that was really a very nice addition to what is this annual report chapter.

So I think overall, I do support the Chair's recommendation. I think we have to keep a close eye on what's going on with access to care. I think it is deteriorating. I don't know to what extent payment is sort of the primary driver of that, but I do think we need to, you know, keep close attention to this particular piece, in part, because I think we still have issues related to inflation, related to supplies, and while we think that's going to moderate in the future, I think that's still a TBD. So thank you.

MS. KELLEY: Brian, I think you had a point you wanted to make.

DR. MILLER: Yeah, I did. I agree with many of the comments that Lynn and others made about sort of crushing on physicians. I don't think it's helpful, though, for us to critique specific politicians and other national health systems. Margaret Thatcher made choices that she made at the time. We were not sitting in the

chair, and I think it's very easy for us here to critique the choices of other leaders, and, you know, we should try and be understanding that people make tradeoffs as they are.

An example would be, I'm a big fan of the Biden administration's MA marketing regulations, because I think that they have massively improved the system -- there's still more work to be done -- just as I'm a fan of the Trump administration's support for primary care. So I at least encourage my colleagues for us to try and be more balanced in how we refer to other political leaders' decisions about health care, especially retrospectively.

MS. KELLEY: Mike, I think I've reached the end of the queue, but people should wave if I've missed anyone.

DR. CHERNEW: So that's right, and there's a few people that haven't spoken.

So Lynn's waving. So, Lynn, why don't you wave?

MS. BARR: Thank you.

I'm not criticizing Margaret Thatcher. I'm pointing to historical fact, and it's just an example of historical fact, and it happened, right? And so I don't think anyone's going to disagree with the historical fact.

It's not a criticism. You know, it is simply historical fact.

DR. CHERNEW: So thank you, Lynn. And so, first of all, Lynn, you didn't say -- if you just want to say in one second, like, your views on the rec, I'll summarize in a minute.

MS. BARR: Oh, I'm sorry. I thought I made it very clear in my comments, but yes, I do support the recommendation.

DR. CHERNEW: Gina, also in your comments, you didn't say much about the rec. So if you want to say something very quickly, that would be useful.

MS. UPCHURCH: I support the rec.

DR. CHERNEW: And there's a few people. I think I have Wayne and Gokhan that haven't said things -- and maybe Greg -- specifically about the rec. If you want to say something, that's fine. I'm not forcing anyone to speak.

DR. RILEY: I support it, Mike.

DR. CHERNEW: Thank you, Wayne.

MR. POULSEN: I would just say I support it, that the points that I would have made were made effectively by

others. Thanks.

DR. CHERNEW: Thank you, Greg.

DR. METAN: I support the recommendation.

DR. CHERNEW: Thank you, also, Gokhan.

So let me summarize. We have a few more minutes.

There's a lot of frustration, I feel, across the board for how the fee schedule is working. I've heard several of you say something that, if you know my work, I obviously agree with, which is we need to think about not just what the updates are, one way or another, because I don't think we're going to solve a lot of these problems with moving the update a percent or so. I think we need to think about broader structures and how the system works. I'm particularly worried about, for example, the administrative burden that physicians are facing.

I think it's just really challenging to be a physician these days, and that transcends a lot of other activities. I'm very worried about the relative payment across different services and the relative payment across specialties and a whole slew of other things.

We've done some work on the education system, and they may come back again, because I think a lot of this has

to do with the underlying core supply of professionals, and that transcends what we're going to do here.

I will say tomorrow we're going to be talking about payment methodology work, which in some ways is supposed to give us -- it's not going to be perfect. We have a lot of different views, but at least part of the vehicle for channeling some of this energy to try and find ways to allow professionals, non-physicians and physicians to both work together -- there have been several team-mates things -- in ways that allow efficient substitution and avoid some of the fragmentation of the codes, which I understand the motivation for the codes, but they also create a lot of other documentation issues, which I think some of the questions got at. So it's just really, really big.

So I appreciate the support and the comments for the rec. I will say that I'm very conscious that this is a narrow exercise with one lever. We do understand that current law -- and this came up in our June report as well -- is because it doesn't have an inflation factor in it and we do believe that it is worthwhile to increase payment relative to current law and that is where the rec lies, it

is obviously a balancing factor, because while we could discuss paying more, I don't think, for example, it's the case that if we pay more, commercial will go down. I actually think we'll just, broadly speaking, pay more.

So I think, again, all of your views are important. We will go through the transcript and see where things are. I think when you see the chapter again, which will be before, and you go through and send comments about the particular wording, there's been a lot of really important comments that I think can be incorporated into the wording there.

But, Paul, do you want to add anything?

MR. MASI: No. This has been a really good conversation, and as Mike said, we will take this back and go over the transcript very carefully. In particular, this is very helpful when striking the right balance of tone in the chapter. So we'll keep working and look forward to the continued conversation.

DR. CHERNEW: Okay. Looking in the chat, I will say to those at home, if you've joined us, we appreciate -- well, obviously, you've joined us, so you can hear me. I'm going to hate reading that of the transcript. But, in any

case, please reach out and give us your comments at meetingcomments@medpac.gov, You can reach us in a bunch of other ways.

I've heard from several of you, several other organizations about their views of this. I think we are struggling with how to have sort of a long-run stable physician payment system, and hopefully, this will help us move in that direction. There's obviously going to be a lot more to do, and ideas and stuff from those of you at home will very much be appreciated.

So, again, to all the Commissioners and particularly the staff that did a voluminous amount of work, I really could not thank you for both your patience and your support and your comments and insights, and we will continue this.

But I think, if I have this right, we are now going to take a break, and we're going to come back at 1:30 where we will be talking about the hospital update book.

So, again, thank you all, and we'll see you in about 45 minutes.

[Whereupon, at 12:41 p.m., the meeting was recessed, to reconvene at 1:30 p.m. this same day.]

AFTERNOON SESSION

[1:33 p.m.]

DR. CHERNEW: Hello, everybody, and welcome to our afternoon session. We're going to continue to go through the update recommendations for fee schedules. We're going to start with the hospital inpatient and outpatient one. Before we do that, however, Kenny Kan couldn't join us, and he wanted to read a very short comment on the physician work into the record. And in the heat of the moment I forgot to have that read in. So I appreciate everybody's patience, but Dana is going to read that in and then turn it back over to me and we'll start the hospital stuff. So Dana.

MS. KELLEY: All right. I have Kenny's comment as follows. He appreciate the insightful analysis and the complications of the 2027 payment update, given the earlier temporary bump and APM rollout changes. While access does not appear to be an issue from the applied MedPAC metrics, he is leaning towards keeping the temporary bump plus 0.5 percent prior to any additional APM adjustment.

And that is it.

DR. CHERNEW: Okay. And so now that we have

wrapped that up, we are now going to start our work on the hospital inpatient and outpatient services sector, and for that I think Alison, you are starting. Take it away.

MS. BINKOWSKI: Thank you, Mike, and good afternoon, everyone, and welcome back to MedPAC's December 2025 meeting. The handouts for this presentation can be found on the control panel on the righthand side of the screen.

Many MedPAC staff helped with aspects of today's work. In addition to the staff listed on the slide, we would also like to thank Brian O'Donnell, Ledia Tabor, Dan Zabinski, Pamina Mejia, and Chinmay Amin.

In today's presentation we will cover several topics. First, we will provide an overview of hospital use and spending under fee-for-service Medicare. Second, we will assess the adequacy of fee-for-service Medicare payments to hospitals. Third, based on these indicators, we will present the Chair's draft recommendation on how to update fee-for-service Medicare base payment rates to hospitals in 2027.

We will then transition to discuss two other topics, a mandated report on rural emergency hospitals, and

an update on site-neutral payments. And we will conclude with turning the floor back to Commissioners for discussion.

To pay hospitals for the facility share of providing services, fee-for-service Medicare generally sets prospective payment rates under the inpatient and outpatient prospective payment systems. In 2024, over 3,000 hospitals were paid under these payment systems, and these hospitals provided 6.5 million inpatient stays to fee-for-service Medicare beneficiaries, for which the Medicare program and its beneficiaries paid $104.6 billion dollars, as well as an additional $5.9 billion in uncompensated care payments. These hospitals also provided 64.7 million hospital outpatient encounters to fee-for-service Medicare beneficiaries, for which the Medicare program and its beneficiaries paid $52.4 billion, as well as an additional $22.0 billion for separately payable drugs and other items. Together, these payments totaled $185 billion.

As described earlier this morning in the clinician presentation, each year MedPAC assesses the adequacy of fee-for-service Medicare payments by looking at

four categories of payment adequacy indicators: beneficiaries' access to care, the quality of that care, providers' access to capital, and 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 fee-for-service Medicare payments to hospitals are enumerated on this slide. Based on these indicators, the Chair develops a draft update recommendation for hospital base payment rates.

Our first category of payment adequacy indicators relate to beneficiaries' access to hospital care. We found that hospitals continued to have available capacity in fiscal year 2024. Specifically, hospitals' inpatient capacity was stable, with about 674,000 inpatient beds. Hospitals continued to have available inpatient capacity in aggregate, with a 71 percent occupancy rate. However, some hospitals had very low occupancy rates while others exceeded capacity at times. Hospitals continued to have

available emergency department capacity, with patients spending about 150 minutes in the emergency department. And hospital employment increased to 4.8 million employees.

Another indicator of beneficiaries' access to care is the supply of hospitals. As shown in the figure on the left, the supply of hospitals, as measured by the number of unique provider numbers, was relatively steady in 2024, decreasing by 0.6 percent to 4,530. This number is higher than we presented in the inpatient and outpatient prospective payment systems summary slide as our access to care measures include acute care hospitals Medicare pays under other methodologies, such as critical access hospitals.

More specifically, as measured by hospital locations, in both fiscal year 2024 and 2025, 8 more hospitals closed than opened, with low volume and high operating costs being the most commonly cited reasons for closure. In addition, several hospitals converted to rural emergency hospitals, as Alex will discuss later in this presentation.

Our final indirect indicator of beneficiaries' access to care is the volume of services. Both fee-for-

service Medicare inpatient stays and outpatient encounters per capita increased in 2024. Specifically, as shown in the left figure, inpatient volume increased to 208 stays per 1,000 beneficiaries, a 1.5 percent increase from 2023, and as shown in the right figure, hospital outpatient volume increased to 3 encounters per beneficiary, a 4 percent increase from 2023.

Our second category of payment adequacy indicators relate to the quality of hospital care. In 2024, these quality indicators were mixed, both relative to 2023 and prepandemic levels. Specifically, fee-for-service Medicare beneficiaries' risk-adjusted mortality rate was 7.4 percent in 2024, a slight improvement from 2023; fee-for-service Medicare beneficiaries' risk-adjusted readmission rate was 15.4 percent, slightly worse than in 2023 but still an improvement relative to 2019; and performance on most patient experience measures, such as the share of patients who would definitely recommend their hospital, remained stable from 2023 to 2024, but almost all remained at least one percentage point lower than in 2019.

Our third category of payment adequacy indicators relate to hospitals' access to capital. As shown in the

right figure, hospitals' all-payer operating margin in 2024 was 6.5 percent, a 1.3 percentage point increase from 2023. This increase was driven by two factors. First, hospitals received $9 billion in 340B remedy payments to offset lower Medicare payment rates for drugs obtained through the 340B Drug Pricing Program from 2018 to 2021; and second, hospitals' labor costs grew more slowly than in past years, driven by large decreases in hospitals' contract labor costs.

We do not yet have complete hospital cost report data for 2025. However, financial statements from eight large hospital systems suggest that hospitals' all-payer operating margin increased in 2025.

Other measures of hospitals' access to capital also improved in both 2024 and 2025. Specifically, hospitals' investment income increased, and investor's risk premium on hospital bonds decreased to near zero, suggesting that investors see little risk of hospital defaults on their bonds.

I will now turn it to Betty.

DR. FOUT: Our fourth and final category of payment adequacy indicators relate to the comparison of

fee-for-service Medicare payments and hospitals' costs. As shown in the left figure, hospitals' fee-for-service Medicare margin increased in 2024 to -12.1 percent, a 0.5 percentage point increase from 2023. This increase was due to continued growth in profitable outpatient drugs and slower growth in labor costs, among other factors, but it was offset, in part, by a decline in uncompensated care payments.

We note that the Medicare margin here does not include 340B remedy payments hospitals received in 2024, and that there continued to be substantial variation in the fee-for-service Medicare margin across hospitals.

Each year, the Commission examines the median fee-for-service Medicare margin for a group of hospitals that historically performed relatively well on quality and cost metrics. This method does not identify all efficient hospitals but rather is one source of information on whether Medicare's payments cover the costs of providing hospital care efficiently.

This year, in response to Commissioner interest, we refined our methods and relaxed our consistency requirement. Relatively efficient hospitals now need to

meet criteria in 3 out of the prior 4 years, rather than 3 out of 3 years. This allows for some year-to-year variation in performance measurement, and this roughly doubled the share of hospitals identified as relatively efficient compared to last year, as shown in this table.

The median Medicare margin among relatively efficient hospitals increased to -1 percent in 2024 from -2 percent last year. These hospitals also have higher quality metrics than the median comparison hospital.

For 2026, we project that hospitals' fee-for-service Medicare margin will increase relative to 2024. We project the margin to increase from -12.1 percent to -10 percent in aggregate, and from -1 percent to 1 percent for the median relatively efficient hospital.

These projections are driven by factors such as a positive effect from a $1.8 billion dollar increase in uncompensated care payments in 2026, and a positive effect from projected continued growth in profitable outpatient drugs. While there is more uncertainty for our 2027 projections, we expect them to be slightly higher than in 2026.

Since 2023, the Commission recommended

redistributing existing Medicare disproportionate-share-hospital and uncompensated-care payments via the commission-developed Medicare Safety Net Index, which identifies hospitals that serve large shares of low-income Medicare patients. As a reminder, for each hospital, the MSNI is calculated from three components: the share of Medicare volume for patients who have low incomes, uncompensated care costs as a share of all-payer revenue, and Medicare's share of all-payer volume divided by two.

In addition to the MSNI better targeting hospitals that treat larger shares of low-income Medicare patients, the MSNI continues to be a better predictor of hospitals' all-payer margin than the current DSH metric. Our recommended MSNI mechanism has other advantages, such as direct payments to hospitals for both their fee-for-service and MA patients.

In summary, across our four categories of indicators of the adequacy of fee-for-service Medicare payments to hospitals, we found that beneficiaries' access to care is positive, the quality of care is mixed, hospitals' access to capital is positive, and fee-for-service Medicare payments relative to hospitals' costs is

negative.

In considering how to update fee-for-service Medicare payments to hospitals, the Chair's draft recommendation aims to balance several objectives. These include maintaining payments high enough to ensure beneficiaries' access to care; maintaining payments close to hospitals' cost of providing high-quality care efficiently to ensure value for taxpayers; maintaining fiscal pressure on hospitals to constrain costs; and limiting the need for large, across-the-board payment rate increases by better targeting Medicare payments to Medicare safety net hospitals serving large shares of vulnerable Medicare patients.

We now turn to the Chair's draft recommendation for 2027.

Based on the hospitals' payment adequacy indicators and the expected increase in fee-for-service Medicare uncompensated care payments by about $2 billion, the Chair's draft recommendation reads:

The Congress should, for 2027, update the 2026 Medicare base payment rates for general acute care hospitals by the amount specified in current law; and

implement the Medicare Safety Net Index (MSNI) described in our March 2023 report, with an additional $1 billion added to the MSNI pool.

The implications of the Chair's draft recommendation would increase spending relative to 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.

I now turn the presentation over to Alex.

DR. HARRIS: Thanks Betty. Before turning to our discussion of the Chair's draft recommendation, we will discuss two additional topics, the first of which is a mandated report on rural emergency hospitals, or REHs.

The creation of the REH designation was a response to changes that occurred in rural areas over many years. Rural hospitals were traditionally inpatient-centric organizations and rural Medicare payment policies often focused on increasing payment rates for inpatient services as a mechanism to support rural hospitals.

However, more recently inpatient volumes at some rural hospitals have declined substantially while the need for emergency care in isolated, rural towns has remained.

To address these changes in rural patients' needs, in 2018 the Commission recommended the creation of a new category of hospital: a rural, outpatient-only hospital that Medicare would support with a fixed annual payment, to help cover stand-by emergency room costs, in addition to traditional fee-for-service payments for outpatient services.

Broadly consistent with the prior MedPAC recommendation, the Consolidated Appropriations Act of 2021 created a new REH hospital designation, starting in 2023. Critical access or rural hospitals with 50 or fewer beds as of December 27, 2020, can choose to transition to an REH.

Under this designation, REHs do not furnish inpatient care, they do staff an emergency department 24/7, they receive fixed payments from Medicare, and are paid 105 percent of standard outpatient prospective payment system rates for emergency and outpatient fee-for-service services.

The Consolidated Appropriations Act of 2021 also

mandated MedPAC to annually report on payments to REHs. Since the start of the REH designation in calendar year 2023, the number of REHs has grown to 38 in 2024 and 44 in 2025.

In 2024, the 38 REHs received over $100 million in enhanced Medicare payments. $100 million of these were from fixed payments, and $1.2 million were from higher than standard fee-for-service payments for hospital outpatient services.

The Commission has also continued to monitor the REH designation, including through hospital site visits and interviews with REHs. Hospitals have told us that MA plans tend to match fee-for-service's enhanced claims-based payments but do not pay REHs' fixed payments.

And now, the second additional topic is an update on site-neutral payments.

To recap, in 2014 and most recently in June 2023, the Commission recommended aligning Medicare payment rates for certain outpatient services across ambulatory settings. More specifically, this recommendation applies to services that are safe and appropriate to provide in all outpatient settings, and when doing so does not pose a risk to access.

The potential impacts of site-neutral payment rates are substantial. First, site-neutral payments improve incentives by setting payment rates based on the efficient delivery of care and not based on setting; and second, they reduce incentives for provider consolidation.

Over the last decade, Medicare has implemented some site-neutral policies. Beginning in 2017, most services in non-excepted off-campus provider-based departments, or PBDs, were subject to site-neutral payment rates. In 2019, Medicare expanded site-neutral payments to clinic services in excepted off-campus PBDs.

Starting in 2026, drug administration services in excepted off-campus PBDs will also be subject to site-neutral payments.

There are additional site-neutral payment expansions that could be considered in the future, including clinic visits in on-campus hospital outpatient departments, and expanding site-neutral payments to more services provided in excepted off-campus PBDs.

We'll now answer any questions you have and take your feedback. I now turn it back to Mike.

DR. CHERNEW: Great. Thank you all so much.

Before we jump into the Round 1 comments, I want to -- we have sort of a special thanks to give. And, Paul, you're going to start, and then I'll say something. Then we're going to jump into Round 1.

MR. MASI: Yeah. I'll jump in. Thanks, Mike.

So that was a terrific presentation, but I've been dreading this part. I want to acknowledge that this is Jeff Stensland's last MedPAC meeting. Now, Jeff has been a cornerstone of the MedPAC staff for a long, long time. In fact, if you see on MedPAC's website, the name Jeff Stensland, you get more than 23 pages of results. And I think that is one small measure of just the tremendous contributions that Jeff Stensland has made to MedPAC for a long time. He's really a giant in Medicare payment policy.

And on behalf of the whole staff, I want to express our gratitude for his expertise, excellence, and also his creative approach to solving public policy problems. But more importantly, we're grateful for his friendship because he's just a humble and generous colleague, and we're wishing him well in retirement, but we will dearly miss him. So thank you to Jeff.

DR. CHERNEW: I'm going to add my own special

thanks. When I first joined MedPAC, my first go-around in 2008, Jeff was a leader then, and you can see all that he's contributed. He exemplifies sort of the dedication to evidence and analysis. I still can't tell exactly how he feels politically about a whole bunch of things, but I do understand he is passionate about the data and the analysis. I won't say I always agree with him on particular things, but I consider him to exemplify sort of the open-minded analytic willingness of the staff to engage in these things. And I think you all sort of experienced that.

And so I think, broadly, we will all very much miss having Jeff's intellectual leadership on a lot of these topics. But for now, we're going to leave it at that.

And, Dana, why don't you take us through Round 1?

MS. KELLEY: All right. Thank you. I have Lynn first in Round 1.

MS. BARR: Thank you. And again, thank you, staff, for this great work.

I have a couple of questions. One of them is, do you have a similar chart as we did in the last one that

shows sort of the increases we've given over time, inflation, and how that's affected hospital spending? I'd love to see that maybe next year. I know you guys are super busy, but I found that chart to be very helpful. And I'm assuming the answer is no, because it wasn't in the presentation.

I have to make a comment about the efficient hospital model that we use. I was curious. What have we done to validate that model? Has that been published? I mean, this is a MedPAC model. I think it's one that we struggle with as Commissioners. I appreciate you broadening it. But, you know, the negative 12, you know, still kind of sticks out there as a big number, and so I'm just curious. How have we validated that model so that this is what we're relying on for our recommendation?

MR. MASI: Betty or Alison and Jeff, please feel free to jump in.

I'm not exactly sure what kind of validation exercise you're interested in, but we're very open to other ways of approaching this. I think we have tried to put out information about the method we've taken for constructing the measure and, you know, refined it over time.

Alison, Betty, Jeff, please feel free to jump in with any additional detail that you'd like.

MS. BINKOWSKI: I'll say one thing while I'm waiting for Betty or Jeff.

We have looked at the list that it results in. We have looked at their costs on both the inpatient and outpatient side, on the stability of these metrics over time, and as we note throughout the chapter and as Betty noted during our presentation, you know, this is one of many metrics that the Commissioners can choose to establish. And we're not trying to say this is one and only definitive way, but more to provide insight that there are hospitals out there that are able to constrain costs while having relatively high quality. And we'd be happy to talk to you more about what you'd like to see in the future.

MS. BARR: Thank you.

I mean, I was curious whether, you know, anybody had ever published on it or, you know, whether there was, you know, sort of some analysis.

I think Brian made this point in the past that, you know, it was like, well, you know, sort of let's look

back at what we've recommended and see, you know, how good it is and, you know, not in terms of what does Congress do with it, but just how good is this model. And so the question I would have is, you know, could you go back and say, okay, we've made these recommendations based on this number and, you know, and how sensitive was it? How accurate was it? You know, I mean, we know what happened. We could go back.

And I know we've changed the methodology. I'm also curious as to what the old methodology would have given us this year versus the new methodology, you know, because it was -- you know, it was negative 2 last year, but I don't know what it would have been this year.

And so it's just I would like to see, you know, since this is, I believe, a construct that we have come up with, right, that is nobody else's, I'd like to see some validation of, you know, how that has played out over time, not obviously for this cycle, but for next year, just because this is a very hard thing for me to accept that, you know, this model is something -- you know, that we're saying, well, you know, relatively efficient hospitals should be able to do this, so, you know, we should be, you

know, in this range.

And I don't know what that, you know -- I appreciate you guys broadening it from 6 percent to 12 percent of the hospitals, but I don't know, you know, is this really a valid metric and would love to appreciate -- would appreciate further information next --

DR. CHERNEW: So let me jump in. I can't go back to the entire history, but like the safety-net index work, usually this goes through what you call a cycle of deeper dive stuff, and I can't, off the top of my head, tell you when that whole body work was done.

The basic idea was, if we took a different definition of efficiency, which is low cost, we would obviously get a much higher margin. And there was a concern that there wouldn't be quality, that those very low-cost hospitals might not have the same quality. So there's a bunch of analytic issues. So that's where we ended up saying, well, you need to meet both a quality and a cost bar, and that obviously then raises the cost side of things because you're throwing out some of the lowest cost hospitals in that.

And then I think the other approach is -- as

happened last time, is through this process, when there's particular suggestions like happened last year, you make the suggestions, and people look at the suggestions. I think the core problem here, which I think everyone would acknowledge, is we actually don't have great measures of quality. So it's just very hard to know.

We certainly don't have good measures of context in a whole bunch of ways. So we don't know, oh, you can meet this bar because of this feature, that feature, in a range of ways. So that's why we look at all the other distributional facets on things and try and build out. For example, the safety net index is explicitly designed to target money towards hospitals that we think are fiscally challenged. I think the targeting principle is an important one.

There has been related published work, actually, since we're all lauding Jeff. Jeff may want to jump in. But, for example, one of the sentinel things that Jeff published was that costs respond to payment. And so the idea of just paying where we think costs are is problematic, because then the payment just kind of drifts up.

And we have done some, actually, peer-reviewed work, and by we, in this case, I actually mean Jeff. Maybe there were other MedPAC co-authors, Jeff, to those of you that are here. I truly apologize for not knowing on the spot.

So we do try and do that, and, of course, we take into account feedback from all the folks that are listening, meetingcomments@medpac.gov. But that's kind of the process, and we're all ears to hear more things if you have particular technical suggestions.

DR. RAMBUR: So, Michael, can I just pop in one thing?

I had always been concerned about that initially as well, because I was concerned, is it efficient, because it is lower cost by cutting staff and that kind of thing. When I become more comfortable -- we don't have probably all the quality metrics we want, but I've been more comfortable with that being woven in the mix. And maybe some of the new metrics that the Joint Commission is requiring around nurse staffing or something like that or turnover might be added. But I think it's a fair question. But I think it's been refined over time in the five years

I've been here.

DR. STENSLAND: And I would just say we try to actually kind of validate it every year. What's different about what we did and what most people did is most people say, oh, here were the best performers in 2023. Those are the efficient hospitals or these are the best hospitals in the U.S. News and World Report or whatever. And, when we looked at that data when we first came up with this, there was a lot of people bouncing in and out, okay, especially small hospitals. Like, no one died this year, then two people died the next year. You were really great; then you were really bad.

So the way we've done it is we said let's look at the historical data and say who was historically relatively efficient in that kind of 2019-to-2023 period, and then, in the same signal, say, well, then how did they do in 2024? So that's kind of our validation. We're saying the data that we used to categorize you as efficient was from the early years, and then we take a separate set of years that wasn't used to categorize you as efficient and see how you did.

And, it looks like, yes, these hospitals that

historically were relatively efficient continue to be relatively efficient later on, using those years that weren't part of the metric.

So every year we've tried to kind of validate it that way, but you will see some differences from what we produce and what other people produce in terms of what's relatively efficient. And we want to say this is not all relatively efficient. This is just a sample of hospitals that have been able to do pretty well on quality and cost, and the signal there is just for somebody to say, oh, people can produce relatively okay quality while keeping their costs close to Medicare payment rates. That's kind of the general signal we're sending.

MS. BARR: And do those hospitals have a representation of the safety net? Is the safety net represented in those hospitals?

DR. STENSLAND: Historically, we've looked at like how many of these are some large public hospitals, and you do get some of those hospitals in there. Probably what you get fewer of in there is really small hospitals, because we require some consistent performance, and when you have very few and you have a lot of bouncing around and

so then we toss you out, not because we're saying you're bad, but just because you haven't consistently shown good performance.

DR. CHERNEW: And, Jeff, if I understand correctly, things like critical access hospitals aren't included. This is an IPPS construct.

DR. STENSLAND: Correct.

MS. BARR: Yeah, absolutely.

MS. BINKOWSKI: IPPS and OPPS.

MS. BARR: Okay. Thank you. Thank you.

And then so -- I think that's it for my comments for now. Thank you very much.

MS. KELLEY: Scott, did you have something else on this?

DR. RAMBUR: I just have -- sorry.

MS. KELLEY: Oh, sorry, Betty.

DR. RAMBUR: Oh, I was just going to add one thing that Lynn asked about, and I would also mention that we do control for the low-income dual eligibility and standardizing costs in that way. It's not like you're penalized for having high shares of low-income beneficiaries.

But I also say that I think you asked about what the performance would have been, how to be used, the three-out-of-three metric, and we kind of mentioned it in the paper that it is better, as you would expect, like slightly better than the negative one that we found this year.

MS. KELLEY: Scott, did you want to get in on this issue?

DR. SARRAN: As I've listened to this discussion about the relatively efficient hospitals, am I right in thinking that we do not publicly publish the ranking of hospitals as well as individual components of their scores along this scale?

MR. MASI: That's exactly right, Scott, and the rationale is because we don't view this as a really granular U.S. News-ranking exercise, but rather, as Jeff and Alison and Betty pointed out, we view this more as a very broad signal of payment adequacy that the Commissioners can review when making their assessment.

DR. SARRAN: Right. Well, and I hear that, Paul, but my instincts are towards pushing us to consider publishing not just the overall scores, but the individual components of the scores. And here's why, and I'm not

saying, gosh, guys, we need to do this right now, but to further think about why we should or shouldn't.

So, you know, I think there's a concept of -- overlapping concepts of, on one hand, high versus low performers, which implies that a low performer could become a high performer if they did certain things, right? And then there's the concept of haves versus have-nots, which is largely dictated by market forces that have resulted in a hospital or hospital system having achieved a have versus a hospital not having achieved that status, and there's an overlap.

And I think one of the things that could happen if we were to publish these is that in addition to its usefulness, as we've done in terms of setting a targeted payment rate, right -- and I think there's a ton of logic in how you've both constructed these and how you're using them in helping to form a recommendation for hospitals, but it could help define opportunities for improvement.

Just the public -- the publishing of it creates pressure for improvement, because I think hospitals, like every other provider out there, they feel pressured to improve whenever there's public -- you know, public scoring

of any kind.

And also, it could help identify and tease out whether there are, for many hospitals perhaps, actual barriers to them improving, right? And I'm thinking some hospitals that are challenged because, you know, they're servicing a difficult population, whether it's, you know, dual eligibles or patients with high, you know, social determinants of health or hospitals that simply have found themselves for a variety of historical reasons in a have-not category in terms of their payment rates, particularly on the commercial side from insurers, and they just therefore don't have the money to invest in improving.

So I really -- I'm pushing us to think through the why's and why not's and pros and cons of publishing the data.

And last comment on that is my impression of the work you've done along this dimension is it's very good work. So this does not seem to me as though it's not ready for prime time. It seems, not surprisingly, like you've done great work all along. You've refined it, and so I think it could be useful along more dimensions than we're making use of it currently.

MS. KELLEY: I'm sorry. Go ahead, Paul. Go, Paul.

MR. MASI: Mike wants to get in.

DR. CHERNEW: Hi. I appreciate this long discussion, but understand the core thing here is the recommendation. So we can't turn this into a discussion about some of these other broader things. I appreciate that the efficiency issues and measures important. Noted. Let's save all of that discussion for another point in time because we have to get to the core round two stuff. We're going to talk about the recs. So just be cognizant of the time as we go through these discussions because it's been time consuming.

MS. KELLEY: Scott, you had a Round 1 question. Do you want to go ahead?

DR. SARRAN: My Round 1 question was about the relatively efficient hospital work.

MS. KELLEY: All right. All right then. Tamara?

DR. KONETZKA: Great. Great work as usual. Thank you for this chapter.

My question is about you concluded that the results for quality for hospitals are a bit mixed because

readmissions went up when mortality went down. I'm wondering if you considered or looked into whether this is a simple competing risks problem where, for example, the hospitals that had declining mortality rates then had more sicker people who were available to be readmitted, and so that wouldn't be such a bad thing.

If we wanted to look into this a little bit more, I think the way to do that or the way to start would be to just look at whether or not those trends are happening in the same groups of hospitals. Right? Do you see the increasing readmissions in hospitals where you see declining mortality rates? So I don't know if this is something you've given thought to or not, but it might be worth looking into a bit. Yeah.

DR. HARRIS: I can speak to this a little bit. I think it's a really good point. It is something that we have, I think, at a high level thought a little bit about, particularly that the trends that we're seeing here, particularly from 2022 to 2024, are consistent with the CMS measures as well, and so I think it's a fair point and something that we could think about looking into further.

DR. KONETZKA: Great. And I should say, to save

myself the Round 2 part, I don't think that answer would probably change the recommendation, and I'm broadly in support of the draft recommendation.

Thanks.

MS. KELLEY: Cheryl?

DR. DAMBERG: Thank you, and thanks for this great chapter.

I'm going to go back to the Table 11 in the chapter that breaks out different types of facilities, the Medicare margins, and how they've changed over time.

One question that I had -- and I'm wondering if this is either something you could add or maybe you know off the top of your head -- how does this vary based on, say, the percent of dual eligibles or low-income beneficiaries who are treated in the different hospitals?

And I think this relates also to the efficient set of hospitals, and are any of kind of those disproportionately serving low-income patients? Because I don't feel like we have any insights into how that varies based on these two different patient populations.

MS. BINKOWSKI: So I don't have the specific numbers off the top of my head, but I can say we have

looked at the results both by DSH and by MSNI quartile, which are two different ways of measuring vulnerability of patients, though they are related. I'll say that, in general, the hospitals with higher of either metric have higher Medicare margins in large part because they are currently receiving higher DSH and uncompensated care payments.

DR. DAMBERG: Great.

And then I think my other question was -- it seemed like there were a lot of for-profit hospitals that had closed, and I'm just kind of curious if you have any insights into that.

DR. HARRIS: Insights into the reasons for closure? Yeah. So what we could take from most of it, which is not particularly different from last year, the most cited reason by far was low patient volume and kind of has been the same, I think, even in years prior. Yeah, so that's really the main takeaway across the whole group, to be honest. It is generally the thing that we've seen in news reports, articles, things like that.

DR. DAMBERG: Thanks, Alex.

That's it.

MS. KELLEY: Gina.

MS. UPCHURCH: Thank you so much, and great job to the team working on this.

I just have one quick question. So, on page 38, you said -- and you mentioned this in your presentation. I think Alex mentioned it. For example, in our hospital site visits and interviews in the past few years, rural hospitals reported that Medicare Advantage plans tend to match fee-for-service claims, payment rates for rural emergency hospitals, but do not pay REH fixed monthly payments. However, Medicare's fixed monthly payments to REHs are included in the MA benchmarks. So my question is, do we think that's okay, and are we doing something to remove that or extract it from the benchmark?

Thanks. That might be a Round 2 question, but in general, I don't have a Round 2 question. That might have been one, but if the Commission has had made a stand on that in the past -- and I'm generally supportive of the Chair's recommendation.

Thanks.

MR. O'DONNELL: Hi, Gina. This is Brian, and doing a little pop-up comment here.

We did -- so we did on these rural site visits. We did confirm that, and the Commission doesn't have a standing recommendation on that. But we did write that up in a text box, kind of noting that if you remove those payments from the MA benchmarks, it would improve equity, and so we think it was largely an oversight for them to be included in the benchmarks. And so we did write that up a few years ago, and we can recirculate that.

MS. UPCHURCH: Super. Thank you for figuring that out, and let me just also say about the recommendations. In particular, I really support the safety net-addition of a billion dollars. Thanks. Especially with states like North Carolina that are lesser-off states and don't give providers the full 100 percent Medicare payment. Thanks.

MS. KELLEY: Tom.

DR. DILLER: Yeah. I had -- I want to thank everybody for the great information. I had a number of comments about the relatively efficient hospital model, but I'll hold those for another time.

My question has to do with the safety net and the $1 billion. I didn't see any information that told me that

$1 billion is the right number. So is it $1 billion? Is it $10 billion? How did we come up with adding $1 billion to that? It seems random.

MS. BINKOWSKI: Mike, do you want to take that?

DR. CHERNEW: We were just basically trying to calibrate a sense that we wanted to make sure that the margin for efficient hospitals was sort of higher than it otherwise would have been. But we didn't -- before last year when the underlying data was much worse, we had plus $4 billion. So we wanted to retain some acknowledgment that targeting was a good thing, but we were basically just fiscally constrained on the top end.

There's nothing magical about $1 billion as opposed to $2 billion or half a billion. It corresponds to about a half a percent. So, if you went through all the math, the margins that would be in the efficient hospital in this recommendation between one and one and a half would seem like a reasonable balance of where to be. There's no mathematical formulation of why it's one versus two versus a half. It's just a balancing act, a judgment thing.

DR. DILLER: Okay, thanks. I'm supportive of it. I'm just trying to understand where we came up with the

number. So appreciate that.

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

DR. METAN: Yeah. Actually, Tom just asked the exact same question I wanted to ask. So that $1 billion, feeling -- trying to understand why we landed on the $1 billion number.

And also, is there a way to better understand what that $1 billion would result in if there is a possible way to kind of help us get our head around it?

Otherwise, I'm supportive of the decision. I just want to understand.

DR. CHERNEW: The $1 billion is roughly a half a percentage point in margin. I think that's basically right, Paul. The staff can correct me if I'm wrong. But again, it's not going to everybody. It's going -- it's targeted to the places where we think are the most challenged. But anyway, that's the rough magnitudes.

Did I get that right, Alison, Betty, Paul, anybody?

MR. MASI: Yep. Yeah, I would agree with all that, Mike. I think, like you said, it's inherently a

judgment, and we can work on providing some additional information, the impacts as we move through this report.

DR. METAN: Yeah, I think that would be really, really helpful for us to understand, Paul, like what do we expect in return for the $1 billion? And that would also help us in upcoming years as we kind of like go through the same topic.

DR. CHERNEW: I think, Gokhan, just to bring you up to speed from last year, so we did a bunch of work on the Medicare safety-net index analysis. So whenever we have sort of bigger, broader things like targeting, we go through a whole cycle on them, and we had one on the safety net.

One of the things that that analysis showed was that hospitals that scored high in the safety-net index were more likely to, for example, close and stop. And it showed in that analysis, it was a better targeting methodology than, say, DSH, for example. That's what that analysis showed. I think it was probably 2023.

And now I feel obliged to say this because I know Lynn will want to say this. There were some concerns about moving from DSH to MSN because of what that would mean for

things like 340B. And in that original work, we said, look, for other types of programs that are built off of DSH, we don't intend there to be a change. You could still use DSH, for example, for 340B if you wanted. We were just trying to target the money difference.

This is always a challenge when there's so many moving pieces. We're not really trying to write detailed versions of what the legislation would look like. We're trying to make the broader point that we think the hospital sector needs a little bit more money, but that money needs to be targeted, because as you'll see, hospitals overall are actually doing better. The all-payer margin is better. I think the concern that we have is people say, look, hospitals seem like they're okay. Why are we putting any more money in? And the answer is loosely, well, there's some hospitals that aren't. We're trying to rely on our targeting stuff to do that amount of money.

Is it calibrated perfectly? If we ever shut up, if I ever shut up, and we get to Round 2, you can say your comments, but that's for the purposes here, to hear your thoughts on the magnitudes.

DR. METAN: Thank you very much.

MS. KELLEY: Okay. That was the end of the Round 1 queue, unless anyone else wants to hop in.

Shall we go to Round 2, Mike?

DR. CHERNEW: Absolutely.

MS. KELLEY: All right. Lynn, you're first.

MS. BARR: Thank you very much.

I want to say that I am supporting the recommendation this year, which is a different attitude that I've had in the past, because we have to do something about cost. But I don't think cost, if it's squeezing the providers, is the way to reduce cost. I mean, America spends more on health care than any nation in human history, about 15 -- more than $15,000 per person per year, which is roughly three times the average for the OECD, and $5,000 a year per person, more than any other country.

What do we get for it? We have falling life expectancy. We have rising disease. We have a maternal mortality rate that should shame us and health disparities that divide us.

Ask anyone who's trying to get care in rural America. Ask any provider who's fighting to keep their doors open. Ask any family drowning in medical bills and

paying record prices for worse outcomes. And every year, the costs skyrocket again. And what do we do? We squeeze the providers. We hammer the safety-net hospitals. We punish the people that are delivering care as if that has ever solved the problem. And it hasn't and won't, and we all know it, because the real problem is we don't have a healthcare system. We have an illness care system, a system that's built to react and not prevent and a system that pours billions of dollars into sickness and scraps into wellness.

I strongly support where the administration is going to try to get to the downstream effects or the upstream effects of what's happening to our country, but we've got to do something different. This, you know, squeezing the hospitals, squeezing the doctors is not changing the trajectory of costs, and we've got to do better than this as a Commission.

Thank you.

MS. KELLEY: Stacie?

DR. DUSETZINA: Great. Thanks so much for this really great work.

Like others, I really appreciate the additional

analytic work on changing the definition a little bit for the relatively efficient hospitals. So I really appreciated seeing that.

I'm generally supportive of the recommendation, and I'm wildly supportive of the MSNI part of the recommendation. I think it's directionally where we need to go.

So very minor comments. One is on page 31 of the report, you mentioned evaluating the MSNI versus a DSH-based metric, and that it's a better predictor of hospital all-care margins, and that it says data not shown. And I would love if data were shown for that, because I think it's just one of those things to continually beat the drum that this is, you know, our payments could be flowing better in a way that we're more precisely targeted to help those lower-income beneficiaries.

The other kind of couple of points, to Gina's point and to the piece about the rural emergency hospitals and the need to get that fixed monthly payment out of the MA benchmark, I really appreciated that. And I appreciated the clarification that you do reference back to the prior work we did there.

I also had the same response when I reread that. I was like, really? We really shouldn't be doing that. Like, it shouldn't be in the benchmark. So I think good to have -- reinforce that and remind the reader.

And then on the site-neutral payment work, you know, I found this to be really intriguing, and I like the idea of some versions of expansion there and especially for off-campus sites, but I definitely found myself a little bit more conflicted about what to do about on-campus sites of care. So I think that this is one of those areas where additional work in the future will be helpful for thinking about, like, where are the right places where you can do this and get savings without going necessarily too far.

But I really appreciate this fantastic work, and again, I agree and support the recommendations.

MS. KELLEY: Greg?

MR. POULSEN: Thank you.

Let me just pile on and say thanks for great work. This was really a very, very good chapter, and I appreciate the thoughtfulness that went into it.

I loved the follow-up on the REH segment, and that was useful. I've been wondering some of the things

that this made explicit. So thank you very much for that.

On the site-neutral, really plus-one to Stacie. I found myself very much appreciative of the greater nuance that I think we saw than most of the discussions I hear on site-neutral. I think we could do harm by putting a blanket overall look on all site-neutral, which I think would be a mistake. I think that our communities depend upon hospitals for services that aren't available elsewhere in an appropriate time or in an appropriate way or for the appropriate patient types.

So the hospitals end up becoming, you know, the sump for a whole series of things and to be paid in the same way that others who are skimming the cream get paid I think would be a mistake. And so that is not a criticism. That's an appreciation for the nuance that I saw in the discussion and in the chapter. So thank you.

I would be remiss if I didn't say I hope we are going to have a bust of Jeff that we put in all of our meetings and say, you know, I'd love to have the thoughtfulness that he always showed. You always knew when Jeff spoke that it would be both interesting and completely accurate. So, thanks, Jeff, for that.

Now, my biggest area of concern, I'm seeing a set of hospitals -- and this is a large set of hospitals -- that are now consciously shaping their service offerings and their medical staffs to, in some cases, eliminate the least profitable or, if you will, greatest loss, Medicare services. And we're seeing that happen more inpatient than outpatient, more medical than surgical, but they are dropping those services or making those services unattractive to the community and particularly to the Medicare community. And those patients end up going somewhere.

And I'll come back to that in just a second, because the other one that I'm seeing is an even more aggressive stance where some subset of hospitals are structuring services and staff to reduce Medicare and, wherever they can, Medicaid, more broadly. They're not willing to take the step of just simply stepping away from the programs, the Medicare and Medicaid programs, but they are trying to get as few patients as they can from those.

And what that leaves is that those patients end up -- those beneficiaries end up somewhere else. And I know that many of you are probably seeing this, or folks in

your facilities are, because it's going to be the University of Chicagos, the Cornells, the Hopkins, the UCLAs, that are getting those patients when they're no longer going to those other facilities. They are always patients that don't pay their full way. And I'm concerned about that, and I think we ought to keep our eye on it.

And I'm not sure that that would change my attitude towards the recommendation, which is supportive, by the way, but I do think that we need to keep an eye on that because I think particularly our institutions -- and by the way, the Venn diagram on that between the MSNI index and the folks that I think are going to be hit and are being hit by this transfer of Medicare beneficiaries is -- it's not perfect. So simply using the extra money for MSNI will not necessarily add a benefit to the institutions that are being most impacted by this, but I think it's something that we ought to look at very conscientiously over the next couple of years, because I think we'll start to see the impacts. And it's going to have a negative impact on some of the institutions our communities depend upon the most.

MS. KELLEY: Robert?

DR. CHERRY: Yes, thank you.

First of all, Jeff, congratulations on this next chapter. Really, job well done. You're going to be greatly, greatly missed.

First and foremost, just to state right off the bat that I'm supportive of the Chair's recommendation, current law plus the MSNI with the $1 billion added to the pool.

But I do want to be clear. I do have some significant reservations about how we continue to fund hospitals. Hospitals for many years have been undercapitalized, and this makes it really difficult for many of them to replace aging equipment, invest in new technologies, and keep up with general depreciation. And the payment update doesn't solve for this problem.

The expected net margin for efficient hospitals, at least in this category, is expected to be about 1.5 percent under this recommendation. The problem is that acute care hospitals probably need a 3 percent net operating margin just to allow for capital investments, just to maintain or improve the quality of care for the patients that they serve.

So I do believe that we need to make incremental

improvements over time to allow for at least sufficient hospitals that hit roughly a 3 percent target to make sure that those hospitals are financially sustainable, healthy, and are able to deliver a high quality of care and maintain access.

I think more work will be needed on how to better define what an efficient hospital is and how do we incentivize hospital systems appropriately relative to these payments, especially as it relates to quality and safety, patient experience, as well as access.

And finally, one last point. I'm also concerned that these margins will not allow for hospitals to make the necessary investments in artificial intelligence technology, and this is technology that is specifically designed to deliver cost-effective improvements in delivery of patient care.

So, over the long term, if we keep squeezing the margins out of hospitals, it will be problematic in terms of the overall quality of care. And I think we need to start reversing the trend incrementally over time.

Otherwise, I want to thank everybody for their hard work in putting this chapter together. Thank you.

MS. KELLEY: Brian?

DR. MILLER: Sorry. I pressed the wrong button. I thought I pressed the unmute, and I pressed the camera off. They're both green -- or now they're green.

Thank you for this. A lot of the MSNI, both as a concept and the specific targeted recommendation today, I think we -- I went to med school in Chicago, and I think we want the Cook Counties of the world to have support. I think even as recently as like 30 or 40 years ago, some of the wards didn't even have air conditioning, if I recall. So I think safety-net hospitals are definitely worthy of support.

A couple of sort of things that were added to the chapter, which I thought were extremely helpful. One was the Table 4 with the hospital openings and closures. I know that that was an absolute pain in the tuchus for the staff to put together. So I appreciate that, because coming through that is not easy. If I recall, the annual closures, I think were eight to nine hospitals a year over the last couple of years. And someone can correct me if I'm wrong.

A few other thoughts. Quality measures.

Readmissions. I realize we use that as a quality measure, and I agree that there are avoidable readmissions. And my hospital industry colleagues will be excited to hear me say this, but I think of it more as an operational measure rather than a quality measure. So I wonder about us using that as a quality measure. I realize a lot of people do, but most people I know who run these enterprises look at it more as an ops measure for what's happening with patients, because yes, we can prevent some readmissions. But if a patient has heart failure and they get home and order Chinese takeout for the next five days and come back with a heart failure exacerbation, we can't adjust their diuretics. That's not something the hospital can control, and it's probably not reasonable for us to look at that as a quality measure. Think of it maybe as a ops measure with quality implications, perhaps, might be a sort of middle ground framing.

I do take both Greg and Lynn's points about not just crushing people, because I don't think that's reasonable to crush the delivery system at all. I do think, though, I worry about the productivity. So every year I look at the Bureau of Labor Statistics, labor

productivity for community hospitals, and I checked before this meeting, and the 1993 index is 100. The 1995 index when I was in elementary school was 107.5, and the index for the most recent data of 2022 is 101.5. So this is atypical from other industries.

Usually, when industries economically demonstrate a lack of labor productivity growth, it's a marker of a couple things. It could be consolidation. It could be over-regulation, et cetera. And so I recognize that there are things we can do for regulatory relief for hospitals, which could improve their cost structure.

I remember that the Comptroller General came and talked to us during the last meeting, and if you all recall, we had this great discussion. And he talked about using a variety of tools to address cost. I think payment level is one of them, but we could also add sort of regulatory relief as a flavor to allow us to reduce payment levels, which could potentially improve efficiency for hospitals. I want to throw that out there, sort of a creative idea that could fit with a payment recommendation for the hospital industry.

I also think that we shouldn't have combined

updates, because, well, we have IPPS and OPPS, and calculating those margins is hard work. Most of the hospital CEOs I know tell me that they are overpaid on OPPS, and they use the OPPS to subsidize underpayment on IPPS, which businesses cross-subsidize, and that's all right, that's how businesses work. But most businesses don't have, say, the potato chips subsidizing the price of walkers or car parts or whatever it is, which are all set by the federal government.

So I think we should calculate separate IPPS and OPPS margins, and that might allow us to get more accurate prices -- maybe not more precise, but more accurate -- and address some of the consolidation impacts that we see from site-neutral payment, also allow us to think holistically about OPPS payment without overtly penalizing the hospital industry and making sure that we're appropriately pricing for IPPS services, because my sense from most of the hospitals I know is that IPPS services are underpriced massively, leading to shortages, and that OPPS services are significantly overpriced, hence driving the policy and political push for site-neutral payment.

And we might be able to solve this problem or

create positive policy and political energy, nonpartisan political energy, to sort of push as a neutral body an actual workable solution for site-neutral payment that allows hospitals to have a sustainable financial model going forwards, and then also addresses some of the consolidation impacts, because we want hospitals to vertically integrate if it makes sense from a care delivery perspective. We don't want them to vertically integrate if they have to have the OPPS revenue in order to survive, because the IPPS revenue is inadequate because the service markets aren't priced appropriately.

And I know that the job for MedPAC is to make hard calls, and that collectively before joining the Commission made an excellent hard call on site-neutral for 50-plus APCs, and that was controversial and not easy.

And I think that this is a unified market basket update, and instead we should have payment chassis updates. And I'm most interested in accurate or more accurate payment chassis updates. So I'm not even sure if our recommendation for IPPS and OPPS is accurate or not. So I can't support the recommendation.

DR. CHERNEW: So let me jump in, Brian, and I

appreciate all of that. I just want to say, it wasn't in the material. We did, in response to some of the things you said, calculate the margins, and they are in fact similar. So I understand that you're hearing things from who you're hearing things from, but when we looked at the data and tried to assess that, we found similar inpatient and outpatient margins. So that's the data we're working off of.

The broader point about -- the broader point about having a holistic balancing between site-neutral, which is not just hospital, but it's ASCs, infusion centers, physician offices, I could not agree more, and we did have a big cycle on that. Maybe the next year we'll have another big cycle on that, but for the purposes of the update recommendation, if you just take the data we can calculate, because the other indicators like assets to capital are impossible to separate out, but if you just look at the margins, if that was the goal, we would end up very much where we are now.

DR. MILLER: Yeah. So one quick thought on that. So, again, if the margins -- if we think IPPS and OPPS margins are similar, that suggests we might need a new

model, because a lot of the marketplace very clearly states that IPPS margins are low or negative, and OPPS margins are positive and they're used as cross-subsidization.

DR. CHERNEW: And just like the efficiency stuff, I think it is a completely reasonable ask to try and understand what's behind the underlying model, but given where we are now, the staff is pretty expert in how they use the cost reports, and they find similar margins, those in the mailing material.

So I'm going to operate kind of under that assessment, and I think it is completely reasonable for folks to give some input about how we do that type of thing.

I want to go back through the queue, but I will say Greg's comments about service-level stuff actually resonates quite a lot with me. And I think we're going to need to incorporate how to think about different services coming and going, but at least for the purposes now, applying our criteria separately is a big lift for what seems to be, at least on our first pass, basically getting us to the same place where we are.

But you may feel otherwise based on whatever it

is, and that's fine. But I guess we should -- I just want to make sure everyone gets a talk. So we should keep going through the Round 2 queue, and we can continue this.

MS. KELLEY: All right. I have Cheryl next.

DR. DAMBERG: Thanks. First of all, I want to say that I support the Chair's recommendation and especially the Medicare Safety Net Index. I think that's a really important addition, and I hope policymakers listening out there will pay close attention to that.

Secondly, I also support working to expand the push for broader site neutral payments, and I just want to plus-one Stacie and Greg's comments about some of the nuances in that area and the need to carefully considering where those opportunities exist and how to avoid potential harms in that space.

And then lastly, just again for the record, I think that we are measuring quality too narrowly. I would hope in future rounds we could try to broaden that. And I'm not sure, perhaps we've discussed this in the past, why we aren't measuring things like complications, patient safety type indicators, patient reported outcomes. There have been some added to the hospital quality measure set,

so I would hope that staff could go back and visit those and see if we can expand the set of measures that are included. Thanks.

MS. KELLEY: Scott.

DR. SARRAN: Three brief comments. First, overall, great work. I'm really proud of the work our team does. Second is I support the recommendation and would like to, as the discussion earlier referenced, incorporate some reference of what percent increase this represents, as well as, if we can, comment on how the additional billion dollars will improve margins at hospitals with a high safety net index versus hospitals with a low. I think that serves us well in several ways to incorporate that.

Thirdly, a brief comment on site neutral, the three subsidiary bullet point comments on that. First is I think we should move our work forward. Since we are in the middle of a lot of work, I think it's important to continue to move that forward. And the second comment on site neutral is I am very sensitive to Greg's point around as we move that work forward, we really do need to understand and mitigate particularly any sudden or dramatic impacts on hospitals, because there certainly could be some.

That said, last comment there, is that there is no rational world where we have buyers, including beneficiaries as well as payers, making transparent purchasing decisions around their health care needs that does not rationalize the site neutral. We can and should find ways to make sure hospitals don't suffer as we move along that. But if we're going to get to a world where there is more transparency and rational purchasing decisions made, then moving forward on site neutral really is imperative.

MS. KELLEY: Betty.

DR. RAMBUR: Yes, thank you. Thank you for this great work. And Jeff, you will be missed.

I wanted to be on the record sharing my thoughts on this. I do support this recommendation, particularly MSNI. I initially was a little less generous, but I came around, and here is the reason for that. We talk about hospitals and facilities, but it's where people actually go to be cared for. There was a 2021 study by Wang and Anderson that found when hospitals had more resources it went to contribution to reserves, which I understand, and administrative expenses. It did not go to low-revenue

services like more mental health services, and less than 1 R.N. per 100 patient beds, which is not significant in any kind of way.

Just two week ago, a study by Polly Pittman and team at the Mullan Institute at George Washington found no relationship between hospital financial resources and nurse hours per patient day pre-COVID, and during COVID, when there was more money, they actually found an inverse relationship.

Now why do I think that's so important? Hospitals are places people go for 24/7 nursing care as well as care from others, and physicians and physical therapists. And so the argument that more was needed because of staffing, you know, just sticks in my craw, to be honest.

I hear Robert's concern about capital expenditures, but I'm also recalling a study, I think, Michael, this was yours, maybe, or one of yours, that capital expansion increased prices and market power, and it kind of leads to this some doing better and better, you know, the flourishing and the languishing. So that's why I very much support the MSNI, and I do strongly support this

recommendation.

But I hope we continue to think about how it all plays out at the working surface, and when people are putting more money in this segment are they getting more care. Thanks.

MS. KELLEY: Okay. I have a comment that Kenny wanted to be read. He says thanks for the holistic analysis. He appreciates the additional commentary on site neutral and some preliminary analysis on difficulties in teasing out two separate IPPS and OPPS payment updates. That said, given CMS direction and MedPAC's earlier strong advocacy on fostering site neutrality, he believes we need to do more on having two separate updates as this is helpful for the Medicare ecosystem. As such, he struggles with the Chair's recommendation as he is unable to assess its accuracy.

That is all I have for Round 2, unless I missed someone. I will turn it back to you, Mike.

DR. CHERNEW: Great. So thank you all for your comments. As always, they are very helpful. And I think we're going to take just like a 2-minute standup break, and then we're going to come back, I think, and we will be

doing, if I have this right, a general discussion of the post-acute care sector before we then take a longer break and come back and go through the updates for each of the individual sectors. I think that's the basic schedule. Paul, I'm looking for a thumbs up.

MR. MASI: That's right.

DR. CHERNEW: There's the thumbs from Paul. So again, thank you. I'm just going to pause for a minute and just come back onto this link in 5 minutes.

MS. KELLEY: Yes, please don't log off.

[Recess.]

DR. CHERNEW: Okay, wonderful. Hello everybody. We are broadcasting. We are back. We have a lot of different post-acute sectors, and there are a lot of connections between them. We often think about how that all plays out, and so we have sort of a separate piece of work here, just talking more broadly about the trends and issues in the post-acute care sector. And I think Carol is going to take us through all of that. So Carl, take it away.

DR. CARTER: Great. So beneficiaries who require recuperative or rehabilitative care are treated in skilled

nursing facilities, or SNFs, home health agencies, and inpatient rehabilitation facilities, or IRFs. Before diving into the payment adequacy discussions, we wanted to take a step back and review some key issues that PAC providers and the users of these services face.

We undertook this review at the request of Commissioners, who wanted us to look across the PAC settings, not just within each one. The overview is intended to provide some context for the PAC update chapters, and I want to thank the PAC team for their help with this chapter.

Here's a quick overview of what I'll cover. First, I'll provide some background on the different settings. Then, I'll discuss the reasons for overlap in some of types of patients treated in the different settings and note the difficulties in comparing their outcomes. Next, I'll outline how fee-for-service Medicare incentives and benefits may encourage inefficient care, and describe CMS's programs that could promote more effective purchasing. Last, I'll review how alternative payment models and MA counter fee-for-service volume incentives.

Here's a quick overview of the sectors. SNF is

the largest, with $30 billion in spending and 14,500 providers. Next are home health agencies, with over 12,000 providers and they account for over $15 billion in spending. Given the home-based nature of the care, the average payment is considerably lower than the facility-based care.

There are far fewer IRFs, but because the payment per stay is high, they account for $11 billion in spending. Their average length of stay is less than half of that of SNF stays.

Some chronically, critically ill beneficiaries receive care in long-term care hospitals. Because there are few providers and users of this service, we have not included LTCHs in this overview. The Commission continues to monitor this setting and each year includes information about it in the Data Book.

This chart shows the use of SNFs, home health care, and IRFs after discharge from an acute care hospital stay.

Prior to the public health emergency in January 2020, SNFs were the most common PAC destination after discharge from an acute care hospital, accounting for 18

percent of discharges. However, SNF use dropped during the public health emergency, concurrent with the decline in hospital admissions, and while SNF volume has slowly rebounded, it has not returned to pre-pandemic levels.

During the public health emergency, home health use increased and is now the most common PAC. IRF use has also steadily increased.

SNFs, home health agencies, and IRFs all provide therapy, skilled nursing, and personal care, but the level of care varies in terms of the amount of rehabilitation provided and the nursing and physician coverage. IRFs offer the highest level of care, while home health care is for beneficiaries who do not require daily or facility-based care.

Eligibility for Medicare coverage also differs across the settings. SNF users must have had a prior three-day hospital stay and require daily skilled care. Home health users must need part-time or intermittent care, but a prior hospital stay is not required. IRF users must be able to tolerate, participate in, and benefit from intensive therapy. A prior hospital stay is not required, though most IRF users have had one.

Benefits also differ. There are day limits on SNF and IRF use, but no time limits on home health care, as long as the beneficiary meets eligibility requirements.

There are also differences in cost sharing. There is no cost sharing for home health care users. In contrast, there is some cost sharing for SNF users, with the copayments that begin on Day 21 of the stay, and IRF users, who face the inpatient hospital requirements, the deductible, if they have not had a prior hospital stay, and daily copayments for very long stays.

The Commission and others have documented the overlap in some of the types of patients treated in different settings. There are many reasons for the overlap. First there is variation in provider supply across markets. Many markets do not have IRFs. Second, there is a lack of evidence-based guidelines to guide placements, except for treatment of stroke. Third, there can be differences in clinical judgment. Two clinicians evaluating the same patient could come to different decisions about the best course of care.

There is also variation in providers' referring and admitting practices. For example, IRFs vary in the

conditions they are willing to admit. In addition, some hospital discharge planners tend to discharge certain types of patient to one setting over another.

Finally, there are differences in patients' preferences for a specific provider or setting, and their willingness to receive care far from home. Word-of-mouth and prior experience are also important factors in selecting a PAC provider.

To evaluate the care beneficiaries receive and help consumers make informed decisions about where to get care, it is important to be able to meaningfully compare quality across providers and settings. However, comparisons are hampered by two key data limitations.

First, some measures use provider-reported information from patient assessments. We and others have raised questions about the accuracy of the information that is used in the case-mix systems, such as functional status. Some providers may record patients' functional ability as worse than it is so that the patients are assigned to higher-payment case-mix groups. Similarly, star ratings may encourage providers to report information in ways to boost their quality scores. CMS has taken measures to

improve the quality of the information with a validation process for SNFs, but has yet to implement similar processes for IRFs and home health agencies.

The second data limitation is that patient experience measures for SNF and IRF users are not collected by CMS, even though this is a key metric of quality. The Commission has recommended that CMS develop and report measures for SNFs, and noted that patient experience information is needed for all PAC users.

Comparing outcomes across settings is complicated. To draw conclusions about the "best" setting for treating a certain condition, analyses must control for differences in patient populations. Yet, even with robust risk adjustment, using information from claims and patient assessments is unlikely to fully capture patient selection. As a result, differences in outcomes could reflect unmeasured differences in the patients that were treated.

Further complicating conclusions about outcome results is the fact that studies differ in the conditions that they examined and the measures that they were using. Except for stroke, studies of other conditions have not drawn consistent conclusions for similar outcomes measures

or across measures. For example, compared to SNFs, IRFs appeared to have better outcomes for some measures but not others.

Another issue is that high Medicare fee-for-service payment rates, fee-for-service incentives, and Medicare PAC benefit designs may each contribute to inefficient care being provided. Medicare's fee-for-service payments are high relative to the cost of care. By its nature, fee-for-service encourages volume, and those incentives may be stronger when margins are high. Given the day-based payment system, SNFs may extend stays. Home health agencies may add an additional 30-day period. IRFs may admit a patient who, while qualifying for the admission, could have been treated in a lower-cost SNF.

Medicare benefit designs may also encourage volume and intensity. For example, there are no time limits on the use of home health care, while the SNF benefit has no copayments until Day 21. The 3-day hospital stay requirement can prevent some beneficiaries from using SNFs. Instead, they may use an IRF, if they meet the admission criteria and require facility-based care.

To counter the incentives of unnecessary service

volume, CMS has made important changes to the home health and SNF payment systems. In the original PPS designs, the case-mix systems included volume as a factor, which created incentives for providers to furnish therapy so that cases would be assigned to higher payment case mix groups. We recommended that CMS revise both PPSs to base payment rates on patient characteristics, not therapy volume.

CMS redesigned both case-mix classification systems that removed therapy as a factor. The SNF PPS also expanded the clinical conditions considered in the case-mix system to more fully capture a patient's medical complexity.

CMS has also implemented two types of programs aimed at improving fee-for-service purchasing of post-acute care. One type focuses on improper payments, and the other ties payments to quality.

Improper payments are payments that do not meet program requirements. An improper payment is not itself considered fraud. For PAC providers, the most common reasons are insufficient documentation and the lack of medical necessity. CMS has demonstrations targeting improper payments to home health agencies and IRFs in

states with high rates. A program that targeted improper payments to SNFs was in place for 2 years but ended in August 2025, after CMS reported that improper payment rates improved.

Another type of program, value-based purchasing programs, or VBP, ties fee-for-service payments to quality measures. In those, payment rates are lowered by a set percentage and then providers can "earn back" some or all of the withheld amount based on their performance on quality measures. The SNF VBP has been in place since 2018, and has not been successful at lowering readmission rates, the one measure that is included in the program. We and others concluded that the incentive payments were too small to change behavior.

For home health agencies, after a successful nine-state model, a national VBP began in 2025, and is too new to draw any conclusions. C MS estimated the impacts for 2026, and it looks like the size of the adjustments may not be large enough to prompt agencies to improve care.

There is no VBP for IRFs.

The overlap in some of the types of patients treated across PAC settings prompted considerable interest

in the development of a unified payment system for all PAC providers. MedPAC's work on narrowing price differences across PAC providers spanned nine years.

The Congress mandated studies of a unified PPS across settings by the Commission and Secretary of HHS. We concluded that accurate payments could be set but associated issues, such as a unifying eligibility, conditions of participation, cost sharing, and a VBP, would be complicated to implement.

The Secretary outlined a prototype unified PPS design and also discussed implementation of related issues.

MedPAC examined a targeted policy that would lower IRF prices for cases that could have been treated in a SNF. However, it was not obvious how to identify case types for the price reductions without harming access to IRF care for beneficiaries who needed it. Further, the Commission decided there was not a solid evidence basis for selective price reductions.

Another approach to countering fee-for-service volumes are alternative payment models or APMs, such as accountable care organizations and bundled payment initiatives. APMs are entities that are at risk for the

total cost of care.

To lower their costs, APMs have an incentive to avoid unnecessary PAC use by either avoiding it altogether, using less of it, or shifting to lower-cost PAC providers.

Evaluations have found that APMs lowered SNF and IRF use while generally maintaining or improving quality.

Building on the successes of the bundled payment initiatives, especially for surgical bundles, in January 2026 CMS will begin a mandatory five-year demonstration for hospitals in select markets for five procedures.

MA plans are another way to counter fee-for-service volume incentive. Because plans are paid a monthly per-member amount, they also have an incentive to control overall spending by lowering their PAC use, either by using lower-cost user or fewer PAC services.

MA plans often use utilization management tools such as prior authorization and provider networks. For providers, these tools can add burdensome prior authorization and documentation requirements. Networks may shift volume towards some providers and away from others.

For beneficiaries, prior authorization can determine whether care is approved, where beneficiaries can

get their care, and how much care they can receive. The process of getting a determination can postpone treatments that can, in turn, result in worsening of beneficiaries' clinical conditions and weakening of their functional abilities.

The use of networks can restrict beneficiary choice of providers, but depending on the quality of the providers, this can direct beneficiaries to providers with better or worse outcomes. Where care is approved can also affect whether a beneficiary receives care that is close to home.

Over the coming year, we plan to focus some of our work on fee-for-service, by evaluating the relatively new home health and SNF case-mix systems and by monitoring the TEAM alternative payment model.

On the managed care side, we plan to examine differences in fee-for-service and MA use of PAC services, particularly SNF and IRF, including use that does and does not follow a hospitalization. Another strand of work will look at the effects of MA on the financial performances of PAC providers.

We'd like to hear your reactions to this planned

work and any other ideas you have. I'd be happy to answer any questions and I'll turn things back to Mike.

DR. CHERNEW: Carol, thanks a ton. There is so much here, and I think as your presentation shows, the connections across both acute care sectors are very complicated, and the issues are challenging. We're about to go to a bunch of update recommendations where inherently we treat each thing as somewhat siloed, and this is going to attempt to acknowledge that although the update fee schedules are a bit siloed, the sector is not.

So I think we should jump in with Round 1 questions, and I think that is going to Lynn, if I'm right. Dana, you're in charge.

MS. KELLEY: Yes, that's correct.

MS. BARR: Thank you. Thank you for this work and for opening up this avenue of work. It's very interesting to think how these things interact.

So I had two questions. One of them was, in your work have you looked at the utilization of the three-day waivers in SNFs and sort of have any sort of opinion about those?

DR. CARTER: We have not looked at that. I know

other people have, but we have not. I mean, the three-day waiver, you know, there is a lot of disagreement about it. It is an important speed bump for trying to maintain the SNF benefit as opposed a hospital benefit, which is, by design, what the Medicare benefit is supposed to be. So that's its purpose.

We, boy, many years ago, recommended that the three-day waiver include counting time that was spent in observation towards the three-day requirement, but I think that's really the only work that have done on the three-day stay requirement.

MS. BARR: Awesome. Yeah, there is a lot published, but I think that it would be very helpful to the providers that are engaged in these advanced payment models to better understand how it can be used well or not. So I'd love any, you know, an independent analysis if that was possible in your humongous workload.

And the other question I had was, I hear frequently in certain markets, Hawaii being one of them, that hospitals are keeping patients for days because they can't place them in a skilled nursing facility. So there is this bit of, you know, and that related to Medicare

Advantage, as well, and it's like the prior auth, and it's going on.

So I'm wondering, is there anything you can comment on related to that?

DR. CARTER: We have not, I have not looked at the backup in hospitals, but we hear it, and there is at least anecdotal evidence in select markets that this is happening. But it is not a line of inquiry that we have undertaken.

MS. BARR: Thank you. I think that could be very interesting, because it's sort of like cost shifting, right. If you're in MA, you know what? I'm paying you that DRG so I don't care if the patient is there a little longer, right? So it creates incentives, and I'm curious if we have any data on that. Thank you very much.

DR. CARTER: Yeah.

MS. KELLEY: I think that's all we have for Round 1. We can move right to Round 2 if you're ready, Mike.

DR. CHERNEW: It wasn't clear from Tom's message if he was trying to get into Round 1 or the Round 2 queue. Tom?

MS. KELLEY: I took him for Round 2, but I can

check. Do you have a question, Tom, or a comment?

DR. DILLER: No, it's more of a comment.

MS. KELLEY: All right. I'll put you into Round 2.

DR. CHERNEW: So go to Round 2.

MS. KELLEY: I have Tamara first.

DR. KONETZKA: Okay. Great. First of all, Carol and colleagues, thank you so much for being so responsive and including this more holistic chapter looking at post-acute care. I think it's super important to do for all the reasons that you mentioned in the chapter and laid out so carefully. And it's not just that there's overlap in the patients going to these different sites, but so many of the broader policies and trends we're looking at, like MA growth and alternative payment models, sort of affect who goes where. So I think it's a great and necessary framing for all of our post-acute care work.

Okay. A bunch of comments, but each of them is brief. First of all, just about the chapter, and this relates to something Lynn was just asking about, and that is you discussed delays in placement into post-acute care. And I think in the chapter it just came across as mostly

pretty negative, right, that patients were staying in the hospital longer because they're waiting for a post-acute care bed. And that's definitely true for the hospitals in the way that Lynn was just mentioning. Hospitals don't like that.

But I think there's more nuance to it for the patients, in that it's not necessarily bad for the patients to be in the hospital longer, right? We spent decades worrying about length of stay in hospitals being too short, right? And often if somebody, for example, has a stroke, and they're waiting in the hospital for their prior auth to come through for a post-acute care bed, they will start getting therapy right away in the hospital. So it's not even that they're getting their therapy delayed. They may actually be better off, and our team has some preliminary work looking at that. Clearly, bad for the hospital but not necessarily bad for the patient.

I think home health is fundamentally different, because people don't stay in the hospital waiting for home health. So when we're thinking about access to home health and delays in that care, they are sitting at home waiting for care. So that's a completely different beast to me

from the patient perspective.

Okay. That was really the only thing in the chapter, and the rest of my comments are all kind of in the spirit of supporting and thinking a little bit more about the future directions and where to take this, as time allows.

The first thing comes from what you wrote in the chapter about, and as MedPAC staff has documented so well over the past few years, about growth in IRFs. The statistic that really stood out to me in the chapter is that over a 10-year period, there has been a 56 percent increase in per capital spending on IRF, which is huge. Even over 10 years that is just huge, as it dwarfs all the other post-acute care sites. So it's still small but growing at this rate that seems kind of crazy. And it seems kind of crazy and alarming because there is all the uncertainty about the value of that care.

So I would just encourage us to keep looking at the growth in IRF, keep that line of work going to really try to separate out how much of this is increasing access. I mean, we know a lot of that growth is in markets where IRFs already exist, but how much of that growth in IRFs is

really sort of filling an unmet need and getting people access to care, and how much of it is just sort of chasing high profit margins and contributing to the proliferation of low-value IRF care. So that's something in this post-acute world that I'm really interested in following.

You had a great discussion in the chapter about site neutral and all of the work over the years that MedPAC has done on site neutral and PAC. And I agree with you completely that the research just isn't there to really make solid moves towards site neutral payment. And as you said, the gap in the research is that there is so much sort of unmeasured selection into who goes to these different sites that we just have a lot of uncertainty about the value for a particular patient.

And so I agree we can't get there yet, and I think my point here is it's still a really, really attractive idea to move towards site neutral payments in this sector. And so I guess I would explain it as we don't have this research to do it now. We don't have the data to do it now or to take solid steps, even just like for certain conditions between IRFs and SNFs, but I would love to frame it as what can we do over the next few years as

the research emerges to still try to sort of keep that long-term goal in mind and get us to a place where maybe we could propose some site neutral steps.

Similarly, MedPAC has done such great work over the years in assessing the reliability or unreliability in that functional status data, and that's just so disappointing, because that's what everybody is interested in post-acute care. It is really arguably the most important outcome. And in the chapter you mentioned a few sort of ways to improve that data. One is just audit, selected audits, which I'm not that excited about in terms of a solution. Other is selected functional data at hospital discharge. And then a third is collecting patient-reported outcomes and patient-reported data.

And I would love to see us sort of engage in work over the next few years that kind of explore the policy options for doing that. We know that people who are getting discharged to post-acute care, I think often get a functional assessment in the hospital to sort of inform where they should go. So how much more burden, what would need to happen to actually document that data, because getting it from the hospital is really appealing, but I

don't know what the costs of doing that are.

And then the patient-reported, we know that we also love to have patient-reported data, patient experience data in IRFs and SNFs. And, you know, this patient-reported functional status would have to be at admission. The patient experience we'd want later. So I don't know if that's a pathway that could be combined or not, but maybe they can sort of be part of the same push to get patient-reported data.

So I'd love to just see us explore those options, even if we wouldn't actually have a recommendation about them for a long time. But I'd love to move in that direction.

And then the final thing is, I'd just love to support your planned work already on looking at the effects of MA both on beneficiaries and providers. Thank you very much.

MS. KELLEY: Brian.

DR. MILLER: Okay. I have three thoughts. I appreciated, first of all, the prior authorization comment. I know that prior authorization is a pain for everybody involved, and sometimes it is abused, and in other

circumstances it can help people get to the right spot. But I think more work on that would be helpful to make sure we know which direction it is going.

I did want to address some concerns I had sort of about the underlying principles of this work. First, there was an assertion that there are not guidelines. There are actually guidelines for who goes to a sub-acute rehab or full nursing facility versus who qualifies for home health versus who qualifies for inpatient rehabilitation facility or IRF. The physical therapist, occupational therapist, speech language pathologists make assessments using standardized, validated instruments and make a recommendation. And yes, there is some subjectivity in clinical judgment, but those habilitative specialties are highly trained, and frankly better than physicians at assessing people's ability and needs. And there are a lot of instruments. I review their clinical notes in the hospital, and I have to look up some of those instruments because I'm not familiar with them from time to time.

So I strongly disagree with the assertion that there are not guidelines. There are definitely validated guidelines, and there is a component of clinical judgment.

The other comment is that there is a lot of variation, and I would say that that variation is okay because there is clinical variation in how people interpret what a patient can do and what they are capable of. Obviously, there are experienced guidelines, evidence, et cetera, but there is always going to be some degree of clinical judgment. So I could look at a patient and say, you know, borderline home health if I were a physical therapist versus subacute rehab. And it's not wrong to go one way or the other for some of those borderline patients. And then there are patients who are very clearly home health versus sub-acute rehab.

So I think, one, we need to be aware that there are guidelines and research them and talk to the practitioners in those specialties -- PT/OT, SLP, physiatry -- and learn about those guidelines and use them. We need to talk to the operators and managers of skilled nursing facilities, of critical access hospitals which have swing beds, inpatient rehabilitation facilities. Because there are guidelines, and there is variation.

And we need to also be comfortable, and I think this is really important that clinical variation is

sometimes good and sometimes bad. And I felt like in that presentation we were saying that all clinical variation is bad and must be put into a specific bucket. And I don't think any patient I have met clearly fits into one specific bucket. Like we put them in a bucket, and maybe 80 percent of the patients fit there, but there might be 20 percent that don't. And they change over time, and they migrate.

I think the other thing that was missing from this conversation, which also is very concerning to me, is that home health and skilled nursing facilities and inpatient rehabilitation facilities do have some of these same types of worker categories, but that those workers have different skills. So a physical therapist working in home health has a different skill set than a physical therapist working in, say, an IRF, because they're dealing with a different patient population and they become specialized. They might not, like physicians, have certification in internal medicine and then cardiology and then electrophysiology, and be an AFIB ablation electrophysiologist at that, but there is specialization in those habilitative specialties, and we need to recognize that, and we have not recognized that.

I think the other thing is you are correct that you can have the same patient wind up in different settings, with the same, quote/unquote, "diagnoses," but it's about the potential of the patient to improve or not improve, depending on whether we're thinking positive or negative. So to qualify for an IRF you have to have two modalities, several hours a day, five days a week. They're different if you're going to subacute rehab, and they're different for home health. So you can have someone who has the same data set, has the exact same diagnoses, but it's about their potential for rehab and their ability to perform differently. And I realize there's not a lot of research in that space, if you can find it on PubMed, but that's a clinical and operational reality of those three businesses. It doesn't mean that there isn't some payment issue to fix there, because there probably is.

But our suppositions that there aren't guidelines, that's incorrect, that all clinical variation is bad is also not correct, and the assumption that these three care settings are the same and delivering the exact same service is also not correct.

And I think the thing that we also haven't

thought about in, again, the Comptroller General came and talked with us, and I read this in a lot of GAO reports. I testified recently on a benefits coordination subject and read GAO reports back to 1979, which I reminded myself was before I was born. One of the things that the GAO reports that I think we should do in this line of work is that there are multiple tools that can be used. There is a payment tool, there is a regulatory tool, there is a rulemaking tool.

And so I think in the post-acute space, what we haven't addressed is that because the regulations are so specific, whether it's mattress quality, smoke detector placement, or whatever, instead of having a culture of clinical service many of these businesses end up with a culture of compliance. And that culture of compliance, one, doesn't deliver a good care experience for the beneficiary, it doesn't deliver necessarily the clinical outcome that we want, and having a culture of compliance, which unfortunately affects the hospital industry too, is extremely expensive.

And so if we want to have a better payment system and better outcome, I think addressing the regulatory

structure, not just the payment structure, is important. And then in doing so, our statutory charge, yes, is payment and policy. And so this is an important policy lever that we could use to massively improve the post-acute care experience and lower costs.

MS. KELLEY: Gina.

MS. UPCHURCH: Yeah. Carol, thank you so much for pulling all this together beautifully in a chapter that gives us the range of the three services and what it means to the beneficiary and the providers. So thank you for that. I really enjoyed this chapter.

We hear a lot in counseling about the three-day rule for SNF, and I have a real problem with observation status not being counted. So I do hope we will get to that. I mean, it sounds like we've made a recommendation which I'm glad of, but, you know, the patient, you know, they're there to be observed to see if they're going to need to stay, going to need some more intensive care, and found out, yes, indeed you do, but it doesn't go back to the time they were admitted -- they came to the hospital for the first time, not admitted yet but under observation status.

The other thing with the three-day rule, as I understand it, it's really a three-midnight rule and the day that -- it's either the day you arrive or the day you leave doesn't count as a day? So, you know, it's a very strict guidance about three midnights and what days count, and I have a real problem with observation status being so iffy and not counting towards that if people do indeed need -- especially, I mean, I work with a lot of older adults who live alone and that kind of thing, and after a serious hospitalization and even it was under observation status, many of them need some supports to get their function back. So I think it's really important that we pay attention to that.

Anecdotally, we hear of a lot of people that get home health, but it takes a while for the home health to get going. So I don't know -- I don't know what we hear about that, but say they just are discharged from the hospital or even they're admitted to home health from the community. But I don't know if there's a home health workers or whatever, but it can take, you know, days for that to begin, and we know for every day you lay in the bed and don't do much, you know, it's harder for that person to

get their function back.

So I don't know if there's any data to support that or just what we hear anecdotally. Do you know anything about that?

DR. CARTER: I think Evan actually reports on the placement and awaiting of time to receiving home health care, and I can refer to what's in that chapter, because I think it's in his chapter. I'll look at that.

MS. UPCHURCH: Yeah, okay. And I think you're right. I'll look back through that too.

And I just want to reiterate two things that Tamara pointed out, and I just want to be very supportive of patient experience and gathering that data for people in IRFs and SNFs. I think it's really important -- and family members of people in IRFs and SNFs as well as the impact of Medicare Advantage on the beneficiary, you know, and the providers. So we hope we will continue that work, and thanks again.

MS. KELLEY: Stacie?

DR. DUSETZINA: Great. Carol, as others have said, this is really fantastic work, and I really appreciate seeing all of these services in one place. It's

not an area I spend all that much time working in but have had some -- and of one experience of helping a beneficiary try to get into some of these services. So it's nearer and dearer to my heart than it has previously been.

I have a couple of very minor suggestions for things in the chapter, but then also a little bit of data kind of piling on to some suggestions people have made.

So one is in Table 2 in the chapter, I found myself really wanting to know how many beneficiaries were using each of those services. You've got all kinds of other numbers, but I'd love to know the number of people in that.

And I also found myself wondering about the median length of stay in addition to the mean, just based on the nice description you had about the different ways that people might be -- or different conditions people might be coming in with.

There was also a comment on page 26 about MA plans having a financial incentive to prolong hospital stays and I think to avoid PAC use, but I found myself getting a little stuck on that sentence and trying to think through like, oh, okay why would they want to prolong the

hospital stay? And I think just kind of making it a little bit clearer, that it really is maybe that if you stay in the hospital a little bit longer, you might not need to go to these other sites of care or have these other services, and I think just making that a tiny bit clearer would help.

One of the other things I struggled a little bit with is that there were some aggregate spending numbers presented in the chapter, and then you point out that because the number of fee-for-service beneficiaries is decreasing, that that's why you see a decrease there. And I was kind of trying to reconcile in my mind, you know, like but we're paying for MA beneficiaries kind of similarly, right? Like, those funds are coming from taxpayers. It's just that we're not seeing those in the fee-for-service data, and I kind of wondered if we should move away from aggregate fee-for-service over time, just because that denominator of people is changing, so that that's just one kind of broader suggestion.

A couple of things, though. Like Tamara and Gina, I felt very, like, attracted to the idea of more data because, of course, we always want more data, but the functional assessment data from, like, if the hospitals are

doing that right before people transition, it made me wonder if there was enough -- like, that would be the kind of best thing if it were going to, like, order my wish list of data, because it made me think you could get at this issue of postpone therapy and functional outcomes better, so you kind of knew exactly where people were right before they were going to transition into one of these sites of care. It just struck me that that might be the highest yield bit of information to be able to compare a little bit better across the types of services people were getting, so we knew exactly kind of where people right before transition.

I also think patient outcome data like patient-reported data would be fabulous to have across all of these sites of services, like similar measures. That'd be great. I don't know how difficult -- I'm sure that's very difficult to do. So maybe that's too much wish list.

And then one last thing on the kind of data needs or maybe something that we could think about analytically. So there is that you make a really important point about where people go, and sometimes people want to go to a SNF because it's closer to home than maybe an IRF. So, like,

you could have gotten in either one, but you want to go closer to home because it's just more convenient for patients and families.

And I wondered about whether there were any concerns around, like, MA networks and whether or not people ended up in SNFs that were farther from their homes because of networks. And I think that would just be worth, like, taking a look at to think about that's, you know, high priority for patients and family, and that seems like something we could measure in data.

But fantastic work, and thank you again for all of your efforts here. Really truly exceptional

MS. KELLEY: Scott?

DR. SARRAN: Yeah. So two areas of comment. First starting with, again, really excellent, excellent work. I'm very pleased with how we've moved this along.

So the first is in the area of incentives and measurements, and some of this reinforces Tamara's and others earlier comments. First, at a high level, this is such an important sector because our abilities to do things to impact beneficiaries positively in the acute space has increased so dramatically but out of proportion to our

abilities to safely and adequately rehab beneficiaries after they've experienced either an acute illness or injury or procedure, et cetera. So we've got to make those two spaces commensurate and better integrated.

All right. So, with that as preface, I think one of the things that's really important is in a sector that has demonstrated repeatedly and strongly how responsive all of the operators in this sector are to financial incentives -- and we don't need to belabor that, but you've continued to document that well -- we've got to strengthen the VBP program and make it very focused on a combination of two families of measures. One is the improvement in function as largely as patient-reported, I think, as well as the experience, as experienced by the patient in the family, and then safety issues. So I really think we've kind of backed into a weaker, less, inadequately focused set of measures, and they need to be stronger and more focused.

And we've got to -- recognizing it's going to take some time, we've got to work through the barriers around some of the measurements being either poorly measured because the staff isn't doing them reproducibly, accurately versus potentially being gamed. And I'll choose

to believe it's more in the former category than the latter, but that is not an insolvable problem over time, the issue of getting adequate measurement, and we need to do that. It may take several years, but that's critically important. So that's the first area of comment.

The second area of comment is around MA, and by the way, I really agree with Brian's point around there is an equal amount of art as well as science in terms of choosing for a particular beneficiary where he or she is best served in the context of what's in the community, the patient and family's wishes, the resources available in the home setting, et cetera, et cetera. So guidelines are important, but there is a certain amount of art in that.

What shouldn't happen is an MA plan deciding where the person goes based on an algorithm and somebody's sitting 500 miles away. That just is wrong, and so I do think we need to continue to shine a light on the impact of MA plans' prior authorization decisions on beneficiaries in this space.

I think a truism is that MA plans have to act appropriately, respectfully of large hospital systems and important hospitals and how they interact with those

hospitals because of just basics of market cloud, but MA plans, generally speaking, have a lot more power than a small nursing home, and so they tend to drive behaviors and decisions in ways that they can't do when it's a hospital at the other end of the phone or the email.

So I think continued -- again, continued scrutiny around the impact of MA plans' behaviors, particularly around prior auths, is very important.

Thanks.

MS. KELLEY: Betty?

DR. RAMBUR: Carol, thank you so much. I'm very enthusiastic about this work, and I really appreciate all the comments from the Commissioners.

I just wanted to amplify a couple of points that are in the report that I think should disturb all of us, 43 percent of nursing homes fail to report falls, and falls are a direct measure. It's a nurse-sensitive indicator, sensitive to nurse staffing.

And then they underreport the use of anti-psych medicines, and, of course, if you keep people sleepy, they're less likely -- they need less people caring for them.

And the increasing staffing during inspections. So when you think about the fact that 15 percent of Americans will spend up to two years in a nursing home and 30 percent at some point in their life, this is really, really serious. So, in addition to the other great work that's here, to the extent that we can help Congress and the public understand that there's a fundamental tension here in the cases, the market case for the facility is to have volume as high as possible and the staffing as low as possible, right? That's the market case. But the case for the public or the person is who's going to be there for me? Who's going to take care of me? And I'm almost more concerned about turnover in some of these settings than staffing, because if you're confused and whatever and there's different people, this becomes your home and your family. And I still have nightmares about experiences I've had as a nurse in understaffed facilities.

So to the extent that we can help that be understood, the regulatory response was to require staffing ratios, and I understand that we're not going to stand on that. But that's a regulatory response to this inherent market problem, in my view, between the business case,

especially for-profit and the social case.

So many great suggestions from others. This lines up, I think, exactly with what Scott had said about value-based payments. The penalties and the rewards simply are not high enough to create the kind of situation any of us would be willing to be -- many of us would be willing to live there or work there.

Thanks. I'm very excited to see where we take this.

MS. KELLEY: Cheryl?

DR. DAMBERG: Carol, thank you for such a great chapter. This is such an important area that affects so many Medicare beneficiaries, and I think it's great that the Commission is digging in deeper into this space to try to unpack what's going on and try to understand what we could do to not only improve payment policy but improve the overall quality of care and access for patients.

I found myself getting sort of zeroing in on the PAC placement, and I think to that end, I think it will be highly valuable to do comparisons between MA and fee-for-service in that space.

And these delays, as Tamara pointed out, could

potentially be beneficial or they could be a negative. So it would be really helpful to try to understand these delays. What are the drivers? I know staffing came up in the chapter, but I think the issue of prior authorizations that Scott raised is also at the forefront.

And kind of who's winning and losing in this game? Because I think that hospitals right now are bearing the cost for these delays, and many of them, particularly in the MA space, are under these risk-based contracts. And so, again, I think just further unpacking this would be extremely helpful.

I, too, support continued work on trying to understand how to improve the use of value-based incentives in this space. I agree that the size of the incentives currently are too small to have much effect.

I certainly look forward to, you know, seeing what the impact of, say, the TEAM model is in terms of its effects on post-acute care and really think that episode-based payment models probably are the strongest candidate we have right now for, you know, controlling the use of post-acute care, but also creating that sort of team-based accountability for an entire episode, which I think

currently is missing.

I, too, support making sure that in the future, we have access to patient experience data. I think the patient's voice is significantly missing in this space and is so vitally important to really understanding the quality of care and what's happening in these nursing homes.

And lastly, again, per your bullet point about comparing MA and fee-for-service, I think that this is really just so important across the board along all of these different dimensions that we've been talking about.

Thank you.

MS. KELLEY: Tom?

DR. DILLER: Yeah. Hi. I am almost always going to come with comments from a population health, value-based care perspective with this, and so some of my comments are going to be a little bit contrarian to what I've heard, although I'm aligned with a lot of what's going on.

Value-based care should align the population-based payments with high-quality networks, and so the question really is how and when do we optimally use post-acute care that's aligned with the financial risk of the risk-holding entity as well as the patient needs. So I'm

involved in this on a day-to-day basis, and there's a significant disconnect between the care providers, again, due to the siloed fee-for-service health system that we've got. So there isn't a good connection between the hospitals who have the sick patients and are trying to discharge them into post-acute care with those entities.

The hospitals oftentimes look at it from the perspective of we need to decrease our length of stay. We need to get the patient out of the hospital. A way to offload that is to get them into whatever post-acute care exists out there, without really regard oftentimes for what's the optimal approach for the patient.

Once they get into the post-acute care, especially in some of the more inpatient settings, those entities tend to hang on to patients for as long as they possibly can, and so that creates waste within the system that needs to be managed.

I think I'm going to take a little bit of issue with some of the wording around the prior authorization. So I certainly understand that some of them are burdensome and some of them are overdone, and that needs to be scrutinized. But the reality is that in 2012, the

Institute of Medicine published a report called "Best Care at Lower Cost" that demonstrated that 15 percent of all care that's provided to patients provides no benefit to the patient whatsoever. It's just simply waste, and so that is really the focus of prior authorizations.

I agree completely that it's overdone in many cases and that it can become burdensome and abusive, but the reality is if you compare unmanaged fee-for-service care with managed care, there's a need for those prior authorizations.

I think TEAM, which is mentioned here on the screen, is a fairly good start in an alternative payment model, but it also does not necessarily align the hospitals and the providers with post-acute care. But there certainly creates incentives to get patients out of the hospital and into those alternative models.

So I'll stop there, just encouraging us to think through different models other than the fee-for-service approach, and I think CMS is trying to develop a number of those advanced models.

MS. KELLEY: Lynn?

MS. BARR: Thank you.

Just wanted to, you know, in terms of future work, there are a couple of concerns. One of them is none of our work really covers swing beds and which is, you know, very important to roughly 40-, 50 million Americans, and so it'd be nice to -- we don't -- we can't cover it in payment, and, you know, there's just really no place for it. So it'd be nice if we could maybe include that.

And then on Tamara's comments on observation beds, you know, we really move everybody into these rural emergency hospitals. That's all they have, right? And so it would be very appropriate to count those days towards the three, you know, because this is going to disadvantage patients that are in rural populations. So maybe you're in that observation bed in an REH for a day or two before you finally get transferred to another hospital, and they stabilize you. But then they've got to keep you for three days, and so I think we should be thinking about recommendations around recognizing observation days as part of a three-day stay to have parity for rural.

Thank you.

MS. KELLEY: Gokhan?

DR. METAN: This is really great work and amazing

discussion. Thank you very much.

For the sake of time, I would like to kind of like go through a couple of my comments as quickly as possible. So I really like the idea of comparing MA and fee-for-service use of the PAC. I think underneath the two important things is, again, as other Commissioners called out, the prior authorization burden on higher stays is worthwhile looking, and the impact of the MA growth on PAC financial stability is, I think, important areas.

Second, capacity constraints and bed supply shortages is a concern. I think looking at the impact of bed and staffing scarcity on lengths of stay and care appropriateness is an important area. And also market dynamics, are there any consolidations or, you know, those type of trends happening in the market I think might be worth looking into.

The third area I would call out is readmissions and outcomes on -- outcomes accountability. I think post-acute care is, you know, also increasingly responsible for hospital readmission rates. Looking at the trends in that space might be helpful.

And then the fourth area I would call out is

reimbursement models and margins across the PAC settings. What's the financial stability of especially small PAC providers might be of interest. Looking into equity issues, rural versus urban reimbursement gaps, are there rural SNF deserts emerging? That would be an interesting thing to look at and also how alternative payment models shift the risk to the PAC providers.

And the last area I would call out is the rising acuity of patients. I think I'm very much interested in seeing the case mix index trends. For instance, are SNFs effectively becoming mini long-term acute-care hospitals? Are there any trends that you see in that space? Also, whether the home health agencies can safely absorb higher acuity discharges through maybe remote monitoring, introduction of those could be an interesting area.

And lastly, how IRFs maintain compliance with intensity requirements while acuity rises, those are the areas that might be interesting in further research.

Thank you.

DR. CHERNEW: Okay, Dana. If I have it right, that was the last comment. Is that correct?

MS. KELLEY: That's all I have.

DR. CHERNEW: Wonderful.

So, Carol, really thank you for all the work you've done. I think you heard a lot of appreciation to the Commissioners. Thank you for both getting this on the agenda and making your related comments. I actually see a lot of harmony in the general sense of both how complex this is, but the basic directions of how we need to think about this holistically and try and address some of these bigger-picture problems.

The specific comments are quite useful. I'm sure Carol will take this all back and we'll review it.

But our plan for now is we're going to take a break, which is now going to be 11 minutes. Stay on this link. Go off camera and mute. When we come back, we will be live, so remember that. So see you all in 11 minutes.

[Recess.]

DR. CHERNEW: If you are ready, I think we are ready. So again to the folks at home, thank you for joining us. We are now going to go through two of the post-acute sectors that we were talking about, SNFs and IRFs. We are going to start with SNFs. It is obviously a topic of much interest and passion. And we are going to

start with Brian. So Brian, take it away.

MR. KLEIN-QIU: Good afternoon. We are here to present our work assessing payment adequacy and updating payments for skilled nursing facility services, or SNFs. Webinar attendees can download a copy of these slides from the handout section of the control panel on the right hand of the screen.

In today's presentation, we will cover four topics: an overview of SNF use in 2024; then the four domains payment adequacy indicators, which are beneficiaries' access, quality of care, access to capital, and fee-for-service Medicare payments and SNF's costs. Then we present the Chair's draft recommendation for your discussion. Finally, we will discuss the star rating system of nursing homes and potential alternative sites.

This slide provides an overview of the SNF sector in 2024. That year there were about 14,400 SNFs, most of which also provide long-term care that makes up the bulk of services this sector provides.

The median fee-for-service Medicare share of total facility days was 8 percent. In 2024, there were 1.5 million fee-for-service Medicare-covered SNF stays, and the

program paid $26 billion for care in SNFs and SNF care provided in swing beds.

Each year MedPAC assesses the adequacy of fee-for-service Medicare payments by looking at four categories of payment adequacy indicators 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 2024, and include preliminary data for 2025, when possible. We also project a Medicare margin for fiscal year 2026, 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 2027.

Turning to our measures of access, the number of SNFs declined about 1 percent in 2025, consistent with the reduction last year. Given that Medicare is a small share of most nursing homes' businesses, it is unlikely that the closures reflect the adequacy of Medicare's payments. In 2024, 88 percent of Medicare beneficiaries lived in a county with three or more SNFs, the same rate as in 2023.

After falling during the pandemic, the median SNF occupancy rate has steadily recovered to almost the level

prior to the public health emergency, at 83 percent, indicating some available capacity in aggregate, though not necessarily in every SNF or market.

Between 2023 and 2024, SNF admissions per fee-for-service beneficiary decreased 4 percent while covered days increased 1 percent. Fee-for-service continues to be the preferred payer. These trends are in line with levels that have slowly declined since 2010.

Given the level of Medicare's payments, as we'll see later, the declines in the number of SNFs and service use do not reflect the adequacy of Medicare's fee-for-service payment rates.

Shifting now to indicators of the quality of SNF care. On this slide we show four quality measures: two claims-based outcome measures, which are risk-adjusted rates of discharge to the community and potentially preventable readmissions after discharge; and two staffing measures, risk-adjusted registered nurse hours per resident day and total nursing staff turnover rates. There is more information about these measures in your paper.

As shown in the top left table, the most recent data from the fiscal year 2023 and 2024 period show that

the median facility discharge to the community rate improved very slightly from the earlier two-year period, while the median rate of potentially preventable readmission worsened very slightly. In the bottom left table, we see that the median facility registered nursing hours per resident day in 2023 to 2024 slightly worsened.

A small CMS methodology change to the turnover measure in 2024 means the nursing turnover rate is not directly comparable between 2023 and 2024.

The rates for the four measures varied across facilities. Nonprofit facilities and hospital-based facilities had better rates than other facilities for all measures shown on that quality slide.

Ideally, we would also present data on other outcomes and patient experience, but significant gaps in the data persist. First, patient experience data are not uniformly collected for SNFs. The Commission recommended that CMS finalize the development and begin to report measures of patient experience. Second, restoring and maintaining patient function is a key outcome. However, because provider-reported function data are used to adjust payment, the Commission has raised concerns about their

accuracy. In fiscal year 2027, CMS will start to validate samples of the function information.

Regarding access to capital for nursing facilities, investor sentiment in the SNF space is strong. Price per bed was stable in 2025 so far since last year, and investors are optimistic about the agency loan environment.

In 2024, the all-payer margin for nursing homes, which reflects all lines of businesses, all payers, and investment income, was 2.1 percent, an increase from 0.4 percent in 2023. Fewer providers had negative margins than last year.

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.

Now we turn to our last domain of payment adequacy. The aggregate fee-for-service Medicare margin in 2024 was about 24 percent. The fee-for-service Medicare margin increased about two percentage points from 2023, largely due to a 5 percent growth in payments per day in 2024, and cost growth in general continuing to stabilize.

Fee-for-service Medicare margins varied considerably across providers. For-profit facilities had much higher margins compared with nonprofit providers, and high-volume providers had much higher margins than low-volume providers. Urban and rural facilities had fairly similar margins.

We project that SNF fee-for-service Medicare margins will increase in 2026 to 25 percent. In our estimate of costs, we used CMS's most recent estimates of the market baskets for 2025 and 2026. On the payment side, we assumed that payments will increase by the amounts in the final rules for 2025 and 2026, including positive forecast error corrections. Margins could be higher or lower if changes in costs or payments differ from these assumptions.

In summary, our access indicators show that supply of facilities and volume declined slightly, but neither reflects adequacy of fee-for-service rates. Occupancy rates increased to about their pre-pandemic levels. Measures of quality show little or no change. SNFs have adequate access to capital, and the sector remains attractive to investors. The total margin improved

compared to 2023. And in continuation of a now decades-long trend, the average Medicare margin in 2024 was high. Factoring in expected changes to payments and costs, the projected margin for 2026 is even higher at 25 percent.

So this brings us to the Chair's draft recommendation.

The recommendation reads:

For fiscal year 2027, the Congress should reduce the 2026 Medicare base payment rates for skilled nursing facilities by 4 percent.

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 beneficiaries.

Next, Carol will discuss the nursing home star rating system.

DR. CARTER: Since 2009, CMS has publicly reported a star rating for each nursing home. The goal of these ratings is to provide consumers and with easy-to-understand information when selecting a facility for post-acute or long-term care.

In June, the Commission noted that staffing

information does not play a large role in determining a nursing home's overall rating, but that it could, given the strong evidence basis linking quality to staffing.

We explored ways to increase the importance of staffing in the overall star ratings. Just as a reminder, currently, a nursing home's overall star rating is a composite of three separate ratings: one for the nursing home's inspection, staffing, and quality measures. To create an overall rating, the rating begins with the inspection star.

Then, the staffing rating is considered. One star is added for a 5-star rating and one star is subtracted for a 1-star rating. Last, the quality rating is considered. One star is added to the overall rating for a 5-star rating and one star is subtracted for a 1-star rating.

Note that 2-, 3-, and 4-star quality and staffing ratings do not affect the overall rating.

In response to Commissioner interest, we explored alternative approaches that would change the weightings of the three domains, especially to increase the weight of the staffing domain. There are good reasons to revise the current methodology. First, 2-, 3-, and 4-star quality and

staffing ratings do not affect an overall rating, yet this is important information about these providers.

Second, the literature is pretty clear that higher staffing is associated with better outcomes. Especially now that the payroll-based staffing data are readily available, it makes sense to reassess the weight of this domain in the overall rating.

Third, there are problems with inspections. They sometime fail to uncover serious quality problems. Decreasing the weight of the inspection ratings is ripe for reconsideration.

To that end, we explored alternative weighting approaches. In one, we weighted the three domains equally. In the other, we weighted the staffing domain 60 percent and the quality and inspection ratings 20 percent each. The estimated impact of the illustrative ratings does not consider any potential behavioral responses by providers.

This chart shows the distribution of the star ratings under the current design, the far left bar, and under each alternative. Under the current design, the distribution of the stars is pretty even, with about 20 percent of nursing homes having each star rating.

Compared to the current design, the alternatives resulted in far fewer nursing homes with 1- and 5-star ratings. The share of nursing homes with 5-star ratings, those are in the peach color at the top of each bar, would decline from 19 percent to 4 percent and 5 percent. Without a high inspection rating to drive the overall ratings, many 5-star facilities' overall ratings would be lowered.

The share of nursing homes with 1-star ratings, that is the dark blue at the bottom of the bars, would drop, from 22 percent to 4 percent and 6 percent. This reflects the consideration of the 2-, 3-, and 4-star staffing and quality ratings that pull up the overall facility's ratings. Reflecting a combination of those effects, the share of 3-star nursing homes stars would increase substantially.

Looking more closely at the nursing homes with 5- and 1-star rating, we show how the ratings would change. The estimated changes to 5-star homes is on the left and to the 1-star homes is on the right.

Of the 5-star rated nursing homes, only 23 percent would retain this rating. Almost three-quarters

would lose a star and become 4-star rated, and 4 percent would lose two stars.

On the right, only 17 percent of 1-star nursing homes would remain one-star, 71 percent would gain a star and become 2-stars, and 12 percent would gain two stars to become 3-star rated.

Looking across all the current ratings, we see that they would remain the same for about 40 percent of nursing homes and change for other 60 percent, assuming no behavioral responses by providers. Of those that would experience a change, most would gain or lose one star, but a small share would lose two stars. No nursing home would lose more than 2 stars.

Of those whose overall ratings would be raised, over three-quarters had 2-, 3-, or 4-star quality and staffing ratings that would pull up their overall ratings. Of those whose overall ratings would be lowered, over three-quarters had 4- or 5- star inspection ratings.

For many nursing homes, the diminished weight of the inspection ratings would be offset, to varying degrees depending on the nursing home, by the changes to the weights of the quality and staffing domains and by

considering the ratings that are currently ignored.

The alternative weighting approaches we explored would provide a more complete picture of a nursing home's performance across the three domains. By giving less weight to the inspection domain and more weight to the staffing and quality domains, the overall rating may offer beneficiaries with a better indication of the care they would receive at a given facility.

Counting the 2-, 3-, and 4-star quality ratings in the overall score could focus nursing homes on improving their quality. However, because many of the quality measures are based on patient assessment information, it could create incentives for providers to record this information in ways that boost their ratings but may not represent real improvements in quality. It would especially important that CMS effectively monitor the quality of this information.

With that caution, nursing homes could respond to a revised design by increasing their staffing and by making meaningful improvements in their quality to raise their overall ratings. Both of these changes would be good for beneficiaries.

And with that, we'll turn things back to Mike for your discussion and to consider the Chair's draft recommendation.

DR. CHERNEW: Great. So Brian, Carol, thank you. I think, just to be clear, the recommendation is to reduce the 2026 rate by 4 percentage, which I think is on the screen, and I think we should just jump in through Round 1. Dana, you can start taking us through the Round 1 queue.

MS. KELLEY: All right. I have Tamara first.

DR. KONETZKA: First of all, thank you, Brian and Carol, for such great work. My Round 1 question is for Carol. Can you explain to me exactly how you did the averaging? Sorry, there's an echo. Did you take each of the components, let's say inspections, and turn those star ratings into like a 1 to 5, and then average across those three components?

DR. CARTER: Yes.

DR. KONETZKA: So you end up with an average from 1 to 5 for each of those?

DR. CARTER: That's right, yes. We didn't change any of the domain weightings.

DR. KONETZKA: Okay. I asked just because I

think the results that the distribution of ratings change, and there are so few 1 star to 5 star facilities, it was sort of by construction, and there are alternative ways to get a better distribution. But anyway, I'll say more about that in Round 2, but I wanted to just understand what you actually did. Thanks.

DR. CARTER: Yeah, well, we talked with one person in particular who was involved in the standards, designed the system, he was saying was that their construction, they wanted an equal distribution across the ratings. And we didn't focus on that, but that would certainly be a design feature that could be considered. Besides changing the weighting of the domains, you might care about the distribution and how you did that. That's right.

DR. KONETZKA: Great. Thank you. Okay. More on that in the second round.

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

DR. CHERRY: Yes. Thank you for the excellent presentation. I did notice that it was counterintuitive, really, that the staffing ratios and the quality of care

are not really correlating, so we're probably not measuring the right things when it concerns the outcomes. But putting that aside, the turnover rate is just alarmingly high at 46 percent. And I know that you can't compare 2024 to 2023, but I do think it would be helpful if we could perhaps insert a slide that's showing maybe over the last 10 years what those trends have been like. You know, is that 46 percent worsening? Is it stable? Is it improving? Because that would be kind of revealing as we ponder this particular sector.

MS. KELLEY: All right. I think that's all I have for Round 1. So I'll go to Round 2, Mike?

DR. CHERNEW: Yes, absolutely. And for those of you that are going to speak in Round 2, it's really helpful if you say your views on the recommendation, in addition to whatever else you want to say.

MS. KELLEY: Tamara, I have you first.

DR. KONETZKA: I'm sorry. Am I in the queue, Dana?

MS. KELLEY: Yes. You're first in Round 2. Go ahead.

DR. KONETZKA: Okay, great. So let me start with

a couple of, what I would call quibbles, about some of the access measures and quality measures, and these are things that, you know, I don't know if they'll make a big difference, but if time allows it would be great to do these.

In the access measures, Brian, you look at, as we have done for years, I think, looked at the number of SNFs per county, saying that most beneficiaries are in counties with at least three SNFs. You know, county is not a great market for SNFs. For hospitals we have better hits. There is no natural one, really, for SNFs. People have used county over the years for convenience, but like I live in Chicago and if I had to go to a SNF on the north end of my county it would take me well over an hour, for sure, to drive, and probably three hours if I had to take public transportation.

So it would be great if we could explore some alternatives to make that a little bit better of a measure, like maybe a radius measure around a ZIP code or something. There are lots of alternatives in the literature. Minor quibble.

And then on the quality measures, I think this

has come up before, but the readmission rates you use are from discharge from SNF, right, not discharge from the hospital, which is what CMS has always used in Nursing Home Care Compare, or entry to the SNF. So I guess if you're going to change it any way to match the value-based purchasing one, which is an in-stay readmission measure, then maybe you don't want to change this one in the meantime, again.

But I think using a SNF discharge measures comes with a few caveats that you might want to add to the text, and that is it's pretty confounded then by length of stay and whatever else happens during that stay that you're not really capturing in that measure. So it can be confounded by length of stay in the SNF, and it also sort of is measuring the same thing as the discharge to community measure, or they end up being very similar.

Okay, so those were my couple of quibbles.

In terms of the recommendation and the margins, you know, this cross-subsidization problem is perennial, and I think once again the reasoning that you laid out in the chapter to not consider this issue, in terms of what our payment recommendation is, is completely reasonable and

sound.

But I will just sort of reinforce that the fact that this issue persists after so many decades really reinforces my interest in MedPAC continuing to study and monitor models like the I-SNPs, which is, to me, I think the only model out there that kind of gets at reducing some of these adverse incentives around the Medicare and Medicaid payment differential. So I really think that's like the only way we're ever going to solve this is to come up with new models that have different underlying incentives.

Overall, I support the recommendation, broadly, yet honestly, you know, when you look at 25 percent Medicare margins it seems conservative to recommend a 4 percent reduction from current law. But I think it also seems reasonable, in a sense, that we want these providers to survive and maintain access to Medicare beneficiaries. And some uncertainty in the sector has been reduced with the death -- I mean, postponement, really -- but the death of the minimum staffing ratio rule. But there is still a lot of uncertainty in this sector around workforce, and now kind of new uncertainty around Medicaid.

So I think that that, combined with sort of slightly declining supply over the years in SNFs, makes a somewhat conservative approach justified. So I am broadly in support of the recommendation.

I also do appreciate in the chapter the nuanced discussion of which types of facilities had higher margins and lower margins and potentially why. But one thing that stood out to me is that we often talk about heterogeneity and how cuts or payment is up, but we worry about the heterogeneity. But in this sector, even the 25th percentile still had 13 percent margin. So I think that's pretty telling, that if there is a cut we're not going to do serious damage to SNF supply.

Okay. So I'm going to turn for a minute then to Carol's work on the alternative approaches to calculating the star ratings, specifically increasing the importance of the staffing component. Again, thank you for being so responsive to earlier discussions in the Commission on this issue. I think as Betty expressed so well earlier, none of us wants to end up in a nursing home that has low staffing. Like everybody -- and I have said this many times -- everybody recognizes that staffing is everything. It is

one thing providers, policymakers, consumers, everybody agrees on, that staffing is essential.

I really like some of the simulations you did about what this would do, and especially how disruptive it would be. I think it's important to look at that.

I would say that the sort of equal or unequal distribution issue, you know, I don't know if I care so much about it being equal as a goal in itself, but I think having 4 percent 1-star and 4 percent 5-star seems too small, especially the 1-star level. We know there is a lower tier of nursing homes.

So I would love to see you play with ways to get more of a distribution, not at as a goal in itself but because you want these differences to be meaningful, and you really want low-quality facilities to get 1 star. So I would suggest maybe instead of just averaging the three star levels you could assign each one equal points, and then add all the points together and then percentile the point total. And you could percentile it such that you get exactly equal categories, which may or may not be the goal.

But I think if you do that, then you can look at facilities that fall in that 5-star category and fall in

that 1-star category, and see if there is some face validity to that. Like look at what those facilities are like, their size, profit status, location, and what their actual staffing levels are, and which quality measures they do well on or not. Like you can just see if it makes some sense. So that's a direction I'd love to see this go.

And then a final comment about the consideration of disruption. I think CMS, for sure, is often reluctant to implement a huge change in the ratings that would change star levels dramatically, because facilities won't like that, consumers would be confused. And so I really appreciate that analysis.

I think your analyses so far, these preliminary ones, that doesn't seem that disruptive. A lot of facilities stay the same, and most facilities would gain or lose one star, and yet they're getting a lot better information. And I think if one is worried about that level of disruption, it could also be phased in, or you could start with slowly upweight the staffing part.

But I think this is a great direction. I'm so happy that we found time for this in the workstream, and I really look forward to seeing where it goes. Thanks.

MS. KELLEY: Stacie.

DR. DUSETZINA: Thanks so much. This is fantastic work. I am supportive of the recommendation. But I just had a couple of small notes or comments as I was going through the chapter that I wanted to bring up.

In the beginning you mention the occupancy rates being high, or that there's occupancy available. But you also say that many providers reported denying admissions for workforce challenges. And I think that's where it kind of set off a little bit of an alarm bell for me, thinking about future workforce issues for this sector. So I think that's just an important area to continue to monitor. And you obviously have it highlighted in the chapter, but I wanted to just draw specific attention to that piece.

On page 9, you mentioned that SNFs can have separate companies that operate the facility and who hold the property, and then go on to note that this can protect a nursing home from lawsuits, and then you say "and can infuse cash." And I kind of was thinking about it more as extract cash. So I was just kind of trying to unpack that a little bit more in my head about exactly how that might work. So it might be worth another sentence there about

how those relationships work.

I also really appreciated the note about CMS requiring the revalidating of ownership information, because I think in this sector, and more broadly in health care, I find the private equity and the real estate investment trust ownership appears to be concerning. And then when you combine that with staffing concerns kind of more broadly, it compounds a little bit for me. So I think that's an important area to keep up with, and I really appreciate the attention to adding those details in the chapter.

I think, overall, it was helpful to hear in the chapter the pieces about caregiver experience. We've been recommending that for a long time, and CMS almost got there, and then it feels like we're back to figuring out what we want to do with it. It seems crucial to have caregiver and patient experience measures. I realize that this can't always come from the patient, but those combined seem absolutely mission critical, and especially as we think about ownership and staffing and all of these other constraints as we have an older and older population more in need of these services.

Anyway, thank you again for fantastic work in this space.

MS. KELLEY: Brian.

DR. MILLER: I really liked this chapter and the fact that we are thinking differently.

A few quick comments or kind of the potential to think differently. First of all, private equity is not necessarily bad nor good. One, we should remember that private equity is often funded by public-sector retiree pension funds. So before we go on criticizing private equity, we should think about who those returns are for. They're often for retirees.

We also shouldn't be painting an entire industry based upon a handful of bad actors, and I say this especially because private equity investment and care delivery is one of the very few counterweights that we have against monopolization and horizontal integration that's occurring across the care delivery enterprise. So I think that going after private equity is perhaps not the right answer. The answer is to go after actors with poor behavior and police them appropriately.

As for this chapter, I'm obviously biased by work

by anyone with the name Brian.

That aside, I'm generally supportive of the Chair's recommendation, but I think that we should think about how it is that we get to that recommendation. Again, I'm not talking about economic math here. I'm talking about if we think that excessive margins are a problem and we want to change the system and we're talking about changing quality regulation and stars and other things, have we thought about changing the cost of compliance and changing what we are going for?

So if we want to improve the skilled nursing facility experience for the beneficiary, we should move more towards a performance-based system and performance-based pay and let facilities differentiate themselves more, not just on the basis of, say, star rating but on how they are paid, so that better facilities, based upon obviously what better is, get paid more, that other facilities that don't do as well get paid less.

Part of that would involve thinking again about the regulatory framework upon which nursing homes rely. One of them is that nursing homes are subject to a strict liability system, which drives expenditures towards

compliance and away from clinical care. I'm not saying that they shouldn't have liability. Obviously, they should. But perhaps thinking about what that regulatory framework is, again, sort of looking at how the GAO writ large suggests improving programs that involve spending of public taxpayer dollars, we have choices of payment, but also how do we get to that lower or differential payment level. So I think moving away from a strict liability system could direct costs and spending towards clinical care, which is what we want.

The other thing I think we need to think about, which I said in the other section, is the burden and cost of centralized federal regulation. Obviously, these are taxpayer dollars. It's a vulnerable population. Most of us are afraid of ending up, you know, unable to care for ourselves at any age, whether it's middle age or older age or even young age. And so we worry about that population. We want that population rightfully to be protected.

You know, as someone who's had relatives in this sort of sector space, I get that from an emotional perspective. I get it from a physician perspective and sort of the taxpayer fiscal responsibility. So instead of

having -- and if you haven't read the skilled nursing facility requirements of participation, they're not conditions. They're requirements of participation. I strongly recommend you do so, because right now we have federal government regulating mattress quality, doorway size, and smoke detector placement. And I'm not saying that smoke detectors aren't important and doorway. That's a local fire code issue, not even a state issue. I'm not saying that having a clean, comfortable mattress doesn't matter. It definitely matters, but perhaps that's not what CMS should be grading quality on and grading compliance on. And then, because when you do that with a strict liability framework, we have driven an entire industry that is providing residential medical care towards a compliance model instead of a care and service model.

And so I think instead of just recommending payment cuts every year, as we have for probably the past 10-plus years, we should look at spearheading a transformation of skilled nursing facility quality regulation because that would lower costs, improve the quality, and transform the beneficiary experience.

Thanks.

MS. KELLEY: Scott?

DR. SARRAN: Yeah. First, excellent work.

Second, I support the payment recommendation. I really think the proposed changes in the star ratings reflect very well-thought-out work and certainly appropriately recognize the importance of a floor on staffing.

But I just want to be clear. It's a floor on staffing to enable basic patient safety, that putting a floor on staffing isn't going to drive at better functional outcomes. It's a necessary minimum kind of thing, but it's not going to get the other half of what we want, which, you know, besides safety, obviously, is improved outcomes.

I support -- thirdly, I definitely support continuing to tweak, magnify work on the value-based purchasing programs, including the necessary, what realistically will be multi-year work to source more reliably accurate measures than we currently have.

But in some of it that I've come to thinking in my head, going through the sessions today, as well as the readings leading up to it, similarly to our discussions -- or analogous to our discussions about beneficiaries living

in long-term care settings within nursing facilities, we really have to think about a long-term transition using big levers that will get the magnitude of change we want versus continuing to do more or less the same things and expecting dramatically different outcomes, right? So, to recap all our work in the long-term care beneficiary space, we've teased out perhaps a big lever, and change could be moving towards a change of accountable party. Maybe it's I-SNPs, similarly on the ACO side. But we have to change accountability there.

Here, I really think it's got to be moving away from changing -- from paying for care to a mix of paying for care and outcomes. So I really wanted to tee up long-term thinking about -- instead of paying 100 percent for episodes of care or 90, call it whatever, 95 percent for episodes of care and 5 percent for quality metrics, maybe 50 percent for episodes of care, whether it's days, stays, whatever, and 50 percent for a mix of what we want, which is functional outcomes and safety. That would take a multi-year transition, but it would get us to a much different place.

And lastly, I'll comment that, to Brian's point,

I think a lot of why we've ended up with an over-regulated or painfully regulated industry, particularly if you talk to people running the, you know, skilled nursing facilities and clumsily perhaps regulated, is because we've reacted -- we, national and local regulators, have reacted to a variety of safety issues.

And to the extent that we can get better outcomes via a different lever, we could at the same time back off, right, commensurately, back off with what could then be unnecessary regulations. So, they go -- I think those two things go hand-in-hand.

Thanks.

MS. KELLEY: Greg?

MR. POULSEN: Thank you very much.

First off, I should start by saying -- well, first off, I want to say thanks for a great chapter. I really did learn a lot from this, and I appreciated it. And I would be supportive of the Chair's recommendation, although I would personally want us to be just a tad more aggressive than this, but I'm comfortable where we are.

On the stars approach, I guess I think it would be easy to lose focus on operational excellence and the

capabilities that are increasingly available to achieve that, and staffing, I think, may be absolutely necessary for a good outcome, but it certainly isn't sufficient. So I think if we were to put too little emphasis on the other metrics, I think that would be a mistake.

And so, also, I think that we're going to find ourselves in an intermediate time here where the training level is different than things we've seen in the past, and some of the traditional definitions of staff capability may be changing over time, may need to change over time.

I'm thinking of things like the major capabilities that could potentially be added through AI and other automation that could provide enhancements to care in ways that may not be correlated exclusively to the number of people. There still needs to be a baseline. A floor on staffing is described, but it may be that more isn't necessarily the only path to better in terms of better outcomes.

I would agree with Tamara on the distribution broadly. My own prejudice would be -- from only knowing what I've viewed in visiting facilities that we did looking for partners in terms of post-acute care -- would be that

the inspection is still really important, and I would hate to see us denigrate that or downgrade that too much.

My own bias would be that we would come up with a mechanism, maybe at least recommending over the short term, 40 percent on inspection and 30 percent each for staffing and quality as a path forward, and then we could move from there if we see that a change should be there. But I would hate to see us go too far too fast, but I certainly do like the idea of -- and this is what Tamara said -- of sort of putting it all in a hopper, coming out, and then creating a distribution across all of the folks. That seems like that would be the comfortable way.

I recognize that we may end up with some five-star ratings that aren't truly five-star facilities if nobody's doing a really great job, and that would be the potential risk, but on the other hand, that would at least give us a spectrum for people to have the best in our area to the worst in our area kind of an idea.

So that would be my thoughts. Thanks very much for a great chapter.

MS. KELLEY: Cheryl?

DR. DAMBERG: Thank you.

So I want to go on the record as agreeing with the Chair's recommendations. Clearly, the margins are very high in this sector, but I realize per some of the earlier comments made by other Commissioners that this is a balancing act, given other changes going on in the environment.

The second comment that I'd like to make relates to the ownership issues, and this is where private equity came up in the chapter, and I think if there was some ability to encourage CMS to require that facilities revalidate their ownership information, either annually or every two years instead of every five years, I think that would give all of us more current information to be able to try to understand what the implications are of different ownership structures on performance.

And then third, related to the star ratings, I really am pleased that the staff have gone in this direction of trying to model what an alternative star ratings program could look like. The current design is fundamentally flawed, and I like the idea of putting more weight on staffing.

And I agree with Tamara that sort of the current

distribution doesn't look quite right, but I'm wondering if there are some other alternatives that could be modeled. For example, it wasn't clear to me from the description in the chapter whether for those three domains, whether you're assigning a star rating, say, for quality, you know, that's a composite of the scores, and that you assign the star ratings for that particular composite, say, using percentile cut points, and then you take a weighted average of different percentile cut-point stars that you've created for the different -- the three different categories. So I think there's some alternatives that you could model to give us a better sense of what might be an optimal structure for having star ratings focus on the things that we think are important, have impact, particularly staffing, given its relationship to quality and outcomes.

And then I just want to plus-one on Scott's comment about paying for outcomes in the future. I think that that is mission critical.

MS. KELLEY: Gina?

MS. UPCHURCH: First, thanks for all the fellow Commissioners' comments, and I agree with many of them. I won't repeat a lot of them.

I did have sort of one question, and I do agree with the Chair's recommendation. You know, so a lot of people -- several places in the chapter, we say, you know, Medicare covers 100 days of skilled nursing care. It always needs to say up to, because we rarely see anybody -- I don't know what the numbers are -- get the full 100 days. So, in several places, you say up to 100 days, and I know that's what Medicare can cover.

But I'm just curious if we've looked at that. I know you talked about people when they have secondary cover, so you have Medicare, and you either have a Medigap policy or you have Medicaid or an employer plan that pays, you know, the cost sharing after day 20. I'm wondering if we've -- I'm sure we have, but looked at discharges related to that and looked at outcomes related to that, whether somebody's -- you know, and what happens to a person after day 20 and they've got to pay the cost sharing, but they can't afford it? What happens? I don't think I know the answer to that.

I mean, if the person can't go home, I guess they just start to spend down to Medicaid. I'm just curious if we know what happens to that person, if they could, you

know, be eligible for more therapy, but they can't afford it. So, I'm just -- Carol, do you -- or, Brian, do either of you know that?

MR. KLEIN-QIU: We have looked at the patterns of utilization for medical payment after day 21 and beyond. We haven't looked specifically at what I think you're getting at, which is by payer or by secondary payer, and that's something we can look at in the future.

MS. UPCHURCH: That would be good, and I just wonder what happens to the person who just needs more rehab. You know, I guess -- anyway, that would be interesting to see.

And just the other -- just quickly related to star ratings, I agree that I would like more weight on staffing. Being from a small town where I grew up and went back to help with my father, you didn't look at star ratings on a computer. You asked who worked where and what they thought about the place, and the staff would tell you what was the nicer place, where they were proud to work, where they felt like you were really taking good care of people, and they stay longer.

So I think staffing is really, really critical to

this, not to do away with, you know, the other metrics, but I do think staffing needs to have some more importance. So I appreciate you all thinking about that, and I love Tamara's idea of how you make that spread.

And lastly, I feel very strongly that we need feedback from family and caregivers about what Medicare is paying for and how it's working for people in the skilled nursing facility, and building on Scott's comments, not just on, you know, process, but on outcomes. Did they help you learn how to stand and pivot so you could go home? You know, so looking at patient outcomes is a really important part of what we're paying for.

Again, thanks for this great work. Thanks.

MS. KELLEY: Betty?

DR. CHERNEW: Thank -- oh.

DR. RAMBUR: Thank you.

I just want to be on the record voicing my support for this recommendation and my great appreciation for the thoughtful comments of all the Commissioners.

And as you might imagine, I think staffing is very important, but I also think some of these longer-term things that we can look at are important as well. So thank

you, and thumbs up.

DR. CHERNEW: So there's a few other people that haven't had a chance to talk. Comments aside, if you want to jump in now and say what your view of the rec is, now is the time. Otherwise, we're going to take a five-minute break and then come back and do IRFs.

DR. METAN: Thank you, Michael. This is Gokhan.

Great work, and I support the recommendation.

MS. BARR: Mike, this is Lynn. I support the recommendation.

DR. DILLER: And this is Tom. I'm supportive.

DR. LIAO: This is Josh. I'm --

DR. CHERRY: And this is Rob. I also support the position. Josh also support.

MR. MASI: And that was unbelievably efficiently done.

So the SNF team, Brian and Carol, really outstanding job. The issue about how to both get better quality, but I would want to put on the table, make sure that no one gets really bad quality -- those are two separate things. But I spend much more time awake at night worrying about the really bad quality than the difference

between the care and the sort of top-end quality stuff.

And I think it's going to be important for us to think through the extent to which we can get that better quality to any type of incentive system versus if we need other levers, including -- you know, we could talk about regulatory stuff. A lot of that stuff is well beyond what we can do in the update chapter. But what you hear -- and I think this is true across the board -- is both an acknowledgment of how important this sector is and how holistic we have to be in our thinking about what's on the table for trying to make sure that we can give people adequate access to SNF care.

But, again, thank you all.

MS. BARR: Mike, Josh had a comment I'd like to hear.

DR. CHERNEW: Oh, go ahead, Josh.

DR. LIAO: I'm sorry. I just wanted to weigh in on my approval. I retract that comment.

DR. CHERNEW: Josh, I think, put himself in the queue so he could say he supported the rec --

DR. LIAO: That's right.

DR. CHERNEW: -- which is always welcome, of

course.

DR. LIAO: Yeah, you can take me out of the queue.

DR. CHERNEW: Yeah, I think we're all good.

So, again, we're going to stay live, but we can go off camera and unmute, and please come back in five minutes and we'll do IRF.

[Recess.]

DR. CHERNEW: Welcome back, everybody. I'm going to jump right in, and we are now moving on to our last session of the day, which is going to focus on the update recommendation for IRFs, or rehab facilities.

So, Laurie, take us away.

DR. FEINBERG: Good afternoon.

Before we start, I'd like to acknowledge Alison Binkowski for her contributions to the chapter and 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 start with background on inpatient rehabilitation facilities, which I

will refer to by the acronym IRFs, and review our usual payment adequacy indicators listed on the slide. We will conclude with the Chair's draft recommendation on how to update fee-for-service Medicare IRF payment rates in 2027.

After illness or injury or surgery, some patients need intensive rehabilitative care, including physical and occupational therapy and speech and language pathology services. These services can be provided in IRFs. Fee-for-service Medicare pays IRFs for providing inpatient services with a prospective payment per discharge, as described as the inpatient rehabilitation facility prospective payment system.

In 2024, there were 1,170 IRFs. Sixty-six percent were hospital-based units, and 34 percent were freestanding hospitals.

Fee-for-service Medicare beneficiaries had about 435,000 stays. The total payment for IRF care was about $11 billion, including payments by both fee-for-service Medicare and its beneficiaries. Fee-for-service Medicare beneficiaries accounted for 51 percent of IRFs total discharges.

Now we view our assessment of the payment

adequacy for IRFs using our established framework that you've seen in earlier presentations. We will start with access to care.

In terms of the supply of IRFs, in 2024, there was an increase in 1 percent in the number of IRFs compared to 2023. The number of beds increased by 3.5 percent. The majority of IRFs that opened were freestanding and for-profit, and almost all of the closures were hospital-based units.

In 2024, the number of Medicare stays increased by 8 percent, exceeding pre-pandemic levels. On a per fee-for-service beneficiary basis, Medicare stays increased by about 10 percent, and the aggregate occupancy of the facilities slightly increased to 71 percent.

Overall, IRF indicators of access suggest that the capacity is more than adequate to meet the demand for IRF services.

Our second category of IRF payment adequacy indicators is related to quality. The two quality measures we tracked, facility level, risk-adjusted discharge to community, and potentially preventable readmissions were relatively stable.

The median rate of successful discharge to the community was 67.5 percent in the period fiscal year '23-'24, slightly improved from the prior period. The median rate of potentially preventable readmissions was 9.2 percent, slightly worse than in the prior period.

Ideally, we would also consider measures of other outcomes, but significant gaps in data persist. We have continued concerns about the validity of provider-reported function data. A patient experience survey is available to IRFs but not required under the IRF Quality Reporting Program.

Our third category of IRF payment adequacy indicators is IRFs access to capital. Sixty-six percent of IRFs are hospital-based units, which access capitals through their parent institution. As you heard earlier, acute care hospitals' access to capital increased in 2024. Access to capital for freestanding IRFs remained strong in 2024. The all-payer total margin for freestanding IRFs is 12 percent, up from 10 percent in 2023.

In addition, new construction of freestanding IRFs reflects positive financial health. Forty-two percent of freestanding IRFs are owned or operated by one large

corporation. Their investor reports indicate that this corporation had good access to capital. In 2024, the company opened six new IRFs and added beds to existing IRFs for a total of 400 beds.

Our fourth and final category of payment adequacy indicators is how Medicare -- fee-for-service Medicare payments compared to IRFs costs. As shown by the middle blue line, the aggregate fee-for-service Medicare margin has been over 13 percent since 2019. In 2024, the Medicare margin increased to 17.1 percent, which is above pre-pandemic levels.

Financial performance continued to vary across IRFs. For example, in 2024, the aggregate Medicare margin for freestanding IRFs was about 25 percent, as shown by the top light blue line. In contrast, hospital-based IRFs had an aggregate Medicare margin of about 4 percent, shown by the bottom orange line. These differences in profit margins by provider type have persisted over time, and we continue to monitor these differences.

We will move to discuss our projected fee-for-service Medicare margin for IRFs. In fiscal year 2024, the margin was 17.1 percent. For fiscal year 2026, we project

that IRF margins will increase to 18 percent because we expect payments to increase more than costs. Margins for 2026 could be higher or lower if changes in costs or payments differ from the projections.

In summary, our four categories of payment adequacy indicators for IRFs are generally positive. First, in terms of fee-for-service Medicare beneficiaries access to care, IRFs volumes and capacity increased while occupancy rates were slightly increased.

Second, quality of care in 2024 was relatively stable. The median facility-level risk-adjusted rate of potentially preventable readmissions worsened slightly, and the median facility risk-adjusted rate of discharge to community improved slightly.

Third, the all-payer margin for freestanding IRFs increased to about 12 percent in 2024, indicating freestanding IRFs maintain good access to capital markets. The all-payer operating margin among IPPS hospitals increased in 2024, indicating increased access to capital for their hospital-based units.

And fourth, fee-for-service Medicare payments at IRF costs indicators were positive. In 2024, aggregate

Medicare margin was 17.1 percent. We project a margin of 18 percent in 2026.

So that brings us to the Chair's draft recommendation for 2027. The Chair's draft recommendation reads, For fiscal year 2027, the Congress should reduce the 2026 Medicare base rate for inpatient rehabilitation facilities by 7 percent. To review the implications on spending, current law would give an update of 2.3 percent, slightly altered from the old materials. So fee-for-service Medicare spending would decrease with this recommendation. We do not expect adverse effects on access to care for beneficiaries and continued provider willingness and ability to treat fee-for-service beneficiaries.

With that, I will close. I'm happy to take any questions, and now I turn it back to Mike. Thank you.

DR. CHERNEW: Laurie, thank you. That was very well done and very clear.

I think we should jump right into the queue, and in Round 1, I think we have Tamara first.

DR. KONETZKA: Thank you, Laurie. Always appreciate your longstanding and detailed knowledge on this

topic.

My question is about on Table 8-4 in the chapter, you go through margins, Medicare margins by year, by all kinds of different categories of IRFs, so love that detail. Thank you.

The one thing that sticks out is, you know, there's one row in the whole table, looking at all characteristics -- there's one row where everything is consistently negative, and that is these super small IRFs, the 1-to-10-beds IRFs. Who are they? Are they all hospital based? Like, why -- you know, in some sense, like, why do they exist when they've had such negative margins for so long?

DR. FEINBERG: You know, we haven't -- I haven't specifically looked at their identification. I think there may be one freestanding IRF that's that small, but basically, they are all hospital based.

And I must admit, with the occupancy rate that might be in the 60 percent, as a clinician, I worry about how they're doing, but we have never done any analysis on that. Does that answer --

DR. CHERNEW: Tamara?

DR. DAMBERG: Yeah. No, thank you. I mean, it'd be interesting to know. I mean, you know, if -- if there's a -- if there's a significant decrease in margin, those would be the facilities that would be vulnerable, and so it might be good to know, as time allows, more about them.

DR. FEINBERG: Yeah, yeah, especially like their location and whether there are other facilities, you know, within their market area.

DR. KONETZKA: Exactly. Yeah. Thank you.

DR. CHERNEW: Tamara? Tamara, I just want to jump in and say one more thing on this point. This may come up, and Laura, you may want to comment on this. This is not meant to be a clarifying question, but it may end up being one.

The margins for hospital-based facilities are just more conceptually complicated because of the cost allocation issues and a whole bunch of other things going on. So we report what those margins are, but I think as your question alluded to, Tamara -- and I think you're right -- there's a lot of stuff about how the IRF is fitting in to a multi-product, you know, facility in a whole bunch of ways.

So I don't see -- the freestanding margins, you get a sense that that's much more. Would it cost to produce the care if that's what you were doing? And how that plays out in the hospital-based ones, with the reporting and the costing, is a little more complicated. I'm no expert in this area.

But, Laurie, if you have any comments on that, I think it might be useful for people to interpret how we're thinking about the margins for some of the ones that are hospital based, and some of those, of course, could be small ones with negative margins. I'm not sure.

DR. FEINBERG: I think that will take more investigation. I think we will probably need more than the data available from cost reports to analyze that.

MS. FOUT: I thought I'd just point out that they are, like Laurie said, the majority hospital-based IRFs. And when we took a look at what the acute care hospitals margins were for those hospitals that have IRF DPUs, they tend to be like slightly better than other acute care hospitals. So there might be some, you know, ability to shift their patients, but it's still like when they allocate their costs to that IRF, it's a highly negative

margin for that IRF. But it's still better than, you know, the rest of the hospital -- like keeping that patient in the rest of the hospital, if that makes sense.

DR. KONETZKA: Okay. Super interesting. Thank you.

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

DR. DILLER: I did. I unfortunately have to jump off here shortly to go to a board meeting.

The question gets at, you know, why is there such a huge difference between the freestanding IRF margin and the hospital-based margin? Is there a difference in quality that's delivered by those? And if we go down the road of, in this case, a 7 percent reduction, are we willing to potentially start to cause hospitals to get out of the IRF business?

And I'll stop there.

DR. FEINBERG: You know, I think there -- the differences, we sort of broke them out in the chapter, and so there are small differences. But these are in aggregate.

And, you know, in answer to your second question,

the answer is, if the hospital still gets benefit from it, they may still continue to do it. You know, I don't think I can answer that question.

Do you have anything to add, Betty?

MS. FOUT: I was just going to say that I think that the quality measures show that the nonprofit IRFs were a little bit higher quality, and they do in the hospital-based IRFs as well, and they do tend to be smaller and have more negative margins. But, of course, there's also this allocation issue that is hard to address. So it's really hard to like really measure their costs compared to their payments. So it might not really be that they feel like they have this highly negative margin that we kind of have to use when we use the cost reports to, you know, create their margins.

MR. MASI: And I would just jump in to add, thank you for flagging this. As Mike and others have said, this is kind of a perennial issue that we grapple with.

We had hoped to be able to make some additional analytic progress that are teasing out both the cost allocation issue and potential reasons for this difference across the different types, the hospital based and the

freestanding. As we know, there's been some disruption these last several months that has altered those plans, but this is very much on our radar. And we're hoping to continue that work in the future.

But from a payment adequacy assessment, I think in the past, the Commission has been wary of leaning too far into differences by provider type, in part, because of the cost allocation issue that we've talked about.

MS. KELLEY: Okay. I have Robert next in Round 1.

DR. CHERRY: Yeah. Thank you. Great, great report.

I have a clarifying question in terms of what we mean by hospital based versus freestanding. When I think about hospital-based rehab centers, that to me, they fall into like three broad categories, you know, the hospital owns that facility in its entirety 100 percent. Some relationships are complicated. They go into a joint venture with a rehab facility, and maybe they're the majority owner at 51 percent or more, or they might be in another category, the minority owner at 49 percent or less. And so in those joint ventures, are they considered

freestanding, or does it depend on whether they're a majority owner or not just to kind of -- because it does change my thinking about how we approach this in terms of how we think about hospital based versus freestanding.

DR. FEINBERG: I believe that the joint ventures are not reflected in the freestanding versus hospital based. A hospital-based one would be the third floor of a seventh floor hospital within the same building. A freestanding has four walls around it and isn't part of the same basic hospital building.

DR. CHERRY: Okay. So I wasn't even thinking about that. So, in other words, it's a -- so by hospital based, it could be a rehab center separately licensed but in the same sort of physical building as the hospital versus freestanding, meaning they're not attached physically to a hospital, but they're separate. But that means there could be all types of facilities. Some could be joint ventures. Some may be hospital owned. Others may be just kind of purely rehab.

I'm not sure -- you know, once I think about it, I'm not sure if that's the best definition necessarily, but that's interesting and how we're differentiating the two.

MS. FOUT: Just to add that we use the definition that would be used by Medicare and when they're licensed. So they have kind of a provider identifier that would tell you if they are their own hospital or they're a distinct part unit of another hospital, and it's sort of a distinction that like is, you know, on record that CMS also uses to report quality measures and all sorts of other information.

But you're right. There could be a joint venture in which they're really tied, but we don't capture that with that provider number.

DR. CHERRY: Okay. Thank you.

MS. KELLEY: Cheryl, Round 1?

DR. DAMBERG: Yeah.

Laurie, thank you for this chapter.

I had a question, just in terms of volume of services, and I'm just kind of curious whether you thought that 8 percent increase was surprising. And I don't know whether that suggests that sicker patients are getting the needed level of care or there's a lack of available SNF options. I'm just trying to unpack that a bit.

DR. FEINBERG: I think we did notice the growth,

especially when you looked at the per-beneficiary level was a little surprising. It certainly is -- but I'm not sure that we have, you know, looked at the reasons for that.

DR. DAMBERG: I think it would be helpful to try to understand some of the drivers of that, if that's feasible.

MR. MASI: Yeah. Cheryl, thanks for flagging that.

I'd say every year as we begin to get the data back for the payment adequacy analysis, there are a few numbers that when we look at them, you know, we check them and then we check them again, because they are notable, as you're pointing to, and this is on our radar. And we're going to continue to poke at it.

DR. DAMBERG: Yeah, I appreciate that. I'm just trying to figure out if it's signaling a problem somewhere else in this three-part ecosystem.

MS. KELLEY: Okay. That's all I have in Round 1, unless I've missed someone. So going to Round 2, I have Stacie first.

DR. DUSETZINA: Great, thanks very much.

Excellent work. And I agree with the Chair's

draft recommendation.

There were only two minor things that I wanted to bring up. One is very minor, and it's partly related to just my lack of knowledge in this space. But on page 5, going into page 6, you mentioned that the IRFs that don't need the compliance threshold get switched from PPS to hospital PPS payment. And I realize where you're pointing there is that that's lower, that's switched to getting paid less, but I wondered if there was some way to quantify kind of like roughly how much less we're talking about, just to understand the magnitude of like the change. And if that's very difficult to do, it's no problem. It points in the direction that you made, but I felt like I wanted to understand how big of a penalty is that or incentive to stay under that threshold.

DR. FEINBERG: Let me just start with, to the best of my knowledge, no IRF has ever been downgraded. So I think it's a theoretic threat rather than an actual threat. But I'm not absolutely sure that. but that's just based on my own personal knowledge.

It probably, you know, is when you look at the average payment for a hospital visit, it's about on the

order of $10,000. Probably. the chapter was better at that on hospital care. And these are 2024, 25,000. So it's a pretty big difference. But we can -- we can put that in if you like.

DR. DUSETZINA: But also interesting, your point that that hasn't happened to anyone. So that also I guess is kind of important to understand is that, you know, it's a threat that's out there, but maybe it's good as it is, given that it hasn't happened.

The other piece was just sort of a comment that I think we keep hitting on around quality measures and how unsatisfactory the quality measures are in many of these spaces, and I think especially when I think about the qualifications to get into an IRF, like how much therapy you're going to be looking at, it feels like patient function and patient- or caregiver-reported satisfaction and functioning would be absolutely critical here to understand how things are going.

So I guess just another pile on to we really need better quality measures here, so we can understand how care is being delivered and how patients and their families are doing.

But that's all for me. Great, great work, Laurie.

MS. KELLEY: Tamara?

DR. KONETZKA: Okay. I'll just start by saying I support the draft recommendation. I think that given the margins and even given the heterogeneity, that seems fair.

So my other points are two very kind of related points. One, as has already come out in this conversation, I think the market dynamics here in this sector are just really, really fascinating, right? So what we saw in the overall PAC chapter is that we had, you know, over a 10-year period, a 56 percent increase in spending on IRFs and then this statistic that Stacie or that Laurie was just talking about in terms of the, you know, 10 percent increase in fee-for-service days per capita in just one year. And we know that, you know, this one company is expanding at a rapid pace, right?

So I think that, you know, I've learned all of that from MedPAC. So I just would encourage us to, you know, keep following that. I think it all speaks to this value question that I think we're all interested in, right? We want to make sure that that expansion is actually

providing greater access to beneficiaries and it's not just wasteful spending. And so I think we want to keep following those market dynamics and to the extent possible, you know, try to figure out ways to get at the value of that increased spending.

And the other related point is that in these market dynamics, it brings up a lot of heterogeneity that really affects how we think about or how I think we should think about access, right? So, in some sense, the freestanding facilities that are expanding are really, as the data showed in the chapter, really kind of specialize in these other neurological conditions, right? Whereas the sort of more medically complex stroke patients are much more likely to go to a hospital-based facility, right?

And so, in a sense, access isn't access isn't access. You know, it's not the same, just having an IRF in your market, right? And so what I worry about as the market dynamics play out and hospital-based facilities continue to close and these freestanding facilities expand, yeah, it opens up access for certain kinds of things, but I'm not sure about access for sort medically complex stroke patients, for example.

And so I think we want to sort of continue to really dig into, I think, the heterogeneity of which types of patients are being served and, you know, whether we're really getting access for the most severe patients who might need IRF care.

And that's it. Thank you.

MS. KELLEY: All right. I have Brian next.

DR. MILLER: It's the end of the day. Trying to be brief. I appreciate this chapter. It's fun space.

So a couple of things we should think about. One, I just want to remind my colleagues that IRF stay benes need two modalities, a therapy, that's PT, OT, SLP, et cetera, at least three hours a day for five days a week. Again, it's about the beneficiary's potential for rehabilitation. You could have the same diagnosis and end up in home health, subacute rehab. Subacute rehab, you're physically in a SNF but you're in there as a subacute rehab stay. We should correct our language on that, by the way. Or you're in an IRF, but it's the potential for rehab for whatever the diagnosis is.

So a couple of things that I think we should be looking at, or maybe contract out, I have not seen these in

the literature, which is sort of longer-term cost savings from gains in functional status. And I don't mean, you know, just does the bene get home or do they go to a SNF, for long-term care, or are they home with home care, or are they home with no care. It's sort of like what is the long-term trajectory of that IRF bene. Is it over 24 months after?

Because the fundamental question about what the value proposition for the beneficiary of an IRF is is, hey, I'm good enough. I had the decrement from whatever happened -- drugs, spinal cord, whatever the issue was -- I went into an IRF. Before I went to the IRF I had been medically screened, and I am weak but I'm strong enough to participate in more therapy per day, more modalities per day, more days of the week than other care settings, whether you're in a freestanding IRF, whether you're in an IRF chair, whether you're in a freestanding IRF on an acute care hospital facility campus, whether you're in an IRF on the floor of an acute care hospital that is filling as a separate IRF, right, you're discharged from MAIR 8 in my hospital and admitted on MAIR 7. So whatever it is, the goal of the IRF is to restore functional status.

For the Medicare bene, is that restoring functional status, one, lets them have fewer facilities and fewer needs at home, so you're less likely to maybe need home care, maybe you're less likely to end up in long-term care, maybe you need less of a home health aide, you're less likely to get readmitted to the hospital afterwards. Whatever it is, we should be looking at that sort of longer term outcome for IRFs, you know, one year, two years, and see if there is any difference in that population.

Because the fundamental question we're asking is, one -- and I'm generally supportive of the Chair's recommendation, just to be clear -- are we getting good value for the Medicare dollar for this marketplace versus other post-acute care marketplaces, and what is our relative performance? That's fundamentally the question we're asking, in addition to the payment model. So I think we should measure that or contract with someone to measure that, or someone else should measure that for us, hopefully a variety of other people. Because it is not really in the tracker that we have increased utilization of IRFs, and that increased utilization might not actually be a bad thing. That might be a good thing.

I think another thing that we could do that would probably be helpful, again, in thinking about what makes up a payment model, and this is something Betty has beaten into my brain in a good way, which is sort of what is the staffing model of the facility. So we know what the staffing models of acute care hospitals are. We probably should think about what is the staffing model of a skilled nursing facility that is providing subacute rehab care, what is the staffing model of an IRF, and what is the staffing model of home health?

Because part of what I think we haven't done as a Commission is we have looked at what is the profit and the marginal cost, but we haven't really thought about what is the cost of production of the goods and the service. Right? Because, fundamentally, if we are paying for something, we want to know what our cost of production is. We're not going to necessarily be super accurate or super precise. As Mike has said many times, it's about incentives and relative payment. And so part of us getting a better measure in the post-acute care space is probably looking at that staffing and seeing how that staffing can drive expenses. And then we'll also have a better idea of,

for example, that different types of post-acute care spaces have different types of physical therapists. Because if you're in home health and doing physical therapy after you got your knee replaced versus you're in an IRF and you're getting physical therapy because you had a spinal cord injury, you need a different type of physical therapist. And part of that may come from the price that the facility has to pay to get that physical therapist.

So I think that is something we should do that will give us sort of forward looking recommendations, and sort of like bottom-up construction of cost, which could help improve some of our payment accuracy. And I mention this not because I don't like our work, I don't think our work is good. I do think our work is good. But we've been making the same recommendation to Congress in the post-acute care space, for home health, for SNFs, for IRFs, for years, and we have not had a significant change.

So I think the other thing that we could do in this space, again, is look at the list of chronic conditions, or qualifying conditions, the 13 that were set 19 years ago. And again, that's probably something that we should change and address the universe of the cases that

are eligible. And, in fact, if you expand access to IRFs, you know, some IRFs that may increase profit. It may also, frankly, expand access to Medicare benes who need IRF services, and also reduce the profit in the industry, while resulting in better outcomes.

So I think there are a lot of different ways that we can think about what the right payment level is, again, remembering that our charge is payment, but that we have multiple tools to get there. It's not just adjusting the payment level. Our tool also could be a regulatory change. It could be a guidance change. And that we should do that because that's what GAO has done with all kinds of other programs, and I think we should mirror that best practice.

MS. KELLEY: Scott.

DR. SARRAN: I'll be brief. Excellent work. I support the recommendations. We definitely have a lot of room for improvement in terms of capturing functional status measures and patient-reported outcome measures in ways that are reliable and helpful. And I more and more believe that in the entire post-acute sector we need to change the structure of payment, and this would be clearly a multiyear project, away from today, where we pay for

care, and tomorrow, whenever that is, where we pay for a mix of care and outcomes. And the outcomes are so easy to agree on, right. It's functional status compared to the goal that is collaboratively set at the time of admission, it's safety, and it's patient experience.

So I think what's outlined in the recommendation and in the work done today, this is good work, so I support it. I think the bigger opportunity for improvement in value, outcomes, and spend is going to be by changing the structure of payment in this sector. Thanks.

MS. KELLEY: Robert.

DR. CHERRY: Yes. Thank you. I think probably, like many of us, it's this curious thing that the freestandings have a 25 percent margin while the hospital-based have a 4 percent margin. But the definition is around what's the hospital-based versus freestanding that provides a lot of clarity. I've had some experience, actually, with both of those models, and I think that a hospital that owns a rehab facility, and it exists within the physical structure of its own named hospital, probably has a higher cost structure, in terms of its staffing model. But it also provides more medical and surgical

services and cross-credentials people to be able to kind of freely flow back and forth between the facilities themselves. It may be a little more costly. But I think some hospitals are motivated to have that kind of delivery model, simply because it provides an expedited, cost-effective discharge from an acute care bed, and then it frees up that bed for someone else that may need it.

It's not completely obvious to me if a 7 percent reduction will cause these hospitals to get out of that model, or alternatively, they might keep that proximity model, keep this building in the same location, but maybe have an IRF exclusively managed that look at this. I think it's something we'll have to watch carefully and see.

But otherwise, you know, I'm very supportive of the recommendation.

MS. KELLEY: Lynn.

MS. BARR: So I'm curious about this, about how many of these facilities are rural, because to your point, earlier you we talked about with the SNF, there are three SNFs in every county, or swing beds. There's not three facilities with swing beds in every county, because most rural counties have one hospital. And there are a number

of them that have IRFs, that have taken that unused capacity and created an IRF that is serving their area.

You know, I can't support this recommendation because I don't have enough information to know what this would do. What are these hospitals that have these IRFs? What is their profile? I have to have more information, because it's sort of like as we've seen in just the last 10 years, we lost all maternal services in rural because they couldn't afford to do it. So if we take away the margin on this, what harm do we cause, and I don't know the answer to that.

I think we need to know a lot more about these facilities -- what kind of patients, how big a deal is it. Because we could make a recommendation that says 7 percent for freestanding IRFs, and I wouldn't hesitate. But what hospitals are going to be affected? Are these safety net hospitals? Why are they there? I don't have enough information to support the recommendation broadly, because I'm concerned about the hospital sector and what that could do to that sector.

MS. KELLEY: Cheryl.

DR. DAMBERG: I generally support the direction

of this recommendation. You know, looking at the margins they look quite high across facilities of all different types. And I think some of the comments that Tamara made earlier, in Round 1, are spot on in terms of the heterogeneity, especially between the for-profit and nonprofit entities. And taking very different mixes of patients, that I would suggest are leading to very different profit margins.

So I think the more that we can spotlight that and continue to unpack that, I think that will be helpful to Congress and other policymakers.

MS. KELLEY: Okay, Mike. That's all I have in Round 2, unless I've missed someone.

DR. CHERNEW: That's what I had, as well. Again, there are some people that haven't spoken, so this is your chance. If you want to get in and say something about the rec, I'll give you a chance to do that.

MS. UPCHURCH: Gina here. I agree with the other Commissioners' comments. It would be great to have more data. But I do support the recommendation for now. Thanks.

DR. LIAO: Josh, I agree.

MR. POULSEN: I agree. I'm Greg.

DR. RAMBUR: I'll weigh in too with my support and appreciation for the comments of the Commissioners. Thank you.

DR. CHERNEW: So I think, did we get everybody, Dana?

MS. KELLEY: Yes, we did.

DR. CHERNEW: So to the staff, thank you so much for the work in this area. It really means a lot. To the Commissioners, thank you for your comments. I think the most important one is that we think about the heterogeneity here. I sort of mentioned my thinking around how we deal with that heterogeneity, and you all free to assess that, how you want to.

But I think we will go back and talk with Laurie and staff about what more information we can bring, and we will see where we end up there in January.

But for those at home, I'm sure you may also weigh in with giving us some information, and please do that at meetingcomments@medpac.gov, or there are other ways you can reach out to us. We do want to hear what the folks at home say.

But it has been a wonderful day, and I really want to give thanks to all of the staff, a special double thanks to Jeff, and reiterate how much we appreciate all he has done for the Commission. And we will be back tomorrow morning, where we will go through the updates for other sectors and some work on the mandatory reports.

So again, everybody, have a wonderful night. I know those of you on the West Coast woke up particularly early, and those of you on the East Coast are staying up later than normal, at least working later than normal. So I do appreciate everybody's dedication, Commissioners and staff, and everybody.

So again, thank you, and we'll see you all tomorrow.

[Whereupon, at 5:56 p.m., the meeting was recessed to reconvene at 10:00 a.m. on Friday, December 5, 2025.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Via GoToWebinar

Friday, December 5, 2025
10:01 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
BETTY RAMBUR, PhD, RN, FAAN, Vice Chair
LYNN BARR, MPH
ROBERT CHERRY, MD, MS, FACS, FACHE
CHERYL DAMBERG, PhD, MPH
THOMAS DILLER, MD, MMM
STACIE B. DUSETZINA, PhD
R. TAMARA KONETZKA, PhD
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AGENDA PAGE

P R O C E E D I N G S

[10:01 a.m.]

DR. CHERNEW: Hello, everybody, and welcome to our Friday morning December MedPAC meeting. We are thrilled that you could join us, and thrilled for the material that's going to get presented today. As those of you that joined us yesterday, or just follow the general MedPAC cadence, December is the meeting when we talk about our update recommendations for each of a number of different fee schedules, and we are going to continue doing that today, and we are going to start with home health. So Evan, take it away.

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 side of the screen.

In today's presentation I will cover our payment adequacy indicators, 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 in

Medicare fee-for-service. I would note that some of these numbers have been updated since you received your briefing materials.

In 2024, there were about 12,000 agencies approved to participate in the fee-for-service program. Those agencies served 2.6 million fee-for-service beneficiaries, and delivered 8.1 million 30-day periods of home health care. Total fee-for-service payments in 2024 equaled $16 billion.

Now we turn to the payment adequacy indicators. They are similar to what you have seen for other sectors yesterday, so I will not run through them in detail. The four indicators are beneficiary access to care, quality of care, access to capital, and Medicare payments and costs. We assess these factors to determine a payment recommendation for the upcoming payment year, 2027.

Our first category of payment adequacy indicators is access to care. We find that access to care is adequate.

Similar to past years, over 97 percent of fee-for-service beneficiaries lived in an area served by at least two home health agencies, and 86 percent live in an

area served by five or more. The number of home health 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 1 percent nationwide in 2024. This number excludes Los Angeles County, California, which is experiencing a very high growth in supply, which I will talk about in a minute. 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 about HH access.

Home health utilization was also relatively steady in 2024. About 7.9 percent of fee-for-service beneficiaries used home health. The number of 30-day periods per fee-for-service enrollees increased slightly, while the share of beneficiaries discharged to home health from hospitalization in 2024 is higher than the prepandemic level.

As I noted earlier, the number of home health agencies in Los Angeles, California, has increased

substantially in the last five years, by hundreds of agencies. The rapid rise in home health agencies in L.A. has been matched with an increase in spending, and 2024 spending in the county was over $1 billion, or about 9 percent of total fee-for-service Medicare home health spending for the year, even though this county accounts for only 2 percent of the fee-for-service population. The rate of use in Los Angeles County is about double that of the national average.

Such a substantial increase in supply and utilization may warrant closer attention. To the extent the analysis suggests that the aberrant patterns may be attributable to program integrity concerns, CMS does have some tools for responding. These include the ability to enact moratoria in localities that may have unusually high numbers of new agencies that enter the program --

MS. KELLEY: Evan, I'm sorry. We're losing your audio a little bit. Could you just move a little closer to the mic?

MR. CHRISTMAN: Okay. Sorry. Is this better?

MS. KELLEY: Yes. Much better. Thank you.

MR. CHRISTMAN: Okay. CMS does have some tools

for responding. These include the ability to enact moratoria in localities that may have unusually high numbers of new agencies that enter the program, and Review Choice Demonstration, which focuses on medical review to ensure appropriate billing.

Shifting now to indicators of the quality of home health care. Our quality indicators for discharge to community and potentially preventable readmissions rely on data we used last cycle, and these data show a median discharge to the community rate of 80.6 percent, a 1.3 percentage point increase over the prior period. The average rate of potentially preventable readmissions was about 3.8 percent in the most recent data.

The HHCAHPS measures have been updated for 2024, and these did not show significant changes compared to prior years, with the rates on these measures showing most patients had favorable views of their agencies. For example, 85 percent of patients rated their agencies highly, and 79 percent said they would recommend their agency

Next, we look at access to capital. Home health care is less intensive than other sectors. That said, we

note that the all-payer margin was 5.0 percent, indicating that overall home health agencies can yield profitable returns for investors.

The number of home health agency acquisitions has fluctuated in recent years, with big increases in 2021 and 2022 but a slower pace in years since then. But even with this slowdown, some local and regional operators continue to acquire additional home health agencies, suggesting they have access to capital for expansion.

Turning to Medicare fee-for-service margins for 2024, we can see that the margin for this year were 21.2 percent. The trend by type of provider is similar to prior years, indicating that for-profit agencies have better margins than nonprofits, and margins for urban and rural were comparable.

The 2024 margins were above 20 percent, higher than the long run average of 17.1 percent since 2001. These margins indicate Medicare fee-for-service continues to pay well in excess of cost.

This brings us to our margin projection for 2026 for Medicare fee-for-service. We project that margins will decrease in 2026 to 19 percent.

On the payment side, our estimates include the payment updates for 2025 and 2026, and we assumed a cost increase equal to average for 2021 to 2023.

This slide outlines some of the changes in payment policy in 2025 and 2026 that are included in our margin projections. As you can see, they include the payment updates for each year as well as the statutory reductions required by BBA 2018 for each year. Our assumptions reflect the policy included in the recently released final 2026 home health PPS rule.

This brings us to a summary of our indicators, which are generally positive. For access to care, the number of agencies declined by 1 percent, excluding changes in California, 97 percent of beneficiaries live in a ZIP code with two or more home health agencies, and Medicare fee-for-service per capita volume increased. For quality of care, the Medicare fee-for-service risk-adjusted discharge to community rate was stable, and the patient experience measures remained high and more stable.

For access to capital, the all-payer margin was 5 percent, and acquisition efforts have slowed but some firms continue to acquire home health agencies. The fee-for-

service Medicare margin in 2024 was 21.2 percent, and the projected fee-for-service margin for 2026 is 19 percent.

This brings us to the Chair's draft recommendation. The recommendation reads:

For calendar year 2027, the Congress should reduce the 2026 Medicare base payment rate for home health care services by 7 percent.

The implications are that this would decrease spending relative to current law, and for the beneficiary and provider implications, we expect no adverse effect on access to care or continued provider willingness and ability to treat fee-for-service beneficiaries.

This completes my presentation. I look forward to your questions.

DR. CHERNEW: Evan, thank you. This is always an interesting presentation and a very important sector. I think we should jump right into the questions, and I think the first person in Round 1 is going to be Scott.

DR. SARRAN: Yeah, great presentation, Evan. A quick question. Are we able, in California, to do some kind of parsing of utilization by beneficiaries being attributed to an accountable care arrangement versus being,

as I call it, pure fee-for-service?

MR. CHRISTMAN: That's definitely doable. We would have to think about the logistics of it. It might be something that's very challenging to do, for example, for the January.

DR. SARRAN: Right. And I think over time, since obviously -- and I'm trying not to blur this into Round 2 -- but it obviously raises questions about how home health utilization should appropriately be managed. It would be interesting to see whether ACOs and other accountable arrangements do, in fact, create an environment in which it's more appropriately managed.

MS. KELLEY: Greg.

MR. POULSEN: Thank you. Evan, thanks. Great discussion. Great presentation. The question I have is also related to California. Are there indications that this either could be the beginning of something that could happen elsewhere, or is this anomalous and likely to remain a unique situation? I'm actually going back a couple of decades, at least, maybe three decades, into the history of dialysis, where a couple of markets saw explosive growth in concentration, and then it became replicated across the

country over the next decade. And I'm just curious whether we have any indications whether this could be an early identification of a trend or if it's unique and unlikely to be replicated.

MR. CHRISTMAN: I think, you know, given that I think we see these patterns, they clearly raise issues about utilization. From my perspective, we're at the early phases of understanding exactly what's going on there. We haven't heard any fraud enforcement actions announced there, for example, but that doesn't mean that somebody is not thinking about it.

So I guess it's hard for me to say. I would note that I'm not going to be able to recall the states off the top of my head, but one of the things CMS does is they have the Recovery Choice demonstration enacted in about five states, and a lot of those are states that, in the past, raised program integrity concerns. And under that program, almost kind of a gold card program, the agencies basically have to present the medical record for each claim they file, and once you achieve a certain sort of clean claim rate you're put to a lower level.

Those types of things, I think, provide some

protection in areas that have raised issues in the past. But, you know, it's hard to say.

MR. POULSEN: Thank you.

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

MS. BARR: Thank you, Evan. That was a great report. I always look forward to this. And, of course, I'm always scratching my head about the access question, and I think you fairly presented that we don't have a good access measure. We just know that they're there. We don't know who they're serving, and things like that.

So this is not for this year. You know, I do support the recommendation. But going forward, could we look at utilization rates across populations and see if there are any disparities? Do we have the same utilization in rural that we do in urban, I think would be a really good indicator. Because I keep hearing we've got a problem, but we keep saying we don't. I know we've been talking about this for five years, and we'll talk about it again next year. But maybe next year we could have a little more data to look at, so I can go to people and say, "Look, they're getting the same service everyone else is."

And maybe also look at other underserved populations. What do you think about that?

MR. CHRISTMAN: That's certainly something we can think about. I think it is challenging to assess, in general, and when we've looked at this in aggregate there's not that big of a difference between urban and rural areas. But definitely you can find areas in rural and urban that have lower utilization. And I think this is an area that we always think about when we're looking within the payment system. This isn't to say we won't find one, but I guess I would just say that on the basis of what I know today, I don't see anything systematic in CMS's case mix, for example, that creates issues for rural agencies. That doesn't mean that there isn't one or I won't find one, but I guess can be looking in some things at the next -- they will let us look under the hood a little bit more closely and maybe we'll find something.

MS. BARR: And I know, like, you know if you average in the high utilizing states, which have a huge uptick in rural, and we talked about that, so maybe you exclude kind of your highest states. But you said you've looked at utilization and compared it and you found it to

be different. I didn't see that in my data at Caravan. I saw about a 10 percent decrease in utilization. So I don't know. Who knows, right? But I would love to see that data, and we could just see if we could better understand it.

My other question was, I was kind of surprised that with the Medicare margin being as high as it is, that the all-payer margin is 5 percent. So I was wondering if you had any insight into, is Medicare the best payer in home health? I mean, what's happening there?

MR. CHRISTMAN: So throughout my time working on home health, Medicare fee-for-service has always been the preferred payer across the different types of payers. What I will say about the non-Medicare fee-for-service margins is we don't have great visibility into them. So for example, I can't compute an MA margin. And what has been reported to us by the industry is that MA pays much lower amounts on a per-visit basis than Medicare fee-for-service.

And so I think the last five to seven years, wherever you pick the start point, as the growth of Medicare Advantage enrollment has increased, that's been a major shift that the industry has had to adjust for.

MS. BARR: That's interesting. I was wondering, particularly as I look at L.A., and of course, Robert, you just tell everyone what's going on and we can stop. You need to be next. Just tell us what's happening there. But I'm wondering about the interplay of Medicaid and home and community-based services. And are these agencies sort of dual purposing for that purpose? Are we subsidizing Medicaid to some extent here? Do you have the payer mix? Who is number two, I guess is the question?

MR. CHRISTMAN: Yeah, and I don't know, Tamara, if you've looked at this. I can't remember if you've looked at some of this. But I think it's hard to say. I think for a lot of these agencies, their HCBS business, their Medicaid business, is a large part of their book of business. But the interplay between it, we've heard anecdotal reports over the years, that sometimes, for example, if they're waiting for the paperwork on HCBS to be processed they'll put somebody in Medicare home health to get somebody in. I think because of the complexity of looking at Medicaid data and the fact that -- and you're probably more aware than I am -- that the Medicaid side is very heterogeneous in how the programs work, I haven't

really been able to build up a clear story. I'd honestly say a little bit of everything goes on.

MS. BARR: Got it. Well, I do think that California is engaged probably more in home and community-based services than many other states under the waiver. I observed, anecdotally, that there's just a lot more of those services in California than I do in other states. So I was wondering maybe there's something there that's driving that growth.

And my final question is about Los Angeles, as well, and the question of, can you look at other post-acute care and see if there is like kind of an offset? I mean, L.A., or mostly L.A., that's the home of managed care, right. I mean, they pretty much invented it. And so there is a lot of full-risk contracts there that would make sense that there's a big savings between home health and institutional cost.

So it would make sense, and I was just wondering if could see, like we looked at the PAC as a whole, whether if we looked at L.A. we'd just say, yeah, well, you know, they're just not using skilled nursing facilities anymore, and it's all positive for the program.

MR. CHRISTMAN: We can take a look at that.

MS. BARR: Awesome. Thank you. Again, I support the recommendation we're going to vote on in January. Thank you very much.

MR. MASI: And I'll just jump in for a moment.

Thanks so much for surfacing these issues, Lynn, and circling back to the issue of what data we see with respect to how beneficiaries in rural areas utilize home health relative to those beneficiaries in urban areas.

As Evan said, there is a lot of variation across both categories, but when we have looked at this in the past, we've generally seen comparable rates on average. I think you're absolutely right that there's a lot of interesting variation within that average, but we see that kind of on both sides.

But we're very happy to bring some of that information back into this chapter to add some more nuance to the discussion.

MS. BARR: I sure would love to see that geo-mapped, right? You know, I mean, I'd love that color, the color map of the United States showing, you know, the disparities by -- because, again, most of my work, you

know, a vast majority of my work was in the upper Midwest and, you know, the central of the country, which had a very different home health profile than Texas and Oklahoma.

Thank you so much.

MR. MASI: Sure.

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

DR. DILLER: Yes. Actually, Lynn asked it, the last one that she did. It was whether they were -- we were shifting to other -- or shifting out of other types of services into home health.

But the follow-up to that then is, if that's going on, or even if it's not, is there any difference in, like, LA relative to quality overall? So, in other words, I don't think you can look at the readmission rate for just home health. What you'd have to do is look at the readmission rate for the entire fee-for-service population and, you know, if they're increasing home health or whatnot, is that having any effect on quality, that's basically where I was at.

MS. KELLEY: All right, then. That's all I have for Round 1.

DR. CHERNEW: I think Gina may have had an on-point on a previous point, but maybe it's no longer on point.

MS. KELLEY: Gina, did you decide to hop into Round 2?

MS. UPCHURCH: Round 2 is great. Thanks.

DR. CHERNEW: Okay. I'm sorry. Then we'll go to Round 2.

MS. KELLEY: Okay. I have Stacie first.

DR. DUSETZINA: Great. Thanks so much.

Really great work, Evan.

I have -- this is probably bordering on Round 3 kind of question or comment, but it -- first, let me say I support the recommendation.

I had questions about two things related to the beneficiary's interaction with these services. One is about the face-to-face requirements for getting started and staying on home health. I noted in the chapter, it says basically they must be unable to leave their homes without considerable effort, and that seemed like one of those things that could be a potential barrier for people getting started with this type of service if that's like a -- you

have to go to a place of service to be identified as someone who could benefit and then go back, physically go back to another space.

So I was curious about that requirement. I realized with some of the other pieces in the chapter, it feels a little bit like there's a potential for abuse that we have to be careful about, so like you have to balance these things.

But I was wondering, you know, is some of this like people going to the beneficiary and saying that they -- you know, certifying at their home, or do you actually have to go to an office?

And then the other part is kind of related. It's like the co-pay or lack thereof, and I realize this is probably some sort of historic thing that has just stayed, but it strikes me as it's odd that there is no cost sharing for these services at all, so would love to hear a little bit from you about why those things exist as they do.

MR. CHRISTMAN: Sure. So one of the things to keep in mind about the face-to-face requirement is that it has to occur in basically a 120-day window. It has to occur either at the -- you know, you think of it, the

beneficiary's initiation of home health care, either in the 90 days before or the 30 days after. And so I appreciate your point that for beneficiaries who are homebound, this could be a challenge, you know.

One thing to remember is that, you know, often it's ordered for people coming from the hospital, and so there's a bunch of contingencies that apply here because the beneficiary physician managing the patient in the community may not be the one in the hospital. But my understanding is, you know, basically, you know, a person in the hospital can -- that can satisfy it.

The other -- so that's one thing to keep in mind is that there is sort of a broadness of the window, and in some instances, meeting with an APP can help. They can send someone to the home.

The other point I would make, I think, is that, you know, I get -- my understanding is that people -- I think people have learned to live with this requirement. In general, under the CMS's -- under the definition of homebound, you know, certain reasons you leave the home are, for lack of a better word, excused. You still meet the homebound definition, and one of those is going to see

the doctor. And, you know, last I looked at it, over 70 percent of beneficiaries go, have a doctor visit during their home health care.

And so I don't want to say that this doesn't create some complications, but I guess, you know, this was added as something to sort of tighten the loop on the ordering process. So, you know, it's definitely -- but I think, I'm sure it's challenging for some individuals, I'm sure.

On the co-pay front, I would say two things, you know, one sort of broad and one sort of more narrow. And on the broad, I will say, I think it was 2011, the Commission looked at having a co-pay, and we talked about -- we recommended adding one. There were certain conditions on it. It didn't apply to all home health episodes.

You know, on a more narrow, technical level, what I will flag is that, you know, it's -- you know, the fee-for-service cost-sharing structure is a collection of pieces, and changing one piece is challenging because you don't want -- you want to make sure that the whole arrangement makes sense. You know, for example, if we set cost-sharing for home health, we don't want to create a

situation where it might be free for the beneficiary to go to an IRF, but they pay cost-sharing to go to home health.

So I think one of the things you run into is, you know, some analysis might argue that some form of cost-sharing might be appropriate, but even if you conclude that, changing one element, keeping in mind the others, and just trying to change one can be complicated.

DR. DUSETZINA: Great. Thanks so much.

MS. KELLEY: Okay. I have Cheryl next.

DR. DAMBERG: Evan, thank you for a great chapter.

You know, I think the evidence presented particularly these very healthy margins with payments that are very high relative to cost, you know, strongly suggest a need to trim payments to home health agencies.

And so, for the record, I do support the Chair's recommendation for a reduction in payments in this sector, and I think this is a first step in moving payments more in line with costs.

One of the things that caught my attention in the chapter was the acquisition of these home health agencies by some of the large health plans in the space of vertical

integration, and I would certainly encourage the staff to continue to look at the impacts of vertical integration on prices paid across the sector and try to understand what the implications are for the Medicare program.

I mean, clearly, the large margins that we've seen make this very attractive for them to add to their portfolio, and I guess I would like to have better understanding of what we know in that space in terms of implications on costs.

And then I just want to plus-one on Lynn's comments about California. California continues to be an innovator, and I think they really have been pushing very hard on very different models of caring for people. So it would be interesting to try to unpack what's going on in California to understand whether sort of this is a net positive or whether there's some unintended consequences going on.

So thank you.

MS. KELLEY: Tamara?

DR. KONETZKA: Thanks, Evan. Great work.

A couple of comments. The first one spills over slightly into our discussion this afternoon of the home

health payment system, but clearly relevant here. I find the decline in the number of visits a little bit concerning and something that we should continue to follow. So, you know, the payment system that we have now doesn't pay on the number of therapy visits anymore.

You know, one can imagine an optimization problem where, you know, if -- the payment system right now, you know, if there are five or fewer visits or depending on the type of stay, three or fewer visits, home health agencies get paid as a LUPA, as a short stay or per-visit charge. And after that, they get the episodic payment for the whole stay. So one can imagine an optimization problem where we sort of slowly converge to six visits, right, during the month.

And so, you know, I think the convergence over time in the number of visits is not unexpected, but also a little bit concerning, because that's what home health does, right? I mean, these visits are really the fundamental service that they're providing.

And so, you know, I think that this is just something we should continue to monitor and, you know, if necessary, sort of reconsider that incentive in the payment

system to sort of reduce the number of visits, especially because it seems to be spilling over into RN visits as well.

This next comment, Evan, you won't be surprised, but I'd love to see some of the patient-level outcomes separated by those having a post-hospital home health visit versus community-initiated visit, especially things like the number of visits, right? Obviously, the margins apply overall, but I think that we've seen in the past couple of years that these populations are affected in a very different way, and we'll see that this afternoon as well. And so we have the benefit today of getting to revisit this later in the afternoon, but I think in these payment chapters, it'd be nice to do that generally.

In terms of the conversation we were just having and Evan's response about -- you know, to Stacie's question about the, you know, lack of copayments and home health, this sort of goes back to our discussion yesterday about post-acute care in general, but it'd be great to think about all the unintended consequences that these different rules set up.

You know, I think the other obvious one that has

not much to do with home health is that, you know, IRFs don't have the three-day stay requirement, and, you know, so now people, as IRFs expand, are going to IRF just because it's easier to get into an IRF than into a SNF, right?

There's lots of unintended consequences with, you know, either the copayment structure that we have or the requirements to be eligible for these services, and I think it'd be worth sort of adding that to our post-acute list to see if we can even the playing field in some way to avoid some of these unintended consequences.

And then finally, I'll say I do support the draft recommendation. You know, I think we've seen, you know, over the past however many months, you know, CMS really tried to propose a much more drastic cut and, you know, was scaled back because of fears of disruption. You know, I think these sort of high-payment-to-cost ratios over time just sort of accumulate, and it gets, you know, harder and harder to take away a payment that's already there, and so I think it's important to send a strong signal. And I think that the minus-7 seems like a good strong signal that we think payment rates are too high in this sector.

Thanks.

MS. KELLEY: Robert?

DR. CHERRY: Thank you for the excellent report. I didn't have any -- I didn't have an idea this morning that Los Angeles would be a popular topic of discussion, so I'll try to weigh in on some observations on why, you know, home health may have doubled, you know, over that five-year period that was mentioning in the slide deck.

I think first and foremost is the culture within California. So you have an aging population with a strong drive to age in place, and I think one of the reasons why aging in place is so strong is the way property tax laws are designed in California. So if you own a home and you've owned a home for a long period of time, your property taxes are relatively low compared with others, and so a lot of people that are older just want to stay in their homes because it's a cost-effective solution for them.

The other driver too is managed this is the managed care environment like within Los Angeles. So MA is north of 60 percent of Medicare enrollees, you know, versus fee-for-service.

And also, if you look at the Medicaid population too -- so in Los Angeles there's an organization called LA Care. They're a managed Medicaid organization. They have 2.7 million members, you know, as part of LA Care. So the combination of Medicaid and Medicare managed care within Los Angeles are also strong drivers for home health and safe discharges for home for people within California and Los Angeles in particular.

Because of that, there's also then technology enablers to allow for people to actually go home safely. So a lot of organizations, you know, push the envelope on remote home monitoring, care-at-home models, hospital at home. My own organization, although we don't do hospital at home. We found that there's definitely an ROI around going and providing care at the patient's home for those that have very high risk for ED visits and readmissions as just one example.

I think there's also consolidation going on. We all know what happens when there's consolidation, you know, of different sectors within health care, and that could be driving increased utilization as well.

And then you have organizations -- and I'll just

mention one, you know, Partners in Care, which is, you know, a very strong not-for-profit organization that partners with a lot of hospitals throughout Los Angeles on innovative models around case management and home-based solutions to have people safely be able to care for themselves at home.

So I think a lot of these factors -- it's not one particular lever or driving, you know, you know, home health agencies to have a, you know, presence, you know, within Los Angeles. Whether that's good or bad, I can tell you we have our own -- we have those debates within our own population health team.

My suggestion is to actually, you know, objectively measure discharge-to-home rates, you know, in Los Angeles, California, compare it with the rest of the country, and see whether or not, you know, the penetration of home health is actually a good thing, if because patients are actually being discharged to home, preventing ED visits and readmissions, then it may not necessarily be a bad thing. And so coupling it with objective data like that could help.

Otherwise, all Mike wants to hear is my support

of the recommendation, and I'll just give him a yes. Thank you.

MS. KELLEY: Scott.

DR. SARRAN: Yeah. First, I support the recommendation.

Taking off of Robert's comments, it strikes me that when we have an anomaly as high in magnitude as what we're seeing in California and LA, we've got a real learning opportunity to dive into that and get some good take-homes. And my bet is it's -- the explanation is sort of a pie chart with three pieces. One is there's probably some fraud, waste, and abuse. There almost always is, and when -- you know, when you've got that much of a proliferation and it's such easy, you know, lack of barriers to entry and the profit motive is there, there's probably some. But let's assume that's fairly small and no different than fraud, waste, abuse, as it exists elsewhere in the Medicare program.

But the other two pieces, I do think there is something with home health that -- I hate to say the process for engaging in home health, you know, or enrolling in home health, whatever, is too easy. But, in some ways,

it is too easy, meaning that, as we've been discussing, the physician involvement up front, although it is prescribed by CMS, really in practice is perfunctory, right?

What we don't have, I think, by and large, at the initiation of a home health episode is a really thoughtful, deliberative process that involves three parties, the physician, the home health agency, and the patient, which may include, let's say, patient/family, where they all have a conversation together about the current condition of the patient, the beneficiary, and the realistic goals, followed by what should be a check-in, probably two weeks or so later to revisit progress, right? And there can be a virtual -- you know, there can be some virtual process and, you know, tech-enabled and all that sort of stuff. But the point is that that's not, by and large, what happens.

So I think what we've got is a process that is not sufficiently goal-defining with sufficient physician involvement. So there's a weakness in the process. That's the second piece of the pie.

And the third may be -- and thanks, Robert, for teasing out some things I had not thought of, but what I hear you basically saying is, you know what, maybe

partially driven by the property tax things, there have been some really creative and adaptive uses of home health down the right road of how do we creatively, you know, do tech-enabled and do things to keep people safely at home. Well, gosh, if that's the case -- and I bet it is at least some of the case -- then, you know, let's dive in there and learn from that.

So that's my basic take-home is let's use the LA situation as an opportunity to learn more about what the real drivers are.

MS. KELLEY: Greg.

MR. POULSEN: I had a list of things that I wanted to say and Cheryl, Robert, and Scott said them better than I would have. So I will just say I support the recommendation and thanks.

MS. KELLEY: Paul, did you want to get in here?

MR. MASI: Yeah. Thanks so much for this conversation. And I did just want to surface that what's going on in Southern California and L.A. County is very much on our radar, and so I appreciate these ideas for building out additional analysis.

I did just want to make clear that the state

auditor, in 2022, did publish a report expressing concern over the trends in entry of providers and utilization, specifically with respect to fraud and abuse. So I did just want to make that clear, that that is very much on our radar, as well.

We, of course, have badges, so we always have to be careful when we approach those types of issues. But the program integrity issue has been raised by the state, and that's something that we're aware of.

MS. KELLEY: Okay. I have Gina.

MS. UPCHURCH: First of all, maybe some of the staff needs badges, but we'll stay away from that for now, but thank you.

This shows us why the GAO picks people from different parts of the country, because we have very different laws by state related to Medicare and home health and how we pay for health care. They say all health care is local. So thank you so much, Robert and Cheryl, for your insights there.

Just a couple of quick things. From a practical perspective, I agree with all the comments, really, but I think we do need to look at utilization, building off

Lynn's comments earlier, and don't just rely on networks but actually utilization. Because we found out from the Plan Finder tool, I think many of you probably know the Plan Finder tool with Medicare was supposed to show you what providers -- but it's only showing individual providers. It's not showing institutions. And when you dig in more to actual Medicare Advantage's, for example, network, it will show that this home health agency is in network, but when you call to actually get somebody to that rural area they say, "Oh yeah, we don't go there."

So utilization is going to be really, really important as we pursue that, so thanks, Lynn, for surfacing that.

By the way, for those of you that don't know, the Plan Finder will allow a special enrollment period for people who got bad information from the Plan Finder tool. But again, it's just at this specific level. You can't look up hospitals. You can't look up particular agencies and that kind of thing. So really, the Plan Finder is lacking lots of tools that we need to advise people. Hopefully it will get better.

The last thing I would just say is that I'm

wondering if we can look at this by the people who live alone. When live alone, it is much harder to get out and about. Now, if you had transportation, maybe you would love going to that rehab facility down the road and socializing and stuff, but you don't have transportation. So if we could break it down by living status, I think that would be super insightful.

And lastly, I really agree with a lot of the comments about vertical integration and consolidation and keeping an eye on that. Obviously, you have the impact. And Tamara's comment, I do think community-admitted and hospital-admitted home health would be important to look at.

So thanks for this great work, and yes, Mike, I support the recommendation. Thanks so much.

MS. KELLEY: Gokhan.

DR. METAN: So thank you for this great work, first of all. I really enjoyed the material. I have three comments. The first one is paying special attention to some of the home health agencies that might be more heavy on MA, serving the MA population, given again the program is more than 50 percent MA now. And the MA is paying less

than fee-for-service. Would that put some of these agencies heavily serving the MA population in an adverse setting?

The second one is around more on our approach in terms of how we are thinking longitudinally about these kinds of things. What I mean by that is, we can make evolutionary or revolutionary change into these payments. Like we can make small cuts, tiers, or we can make bigger cuts and see the effects. I don't know how we landed on 7 percent, or if that's the right approach. Why not 5? Why not 10? And if that would be a different kind of methodology in terms of approaching over time, and how we see the effects.

Like, for example, when I look from the perspective of yesterday's discussion on skilled nursing facilities and we recommended a 4 percent cut, you are saying the freestanding margin was like 25 percent. So we're saying, okay, in this space we are recommending 4 percent cut over 25, and home health, 19 percent freestanding we are recommending 7. Would it trigger any kind of resource shifts from home health to SNF? It would be kind of a disruptive balance, in other words.

I think it's worth looking into and paying special attention to. I would say these are all my kind of feedback in terms of maybe additional work for upcoming years or maybe January, if possible. But in general, I'm supportive of the recommendation. Thank you.

DR. CHERNEW: Thanks, Gokhan. Let me just jump in for a second and answer your question why minus 7. So when you get to a situation where the margins are as large as they are, which I think are distortionary, and a bunch of other challenges, not to mention our basic charge is to make sure that the fee-for-service payments that we're dealing with now are somewhat more in line, what the right number is at this point is really more of a balancing act and a judgment than, oh, it should have been 7, not 6, or it should have been 8, not 7. We're basically trying to balance concerns that we don't want to have a cut that goes too quickly and risks access to what is admittedly a very important service. We want to signal something significant has to get done.

The different with SNF, and we tend not to go across sectors but just so people understand, is in the SNF sector we were much more concerned about the potential

disruption of a cut, so we just picked a number that was a little bit less. But there's not a magic formula that we sit down with a calculator, or actually an abacus, or whatever, and decide, oh, this is the exact right number. In both sectors we're saying the margins are very high, and some cut is probably warranted, and when thinking about that cut we acknowledge that both sectors are very important, and you shouldn't try and get it all at one time. So we're just trying to do some basic signaling.

I don't think there's a particular reason why we tried to balance across. I do think your point about what would be the equivalent of the site neutralness actually does matter, and I'll say something later about the interaction between the sectors. But at this level of margins I'm much less worried that a slightly different update cut is going to move people one way or another. I think there are a lot bigger things that are going on in how this is playing out. A lot of supply stuff, a lot of access things, many of the things that I think people that have worked in this sector or follow this sector kind of understand.

So I guess what I would say to folks at home is

the signal here is the margins are very high, and we think the margins should be lower. We don't think they should go down as rapidly as one might, because we want to see how the sector responds. And within that basic framework we're just picking a number we think is reasonable, more judgment than science.

Anyway, I hope that was useful, and I think Josh is next.

DR. LIAO: Yes. Thank you for this thoughtful analysis. I won't repeat what others have covered, but just in reviewing these figures that you presented here against prior year values I'm just struck by how similar the overall picture is, but the sector appears to be relatively stable when we actually reach that comparable conclusion of the Commission.

On the access front, supply appears to continue to be strong, 97 versus 98 percent, benes living in ZIP codes with multiple agencies. The modest decline in agency count, actually 1 percent is, at least to my read, smaller than in prior years if you exclude L.A. Utilization trends, to reinforce this, the share of beneficiaries using home health have been at 7.9 percent compared to prior

years, and the number of 30-day periods increasing, as well.

On the financial front, I just want to underscore kind of my read on the cost growth remaining modest, relative to payment updates. I think there are some legitimate concerns here, such as those mentioned by the Commissioners about continued decline in a number of visits and possible shifts in service mix and how that might explain potentially cost growth versus, say, market basket changes.

I think a deeper assessment of these dynamics are probably better suited for other discussions, including our forthcoming review and discussion about changes in the home health PPS, but worth saying here.

All that said, for the purpose of the payment update I do support the draft recommendation. Thanks.

MS. KELLEY: Betty.

DR. RAMBUR: Evan, thank you for this great work. Very thoughtful and insightful, and Commissioners, I really appreciate all the wisdom you've brought to the conversation. I support the recommendation and have nothing to add to your already brilliant comments.

MS. KELLEY: Mike, that's all I have in the queue.

DR. CHERNEW: Thanks. I'm looking to see if there are folks that haven't expressed their opinions on the recommendation. Tom, I'm not sure you have, and Wayne, I'm not sure you have. I'm sorry if I missed them. But if you want to take a second, please jump in. Otherwise, I will make a closing statement and then we'll move on.

DR. RILEY: Yes, I support the recommendation.

DR. DILLER: I support the recommendation.

MR. MASI: And I'm so sorry to interrupt, Mike. Was Dana going to read --

DR. CHERNEW: Oh, right. Yeah. Dana is going to read a comment. Yes, we're still learning.

MS. KELLEY: Yes. I'm so sorry about that. I have comments from Brian. He's very supportive of the Chair's recommendation. Generally, he believes we should think about ways to better measure the long-term clinical and financial value of home health. It's a critical component of the delivery system that can help elderly beneficiaries remain in the home and outside of the hospital or institutional settings. And he believes this

is helpful to both beneficiaries and taxpayers.

DR. CHERNEW: Thanks, Dana. Thank you. Just an overarching comment here. First of all, I appreciate the support. I think it is both reasonably correct substantively, and more importantly, sort of fulfills our charge of meeting the criteria that we've been asked by Congress to impose. So I think that's all good.

But I think the comments, as always, are broader than our update charge, which is always useful to hear. And in particular, I think there's widespread recognition that in all sectors, but particularly in the post-acute sectors, there are interactions across the sectors, there are interactions with other payers, there is geographic variation. It's a really hard sector because our quality measures are never what we actually want them to be. And we have a tendency to want to impose sort of more administrative requirements, that that ends up being burdensome to all of these various organizations. And so we struggle with how to integrate all of this broadly.

I think there's been a lot of work we've done, including you'll see some of this this afternoon, as several of you have mentioned, with our mandated home

health report, but in some of the discussions we had on the SNF chapter, we did some work in the past on an integrated post-acute system, in general. This is a topic that is very, very important, very, very high on our radar. I think we're very aware that despite the sort of fragmented nature of the fee schedules, the solution is clearly not going to be quite as fragmented. And so we continue to sort of work around how we can help direct policies, many of which extend beyond just the update work, to try and help the sector improve, and make sure that people have access to the care that they need, in an efficient way.

I love your dog, Lynn. That's like the highlight of my time. I hope that goes into the transcript, by the way.

Anyhow, we understand all of those sorts of interactions. It's just a really, really hard problem to solve. Maybe some of this will come up in the payment work that we talk about a little bit this afternoon. But we will keep working, and your expertise and your insights are really, really appreciated as we try and figure out how to make sure that the payment system promotes adequate access to these services without spending more than actually is

appropriate.

Anyway, that's where we are. Let's take about a five-minute break and try and come back a little bit after 11. Stay paused on this, because we're going to stay with the same link, and we'll be back and we'll talk about hospice in about five minutes.

[Recess.]

DR. CHERNEW: Welcome back. We're going to continue to go through our update recommendations with another sector that gets a lot of attention and is important in many ways beyond just the update work, but nevertheless, we're going to go through the update exercise. And for that, Kim is going to take us through the update for hospice services.

So, Kim, take it away.

MS. NEUMAN: Good morning.

The audience can download a copy of the slides in the control panel on the right side of the screen.

So next, we're going to talk about hospice. Like other presentations, we'll cover six topics today. First, I'll provide an overview of hospice. Then I'll summarize results from four categories of payment adequacy

indicators, beneficiaries access to care, quality of care, access to capital, and the relationship between fee-for-service Medicare payments and hospice's costs. Then we'll conclude with the Chair's draft recommendation.

So first, we have a slide with background on hospice. I'll just highlight a few points.

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 enrolled in hospice as long as the physician certifies they continue to meet this criteria.

Fee-for-service Medicare pays for hospice for both beneficiaries in fee-for-service and Medicare Advantage.

Medicare pays hospice providers a daily rate for each day of beneficiaries enrolled. There are four levels of hospice care. Routine home care is the most common level, and there are two RHC payment rates, a higher rate for the first 60 days and a lower rate for days 61 plus. Despite this rate structure, long stays in hospice tend to

be more profitable than short stays.

The hospice payment system includes an aggregate cap that caps the total payments a provider can receive in a year. Because the cap is applied in the aggregate across the provider's entire patient population, a hospice can furnish a substantial amount of long stays and remain under the cap.

So here's a snapshot of hospice in 2024. There were over 6,700 hospice providers. These providers furnished care for over 1.8 million Medicare beneficiaries, including more than half of decedents. This involved 148 million days of hospice care, and beneficiaries on average received 3.9 visits per week from hospice staff. Medicare total payments in 2024 were just over $28 billion.

As we consider hospice payment adequacy, we'll use the same general framework as you've seen in other sectors. One difference, though, is that we'll present margin estimates for 2023 instead of 2024, and this is because the data needed for the hospice aggregate cap calculations lag.

So first, provider supply. Between 2023 and 2024, the number of hospices increased by 2.6 percent. All

of the net growth in provider supply was accounted for by an increase in the number of for-profit hospices.

Prior to 2024, we observed a several-year period of rapid growth in the number of hospices, driven by large increases in a few states where CMS has highlighted program integrity concerns.

Since mid-2023, CMS has been conducting an enhanced period of oversight for new hospices in Arizona, California, Nevada, and Texas.

Next, we look at hospice use rates among Medicare decedents. In 2024, the overall share of Medicare decedents who used hospice increased to 52.9 percent, up more than 1 percentage point from the prior year and a new high.

Looking at hospice use by decedent characteristics, the hospice use rate increased in 2024 for all subgroups examined, such as by age, race, and rural and urban location.

Now looking at a wider set of access indicators, they are positive. As discussed, the share of decedents using hospice increased. In 2024, the number of hospice users increased by over 4 percent, and the total number of

hospice stays increased by over 7 percent.

Among decedents, average length of stay increased 3 days to just under 100 days, and median length of stay increased by 1 day to 19.

Average number of visits per week increased slightly, but remained below the 2019 level.

Next, quality. Measures of hospice quality were generally stable in the most recent data. Performance on the hospice CAHPS measures were stable. Of the eight measures, seven were unchanged, and one improved slightly.

Performance on a composite measure of seven processes of care at admission improved slightly, but was topped out for most providers. Provision of visits at the end of life is also a measure of quality. For the median hospice, the share of patients receiving nurse or social worker visits on at least two of the last three days of life increased slightly, 2 percentage points in the most recent period.

So next is access to capital. Overall access to capital appears positive. First, it's notable that hospice is less capital intensive than most other Medicare sectors.

In terms of for-profit hospices, we saw a 5

percent net increase in for-profit providers in 2024, suggesting capital is accessible to these providers. Also, reports from publicly traded hospice companies indicated generally strong performance in 2025.

Mergers and acquisition activities have slowed in the last couple of years, but financial analysts indicate the hospice sector continues to be viewed favorably by investors.

In terms of non-profit hospices, we have less information on their access to capital, and provider-based hospices have access to capital through their parent providers.

So next we have margins. Different from other sectors, we have historical margin data through 2023 because of the standard data lag in calculating aggregate cap overpayments.

First, looking at the chart on the left, the fee-for-service Medicare margin in 2023 was 8 percent. The 2023 margin declined from the prior level of 9.8 percent, reflecting growth in cost per day outpacing payments per day. This was due to several factors, the largest being the sequester, which went from being partially reinstated

in 2022 to fully reinstated in 2023.

On the right side, we have margins by type of hospice in 2023. Freestanding hospices had higher margins than provider-based hospices. Margins also vary by ownership. For-profit hospices had a substantial margin at about 14 percent. The overall margin for non-profits was minus 1 percent. The margin for non-profit freestanding hospices, though, was higher at about 3 percent. Urban hospices had slightly higher margins than rural hospices, 8 percent versus 5 percent.

We now have our margin projection. For 2026, we project a margin of about 9 percent. We arrive at that projection by starting with the 2023 margin and making several assumptions. In terms of revenues, we incorporate the statutory payment rate increases for future years. We also incorporate the increased payment penalty on hospices that don't report quality data.

In terms of costs, we take into account observed cost growth of 1 percent in 2024, and for 2025 and 2026, we make assumptions about cost growth based on historical trends. We also incorporate additional administrative costs related to implementation of the new hospice patient

assessment instrument beginning fiscal year 2026.

So, to summarize, indicators of access to care are favorable. Supply of providers continues to grow. The share of decedents using hospice, the number of hospice users, and total days of care all increased. Length of stay increased. In-person visits per week was stable. For quality, measures of patients' experience from CAHPS were stable. A measure of visits at the end of life increased.

Access to capital appears positive. The 2023 aggregate Medicare margin was 8 percent, and the 2026 projected margin was 9 percent.

Based on our positive payment adequacy indicators and the projected margin, the Chair offers the following draft recommendation. I'll read it: For fiscal year 2027, the Congress should eliminate the update to the 2026 Medicare-based payment rates for hospice. In terms of implications, the recommendation would decrease spending relative to current law. In terms of beneficiaries and providers, we expect that beneficiaries would continue to have good access to hospice care, and the providers would continue to be willing and able to provide appropriate care to Medicare beneficiaries.

So that concludes the presentation, and I turn it back to Mike.

DR. CHERNEW: Kim, thank you. I'm sure there's a lot to say here.

Again, all of these sectors are tricky, but let's start with Round 1, and I think, if I have this right, Stacie is first in the queue.

DR. DUSETZINA: Thanks so much, Kim.

The question I had was on page 11 of the chapter where you're talking about rural and urban beneficiaries' access to hospices. You mentioned that some urban hospices provide services in rural areas, and I was just curious, like, how do we know that? Is it, like, where they report that they cover service, like, areas, or is it, like, actual beneficiary use data?

MS. NEUMAN: So, on the hospice claim, the benefit -- the hospice reports the location where the care occurs. So we can look at geographically where care is occurring.

DR. DUSETZINA: Okay. Great. Thank you.

MS. KELLEY: Okay. I have Lynn next with a Round 1 question.

MS. BARR: Hi, Kim. Great work, as always. I really enjoyed reading this.

So my question is, first of all, I'm super excited to see that half of the decedents had hospice care. I mean, you know, having watched hospice sort of be born in Northern California and see where we are now today is just really amazing that this has become a benefit and that it's doing so well.

And so my question -- so, you know, we know about, like, the benefits to the decedent and the family, but we've also had, you know, a lot of aspirations about how this can replace a very expensive end-of-life care. And I wonder, is there analysis that's been done that really looks at what is the impact of hospice? Did that happen? You know, we always think, like, we're going to do this and that's going to reduce care, you know, these other costs over here, and a lot of times, it doesn't happen. So I'm kind of curious. Have you looked at that, and do you see an impact on end-of-life care costs based on 50 percent of decedents now getting hospice care?

MS. NEUMAN: So that is an issue that there's been a variety of different work done on and is still sort

of ongoing.

The literature is really mixed in terms of its findings on what hospice's effect is on Medicare spending. The Commission did a study back in 2015 that showed that there may not be an overall effect, but there have been other studies and some recent ones that have suggested that hospice may, in aggregate, reduce Medicare spending, and the Commission has work underway now as well looking at that question.

So we'll be able to come back at some point and give you more information on sort of the latest lay of the land on that, but I would say that it is very methodologically tricky, and thus far, the literature is mixed.

MS. BARR: Thank you. I appreciate the comment about 2015, because I think the hospice program in 2015 is very different than it is today. I remember it wasn't -- like, our average length of stay was, like, a week. You know what I mean? Everybody got hospice, you know, the last week of life, or they were there forever, you know, so it was very interesting.

So I'm very excited about the improvements.

Thank you very much for the work.

MS. KELLEY: Gina.

MS. UPCHURCH: Yeah. Kim, thank you, as usual, for a wonderful chapter and for your hard work. Your expertise is greatly appreciated by the Commissioners.

Just a couple of brief questions. I don't see any mention of pastoral care, and I don't even know if that's a requirement. I see social work, but is pastoral care a requirement, and how is that cost included?

MS. NEUMAN: Yes. So the hospice is required to have spiritual care available to patients, and that is part of the conditions of participation, that they either must provide it or facilitate it if they are not able to. That would be included on the cost report. So there would be costs associated with that on a cost report. We don't see that on the claims. Like, we see nurse visits and things like that, but we don't see pastoral visits on the claims. But we do -- the costs that you're getting in these margins should incorporate that.

MS. UPCHURCH: So when we see this breakdown of who's doing what, it just leaves pastoral care or spiritual care off, because it's based on claims?

MS. NEUMAN: Right. So okay. There's two sources of data. So we have the cost reports, and the cost reports give us information about the costs, and that's how we calculate the margins, and pastoral care is included in there.

We also have claims, which is a source of information about, on each day, if a patient was getting a visit and what kind of visit and how long. Pastoral care is not included in that reporting.

MS. UPCHURCH: All right. Thank you.

Second question, it mentions volunteer cost, and I'm not sure what that means. I mean, I know we have volunteers as senior pharmacists. So it costs money to oversee and work with volunteers, but what is volunteer cost in hospice?

MS. NEUMAN: Yeah. So that is an issue that's always been a little opaque. So hospices are required, as part of the conditions of participation, to have a volunteer component, and so there are some costs associated with volunteers that are considered allowable costs on the cost report. And we've never been able to really get into what is in that category.

You know, you could imagine maybe there's a coordinator who's coordinating them, and maybe that could be, but we don't know.

So the long and short of it is, it's a very small amount of money in that category. If it's in the allowable line, it's in our margin. If it's in the non-allowable line, it's not.

MS. UPCHURCH: Okay. And the last question -- and I couldn't find it right as we were preparing for this, but I know somewhere in the chapter, in a footnote, I think it said something that, you know, after the person passes and social worker is in touch with the family or whatever, that that's no longer covered by hospice. I was just like, how is that possible? Who's paying for that? Am I imagining things?

MS. NEUMAN: I think what you're referring to is the bereavement piece of the hospice benefit. So hospices are required to offer bereavement services to the family members of deceased hospice patients, and it's maybe about for a year period, possibly. Hospices have discretion.

MS. UPCHURCH: It's for a year. It's for a year. Yeah.

MS. NEUMAN: Yeah. And so they are required to have some bereavement services. The statute says that we cannot pay for the bereavement services. It's explicit in the statute. And so, for that reason, that's sort of what's in the footnote that you're alluding to is that they are required to provide it, and we provide some information about how much it costs based on the cost report, but Medicare's payment is not intended to incorporate it.

MS. UPCHURCH: That's interesting. I don't know why that is, but apparently, there's healthy enough margins that it gets covered. So thanks.

MS. KELLEY: Cheryl, do you have Round 1 question?

DR. DAMBERG: Yeah, I have a couple.

Kim, thank you so much. This is an excellent chapter, and this is an area that's so important for Medicare beneficiaries and their families.

My first question related to -- I think this was on page 8 -- that there was a note that Medicare continues to pay the Part C rebates when a person enters hospice for MA enrollees, and I was trying to understand why that's the case or what that money is being used for. That's maybe a

bigger question, but I don't know if you know.

MS. NEUMAN: So I don't entirely know the original rationale.

What I can tell you is that within supplemental benefits, there is some reduction of cost sharing that occurs in some plans, and when a beneficiary enrolls in hospice, the hospice is responsible for the care that is related to the terminal condition and related illnesses, and if the beneficiary needs care for something unrelated, then that is covered outside of hospice.

And so, theoretically, a Medicare Advantage beneficiary, if they were getting unrelated services and they happen to be in a plan that had that cost-sharing reduction and they went to a network provider, they get that benefit. So that is one piece of where there could be some of that going on.

DR. DAMBERG: Okay, thanks. That's a helpful clarification.

And then I know when you were focused on your indicators of capacity, you noted that it does not capture either the size of the providers or the size of the service areas, and I was curious whether the Commission has ever

done any research to kind of infer those service areas based on utilization, because I think you noted -- I'm trying to remember who made the comment -- that you know where the hospice service took place. And so I don't know if you can maybe broaden your indicators of supply or enrich them in some way.

MS. NEUMAN: So we haven't tried to scope out what might be the sort of implied service area of each provider. I think theoretically that's possible.

DR. DAMBERG: Okay.

MS. NEUMAN: We should think about that and whether there's a way that we could do something that would provide some additional information.

DR. DAMBERG: Yeah. And I would just ask that the staff think about it, whether it would add significant value, because I realize you have trade-offs in terms of how you can spend your time.

And then my last question was -- I think there was a statement in the chapter that said patients with the same clinical condition have longer length of stay in for-profit hospice versus non-profit, and I don't know whether you've dug into that to try to understand. You know, are

they really patients with the same conditions, and what might account for those differences?

MS. NEUMAN: So we've looked at it at sort of the terminal diagnosis that's reported on the hospice claim to see, you know, if you control at that level, what does length of stay look like across different providers? We haven't looked -- you know, there's other -- you could try to go deeper and look at, you know, pre-hospice patterns of care. Did they have hospitalizations? Maybe HCC scores? We could think about things like that to see if you tried to control further, something claimed it.

DR. DAMBERG: Yeah, that's helpful. I mean, I recognize that the data may be less than optimal to try to unpack this, but I just thought that was an interesting finding.

That's it. Thank you.

MS. KELLEY: Okay, Mike. That's all I had for Round 1. Shall we go to Round 2?

DR. CHERNEW: Yep. That matches with what I had too. On to Round 2. Thank you, everybody.

MS. KELLEY: Stacie, you're first.

DR. DUSETZINA: I'm quick on the buzzer today. I'm going to get the first round. Thanks again. I will plus-one on Lynn's comment about how positive it seems to me the increased use of hospice overall and the increased number of days both at the mean and median stays. So I think that seems like great news.

I had a couple of questions, as I was going through the chapter, and some of them are mainly just clarifications that I think would be helpful. One is on page 21; you mentioned some recent studies raising questions about the effect of the cap on outcomes and spending. And I wondered if you would be able to put like a couple of extra sentences there to just describe what those studies are finding, what questions that they're raising. Because I think that for those of us who don't spend as much time studying this area or thinking about this area, I think that would be useful to understand.

Also, there were a couple of things I noted throughout that you flagged. On page 32, you mention a change in like an insurer purchasing a hospice. And I wasn't sure if that was like the first time that's happened or like it's just because it's a large insurer. But I was

trying to work through in my mind the interaction between a large health insurer that has MA presence and also owns hospice. And so I think that's interesting and notable and probably worth kind of tracking over time.

I also really appreciated your note about the over-the-cap spending. When I first saw the percentage, it was something like 28 percent of hospices had over-the-cap spending, but then you drilled down that it's kind of concentrated in a few states. And so I thought in future work it will be helpful to think about what does that mean for those states, like why is that happening. I know you mentioned that this is something that CMS is looking into, as well.

The one thing I also just wanted to note is that distinction between the for-profit and not-for-profit. Table 9,10 in the chapter does a nice job of laying out the change in the margins by those different groups. And I think my initial impression was that nonprofit was a small subset of beneficiaries, because it is a relatively small subset of providers. But you do a nice job of showing it's like 42 percent of beneficiaries being treated in those sites. And they have very, very slim margins, and even go

negative in the most recent year.

So it just sticks out to me as kind of a stark contrast between the for-profit and nonprofit, what happening in their margins. And I'm not exactly sure what to do about it or make of it, but it stands out. And then when thinking about update recommendations, you know, it's another one of those things where on average across everyone it's very high, but there are these distinctions.

All that said, I am supportive of the Chair's draft recommendation. I think it's an excellent chapter, and I look forward to continuing to see the support for hospice providers, moving forward. Thanks, Kim.

MS. KELLEY: Scott.

DR. SARRAN: Kim, great work, and I support the Chair's draft recommendation. I continue to be concerned about the quality issues in hospice. Reading from page 26 of the pre-read, referring to the CAHPS survey results, we say that 10 percent of patients and formal caregivers give the bottom rating -- the bottom rating -- on help for pain and symptoms, i.e., reported that the patient sometimes or never got the help they needed for pain or symptoms. And 9 percent gave the bottom rating on providing timely help,

i.e., reported that the hospice team sometimes or never provided timely help. You go on to say that those figures were similar to the prior period.

I mean, I truly believe that we should look at those kinds of occurrences as analogous to never events in the hospital. I mean, essentially, the promise of hospice is and always has been that somebody will be there alongside the patient and family at the critical moments, whether they're in the last days or hours of life or they're in the time during the times when symptoms are difficult, burdensome, distressing to the patient and/or caregiver. That is the reason for being in hospice.

And the concept, again, that sort of the promise, or the flip side of that being the never event nature to failing to deliver on that promise, I really think it's analogous to, for example, wrong-side surgery. And my understanding is the way CMS deals with wrong-side surgery is they consider that service not reasonable and necessary, and therefore they don't pay for it, because CMS pays for care, Medicare pays for services that are reasonable and necessary.

So maybe more for this afternoon's follow-up

discussion. Yes, I support the Chair's draft recommendation, so I'm not suggesting that it change or an addition to that. But I really think part of better aligning, particularly in the out-of-hospital space, better aligning what we pay for, how we pay, with the care that we want our beneficiaries to experience, we should consider moving towards -- it may take some time -- a recommendation that there be non-payment for all or part of the hospice service when there is the lowest rating on the pain and symptom management or the responsiveness in the last portion of life. Thanks.

MS. KELLEY: Cheryl.

DR. DAMBERG: I support the Chair's recommendation, and I had a few comments in addition.

So I want to give a big plus-one to what Scott just said. I do think it is concerning that 10 percent of CAHPS respondents gave the bottom rating on managing pain symptoms. This is precisely the sweet spot for hospice. And Scott referred to them as never events. I think we should be trying to drive that number close to zero. I recognize it won't be zero in most cases, but it should not be 10 percent. So I think we need to continue to spotlight

that issue and to try to determine what could be done to better support patients at this point, at the end of their life.

The other thing that caught my eye was the decline in rural hospices over five, six years. I think that Commission needs to continue to keep an eye on this, to ensure access for rural beneficiaries.

My third point is I noted that you're going to continue to carry our research related to the cap. I think that's really important work, particularly given the bifurcation of the types of beneficiaries that we're seeing in the hospice data.

And then, lastly, I will make a plug for -- it sounded to me like we still don't have access to information on telehealth, and I can't recall whether CMS is intending to collect that data. So I might need a reminder of that and perhaps we need to put that in the chapter. But if that's not happening, I do think that we need to be capturing that information, moving forward. Thank you.

MS. NEUMAN: One clarification on the telehealth, if I could. When the public health emergency ended, CMS

withdrew the ability to do the telehealth. So it's no longer a supplemental service to providers.

DR. DAMBERG: Yeah. It might be helpful to clarify that in the chapter.

MS. NEUMAN: Yeah.

DR. DAMBERG: Thanks, Kim.

MS. KELLEY: Lynn.

MS. BARR: Kim, I had one follow-up question. Is the growth of home health agencies and the growth of beneficiaries that are actually participating, are they tracking each other? Is this a supply-side driven kind of utilization?

MR. MASI: And maybe just clarifying, you may have said home health.

MS. BARR: Oh, did I say home health? I meant hospice. I apologize. Hospice, yes. Thank you.

MR. MASI: Oh, good. I could see Kim's expression, and I was reading her on the screen.

MS. BARR: And the transcript. It'll be in the transcript.

MS. NEUMAN: So on the agency piece, especially in the last couple of years, before 2024, we had a real

large increase in the number of agencies, and it was concentrated particularly in a few states. And in California, in particular, the auditor noted that the number of agencies was outpacing any demand. So I think that it's hard to draw a conclusion about sort of agency growth and the bene growth, because it has been skewed by these states in recent years.

MS. BARR: Understood. The reason I bring it up is, you know, I support the Chair's recommendation, but I'm trying to understand how this fits into the whole ecosystem. And do we want to encourage the growth of hospice because is it really reducing end-of-life care. Does making it less attractive for hospices to start and to grow, are we hurting ourselves? You know, it will save a percent over here but miss 10 percent because of end-of-life costs.

So I want us to be cautious, because if this is something we want in that the growth of these organizations are driving utilization, then we might not want to get in the way of that, and shaving a percent here or there off of their profit margins could actually work against us. So that's just what I'm trying to put together in my head.

I would also like to make a comment. I really appreciate what Scott and Cheryl are saying about these never events. But the challenge is, in a rural community, it might be an hour's drive to get to that patient. And you cannot possibly staff enough to be able to reach all of those patients in a timely way. So you wouldn't be able to even get that staff in these rural areas.

So I was curious if you looked at some of those never events, if you could break it down by rurality or urban, because it's certainly a lot harder to get to people, and that, of course, is going to affect the overall benefit. But you wouldn't want to not get the benefit, right. So if you start thinking about, well, you know, we're not going to pay them for those, if that patient had one of those events, well, maybe we might not have access anymore in areas where you can't easily reach them. So we just have to balance all of that for the rural populations.

Great work. I'm super excited that hospice is doing well, and I just want to know, like what are we getting for it in the future. Thank you so much.

MS. NEUMAN: Lynn, if I could just add one point to the discussion we were having before about the number of

providers and the number of beneficiaries using hospice. One additional piece of context to consider is that we're seeing hospice use rates increasing in states where the number of providers is not increasing. So the number of providers is not necessarily an indicator of capacity, because hospices can hire more nurses and more aides. So in one the hospice may be small, another may be really large, and so the number of providers shifting is not necessarily an indicator that beneficiaries might be getting more or less hospice.

MS. BARR: Thank you. Thank you very much for that, Kim. I think the exciting thing that we see is an acceptance of hospice, that we didn't see initially. That wasn't culturally sort of acceptable across the provider space. In fact, I'm happy to see they are getting this help just warms my heart. Thank you so much.

MS. KELLEY: Robert.

DR. CHERRY: Yeah. Thank you, Kim, for an excellent summary and an excellent report. You know, on a personal level I just have a lot of respect for the work that palliative and hospice care providers perform. They are critically important to providing holistic care. And

it could be a little demoralizing for some to see that we are moving towards a payment decrease.

But I just want to emphasize that all because we may be voting on that, that doesn't mean that this is not a critically important sector, and that we greatly appreciate the work that many of them are doing for our patients and our communities. So I just wanted to say that.

And then in terms of the work over the years, just consistent with Lynn's other comments, a lot of advancements have changed the culture around the acceptance for hospice and palliative care. I think there are improvements in various parts of the country around goals of care conversations, getting advanced directives, and moving palliative and hospice care not as an impatient service but as an outpatient service, and even being provided within the home, too. That work should continue.

I do agree with Scott that there are probably improvements that can be made in symptom management, but there are limitations. Lynn mentioned one in terms of rural areas. I think also sometimes areas can provide that, cannabis for medical use, but it may be limited in other areas. So those could be factors, too, in terms of

providing the type of palliation that's needed towards end of life.

And the other thing I wanted to mention was just regarding the survivor benefit, because a lot of people don't realize that that's an important underpinning around hospice care in terms of the counseling and bereavement services that is provided. I do find, though, that there is variability among hospice providers in providing that benefit to surviving family members, and I think this may be, in large part, because it's not a direct Medicare benefit. It has to come out of the margin of hospice care provider companies. And that may account for some of the variability.

So the next time we're talking about palliative and hospice care, separate from the payment updates, we may want to sort of revisit are there stronger ways of actually supporting the survivor benefit than what we're currently doing.

Otherwise, I appreciate the report and I'm supportive of the Chair's recommendation.

MS. KELLEY: Gina.

MS. UPCHURCH: Yeah. First, I support the

Chair's recommendation, and I just want to reiterate Robert's comment that he just made, that the survivor benefit or the bereavement services are really critical, and taking a look at that to see the disparity in who is providing it, not if it's based on payment would be a really important thing for us to do.

I also agree with Scott and Cheryl and Lynn's comments about the idea of having never events. I do find that people are shocked when the realize what hospice does and does not do. So, you know, there's not a nurse that sits there. You know, they do symptom management and that kind of thing. They don't stay with you. So I think families are really stressed out oftentimes, especially if they can't afford to get help, 24/7 help towards the end of life.

So it'll be interesting to tease out if we asked people about these horrible events, when their symptoms are not well controlled, if there are other things that conflate that response. So we do need to dive into that a little bit more, because we do need good symptom management, obviously, towards the end of life. And there are so many compassionate people to make sure that does

happen, but when it doesn't happen we need to understand it a little bit better. So thank you for those comments.

Cheryl brought up something earlier about the rebates, and I know we're going to talk about this later, but I have a problem with Medicare Advantage still getting paid rebates when they're not really providing the benefits. If people aren't seeking dental/vision/hearing care during this time period, why is the privatized Medicare Advantage plan still receiving the funding? Because hospice is supposed to be giving you the adult diapers and that kind of thing, the things that you would need. So you don't need to use that cash benefit necessarily to get those things.

Now some Medicare Advantage plans have cash benefits that could be used for other things, and I'm sure people appreciate that. But if a lot of that rebate money is set aside for things people aren't getting when they're already on hospice, then I have a problem with us continuing to pay for that. So I do think we need to look at that. Not a part of this recommendation but something we need to dive into.

And lastly, Stacie's comment about the for-profit

and the not-for-profit. I mean, I know the margins there. I just thing understanding that a little bit better, why are the for-profit companies able to have such healthy margins? What is or is not happening that maybe the nonprofits can learn from, or vice versa? I think we just need to know a little bit more about that, because it is concerning, the disparate margins.

Thanks for this work, and again, I agree with the Chair's recommendation.

MS. KELLEY: Greg.

MR. POULSEN: Thank you. I am supportive of the Chair's recommendation, but with some real hesitation, candidly. And Gina just brought it up again, but it very much relates to what Stacie initially brought up regarding the not-for-profit issues. I'm concerned that this isn't something where there's simply greater efficiency. In the chapter you mentioned, Kim, that the not-for-profits tend to perform better on the CAHPS scores, and I think that goes very much to what Scott was just saying. And I'm concerned that we may be negatively impacting the organizations that are performing the way we want them to, in order to pay less to organizations that maybe aren't

living up to our expectations. And that concerns me a little bit.

So again, as I said, I support the Chair's rec because I don't think we can do what I think could be done in the period of time we have remaining. But going forward I would strongly encourage us to look at something that maybe riffs off of what Scott was saying. Can we find ways to reduce pay when services aren't being performed at the level that we should expect? And that would end up with a global pay reduction were that to occur, or we would see performance improve and probably it's not free -- to Lynn's point -- it's not free to meet people's need in the home health setting, and it probably would require an increased number of visits. It would probably require more time. It would certainly require more medication, for example. I mean, there is a series of things that it's not free to meet people's needs.

So as I said, I'm supportive of the Chair's rec, but I'd like to see us get to something that's a little bit more directional -- maybe we'll talk about this this afternoon -- but more directional in terms of rewarding what we really want from hospice, which is people that are

comfortable, as comfortable as they can be, both for the beneficiary and the family that surrounds them. And I'm concerned that our recommendation may penalize the organizations that are meeting the needs, because we're overpaying for organizations that are not meeting the needs as effectively.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you so much, Kim. I just want to acknowledge this great work and the depth of knowledge that you have on the details and also the great questions from the Commissioners. I wasn't aware of this issue of the volunteers, you know, the bereavement piece.

Just a couple of comments. I hear Lynn's thoughts about growth and others talking about this, and I think the growth really we're looking for is in the well-executed, well-executed hospices.

And another thing for the future, which isn't directly for this recommendation, is that the nature of dying is changing, right? Stage 4 cancer can become a chronic condition for some people, more people with dementia. So as future work down the line, I think that needs to be in the mix.

I did want to comment about the rural-urban difference. I did home delivery, home care in Chicago and later in western North Dakota and frontier counties, and I was actually stunned at how similar the issues of the logistics of getting places were. The details of it were different, right? The traffic, the distance in the western states, but there's a lot of complexity with that in concentrated urban areas in very different kinds of ways, at least in my experience.

And then a number of you have talked about this, Greg just now, Scott earlier, aligning payment towards what is needed is really, really critical.

As Scott said so well, I mean, pain and symptom management is what this work is all about, and these are people at the most vulnerable times of their lives.

So I strongly support the Chair's recommendation. I do think there is a line of work here that will need to continue, and I appreciate all your thoughtfulness so much, and thanks again, Kim.

DR. CHERNEW: If I'm right, Dana, that was the last person in the queue?

MS. KELLEY: Yes, but I have a comment from

Brian.

DR. CHERNEW: Okay. So, before we do Brian's comment -- actually, do Brian's comment first, then for those of you that haven't spoken or said what you feel about the rec, I'm going to go to you right after Dana reads Brian's comment.

MS. KELLEY: All right. Brian says he's very supportive of the Chair's recommendation. He believes hospice should be a part of the Medicare Advantage benefit package in order to avoid adverse selection at the end of life and promote balance between the two formulations of Medicare benefits. While practitioners have reasonable fears of access restrictions, there are operationally-oriented regulatory and sub-regulatory policy levers available to address this.

He remains concerned about length-of-stay management practices in the hospice industry. Increasingly, hospices approach hospitals and ask them to administratively discharge patients who are expected to pass away quickly, with the patient physically remaining in the hospital bed for a day or two, cared for by a hospice nurse and physician. This lowers the length of stay for

the hospice to counterbalance a tail of long-stay patients. This does not respect the spirit of hospice nor the payment rules surrounding it. The Office of Inspector General or GAO should study this practice.

And back to you, Mike.

DR. CHERNEW: Okay. so there's a few people that haven't said what they thought about the rec. I have no idea how to order all those things. It seems to come all at once, but if you haven't spoken and you get the chance to, now's the time.

DR. RILEY: Mike, this is Wayne. I support it. Thank you.

DR. DILLER: And this is Tom. I support it.

DR. METAN: Hi, Mike. This is Gokhan. I support the recommendation.

DR. LIAO: Josh, support.

DR. CHERNEW: Okay. I think that's everybody, so thank you.

Kim, thank you.

I do want to say a few summary things before we break for lunch. The first is I think there's a lot of agreement amongst all of us about a number of things;

first, the importance of the sector, the incredible compassion of hospice workers. The potential for efficiencies here, you can both improve patients' experiences and save money if this is done well, and we have to acknowledge that potential. Concern about places where that potential is not being met -- and I think, again, it's very challenging because the quality measures are, broadly speaking, difficult. But I think we really do want to make sure that there's people that are getting the care that they need within the limitations that we face.

I'm actually quite sympathetic to what Greg said, that we want to avoid what I'd call a race to the bottom, where we have the payment rate calibrated to the lowest quality, say, stinting organizations, driving out the ones that are providing the access and the care that we need.

In fact, I'll just say I view the recommendation, honestly, as a little bit timid, given where the margins are, for exactly that reason. So it's hard when you see some of the projected margins to say, yes, we should just pay all of this in a whole bunch of ways, but it's also the case that we want to be very mindful of what you said, Greg, that we don't want to make big cuts. Normally, I

think we would have probably recommended a bigger cut or, you know, instead of a freeze, if you will, a direct cut, which we haven't done.

But, again, as I said to an earlier question by Gokhan, this is a little bit more of an art than a science to know what the right measure is. So we're trying to sort of push the margins in a particular direction, know clearly we want to make sure that people have access to the important hospice services, and not drive out organizations that we really rely on to provide high-value care.

So, anyway, that's where we are. I appreciate all of your comments.

For those of you at home, I'm sure you have comments. We get letters that we read from many of the related organizations, so thank you for sending the ones that you've sent. If you want to send more, you can reach us at meetingcomments@medpac.gov.

And I think our schedule now is we are going to break for about an hour. I think we're going to come back at 12:45, if I have that correct, Paul?

And I love it when they get the thumbs up from Paul. It's like the highlight of my day.

So we'll be back at 12:45. We're going to start with dialysis, then we'll move into a broader payment topic, which I actually think is going to be very consistent with much of what we've heard over the last day and a half. And then we'll focus on the two mandatory reports, home health and ambulance. So that will be our afternoon schedule.

But for now, remember, everybody, to log off of this link. There'll be a new link for this afternoon. And for those of you at home, please join us. We'll see you at 12:45.

And again, Kim, thank you and thanks to the staff in general for all this work.

[Whereupon, at 11:56 a.m., the meeting was recessed, to reconvene at 12:45 p.m. this same day.]

AFTERNOON SESSION

[12:47 p.m.]

DR. CHERNEW: Good afternoon, everybody. Welcome back for our Friday afternoon session. We are going to continue with one session on update work. In particular, in a minute, Nancy and Grace are going to take us through the dialysis work, and then we have a few other chapters, including two on mandated reports.

But in any case, without further ado, I think Grace is going to start to talk us through the dialysis materials.

Grace?

DR. OH: 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 this presentation, we will go over the outpatient dialysis payment update for calendar year 2027. We will begin with an overview of this payment system and walk through our payment adequacy analysis and end with the Chair's draft recommendation.

Outpatient dialysis services are used to treat

most patients with end-stage renal disease or ESRD. Since 2011, Fee-for-Service Medicare has paid dialysis facilities for each treatment they furnish using a defined ESRD bundle. The bundle includes drugs, lab tests, and other ESRD items and services. Medicare also pays an add-on payment for certain qualifying drugs, supplies, and equipment.

In 2024, there were roughly 240,500 fee-for-service beneficiaries on dialysis, receiving on average 2.8 dialysis treatments per week at around 7,600 facilities. Total fee-for-service spending for dialysis services was about $7.6 billion.

In our payment adequacy analysis of Medicare's payments for dialysis treatments provided to fee-for-service beneficiaries, we look at the same indicators as in all other sectors, including beneficiaries' access to care, the quality of care, providers' access to capital, and fee-for-service Medicare payments and provider costs.

One notable difference for this sector is that we have more clinical information to examine quality of care, including dialysis adequacy and anemia management, because such data are reported on the fee-for-service claims,

dialysis providers submit to CMS.

We assess beneficiaries' access to care by examining the industry's capacity to furnish care, as measured by the number of in-center dialysis treatment stations. Between 2023 and 2024, the capacity of dialysis facilities declined by 1 percent. However, the number of all Medicare beneficiaries on dialysis in both fee-for-service and MA also declined by 1 percent during this time.

We consider beneficiaries enrolled in fee-for-service or MA for our analysis of access because a statutory change in 2021 allowed all beneficiaries on dialysis to enroll in MA. Although we see a significant shift in enrollment from fee-for-service to MA beginning in 2021, the number of fee-for-service dialysis treatments per beneficiary per week remains steady at 2.8, indicating that fee-for-service beneficiaries with ESRD continue to have access to dialysis services.

The decline in capacity between 2023 to 2024 may be in response to a decline in demand for ESRD services attributable to excess mortality among patients with ESRD due to the COVID-19 pandemic and the flu, a slower growth in the number of individuals newly diagnosed with ESRD over

the last decade, and the increase in the use of home dialysis.

We also look at changes in the use of ESRD drugs that are furnished to fee-for-service beneficiaries on dialysis. We measure the volume of ESRD drugs used per treatment weighted by constant prices. The inclusion of these drugs in the payment bundle under the ESRD PPS beginning in 2011 increased providers' incentives to be more judicious about furnishing these drugs.

For example, ESA use, as represented by the black bars on the graph, declined significantly since 2011 with shifts to less costly drugs within the therapeutic group as well as with changes in the share of beneficiaries receiving a drug and changes in the prescription of a drug.

Under the ESRD PPS, we have noted shifts to less costly clinically similar products within a therapeutic group for several drug classes, including ESAs and vitamin D agents.

Most recently, between 2023 and 2024, ESRD drug use, estimated by weighting the units of each drug by constant prices, dropped by 4 percent. The changes in ESRD drug use since 2011 under the PPS has occurred without any

sustained change to beneficiaries' health status according to CMS.

Quality of outpatient dialysis care was mixed between 2023 and 2024. Among fee-for-service beneficiaries on dialysis, measures of dialysis adequacy, anemia management, hospitalization rates, and in-center hemodialysis patient experience remained generally stable. Use of home dialysis and number of kidney transplants increased. These are positive trends, as home dialysis has been linked to better quality of life and greater independence than in-center treatments. And kidney transplantation is widely regarded as a better ESRD treatment option than dialysis in terms of quality of life.

Use of ED visits, on the other hand, increased, and mortality remained stable but has remained elevated relative to before the COVID-19 pandemic.

I will now turn it over to Nancy to go over access to capital.

MS. RAY: Thank you, Grace.

Regarding access to capital, indicators suggest it is strong. The two large dialysis organizations have reported positive financial performance related to their

dialysis business for 2024, including improvements in productivity. In addition, both large dialysis organizations are vertically integrated, suggesting good access to capital. The 2024 all-payer margin was 16 percent.

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 trends contributed to a decline in the aggregate fee-for-service Medicare margin, while in 2023, cost growth moderated. In 2024, cost per treatment declined and the aggregate fee-for-service Medicare margin increased. Throughout these periods, beneficiaries' access to care has remained positive.

Moving to the 2024 fee-for-service Medicare margin, the increase to 4.5 percent in 2024 from negative 0.2 percent in 2023 is linked to lower overhead cost per

treatment, lower cost per treatment for ESRD drugs, particularly the ESAs, and the statutory increase of the fee-for-service base payment rate.

The fee-for-service Medicare 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 correlated with treatment volume.

The 2026 projected Medicare fee-for-service margin is 4 percent. We project the 2026 fee-for-service Medicare margin based on statutory payment updates in 2025 and 2026, historical cost growth, and the reductions in total payments due to the ESRD QIP.

Factors now considered that may have a positive effect on future margins include the potential effect of the add-on payments for ESRD drugs, including phosphate binders, in 2025 and 2026.

So here is a quick summary of the payment

adequacy findings. Access to care indicators are generally favorable. In 2024, capacity, as measured by in-center stations, and the number of all Medicare beneficiaries on dialysis declined.

Quality is mixed. On the one hand, in 2024, dialysis adequacy and anemia management continues to remain high, and home dialysis continues to increase. These are good trends. On the other hand, emergency department use increased. The 2026 Medicare margin is projected at 4 percent.

This leads us to the Chair's draft recommendation, which reads: For calendar year 2027, the Congress should eliminate the update to the 2026 Medicare base payment rate for outpatient dialysis services.

Current law is expected to increase the base payment rate by 1.6 percent in 2027. This recommendation would reduce federal program spending relative to the statutory update. 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 the presentation. We look forward

to your discussion.

DR. CHERNEW: Thank you. That was terrific.

I think we should probably just jump into our queues, and I think if I followed this correctly, the first person in the Round 1 cue is going to be Cheryl.

Is that right, Dana?

MS. KELLEY: Yes, it is.

DR. DAMBERG: Great. Terrific chapter. I will echo that comment that Mike just made.

I had two questions. The 20 percent of beneficiaries who are on dialysis that are using the ED per month, that percentage struck me as high, and I was kind of curious if MedPAC has ever tried to unpack what some of the drivers of ED utilization is and to what extent any of that's preventable. So that was my first question.

MS. RAY: We have not tried to unpack that.

DR. DAMBERG: Okay. I think it would be interesting to try to figure out, you know, whether there's anything. It's not coming to mind what the something might be, but that just seems like a really high rate. And I don't know whether it suggests other access problems for these beneficiaries or that they're just extremely sick

patients and somehow or other they aren't able to access primary care.

My second question is related to the base payment, which I know doesn't differ by the type of dialysis, but do you know whether home dialysis is less expensive to deliver than in facility?

MS. RAY: No, we have not unpacked that in the cost reports, and it has been a while since we have unpacked that in the cost reports.

DR. DAMBERG: Yeah. And I think partly I'm trying to sort out whether we're -- I don't know whether that current base payment reflects some kind of average between at-home and in-facility or we're potentially overpaying for in-home care, so just something to consider moving forward.

Thanks.

And oh, before I sign off, I do support the Chair's recommendation.

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

MR. POULSEN: I did.

First off, great, great job, and I'll avoid Round

2 by saying I support the recommendation.

My question was, with the concentration in the two providers, basically nationwide, does that -- do we have any sense for whether that improves access in underserved areas or denies access in underserved areas? Do we have any indication there? I can imagine it going both ways. They certainly have the resources to provide services everywhere, but at the same time, they may not be motivated to do that. So do we have any indication whether that has proved to be helpful or deleterious to access?

MS. RAY: So that's a good question. I don't have recent data on that. However, when we were doing our June 2020 chapter on the low-volume payment adjustment, when we made a recommendation that CMS should modify it to make it more targeted, I think we found roughly 60 to 62 percent of all the low-volume facilities at that point were the LDOs.

I know that doesn't exactly answer your question, but it does give a sense that some of them, some of the LDO facilities are small.

MR. POULSEN: Great. That is helpful. Thanks.

MS. KELLEY: Gina.

MS. UPCHURCH: Yeah. Thanks, Grace and Nancy, for this wonderful work always. Lots of details.

I've got three sort of clarifying questions, and I read this first one a couple of times. I couldn't get my head around it, but on page 8 of our materials, there's something that says -- and it's different in the text than the footnote, or either I'm not reading it correctly. "The base payment rate does not differ by dialysis type" in the text, but then in the footnote, it says, "Capitated payment rates vary whether it's home-based or facility-based." Which is it?

MS. RAY: Okay. The base payment rate does not vary based on whether it's home dialysis or whether it's in-center dialysis.

MS. UPCHURCH: Okay.

MS. RAY: What does differ with respect to the base rate are the case-mix adjustments for adults versus children.

MS. UPCHURCH: Okay, okay. So we might just want to check that footnote then, because I think that might be the one that's not exactly right, or I misread it.

And then just Table 5-2 in our materials, given

Robert's comment -- I think it was yesterday. It might have been this morning. I don't know. They're all blurring together. But where, you know, I sort of, in my mind, had freestanding being analogous to not hospital-based, and hospital being hospital-based, when we were talking yesterday about IRFs, but we came to learn that some of the freestanding may have affiliations or some sort of association with hospitals and hospital payments.

So is that also true with renal dialysis, or are they truly separate? When you say there's a freestanding renal dialysis, you know, owned by these two major companies usually, does that mean it's not associated with the hospital?

MS. RAY: That is correct.

MS. UPCHURCH: Okay. So that's very different than the IRF situation. Okay. Thank you. I just wanted to make sure I understood that.

And lastly -- and this is a bigger question. It goes beyond obviously this, but I just want to make sure I understand it. I've never understood while, you know, people can go on to Medicare for four reasons, 65 or older, ALS or Lou Gehrig's disease, permanently disabled by Social

Security for two years after a two-year wait, or, you know, depending. With end-stage renal disease, people have to wait until month four, for dialysis to be covered by Medicare. Do we -- is that because we're looking to see if the person has acute kidney injury first before we, you know -- what's the reason for the delay? It seems unfair.

MS. RAY: Yeah. Honestly, I'm not sure about that.

MR. MASI: Yeah. You guys are asking really good questions.

MS. RAY: Yeah. That's a good question. Historically, I can't believe I'm saying this. I don't go back, quite that far.

DR. RILEY: Maybe I can get assist from my other internist, but yes, we do not -- acute kidney injury is a short-term thing that can be managed plus or minus with dialysis. So we don't, you know, sort of assign folks to the permanent dialysis category until we've tried everything else, short-term dialysis, sometimes we'll try peritoneal dialysis. And you're right, there is a delay, but there is some medical aspects to why we delay, you know, the going on to the official dialysis, you know,

list.

Robert, Josh, you may want to weigh in as well as internists.

DR. MILLER: I was going to say, also, there are some people who sort of live in CKD-5 land just before dialysis, and they live there for a long time, and they die of something else. And that's okay because they didn't need to start dialysis.

And then there are folks who are just at the border of dialysis for a long time, and then they eventually have to go on dialysis. So it's sort of -- it's like a car with 300,000 miles. Sometimes I can go another 50, and you're surprised.

DR. RILEY: That's correct.

MS. UPCHURCH: Thanks for that to the doctors in the house, and we appreciate that.

I guess my concern is just sort of like why I have a problem with observation status, not counting towards a three-day stay, is that once you do know that the person has chronic kidney disease and they have to go on dialysis, they may have three months of incredible out-of-pocket spending that I think feels unfair because the

person ultimately went into chronic kidney disease and needs dialysis. So I just think we need to pay attention to that over time.

DR. RILEY: Well, technically, end-stage renal disease, which is the further extension of CKD --

MS. UPCHURCH: Right.

DR. RILEY: So not all patients who have CKD end up in ESRD, but ESRD, it triggers the need for dialysis.

MS. UPCHURCH: Thanks. So I guess I mean people that end up in end-stage renal disease. Thank you.

DR. MILLER: Yeah. And to further clarify, you can be CKD Stage 5, not ESRD, not on dialysis for quite a while.

DR. RILEY: Right.

DR. MILLER: Sometimes it's quick; sometimes it's not.

DR. RILEY: That's right.

MS. UPCHURCH: Yeah.

DR. RILEY: Thanks, Brian.

MS. UPCHURCH: Thanks. Thanks a lot.

MS. KELLEY: Okay. I have Robert next with a Round 1 question.

DR. CHERRY: Yeah, thank you, and I totally agree with my colleagues regarding the discussion and the medical rationale for some of the delays that has perceived for the administrative data.

I just want to revisit the increase in ED visits that the report highlighted. And by the way, this was an excellent report. Nice job. I don't pretend to know the drivers, because there isn't sufficient data to understand why the ED visits are going up. But I do wonder about the adequacy of staffing as far as redirecting patients appropriately instead of having to go to an ED.

The pre-read materials didn't seem to have any data on staffing, and I was just wondering if there were any plans to collect staffing data on dialysis centers, or if that's not in the works any time soon.

DR. OH: We do have information on staff data on an average week at each dialysis facility from the cost report, and we are in the process of just exploring the feasibility of coming up with additional capacity measures, motivated by Scott's comment last year in terms of capacity, in terms of number of stations, in terms of number of staff at each facility, and how that contributes

to the actual number of treatments that are provided. So in that stream of work we could take a deeper dive at the staffing at each location.

DR. CHERRY: Great. That's nice to know that that's in the works. Thank you.

MS. KELLEY: Tamara.

MR. MASI: Brian, did you have --

MS. KELLEY: Oh yes, I'm sorry, Brian. Go ahead.

DR. MILLER: I think emergency use in the dialysis population can be for a variety of things. It might also be due to changes in the population access, and I mean like what their dialysis access is, because you have a different infection rate if you have a tunneled line versus a fistula. So there may be some year-to-year changes in who has what type of vascular access, and that might be driving some of the emergency use. So it might be highly related to dialysis care, but totally unrelated to facility staffing. So we should probably look at both of those.

MS. KELLEY: Okay. Thank you. Tamara, you're next, with Round 1.

DR. KONETZKA: Okay. I'm asking this as a

question because I just really don't know the answer to it, but it's sort of building on Cheryl's question about differential costs between home dialysis and in-facility dialysis, and some of Gina's comments, as well.

I'm wondering, Nancy, in your work on this, or some of the other clinicians in the room, given that there are these sort of preferred treatment modalities, that transplant is generally considered a better treatment, and that a lot of people would prefer home dialysis, I know that there's a lot of -- obviously, the transplant is complicated because there has to be availability, et cetera, and people have to get referred to transplant, and in the home dialysis there are a lot of considerations that are sort of unique clinical considerations and sort of family environment considerations probably, with every person. So I know there's a lot of clinical judgment there.

But do you think that there is anything about the way we pay for these services that sort of encourages some of those more preferred treatment modalities or discourages them? You know, for example, if costs are lower for home dialysis and we're sort of paying the same rate, is that

sort of intentional? Are we encouraging more home dialysis by overpaying for it a little bit?

MS. RAY: Since 2011, the use of home dialysis has steadily increased, and there's been some research that specifically attributes the positive change in home dialysis to the ESRD PPS.

Most recently, CMMI tested the ESRD Treatment Choices Model, the ETC model, and that model's aim was to increase home dialysis and transplantation through the use of incentive payments. CMMI has decided to end the model early. I think it was supposed to run out through 2027, I think, and it's ending December 31st of 2025, because though they have seen home dialysis increase, they cannot attribute it to the model itself.

So I think the ESRD PPS, where we have drugs in the bundle, where we have most all ESRD-related services in the bundle, I think that incentivizes providers to furnish either home dialysis or in-center dialysis, and I think what's key is patient education, informing patients that they have a choice, and that it is their choice.

DR. KONETZKA: Great. That's super helpful. And I'll save my Round 2 question by saying I support the

recommendation. Thanks.

MS. KELLEY: Okay. Scott is next.

DR. SARRAN: Yeah, thanks. Excellent work. A few questions. First, just building on Cheryl and Robert's comments about the hospitalization and ED visit rates, I mean, this is a very sick, although somewhat heterogeneous, population, so you're never going to get hospitalization rates down to what it would look like in a non-ESRD population. But still, these seem high. In a previous life I did some work on exactly that issue of reducing ED and hospitalization use in patients on chronic dialysis, and we did get numbers way below that.

So I'd like to see some parsing of that data, maybe high level to start, using ambulatory care sensitive definitions. But I don't think that those are going to be sufficient to truly understand what's going on. There may be a way to also home in on ED and inpatient admissions that relate to either access and the complications of the access route, showing what specific codes would be. You know, I think we could work through that, as well as fluid overload, whether it's coded as heart failure or something else. Brian, you live downstream from these so you can

probably help us think through the taxonomy, et cetera.

But I think it would be worthwhile if we can parse that data a bit, to better understand, and then we could look at it across different providers, et cetera.

The second question I had, and I'm sorry, this one is a brief one, do we have any data on use of hospice services by dialysis recipients and how that may be changing over time?

MS. RAY: Did you say hospice?

DR. SARRAN: Yes. I'm sorry. Use of hospice service by dialysis recipients and whether that's been changing over time.

MS. RAY: I think it has been slowly increasing. There was, I think, a small uptick between, I think it was 2022 to 2023. We can definitely nail those numbers for you.

DR. SARRAN: It could be worth following over time.

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

DR. DILLER: Yes. I changed from Round 2 to Round 1. So the ED visit rate has been very interesting to

hear the discussion. It is going up across the country, and is very, very complex. We're doing some work in that area. But it has to do with access to care, physician and patient preferences. There is actually some perverse financial incentives for people to go to the emergency department. It's a kind of a one-stop shop, so you can get everything done all at once.

There are significant social determinants of health factors that drive that and marketing. For example, in the metropolitan area that I'm at there's, I don't know, 1,000 billboards that say, "Go to the emergency department," and none that say, "Go see your primary care physician." So it's a variety of different things that go into that.

So my question, really, is the 20 percent rate seems high, I agree, although I'm not terribly surprised by it. And the question is, have we compared it to the rate that we would see in other significant chronic diseases? So for example, patients with congestive heart failure or COPD, things along that line, where they may end up needing to use the emergency department much more frequently.

And I will say I support the recommendation of

the Chair. Thanks.

MS. RAY: We do not have such comparisons.

DR. DILLER: Okay.

MS. KELLEY: Okay. I think that's it for Round 1, unless I've missed anyone.

DR. CHERNEW: Yeah. I think it's going to go back to Cheryl.

MS. KELLEY: I actually have Stacie first, I thought.

DR. CHERNEW: Okay. Go with Stacie. I'm just following along here. Go on, Stacie.

DR. DUSETZINA: We will all listen to Dana on this one.

Thanks, Nancy and Grace, for a great chapter. I want to give special kudos to the massive footnote on page 9. I felt like I learned so much about these add-on payments and kind of temporary payments for drugs and other services by reading all of that, and found it to be really fascinating.

I had just a couple of quick comments. First, I agree with the Chair's draft recommendation.

There were two things that really stood out to me

in the chapter. One is this issue of the lack of access to guaranteed issue and community-rated Medigap for people in this under-65 ESRD situation. I think you guys did a great job in your call-out box kind of outlining. You noted that only 36 states have required options for people to be able to buy a Medigap plan in that particular under-65 situation. That seems absolutely unacceptable that you can qualify for Medicare and not have this as an option.

And it does help me more to understand what's going on with the huge uptake of Medicare Advantage. So have always felt like the rate of increase in Medicare Advantage, once people were allowed to select into that, was higher than I thought looked like kind of a normal trend. And so this really helps to explain it to me as people were facing, in a lot of states, really no real option to stay on traditional Medicare and have reasonable costs. So I think that's important, but also something that, you know, it does feel completely unacceptable. And maybe I'll save more of those comments for our next session on talking about big picture Medicare, what we should be doing.

The other thing that stood out to me was on the

patient experience ratings. You know, they don't look good. So maybe top marks is not something we think people are able to achieve. But a couple that stood out, the 60 percent of beneficiaries rating their nephrologist a 9 or a 10. Sixty percent seems pretty low. And then 64 percent gave their centers a top score. And again, that feels pretty low to me.

I don't know if there are other ways we can break that down to try to understand more about what's happening there. Are we going to have any people that were really, really worried about the quality of the centers and the satisfaction with their care because of where they're going or what's available in their area? But I think kind of given those low average marks it might be worth digging in a little bit more into that space.

Overall, again, really exceptional work, and I support the Chair's draft recommendation.

MS. KELLEY: Scott.

DR. SARRAN: I'll be very brief. I support the Chair's draft recommendation. Plus-one to Stacie's comment. I think there are a variety of reasons why it's challenging to achieve consistent top quality patient

experience ratings in these settings, but I think we can do better overall. I also think we can do better, as I was referring to earlier, with ED and inpatient utilization, virtually all of which are theoretically preventable, maybe challenging to prevent, and variable of that it's elective and value added, it's almost always something has gone wrong, whether it's preventable or not.

I'm disappointed CMMI gave up on the Choice, pursuing that. I think the Choice, there is a lot of room for improvement in the Choice architecture of how patients wind up, either in-center hemo, home-based PD, or palliative care, frankly, and I definitely think there's room for improvement in palliative care and hospice, broadly defined, in this population. So I'd like to see, as we continue to look at data, hoping to tease out all those pieces.

The hospice piece is, I think, real interesting because it overlaps, as we had previous discussions with hospice about what are the goals of dialysis, who is paying for those services, are we sure that beneficiaries have access to services consistent, and are getting the services consistent with their defined goals, et cetera.

But excellent work, and I support the Chairman's draft recommendation.

MS. KELLEY: Gina.

MS. UPCHURCH: Yes, I also support the draft recommendation, but I do have three comments.

I don't want to steal Greg's thunder, but the explanations of the medication costs and how they get paid for in bundle versus how you have these add-on payments makes it even more important that we look how Medicare pays for medications. So you've got Medicare paying for medications. So you have Part A, hospital-based; Part B, outpatient; Part C, combination of the two; Part D. And now you have end-stage renal, how we pay for drug, and, of course, you know, we also have it with hospice, how medications get paid for.

So we need some economies of scale or something to take a peek at that to see if Medicare's getting value for what we pay for the medications throughout the system, and I know that's beyond the scope of this conversation. But I just want to reiterate how important I think that is. And I think bundling is helping with that and obviously bringing some of the medication costs down here, as we've

seen in the examples.

Secondly, and this may be a little surprising to people, but I'm concerned that Medicare Advantage plans have to pay 27 percent more for, you know, to people to get treatment on dialysis, and because there is such a captured audience with two major providers, I mean, ultimately, the taxpayer pays for this. When we're paying 27 percent more, we're paying for it because it's Medicare payments.

And so, I'm just -- you know, is there any leverage we have with that? Because that is huge and obviously goes into the benchmark for the Medicare Advantage plans that we're all paying for it. So I'm just wondering if there are any levers we can pull to try to bring that down some for the Medicare Advantage plans.

And then lastly, just to build off Stacie's comment about people in many ways with renal disease in many states being forced, basically, to have Medicare Advantage plans versus having a fee-for-service benefit, even though I really appreciate that you put that the foundation -- the kidney foundation sometimes helps people with medical insurance. But I think I have a major concern about this because -- I don't know if people know this, but

one big distinction in sort of preventive services, when you're in Medicare Advantage and you need PT or OT or speech therapy, you have cost-sharing with that, which you do not have -- you know, we said home health, you know -- home health, you get PT, TO. You don't have any cost-sharing. Well, if you're in a Medicare Advantage plan, you do.

So, if people are being forced to that and you have a more limited income, are you foregoing PT, OT, those kinds of things you would need because you're in that Medicare Advantage plan? This is a much larger conversation, but it did come up in this conversation. So I just wanted to add that as a little nuanced piece of the pie.

And again, I support the Chair's recommendation.

MS. KELLEY: Brian?

DR. MILLER: I'm going to solve the Chair's anxiety and answer that question first and say I am very supportive of the Chair's recommendation.

So moving on to thoughts. I was listening to some of the questions people had in the discussion earlier. I know that our payment update window is limited in terms

of time, but maybe in the fall or the spring, we should invite the American Society of Nephrology to come talk to the Commission and the staff in a public setting so others can listen in and sort of educate folks about the mechanics and clinical dialysis initiation, sort of dialysis modality choices, vascular access choices.

This is sort of a clinical discussion that I think would probably help us all if we engage the medical community to educate us and educate the staff and the public a bit.

I know I deal with this on a regular basis, as do one or two of my other internist colleagues, but not everyone else has that easy benefit.

I'd also note that the dialysis community has the best dataset ever, and the USRDS maintained by the NIDDK at the NIH. I don't make the decision if ASN comes and visits us, but I just wanted to put that out there as something I think would be good for a 30- or 60-minute education session for everyone at another meeting when we don't have the time pressures of payment updates.

In terms of market structure, I share everyone's worry about duopoly market structure. Being a former

special advisor at the FTC, I know that that's bad, and it's so bad that we use the term "very large dialysis organization." So we've gone beyond concentration, beyond oligopoly to duopoly.

The other problem with this is that then we sort of lack good incentives for home hemodialysis and peritoneal dialysis. We have differential uptake of those services compared to other countries. This is not saying that we should have the same or more or less, but those modalities offer more convenience for the beneficiary and often greater sort of cost efficiency. So it might be worth at some point thinking about how we can pay differently for dialysis to encourage some of those modalities.

We could also think about sort of the ossified nature of service delivery in this space, which is a problem for the beneficiary and increased costs.

One thing I know that many of us have concerns about private equity in health care. I would say this is one of the spaces where private equity is a massive force for good, because the only people who are building chains usually are private equity firms that are going out and

starting up new dialysis centers and trying to build a new chain and compete directly on the nature of price competition, especially in the commercial market and in, of course, the MA market, where Gina rightfully noted it's concerning that MA plans pay 27 percent more.

That's a direct measure of market power. That's why we need new market entrants, whether they be tax exempt, tax paying, publicly funded, privately funded, whatever it is. Whether it's Cook County or Welsh Carson, we want someone building new dialysis facilities to increase access.

I think on sort of the benefit design angle, I share many of the concerns that folks have where they feel people are trapped in sort of one plan design or benefit package or another. I think we want to facilitate people to move more freely between those markets so that they can find the formulation of the Medicare benefits that works best for them, whether it's fee-for-service or whether it's MA.

And I would say one thing that hopefully CMS can do and maybe Congress and the policy community can think about is sort of the chronic disease special needs plans.

There's an option to think about what an advanced CKD certainty plan would look like. That could then change incentives for the delivery system to help put peritoneal dialysis and home hemodialysis on a more equal footing with in-center dialysis.

So I think that this is a space where we have an opportunity for education for us and others. We have an opportunity to think about competition, and then we have an opportunity to think about benefit design, so lots of potential positive change.

MS. KELLEY: Cheryl?

DR. DAMBERG: Just a few final comments. I want to support the comments made by others about the federal guaranteed issue rights not extending to those under age 65.

You know, this is placing huge cost burdens on the beneficiary, and I would hope that we could make some recommendations in the future about changing that policy.

I also want to plus-one Stacie's comments about the patient experience readings and how low they are, and I think it would be important potentially in the future to do some interviews with people who are on end-stage renal

disease treatment to try to understand what are the issues related to that care that potentially are playing out in these patient experience measures.

And then lastly, and going back to this issue of ED utilization, it would be really helpful to try to get a better understanding of the reason for the ED visit, and to also include some information in the report to the extent possible stratifying ED utilization by beneficiary characteristics to try to get a better understanding of whether there are social determinants, possible access challenges in certain communities, and relatedly whether we can sort of look to see to what extent they have a usual source of primary care and whether they've been seeing that usual source in the period prior to the emergency department visit.

MS. KELLEY: Lynn?

MS. BARR: Thank you. And excellent work on the chapter.

I support the Chair's recommendation because we have to do what we can to restrain the cost right now. It's just ridiculous, and so we have to do everything. I don't think this is really going to help, and I think it

can do harm.

I think that we're going to squeeze margin here in an area where we don't have good quality, right? And in a for-profit sector, do you think that they're going to increase staffing and increase quality if we squeeze their margin further, or are they going to try to decrease staffing, decrease skill level even further?

So, you know, even though the margins are sufficient for the for-profit sector, I'm not sure we're getting the value, and so, obviously, we need a different payment model that really focuses on value and not just volume.

But, in the meantime, I don't think squeezing the providers is a good idea when you have the kind of quality and experience that we see.

Thank you.

MS. KELLEY: Betty?

DR. RAMBUR: Thank you so much for this great work. I learned a ton and really appreciate it and appreciate the comments of the other Commissioners.

I just wanted to underscore a couple of things that were said by others. I appreciate staffing being

brought up, and I'm especially happy when it's not just me bringing it up, frankly.

And the issue of not just the staffing but the skill mix of the teams -- and I know that's beyond this particular piece here. But the relationship of that to the patient experience rating, I would bet would be pretty well correlated. So that would be really interesting to look at, and I know it's beyond the scope of this.

I do hear what was said about the duopoly and do share those concerns, and I'm in strong support of the Chairman's recommendation.

Thank you so much.

MS. KELLEY: Scott, did you have a follow-up comment?

DR. SARRAN: Do we know anything about chronic disease SNFs that are specific to CKD or ESRD? If I recall right, there were or are a handful of those out there. And I think seeing what they're doing, how they construct their benefit plans, any information that's available in the public domain about the care processes that they've deployed or the results they may be speaking to, even if it's something they publish in an investor document or

whatever, I think that'd be useful, because those are laboratories for experimentation across the spectrum, not just parsed by how we pay for dialysis services.

MS. KELLEY: Gina, did you have a follow-up?

MS. UPCHURCH: I do, very briefly.

This is moving upstream. So, when we look at who is receiving dialysis in the home or in facilities, we know there are incredible racial and ethnic disparities in who gets it. So I feel like we're at the end of life when people are really sick, and what we need to be talking about is more access to primary care, more access to specialty care, because diabetes and uncontrolled hypertension are what's driving chronic kidney disease. And that drives -- you know, flips it to end-stage renal disease when it's uncontrolled for so long.

So, as much as we can think about going upstream to focus on how we handle diabetes, how we handle the medications for diabetes, hypertension, because this just totally shows you, after years of disparities in access to care -- and not only just access to medical care, but other disparities in our country. This is what it leads to, and we're getting what we asked for

So, as much as we can go upstream, that's a good thing. Thanks.

MS. KELLEY: Okay. Mike, I think that's the end of the queue, unless I've missed anyone.

DR. CHERNEW: Yes, I think so. I just want to make sure that everyone -- and I'm sorry I haven't kept exact track -- got a chance to weigh in on what they think of the rec, and then I'll make some summary comments as we bring our update work to a close this month.

DR. METAN: Mike, this is Gokhan. I support Chair's draft recommendation.

DR. LIAO: Josh, I support.

DR. CHERRY: This is Robert. I support.

DR. RILEY: This is Wayne. I support.

DR. OH: Okay. I think that was it, and thank you.

A few things before we take a quick five-minute break and come back to talk about some bigger, broader issues. The first thing, there's some themes in all of the work that we've done over yesterday and this morning, which is the update exercise in general focuses on the averages, and we worry a lot about the tails. I could probably find

in the transcript five places, six places, forty places where some theme of that has arisen, and that's a concern.

We've tried to, in certain areas, particularly with our safety-net-type work, try and address that to some extent, but admittedly, we do so in a way that is crude and a bit lumpy.

I think there is a concern, and it's come up, about the margins, and so I'll make a comment specifically about the analysis area.

I view the rec as a little bit timid in some ways because I'm less worried because the all-payer margins are around 16 percent. So, to the extent that there's concerns about quality -- and I don't dispute there's always concerns about quality, and several of you raised issues related to quality here -- I think the key thing is we have to find ways to address those problems that don't involve paying very high margins. It's just not, I think, where we are to have -- at least for me, to have sort of the premise if there's quality problems somewhere, we have to pay the entire sector more and have margins that are particularly high. I think that's the core concern, although I'm not too naive to believe that one can just easily figure out

how to address all those problems. So I appreciate those comments.

I do think we have to keep monitoring those things, but I think the solutions do involve things other than high payment updates.

The thing about the dialysis sector that concerns me the most -- it didn't come up -- it came up, but not quite in this context -- is there's wide variability of the margins in the sector. They go up; they go down. And they're driven in part by some of the aspects of the way the drugs are built into the bundles in a bunch of ways.

So I feel that our ability to figure out what's going to be going on in 2027 is a little more challenged in this -- it's challenged in all the sectors. I think, for me, I felt a little bit more challenged in going through the materials and thinking about 2027, given the variability of the margins in the sector.

But that said, given the all-payer margin, I'm more soothed that if we're off by a little bit, we'll be able to adjust at subsequent points in time.

Anyway, so that's where we are here. I don't think we have any other comments to read into the record,

Dana. So I'm about to call this session to a close, and I'm just looking around.

MS. KELLEY: I think that's right, Mike.

DR. CHERNEW: Okay. So, again, to Nancy and Grace, thank you. To all the staff that worked directly or indirectly on the update chapters, thank you. This is an enormous amount of work, and I'd be remiss if I didn't note that a ton of this is going on over Thanksgiving and around Thanksgiving, and the amount of information that you asked -- it's really interesting to listen to all the amount of information you asked for. It's amazing for me to realize that the staff knows, even having high expectations of them, it's constantly exceeded. And I'm sure they will continue to drill down and find more of the information that's wanted. But I do want to call out and acknowledge how much work the staff does to develop the levels of expertise that they have, not just by looking at the data, but by talking to the people in the field and really trying to understand the issues that are going on institutionally. So broadly across the board, kudos to all of the staff.

We're going to come back and have a much, much higher-level conversation, which I will provide the intro

to, and maybe a little more engagement than I normally do, roughly. Let's try and come back at -- I think we're scheduled to come back at --

MR. MASI: 1:50.

DR. CHERNEW: At 1:50. So let's try and come back at 1:50. That's perfect. We'll stay on time.

So, everybody, thank you. Remember, we're going to stay on this link. So pause yourself, mute yourself, but don't get off.

[Recess.]

DR. CHERNEW: All right. So welcome back, everybody. As the morning and yesterday indicated, a lot of our work is very technical. And we hear continually, in many of the comments, in many of the sessions, versions of a comment that's along the lines of, "We need to think of new payment models." "We need to think of new structures," sort of much bigger type things.

And so this presentation, and what I think will be a chapter in the June report, it will be a short chapter. I'll say more about it after the presentation. But it is intended to be sort of an outlet for some of those feelings about broad payment issues. And I'll try

and put a little more guardrails on that scope after the presentation, but I think we should start with Rachel. So Rachel, go ahead.

MS. BURTON: At the Chair's request, this presentation will explore ways to improve Medicare's payment approaches. A PDF of these slides is available on the right side of the webinar's control panel in the Handouts section.

Today's presentation will begin with an introduction, mention some key drivers of Medicare spending trends, describe incentives in stand-alone fee-for-service Medicare, alternative payment models, and Medicare Advantage, and discuss ways to improve incentives in these payment approaches.

Medicare uses three different approaches to pay for care: standalone fee-for-service Medicare, alternative payment models that are layered on top of fee-for-service Medicare, and Medicare Advantage. Each has advantages and disadvantages. Some may be addressed with policy changes, while others may be more challenging.

CMS's annual survey generally finds that beneficiaries are equally satisfied in fee-for-service

Medicare and MA.

MedPAC regularly assesses Medicare's payment policies and recommends improvements. Three principles guide our work:

Number one, payments should be sufficient to support beneficiary access to high-quality health care in an appropriate clinical setting.

Number two, providers should have incentives to supply appropriate and equitable care in an efficient manner.

Number three, Medicare payments should reflect efficient care delivery, thereby ensuring that the program's fiscal burden on beneficiaries and taxpayers is not greater than necessary.

In the decades since Medicare was created, spending on the program has made up a growing share of GDP and a growing share of national health care spending. Since 2006, Medicare has constituted about 20 percent of national health care spending. Currently, we're spending one trillion dollars a year on Medicare.

In addition to Medicare payroll taxes deposited into Medicare's hospital insurance trust fund, Medicare is

also funded by personal and corporate income taxes paid to the federal government. In 2024, 16 percent of income taxes were used to pay for Medicare, and by 2035, 25 percent is expected to be used for this purpose.

As the share of general revenues needed to finance Medicare increases, it leaves less revenue for deficit reduction and other national priorities.

Health care spending doesn't always grow rapidly. From 2010 to 2017, there was a slowdown in Medicare spending growth per beneficiary. This was partly caused by a slowdown in national health care spending more generally, as well as legislative changes to Medicare.

This period is also when baby boomers first started aging into Medicare, and is a period that saw reduced utilization of certain types of Medicare services, such as inpatient hospital admissions.

Since 2017, growth in Medicare spending has again ticked up, especially for Part B, shown by the orange line, which includes payments for clinicians, hospital outpatient departments, physician-administered drugs, and other ambulatory services and items.

When CMS's actuaries have separated out the

influence of different factors on Medicare's Part B spending growth, it has found that spending is not driven by increases in Medicare prices, the number of beneficiaries enrolled in Medicare, or the demographic risk profile of beneficiaries. Instead, it is a residual category of "Other" factors that drives Part B spending, which includes growth in the volume and intensity of the services and items furnished per beneficiary.

Over the next 10 years, CMS actuaries estimate that the volume and intensity of Part B services and items delivered per beneficiary will increase by an average of 4.5 percent per year. This refers to clinicians prescribing more services and items over time, and to clinicians prescribing more costly services and items in place of less costly services and items over time.

I'm now going to pass things over to Stuart.

MR. HAMMOND: Thanks, Rachel. Fee-for-service Medicare, alternative payment models, and Medicare Advantage all include incentives that can influence volume and intensity growth. The basic design of a payment approach can create these incentives, as can the overall or relative payment rates used under the approach.

The basic design of each payment approach can incentivize higher/lower volume and intensity growth. For example, paying for each item or service, as in standalone fee-for-service Medicare, incentivizes providing more items and services. Capitated payments, on the other hand, can encourage efficiency, but can also incentivize spending time and resources coding patient diagnoses to maximize payments.

The overall level of payment rates can also incentivize greater and lesser volume and intensity growth. If payments are too high, it can lead to overprovision of care or unintended subsidies. If payments are too low, there is a risk of some providers or plans not participating in the program.

Finally, the relative payment rates used within any of the payment approaches can incentivize higher or lower volume and intensity growth. If payments are too high for some services or plans relative to others, it can lead to unintended changes in which services are delivered and where they are provided.

In the next few slides, I'll walk through the incentives of the three payment approaches in more detail.

In standalone fee-for-service Medicare, Medicare sets prices and pays separately for each item, service, or stay a beneficiary has. This creates an incentive to increase the volume of services provided. In some fee-for-service payment systems, bundling of services helps to mitigate some of those incentives.

Fee-for-service Medicare gives providers relatively few incentives to stint on care, but can incentivize providing as much care as possible, including potentially unnecessary services. Beneficiaries have wide access to providers, but cost sharing can be a barrier for beneficiaries who don't have supplemental insurance through Medicaid or a Medigap plan.

In terms of overall payment levels, it is hard to know if fee-for-service Medicare's prices are "right." MedPAC's payment adequacy analyses find payments too high in some settings and too low in others. If payment levels are not high enough, providers might not participate in Medicare and beneficiary access could suffer. If payments are too high, it can encourage overuse of services.

In terms of relative payment rates, payment rates for some services are too high while others are too low,

which incentivizes the provision of some services over others. For many services, the payment rate varies depending on what setting it is provided in, which incentivizes delivering care in higher-paid settings.

Setting prices can be challenging, because accurate cost and time data are not always available to CMS when it sets payment rates. Additionally, payment rates tend to be "sticky upward," meaning they don't decline even when efficiencies develop, leading to some services potentially becoming overvalued over time.

Alternative payment models or APMs, require providers to bear more-than-nominal financial risk for their patient spending. This provides an incentive to deliver services more efficiently. APMs can use tools such as referrals and care management services to control costs. Providers who meet the applicable spending targets can earn bonus payments from Medicare, and have flexibility in how they spend the payments.

In terms of overall payment levels, it's hard to get APM payment levels right. If APM payments are set too high, no net savings will be generated for Medicare because providers who are likely to earn bonuses without much

change in behavior will self-select into the program. If APM payments are set too low, and participation is voluntary, less efficient providers won't voluntarily participate. A further challenge is the fact that provider organizations' clinician-level compensation arrangements tend to reward maximizing volume and intensity, which dulls APMs' clinician-level incentives.

Relative payment rates within APMs can also affect incentives. For example, CMS pays ACOs different amounts for different patients. Since providers in APMs have easier spending targets if they code patients' diagnoses more intensively or if they strategically curate their participating provider list, there can be an incentive to focus on coding and provider selection rather than just on delivering care more efficiently.

Finally, providers in certain geographic areas automatically have easier spending targets based on how APM formulas are currently constructed.

In Medicare Advantage, Medicare makes capitated payments to MA plans, which then pay providers for delivering care to their enrolled beneficiaries. This can be a powerful incentive for plans to manage enrollees'

spending. When MA plans use fee-for-service payment rates to pay providers, many of the incentive issues we discussed in the previous slides remain.

To try to limit spending, MA plans can use utilization management tools like prior authorization. Plans have an incentive to keep their spending on Part A and Part B benefits low, in order to earn rebates that enable them to offer extra benefits or to lower cost sharing to attract enrollees.

In terms of overall payment levels, it has proven difficult to get MA's payment levels and risk-adjustment right. Issues with MA payment design have made it difficult for Medicare to realize savings from MA. As a result, Medicare's payments to plans tend to exceed what the program would have spent if the same enrollees had been enrolled in fee-for-service.

High payments to MA plans have prompted many insurers to offer MA plans. High payments have enabled plans to offer low cost-sharing and extra benefits, which have attracted many beneficiaries to MA.

CMS pays MA plans different amounts for each enrollee, and payment rates vary geographically. Thus, the

relative payment rates give an incentive to code patient diagnoses more intensively or curate provider networks strategically, and attract beneficiaries who are likely to use less care than expected under the risk model.

Further, plans in certain geographic areas have higher benchmarks, based on how formulas are currently constructed, which could affect where plans participate and where certain benefits are available.

Now, I'll hand things over to Luis.

MR. SERNA: Fee-for-service, APMs, and MA would all benefit from MedPAC's suggested policy changes. Medicare spending makes up a larger share of national health care spending than it did when the program was created. The program's actuaries project that growth in the volume and intensity of Part B items and services will be a primary of driver of spending growth over the next decade.

The opportunities to improve the incentives in fee-for-service, APMs, and MA differ. Fee-for-service tends to promote volume and intensity growth. APMs and MA plans have incentives and tools to manage spending, but designing payment systems by which Medicare can realize

savings is challenging. The Commission has recommended improvements to each payment approach and has ongoing work to identify additional ways to improve incentives, guided by our principles.

In this next section, we recap some key prior MedPAC recommendations aimed at improving incentives in Medicare's payment approaches.

Improvements to standalone fee-for-service Medicare include overhauling the fee-for-service Medicare benefit design to allow cost sharing to vary based on whether a service is high or low value and adding an out-of-pocket maximum for beneficiaries.

In terms of overall payment levels, fee-for-service Medicare payment rates for hospital and clinician services should increase and payments for post-acute care should decrease. In addition, the amount Medicare pays for certain physician-administered drugs paid for under Part B should be reduced.

To improve relative payments in fee-for-service Medicare, CMS should improve how it sets prices for services by using empirical data and a new advisory committee. In addition, where applicable, payments should

be site-neutral, and Medicare should change how it pays for particular Part B drugs under the hospital OPPS.

To improve alternative payment models, CMS should offer a more harmonized portfolio of fewer APMs, designed to work together. CMS could also operate one ACO model with different tracks for different sized providers, and a mandatory episode-based payment model for proven episodes.

To improve overall payment levels in APMs, Medicare should stop periodically "ratcheting down" ACOs' spending targets in MSSP. And to improve relative payments, Medicare should change how spending targets are calculated in APMs to reduce ACOs' coding incentives and reduce the favorable selection of beneficiaries likely to generate lower-than-expected spending.

To improve MA's basic design, Medicare should include hospice in the MA benefit package, and using larger geographic markets as MA plan payment areas. To improve overall payment levels in MA, Medicare should change how it calculates the spending benchmarks that MA plans big against. To improve relative payments to different MA plans, Medicare should overhaul the MA quality bonus program and improve how Medicare risk-adjusts payments to

MA plans to reduce disparities in plan-level coding intensity.

In conclusion, standalone fee-for-service Medicare, APMs, and MA each have a role to play, but they all have room for improvement. MedPAC will continue to study Medicare payment approaches and identify ways to improve their incentives, guided by our principles.

Future work could potentially include better understanding the sources of spending growth; identifying additional payments that could be harmonized across settings and service types; improving the design of APMs; exploring alternative ways to set MA payments; and better understanding plans' incentives to achieve efficiency and maintain access to care.

In your discussion, we welcome your questions about any of the content we covered, any other feedback you have on this topic more generally, and your thoughts on future work in this space. Based on commissioner interest, this presentation could form the basis of a chapter in the June report.

I'll now turn things back to Mike.

DR. CHERNEW: Luis, Rachel, thank you. Stuart,

thank you. So we're going to run this a little bit differently. First of all, we're going to have one queue, and I am broadly going to be the person answer all of the various questions, because this is a much broader thing than we normally do.

Let me start with a few sort of basic introductory remarks about how at least I'm seeing this play out, and then, of course, we're going to get your feedback on that.

So the first thing is, this is going to be a relatively prescribed chapter, and so it's not going to be a broad chapter on how should we reform Medicare. There are going to be some guardrails, and that's going to have to be sort of laid out in this discussion and as we sort of engage back.

Relative to some of the other stuff, it's going to focus on a bit more conceptual issues related to the major payment approaches that were just outlined by the team.

I think it's important to say publicly that MedPAC doesn't try and hit a specific budget target, but we are charged with providing advice on how the program can be

a good steward of resources. There are many ways to do that. Again, I think this work is largely going to focus on some of the conceptual issues behind the payment approaches that were discussed.

In my mind, and again that's the point of this discussion, there are sort of three main points. The first one is that spending growth, particularly A and B spending growth, is driven by volume and intensity. So if we're going to address the spending growth, we really have to focus on structures that deal with volume and intensity.

I personally believe that it's hard to address that in fee-for-service without anything wrapped around it, because if you set the price you put an average cost, and that will often be above marginal cost, giving an incentive for greater volume, and if you set a marginal cost you run the problem of how you're going to support the broad investment in infrastructure. There are ways to deal with that. They may come up in this conversation. But that's what I see the core challenge is.

So in that sort of fee-for-service chassis, we need structures to address those sort of incentive issues. Some of those structures will be fee-for-service, and some

of them may involve the incentives built into some of the other payment approaches.

We're not going to have the scope in this work to explore every possible thing, although you can certainly mention the things that are important to you now. But we're intending instead to outline the issues that are reasonably high level.

The key themes, in my mind, are that all payment approaches face challenges. I hope that was clear from the presentation. And that all of them must be improved. Much of our work that focuses on MA or APMs or TM, fee-for-service, focuses on ways to improve each of those payment approaches, and the team went through some of those particular approaches.

But all these different approaches will play some role. I just think our goal is to outline kind of the conceptual issues of what we're trying to do to create an efficient Medicare program.

The core questions that I'd love your general response to is overall reactions to the role of incentives in these models and the role of bigger or smaller bundles. I think that's one of the key issues in how this plays out.

There is a lot of detail in some of the stuff that Luis just talked about, which I think is important. I'd rather you focus on the potential than get into the nitty-gritty of how we address some of those specific things like what do we do on MA risk adjustment or allocation of indirect practice expenses. You're welcome to talk about those if you want, but I think the chapter is going to be a much higher level than those particular, more micro solutions that we spent so much time talking about in the other contexts.

So with that I'm turning it back to Dana to run the queue, but I'm going to be the one that's probably going to do most of the engaging with your questions and comments. So Dana.

MS. KELLEY: Okay. I have Greg first.

MR. POULSEN: Thank you.

I'm concerned about this. I actually intended to just be a Round 1 kind of a question, but I do think I need to jump in much more deeply here.

If we look at slide 11 -- I don't know if we can go back and take a peek at that or not. Maybe slides 10 and 11, but 11 is the operable one here, where we talk

about where is the biggest growth, where is the biggest impact, where therefore is the biggest opportunity, you can see it's Part B is huge. I think that that's really interesting, because if we go back and look at prior to -- it wasn't too long ago where Part A dwarfed Part B, and now Part B is far bigger. Part of that is a move to outpatient care, but a big, big part of it is the drugs that are embedded in Part B.

Stacie would have a better definition of what percentage there are, but it's enormous.

If we go to the next slide after that one, what we see is where's the biggest growth in Part B is in volume and intensity. I guess I would argue that we probably -- and I'd stand to be corrected if I'm wrong here, but I don't think I am. If we look at this, what we're seeing is that that volume and intensity is not volume and intensity of the same old stuff being done more. It's new stuff, the majority of which are pharmaceuticals.

For example, if you add Hemgenix into the mix at $3.5 million for a treatment, that's going to add an enormous amount of impact to that growth rate. And we're seeing dozens and dozens of new capabilities. New

capability pharmaceuticals are wonderful, and I think we're incredibly blessed to have them coming. But that's where it's going to show up is in that red round circle, by and large. We may see some of it in Part D, but a big, big chunk of it is right there.

Let me get this stated first. I absolutely agree with the broad direction that we're talking about. I like the idea of where we're going with the APM and ACO approaches. I like where we're going. I like the coding discussion. I like lots and lots of things that are going there. None of those will address that 4.5 percent growth, which I think could actually get bigger, because we're going to see more and more capabilities being brought to bear that will treat patients that previously simply were untreatable. Either they would die or they would be debilitated for their life, and here we're going to see opportunities which are wonderful and capable, but they come at very, very, very high expense. To assume that clinicians will be able to make decisions that change that trajectory, I think is incorrect.

Again, you can pick on just about any of the new capability drugs that are there, and they're wonderful

drugs. I certainly don't want to be thought as being critical of those wonderful capabilities, but a physician will make a decision. A clinician or an ACO or a Medicare Advantage plan is not going to be in a position to say, okay, we're not going to provide something that will save somebody's life or dramatically improve their life.

Right now, they are not in a position to negotiate prices for that. They're not in a position, by and large, to come up with substitutes for that.

To pick a somewhat old example, but one probably you all recognize, the ability to treat hepatitis C, the prices are now lower, but it used to be $90,000 for a treatment, $94,500 to be more precise. The decision is, do you do that, or do you not do that? If you don't do that, the alternative is probably that somebody will simply have a dramatically worse trajectory in their life. They may end up going to a liver transplant, but by and large, that's not the case. We do 20 times as many treatments for hep C than we do liver transplants. So it's not going to be a cost savings by eliminating, a one-for-one kind of elimination of the liver transplants.

I started to ramble a little because I really was

just going down the question, the question of what percentage of that 4.5 is due to drugs, but I know the answer. So it was rhetorical.

Let me just close there and say I love the direction we're going. I think it's exactly right, but I think that we are playing around the periphery if we're unable or unwilling to find a way to bring the cost of new and capable and wonderful pharmaceuticals into the discussion.

MS. KELLEY: Okay. Mike, do you want me to go down the queue and you'll let me know when you want to stop?

DR. CHERNEW: For those who know me, you understand how tempting it is for me to stop after every comment and give some reaction, and I am going to not do that. I think we should go through the queue, and I will try and jump in, maybe after a bunch have been said or when there's common themes to allow this to run a little more smoothly and having me a little bit less airtime than I naturally would want.

Anyway, let's keep going through the queue.

And, Greg, thank you.

MS. KELLEY: All right. I have Cheryl next.

DR. DAMBERG: Thanks.

I think you can tell we're all pretty excited about this chapter, and I think we're all struggling a bit with what I call the bounding problem, and I'll get into that in a minute.

But I did like, you know, the slide deck, and I realized this is sort of the outline for the chapter. And I really appreciated toward the end of the slide deck, laying out the different strategies for each of the different areas of fee-for-service, MA, et cetera, alternative payment models. I think that's going to be especially helpful for policymakers who want to see something at a glance as to actions that they could take to, you know, drive change.

And I particularly liked the focus on bundled payments, and I think that that's an area where, you know, it's clear there's opportunities to control volume and intensity and, you know, save taxpayers and Medicare beneficiaries money.

And I also like the focus on revisiting or revising the benchmarks against which MA plans bid.

But, again, sort of back to the struggle with the bounding of the work, you know, I understand that what we're talking about is different payment approaches to get what we want, but one of the things I'm still struggling with is issues about what is paid for, particularly given the imbalance between MA and fee-for-service. So I'm trying to figure out, can we be more expansive here in terms of, you know, what Medicare pays for and therefore how much they pay for, which relates to caps on consumer out-of-pockets?

And then, secondly, the issue around MA. So MA was originally designed to save the program money, and as I think was noted, that's yet to be realized. And so I was kind of curious, and I realized that this is sort of a big issue for Congress to tackle, but I still feel like we haven't figured out how to realize those cost savings from MA. And so that suggests to me the need to revisit things like the rebates, the quality bonus payments, as well as how benchmarks are established.

But very much looking forward to this work.

MS. KELLEY: Stacie?

DR. DUSETZINA: Thank you so much.

Yeah. I will echo, same as others, very excited about this chapter and this kind of big-picture orientation.

I love the solutions that you all started to put forward, and I just have a few minor kind of suggestions or tweaks of things that I was thinking about or wanted to reemphasize.

One is in the fee-for-service. I think, you know, you point to like aligning patient cost sharing with value. I think we should also emphasize that for what we pay, so there's kind of a broad, like, let's pay less for Part B drugs, for example. Like, let's pay for value. Like, let's align the payment so it reflects the benefits that those drugs provide to our patients and society. So I would love to see that emphasized more.

I think that fits kind of hand in hand with the idea of doing more alternative payments or bundled payments. So I think it's consistent with where you all are going.

I also absolutely think that it's time to visit a cap on fee-for-service out-of-pocket for beneficiaries. I think that would help with a lot of the issues we bring up

around equity for the under-65 population, for Medigap and where you live and how it affects whether you can even buy it or whether you can afford to. So I love the idea of working towards that.

In the MA space, I'm a little bit less convinced on the hospice being incorporated within MA, and part of it is just that, you know, like there were a couple of other read-ins this time where, you know, you see that like a demo has ended early because it didn't seem to be working super well. We got some letters from stakeholders that kind of were arguing against that. So I think I'd want to, like, know more and think more about that particular piece of the wish list.

I'm not against it. I'm just -- like, I find that those conflicting bits of information make me wonder, like, what's going so wrong there.

And then I would love to see something here on the supplemental benefits and the value that beneficiaries and taxpayers are getting for those in MA. I know we have other work streams where we look at that, but I think that's a key concern that I have is we spend a lot of money as taxpayers and Medicare dollars on those benefits and

don't have much accountability for them.

So really, really excited about this type of work and where it's heading, so thanks again, everybody, for the excellent, excellent work here.

MS. BURTON: I just wanted to clarify that the material that Luis went over is a summary of our prior recommendations.

DR. CHERNEW: Oh, I should say as well, we're not going to use this chapter to revisit our recommendations or, for that matter, to make more recommendations. Our goal is to kind of lay out some of the sort of conceptual issues around what can or can't be done in each of these sectors.

So, for example, we're not going to revisit all of our detailed recs around Medicare Advantage risk adjustment or all the things that was laid out in the presentation.

I personally view limits to certain types of approaches. Like, I think there's some inherent limits in fee-for-service that are at least different than the inherent challenges in the other sectors.

I have my opinions about which ones I think are

more easily addressable and which ones aren't, but the point of this is to hear your opinions on that.

MS. KELLEY: Okay. Gokhan.

DR. METAN: First of all, thank you very much for this report, for this work. This is great.

One of the things that keep me up at night is the growth of the spending. Like, every time I look at my child, I feel like they will be the ones paying for the growth and the debt that we are building through the spending. So I think this chapter is very important and dear from my heart.

I think in our 2025 report to Congress, we estimated the Medicare spent about, like, 20 percent more, which equates to $84 billion more, if those members were in fee-for-service.

And from that perspective, I share Cheryl's feedback in terms of Medicare Advantage was supposed to bring efficiencies, and we are not observing that. So I think doing more research and recommendations around that is important.

In terms of how MA plans are using the rebates is also an area of interest to me. We see new records

spending supplemental benefits in this area. So visiting that big benchmark differential and how we use the ratio of some of that differential to kind of pay for the rebates, I think that's an important area to take a closer look.

I also second Stacie's comments on putting some sort of maximum out-of-pocket spend in the fee-for-service space, and again, we may look at in terms of, like, whether that would vary age, limit by income, or what kind of effects we would see if such a spending cap would be introduced, especially in the markets of Medicare and also the fiscal impact of such a change on the program.

I also share Greg's feedback and sentiments around the volume and intensity-driven increase in Medicare Part B and pharmaceuticals, especially looking into the impact that would be great.

So, overall, I love this work and looking forward to kind of like being part of this. Thank you.

MS. KELLEY: Lynn?

MS. BARR: Thank you for this work and the opportunity to comment on this.

So MA is 50 years old. We're still waiting to, you know, get the value from it. You know, why do we think

it's going to change? And, you know, MA -- the big winner in MA is the insurance company, right? It's not the providers. It's an insurance company.

We look at APMs, you know, a little marginal effect, a lot of it, you know, affected by coding and selection. And then -- but it doesn't engage the ecosystem. It only affects, you know, who gets the payments, right? Primary care providers, the specialists are completely out of it, you know, the -- potentially the hospitals, you know, but it's not the whole ecosystem.

And I feel like we're, you know, kayaking up the rapids, you know, coming -- kayaking into a tsunami of incentives where everybody makes more money if we fail, right? And I don't -- you know, you all are the economists, right? I don't know why we keep thinking things are going to change the way we're doing things.

And I think that, you know, all of those recommendations are great. I support all those recommendations, and I don't think it's going to matter. I think we have to find a way to engage the entire ecosystem, that everybody needs to win if we do the right thing, right?

And so, when I think -- you know, this idea that, you know, this guy gets paid, but this guy doesn't, isn't really working on changing the culture of how we, as an entire system, look at getting paid and looking at providing care.

And so I think that we need to think about some sort of, you know -- for example, a targeted -- a target of what kind of savings we're trying to get to, and we need to share that savings across the entire ecosystem.

So, if every year, you know, hospitals are going to get, you know, 1, 2 percent, you know, doctors are going to get, you know, very, very small incentives, and we can actually reduce the cost of care, can we share it with everyone and put it into the updates? Right? We have these super complicated things that are not really covering what we're doing.

But if we can -- and if we look at the growth trajectory, we say between, you know, 2010 and 2017, but it was really between 2010 and 2013 that we had a cultural shift where people were really, really trying, and then it went away. And then, you know, I think between 2013 and 2017, costs started going up, and then it's way out of

control again.

We need to think differently, and I don't believe that the solutions we have on the table have demonstrated efficacy in actually changing the trajectory of health care spend. And so we need to start thinking about how do we engage the entire system, and it isn't just by cutting their rates, but how can they benefit if, as a country, we culturally shift and we all get together and work together? Because we can't -- you know, as long as some people can make a lot of money by ignoring all of this, it's still going to happen. And so everyone's got to win.

Thank you.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you so much. I think Michael probably largely knows how I think about this, but I do want to be on the record and share it with all of you.

First of all, I do think all three of these can be improved. I want to start with fee-for-service. Can it be better? Yes. Can it be fixed? That I'm less sure of, and for reasons you all know. It's inherently inflationary. It fragments care. It disincents teams. It's hard to get the prices right. It's reactionary.

But my greatest concern is the incentive to overtreat, and this is not only an economic issue. To me it's an ethical issue. People are harmed by receiving care that they didn't need. And there's nothing, in a sense, more tragic than patient harm. But if it's for something that had low or little value in the first place, it's really tragic. You know the data on this. Some say 25 percent is low value or whatever.

Now, there is a radical and underused approach to that, which is to stop paying for it, but the complication with that is contextual. What might be low value in some situations isn't in another. But I think this is really important.

In my day job I'm working really hard to help nurses in this country understand the importance of value-informed practice. And I can tell you it's very, very hard because just like physicians and others, they have all been marinated in episodic fee-for-service care.

The last thing I want to say about fee-for-service is the nation is in an outcry about the cost of health insurance, but that's a reflection of the cost of care. Other payers follow Medicare, so I think this is

really important.

So that's my piece about fee-for-service. That's why I remain optimistic or hopeful about the potential of alternative payment models. I'd rather see more of them not be alternative, but I really do support mandatory approaches. And in many ways, I'd like the nation to move away from the term "mandatory" and move to terms of "participation in Medicare." You think about if the prospective payment system was voluntary, hospital industry would still be arguing that they can't move away from per diem reimbursement. So if we change the money, we'll change the behavior.

And then finally, in terms of MA, I think at our first retreat I brought up the issue of benchmarks, and I hadn't realized how naïve my understanding was of what it would take to address that. I think that's very important.

But in the MA space my greatest concern, and biggest hope, is to really make it more transparent, so people know what they're getting and what they're giving up. I think that's really the fundamental challenge. And if we are relying on more of a market-based system, that information is essential.

So I am enthusiastic about this work and enthusiastic about hearing the vision from all of you, as well. So thanks for the opportunity to share.

MS. KELLEY: Scott.

DR. SARRAN: Yeah. Excellent work, and I think I actually can get my comments in in a little bit under 60 minutes. So I'm going to try to make brief comments on each of the three spaces -- fee-for-service, APM, and then MA, and then I'll end with one sort of wild, out-of-the-box thought.

All right, fee-for-service space. I think, by and large, fee-for-service Medicare works well for relatively young, relatively healthy beneficiaries. It leverages Medicare's strengths as a traditional insurer, and what do traditional insurers need to do well? They need evaluate and price risk, and they need to have a reasonable benefit plan, manage a network and contracted rates, and do adequate adjudication of medical necessity. And by and large, I think Medicare does that pretty well, particularly well in terms of setting prices.

The only things I'd add to what I think are a really series of excellent suggestions on Slide 27 is the

comments I made yesterday in the post-acute space. I would like to see us add those. And those essentially come down to we need to change the structure of how we pay in post-acute, not uniformly pay the same rate across the different post-acute sectors, but change the structure so we get to something that looks like 50 percent of the payment based on outcomes, which would be a mix of functional outcomes, patient experience, and safety measures.

I'd also probably add into the slide, because I think it reflects good work, what we saw on Table 4-6 of the PFS presentation, which is we have all of these, call them, patches or round-peg-square-hole solutions in fee-for-service Medicare, PFS. Let's double down on those in terms of double down on the scrutiny around those, the tracking, see how those work out, maybe tweak those, maybe increase the volume, because I think there are a lot of good ideas there. And they're all round peg, square hole, but that's fee-for-service.

All right. As people move out of fee-for-service -- and by the way, ideally, one of the things I think we'd like to see, ideally, is a migration as people go from being relatively young and healthy to a population that is

characterized by one or more of either multiple chronic diseases, social determinants of health, a mix cognitive and physical impairments, a mix of medical and behavioral health needs, that they are incented to transition to either an APM or an MA, and I would love to see us to take continued actions to ensure that there is a relatively level playing field with opportunities to succeed for entrants in either the APM or MA space.

In the APM space, the only additional comment I have to what I think is really excellent suggestions on Slide 30, is overall, and this fits Lynn's comments and others' comments. I don't think there has been enough dollars and enough overall risk -- call it risk, call it incentives, call it change in the structure of payment -- to get APMs to be able to reengineer the structure and processes of care. Because again, if we think about we want to serve a population with multiple chronic diseases, social determinants, cognitive, physical, behavioral health needs, we need a longitudinal approach, we need multi-modality and continued access, we need an accountable team that is multilevel, physical/behavioral health integrated with community, all of those good things that we all love.

But there is not enough money on the table to either force or incent APMs, by and large, to make those changes.

So the one thing I'd like to add to Slide 30, or two things, rather, is how do we adequately incent, put the dollars in front of APMs, to drive the needed structural changes? And the other comment, how do we incent beneficiaries as they become less healthy and as they age to engage in APMs? And again, on ideally a level playing field where a beneficiary can look and say, "Well, you know, I can get a pretty good deal with an APM. I can get a pretty good deal with MA."

In the MA space, first of all, I'd double, triple down on the comments around overhaul and reforms of the quality bonus and risk adjustment mechanisms. We have done, I think, as a team, excellent work, enabled by excellent work from the staff in that space. So I'd just double, triple down.

I would add that the prior auth and denial processes need to be scrutinized and reformed. We don't need to belabor the point today, but there is a huge amount of room for improvement.

Also, similarly, the requirements, I think,

around network and access, those are two somewhat overlapping, two somewhat separate concepts, need to be strengthened. What I'm getting at there is, in MA there is enough money in the industry to do what we want the industry to do, if we put the right incentives in place of it. The MA industry, by and large, has a lot of money, and they have a lot of really smart people.

The problem I think we have on the societal level in MA now is it's easier to make money in MA doing things that are not what we care about, in terms of improving the health of the population or the value to the taxpayers. So we need to change that. We change the playing field, we change the incentives, then the private sector does what we want it to do.

The only thing, also, I'd add to the MA is I think we do want to put something in there about continuing to explore the unique opportunities that the C-SNP and the I-SNP programs have, because of their ability to focus on a particular population, manage a tight network, manage a specific creative benefit plan, et cetera. So I'd like to at least capture that thought.

The last comment I have, the out-of-box thought,

I wonder about the feasibility and the outcome if CMS did some kind of state-by-state budgeting. Obviously, there are a lot of issues to that and consequence to make it happen. But I'm intrigued by the little bit I know about states where they've done some work on a global budget, and I wonder if that's what it will take, in addition to everything else we're doing, to really try to bring some discipline to the overall spend.

So thanks again. Excellent work. I really look forward to our ongoing work together.

MS. KELLEY: Brian.

DR. MILLER: I have really appreciated this formulation of work because it clearly lays out sort of three streams and three options for Medicare, and a lot of people don't necessarily always have that query. So I think it's really nice to see this laid out in a clear way. This is very easy for staff, policymakers, industry experts, academics to sort of focus on.

I'm looking at readmission for this one DRG, and I want it do this little thing, and we use that big, philosophical framing of that there are multiple formulations of your Medicare benefits, and that was an FDA

joke, for FDA folks in the audience, formulations, right. So multiple formulations of your Medicare benefits. So making the tradeoffs of those clear is really good, and I think helpful.

Some comments for each of those formulations as we think about them, sort of, again, keeping it at a high level.

Starting with fee-for-service, I think one thing that we haven't done is we haven't thought about fee-for-service framed as a health plan and how to improve it. What does that mean? The Commission has done some excellent historical work on improving the MA quality bonus program, because collectively I think we agree that that is a bonus, and maybe a bonus should also be a bonus penalty, and some of those metrics aren't meaningful. There is a lot of opportunity to improve that.

But if we think about fee-for-service as a plan, because it is a plan, it's a bit of a clunky plan, then we'd say, well, why isn't there a star quality rating and bonus penalty system for fee-for-service Medicare? Like why does MA only get that? Why doesn't fee-for-service get that?

So I think if we spend some time policy-wise thinking about fee-for-service and framing it as a plan instead of a conglomeration of provider programs, I think we can get a lot of good ideas about how to improve fee-for-service that will create a more dynamic environment that probably works better, frankly, for both the beneficiaries, the doctors and other clinicians, the hospitals and other health care providers, and give us a little bit of a step back from sort of the micro-targeting arguments that we end up dealing with. It's not that we should deal with those, but we can give ourselves a different set of potential improvements.

This sort of fits with something else when I looked at the fee-for-service section. A lot of the recommendations on Slide 19 focused on increasing centralization of authority and decision-making and increasing government control. And I'm not saying that we should -- I mean, I'm more of a decentralization, libertarian-esque person, but that doesn't mean that there aren't opportunities in the centralized decision-making to improve those decisions. But part of what we should think about in improving fee-for-service is what decisions and

plan operations are centralized and what is decentralized. And some of those things might do better centralized, like some of the coverage decisions that Medicare does are centralized and works well. There are other coverage decisions that are decentralized in Medicare that actually work better that way.

So I think the sort of lens I would think about is going from program for providers to a plan for beneficiaries, and then thinking along the spectrum of centralization to decentralization, and how do we want to change that.

Other sort of lenses I would look at for fee-for-service is I would think about improving benefit design, improving provider incentives, and then improving plan operations, which can mean a lot of things. Because again, fee-for-service is a clunky plan, and if you spend a lot of time with CMS staff over many years, they'll tell you many of the programmatic, operational things, that if we fixed them will make the program and the plan better for everybody.

Going to APMs, I am personally often very cynical about APMs, because the evidence is often lukewarm. I

still think that we should do a lot of work on APMs, because again, I think that's a stream, and there are positive impacts that can emerge from that.

I note that our Slide 20 focuses mostly on ACOs. I know that's where a lot of research and investment has been. I think that there are a broad portfolio of health insurance and finance tools that can modify outcomes and behavior. I would like to see more on bundles, episodes, risk corridors, even partial capitation. There are other tools that are in the sort of health-finance bucket that we can use, and if you go talk to insurance nerds, we can learn a lot, and also perhaps find a cure for insomnia. I like talking about insurance, so I have many other problems.

The third bucket is sort of the MA bucket. I agree 100 percent with our Vice Chair, Betty, that we have to improve consumer shopping. I'd say that both the Biden administration and the Trump administration have worked to do those things in terms of addressing some of the marketing and advertising regulation, improving the Plan Finder, provider directories, which are not up-to-date, shall we say, and haven't been up-to-date for as long as

I've been alive. So there are lots of opportunities to improve sort of consumer shopping. We should include that.

I agree with Scott that improving and building upon C- and I-SNPs to offer customized benefits. Would that result in customized care for complex populations is important. Because one of his, and many others', valid critiques of MA is that it encourages coding or other behavior as opposed to benefit design changing care delivery, which is what we want to have happen in MA, and I'm 100 percent on the same page with Scott on that.

I think some of our comments on Slide 16 on MA have lacked the wider range of evidence that I would want in a chapter. So I think more about what are the sort of buckets again that we can do for MA. Those buckets don't always involve payment. So there are a lot of things that determine payment and payment levels. And again, I would say thinking about regulations, subregulations, or subreg guidance, that can change.

And then I do disagree about the value of MA, and I would refer folks to my Ways and Means testimony from this year.

So I think that the biggest winner in MA is

actually the beneficiary, because what the beneficiary gets, and the reason people keep buying MA, as a customer, is that they get affordable Medigap and Part B coverage. And I'm all for making Medigap coverage more affordable or reducing Part B premiums, and if we think about going back to fee-for-service. If we think about fee-for-service as a plan and changing plan operations and how it is structured a bit, in addition to addressing benefit design, we could actually lower Part B premiums and potential lower Medigap costs.

So I think for MA in the context of fee-for-service, we need to think about sort of three questions for taxpayers which is, are taxpayers getting a good program statutory cost, or a statutory program spending for fee-for-service and MA, per-component benefit cost to the individual and society overall and taxpayers, because that matters. What is the cost of A benefits, B benefits, Medigap benefits, and D benefits, because the bene, when they retire and join Medicare, needs all of them.

And then I think the other thing that we should be doing is looking at what the total cost of that benefits package is for the beneficiary, the taxpayer, and society

overall, because that's fundamentally the question that we are having in fee-for-service, APMs, and MA, which is the beneficiary needs an integrated health benefits package. MA is an integrated option, APMs are sort of a more integrated option, and fee-for-service is a constructed option. And we should sort of look at what those costs and tradeoffs are.

And I think I'm only at 95 minutes in the duration of my comments, risk adjusted.

DR. CHERNEW: Risk adjusted. So this is Michael. I want to jump in because a lot of the discussion is focused on a bunch of very tactical, specific things about we should or shouldn't do in Medicare, which is all fine. But I want to emphasize a few of the question that I put into the chat.

Number one, how important are population-based payments? We can talk about all the details later. There will be a lot of time, potentially, to reach out and talk to me. But there is a big-picture question. How important is it that we do population-based payments, or episode-based payments, or some other thing. And do we need plans to do that, or we could do it doing APMs, or do we not need

APMs and we just do it in plans? Just big picture, conceptually, kind of questions like that.

And relatedly, do you agree or not, broadly, that to make the fee-for-service system work we need more than just fixing the prices but we need broader structures around it? And Like if we could get to sort of some view there about those bigger picture, conceptual things, then I think we can have longer discussions or other discussions about some of the underlying specific about how we manage choice and how we deal with benefit design and how we deal with risk adjustment and how we set benchmarks, and how we do attribution. I could go on longer than Brian about the things we have to figure out how to do.

But really, I think getting some sense, conceptually, about the role that sort of broader payment bundles, be they population- or episode-based, would be actually useful.

We can keep going through the queue and we'll see how much time we have.

MS. KELLEY: Scott, did you want to address something specifically that Mike said here?

DR. SARRAN: Yeah. Again, in my mind, the key

point on that, in terms of whether fee-for-service Medicare is adequate to meet population and taxpayer needs, is for a segment of the Medicare beneficiary population, fee-for-service, I think, does relatively well, and with the changes we've teed up, slide 27, I think can do even better.

It's the populations with greater needs where I think fee-for-service Medicare is completely inadequate to address the issues around quality and cost, and those are the populations also who do not have, by and large, the wherewithal to engineer their own health care microsystem, which is what's required if you're trying to navigate fee-for-service Medicare and you have a lot of needs.

MS. KELLEY: Okay. I have Gina next.

MS. UPCHURCH: Okay. I'm going to start off by saying I'm not an economist in these comments.

The whole time we've been talking and when I read these slides, all I keep thinking of is somebody who's learning how to ski and say they have old skis, and they have one ski in 1995, when we started with Medicare for older adults and just hospitalization, and then they get another ski. And we added people with disabilities. But

we think that we're supposed to just lean back to ski instead of leaning down and being firm, and we have such variance. And we're going in different directions, and we're out of control. And we're getting ready to go over moguls.

So the way that we built a patchwork of Medicare feels totally out of control, and it feels like, to me, one of the major themes that we need to think about is decreasing the variance that we have created through this year, partially through decreasing administrative costs and not allowing such skimming off of money that's going less towards care and more towards profit. So as much as we can do to focus on that, I think would really be helping us investing in the health care of the beneficiaries we're supposedly helping. So less variance is a big theme in my mind.

A couple of brief comments about specifics, and I know this was the prior recommendation from the MedPAC. I have serious concerns -- and I think Stacie mentioned -- about hospice going into the Medicare Advantage benefit. There needs to be significant beneficiary protections if that's the case, and so I just want to put a little

exclamation point by that.

The other thing that I've raised before, and I don't know how this fits in the economics of it all, but the annual shifts and the administrative burden that puts all the different Medicare Advantage plans, different marketing, the SHIP programs, the agents and brokers having to learn everything new, everybody having to get different networks every single year, the administrative costs that go into that are just ridiculous.

So just thinking about how we can create less variance, whether that means locking in not only the people in the plans but the plans beyond a year, like, can we do something to save some money there so, again, we can put more money into the care that we provide to people and less into the insurance companies' pockets and just to everybody else's pockets just because of the variance that we've created?

And then the last thing that I would say is I just want to go on record with Greg's earlier comment and Stacie's about the medications and some savings to be had. Again, we have Medicare A, we have B, C, D, end-stage renal disease drugs, hospice meds. There's no economies of scale

in any of this.

And just a very brief example, I'm looking at value that medicines bring, can be incredibly value, and I always want to go upstream. So, again, if we can control blood pressure and diabetes, we have less end-stage renal disease. So there is value with medications, but we need to look at that.

Just a very brief example, small example of how the variance has created administrative burdens and costs, just in the Part D benefit alone. Last year we started the MP3 program, if you all remember, the Medicare Prescription Payment Program. Well, the administrative burden, all of a sudden, every insurance company had to create a way to have Ms. Jones, instead of paying at the pharmacy, to pay the insurance company. So they all had to go through the process of creating that administrative burden.

And the negotiated drug prices, great on those 10 medications. The pharmacies are having to create all this administrative -- they're having to go through this process of signing up to get reimbursed and made whole by the drug manufacturer. More administrative burden. We didn't simplify; we made it more complicated. So as much as we

can do to decrease the variance overall and bring more value to health care delivery, instead of all the players that get into the game, is something that I'm interested in.

And with all that savings, we're going to add dental, vision, and hearing to fee-for-service Medicare.

Thanks. I'm excited about this work.

MS. KELLEY: Tom?

DR. DILLER: Yeah. Hi. I really appreciate this opportunity in this chapter.

And, Mike, to try to answer both of your questions, are population-based payments worthwhile and should we make structural changes to fee-for-service system, I think the answer is profoundly yes on both of those.

There's a few concepts, I guess, that I wanted to just talk about at a high level. The first one is I think the need for MedPAC to support the stated goal of Medicare to move away from the fee-for-service system and into advanced payment models in some way, shape, or form. Medicare has said they want to have 100 percent of patients in some sort of program by 2030, and I think that's an

optimal goal.

Unfortunately, the fee-for-service program, I agree it works for some folks, but mostly, it's promoting or incentivizing growth and intensity changes.

And even to comment a little bit about that, MA, for example, gets a cap, but in most of the programs where they're paying providers, they revert back to a fee-for-service plus some sort of bonus model. So we're still dependent on the fee-for-service system.

And most of the CMMI programs are paying in a fee-for-service basis with a very small incentive, or the amount of the incentive is not enough to change behaviors overall.

I think the second thing -- and I've heard it mentioned a couple of times, but I want to reiterate it -- is we need to engage and incentivize the beneficiaries. So, in MA programs, the insurance company is trying to do that oftentimes, and they have some strategies around that. But in regular fee-for-service and even in the CMMI programs, often the patient doesn't even know that they're in the program. So we've got to figure out some way to incentivize them through benefit design or other things to

engage in their own health.

The third concept, I think in the MA and APM programs, providers win by doing two things. They document and code extremely well, and they'll close HEDIS or starts gaps in care. All of that is antiquated. It's not helping to improve the quality of care that's delivered, nor is it helping to improve the efficiency of the care.

And that leads into my fourth concept, that the quality programs that are often aligned with the various APMs are antiquated and probably holding us back from really achieving much better quality. They're oftentimes poor measures, and they're not really moving the needle.

The final concept, I think, that I've got is encouraging local ACOs and CINs to manage populations. And, Mike, that gets to one of your main questions.

With the correct incentives, they can change the course. If we were to decrease the dependency on fee-for-service payments and reward quality and efficiency, I think that would be of significant benefit.

We need to encourage high-value providers, and the concept of any willing provider is probably antiquated. So one of the big problems that our area has run into is

the regulations around adequacy, and all that seem to be somewhat stripped. We need to engage specialists in value-based care, and we need to engage hospitals in value-based care.

Right now, the main focus has been on engaging primary care physicians, and I support that, but we need to get the rest of the systems involved.

So thanks so much for the opportunity.

MS. KELLEY: Tamara?

DR. KONETZKA: Great. Thanks for this really clear outline of these issues.

I'll start with, you know, there's a long list of things that people have brought up that I would plus-one on, the idea that we really need to do something about post-acute care payment, you know, sort of on a bigger picture, on a broad level, to think about, you know, I think there are so many efficiencies to be gained there. There's just so much wrong with that payment system.

I would also plus-one the max out-of-pocket for fee-for-service and looking at the value of those extra MA benefits and digging into the volume and intensity, especially the drug spend.

But I think the rest of my comments, I want to keep very big picture. When we looked at the beginning of these slides at the sort of conceptual pros and cons of each type, I thought there were a couple of things missing that are really critical, and that is sort of on slide 14. When we're thinking about capitated payments, you know, there's the incentive to provide more efficient care, but I think an important incentive there is that, you know, in sort of minimizing cost, there's also the incentive to stint on care or potentially, you know, under-provide care.

Conceptually, I think that's a really important thing, because on the extremes, that's what people get really concerned about in MA.

And then I also think on slide 15, another downside of fee-for-service -- and this is sort of people have alluded to this indirectly at least -- is that there's a complete lack of coordination. There's no incentive for providers or beneficiaries to really -- you know, there's a challenge to coordinate their own care, and there's no incentive to providers to coordinate that care, and, you know, sort of the opposite for capitated models.

So those things, I think, are part of the

complete conceptual picture, which leads me to these other bigger-picture comments, which is, you know, I'm not sure that, first of all, the fee-for-service bucket without APMs should really be its own bucket. I think we should move toward sort of eliminating just pure fee-for-service, which doesn't mean like from the beneficiary perspective, we should eliminate that. I think there's, you know, obvious value in maintaining a traditional Medicare, but to the extent that we can broaden APMs and, you know, models like bundled payments that I think have actually worked very well to tamp down some of the adverse incentives in fee-for-service, I think that needs to keep going.

I know the evidence on ACOs, for example, and some of the other alternative payment models has been, you know, kind of underwhelming or lukewarm, but I don't see those APMs, that evidence or those APMs as sort of, you know, an end goal in their design. I think it's a process, and we just keep working on designing, you know, tweaking the designs and changing them, such that we get the result that we want. You know, it's incremental and not very exciting, but I think we need to keep pushing in that direction.

On the other side, the MA part, you know, I think, you know, as opposed to fee-for-service, which I think, you know, those incentives for volume and intensity and sort of increased volume and increase volume -- it's really hard to get rid of those incentives, right, without the APMs. And so I think there's sort of a fundamental challenge there, which is why I think, you know, we should expand the APMs.

On the MA side, though, I think the potential is really still there to sort of fix it, right? The incentives are pretty -- the underlying incentives are pretty good. We just have set it up all wrong. I mean, I think the idea of changing the way we pay MA plans, changing the benchmark, changing the whole rebate system, such that we could achieve some savings out of the MA program, I think that's all actually, you know -- politics aside, I mean, I think that's all feasible. It's not inconsistent with the conceptual incentives. And so I think there's just so much work to sort of redesign how we pay MA plans.

And then the other part of that is, you know, I think -- I remember this quote from Stacie once from -- I

don't know -- a year or two ago, that I thought was great, which is, you know, for a lot of people, MA plans work just fine, but when it's bad, it's really bad. And, you know, I think that that's the other part of MA incentives, the kind of incentives for stinting or denying valuable care, high-value care, that -- I don't know what the solution is, but that part we would have to fix as well. You know, but I think that continuing to invest in ways to reap the advantages that MA can offer, while not overpaying them and not setting up the payment incentives to just encourage more profit is, you know, really a still promising avenue to keep following.

Thanks.

MS. KELLEY: Robert?

DR. CHERRY: Yes. Thank you.

First of all, this is an excellent report. I like the way, just in general, the chapter is framed because I think the three different approaches with the pros and cons allows us to, in a more digestible way, understand what the problem statement is. And there's definitely no shortage of problems, as we've articulated here.

I think one of the things that struck me was really, like, slide 32, where there was kind of simple statement there, but there's a lot to unpack. And basically, it was under the improvement section where we should, you know, perform a calculation of the benchmarks that MA plans bid against and that they should be changed.

I think we could agree with that, but the devil's in the details, so to speak, because, you know, what calculations really need to go into the methodology?

We do know that the, you know, MA spend exceeds fee-for-service, and I think at a very basic level, what we need to kind of drive, I think, is parity between the two, to make sure there's not a fundamental difference between what we're paying for fee-for-service, you know, versus MA. And if that is the starting point, then that simplifies a little bit, you know, the problem and the approach, because then we can start thinking about creative ways of redesigning the model, and some of which has been, you know, tossed around, you know, today. You know, should we be using, you know, the fee-for-service as part of the model for judging, you know, a good or bad bid? You know, what role does benefit redesign actually, you know, play in

all of this? And how do we minimize unnecessary utilization and low-value care?

But I think the first step is trying to at least control the spend and make sure that there's no differences between the two, so that we can improve the quality of care and that the beneficiaries are getting the maximum benefit out of it.

Part of the challenge, though -- and we've known this for quite a while -- is getting effective data, you know, out of the MA program. So we need to figure that out, too, if we're able to drive, you know, better solutions.

I think the other thing that I want to mention, but for fear of getting into mission creep, and that's not really the intent here, but I think where there's opportunities to cross-reference some of the good work that we've done in the past, we should definitely do that, because I think with all three of these approaches, you know, pharmacy is a major driver in increasing, you know, the costs, and it's difficult to get, you know, control over, as you know.

And I'm not saying that we should, you know, be

heavy on, you know, pharmacy solutions with all these approaches, but just merely to at least acknowledge that that's a major driver and then refer the reader to further work that we've done in terms of other chapters that have been published, et cetera. So this way we're not getting into mission creep, but we're not ignoring, let's say, the elephant in the room in terms of a major driver with some of the costs.

But, you know, I'll kind of, you know, stop here, but I think that, you know, the basic take-home message is really, at least my preference is, is to kind of explore models that can drive, you know, parity between fee-for-service and MA.

So thank you again for the excellent work.

MS. KELLEY: Josh?

DR. LIAO: Great work here. Like many of the Commissioners, I think often in my day job and other things about many of the operational and tactical things that other Commissioners have mentioned. I try to keep my comments more kind of on a set of five principles and then react a little bit to the slides that were presented today.

I think, first, you know, it's worth stating

every payment approach -- fee-for-service, APMs, MA -- in my view, come with real strengths and real limitations. And while perhaps self-evident to some, it's worth stating that none are immune to gaming, in my view. None are fully self-executing. None of them solve the challenge I think we are confronting in Medicare writ large. And so the question is not so much which approach is perfect, but how we manage incentives and approaches across the program as a whole.

Second, I think none of these three approaches operate in a clean silo. You know, the tools and incentives we often associate with one approach, you can see increasingly appear in others. So, for example, fee-for-service underlies the APMs we think about, like bundled payments and ACOs.

Volume-based compensation I think noted to exist under APMs, also exists in many MA arrangements as well. Utilization tools like prior authorization are increasingly emerging in parts of fee-for-service, not just MA. And I think the point here is that these overlaps to me remind me that the boundary between these approaches are somewhat porous and that, you know, improvements is much about

calibrating these tools, these shared tools you might call them, as it is about choosing amongst kind of distinct features. That's second.

Third, I think it's important for us to consider where each payment approach sits in what I call the maturity curve. So fee-for-service and the tools such as a fee schedule have been in place for more than 30 years. We continue to try to refine it rather than discard it. I think that's appropriate.

Medicare Advantage is similar to undergoing decades of iteration, and to my knowledge, there are no widespread calls to eliminate it.

In contrast to that, I feel that APMs, such as ACOs and bundles, at least in some quarters are calls to write them off or to stop doing them, even though they're comparatively younger, and I believe still maturing. I think a common rationale for some of these calls that I'm aware of really focus on the fact that they haven't consistently generated net savings for the Medicare program.

While that is true kind of in the math, I think even in early years, it's also important to recognize that

many APMs did drive care redesign changes that produced A and B savings. It's only when incentive payments and shared payment savings were incorporated that net program savings disappeared.

I mention this because I think from a maturation perspective, if you look at another approach like MA, it offers an instructive parallel. You know, early aspirations really were focused in part on reducing spending. But since that time, overall MA spending has increased significantly. And again, we've worked to improve it, not discard the program.

So I think that history cautions, at least me, to avoid kind of using near-term program savings, especially when incentives are needed to spur participation as a sole basis for kind of judging a model's value or deciding kind of whether to abandon it.

I think the broader point in this third principle is just that a maturity curve lens may be essential here. For us, as we think about the different models -- and I think we would benefit from avoiding inconsistencies in how we evaluate payment approaches at different stages of maturity and development and how quickly we think to kind

of improve versus discard them.

Fourth, you know, I also kind of, on a principle level, think it's useful to distinguish between what an approach can achieve in theory and how it performs in practice. You know, in theory, fee-for-service offers a neutral, open-access way to access many clinicians. APMs promote efficiency and coordination, and MA has strong tools to address avoidable and unnecessary use. In practice, which I won't relay here, there are many challenges in implementation across all of these, many of which other Commissioners have mentioned. But I think the point is just that I think part of this work and our task would be to manage these approaches intelligently, you know, across the Medicare program.

I think fifth, and finally, it's important to kind of ask in work such as this, you know, whether fixing implementation issues would still leave persistent problems that are rooted in a model's or an approach's inherent design. So I think some challenges, coding intensity, benchmarking, are implementation problems that can and are trying to be managed and mitigated.

I think others are more structural, and in fee-

for-service, in particular, I think Mike and others have mentioned this, but I think there are inherent challenges to setting prices across a highly heterogeneous set of clinicians and delivery organizations. There are a number of others I won't mention here. But I think the point is even if we were to solve some of these things, address code misvaluations, relative payment rates, the fundamental dilemmas would still remain.

So I think distinguishing between structural limitations and implementation flaws, I think will help clarify how we go to improve these different approaches that this material lays out.

So those five principles -- in terms of the feedback I have for future work, I'd say at the highest level, I would welcome future iterations of this work to kind of mention some of these principles, if possible, to articulate the strengths and limitations of each approach, to recognize when tools and incentives overlap between them, to assess the impact of each approach along its maturity curve, to distinguish kind of conceptual and implementation challenges, and to use that framework to clarify, you know, how each approach could be improved and

what benefits we might realistically expect to get from each of those.

And at a more specific level, looking at what's listed on the slides here, I like the examples listed. Some of these focus on refinement of fee-for-service, which I think are certainly needed.

I am concerned about, however, the extent to which fee-for-service, even if we address some of these implementation issues, has the fundamental design to address some of the rising spending concerns that I share with other Commissioners, absent the more population management capabilities that APMs and MAs bring to the table. So I think that just context, to me, makes it important, in my view, to focus more deeply on MA and APMs as ways to provide those tools more effectively.

Finally, I'd really welcome a deeper analysis of how we can strengthen design and methods used to drive APMs. You know, through the lens of the principles I've just shared, I think APMs have, you know, comparatively fewer unique inherent limitations. I think there's more substantial room for further maturation and room under which implementation challenges, rather than structural

constraints, can be addressed. And so, I think, given that, plus the longstanding structural and implementation challenges that we have, both within fee-for-service and MA, it's difficult for me to reconcile the idea of stepping away from APMs at this juncture.

So I think highlighting all this in future work would be really wonderful, but thanks again for the material.

DR. CHERNEW: Josh and everybody, thank you. That was a really interesting discussion.

I'm going to try and wrap very quickly because we're at time, and then we're going to take a 10-minute break.

Before I do, I want to make sure I thank Stuart, Rachel, and Luis for their work on this chapter and their presentation. As always, they spent a lot of time with it in the midst of doing a whole bunch of other stuff, and I think that's the real thing you need to understand. This is in the midst of doing a whole bunch of other stuff.

I'll pick up on something you said, Josh, just because it's fresh in my mind. I think there's a distinction between technical problems and conceptual

problems, and we will continue to work on all the technical problems. Most of what we do involve working on technical problems, and I think that's important, and it spans all of the sectors.

But in some situations, there's really conceptual problems. The one I mentioned in fee-for-service, I call the marginal cost-to-average cost problem. How do you even know how to solve that by getting the prices right?

Tamara raised my biggest concern in the other areas, which is how you deal with these sort of inherent stinting problems if you pay in some other way, and that's a little bit of a technical problem, but I think it's also a bit of a conceptual issue you have to deal with.

In any case, a few other just big-picture things before we wrap, and then you will get to see this again as the chapter comes out. It's actually a real chapter as opposed to slides.

The one that I want to focus on is Greg's point, which is really a broad notion about the role of prescription drugs, which is admittedly a huge issue, somewhat beyond the scope of where this will be. I just want to point out that I do think some of these other

mechanisms, like MA plans with formularies or substitution incentives, can help us get some of that. There may be more one can do, but I certainly think that the tools that one has to address those issues in a, say, MA or even an APM model might be broader than what could happen in how we try and deal with them in a pure fee-for-service setting. But, again, that will be for longer discussions.

So, again, I'm going to thank you all for both the work that the staff did and for the comments you made. There will be a lot for us to think about. Luckily, we'll have a holiday season to think about it.

And now let's take a 10-minute break, and we're going to come back, and we're going to go through the two mandatory report chapters that we have to discuss. So I'll see you all at the bottom of the hour. Remember to come back to this same link.

[Recess.]

DR. CHERNEW: Okay. I think we're going to jump back in. Welcome back, everybody. We are going to jump back into a discussion of home health. We talked earlier about the home health update, but we also have to complete a mandatory report on the home health payment system. And

we are now going to walk through that report, and as you might expect, that is going to bring us Evan and Betty. And I think Evan is going to start. Evan, take us away.

MR. CHRISTMAN: Thank you, Mike. Good afternoon. Now we will look at the analysis for a mandated report about the home health payment system that is due in March 2026. 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's presentation will have five parts. First, I will provide a brief overview of home health benefit. Second, I will explain the policy changes the BBA of 2018 requires us to study. Then, I will explain the mandate and how we conducted the analysis. Next, I will present the results. And then finally I will turn it over to the Commissioners for discussion.

As a reminder, here is an overview of the home health benefit. Medicare covers care in the home for beneficiary that are homebound and require skilled care. The covered services include nursing, physical, occupational and speech therapy, medical social work, and home health aide services. The bulk of services are

nursing and therapy. A prior hospitalization is not required to receive home health, and there is no limit to the duration of care as long as a beneficiary meets coverage criteria. Finally, there is no cost-sharing for home health services in fee-for-service Medicare.

Before turning to our presentation, here is a brief overview of home health care in Medicare fee-for-service.

In 2023, there were about 12,000 agencies approved to participate in the program. Those agencies served 2.7 million fee-for-service beneficiaries, and delivered 8.3 million 30-day periods of home health care. Total fee-for-service payments in 2024 equaled $16 billion.

Turning to today's topic, let's begin with a review of the policy changes mandated by the BBA. As you can see here, prior to 2020, Medicare paid for home health care in 60-day episodes. The BBA required that Medicare switch to the shorter 30-day period. Also, the statute required that the home health PPS no longer use the number of therapy visits provided during home health care as a payment factor.

The changes in BBA reflected policy concerns

raised by the Commission and others in preceding years. One major issue was the use of therapy visits provided during a 60-day episode as a payment factor. Prior to 2020, the home health PPS had payment adjusters that increased payments when additional therapy visits were provided.

In our March 2011 report to Congress, we found that agencies adjusted the number of therapy visits they provided to increase their payments and financial performance. This led the Commission to recommend the elimination of therapy from the home health case mix in 2011.

Separately, the Senate Finance Committee investigated trends in home heath, and concluded that the inclusion of therapy was influencing how agencies were providing these services, and it also concluded that Medicare should move away from using therapy in the payment system.

In 2017, CMS proposed, but did not finalize, a new case-mix system that had the two policies later mandated by the BBA.

Now we turn to the mandate for the Commission.

The language for the mandate is in your paper, but generally the mandate requires us to assess changes in payments, costs, quality, and any unintended consequences of the new 30-day unit of payment. The BBA required two mandated reports, one we transmitted in March 2022, and the second, which we are discussing today, is due March 2026.

In 2020, CMS implemented the BBA changes through a new system referred to as the Patient-Driven Groupings Model, or PDGM. In PDGM, beneficiaries are assigned to a payment group based on five dimensions of severity. These include the timing of the current 30-day period relative to prior home health services, the source of the referral to home health care, 12 clinical groups based on primary diagnosis, functional impairment, and the amount and type of clinical comorbidities. You can see the unique categories in each of the five dimensions on this slide, and there is more detail on them in your paper.

Before I turn to our analysis, I want to review the results of our March 2022 interim analysis. That report found that utilization of home health fell in 2020, but that several other factors, likely contributed to the decline.

First, there was the disruption of the pandemic and workforce shortages. Second, there were other factors that may have affected utilization, such as a pre-2020 trend of declining hospitalization rates in Medicare fee-for-service. In addition, this analysis relied on only one year of data, from 2020.

Even with these limitations, we found some measures of stability, that in the first year, things had not changed significantly. For example, for PDGM measures of severity, the mix of patients within each of the timing, source of referral, and clinical groups of the PPS was the same in 2020 compared to the prior year. Finally, we noted that assessing quality was challenging due to the disruptions of the pandemic.

The final mandated report due in 2026 is an opportunity to assess PDGM with more years of post-implementation data, use methods that account for pre-PDGM trends and examine a broader set of analytic measures.

The analysis I present today will use an interrupted times series. In this method we use pre-PDGM data from 2016 to 2019 to estimate a counterfactual of what would have occurred in 2020 to 2023 in the absence of PDGM.

This approach is useful because it allows us to account for pre-2020 trends that may have affected outcomes in the PDGM era.

As noted in your paper, we include control variables to account for non-PDGM factors that could affect outcomes, such as changes in fee-for-service enrollment, beneficiary characteristics, local market factors, and other factors related to home health care use.

Before I present our results from working with the interrupted time series model, I want to give you an overview of home health utilization during our study period.

In the graph on the left, you can see that from 2016 to 2023, the share of Medicare beneficiaries with at least one home health stay declined, with the largest decrease occurring in 2020. Looking at the graph on the right, you can see that the average number of visits per stay decreased in the same period, again with the greatest decline occurring in 2020.

One takeaway from this graph is that, 2020, the year of the pandemic and the implementation of PDGM, saw the biggest changes in utilization during this period.

Now we turn to our analysis, but before I proceed, I want to note some cautions about interpreting this data. Many factors can affect home health utilization. While our models control for measurable factors that we have identified, we cannot be certain they fully account for them. As the previous slide implies, chief among these is the COVID-19 pandemic. In addition, there may be other unmeasured factors that we have not accounted for that could affect our estimates. Second, as I mentioned earlier PDGM was implemented for all beneficiaries in 2020, and so we cannot rely on a control group.

We will have to consider these limitations when presenting results and making conclusions. For these reasons, in general, I will frame the results we find as "associated with PDGM" as opposed to be caused by it.

In the rest of the analysis I will be presenting results from 2023, the most recent post-implementation year of data available and also a year less likely to be affected by the pandemic as prior years. I will also focus on our analysis for all fee-for-service beneficiaries in this presentation. Your paper includes analysis for

beneficiary subpopulations, and in most cases, results were generally consistent across these groups.

In these results, I will present two estimates for our outcomes: a without-PDGM estimate that reflects what we estimate would have happened in 2023 in the absence of PDGM, and a with-PDGM estimate that reflects what actually happened. The difference between the two is our estimate of the change associated with PDGM.

You can see an example in the figure on the right with hypothetical data, and the orange bar is the counterfactual without-PDGM estimate for the outcome, and the blue is the with-PDGM estimate. As the orange without-PDGM value is higher, in this example the implementation of PDGM was associated with a lower result relative to the counterfactual.

In the following slides, the results are statistically significant with a p-value of .05, unless otherwise noted.

Now we turn to our first outcome, the probability of a fee-for-service beneficiary having home health services in 2023. As you can see from the graph on the left, the overall the probability of a fee-for-service

beneficiary receiving home health care was slightly lower with PDGM, 8.6 percent, compared to without PDGM, 8.8 percent.

PDGM had varying effects depending on the referral source. It was linked to a higher likelihood of at least one post-hospital 30-day period, but a lower likelihood of experiencing at least one 30-day period community admission period.

Our next metric is the average number of visits per stay. As you can see from the graph on the left, PDGM was associated with 15.9 visits per stay, or 2.9 fewer visit per stay compared to the without-PDGM estimate. The magnitude of the reduction in visits per stay varied for skilled nursing visits and therapy visits, with the latter having a larger drop.

It is notable that both services were lower, as PDGM most directly changed the incentives for therapy. The removal of therapy was intended to discourage the provision of care based on financial incentives, and the change in therapy may reflect revised care plans that better align services with patient needs.

We also examined home health aide visits, which

are challenging to assess because they are relatively infrequent, and most stays do not have these services. The model indicated that PDGM was associated with more aide visits, but other factors may be at play as PDGM did not directly change payment incentives for aide services.

Turning to quality, we examined two functional measures and one hospitalization measure, and I would note that the last measure is updated from what you have in your paper.

For our functional measures, the rate of improvement in self-care and the rate of improvement in mobility were stable, and no substantial change was associated with PDGM. However, it is notable that the Commission has raised concerns about patient function data that is self-reported by home health agencies, and reported results for the functional measures may also reflect agency coding practices.

For the third measure, the rate of potentially preventable hospitalizations, we saw that with PDGM was lower.

Overall, these measures indicate that PDGM was associated with no real change, or actually a slight

improvement in the case of hospitalization, in the quality of care.

Finally, we also assessed financial performance by computing payment-to-cost ratios for home health stays. We found that PDGM was associated with a slightly higher payment-to-cost ratio compared to the without-PDGM counterfactual. The higher ratio observed under PDGM likely reflected many factors, but the decline in fewer visits per stay associated, that I mentioned a few slides ago, likely play a factor.

Separately, it is important to recall that even without the effects of PDGM we have found Medicare fee-for-service home health payments were well above costs. In our most recent report we reviewed this morning, fee-for-service margins exceeded 20 percent in 2024.

This bring us to our last slide. Overall we found that the PDGM was associated with little effect on fee-for-service beneficiary use of home health care, with a slight decline in the rate of use. We found that there were fewer visits for a fee-for-service stay with a decline in overall visits per stay of 15.3 percent, and a decline in therapy visits and skilled nursing visits, with the

therapy visits declining by a higher rate. There was little effect on the fee-for-service quality metrics, with the exception of the hospitalization rate. That did improve.

And then we also found a higher fee-for-service payment-to-cost ratio, 3.6 percent higher, but we noted that the margins were quite high, as we found in our other work.

This bring us to our last slide. For our next steps, we plan to return in January with an additional quality measure and some analysis examining our outcomes for select clinical groups. We also look forward to your feedback on our materials. After the January meeting we plan to include our findings in the in our March 2026 Report to Congress.

This completes my presentation, and I look forward to your questions.

DR. CHERNEW: Evan, thank you very much. As you noted, we have been looking at this payment change for a long time. It is nice to see all the evidence that you presented related to it. And so we are going to go through the set of comments, and I think Tamara is first. Did I

get that right, Dana?

MS. KELLEY: Yes.

DR. CHERNEW: Way to go, Michael. Okay, Tamara.

DR. KONETZKA: Great. Thank you, Evan, so much for this really excellent work. I have two Round 1 questions. First of all, in Table 4, which I think you also have a slide on, or referenced in a slide, the difference between post-hospital and community-initiated home health use the sort of effects that you measured from the PDGM. They are just strikingly different, right? So at the top of Table 4, on the righthand column, your estimated effect or association with PDGM is a 6.9 percent increase in the probably of home health use for post-hospital, and a -7.1 percent decrease in community-initiated.

It's somewhat consistent with the payment-to-cost ratios, but what's your feeling? Do you have an explanation for why that's so different? And is there something about the change to PDGM that sort of disadvantaged payments for community-initiated patients? I want to get your gut sense.

MR. CHRISTMAN: So, yeah. That was one of the

first things we noticed, and I think maybe we can a little bit about this in the paper. But I guess the thing I would note is that this table shows results for 2023, and this shift really happens in 2020, you know, the year of the pandemic, where the volume of services tilts a little bit to the post-hospital cases. And it kind of stays at about the same rate through the entire post-PDGM period. So when we looked at it, it's sort of step change.

And I guess I would say that we're still investigating whether community-admitted periods or stays, however you define it, have lower financial returns than post-hospital stays. I haven't found clear evidence of that, but it's substantially different.

I think there are some different ways to think about it. I believe that there's probably more enthusiasm or interest or press from hospitals to move beneficiaries to home health when they can, so they can discharge beneficiaries. And whether there's similar motivations in the community, the pressure may not be the same. You know, there's also a case that if a home health agency is facing financial resources because of workforce constraints or other things, the hospitals will be some of their biggest

referring clinical partners. So ensuring that they satisfy that demand may have a heavier weight than what's coming from the community.

And I really appreciate you mentioning that. That's something we have talked a bit about. Everything I just said is sort of based on my understanding of the structure of the industry. I can't say that we have a great explanation for it. What I would say is that when we look at the payment system, I appreciate that we show the payment-to-cost ratios changing in a certain way.

You know, we're still refining this work, but I don't know that the financial margins will be that different. And so there are some things that might be true in this area, but I will confess it's still a little bit of a mystery. That said, I'm not sure that this work yet has uncovered anything that suggests that there was something systematic in the case mix that did that, but there are probably still some rocks we can overturn.

DR. KONETZKA: Great. Yeah, I think those explanations make a lot of sense, and yeah, I look forward to having you dig into them a little bit more. I think one thing to just keep in mind is I think those community-

initiated -- I mean, both of these, I think, are incredibly important services for beneficiaries, and so we should keep in mind, moving forward, whether there's something inherent in the payment system that's discouraging one type versus another.

My other question is somewhat similar, like do you have answer for this. But I'm wondering, the decrease in RNs per stay, the RN visits per stay, even though that wasn't targeted in the payment system, do you think that's just a function of workforce constraints, or do you have other explanations?

MR. CHRISTMAN: I really don't, so I want to be very careful when I speculate about these things. It could be workforce constraints. I guess when I look at the change in visits, which is very important, I think it's important to put them next to the quality results. And I'm very sympathetic to the notion that there may be important outcomes that we're not covering. But I would say for the ones that we've seen we have not seen the quality measures worsen. And I want to be very careful here, because that doesn't mean there isn't some impact somewhere, and it doesn't mean that's a long-term trend that can continue

But when we look at the decline in nursing, certainly we heard a lot of concerns around the tightness of the labor force is one of them. And this is one of the challenges of this project. I guess outside of some of the technical aspects of some other changes BBA made, I would say when we talk to agencies, payment pressure on the Medicare Advantage side is an enormous concern of theirs. And so making sure they have enough money to make up for their losses on the Medicare Advantage side is frequently something that creates pressure, and whether that affects, you know, they look for efficiencies in other areas is a possibility.

But in general, it was a little bit of a surprise to me that that happened, but the quality metrics don't appear to be negatively affected by it.

DR. KONETZKA: Great. Thank you.

MS. KELLEY: Okay. I have Stacie next with a Round 1 question.

DR. DUSETZINA: Great, thanks.

Great work, Evan. This is really fantastic. And as somebody who identifies as more of an epidemiologist, I appreciate the adherence to associations for this type of

analysis.

The one thing I was wondering as I was looking at the trends -- or did you think about -- and apologies if I miss this and you did it -- censoring the 2020 period and trying the models that way? Like, I realized some of them have like a sharp dip, come back up a little bit and then go back down. And so that might just be one suggestion as an alternative is to just say, like, let's kind of ignore this one year that we know is very strange and then look at the estimate to make sure it's not wildly different. From your graphs, I don't think it will be wildly different. But that's just one, you know, maybe way to think about it.

Also, to Tamara's point just now about the RNs and that conversation, it does strike me that would be particularly sensitive to the kind of early COVID time because of -- you know, I know like the demand for nurses, the pay, you know, the bonuses, everything to try to get people to move into hospitals for that short amount of time could have messed up the workforce in a way that it's hard to overcome.

But excellent job on this. It's really hard when something like a pandemic hits at the exact same time as

your policy change. So great, great work.

MR. CHRISTMAN: Just really quickly on the censoring one, we did -- I'm not going to be able to recover it, but we did do variations looking at pulling out 2020 and other things. You know, I can -- in a technical note, I can note that. But yeah, it wasn't -- it didn't -- that was part of the reason we left it in. It didn't appear to be sensitive.

DR. DUSETZINA: That would be great to include it as a note that you've done that in its same patterns.

MS. KELLEY: Okay. I have Tom next.

DR. DILLER: Yeah, very great work, Evan. I appreciate this.

In overall looking at this, by making the changes, we decreased the visits per episode, which I think is probably one of the goals of the program. But the quality metrics, this reduction in potentially preventable hospitalizations is very significant. I mean, that's a very good outcome with that.

Have you done anything to try to quantify the cost effectiveness or the ROI of that? And specifically, what does the reduction in preventable hospitalizations --

that's a savings to Medicare and a benefit to the patient -- what dollar amount was that worth, and did it pay for the program?

MR. CHRISTMAN: Yeah. I mean, I think we can think about ways to measure the impact of the lower rate of potentially preventable hospitalization. I guess, you know, this was one of those results where, you know, we had a few slides here where we were really trying to walk cautiously. And I'll just be frank and say it was rather, you know, counterintuitive. You're talking about a policy change where we cut the amount of services people were getting and their hospitalization rates go down.

And, you know, I think -- you know, one of the blessings of this data study is we have, you know, a huge data set with millions of records. So if the rate did change during the period, for any reason, and we haven't perfectly controlled for it, it's going to show up.

And so I think, you know, we can say with some confidence that we found that PPH was lower, and based on the pre-trend as we've measured it, you know, you would say it would make some savings. But I guess the challenge is, you know, when Medicare changed the payment system from

Medicare's seat, it was simply trying to change the incentives for home health agencies. There's no -- you know, there was no plan of reducing hospitalizations. There was no plan of, you know -- again, I'm going to speak in shorthand. I know these things are important at CMS, but this was not based on any sort of effort for value-based care or anything like that.

So the quality result is, you know, especially across with the utilization result, with people getting fewer services, it's one that I guess I approach very carefully.

DR. DILLER: But there's potential for there to be unintended positive consequences when you make a change, and I guess that's what I'm getting at.

And another way to look at this, too, would be to control for cost or control for inflation, but to look at the total cost of care for patients enrolled before and after and compare that to the cost of the program. I'm just curious about, is the program cost effective, number one? And number two, did the changes in the payment structure actually perhaps drive changes in efficiency, and they learn how to deliver home health better? And I know

that may be beyond the scope of this, but the results look good.

Thanks.

MR. CHRISTMAN: We can take a look at that.

DR. DILLER: All right. Thanks.

MS. KELLEY: Okay. I have Gina next for the Round 1 question.

MS. UPCHURCH: Yeah. Thank you, and thank you, Evan, once again for good work.

So home health is one of those odd ones where it's paid for under Medicare A post-hospitalization, but it's covered by Part B if it's community-initiated. So I guess my question is, if I'm the home health agency and I could be paid by Medicare A or Medicare B -- and I'm just talking fee-for-service -- is there a difference? Is it easier as a home health agency to deal with one versus the other? Do we know anything about the complexities there?

MR. CHRISTMAN: So I think what I would say is that the payment system runs completely independent of whether it is an A coverage day or a B coverage day. It's the same payment system. The eligibility is the same. The coverage is the same. So the two aren't coupled like that.

It is my understanding that whether it's something as an A stay or a B stay, generally its biggest impact is what side of the ledger CMS records the expenditures on. Does it go into the hospital insurance trust fund or the supplementary medical insurance trust fund? And generally, everything else is completely divorced from that.

MS. UPCHURCH: I got you. Thank you. So I was trying to see if there's any reason that the home health agency would act any differently. So both of them obviously had to follow the new PDGM guidelines or monitoring or however you want to call it.

So the other thing I would say, we're not looking at Medicare Advantage, and you mentioned it a little bit. But obviously, they have a choice. They don't have to pay on PDGM. I mean, there's a choice there, right? They get to do what they want in terms of paying for home health, right? So we just don't know about that.

And as I said in our last session, a lot of people are surprised to understand that fee-for-service does not charge cost sharing to the beneficiary. If you're under traditional Medicare, whether you have secondary

coverage or not, there's no cost sharing. But with Medicare Advantage, there can be, obviously, for some of these visits, so just to put that in there.

Thanks again.

MS. KELLEY: Cheryl?

DR. DAMBERG: Thanks for the chapter.

I had a couple of questions that relate to Table 9, which is the payment-to-cost ratio for stay and how you've broken that out by different characteristics, and I think I was puzzling over why there were differences or why the differences were larger for Black patients and duals. And I didn't know if you had any potential insights into that in terms of the effect.

MR. CHRISTMAN: I don't.

We can look a little bit more closely into that. The duals, there's this -- understanding some of what's going on there is challenging. They actually tend to sometimes get fewer visits on average than non-duals. Some of this correlates to how the visits changed and the cost structure, the agency changed and to how the payments change. And teasing out those two pieces, perhaps we can add a little bit of that in there saying how much of this

would shift some payments and how much of it was due to shifts in cost.

DR. DAMBERG: Yeah, I think that would be helpful. I appreciate those insights.

And then I guess relatedly, I was trying to figure out -- so we know there were fewer therapy visits and there were fewer skilled nursing visits, but I was curious if there were other changes, say, to the labor mix, that would make that payment-to-cost ratio per stay more favorable.

MR. CHRISTMAN: Yeah, so that's a fair point, and maybe that's something we can discuss in the paper. It's not something we had time to measure.

I think this gets to the key point, particularly with nurses. For each of the covered services, particularly nursing and therapy, example of the nurse, you could use a -- excuse me. I'm going to -- a registered nurse or an LPN. The LPN is less expensive. So, in some circumstances, they can send an LPN, and that satisfies coverage, and they can do it.

And the same thing with fully licensed, top of the license physical therapists and OTAs. And there's some

rules to the extent to which these different disciplines can be used, and it varies somewhat at the state level. But we didn't get a chance to measure that on the course of this, but that's definitely something we can note that might account for some of the shifts.

DR. DAMBERG: Yeah, I think that would be interesting.

And then just lastly, to the extent that you're going to continue to do work in this space and trying to get a better understanding of why there were fewer skilled nursing visits after implementation, if you had a chance to do some limited number of qualitative interviews, it would be helpful to just get some insights from the home health agencies of why that shift occurred.

Again, thank you for a great chapter.

MS. KELLEY: Okay. That's all I have for Round 1, unless I've missed someone.

Shall we go to Round 2, Mike?

DR. CHERNEW: We should, and I think again, it's going to be Tamara.

MS. KELLEY: Yes.

DR. KONETZKA: Yes, just a couple of comments.

One is about the model. I mean, first of all, kudos to you for finding a way to look at this rigorously when you have no control group built into the policy, and so I think you picked the right model, did what you could do, and you're very, very transparent and cautious throughout in talking about the results.

I guess my comment on that note is there's one place where I think you should maybe be even more cautious, and that is, you know, the assumption of this model is basically that those trends would continue, right, that the trends that you saw from 2016 to '19 would continue in a kind of linear fashion. And, you know, that's the main drawback to this model.

I think it's complicated in this case, as you know, because of the pandemic, and so, you know, what you're really assuming in this model is that even if you drop out the pandemic years and just look at 2023, you're assuming there was kind of like no resetting during the pandemic, right? That those trends would have just continued in a linear way.

And it may be because of workforce issues or because of practice changes during the pandemic that didn't

have anything to do with PDGM, you know, that there was some kind of resetting or change in trend, right? And that's just the limitation of the model. You can't do anything about that.

And so, in that sense, when you talk about some of the statistically significant results, like the, you know, probability of -- what was it? -- probability of use going to 8.8 percent to 8.6 percent, you don't make a lot out of this. It doesn't end up in the abstract. So that's great.

But even in the chapter, you know, when you say there was a slight decline, I would just caveat that because -- not because it's not statistically significant. But, I mean, so it is apparently. But just because like the assumptions of the model are, you know, somewhat tenuous, and so even if it's statistically significant, I would say that's basically not a change. Like, it's well within the error you might get from having an imperfect model and not a good control group, right? And so I think you'd have to have pretty big changes here to really want to conclude anything. So that's just, you know, about small wording issues.

You're already very careful. I would say be more careful, and you might want to just add that caveat that, you know, this model is not designed to give you very tight estimates on these effects.

My other comment is about kind of some of the things we've already been talking about, and so maybe I'm just repeating myself here. But, you know, I think, again, the declines in the number of visits, at least the therapy visits were expected, because that's the incentive that was set up in changing from the old payment system that paid on therapy to the new payment system. And so that's not necessarily bad.

But, you know, if we think about just this continuum where, you know, probably therapy was over-provided before and then you try to get to some sort of, you know, magic equilibrium where just a right amount of therapy is being provided, you know, hopefully, we're moving there or have moved there, you know, based on the patient needs and complexity. But, you know, then continuing that, you know, you have an area where therapy is under-provided.

And so even though the quality measures look good

now, I think two things. One, we really want to, you know, keep an eye on that over time and see if it sort of crosses a level where it's actually bad for patient outcomes, and two, I just want to voice support for your plan to look at this by a case-mix group, because I think that could be really revealing in figuring out, you know, for whom, for which groups, for community-initiated, for post-acute care, you know, for which groups might the reduction in visits be harmful or where are we seeing the biggest changes here due to this payment system.

So, other than those two things, you know, great work. Thank you so much for a rigorous approach to this, given the limitations.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you so much, Evan. This was absolutely great work.

Just a couple of comments piling on to some of the things the other Commissioners have said. The issue of nurse staffing during COVID is exactly as it was mentioned. There was an enormous pull of people to work as travelers at much higher salaries, and so there was a real market perturbation there.

In terms of the ability to discern between RN and LPN, I don't know to what extent we can do that, but they really are very different skill sets. And it's important that everybody's working at the top of their license, so sometimes it's very appropriate for it to be an LPN. Other times you really do need the registered nurse, and I don't know to what extent we can do that.

But I do think that with the next set of data, the rate of discharge to community, and the outcomes for specific clinical conditions, we'll have a more full picture of are some of these reductions good, you know, they're more efficient care, or is there some areas of concern?

So I look forward to seeing the next steps, and I just thank you so much for the great work and the great comments from the other Commissioners.

MS. KELLEY: Okay, Mike. That is all I have in the queue, unless there's someone I've missed.

DR. CHERNEW: Well, I'm going to give a little bit of a wrap-up, and I'm going to, you know, look at everybody on the screen and see if anyone else wants to get in here. But let me say a few things.

First, we were asked a very hard question in general. I think you did a really good job of trying to answer a very hard question. COVID made it much harder to answer the question, but we were told to answer it. I think you did a really good job of trying to go there.

I think the material is quite well caveated. I take Tamara's point about how one thinks about the assumptions and sort of how much noise there is that's generated just by what might have happened in sort of a violation of the assumption, as opposed to just sort of statistical noise. And I think that's valid, but I think given the data we had, I think you did a quite good job, and I'm happy with it And obviously, if anyone wants to jump in and say any other things, that's welcome.

I do think, for me, there's a lot of underlying issues here, but one of the core ones has to do with just the quality measures in general. And one of the concerns with some of sort of utilization-based quality measures is that if for some reason you're having fewer people see you -- you see this in primary care, for example. People don't go to the primary care doctor very much. Whether that's for better or worse, they often avoid getting into the

system and the process, which would send them other places.

So, for example, it's conceivable that by just having fewer visits, there's fewer times when someone might say, oh my God, you need to go to the hospital, for one reason or another. And so I think there's a lot of people that maybe we should have gone to the hospital that just didn't, and so it's never clear to me if you see more or fewer hospital visits, that means quality is good or bad.

I don't know much we're going to do about that. That's not a critique of anything we've done. I think it really fits into a theme that you see through this and even through the update work, which is quality is really hard to measure. And even if you can get something that's sort of broadly correlated with quality, that doesn't mean that the way that measure changes in response to various other changes, like payment change and stuff, is capturing actually true changes in quality or other aspects of things that are going on, given the cascades and other types of things happening.

But, in any case, I'm happy with where the report is. It's the culmination of a lot of work. What I take in part is that we put in a new payment model, and for

whatever happened -- I'm not sure this is the right way to say this -- it wasn't a disaster. We don't seem to believe that quality really went down a ton. It may have gone up some. Something else may be going on. But I think that's sort of the limits of what we might be able to say.

And the other thing that gives me some solace is, although this is a mandatory report, our final report on the new payment model, this is a sector that we're going to look at annually, because we go through the update work and we look at the quality measures. We look at the spending measures. We look at all of our general indicators.

So it's not the case that if something happens, we're no longer going to monitor what's going on. I think we're going to continue to think about what happens in the sector, how the payment is working, whether the new model is calibrated appropriately, what's happening to quality and all of those types of things, trends in the industry. So that's where we are on this.

And I think I'm going to pause for a second, see if anyone wants to say anything else.

[No response.]

DR. CHERNEW: All right. So we're ahead of

schedule, but I am fine with us being ahead of schedule. So let's take our scheduled break. And we have one more section, one more chapter. We're going to focus on the mandated ambulance report.

So, Evan, you did double duty today. Really appreciate it, and thank you to all the Commissioners for their thoughts on this. And we will move this forward.

So, again, let's come back in -- it's 4:17. Let's come back around 4:25.

[Recess.]

DR. CHERNEW: Okay. I think we're about ready to go with our last session of the December meeting, and we are again going to be looking at a mandated report, this one on Medicare ground ambulances, with a particular focus on the data gathering aspects of this.

Dan, why don't you lead us through it.

DR. ZABINSKI: Okay. Thank you, Mike.

Okay. So today Jeff and I will be covering a mandate from the Bipartisan Budget Act of 2018 that directs MedPAC to use data collected by CMS to produce a report on the cost of Medicare ambulance services.

We previously provided an introductory

presentation last March. Over the current MedPAC production cycle, we'll present an in-depth analysis and produce a report that has a due date of June 15th, 2026.

For the audience, a copy of the slides can be accessed through the control panel on the right side of your screens.

Our plan for this presentation is to discuss the report mandated by the Bipartisan Budget Act of 2018, provide background information and a description of the Medicare ambulance fee schedule, describe the ground ambulance data collection system, the BBA of 2018 required CMS to develop, go over the interviews with stakeholders in which we discuss whether collection of the GADCS data should continue, discuss our results from an analysis of the GADCS data, and then close with our next steps and a discussion.

So ground ambulance services that are provided to fee-for-service Medicare beneficiaries are paid under the ambulance fee schedule, the AFS. The Bipartisan Budget Act of 2018 required CMS to implement a comprehensive ground ambulance data collection system that includes data on ground ambulance costs and revenues.

CMS has responded to this BBA of 2018 mandate by creating the Ground Ambulance Data Collection System, the GADCS. The BBA of 2018 also directs MedPAC to use the data collected by CMS to produce a report that assesses the GADCS and reviews AFS payments.

The motivation for requiring CMS to collect the ground ambulance costs and revenue data starts with the fact that the ambulance fee schedule payment adjustments are largely not based on cost data and have not been updated since they were implemented. Without cost data, it may not be clear if AFS payments vary appropriately with the cost of providing care to beneficiaries who have different needs in different locations. It also may not be clear if aggregate AFS payments are adequate to ensure access to care and good value for the Medicare program.

The BBA of 2018 specified that MedPAC produced a report that includes an analysis of the GADCS data, an analysis of the burden on ground ambulance organizations associated with the collection of the GADCS data, and most importantly, a recommendation as to whether the collection of the GADCS data should continue or if a data collection system should be revised. And once again, the report is

due June 15, 2026.

Before we dive into our work on the mandated report, we'll provide some background on the Medicare AFS.

In 2002, Medicare payments for ambulance services shifted to the AFS from a system that paid based on cost for organizations that were affiliated with hospitals and based on charges for all other organizations. At that time, there was little data available for setting the payment rates.

Under the AFS in 2024, about 10,600 ground ambulance organizations provided ambulance services paid under the AFS to fee-for-service Medicare beneficiaries. These organizations provided 11.3 million ambulance transports that resulted in $5.3 billion in payments under the AFS.

The AFS covers both emergency and non-emergency transports from the point of a patient pickup to an appropriate medical facility or to the patient's home. Examples of covered transports include unscheduled emergency transports to a hospital emergency department, scheduled non-emergency transports from inpatient care to a skilled nursing facility, and scheduled repetitive non-

emergency transports to and from dialysis facilities.

Finally, payments under the AFS have two parts. One is for the mileage and one for the services that are provided during the transport.

The AFS payments for mileage are a function of a conversion factor, which is $8.97 in 2025, the location of where the patient is picked up; being urban, rural, or super-rural; and an add-on payment for the first 17 miles of a transport that occurs in a rural or super-rural area, where super-rural are zip codes located in rural counties that are among the lowest quartile of all rural counties by population density.

This table shows the differences between the payments for mileage between the pickups from rural areas versus those in urban areas. In the first row. we show that payments for urban pickups receive a 2 percent add-on. The second row, we show that rural pickups receive a larger 3 percent add-on, plus an additional 50 percent add-on for the first 17 miles, and then the third row shows that rural pickups receive only a 3 percent add-on for each mile beyond 17 miles.

The payments for the services that are provided

during a transport are a function of a conversion factor of $278.98 in 2025, a relative value unit, or RVU, that represents the complexity of the services provided; the location of the pickup, again, whether it's urban, rural, or super-rural; and a practice expense, or PE GPCI, from the Medicare physician fee schedule that adjusts for geographic differences in costs.

This table shows the differences between the payments for services between pickups in urban, rural, and super-rural areas, and that 70 percent of the payments are adjusted by the PE GPCI.

The overarching point is that transports from urban areas have an adjustment of 2 percent, and transports from rural areas have an adjustment of 3 percent. Then the transports from the super-rural areas have a rural adjustment of 3 percent, plus an additional adjustment of 22.6 percent. However, these adjustments for urban, rural, and the super-rural areas are temporary. They began in 2008 and have been extended several times.

The payment adjustments on the previous two slides largely were not based on cost data and have not been updated, which is the main motivation for collecting

the GADCS data. The GADCS data include information about the organization's characteristics, service area, service volume, service mix, staffing, costs, and revenues.

CMS surveyed ambulance organizations that provided ground ambulance services in 2017, 2018, or 2020, and included 10,600 organizations. Ultimately, CMS collected 2022 or 2023 data from 7,572 of these organizations, as about 1,650 of them were dropped because they were no longer active, and an additional 1,350 organizations chose not to participate in the survey.

On the next two slides, we present our assessment of the GADCS.

The GADCS is a comprehensive data set, as CMS was able to collect data from 71 percent of the organizations that provided ground ambulance services and has 7,572 records.

In contrast, previous data sets for analyzing the AFS had a few hundred records and excluded ambulance organizations that share costs with emergency responders or with hospitals out of concern about the accuracy of the data for those organizations. But for the GADCS, CMS worked with the organizations that share costs to ensure

the accuracy of the data.

The most important attribute of the GADCS is that it includes the cost data that can be used to evaluate the cost of providing ambulance services and assess the accuracy of AFS payments. In addition, the GADCS includes sampling weights so that nationally representative results can be obtained.

We do, however, have two concerns about the GADCS. One is that it is a very large data set and has over 600 variables, many of which we found were not needed for evaluating ambulance costs. For example, we use only 150 of the variables in the empirical results that we'll discuss later.

The second concern is that the GADCS does not include data on providing care specifically to Medicare beneficiaries. With this iteration of the GADCS, analysts can only calculate transport costs for all patients and not specifically for Medicare beneficiaries.

And based on what we learned about and from the GADCS, the BBA of 2018 requires the Commission to recommend whether the GADCS data should continue to be collected and whether the data collection system should be revised.

To inform these recommendations, we had discussions with industry stakeholders, including ambulance organizations, CMS, RAND, which contracted with CMS for a collection of the data, and ambulance trade associations. In general, these stakeholders noted that continued data collection would be beneficial to ensure payment accuracy and adequacy, that small rural organizations reported difficulty collecting and submitting data and wondered about the usefulness of many of the questions. And the survey instrument could be streamlined without the loss of effectiveness.

Also, the trade associations and the organizations felt that startup costs have been incurred, so stopping the GADCS at one iteration would be unfortunate, and that the quality of the data the organizations submit should improve as we gain more experience.

Over the next few slides, we'll present results of our analysis of the GADCS data.

So we've analyzed the GADCS to identify which organization characteristics do and do not affect ground ambulance costs. Thus far, the most striking finding has

been the effect that organization size has on organizations' cost per transport.

We sorted the organization by the number of transports and collected them into quartiles. In the lowest quartile of transports, cost for transport was $2,852, but in the highest quartile, it was $914, a ratio of 3 to 1.

Note that MedPAC in 2013 and the GAO in 2007 and 2012 also found that the number of transports has a strong effect on costs.

And we also found differences in cost per transport by type of ownership. That is, for-profit organizations have lower cost per transport than the government-owned and non-profit organizations. We found a smaller difference in cost between transports -- let me try again. We found a smaller difference in cost per transport based on whether an organization serves an urban or rural location. However, organizations that serve super rural areas have higher cost per transport than the organizations that serve either urban or rural areas.

And many factors contribute to the differences in the cost between ground ambulance organizations. For

example, the lower cost of for-profit organizations relative to those that are government-owned is likely due to several factors such as more transports, a less complex service mix, and use of different staffing models. Sample tabulations like we did on the previous two slides can't tell us the magnitude of the impact on cost of each of these factors. So to isolate the effect of each cost driver, we did a regression analysis.

The dependent variable in this regression was the natural log of each organization's ground ambulance costs. Explanatory variables were characteristics for each organization.

In the interest of time, I won't cover them now, but you can see the list on this slide, and there's more detail about them in your mailing material.

The benefit of this regression is that it allows us to see the impact of each cost driver while holding all other factors constant.

Several of the explanatory variables were significant, but two stand out. One is the number of transports by the organization, and the second is the location of the organization being urban, rural, or super

rural.

So concerning the transports, the regression indicates that costs rise at a slower rate than the number of transports, which suggests economies of scale, because the coefficient on the number of transports is less than 1.0 at 0.71. This coefficient means that a 10 percent increase in the number of transports increases costs at a lower rate of 7 percent, so cost per transport decreases as volume increases, holding other factors constant.

The implication is that the smaller organizations have higher cost per transports relative to the larger organizations, and this is important because the AFS doesn't have a payment adjustment for the low-volume organizations.

However, the Commission recommended that the AFS add-on payment for the first 17 miles of a rural transport be replaced with an adjustment for low-volume organizations that are located in isolated areas.

And the second regression result of interest is that the coefficient for the rural organizations of negative 0.13 indicates that costs were lower for rural organizations relative to the urban organizations.

However, the AFS has adjustments that increase payment for the rural organizations relative to the urban organizations. This result of lower costs for the rural organizations is due to controlling for the effects of other factors, such as volume.

And I also want to mention that the coefficient for super-rural organizations is positive but not statistically significant.

So to summarize today's presentation, the GADCS is a good first step in creating a data set that can be used to evaluate the cost of providing ambulance services and assessing the advocacy of AFS payments.

Moreover, stakeholders believe collection of the GADCS data should continue and that the GADCS has a lot of variables and could be improved through streamlining.

One concern we have about the GADCS is that it doesn't have cost data specific to Medicare beneficiaries. However, it's not clear that the Medicare-specific data are needed, and it's not an issue if Medicare costs match those for all patients.

Finally, we presented a regression analysis that showed that volume is a strong driver of costs and that the

current AFS payment adjustments aren't well-targeted. However, MedPAC in 2013 recommended a payment adjustment for isolated, low-volume organizations that would produce better-targeted adjustments.

The next time we will talk about the GADCS is at the March 2026 meeting. At that time, we'll return with refinements to our analysis of the GADCS based on your discussion today and with the Chair's draft recommendation or recommendations. Note that the final report is due again June 2026, and for today's discussion, we'll address your questions on the paper and the presentation. But we'll also seek feedback on two questions that are in the paper. Should the data collection continue, and should the GADCS be revised?

Thank you, and I turn back to Mike.

DR. CHERNEW: Dan, thank you very much.

I will make a comment between Round 1 and 2 about the rec and sort of what I'm looking for, but why don't we start now with Round 1. And again, I think -- and, Dana, correct me if I'm wrong -- it's going to be Tamara.

MS. KELLEY: Yes, that's right.

DR. CHERNEW: We love you, Tamara.

DR. KONETZKA: It's my pattern.

I have two questions for you, Dan, and this was a great work, really a very interesting chapter.

The first question is -- and I was looking for this in the chapter. I don't think it was there, unless I missed it, but what percent of these transports are Medicare on average, and how much of a range is there?

DR. ZABINSKI: It's about 25 percent on average are for Medicare -- fee-for-service Medicare beneficiaries. I'm not sure how many are MA, and I don't think that's something I can get out of the data. And it's -- what I found is like -- and this is a pretty wide range, but like over 90 percent of them are between zero and 50 percent. And then, you know, it kind of goes down slowly. There's some that are -- you know, a few organizations are actually close to 100 percent, but the bulk are less than 50 percent.

DR. KONETZKA: Okay. Yeah, interesting. It's one of those rare cases where, you know, based on your interviews or your qualitative data, that like everybody seems to be in favor of continuing this data collection, but, you know, for companies that have, you know, 10

percent Medicare, it seems like it could be a lot of work, right?

DR. ZABINSKI: Yeah.

DR. KONETZKA: Okay. So, anyway, that's helpful.

My other question is about the economies of scale that you found, the volume gradient. What do you think is the source of the economies of scale? This is like one of those things where it's not like they can go pick up several people at once, right? It's just -- you know, is it about staffing and slack in staffing and that they have, you know, sort of management and staffing efficiencies?

DR. ZABINSKI: I think there's some of that. Yeah, I mean, there's cases like -- you know, you can kind of divide the organizations into two types, those that have what's called a static model, where they're -- the number of available ambulance units is constant over time, and these tend to be really small organizations. If you, you know, think about the extreme, you can't have any flexibility in terms of the number of, you know, ambulances available for use if you only have one ambulance. You know, really small ones only have one. So, you know, they're kind of stuck with it.

The larger ones can use dynamic staffing where they can actually vary the number of ambulances that are available at a given time.

The other thing is it really seems like there's a lot of fixed costs for the -- and fixed costs are really -- seem to be a really high share of their overall costs. So it's like, you know, like anything, if you're not doing a lot, but you have a lot of high fixed costs, your cost per unit is going to be really high, while another organization that's able to, you know, have a lot more volume is able to spread the fixed costs over more units.

DR. KONETZKA: Yeah. Okay. That makes total sense, the high fixed cost part for sure.

All right. Thank you.

MS. KELLEY: Okay. I have Cheryl next.

DR. DAMBERG: Thanks, Dana. And Jeff, great work. I had a question about the dynamic versus the static staffing model, and I was trying to understand what determines whether a physician uses dynamics versus static. And maybe I don't fully understand the static staffing model. But is static used more often, say, in what I'm going to call local fire departments, you know, where they

need to have somebody on call 24/7, and they have to be ready to go, whereas the other entities -- because it seemed as though the ones choosing dynamic staffing were more often treating the lower acuity patients, if I followed that correctly.

DR. ZABINSKI: Let's see. You know, what determines it, I can't exactly say what it is. I mean, it was a question asked of the organizations, do you use a dynamic or static model. Now, my understanding of how it works is that, again, think about really small organizations that have only one ambulance, and if they're going to provide ambulance service 24/7, they don't have an opportunity to not have their ambulance fully staffed. It's just not an option if they want to be 24/7. But if you have a really big organization which has maybe a dozen ambulances, they can kind of figure out periods, well, we don't need these things fully staffed all of the time. Sometimes we do, but sometimes we don't, and we can reduce the number of staff we have available at some point in time.

DR. DAMBERG: Thank you.

DR. ZABINSKI: That's my understanding of how it

works.

DR. DAMBERG: Okay, thanks.

MS. KELLEY: Gina.

MS. UPCHURCH: Thank you for this work. I have a simple question. You mentioned that a lot of this data is collected on Medicare plus beneficiaries, so it's all ages, I guess all incomes, all over the place. Is there a reason to think that Medicare beneficiaries would be in any way different than other groups in regards to ambulances services?

DR. ZABINSKI: In discussions with them, like CMS and the trade associations and to some degree the ambulance providers themselves just said, "Yeah, it just doesn't seem like our costs are going to be different for Medicare versus non-Medicare." And I think a lot of the reason is that because so much of their costs are fixed, it doesn't matter if the patient is Medicare or non-Medicare. Your fixed costs are your fixed costs, irrespective of what type of patient you have.

And another thing is it seems like to CMS it became evident pretty early on that they weren't going to be able to collect Medicare-specific data from the really

small organizations, because they just didn't have the accounting sophistication to do it.

MS. UPCHURCH: Thanks.

MS. KELLEY: Scott.

DR. SARRAN: Yeah, excellent work, for sure. What I'm trying to understand is going ahead, what problem are we trying to solve for or solution are we trying to create by continuing to gather the same data, or gather the same data refined or incrementally added to? You mentioned, I think, on the previous slide something about stakeholders were interested in ongoing data collection, and I apologize if I missed an obvious. But now that we have sort of a handle on this, it's only a $5 billion sector -- I never thought I'd see the day where I said "only $5 billion" but it's a small sector in the scheme of Medicare -- access seems okay, what are we trying to solve by continuing to carry the increment work around data collection?

DR. ZABINSKI: Well, I think the big issue is, you know, let's go back to why we're doing this in the first place. What was the argument for doing it? Is when all the features of the AFS payments, you know, the

adjustments that are done, depending on what the characteristics of the provider are, a lot of it was just based on negotiation and discussion without data. And the providers are saying that it is really, really outdated in many instances, in a lot of locations, that the payments really aren't adequate, for any number of reasons, and they really want to get it nailed down, to get the payments adjustments so that the payments really match what the features that affect the organization's cost, they vary according to those.

And ongoing, I think there's just this feeling of, well, you know, it would be really nice if we were able to keep it up. Things change over time, and we'd really like the payments to continue, you know, get them fixed so that payments do accurately reflect costs on a case-by-case basis, that we can keep it going. Plus, you know, we did all this work to get this started, so it's kind of a shame to let it then go to waste.

MR. MASI: Yeah, if I could jump in real quick to maybe underline one or two things that Dan said. I think we hear both, like Dan talked about, an issue of that overall level of payment from stakeholders as well as the

relatives. And to underline one thing Dan said, my understanding is since the AFS was first implemented in 2002, again, I think based on negotiated rulemaking as opposed to some kind of empirical analysis, I think those RVUs for the different types of services, as well as the different payment adjustments, those haven't changed since 2002.

And so I think when we talk with stakeholders and organizations, I think there's some real frustration that the payment system is just outdated and stagnant. And then as Dan said, concern over the adequacy and overall level of payment, and I think that's really the big messages we heard loud and clear in those conversations. And then it is, of course, up to you to kind of grapple with those and how you want to weigh those.

DR. STENSLAND: The only thing I would add is when we do talk to ambulances, I think they're okay with the idea of continuing to collect data, but that's different from continuing to collect all 600 different questions. So I think there's a difference there.

DR. SARRAN: Yeah, that's my --

DR. ZABINSKI: Good point, Jeff.

MS. KELLEY: Okay. I have Greg next. Greg, I'm sorry. We can't hear you. Can you check your mic again? No, I'm sorry. I'll tell you what. Why don't we go to Robert and we'll work on your mic.

DR. CHERRY: Okay. Maybe I'll try to channel Greg and try to read his mind while he's fixing the mic. But, you know, my question goes back to the variables that are collected. You know, on one level, dealing with different data collection systems for registries for different clinical services, 600 variables doesn't sound like a lot. But it is problem that there's 450 variables there that seem to be never utilized. So there's definitely a problem with how it was created and constructed, and it goes back the question of what problem are we actually trying to solve here.

I am curious to know, just to kind of keep things simple, if you have a flavor, what's in those 450 variables, why they're always left blank? Like do you know a few of them, just to give us a flavor of what they're asking for, that no one seems to have data on?

DR. ZABINSKI: The big issue, at least -- I'm not sure if it's okay to -- this is my opinion. I look at it,

and it really seemed like the level of granularity was oftentimes more than needed. In particular, when they're asking about the different types of labor that they have at the organizations, they got really, really specific. And there's an entire section of -- you know, the biggest section is that's all they're asking. It's not any specifically about cost or revenue. It's just specifically what type of labor do you have. And I did not use one of those variables in this analysis.

And so it's more of a case of granularity that this got down to. And for the purposes of this analysis, I just didn't find it necessary to have that level. And it seems to be a bit of an agreement among all the stakeholders, including CMS.

DR. CHERRY: Well, Dan, hats off to you, because you seem to be trying to make sense of the nonsensical. You're doing a pretty good job at it, so thanks.

MS. KELLEY: We're still working on Greg. Greg sent me his question. He basically wanted to make the point that a much smaller set of data might be just as useful, and he wondered variables are viewed as beneficial by the providers.

DR. ZABINSKI: The variables that are beneficial, actually, Jeff talked to a couple of providers himself directly, and he might be able to answer this better. But I'll give it a shot and he can fill in.

It just seemed like the more generalized, higher level costs, not like costs for each specific type of labor, but just the general labor costs, the general cost of your ambulances, instead of just really specific questions about all the parts of that ambulance cost and that sort of thing. That could really simplify it and still make it useful, without losing any effectiveness.

DR. STENSLAND: I think the big things that are useful is what did you do, and that's always clear. Like if they bill for all these services, so they know how many miles they went, and they know what type of transport it was. It was a basic transport, or a paramedic transport. Then just the big buckets of what your costs are. And they told us, even the places that were split in their business with the fire department, they could pretty much say, "Oh, these are our labor costs, this is our cost for our rigs, this is our cost for our rent, and this is our cost for our utilities." And that's like the vast majority of their

costs. There are other little costs like supplies in the ambulance, but that's like maybe 2 percent. So just give them the big categories of cost and what they did, you could pretty much use regression analysis to kind of figure out what the relative costs are of the different services.

I think what they didn't want is if you asked them really specific questions, like how many hours did people use to support fire in addition to ambulance, who were an immediate EMT, that kind of thing. When you get to that level of detail, which is something they don't have in their books, and they have to go try to dig that out separately from something they've already recorded, that's what is maybe seen as problematic.

MS. KELLEY: Gina, did you have another question?

MS. UPCHURCH: Yes. Sorry. And I don't remember if this was in the chapter. You know, we heard in another report about ambulances that a lot of times you take the ambulance and you go to pick up Ms. Jones, but Ms. Jones doesn't need to be transported, and Medicare doesn't pay for that. Is that picked up in this dataset?

DR. ZABINSKI: Yes, it is.

MS. UPCHURCH: Okay. So I can see why some of

the providers may want this data captured, to demonstrate that there is a lot of that, and it's not paid for. I mean, I can see that being in their argument.

DR. ZABINSKI: Yeah. I mean, just on the numbers, my recollection is about 28 percent of the responses don't result in a transport. But only a small share of those actually involve any sort of medical treatment.

MS. UPCHURCH: Okay. But it involves lots of labor costs. So that's interesting. Thank you.

DR. CHERNEW: Dana, I think that's the end of Round 1. Is that right?

MS. KELLEY: Yes, Mike. Go ahead.

DR. CHERNEW: I want to make a few comments and then we'll go to Round 2 in a second. The first one is, it's actually less clear to me, Gina, how much added labor cost it is, because that labor cost might well be fixed. Salaries, for example. It might cost more, but it might be not that much more expensive if the alternative was you were still getting paid. You just weren't on a run. That's a knowable type of thing. I think the fixed and variable component here matters.

But I want to talk about a broader point. So we're going to come back in March with a recommendation, so I want to give you a sense of least where my head is, so you can react to the recommendation you may see in March.

There seems to be a lot of consensus around getting more data. The motivation seems to be to try and get the payment rates more accurate. That seems reasonable to me. It seems sensible that we don't collect some of the very granular data that's not necessary to get the prices right. Although I will say, while I do believe we want to scale back the data, I think we should keep variables that might be necessary to understand what's going on with access and quality, like time to dispatch or some version of that, even if we're not using for cost. Because I think there are other things I think we're going to want to know. The core question here is are people waiting a long time for ambulances and such. So to the extent that that's in the database, even if it's not used for cost, I wouldn't get rid of those variables, but I do agree some of those very granular ones, one might get rid of.

I am less enthused about getting Medicare-specific cost data, in part because I agree. I think it

Gina, you asked in your Round 1 question why would the cost be different. I don't think it would be that different. It also might be hard to get Medicare-specific cost data, so I'm little worried about the burdensomeness of gathering that data. And I think we might be able to assess the impact of your Medicare mix by just using variation in a mix that Tamara asked about, in sort of a regression framework, without trying to get actual allocations of a cost for different kinds of patients, particular when a large amount of the cost are fixed anyway. I'm not sure that allocation exercise is all that useful.

In any case, if we do want to get more data we might do the Medicare data, a smaller study, a one-time study, or other thing to verify empirically that the costs aren't different. I don't know much we want to do that. But where I'm leaning towards -- and again, thoughts on this matter because you're going to see a version of what comes out of this meeting in March -- is keep collecting the data, a scaled-back version, and probably don't emphasize, at least on an ongoing basis, Medicare-specific data.

So that's loosely the status quo of what's in my

head, and now we're going to go to Round 2 and see if there are dramatic reactions to that.

MS. KELLEY: All right. Stacie, I have you first.

DR. DUSETZINA: I don't know how dramatic I'm going to be. This is really excellent work. As a data lover it's hard for me to imagine saying no to more data, but I think in this case I would say yes to collecting data but many, many fewer measures, because it sounds like that is consistently what you were hearing. And also the fact that you don't feel you need to use most of the measures to understanding what's happening. It feels like there's a lot of room for pull-back on what we're asking people to fill out.

I also thought the interview information was super helpful, and I appreciated especially, like it took time and energy to get the information, but now that we've done it, we can do it again, seemed like a message you were getting. So it feels like collecting on an ongoing basis, or less information but more regularly would be helpful.

I guess one thing I wonder is do you need it every year? How often is often enough to collect the

information so that you have a good feel for how much these services are costing. And I don't know what the right frequency is. I seems like not since we originally set up the payment system, it feels like we've waited too long. But now this seems like the right step to continue to gather information, but I don't know, maybe not necessarily annually.

I also wondered about the organizations, the smaller ones that you said that they felt it was kind of too burdensome, and if the measures that you could cut down to would end up being ones that they would be more likely to also fill out. That seems it would, again, be worthwhile to figure out how to cull the set of measures to get more participation from the smaller entities, if possible.

One of the other things that just struck me from the chapter and the presentation is, you know, I was kind of thinking this doesn't feel like -- I don't think I mind that we don't really have Medicare-specific data in volume here, because it almost strikes me a little bit like when we talk about rural emergency hospitals and other places. Like you need these services. You need them. So there are

some reasons, I think, to want to know about these and know about the cost and make sure that these organizations are viable.

And then that had me wondering a little bit about the economies of scale, the high fixed costs, and does it create a scenario where there are just some areas where you're never going to really get it right based on the cost report type of summary. Like there's some sort of minimum amount of payment that has to be made to keep these groups financially viable. And then that makes me come back and wonder, how much of that Medicare's responsibility versus like the community and the other payers and everyone else using the services.

So I guess I can boil that down to saying I think we should continue to collect this information. I think it was great that it could hopefully lead to providing more clarity about whether or not payments seem like they're on target.

Oh, one last thing. In Table 4 in the reading materials, one of the other things I thought that was interesting there is the breakdown of emergency or non-emergency transport by those different groups. So

government-owned and nonprofit having much higher shares that are emergency transport as opposed to non-emergency, and I think that's probably important information just having in the backs of our minds when we think about these different entities and how they're serving their communities.

But as per usual, excellent work, you guys, and Jeff, thank you again. Happy retirement.

MS. KELLEY: Okay. I have Scott next.

DR. SARRAN: I was fine being pulled out of the queue.

Greg commented in the chat along the lines of, can we continue the data collection, but in some way, shape, or form that minimizes any burden on the providers as well as our staff who obviously has to do something with the data when we get it. So that would be my recommendation, is we find a way to get what we need but nothing more than that, so in as minimalist fashion as possible, continue the work.

Thanks.

MS. KELLEY: Cheryl?

DR. DAMBERG: I agree that we should continue to

collect these data, but obviously in a much more streamlined fashion to what I would call the minimally necessary data set required to do what we need to do.

And I think to Mike's point, I don't feel like we need to have payer-specific information, given sort of the large fixed cost elements in this space.

But in terms of minimizing burden, in addition to reducing the number of data elements, I do think CMS could either elect to collect this every two to three years or only collect it on a sample of organizations, because it doesn't feel to me like we need to have this information on every single ambulance provider in the country. So I think this was great work.

And I think the last comment that I want to make was related to the under-adjustment for geographic differences in costs. It didn't seem appropriate to have a single practice expense, a GPCI, for an entire state.

But great work.

MS. KELLEY: Brian?

DR. MILLER: I really liked this chapter.

I just wanted to run us through a couple scenarios here. I could propose that we should collect the

cost of goods sold and per-unit costs for making canned pineapple as SNAP beneficiaries are a taxpayer-funded program, and we should know the cost of unit production and components thereof for the can, the pineapple processing, and transport. I could also propose that we should look at per-component costs for Chevy Suburbans used by government agencies carrying out taxpayer-funded activities. I could also propose that for a private enterprise, we should collect the cost of chopped tomatoes, shredded lettuce, chicken versus beef versus pork versus the vegetarian option, and the fixed cost of establishing physical storefronts for Chipotle as a food chain fast service.

I mention these three scenarios because they're three different scenarios about data collection, some of which involve taxpayer-funded services, some of them which involve consumers using taxpayer-funded funds to purchase goods. And for none of them, are we suggesting a per-component, cost-structure, payment model data collection with 600 data fields, 150 data fields, or frankly, none. We're contracting either for the beneficiary to get dollars to buy products through SNAP. We're buying vehicles for the federal government for use for federal tasks, and in

the case of some private businesses, we are not collecting any data, nor are we subsidizing any purchase of goods.

I do agree that ambulance payment needs to be sensible. I don't see a need for us to micromanage public and private enterprise with data collection. If we went around the screen, we'd have 17 different versions of what necessary data is. Someone clearly thought that 600 data items was the minimum necessary data set. Someone else has now suggested in this conversation -- I lost track -- that we used 150. Someone else thought that 150 would be good. Someone else might say 50. I would say I don't see the need to continue this data collection.

And the reason is, if we do so, we're going to end up in the endless cycle of technical targeting of payment, which we have done in other provider areas, and we still haven't gotten it right. Whether it's home health, skilled nursing, IRF, physician fees, we are functionally driving a centralized administrative payment system, which is a static system, which does not respond to changes in market forces. The cost of goods has a variety of goods, which are subject to market forces.

In the case of vehicles, something I know really

well, gasoline, truck parts, labor costs, et cetera, that's a dynamic market, and we are suggesting collecting data to support the continued technical administration of a micro-targeted administrative payment system.

I think instead, we should go to first principles and say that ambulance providers or EMS providers should be paid for services that are rendered, right? If you are transporting someone urgently, you should be paid. If you're transporting someone non-urgently, you should be paid. You should probably be paid more for advanced versus BLS. If you drive to someone's house and render a service and don't transport them, you should also probably be paid. We all want EMTs and paramedics to be an expansion of the delivery system rather than just driving the person to the ER. Having care onsite is good.

So I think instead of doing further data collection, we should think about what are the buckets of services that we want these service providers to be providing. We want emergent transport. We want non-emergent transport. We want onsite service, and think of a unified way to pay for that that is less subject to micro-targeting of component items and costs and services,

because if we're going to get those wrong for the next 30 years, it's going to have significant burdens on small enterprise.

If we look at Medicare, almost all the small enterprises and physician practice, home health, skilled nursing facility, hospitals, even health plans, everything has massively consolidated. One of the key reasons it's consolidated is administrative costs. So I think we want to decrease administrative costs, not perpetuate administrative costs, simplify payment, and make sure that we're paying for a bucket of services as a bundle, as an episode, whatever it is. That way, we can avoid worrying about in five years whether we've adjusted for gas price inflation or the introduction of electric ambulances.

DR. CHERNEW: Brian, I'm going to jump in. Thank you for your comment.

I think the issue is -- first, I think I largely agree with at least the portion of your comments which are we should really be cognizant of the administrative burden of collecting the data and the tendency to try and collect a lot of data and micromanage.

I think the question for what Scott said about

what was trying to be solved is -- where we agree that they should pay differently for emergency and basic services, the question is how much more. In most other sections, the DRGs have cost reports. SNF have SNF cost reports. They rely on some cost collection.

I'm sure we could streamline a lot of those other cost collection tools, by the way. That's not the topic for right here. But I think what we're going for or what I'm anticipating going for is a much more aggregate measure that will allow us to statistically estimate the relative prices of the different buckets you talk about so we can try and get some loose information when setting the price that we pay for those various aggregate buckets.

We don't have to do it in -- I was going to say this later. I'll say it now. We don't have to measure the cost to an allocation model. We could measure the cost statistically. This is what your total costs are. This is the number of these things you do. We have volume adjustments we might need to make, for example.

So I do think it's -- I don't want to micromanage any data collection, and our recommendation will try not to do that. But I think thematically, we're going to be quite

consistent and try and collect the information necessary to assess what the relative prices of those buckets should be. And as I said in my earlier comment, I think there's some data that's important to understand what we're getting quality-wise. It's already being collected, and the industry is willing to give us that data. I think it is useful to know so we can understand if we're actually having access problems or not.

This is one sector where relying on competitive forces, which I tend to like, is particularly challenging, because they're simply not practical in a lot of places that believe we have some sort of competitive ambulance model.

DR. MILLER: What I was saying is that the government purchases a lot of services and items, some in competitive ways and some in non-competitive ways, right? Like, how many people are making aircraft carriers, right? You don't have a lot of vendors to purchase aircraft carriers from. It's the government. But the government specifies what it wants in it and comes up with a price that's willing to pay, and there's a pricing structure. But we're not sitting there collecting data from all these

businesses.

And I think on the whole in health care, the centralized administrative payment built upon cost reports and, et cetera, as opposed to a more dynamic market-driven system with bundles and episodes and other things, has essentially created massive burdens for the entire provider enterprise and driven a compliance culture instead of a service culture, right? Because if you're a hospital, a home health agency, whatever it is, you're focused on filling your administrative burdens, you're not focused -- and maybe they are focused on providing care, but that's not your primary focus, because you're so focused on the data and regulatory requirements that you must submit to get Medicare payment.

I want delivery systems, whether they're doctors, EMS, or whatever, to focus on providing clinical care to beneficiaries. And so that's why I don't think data collection here is a good idea, because in all the other markets that we have done it in, it has blown up in our face in the long term, and then we continue to mistarget payment constantly.

DR. CHERNEW: Okay. Thank you.

I think we're going to keep going through the queue.

MS. KELLEY: Tamara, you're next.

DR. KONETZKA: So before I talk about the data collection part, I want to just make one request about the report, Dan, and that is -- I won't engage you right now in a Friday afternoon discussion of survey weights, but I'd love to know in the report a little bit more about those survey weights. You said they were -- you know, they provided weights to make it nationally representative. And there are -- you know, this could be like a long footnote in the report or whatever, but there are a lot of pros and cons to survey weights and sort of details that I think are often important. Like, you know, what did they re-weight on? Was it a nonresponse weight? Was it a -- were they trying to weight to make certain things representative? You know, you can't just do everything usually.

So, anyway, I would just love to know a little bit more about the weights to know more about those validity of the underlying data and analyses.

But about the actual data collection and our recommendation considerations, I am honestly a little bit

more ambivalent than most people who have spoken so far. I think I want to double down on Scott's question about what's the end goal here, and the end goal seems to be -- which I agree with, that, you know, we need some data. These payment rates were based on, you know, sort of insufficient data a long time ago.

And so regardless of how we pay it and how we want to pay it in the going into the future, I think that data on their cost structures will be very, very useful.

And so I think the question to me becomes, okay, we have some data already. What will it give us in achieving that goal if we collect more data? Right? It will give us maybe a longitudinal look at this. What will longitudinal look at this give us in terms of achieving that goal? Well, it might be helpful to identify underlying trends. I'm not sure that's, you know, essential or not.

Also, you know, if the quality here of some of these data were not great, you know, doing it multiple times is likely to increase the quality of the data.

So I do think, given the burden of data collection, you know, we should be very deliberate about

exactly why we want them to collect that data.

I love Cheryl's suggestions of, you know -- if we decide it will actually be helpful in achieving that goal to get more data, I love Cheryl's suggestions of doing it, you know, based on a sample and not getting it from everybody or doing it -- and probably not doing it every year, but rather every, you know, whatever it is, two or three or five years.

I don't have a lot of -- maybe it's the economist in me, but I don't have a lot of -- I don't put a lot of weight on the idea that like, you know, we've spent all this time giving you data once. It's kind of a sunk cost, right? And so, you know, we can't do anything about that. So, you know, we should really evaluate the additional burden moving forward, you know, relative to what we're getting out of it.

And, you know, I certainly agree with what's been said before, that it does not have to be specific to Medicare if we decide to collect more data, and that it should probably be, you know, a pared down version to reduce that burden.

So I'm a little bit ambivalent, but I think, you

know, if it's going to help us achieve our goals of informing, you know, future payment changes, I think there are ways we can do that while minimizing the burden.

Thanks.

MS. KELLEY: Robert?

DR. CHERRY: Oh, there we go. I was trying to unmute myself.

Well, thanks again for the presentation. And I'll just say that, you know, I'm biased here because I'm a trauma surgeon by training, and so there's a lot of interest in pre-hospital data. I mean, that's also true for other specialists who deal with stroke patients or acute myocardial infarction out in the scene, where there are a lot of individual clinicians that really want to understand what's happening before they reach the hospital. So there's enormous potential here if done correctly.

All over the country there are actually EMS data sheets that are completed all the time on runs all over the country. I don't think anyone has really looked at what are the critical elements nationally that we want to collect. How do you organize them? How do you input them into a streamlined retrieval system? Because right now,

EMS is very decentralized, and so we don't really have that, you know, across the board.

So even though it's a relatively small sector, you know, by spend, having a basic understanding of the costs and the clinical services provided in the pre-hospital phase of care has enormous utility downstream in terms of improving the quality of care for those that get hospitalized, for clinical research purposes, understanding cost effectiveness, and what works out in the pre-hospital phase of care and how to provide overall value. So I wouldn't discontinue this, but I do think that the data collection system needs major revision.

Realistically, EMS may have no idea who the payer is, you know, and even in hospitals, it could take days or longer to figure that out.

And I do agree with other statements here that the current data collection system is a bit burdensome in terms of what's been proposed.

But what I would strongly recommend is a single system where baseline data is collected across all patients, regardless of payer, where you have local authorities that are allowed to customize their own

variables based on their own community assessment. And this may not be a lot of variables nationally. It may be 50 or fewer, not 600, just to have some baseline understanding. But at least there's an opportunity to kind of centralize some critical elements of the EMS data and then allow for the decentralized model to customize accordingly.

And quite frankly, this may not be a Medicare issue. This is beyond Medicare, and it may be out of scope for us at the end of the day. But I do think there's some utility, again, if done correctly.

So thanks again for teeing up this conversation. Appreciate it.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you so much. I thought this was so fascinating, and I have to say up front, it's a sector that I know much less about than many, so take that caveat.

But I did want to share that in my experience, the staffing models are very different in different regions of the country. When I was in North Dakota, they were very, very proud that they had a paramedic-first,

paramedic-forward kind of model. And when I moved to Vermont, they really did not want to have a paramedic model. They wanted to have sort of EMT-driven, because they didn't want people sort of being treated in the field as much.

And maybe part of it is one was a regular rural state and the other one was a frontier, and then here where I live now, the ambulance services actually does fundraisers, so I try to understand what that means. You know, I don't really understand that.

I did hear some of you talking about collecting more. To me, the question that I'm hearing is, should collection be ongoing? And it seems to me it should be ongoing but much less in terms of the variables, very curated. And there's been a lot of suggestions about that.

And I think what really influenced me is on page 15, it says all the entities we interviewed believe that would be beneficial to continue the data collection and that discontinuation would be a mistake. So to the extent that this can be made simple and elegant, I think that would be what I would advocate for at this time.

MS. KELLEY: Okay. That's the end of the queue,

Mike.

DR. CHERNEW: Thank you, Dana, and thank you, everybody.

Let me try and just summarize quickly, building off of Scott's comment of what we're trying to solve.

As long as there's an ambulance fee schedule -- and there is one -- there needs to be some set of relative prices for various things. So we need to figure out how much to pay for an Advanced Life Support Level 1 trip versus Advanced Life Support Level 1 emergency versus Advanced Life Support Level 2. We need to get those relative prices right.

It's complicated to figure out how to do that. We need to figure out how with each of those you might want to adjust for distance, for example, and maybe other things. It's unclear. But I think that by collecting this data, we'll be able to do a better job of informing CMS about those prices, and there seems to be some consensus in the industry, and certainly, Congress mandated us to do this, suggesting they want to continue to run such a fee schedule.

So my general view is that we should try and do

that in the least burdensome way possible. That includes a few examples that can come up in the chapter, sampling, cutting back the number of variables, managing the periodicity. So we collect data on a whole bunch of things. We have our physician fee schedule, indirect practice expense, allocation discussions, and there's a question. We have recommendations to update that data. We don't think it needs to necessarily be annual. So we can think about essentially, what I hear is, ways to simplify the burden and rely on data that's already being collected anyway that the organizations have to minimize the burden.

But I think that to the extent that there's a sense that the prices now might be wrong, it would be useful to have some data to figure out if they could be "righter," which, by the way, is not the same as right. I'm not a believer we're ever going to get them exactly right, but I think we can do better, and I think there's probably low-burden ways to help us do better.

And so, Dan, we very, very, very much appreciate your analysis. And, Jeff, we really appreciate your involvement with this and your involvement with us. So thank you both.

To those at home that may have opinions, please reach out to us at meetingcomments@medpac.gov. We do like to hear from you and read the stuff you send closely. Your input does matter.

But, with that, barring any other comments from Paul or others, I think we're going to say thank you, and everybody have a happy and healthy holiday. And I'm very much looking forward to seeing you all in person in January.

So, again, thank you for a really productive set of comments.

DR. SARRAN: Thanks, Betty. Thanks, Paul. Thanks to all of the staff.

DR. DAMBERG: Thank you, staff.

DR. RAMBUR: Thank you, everybody.

[Whereupon, at 5:34 p.m., the meeting was adjourned.]