MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

VIA GoToWebinar

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10:17 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[10:17 a.m.]

DR. CHERNEW: Hello, everybody, and welcome to the December MedPAC meeting. As is the norm every year, this is the meeting where we discuss the draft payment update recommendations for various Medicare fee schedules. It's a very important meeting. It's the first time that we are doing it virtually, so I thank you all for your patience. We have a lot of material to cover, and so we're going to go to it straightaway.

I will say one thing before jumping into the day. I want everybody to know -- and I've said this to the Commissioners as well -- we are very, very, very aware of the challenges posed by the COVID pandemic and the public health emergency. We obviously have an immense amount of concern for the human toll that COVID has taken across the country, and that is clearly the most important thing that we worry about.

That said, our task today is about payment updates, and we recognize that the pandemic has really influenced the way that the providers -- hospitals, physicians, nursing homes, and all the other set of

providers that we deal with -- operate.

We are very concerned about the ability to maintain access to adequate high-quality care for our beneficiaries, and we will be very clear about that concern in the March report.

All of that said, I think it's the MedPAC belief, it's my belief -- I'll speak for me now, and I'll let the Commissioners speak for themselves -- that the appropriate approach to addressing the challenges providers face, the financial challenges that providers face from the pandemic, is targeted relief as opposed to building increases into the base payment rates. We are today discussing payment rates for 2022. As those of you who saw the -- the Commissioners know from the mailing materials, we have spent time thinking about the 2022 time frame and what type of durable payment updates we need to provide adequate payments in 2022. Our belief is that to the extent that COVID relief -- additional COVID relief is necessary, that that should be dealt with in a targeted manner to provide that efficient relief.

So our payment discussion today is largely going to focus on -- it will focus on changes to the base payment

updates, which are intended to go well beyond the COVID pandemic.

So that being said, I'm going to now turn it over to Alison, and we are going to start with our discussion about hospital services. So, Alison, the floor or the Zoom or the GoToMeeting is yours.

MS. BINKOWSKI: Thank you, Mike. Good morning.

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

This presentation will assess the adequacy of Medicare's payments for hospital services as well as present final results from a mandated report on expanding the post-acute care transfer policy to hospice. The presentation will conclude with the Chair's draft recommendation for fiscal year 2022 updates to base payment rates in the inpatient and outpatient prospective payment systems.

Numerous MedPAC staff made significant contributions to this work. In addition to those staff listed on the slide, we would also like to thank Brian O'Donnell and Sam Bickel-Barlow.

As in prior years, MedPAC assesses the adequacy of fee-for-service Medicare payments by looking at four categories of payment adequacy indicators: beneficiaries' access to care, quality of care, providers' access to capital, and Medicare payments and providers' costs.

The specific set of indicators for hospitals are enumerated on this slide. Based on these indicators, we'll present the Chair's draft updated recommendation for IPPS and OPPS base rates in fiscal year 2022.

As we note in the chapter, given the growth in the use of fee-for-service Medicare payment rates to hospitals as a benchmark, any update to these rates will also affect Medicare Advantage plans and other payers.

A chief difference from prior years, both for hospitals and all other sectors, is the coronavirus public health emergency which has had tragic effects on beneficiaries' health and the health care workforce and material effects on hospitals and other providers.

As in past years, to recommend payment updates for the upcoming year, we start with indicators of payment adequacy based on the most recent available and complete data, which this year is generally 2019. We then consider

preliminary newer data from 2020 and evaluate current law and expected environmental changes in 2020, 2021, and 2022 to develop the Chair's draft update recommendation for 2022.

Given the larger environmental and policy changes this year, we will continue to closely monitor these changes and whether those effects are likely to be temporary or permanent.

To the extent the coronavirus effects are temporary or vary significantly across providers, they are best addressed through targeted, temporary funding policies rather than a permanent change to all providers' payment rates in 2022 and future years.

With that introduction, Carolyn will now provide some context and present results on the first two categories of payment adequacy indicators for the hospital sector.

MS. SAN SOUCIE: Before jumping into our assessment of the adequacy of Medicare payments to hospitals, we wanted to first provide some context. Fee-for-service Medicare's payment rates for inpatient and outpatient services are generally set under the inpatient

prospective payment system and the outpatient prospective payment system, respectively. About 3,200 short-term acute-care hospitals are paid for inpatient services under the IPPS. In fiscal year 2019, these hospitals received $111.3 billion in IPPS payments for 8.7 million inpatient stays. Approximately 2,700 of these hospitals also received an additional $8.1 billion from the Medicare program for uncompensated care, which is charity care and non-Medicare bad debts.

Medicare pays short-term and other hospitals for outpatient services under the OPPS. In calendar year 2019, these hospitals received $66.2 billion from the Medicare program and its beneficiaries.

Starting with the first category of payment adequacy indicators, beneficiaries' access to hospital care, two key indicators we assess are hospital occupancy rates and Medicare marginal profit. Hospitals continued to have excess inpatient capacity in 2019. The aggregate occupancy rate at short-term acute-care hospitals was 64 percent, indicating that about two-thirds of inpatient beds were occupied, consistent with prior years.

In addition, hospitals continued to have a

positive marginal profit on IPPS and OPPS services of over 8 percent, indicating that hospitals with excess capacity have a financial incentive to serve fee-for-service Medicare beneficiaries.

Another indicators of beneficiaries' access to hospital care is the number of hospital closures and openings. After an all-time high in fiscal year 2019, the number of hospital closures decreased in 2020, with 25 short-term acute-care hospitals ceasing inpatient services. Some of these hospitals closed completely while others converted to outpatient or other facilities. In addition, some are working to reopen.

Among the hospitals that ceased inpatient services in 2020, most struggled with low occupancy, were small, and within 15 miles of another hospital, suggesting most had a minimal effect on beneficiaries' access to inpatient care.

A second indicator of fee-for-service Medicare beneficiaries' access to hospital care is the volume of hospital services per capita. In 2019, there was a continued shift from inpatient to outpatient services, including a 1.9 percent decrease in inpatient stays per

capita and a 0.7 percent increase in outpatient services per capita. These both reflect long-term trends.

We also have been tracking volume in 2020 closely and will discuss it and other trends related to the coronavirus public health emergency later in this presentation.

Shifting gears to the second category of hospital payment adequacy indicators, the quality of hospital care, we found key quality indicators improved modestly or remained stable. Specifically, between 2016 and 2019, risk-adjusted mortality and readmission rates declined modestly, and patient experience remained high. As a reminder, the Commission has a standing recommendation that the Congress replace Medicare's current hospital quality programs with a single, out-focused, quality-based payment program for hospitals. That is the Hospital Value Incentive Program, or HVIP. The HVIP aligns with the Commission's principles for quality measurement and has the potential to drive further improvement in hospital quality. While we are not voting again on the HVIP this year, our presumption is that this standing recommendation would be implemented in conjunction with the update recommendation.

And now Alison will go over the remaining categories of hospital payment adequacy indicators.

MS. BINKOWSKI: Turning to the third category of hospital payment adequacy indicators, hospitals' access to capital, we found key indicators reached record highs in 2019. The key indicator of hospitals' access to capital is their all-payer margin as it largely determines hospitals' access to capital for expansions and acquisitions.

IPPS hospitals' total and operating all-payer margins increased to record highs in 2019, and hospitals' cash flow margin reached its highest level since 2015. Within these aggregate results, there continue to be substantial variation, including a much higher all-payer operating margin at for-profits and a near zero operating margin for all IPPS hospitals.

As shown on the right-hand side of the slide, other indicators of hospitals' access to capital also remained strong in 2019.

Turning to our fourth category of hospital payment adequacy indicators, Medicare's payments and hospitals' costs, we found increased profitability on inpatient services in 2019, with IPPS payments per stay

growing faster than costs per stay, primarily due to CMS' overestimate of input price inflation.

Second, and the primary factor contributing to hospitals' higher Medicare margin in 2019, the Medicare program's uncompensated care payments to hospitals increased 22 percent, or $1.5 billion, driven by a 16 percent increase in the uninsured rate.

Third, there was a slight decrease in profitability on outpatient services, in part due to a large number of drugs with expiring pass-through status in 2019.

Based on the factors discussed on the prior slide, IPPS hospitals' overall Medicare margin increased in 2019 to minus 8.7 percent, the highest rate since 2015. Within this aggregate margin, there continued to be substantial variation, including Medicare margin at two groups of hospitals -- those that are high fiscal pressure and for-profits -- increasing to near zero.

To better assess the adequacy of Medicare payments for relatively efficient hospitals, we identified a set of hospitals that performed relatively well on both quality of care and cost measures. Consistent with prior

years, we found these hospitals had better performance and higher margins than other hospitals. In particular, these relatively efficient hospitals had mortality rates that were 10 percent lower than the national median and readmission rates 8 percent lower, all while keeping costs per inpatient stay 9 percent lower. Lower costs allowed these relatively efficient hospitals to generate better Medicare margins, with a median margin of minus 1 percent in 2019 compared to minus 7 percent among other hospitals.

As the last piece of our assessment of the adequacy of fee-for-service Medicare payments to hospitals and to help inform the Chair's draft recommendation for 2022, we reviewed key policy and environmental changes subsequent to the most recent year of available and complete data for 2019.

One key change to current law, which began in 2020, is the expiration of statutory decreases to the annual update to IPPS and OPPS rates, which together with much lower productivity offsets led to substantially higher payment rate updates in 2020 and 2021 than in prior years.

Specifically, the annual update increased from 2.35 percent in 2019 to 2..6 percent in 2020 and 2.4

percent in 2021, and is expected to remain near that level in 2022.

As a reminder, for each of 2018 through 2023, inpatient rates are increased by an additional 0.5 percent due to an unwinding of a prior adjustment for documentation coding such that IPPS operating rates will increase 2.9 percent in 2021.

On the environmental front, since early 2020 the coronavirus has been a human tragedy. It has also affected hospital services as described in more detail in your mailing materials. In particular, inpatient and outpatient volume declined in April 2020, followed by partial summer rebounds that varied by type of service. However, as we speak, we are into a third wave and will closely monitor the situation between now and our January meeting.

The collection of quality data was suspended, making it hard to assess the quality of hospital care. Hospitals' access to capital remained strong due to federal support of over $70 billion in supplemental funds to hospitals to help them rise to the pandemic challenge. As of now, we find no evidence of widespread financial struggles at hospitals in 2020. However, the circumstances

of individual hospitals may vary substantially.

Some hospitals may have struggled with access to capital while several large hospital systems have returned some relief funds they received as they exceeded their pandemic-related losses. We estimate that both Medicare payments and costs per stay increased in 2020 as Congress increased Medicare payments to help offset hospitals' increased costs during the public health emergency, including the suspension of the 2 percent sequestration and the 2 percent increase for COVID-19 inpatient stays.

Therefore, while the effect of the coronavirus on hospitals varied substantially across hospitals and time periods, at this time we do not anticipate any long-term changes to the hospital landscape that will persist past the end of the public health emergency.

Combining 2019 data with these policy and environmental changes, we project hospitals' overall Medicare margin for 2021. We estimate that IPPS hospitals' overall Medicare margin will increase for minus 8.7 percent in 2019 to about minus 7 percent in 2021, and that the margin among relatively efficient hospitals will increase to near zero. We expect IPPS hospitals' Medicare margin to

increase in 2021, primarily due to higher payment rate growth than in past years due to substantially higher payment rate updates in 2020 and 2021 than in prior years. Cost growth is less certain, but we anticipate will continue to be less than the combined growth in input prices and case mix.

In summary, indicators of beneficiaries' access to hospital care, quality of hospital care, and hospitals' access to capital are positive. Indicators of fee-for-service Medicare payments and hospitals' costs were more mixed. Hospitals' Medicare margin remained negative but improved, including to near zero for relatively efficient providers.

Before we turn to the Chair's draft recommendation to update hospital payment rates, we also want to update you on the results of the mandated report. The Bipartisan Budget Act of 2018 mandates that MedPAC evaluate the expansion of the post-acute care transfer policy to hospice and its effect on beneficiaries' access to hospice services and on hospital payments. As a reminder, under the post-acute care transfer policy, IPPS hospitals receive per diem payments for certain conditions

instead of the full amount when a Medicare beneficiary has a short inpatient stay and is transferred to a post-acute care setting.

Starting in 2019, hospice was added to the existing list of post-acute care settings to which the transfer policy applies. Our analysis indicates that the policy change produced savings, about $300 million in fiscal year 2019, without any discernible changes in Medicare beneficiaries' timely access to hospice care.

Now, returning to the discussion of hospital payment adequacy, the Chair's draft recommendation seeks to balance several imperatives. These include: maintaining payments high enough to ensure beneficiaries' access to care and close to hospitals' cost of efficiently providing high-quality care; maintaining fiscal pressure on hospitals to constrain costs; and minimizing differences in payment rates across sites of care, consistent with our site-neutral work.

Clearly, there are tensions between these objectives that require a careful balance in the Chair's draft recommendation.

Furthermore, as you mentioned previously, the

extent that coronavirus public health emergency continues, any needed financial support should be targeted to affected hospitals that are necessary for access and done outside the annual update process.

With that, the Chair's draft recommendation reads: For fiscal year 2022, the Congress should update the 2021 Medicare-based payment rates for acute care hospitals by 2 percent. Recall that there was a lower increase in 2019, 1.35 percent, and hospitals maintained their patient care margins. Therefore, we believe that hospitals will be able to maintain or increase their margins in 2022 with the Chair's draft update.

A 2 percent update in the draft recommendation along with the 0.5 percent statutory increase to inpatient payments would result in a net update to inpatient payments of 2.5 percent, while the update to outpatient payments would be 2 percent.

Together with our standing HVIP recommendation, the removal of the current quality program penalties would increase inpatient payments by an additional 0.8 percent, for a net update of 3.3 percent for inpatient payments above estimated current law. The outpatient update would

be 2 percent below estimated current law. We do not expect these changes to affect beneficiaries' access to care or providers' willingness to treat Medicare beneficiaries.

And with that, I hand it back to Mike.

DR. CHERNEW: Thank you so much. That was a ton of material.

I am going to essentially go around and call on folks, and not seeing anything else in the chat to me, let's start with Jon Perlin. Jon?

DR. PERLIN: Well, good morning, and let me thank the staff for a really tremendous report and incredibly thoughtful and, Mike, as you indicated, a very complex set of circumstances.

Let me just say for the record that I fundamentally agree with the premise that there is an underlying base rate change, and then there are temporary, we hope, perturbations in the form of COVID.

I do want to comment on a couple of pieces that are more durable. The high fiscal pressure is--set of circumstances for those hospitals may be different than others, and that may be staffing. And that, I don't think is what we want in terms of quality. That's why I argue in

favor of a full update.

When you look at the high efficiency of the most efficient hospital group, they tended to be more sophisticated hospitals that can substitute automation, and that means they probably have the capital for whatever reasons to invest in that. There's less pressure, and so there's an interrelationship between the capacity for efficiency and the underlying status.

I think also when we look at the durable policy issues, we know that the sequester cuts are poised to resume January 1st, and that's 2 percent. Your guess is as good as mine as to whether that will be a continuing moratorium, but that erodes against the pressure.

I can't resist but to indicate that there are some contextual aspects of COVID, and one is that, as the public health emergency ends, the cost of PPE, the increased cost of supplies continues on. But the biggest issue really is the disruption that will transcend that in terms of staffing. A lot of nurses are retirement age, have retired. The market shifted from sellers -- buyers to sellers' market. The cost has gone up.

For physicians, it's been disruptive practices,

increased subsidization. It's fundamentally a requirement.

And the economic effect will be durable. We can anticipate decreased employer-sponsored insurance, decreased state budget revenues, decreased support then for Medicaid, increase uncompensated care needs.

So I think combined, those things are going to create a context that we'll have to acknowledge. I would hope there would be -- even as we say we want to separate the durable budget update from the context, some acknowledgement -- you know, I appreciate we've outlined that in the boxes -- of that context.

One of the most others is -- one of the other challenges is really the HVIP. It's not in place yet. Removing a couple of the current quality measures has some statutory requirements, legislative requirements to go into effect, and with that in mind, I would also note that those hospitals that had the greatest number of COVID patients may have had the biggest disruption that you observed this past year and under those measures where they're suspended or made data optional, so that the way in which those reimbursements for performance-made work is even less predictable than it would be otherwise.

So I'm generally supportive of the approach but really just can't overstress that as much as I support the general, there are a couple of durable structural features, the sequester end, and the context that this is going to be a very tough one.

Thanks again to the staff for a terrific outline of this topic.

DR. CHERNEW: Jon, thank you.

Amol, I thought you wanted to make a comment. You're up.

[No response.]

DR. CHERNEW: Amol?

DR. NAVATHE: So thank you for the great work. A lot of data, a lot of analysis always doesn't present in a great, clear way, so thanks to the staff for great work here.

I have one clarifying question, which I think mainly wanting to elicit from the staff here, from Alison and Carolyn, a little bit of narrative around how to think about some of the analyses that we're doing here, especially as we go forward, and then will also sort of respond to a couple of my general comments.

One general observation -- and I know we haven't gotten to the other areas, but also from past meetings, for hospitals in particular, we observed the situation where the marginal profit is positive. So, in this case, I think we saw an 8 percent marginal profit for an admission, and yet we see that the Medicare margin that's estimated is negative.

I just wanted Alison or Carolyn, one of you guys, to maybe help us think through how best to interpret those different pieces. I think the main difference there is sort of variable fixed cost in the context of the margin versus profit, but can you just talk us through a little bit about how we should be thinking about those numbers as we interpret them?

MS. BINKOWSKI: Yeah. I can give a quick start, but you exactly hit on the difference is between fixed and variable costs and what the marginal profit is showing is that the variable costs -- the variable payments exceed those variable costs, those costs that are excluding primarily related costs. That's the primary difference between those two.

There's also some differences in GME. Jim or

Jeff, did anyone else want to elaborate on that? I don't know if that answered your question, Amol.

DR. STENSLAND: I think I would just say that when we think about the Medicare margin, we're essentially saying over the long term is Medicare for the average hospital paying the whole cost of care, and for the average hospital, that currently would be no. With the efficient hospital, it's about a break-even on the total cost.

But the marginal profit is still positive. So they're going to want to see those additional Medicare patients because it will increase their profitability, but we're acknowledging that over the long term, Medicare isn't contributing for the average hospital enough payment so that they would also cover the long-term capital costs of renewing your plant and equipment.

DR. NAVATHE: Thanks, Jeff.

DR. STENSLAND: Yeah. I think I want to just emphasize the average hospital versus the efficient hospital. I think that's important too.

DR. NAVATHE: Thanks, Alison and Jeff.

I saw that Brian had a comment, so I will try to wrap up quickly here.

I think that's very helpful because I think, in some sense, you see these kind of different directions, signs on each of these pieces that seem to have somewhat similar constructs. Anything that's helpful to understand that from an access perspective in particular, having a positive marginal profit is actually the most important piece, and I guess that's the point that I would think of highlighting here.

And then from a broader, to the extent that we want Medicare to cover its own costs, quote/unquote, the question is that not the -- the entire hospital's volume but not Medicare. So how we allocate the fixed costs may actually be a challenge, to some extent, in the Medicare margin.

So I think that was just worth clarifying. Thank you. It's helpful for me as well.

In general, before I turn it to Brian, I would say I am supportive of the recommendation, generally speaking. I'm also supportive of the approach, I think, notwithstanding some of Jon Perlin's comments. I'm also supportive of the approach on how COVID is being handled.

So, Brian, to you.

DR. DeBUSK: Thank you.

Before we get back to the variable cost versus fixed cost discussion, Amol, again, I really appreciated your comments, and I have a lot of the same questions that you have on that structure.

I do want to say I'm generally supportive of the measure. I do think it's important that we treat this, though, as a combined recommendation. I hope in the March report, we can make it clear that the 2 percent increase is linked to the adoption of the HVIP because I would hate to see them take half of our recommendation and do a less than full update and not incorporate the HVIP payments.

So I hope that we do a thorough job of linking those two in the recommendation so that they're seen as going hand-in-hand.

Now, regarding the variable versus fixed cost issue, I do realize the time horizon that we're looking over does matter. In theory, over a 5-year or 10-year horizon, I think, to quote Jon Perlin, all costs are variable if you look at a long enough time horizon.

But the one thing I would ask staff and fellow Commissioners to watch closely is the behavioral response.

If we really think that hospital variable costs are 80 percent -- and I'm not trying to start that argument in this meeting, but if we really think that variable costs are 80 percent and the contribution towards fixed costs, the contribution margin is only 8 percent, as we wrote in the chapter, let's anticipate the behavioral response of hospitals.

They should be somewhat tepid towards Medicare payments. I mean, they should still want them, but they shouldn't be -- consider hospital rates are approaching 200 percent of Medicare rates. So would you go after the minus 9 percent payment, or would you go after the 50 percent margin payment?

But back to their behavioral response, we should anticipate them being lukewarm toward Medicare payments but very, very agreeable, very, very excited about ACOs. I mean, if you could shed 80 percent of the cost and then get 50 percent of it back in a shared savings payment, that's the highest margin program in all of Medicare. That should be their singular focus.

Now, my observation is that behaviorally, the response is just the opposite. You see sort of mixed

reaction to the financial incentives in ACOs. To quote Sue, I think Sue Thompson a while back said they've always seen the ACO program as transitional. And then back to looking at how aggressively hospitals do pursue Medicare beneficiaries; I think their enthusiasm for Medicare beneficiaries remains high.

So I would encourage us -- again, I do support the update, but I would encourage us over time to be very skeptical and look very closely at what the fixed versus variable cost structure really is.

Thank you.

DR. CHERNEW: Thank you, Brian.

I think, Paul Ginsburg, you are next on the list.

DR. PAUL GINSBURG: Yeah. I really appreciate the fact that in the slide on the recommendations, you have made clear comparisons to current law, because that's the point I like to think about all recommendations is how do they relate to current law, and the cost of the combination with the HVIP, you know, that carries importance.

But I started thinking that the inpatient recommendation makes a lot of sense because, in a sense, we're taking the funds and saying we want to focus it more

towards the hospitals that are performing better, to maintain the incentive to perform better, but I was surprised to see that, in a sense, whereas for inpatient care, the update would be -- assuming the HVIP is enacted, would be very close to current law, slightly above it.

But for outpatient care, it seems substantially below it and was just wondering what our rationale is to, in a sense, basically give different updates for inpatient and outpatient care, since so much of our analysis really treated the two of them together.

MS. BINKOWSKI: So I'll take one first stab at that, and Mike and Jim can say more.

But as explained in one of the prior slides, one of the tensions or goals that the Chair's draft recommendation is trying to balance is site-neutral payments, and so there's this tension between trying to provide increases for hospital outpatient care without creating too large of a differential with office care.

I'll pause there and see what other folks had.

DR. CHERNEW: So that was the first thing I would have said as well, Alison. So now I'm redundant.

DR. MATHEWS: The other thing I would mention

here is that the differential updates that appear, given the draft recommendation that's on the table, reflect, you know, one, there is the statutory .5 percent increase that applies only to inpatient services. That's one element that drives the differential. The second, of course, is the fact that the HVIP dollars are primarily inpatient-centric, and so we have allocated those to the IPPS.

But the base update recommendation, as you see on the slide that's currently shown here, would be 2 percent in either case. But there are specific elements for inpatient that drive the effective update higher.

DR. CHERNEW: The other way to think about this writ large, two things. We have assessed efficient hospitals in the way we do this analysis. You look at the methodology. I actually think it's a reasonably generous sense of efficiency for a bunch of reasons that I won't go into. So I think there is some room for greater efficiency writ large. We could decide how much.

But I think the other point is we don't yet see -- and I don't believe there is -- real concerns with access to care in a variety of ways, and so if you combine that the -- compared to where we were last year, for example,

hospitals are doing better actually in terms of their margin. And we think, therefore, the aggregate Medicare margin gets us close to a sort of efficiency level, which is reasonable. There's always some play, one way or another, that's small, but we think this set of recommendations would be able to preserve access and quality, given what we know about where the hospital cost structures are and what we think is going on with access and quality.

But there's not a specific answer beyond where Alison started, which is because of the connections between the hospital and other payment systems, et cetera, we don't want there to be a bigger discrepancy for outpatient office care than is otherwise needed, I guess, is probably the best way to say that.

DR. PAUL GINSBURG: I really appreciate all the clarification. It makes a lot of sense to me. I just want to mention that it might be wise for MedPAC to put on its future agenda another go at site-neutral principle to whether there's more that we could be recommending beyond what we have in the past.

MS. BINKOWSKI: Thanks, Paul.

The one other thing I wanted --

DR. CHERNEW: That's certainly wise advice.

MS. BINKOWSKI: -- add in response to your emphasis on current law is what we have is estimated current law as of this point, and as a reminder of 2022, current law will not be finalized until next summer. So it could go -- it could shift.

DR. CHERNEW: The current-current law.

So I think I have been trying to see the list of folks, but I think where we are now is I'm going to begin to go around in the order on my screen. And I want to start with Bruce.

DR. CHERNEW: So Bruce, you're up.

MR. PYENSON: Thank you, and also my compliments to the staff on this chapter, which I thought was very clear and contained a lot of really useful information. Overall, the chapter paints a positive view of the hospital industry. The challenge, of course, is there are some organizations that are hurting and others are doing relatively well.

However, all of the indicators that are presented show improvements over previous years, and in that context

I see very little reason for an increase in payment rates, especially an increase that's above consumer price index. We're not in a period of 3 percent, 4 percent inflation. We're in a period of about 1 percent inflation.

So I'm really puzzled at the recommendation for increases. I think we have an opportunity to not increase payments. I think that would not hurt Medicare beneficiaries. It would create opportunities of also to pay Medicare Advantage less. So I'm puzzled why we're not taking advantage of that opportunity.

And I would also point out that because of what's happening with the physician fee schedule that we're likely to see, if we continue with this pattern of increases, we're likely to see a divergence between physician and hospital.

So I've got concerns that we have an opportunity to pay less without hurting beneficiaries. Thank you.

DR. CHERNEW: Okay. So what I hear there, Bruce, is that you would be comfortable with where we are, but you prefer to go lower, actually. I'm just trying to get a summary. We'll have a broader conversation on this, but I just wanted to summarize your point.

MR. PYENSON: I'm uncomfortable with where we are because I'd prefer to go lower.

DR. CHERNEW: Got it. Okay. So the next person on the list, I think, is going to be David Grabowski, and then we'll go to Wayne, just to give you guys a little bit of a heads-up.

DR. GRABOWSKI: Great. Thank you, Mike. First I'll say I'm supportive of the Chairman's draft recommendation. I want to make just one short comment. I think it's easy to focus solely on the Medicare margin here, which is negative even to those efficient hospitals. But I think it's a mistake to just narrowly focus on that measure alone. Medicare obviously pays hospitals alongside other payers. The chapter does a really nice job of describing this. But the basic point being costs are not fixed here.

So rather than just focus on Medicare margins, I'd like to see us -- and I think the chapter and the discussion today did a really nice job of this -- think of the full set of indicators, entry and closure, quality of care, beneficiaries' access to services. Those are always important metrics, but I think they're especially important

here, given Medicare's role alongside commercial payers.

So I think given this full set of indicators, Mike, I'm comfortable with the increase, but I'd be very wary of going any higher. Thanks.

DR. CHERNEW: Thank you, David. Wayne, you're up, and after that I'm going to go to do Dana Safran.

Wayne, you're muted.

DR. RILEY: this has been an eye-opening chapter for me. I had PTSD back to medical school days, trying to cram in 600 days to 600 pages. But, you know, I have to underscore. I agree with David's point, Commissioner Grabowski, here, about the Medicare margin issue. I think we have to be careful about how we interpret that.

And then, of course, my ideological twin, Dr. Perlin, has really sort of laid some cautions out in terms of, you know, the environment feels different now because of COVID, and I think there's going to be more long-lasting impact to hospitals that we probably can't even fathom right now.

You know, I shudder to wade into your area, Mr. Chairman, economics, but, you know, I think back about my one economics course at Yale, and the macro environment is

going to be incredibly disruptive, even in spite of the targeted relief that we all, I think, agree, conceptually, is the preferred route. I do think we have to be cautious about the rate-setting issue.

So, you know, a rich discussion, nubby problem, but I do want to underscore some of the cautions.

DR. CHERNEW: Okay. We are going to go to -- thank you, Wayne -- I think we're going to go to Dana and then to Marge Ginsburg.

DR. SAFRAN: Thank you. So I am generally supportive of the Chair's draft recommendation, though I find Bruce's comments worthy of our consideration. I will share that I, like others, kind of did struggle a bit to put in context the negative Medicare margins, and so I really appreciate the comments that David and others have made about really using the chapter to draw out why it is that in spite of those negative margins we believe the evidence is overwhelming for good financial health and the access and quality that follow from that.

So I also -- I won't take time now to ask staff to answer this question, but I did find it curious to understand why this is the one sector where we look at all

payer margins and we compare the negative Medicare margins to others. So I think that just is striking, that we do that here, and as I recall not in other sectors. So I think that's just worthy of also some explication in the text.

I think the final couple of comments I would make is, we make quite a lot of the efficient hospitals, but we don't ever say who they are. Maybe we can't, but even if we can't say who they are to just say something more than we do about the characteristics of the hospitals that are efficient, not just their financial performance, but what kind of hospitals using the usual characteristics classifying them would be, I think, important. Where are they? Large, small, teaching, not, et cetera?

And then a final couple of things. I thought the explication in the chapter about trends for different types of services with respect to the public health emergency was really valuable, and thought it could also be valuable to talk about these in the context of differential margins for those services. Because, for example, we all understand that the loss of elective surgeries is particularly hard-hitting for hospitals because of the high margins there.

That doesn't really come across, and I think that's a valuable set of facts to have out there, even notwithstanding that I whole-heartedly agree that our solutions here, you know, that the solutions to the financial challenges of the public health emergency are best handled through targeted support and not through overarching shifts to payment rates that Medicare recommends.

Those are my comments. Thank you very much.

DR. CHERNEW: Thanks, Dana. We're now going to go to Marge, and after that it's going to be Larry. So Marge, you're up.

MS. MARJORIE GINSBURG: Good. Yeah, my mute is off. I think you can hear me.

This chapter was really, really well laid out, and as somebody who is more of a layperson than the rest of you I think really made it crystal clear on what the issues are.

In general, I am supportive of the increase, but I always get nervous. I somehow have it in my mind that I remember that we're never supposed to add to the budget unless we can find some way to take away. So I know there

are other chapters that deal with reductions in costs, and my main hope is that we can, in fact, bring those to light and find a way to balance this increase.

I do share, was it, Brian's, somebody's comment about anything that will add to what we pay Medicare Advantage plans, and that part makes me nervous as well.

But in general I could find there was nothing in this chapter that would dissuade me from supporting the increase. Thank you.

DR. CHERNEW: Yeah. So let me jump in. We're going to go to Larry in a minute but there's a few themes that have come out that I think I should comment on.

The first one is I don't consider the recommendation an increase over current law for two reasons. One of them, of course, is, as Brian mentioned, it incorporates the HVIP recommendation that we have, which we think about but it's not really part of this update recommendation.

The second thing is the outpatient part is not above current law. So I think when you look broadly at our recommendation, it is probably mildly below where current law is, recognizing that there is an improvement in

hospital fiscal situation, and it's tended to try and get up, as best we can, at a sense of where the efficient hospital is.

And there's a lot of technical issues about how we compute that. One of them, of course, is just how we measure efficiency. The other one is issues related to what our bar on efficiency is. Right now it's not a particularly strict bar in the belief that costs are endogenous -- I shouldn't say that in a public meeting -- costs respond to payment.

The other thing I want to say is that while I am very sympathetic to the point that David laid out about overall hospital performance, which by and large seems reasonably fine, as I think I said, and I can't remember what I said at the beginning of this meeting or the beginning of the Executive Session, our goal is absolutely not to lower Medicare payments to offset potentially high commercial payments.

For those of you that know me, you understand I spent a lot of time worrying about high payments and high prices in the commercial sector. I think there's a lot of policy response we may need to deal with issues in the

commercial sector, but at least in this role, in MedPAC, I don't think our job is to try to lower payments to offset higher commercial payments, just like I think our job -- you will hear me say in other contexts -- is not to raise payments because of lower payments coming from Medicaid or other types of payers or that. We are trying -- I'm not sure we're always getting it right -- we are trying to come up with a payment rate that allows efficient hospitals to do well and give some incentive for hospitals to become efficient. So we have a recommendation that was intended to meet that goal.

The interesting thing, and again, I'm going to go to you in a moment, Larry, is so far the set of comments have ranged from some reasons why we should worry about going too low -- the environment's changed, there are some other challenges that hospitals face that might be more durable. We are relying on aspects of the HVIP for some of the conclusions here, that I hope was clear on how we did the analysis -- to the other side, which is we should go even lower.

So I guess the point that I have taken so far, and there's about seven or eight of you left to talk, is my

goal is to get people on both sides of where the recommendation is, and that seems to be good. So I take it you're on the exact same page. At least I want you on either side of it. We seem to be there.

With that said, I have a bunch of other important people to talk, and we are going to start now, just because of the random GoToMeeting placement, with you, Larry.

DR. CASALINO: Yeah. Thanks, Michael. I didn't think I had much to say, but as usual listening to other Commissioners has given me a few thoughts, which I think I can say very briefly.

One is I agree with Paul. I'd like to see us, in the near future, a little, and not at this meeting, revisit the site-neutral issues.

Second comment, related to the HVIP, the chapter is fantastic and I learned a lot from it. But I wonder if we should have a little more discussion about -- I don't know how likely it is that HVIP will be adopted, and what impacted does it being adopted or not adopted, would that change our update recommendation or not? Maybe a little bit of attention to that. What are the implications if it isn't adopted, which I think probably could easily happen?

And then the third thing, and last thing I would say is I think that it's not entirely clear to me on what principle we are making the update recommendation, the 2 percent or whatever. I think that if the principle is -- well, first of all, I'll go back to what Dana said, which is that we say what the aggregate Medicare margin is for hospitals but we don't do that, I don't think, for physicians, for example, and possibly for other sectors. So that might be something we might want to look at for other sectors as we go forward.

But on what principle are we recommending the 2 percent, actually 2 percent plus? Is it, as Michael, I think, has said a couple of times, is it to try to match the payment more or less to the costs of efficient hospitals? If that's right, I think that we would looking at a 1 percent update, maybe, based on the data in the presentation, or possibly 2. But I think the aggregate margin for the more efficient hospitals was -1 percent, so one could say then, well, why a 2 percent update plus the other factors that were making the update larger?

So I guess I'm just asking, what is the principle that we're using to suggest an update? It's interesting,

we should have a behavioral psychologist or a behavioral economist on the Commission. The anchoring or framing effect of the recommendations is probably very large for any sector that we're discussing. So it would be interesting if we didn't have the recommendation versus if the recommendation was -3 percent or +5 percent, would we be getting entirely different responses from the Commissioners?

In any case, my main point is what is the principle on which the 2 percent is based? And that's all I have to say.

DR. CHERNEW: I guess I can answer that, although the answer is obviously a complicated one, Larry. And as you note, we are making a projection for 2022, which we turn out not to observe. So I think the notion is that the 2 percent recommendation will allow efficient hospitals to come close to a reasonable Medicare margin. There is some other money that's in there. We aren't making our recommendations contingent upon anything else, although the recommendations taken as whole were presented, because we have some other standing recommendations.

We have not done the analysis to ask what would

happen if you did just one versus another, in a whole bunch of particular ways. I wouldn't tie them directly that way. I think I would think through it as holistically we believe that given the direction and the quality, and sort of trying to project out into the future, that we would be able to get to a reasonable margin for efficient hospitals in 2022, with the recommendations we have.

Jeff Stensland may want to add more about the projections going forward and the related thinking, but we certainly are not worried right now about beneficiary access to hospital services, under our recommendations in 2022.

To maybe less verbosely answer your question --

DR. CASALINO: If I can just focus on -- I'm sorry. If I can just focus the question a little bit more. Can you hear me?

DR. CHERNEW: Yeah.

DR. CASALINO: Okay, good. No, I guess my question is, and I don't mean to be pedantic, is, we show an overall Medicare margin of -1 percent for relatively efficiently hospitals. I guess my question is, how do we get from -1 percent to a 2 percent -- 1 percent. And

again, I'm not trying to make an argument that that's what we should do. I'm just trying to understand how we got to the --

DR. CHERNEW: And just to be clear, I think we would have ended up with a higher than 1 percent, Larry, because that's the margin in 2019, if I follow the analysis correctly. And so we would have to make an adjustment for where we think they're going to be in 2022. So if you saw the trajectory of where they were going, the idea is that with our recommendation we would be able to get there in 2022 in a reasonable way. Alison, you may want to jump in as well on that, but there's a year issue. Giving them a 1 percent update actually would leave us with a lower projected margin for efficient hospitals in 2022. I think that's right. Alison, do you want to jump in and make sure I understand it correctly?

MS. BINKOWSKI: The one thing I would add, I think it was on the prior -- or two slides earlier, but we said how we projected the efficient hospitals' Medicare margin would be near zero in 2021. We did not explicitly project for 2022, but I think the rest of the comments hold, and I think there's also discussions about what the

input price growth is and/or CPI, and that will affect the recommendation as well.

DR. STENSLAND: I think that's the main thing. They have a negative 1 margin now, and if you're going forward into 2022, you know, maybe their margin, we think, will get a little bit better, given the larger updates they had in '20 and '21, and then the 2 percent in 2022. But you kind of think of the 2 percent as partially being offset by input price inflation, and that's how we end up, you know, as Mike said, I think perfectly accurately, that we would end up with probably -- we think we would probably have a reasonable margin in 2022. With this update recommendation it would be a little higher than we were in 2019.

DR. CASALINO: Thanks.

DR. CHERNEW: Again, there's a lot of ways to think through this, and being new to the Commission -- at least I had a hiatus -- the key thing is I think this recommendation is mildly more generous than the one last year, but not so much so that I think we run the risk of overpaying where hospitals were.

So, again, I wasn't around for the discussion

last year, but that's sort of the way I view the historical trajectory of this recommendation relative to both current law and where we were with past recommendations.

I'm a little cognizant of time, so I'm going to move a little quicker. Next up I have Jonathan and then Betty.

DR. JAFFERY: Great. Thanks, Michael. I am generally supportive of the draft recommendation as well as this underlying principle that will address the public health emergency impact through more targeted efforts and not into the base.

In the interest of time, I'll just make one other comment that maybe builds a bit on some of the things that Jon Perlin said initially. You know, when we think about health care's role, whether that's delivering health care under the normal circumstances or dealing with public health responses, we often think about space, staff, and stuff, with the "stuff" being equipment and whatnot. And it strikes me that in all of our analysis here, we are talking about capacity -- beneficiary access and capacity issues. It seems to me pretty limited to the issue of space, and I think, again, to Jon's comment, staff is a

pretty key issue here, too.

So I just wonder if there's an opportunity for us going forward to think about that a little more holistically, and maybe that ties in some of the workforce discussions that we've had at times in the Commission. So I'll leave it at that. Thank you.

DR. CHERNEW: Jonathan, thank you. Betty, you're up, and then we're going to Pat.

DR. RAMBUR: Thank you so much. I really appreciate the report and the comments from the Commissioners.

In general, I am supportive, but I am also attending to this issue of anchoring that Larry raised and the point that Bruce and others commented on about thinking about the direction we should be going here.

Jonathan just tipped -- or handed this off perfectly to me because, as I'm hearing this conversation, I'm so struck by the fact that we're talking about providers of hospitals and physicians, and then we're also talking about these costs, these labor costs that are fixed, often, or variable, and really the prime -- the largest labor force, of course, is nurses, and they end up

being a labor cost. And so it seems to me the heart of this broader looking we need to think about is more considerations of all-inclusive total cost of care, because we have issues where physicians and hospitals generate revenue, but nurses are a cost. And yet if a person is hospitalized, it's because they 24/7 nursing care.

So I know we can't get at that with this particular piece, but this tension, you know, it's all part of the same thing, but in many ways driven by what we pay and how we pay for it.

I am very supportive of looking at durable versus the crisis right now, particularly given the magnitude of the overbuilding of facilities that was historic before COVID and how rapidly places have been able to put up more temporary sorts of services. We'll see how those go. We're building those right now in Rhode Island. And I strongly support -- I think it was -- I think it was Paul who initially suggested looking at site-neutral more, and I would like that as well. I'd like us to look at that as well.

That's it for me. Thank you so much.

DR. CHERNEW: Thank you, Betty. We're on to Pat.

And after Pat is going to be Sue.

MS. WANG: Thanks. I am very appreciative of all the comments that people have made about the durable impact, and I think that this report and the recommendation does the best we can based on what we know, because it's unknowable what is actually going to emerge, and so the approach of targeted COVID relief and being flexible, I think, that we will have some changes and see some changes in the cost structure and revenue structure of these providers is a certainty.

I had a somewhat technical inquiry, which we don't have to deal with here, but I'd love to explore it further when we have the chance, which is the -- I was struck when in the description of the Medicare margin, IPPS margin improving, one of the drivers was an increase in uncompensated care payments, which my understanding is today composed of the DSH component, which is sort of the old formula, and a new portion which is called the "uncompensated care pool," which is based on cost report information, you know, charges reduced to cost, or it's self-reported, it's new. And I get that there was an increase in the uninsured rate and a logical increase in

uncompensated care costs. It's interesting that there was also an increase in DSH costs, I think probably as a result of some of the ACA expansions of Medicaid which qualified hospitals, perhaps for the first time, for DHS payments. I'm just speculating.

So you have these two things going on at the same time: expansion, perhaps with Medicaid, has qualified more folks for DSH, and at the same time I think that UCP cost pool apparently has increased significantly.

My question for future discussion perhaps is I have always understood DSH as sort of like a component of the operating cost of an institution. The UCP -- the Medicare share of increased operating cost from treating a lot of low-income folks, not explicitly uninsured. The UCP portion of the new formula is explicitly Medicare payment for people who are not Medicare beneficiaries. And so I guess I just -- there's two observations. One is the volatility in the DSH UCP portion of inpatient payments, and whether or not in calculation of margin -- I just want to sort of reaffirm that it is appropriate -- that there's not the possibility in the swings year to year of overestimating Medicare revenue and underestimating

Medicare revenue because of changes sort of happening outside of the Medicare program.

I don't know if that makes sense. It's just it doesn't feel like a stable component of the inpatient rate to be subject to those kinds of swings year to year. And so that would be my question perhaps for further discussion. But in the meantime, I am very comfortable with the recommendations as put forth.

DR. CHERNEW: Okay, great.

MS. WANG: Thank you.

DR. CHERNEW: So, Pat, thank you, and that is really a valuable point that we will look into analytically between now and when we come back in January.

We're now going to go to Sue, then Jaewon, then Karen. We have three of you. We have roughly five minutes. I tried to manage the time better. We'll see. Sue?

MS. THOMPSON: Thank you, and thank you to the staff for a great chapter, a detailed chapter. Very well done.

Generally, I do want to say I do support MedPAC's posture, if you will, on how we're thinking about these

updates as it relates to the context we're currently operating in, that being the pandemic. However, this bifurcation of thinking I must say is challenging when you're living in it. And I think I just want to take an opportunity -- I feel like I would be remiss to not call out what I see to be a transformation of our care delivery system happening in this very moment. We need to look no further at the increase in utilization of telemedicine, the increase in our utilization of supply costs. It's hard to imagine a workforce that will not continue to want and expect these sorts of protective equipment going forward, even after we have vaccines available for this particular virus, but I think most importantly the conversations we've been having about labor. And I just want to underscore what I heard Betty say, what I heard Jonathan say. The labor availability issue is really how we operate from a standpoint of what we can manage in terms of access to all patients.

So this concept of bed availability -- and this has become abundantly clear as we've been caring for patients in COVID -- has very little to do with how many beds we have. It has everything to do with how many nurses

and physicians we have available. So I just don't want to end this session without making those comments. This care delivery industry is absolutely being transformed before our very eyes. The impact on costs is completely uncertain.

Having said all of that -- I know there's two more people who want to make comments -- I do substantially agree with the Chairman's recommendations, and I simply want to call out that we continue to year after year -- and this is my sixth year of December updates -- look at a negative Medicare margin for hospitals, in the negative 8 percent range, and I think that's okay. And we're going to have a number of chapters that will follow with 8, 11, 15 percent positive margins. I just want to one more time say during this pandemic it has become clear how important hospitals are to our health care delivery system.

Thank you.

DR. CHERNEW: Thank you, Sue. Jaewon.

DR. RYU: Yeah, I'm largely supportive as well. I think it at least feels like it's in the right ballpark. I do think it's worth calling out. I don't think the outlook is nearly as positive as the chapter might suggest,

so a couple examples, you know, points to closures of hospitals going down year over year, I think that's being driven largely by the pandemic. Obviously, the bar to close a hospital in the middle of a public health emergency is very different than a bar to close the hospital, you know, in 2019.

I think the other is if you look at uncompensated care, and there is, I think, a 22 percent increase in those payments, those payments, while a 22 percent increase looks fabulous, I think we have to remind ourselves that's because the care is uncompensated and it doesn't go towards nearly the compensation that would be there if those folks were insured or able to have care that is compensated.

So I think there's a little more caution that I would exercise versus the outlook that feels like it's the tone in the chapter.

The other is getting back to the HVIP linkage, and I think Brian mentioned this first. I would agree. I think without that HVIP component it does feel like this gets to a lower range where I'm not so sure I'd be as comfortable. And so I get that we cannot have contingent recommendations, but I think it's that HVIP that to me

lands it in that comfortable range. Without that, I'm not so sure I'd be there.

The other comment, I want to echo Sue's comment. I think the cognitive dissonance here, it's sort of something I've struggled with the last few years as well, where this is the only segment that's got a significantly negative Medicare margin, and even if you look -- and I think David's point was spot-on. Even if you look at the all-payer margin, the all-payer margin for hospitals is less still than the Medicare margin for all the other sectors that we're looking at. And so I think somewhere there's a disconnect that we need to grapple with.

And then, lastly -- and I think this echoes Dana's point on the efficient hospitals -- I do think we have to understand that in greater depth because hospitals taken as a whole as a sector, I think it's a very heterogeneous group and understanding the dynamics of what drives that greater efficiency. I think Jon Perlin mentioned, you know, somewhere along the way they were able to get greater automation and have less of a reliance on labor. I think that's exactly right. Understanding why and how would be helpful.

DR. CHERNEW: Jaewon, thank you. Karen, you're going to bring us home.

DR. DeSALVO: All right. Again, thanks to the staff for a really informative chapter. I'm supportive generally of the Chairman's recommendations, though, frankly, Bruce made some compelling points earlier, which I'm glad we're going to give a little more reflection to. I think I'm in agreement.

I would say I also agree with this general concept of needing surge support for COVID, but not making dramatic changes to the base rate.

I want to underscore some of what's been said by other Commissioners about the fact that there are very likely dynamic times ahead for the hospital infrastructure, even beyond the pandemic, given that there's going to be an increased need to serve people who -- on the other side of this pandemic, we'll have more folks who are uninsured, dealing with pent-up demand from people who haven't been able to attend to chronic disease or get screened for malignancies, and then, you know, rising rates of mental health and substance use disorder that we're already seeing in the background. Because, as Sue said, I also agree that

there's a transformation at play even in some of the current rules from CMS around hospital at home and telemedicine options, which will change the way hospitals need to think about, as Jonathan said, space, stuff, and staff going forward, and so even some of the ways we think about capacity and access, we may have to start to consider as a Commission how to measure and mark that, because it won't necessarily be beds. It may increasingly be the kinds of services that are located even outside of the hospital walls.

So thank you guys very much.

DR. CHERNEW: Great. So thank you all. We are going to switch as expeditiously as possible to our ASC discussion. I'm going to turn to Dan in a second.

That was a wonderful discussion. I will save my thoughts for when we have more time, but I will just close by saying several of you said something that I would just echo. It is absolutely 100 percent clear to me -- and I think we all share this point -- during a pandemic or not, that hospitals are a critical part of the nation's health care infrastructure, and paying them in a way that allows them to provide the care that we need is an important goal.

We just want to make sure we pay the ones in a way that we sort of pay them efficiently.

So we will think about how to balance the different ranges of comments that came across in this call and be in touch, but for now I'm turning it over to Dan.

Dan, are you ready?

[No response.]

DR. CHERNEW: I see a cursor moving, but I don't hear Dan talking.

MS. KELLEY: Hang on one sec, Mike.

DR. CHERNEW: Okay.

DR. ZABINSKI: Can you hear me now?

DR. CHERNEW: Yeah. You're like the Verizon guy. Go ahead.

DR. ZABINSKI: Okay. Thank you.

All right. Ambulatory surgical centers. In this presentation, we will discuss payment adequacy for ambulatory surgical centers, or ASCs.

For the broader audience, PDF versions of the slides are available on the handouts panel on the right side of your screen.

In our assessment of payment adequacy for ASCs,

we use the following measures: access to care as measured by capacity and supply of ASCs as well as the volume of services; quality data, using measures from the ASC Quality Reporting Program, or the ASCQR; access to capital; and aggregate Medicare payments.

Finally, we are not able to use margins or other cost-dependent measures because ASCs do not submit cost data to CMS.

Important facts about ASCs in 2019 include that Medicare fee-for-service payments to ASCs were nearly $5.2 billion. The number of fee-for-service beneficiaries served in ASCs was 3.5 million, and the number of Medicare-certified ASCs was about 5,800. Also, the ASC payment rates will receive an update of 2.4 percent in 2021.

In our assessment of payment adequacy, we use the measures we presented on the second slide. On this table, the values for measures of payment adequacy in the second column indicate growth in the ASC setting in 2019. In particular, the number of Medicare fee-for-service beneficiaries served increased, as did the volume of services per fee-for-service beneficiary and the number of Medicare-certified ASCs.

Turning to quality, we have data from 2013 through 2018 from the quality measurement program for ASCs, the ASCQR. From 2013 to 2017, the measures in the ASCQR showed some improvement, but the measures were largely unchanged from 2017 to 2018.

In addition, CMS has decided to discontinue some measures that were topped out or where the cost of collecting the data was greater than the benefit, and we supported those changes. However, some measures, such as the share of average-risk colonoscopy patients who receive the appropriate endoscopy and polyp surveillance is only 83 percent. So there is room for improvement.

Also, we believe CMS should move the ASC sector away from pay for reporting and implement a value-based purchasing program that rewards ASCs for performance, which the Commission has recommended. Use of a VBP program would align the ASC sector with other fee-for-service Medicare sectors.

Measures that should be included in an ASC VBP program include CAHPS-based patient experience measures and more claims-based outcomes measures because the current set of outcomes measures do not apply to all specialties that

are practiced in ASCs, such as ophthalmology and pain management.

The best measure for evaluating ASC's access to capital is the growth in the number of ASCs, as capital is needed for new facilities.

This graph shows that the number of ASCs has steadily increased. A positive growth of 2.5 percent in the number of ASCs in 2019 indicates that access to capital has been strong.

In addition, hospital systems and other health care companies such as HCA and United Surgical Partners have been acquiring ASCs, and this trend continued in 2019. These acquisitions suggest that ASCs are profitable. However, keep in mind that the number of ASCs involved is less than 20 percent of all ASCs.

Also, it is important to understand that Medicare is only a small part of ASC's total revenue, perhaps 20 percent. Therefore, Medicare payments may have a small effect on decisions to create new ASCs.

In this graph, we indicate that Medicare spending per fee-for-service beneficiary in ASCs has been increasing, with a strong increase of 8.3 percent in 2019.

This growth in 2019 was driven by a combination of factors, but primarily by an increase in the average relative payment weight for the services provided in ASCs, an increase in ASC volume and an ASC payment rate update.

On a final point, we can't determine a margin for ASCs, because ASCs do not submit cost data to CMS. However, a Pennsylvania state agency collects cost and revenue data from all ASCs in Pennsylvania each year. The agency uses these data to calculate a total margin for ASCs in the state, which was 25 percent from 2019.

On the environmental front, since early 2020, the coronavirus has been a human tragedy. It has also affected the ASC landscape, as described in more detail in your mailing materials.

From the first six months of 2020, we evaluated the most frequently provided ASC services, which constitutes 75 percent of total ASC Medicare volume. We found that by April 2020, the volume of these services dropped to 11 percent of their January 2020 level. However, the volume rebounded quickly and was 87 percent of the January level by June 2020.

In addition, access to capital has remained

strong for ASCs because ASCs have continued to open and health management companies that own ASCs have received federal grants.

But we're in the midst of another surge in coronavirus cases, and it's not clear how ASC volume looks right now. We do intend to keep track of the effects of the public health emergency to keep our analysis as current as possible, but the effect of the PHE on volume in 2021 is uncertain.

In the end, the effect of the pandemic has varied over time, but we do not anticipate any long-term changes to the ASC landscape that will persist past the end of the PHE.

To summarize our ASC findings, indicators of payment adequacy suggest access to care is strong. In 2019, measures in three of the four categories for access to care improved, and the quality category was largely unchanged.

In addition, the ASC sector should move to a value-based purchasing program for measuring quality. The increase in ASCs also suggests access to capital is strong, and corporate entities such as hospital systems have

obtained and invested in ASCs.

Finally, Medicare payments increased substantially, but we remain concerned that ASCs do not submit cost data, even though the Commission has recommended doing so since 2009.

We believe that ASCs should be able to submit cost data because other small providers such as hospices and home health agencies are able to furnish cost data.

So for the Commission's consideration, the Chair has the following draft recommendation. For calendar year 2022, the Congress should eliminate the update to the 2021 conversion factor for ambulatory surgical centers.

Given our findings of payment adequacy and our stated goals, eliminating the update is warranted. This is consistent with our general position of recommending updates only when they are needed.

The implication of this recommendation for the Medicare program is that it would produce small savings. As the anticipated update for the ASC conversion factor is 2.7 percent for 2022, so anything less than that will produce savings.

We anticipate this recommendation would not

diminish beneficiary's access to ASC services or provider's willingness or ability to furnish those services.

We note that, to the extent that the coronavirus PHE continues into 2022, any needed additional financial support should be targeted to affected ASCs that are necessary for access and done outside the annual update process.

The Commission has also wanted to collect and submit cost data for many years, and the Secretary has the authority to require it. Therefore, the Chair has a second draft recommendation that the Secretary should require ambulatory surgical centers to report cost data.

Collecting these data, which Medicare does for other providers, would improve the accuracy of the ASC payment system. The Secretary could limit the burden on ASCs by requiring a cost report that is limited in scope.

Implementing this recommendation would not have a direct effect on program spending. We also anticipate no effect on beneficiary's access to ASC services; however, ASCs could incur some added administrative costs.

So that concludes this presentation, and I appreciate your time. I would like to open up the session

to discussion about our analyses and the Chair's draft recommendations.

Thank you.

DR. CHERNEW: Great. Dan, thank you.

We're going to start with Brian, and then we're going to go on to Marge.

Brian?

DR. DeBUSK: First of all, Dan, thank you to you and the staff for pulling this report together.

I do want to challenge this year some of their conventional thinking around ambulatory surgery centers. I'm very supportive of what they do, and I'm concerned that Medicare payment policy may be holding them back.

And I would offer two facts here, first, that, Dan, you mentioned earlier, which is that Medicare is only about 20 percent of ASC revenues. Medicare is underrepresented in this payment sector, and I think in the process of being underrepresented, we're also denying your beneficiary's access to lower cost sharing, because ASCs are around 52 cents on the dollar, of what an outpatient department would cost. But I also think we're denying taxpayers access to savings through ASCs, because taxpayers

enjoy that same benefit.

The second piece of evidence that I want to offer is on page 17 of the reading material. If you look at ASC-eligible procedures and you look at the growth for fee-for-service beneficiaries, it's 2.7 percent. When we look in hospital outpatient departments at those ASC-eligible procedures, that growth is 3 percent. So consider this. It's the higher-cost revenue venue -- or the higher-cost venue is growing at a rate faster than the lower-cost one.

Consider this, say, in a Part B drug. If we had two Part B drugs that were in a combined billing code and one drug was half as expensive and more convenient, but the more expensive drug was growing faster, wouldn't we consider that an indication of a problem? I mean, to me, that is a sign that there's an issue here.

Before I get into talking about ASCs more, too, I do want to say I categorically support that they should file cost reports. I think there is no excuse for them not filing cost reports.

I do think in this highly vertically integrated sector and as we see vertical integration increase, it's going to be difficult to interpret what those cost reports

mean, but I still think we should have access to them.

Secondly, I do think that they should adopt a value-based purchasing program that's consistent with the frameworks that we built in other areas, like the HVIP and the MA value-based purchasing program. So I don't think any of this is an excuse for not filing cost reports and not moving to a modern cost-reporting platform. I think those are a given.

But with that said, ASCs do offer around 50 percent savings to taxpayers and to beneficiaries, and a lot of the issues -- in the reading materials, we talked about some of the questions about, well, do they induce volume. Well, first of all, those studies are around a decade old, and even the authors in those studies agree that what we may be measuring are ASCs' ability to locate themselves in areas where they know they're going to flourish.

And, you know, the same could be said for fast-food places or dry cleaners. This isn't a novel idea that you would locate your business in an area where it's going to flourish. So I'm a little skeptical about some of these more abstract arguments around that ASCs are inducing

volume.

I also want to talk about a great opportunity here to look at site-neutral payments. I do believe Medicare should pay similar rates for similar care, and we already have a venue here with ASCs that have a build-in site-neutrality mechanism in that there is no incentives for procedures that are now done, the majority in a physician's office, to be moved into an ASC. So we have protection from those procedures moving upstream, but we really don't have protections or something to safeguard the more expensive venue doing some of these procedures.

I mean, ask yourself, do you want a Level 1 trauma center, do you want an academic teaching hospital to be doing routine colonoscopies anyway?

Again, I do hope that we can take measures to induce more volume into ASCs because I think they should be growing much, much faster.

I also want to take the time and talk about -- excuse me?

DR. CHERNEW: Brian, we don't have too much time. We have a 45-minute session. I don't mean to cut you off.

DR. DeBUSK: I'm sorry.

The last thing I'll say, Dan, I want to challenge you. On the zero-cost update issue, how do we get from we don't have cost reports, so we should do no update? To me, it's like asking me how many cars are parked on the street outside my house. The answer is I don't know. The answer isn't necessarily zero.

So I guess I'll leave my opening comment with one question: How do we translate not knowing how their costs are changing to a zero update? Why not plus 3? Why not minus 3?

Anyway, thank you. Thank you.

DR. CHERNEW: Brian, thank you.

Paul, you jumped in to want to respond exactly to this, so, Marge, I apologize. I'm going to go to Paul and then to Marge and then to Amol.

DR. PAUL GINSBURG: Okay. Thanks, Mike.

I think what Brian says, a lot of it makes a lot of sense, that we certainly wouldn't want to get in the way of ASCs doing services which they're appropriate for in place of hospital outpatient departments, but I don't think we're constraining them now.

I look at the indications of entry by for-profit

ASCs, and it looks very strong. I think it's no surprise that Medicare beneficiaries use ASCs less than others because -- and my clinician colleagues can get into this -- is that there are many cases where patients that are older are directed to hospital outpatient departments just because of their age and the risks in the procedures.

Also, a lot of ASC entry is blocked by state certificate of need laws, which is sometimes used by hospitals to keep ASC competitors out of their market.

So we may have a case that even though Brian's logic makes sense -- we may have a case where the Medicare payment is not really discouraging ASC entry at all.

And then a final thing, I'm comfortable with the recommendation.

DR. CHERNEW: Paul, thank you.

We have about 20 minutes, 25 minutes, a little less, and it's on to you, Marge.

MS. MARJORIE GINSBURG: Thank you, and I'll make this quick.

Is there any previous history of not being able to get cost information and why CMS is so reluctant to push this with them, and will we ever succeed unless we do

something like this, which basically says we're not going to increase any money until we actually see results?

I'm also curious about two things. One, on page 12, where it shows the number of ASCs per capita and the state, that Maryland is practically off the charts in terms of its number, and I wondered whether that had anything to do does Maryland have a global payment system for hospitals. But I'm curious whether anybody else noticed how different Maryland was.

And the last question, which we probably don't have the answer for, do we know anything about the use of ASCs in Medicare Advantage plans?

I think that even though 20 percent of Medicare use currently in original Medicare -- I think that's going to skyrocket. It's going to change, and it's going to grow a lot. So the more we push now on getting that cost information, the better off we'll be.

Thank you.

DR. CHERNEW: So this brings us to Amol, and I'll watch the chat to see who wants to go next. Otherwise, we're going to go to David Grabowski.

DR. NAVATHE: So first off I just wanted to voice

support for the Chairman's draft recommendation here. I like many of the points that were made, particularly around trying to support getting this towards a value-based payment arrangement, as we have for many other settings.

That being said, the question that I had was, it seems that some CON laws cover ambulatory surgery centers, and I was curious, in terms of Medicare growth, in terms of additional ASCs popping up, how does it actually relate to CON laws? I think there was a figure in the reading that showed the distribution across states, and there's quite a bit of variability. So that was one question. If we don't know the answer or not, it would be great to get that and follow up.

DR. ZABINSKI: On the CON there is a relationship between how many ASCs the state has and COM laws. There's typically fewer in states that have a COM law than those that don't. In particular, Vermont has apparently very stiff COM laws for ASCs, and that's why you have so few ASCs in the state. I mean, there's two. A new one just opened last year. They went for a long time with just one in the entire state.

DR. NAVATHE: Okay. That's helpful to know. The

other question that I had is, now that we're seeing some relaxation of the self-referral statutes as well, we noted, I think, some language in the reading about this, but do we have any speculation on how that might influence ASC growth, either in terms of volume payments but also in terms of actual facility growth in those non-COM states?

DR. ZABINSKI: Well, yeah, the Stark law really didn't apply to ASCs, so I'm really not sure how the changes in the law are going to affect things, offhand anyway.

DR. CHERNEW: Okay. I want to -- again, I don't mean to push everybody along. Hopefully we'll have a little time at the end to go back. But I want to go to David Grabowski and then we're going to go to Sue Thompson.

DR. GRABOWSKI: Great. Thanks, Mike. I'm supportive of the recommendations. I've said this in prior years, but I always find it offensive that we can't get the cost report data. And I think I also said this last year and I'll say it again this year, that I think it should be MedPAC principle, if you won't show us the cost report data we won't show you a payment rate increase or recommend a payment rate increase. And I wonder, Mike, if we even want

to go further there, to suggest maybe some sort of penalties in place to actually push that even further. Thanks.

DR. CHERNEW: So I will say I understand the frustration -- again, I wasn't on the Commission in the previous two years -- about cost reports. I will say that the recommendation for cost reports is strong, and we could discuss about making it stronger. But the payment update is in no way intended to reflect the lack of a cost report as much as tremendous growth in the sector constrained by things that are a little bit out of control, like CON, and the belief that some of the patients that are being treated there are less costly patients than they would be other places.

So while I support all the site-neutral discussion, there are a lot of unobserved case mix issues that make it kind of complex. But as long as we see as rapid entry of for-profit facilities, I don't know how many cars are parked outside my house but I'm not worried that we're discouraging the diffusion, when you see that entry by for-profit organizations. But that will be a separate call discussion. I'm taking up too much time. Someone

needs to cut me off.

Let's go to Sue.

MS. THOMPSON: Thank you, Michael, and thank you to the staff for this chapter. And actually, Michael, you just made all the points that I wanted to make, so in the spirit of not taking any more time I want to call out I do support the Chairman's recommendations here. I find the conversation we've been having to be very relevant and important to further discussions, and I'm just going to echo the point that we need some cost report data.

DR. CHERNEW: Okay. Great. You were so quick, you caught me off guard. I think we're going to go to Jaewon and then Karen.

DR. RYU: Yeah. Thanks, Mike. I'm also supportive of the draft recommendation. I think the key here, to me at least, is being able to continue to see migration of cases outside the hospital and into these settings, and I think we're seeing that, or at least evidence of that. I think the other is making sure that there's levels adequate to support the continued growth, and I think we're seeing that as well. And so for those reasons I'm supportive.

DR. CHERNEW: Jaewon, thank you. Karen.

DR. DeSALVO: Yeah. Thank you. I'm supportive of the recommendations but want to underscore this concept of accountability, which has come up year over year, in that they should be expected to report their costs, just like everyone else, and need to be held increasingly accountable for some of the quality outcomes. Thank you.

DR. CHERNEW: Wow. Okay. So I'm going to have to be quicker. We're going to go to Pat and then Bruce, and then Betty. That's the way you're showing up on my screen. So Pat.

MS. WANG: Yeah. I have no problem with the Chairman's recommendation, but I really, I mean, ever since I've been on the Commission, every year it has been just baffling to me this issue about no cost reports. It just can't be that burdensome. We know these are low-capitalized organizations. People are rushing in. They're very successful. And so, you know, these are not sort of community-based organizations that are struggling with resources, and therefore it leads one to believe that there's some intentionality in the refusal to file cost reports.

So I'm kind of more in the camp with David Grabowski of, you know, without taking anything away from the consumer friendliness and the growth and the importance of ASCs, it is hard to come up with a payment recommendation, to Brian's question, you know, in the absence of information. Why zero? Why not +3? Why not -3? I mean, it really could go to -3 because there is no information, so you're sort of in the dark. I don't think that we should pay ASCs because they're a cheaper alternative to a facility-based, hospital-based service if their actual costs and financial margins would indicate that the payments could be less than that.

So without knowing, I actually think a zero update is a pretty fair outcome, personally. Thank you.

DR. CHERNEW: Thank you, Pat. So we're going to have Bruce and Betty, and then it's going to go to Larry.

MR. PYENSON: I support the Chairman's recommendation, though I point out it would be consistent with a zero increase for hospital outpatient, which would argue for my earlier point that the hospital inpatient, outpatient might be too high.

I'd like to make one other point, that as we push

for ASC cost reports, let's bring it into the 21st century cost reporting, since we have an opportunity to do that, with something like a standard charge master. So we should not miss that opportunity to update what the cost reports look like. Thank you.

DR. CHERNEW: Bruce, thank you. Betty.

DR. RAMBUR: Thank you. I appreciate the comments as well as the good work on the report. I strongly believe all health care providers need to be accountable for the costs and outcomes of their care, and so certainly I would support the changes in here regarding that. I also support the comments by David, that I think was also echoed by Susan, that perhaps more teeth is necessary. Perhaps that's in a different process than this. I don't know, but I think that's important. And I'm just studying the conversion factor, so I don't have thoughts on that. Thank you.

DR. CHERNEW: Betty, thank you very much. We're going to go to Larry, then it's going to be Jonathan and Wayne.

DR. CASALINO: Yeah. I, too, support the recommendation and I, too, will pile on about costs. I

just want to call attention to one thing that was in the chapter but I don't think in the slides, which is, if I understood properly, how CMS is currently saying that, well, we're going to take five years to evaluate whether we should collect cost reports from ASCs. I think we should call that out more clearly in the chapter, and I guess we don't refer to that kind of thing in the recommendations. But that's actually comical. I mean, whoever the lobbyists are that got five years from CMS to evaluate whether to obtain cost reports, that's should really be Hall of Fame lobbying.

I just want to bring up one other thing. A few people have mentioned it. The value-based purchasing again is a question why there should be value-based purchasing for some sectors, many sectors, but not for ASCs. I guess we've already made a recommendation about that, and just from a MedPAC process point of view I don't know if that means we shouldn't be making a recommendation again about that this time, because that does seem pretty glaring, the lack of any kind of value-based purchasing program, or whatever we want to call it, for ASCs.

DR. CHERNEW: Larry, thank you. We are now going

to go to Jonathan, then Wayne, and Dana.

DR. JAFFERY: Thanks, Michael. I will just echo I'm supportive of this and it's a great chapter. I also continue to be extremely frustrated by the lack of cost reporting and to understand it clearly. If hospices can do this, and others, then so can ASCs.

And I think, maybe to David's point, I understand that the recommendation is based on the assessments we do have in the absence of cost reporting data that reflect the various kinds of adequacy, but I thought I heard that Pennsylvania experience suggested a 25 percent margin. So that is one piece of data. It's not very broad, because we don't have it in the other areas of the country. That's actually the only data we have.

And so based on that I feel like we could get to a point where we're suggesting actually a reduction, and maybe we don't do that this year but we could start to talk about that, trying to utilize the data that we do have. Thanks.

DR. CHERNEW: Thank you. So that leads us to Wayne, and Dana, and Jon Perlin, you're going to get the last word. So Wayne.

DR. RILEY: Yes. Fully supportive of the recommendation. I, too, am perplexed by the lack of cost data, so fully supportive.

DR. CHERNEW: Wow. Thank you, Wayne. Dana.

Dana, I think you're muted.

DR. SAFRAN: Apologies. I was trying to be so fast. I am fully in support of the Chairman's draft recommendation. I appreciate the comments and discussion so far. I will layer on my support for the critical importance of our beginning to have cost data from ASCs and also for the importance of beginning to have a quality measurement and accountability program that goes beyond pay for reporting.

The only other thing I would add is I did have a question about the high number of ASCs that we see in Maryland, and whether we have any idea of whether that is potentially related to the Maryland budgeted hospital payment models. It seems such an outlier that it would be helpful to understand what is driving that and what impacted it's having, though I'm not looking to take us off course here. But I do think that's a very important data point for us to understand.

And then the last thing I'll say is that the fact that Stark doesn't apply to ASCs does concern me, because unlike some of what I think I heard expressed elsewhere I do worry about supply-induced demand for ASC services and the overuse of procedures in those settings. So I would just call that out as something that needs attention. Thanks.

DR. ZABINSKI: Real quick. The Maryland number of ASCs, it does appear that the global budget structure in Maryland does probably contribute to the high number, because there's incentive for hospitals to move the ambulatory surgical services out of the hospital into another setting, in this case ASCs.

DR. SAFRAN: Well then I'll use that to further plug my common refrain that we really do have to continue to look at hospital-based payment reform as an important lever for Medicare. Thanks.

DR. CHERNEW: Dana, thank you. And that brings us to Jon Perlin.

DR. PERLIN: Well, I'll be brief. First, thanks for the terrific report. I support it.

I want to make a comment on context first. You

know, as someone who works with large numbers of ASCs, they do range in sophistication, from sort of corporate and eminently capable to, you know, a surgeon's partnership, kind of mom-and-pop shop. That said, they have a sophistication to do cost reports.

The second is I know, apropos to our prior discussion, that there are temporary issues, but again, the effects of COVID are perhaps even more destabilizing to physician practices in this instance, some of those smaller ASCs. I just note that not as things that we need to fix through this.

That said, we could understand those issues a lot better if we had better cost quality data, and so I emphatically support both the cost reports, and I really hope that we are quite strong in terms of encouraging comparable, broadly available test and quality measures.

I think part of our premise is not only has care moved to the ambulatory surgical setting but, in fact, more complex patients have moved to those settings. More sophisticated procedures are being done there. And it would be really nice to understand more about that. So I hope that we're particularly emphatic on the quality

metrics aspect. But with that I support. Thanks.

DR. CHERNEW: Jon, thank you. I won't give a broad summary of where I am on all of this, but there certainly seems to be a strong consensus for cost information, and I think a reasonable support for the direction of where we're going.

Just to emphasize a few points, although I said some of this before, although we want cost information, we have enough information, I think, to infer that the sector is possible and access is adequate. And while I'm very aware of the site-neutral issues with other types of providers, I think a difficulty in case mix is such that we will explore that. But it is certainly a longer set of analysis than we are prepared to do now.

So that's my summary of where we are on ASCs.

DR. CHERNEW: I think next up we have dialysis. I believe that's right. So I'm not sure who I'm turning it over to but I'm about to find out. Nancy, I think you're going to be up.

MS. RAY: Yes. Is my audio okay?

DR. CHERNEW: Your audio sounds great, Nancy. Thank you. Go ahead.

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

Today we are going to talk about the outpatient dialysis payment update for calendar year 2022. First, I'll discuss some background on this payment system. Then we'll walk through the payment adequacy analysis, and we'll end with the Chair's draft recommendation.

Outpatient dialysis services are used to treat most patients with end-stage renal disease. In 2019, there were about 395,000 fee-for-service dialysis beneficiaries, treated at roughly 7,700 facilities. Total fee-for-service spending was about $12.9 billion for dialysis services.

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

We look at beneficiaries' access to care by examining industry's capacity to furnish care, as measured

by the growth in dialysis treatment stations. In 2018 and 2019, growth in in-center treatment stations, at about 3 percent, grew faster than fee-for-service beneficiary growth, which was roughly flat. However, capacity increase reflects growth for all dialysis patients.

In your mailing materials, we highlight the growth of dialysis patients in Medicare Advantage plans over time. Recall that in 2021, ESRD patients will be permitted to enroll in MA.

The last point about capacity. In 2019, more facilities opened than closed, there was a net increase of roughly 220 facilities.

Another indicator of access to care is the growth in the volume of services, trends in the number of dialysis fee-for-service covered treatments, and fee-for-service dialysis beneficiaries. Between 2018 and 2019, the total number of fee-for-service dialysis beneficiaries and dialysis treatments held steady. The 25 percent marginal profits suggest that providers have a financial incentive to continue to serve Medicare beneficiaries.

We also look at volume changes by measuring growth in the volume of dialysis drugs in the PPS bundle.

Since the PPS was implemented in 2011 and these drugs were included in the payment bundle, providers' incentive to furnish them, particularly the erythropoietin-stimulating agents, ESAs, has changed. Between 2010 and 2019, use of ESAs has declined by nearly 60 percent, with some positive changes to beneficiaries' health status.

In more recent years, we see substitution among ESAs for the lower-cost product, which is consistent with the goals of the PPS. Expanding the payment bundle in 2011 is an example of how Medicare can use payment policy to decrease spending and improve health outcomes.

Next, we look at quality by examining changes between 2014 and 2019. One indicator that measures how well the dialysis treatment removes waste from the blood, dialysis adequacy remains high. The percent of dialysis beneficiaries using home dialysis has increased from 10 percent per month to nearly 13 percent. Hospital admissions per beneficiary, mortality, and percent of hospitalized beneficiaries with a readmission have held steady. These are all good trends. On the other hand, there is a slight increase in the percent of dialysis beneficiaries with at least one emergency department visit.

Regarding access to capital, indicators suggest it is positive. A growing number of facilities are for-profit and freestanding. Private capital appears to be available to the large and smaller-size multifacility organizations. Since the start of the dialysis PPS, the two largest dialysis organizations have had sufficient access to capital to each purchase mid-sized dialysis organizations. There are new entrants to the dialysis sector, including CVS Health that is currently running a clinical trial for a home hemodialysis machine. The 2019 all-payer margin is 18 percent.

Now let's talk about providers' financial performance under Medicare. This slide shows the Medicare margin under the ESRD PPS since 2011. It's a time series. In the early years, the increase in the margin is chiefly a result of the decline in drug use. The decrease in the margin between 2013 and 2017 was due to the rebasing of the base payment rate to account for the decline in dialysis drug use that I showed you on Slide 6.

The TDAPA, the transitional drug add-on payment adjustment, for calcimimetics that began in 2018 accounts for the increase in the margin between 2017 and 2018, and

the significant increase in the Medicare margin between 2018 and 2019 from 2 percent to 8 percent is a result of the availability of generic versions of the oral calcimimetic in 2019.

So let's talk about the factors behind this increase. Recall that TDAPA drugs are paid based on their average sales price, ASP. There is a two-quarter lag in the data that CMS uses to set ASP base payment rates. Consequently, when prices increase or decrease, it takes two quarters before that price change is reflected in the ASP data that Medicare uses to pay providers. When new generic drugs enter the market, their ASPs are often substantially lower than their brand counterparts. But payment amounts remain at the higher brand level for typically two quarters. The temporary larger spread between payments and costs that occurs when generics enter the market gives providers incentives to switch to generics, which in the longer run brings down Medicare payment rates.

Because of this two-quarter lag, in 2019, when generic oral calcimimetics became available, Medicare was still paying brand prices while providers were increasing

their use of the less costly generic products. Your mailing materials show that in 2019 TDAPA payments averaged four times estimated providers' cost per treatment.

In 2020, Medicare's payment rate has partially caught up with generic prices. According to our analysis of dialysis claims data comparing the first six months of 2019 to 2020, the TDAPA payment per treatment declined by 30 percent. And in 2021, the TDAPA ends. Calcimimetics will be included in the PPS bundle and paid under the base rate, which may create incentives for facilities to provide these services more efficiently.

So in 2018, the Medicare margin is 8.4 percent. As you can see, the Medicare margin varies by treatment volume. Smaller facilities have substantially higher costs per treatment than larger facilities, particularly overhead and capital costs. The lower Medicare margin for rural facilities is related to their capacity and treatment volume. Rural facilities are on average smaller than urban ones. They have fewer in-center treatment centers and provide fewer treatments.

Before moving to the projection, I'd like to discuss the effects of COVID on the dialysis population.

Dialysis patients are at increases risk of severe illness from COVID-19. Our analysis of six months of claims data ending June 30, 2019 and 2020, show that the number of dialysis fee-for-service beneficiaries decreased by 2 percent. This could stem from excess mortality as well as new patients delaying the start of dialysis. We see a slight decline in the number of treatments furnished while Medicare payment per treatment increased, most likely from the payment update and the temporary elimination of sequestration.

The LDOs, the large dialysis organizations, in their public statements have said that they have seen an increase in mortality among their patients, particularly the elderly. During the public health emergency, their commercial payer mix of patients, which is linked to each company's financial performance, has remained relatively steady or improved. In-center capacity and treatments are increasing, but more slowly than 2019.

The large dialysis organizations have seen increased interest from patients in home dialysis. In general, third quarter effects from the pandemic have had a lesser impact than the second quarter.

We don't anticipate that the pandemic will substantially alter the cost structure of dialysis providers in a permanent way. To the extent the effects are temporary or vary significantly across individual providers, they are best addressed through targeted, temporary funding policies rather than a permanent change to all providers' payment rates in 2022 that will also affect payments in future years.

That said, there is uncertainty as we are entering the winter with increasing cases and potential for a more intense phase of the pandemic. We will monitor available new information and update you in January as warranted.

So the 2021 projected Medicare margin is 4 percent. We expect the 2021 margin to be lower than the 2019 margin because the increase in payment based on the net updates in 2020 and 2021 will be offset by the reduction in payment when CMS includes calcimimetics into the bundle in 2021. And the projection also reflects a small estimated reduction in total payments due to the ESRD Quality Incentive Program.

So here is a quick summary of the payment

adequacy findings. Access to care indicators are favorable, positive. Quality is improving for some measures. The 2021 Medicare margin is projected at 4 percent. This leads to the Chair's draft recommendation. For calendar year 2022, the Congress should update the 2021 Medicare end-stage renal disease prospective payment system base rate by 1 percent.

In terms of spending implications, this draft recommendation lowers spending relative to the statutory update, which is currently projected right now at 1.9 percent. We expect dialysis beneficiaries to continue to have good access to outpatient dialysis care, and we expect continued provider willingness and ability to care for these beneficiaries.

This concludes our presentation, and we look forward to your discussion.

MS. KELLEY: Mike, we can't hear you.

DR. CHERNEW: Oh. Well, I was saying thank you profusely to Nancy and saying that Marge had asked to be first, so we will let Marge be first, and then we're going to go to Jonathan. Marge.

MS. MARJORIE GINSBURG: Great. Thanks so much.

I realize the point of this is to look at the payment implications, but I'm very concerned about the beneficiaries. As you know, 2021 is the first year that MAs can enroll them directly, and if any of you have seen any of those reports, it's with 20 percent cost sharing. When you're in Original Medicare, in most states you can actually buy a supplemental plan. They cost you more, but at least you can get it. You don't buy supplemental plans in MAs.

And I also know that I think it's almost 50 percent of people on dialysis are probably duals, so maybe we're only looking at half the population. But I am baffled as to how even half the population could afford a 20 percent coinsurance for dialysis.

So my question is: Has the staff looked at this before in terms of what people do who have end-stage renal disease in terms of their cost-sharing implications? So a simple question. Has the staff looked at this before? If they haven't, I would propose we need to explore this in more detail in the future. Otherwise, I agree.

Thank you.

DR. CHERNEW: Nancy?

MS. RAY: Right. With respect to Medicare Advantage, that is not -- and in terms of the coinsurance involved, that is not an area that I have looked into.

MS. MARJORIE GINSBURG: Then it -- I mean, people who were in an MA plan before they got end-stage, in which case they don't get kicked out. I don't know what their cost sharing was back with that scenario. But the other part is those in Original Medicare, if they don't have a supplemental plan, do they just spend down until they become a dual? Do we know anything about that?

MS. RAY: Oh, so we do know that roughly half of all fee-for-service patients are duals, and it's been awhile since I looked at the Medigap coverage, but the last time I looked, which was a couple of years ago, my sense is that most dialysis beneficiaries were either duals or had some sort of Medigap. But I would want to go back and double check that.

MS. MARJORIE GINSBURG: Thank you.

DR. CHERNEW: So I think as a general point, out-of-pocket spending for high-value services is a really important issue, you know, Marge, one I've been worried a lot about. My hunch is -- although I have no data so I

won't claim to know -- is that Medicare Advantage plans are relatively speaking more generous, and, of course, people could leave the Medicare Advantage plan if they wanted to go into -- buy a Medigap plan. That doesn't mean that you get to get a Medigap plan at an affordable price. And so I share your concern. We can look into what the out-of-pocket costs are for something like dialysis. I think that's true in both Medicare Advantage and traditional Medicare.

Jon, was there another comment? Okay? I'm going to Jonathan and then it's going to be Wayne and Dana Safran.

DR. JAFFERY: Great. Thanks, Mike. So thanks, Nancy, for a great presentation and also you and Andy for the report.

First off, I'm supportive of the draft recommendation. I think Marge has a really important point about thinking about cost sharing here for beneficiaries. This could clearly be very substantial for people. So it's something for us to think about.

Just a couple other quick comments. You know, I think dialysis or ESRD payment is a great example of using

-- I don't know if we would really call it "value-based care" yet, but using bundles as a policy to get some of our desired outcomes. The example of the ESA use dropping off pretty rapidly, there's more than one reason for that. One of them has to do with some clinical evidence that emerged around that time about hemoglobin levels and cardiovascular outcomes. But a lot of it had to do with ESA use, and we saw iron use go up very quickly. So I think there's probably some success stories we might learn from that, and I think we also want to be careful that we don't allow other policies to sort of perturb the positive impact. And I think about the TDAPA policies and things like that.

Then the only final comment I'll make is something we've talked about before, really how remarkable it is that in this sector we've got such dramatic market consolidation, and, you know, as we think about expansion to Medicare Advantage, what are the dynamics that are going to come out of that? We talked a little bit about that last month. But I think we really need to continue to keep an eye on that or think about consolidation in this market in particular, because it is so dramatic, as many of us have talked about before.

But, again, I'm very supportive of this recommendation and appreciate the opportunity to comment.

DR. CHERNEW: Thank you, Jonathan. Wayne.

DR. RILEY: Yeah, I'm supportive of this as well. I want to underscore what Jonathan just mentioned in terms of the consolidation is having a real impact on potential physician workforce taking care of Medicare and dual-eligible patients who need dialysis. We're starting to see a decrement in the number of physicians who are choosing nephrology as a subspecialty of internal medicine because of this consolidation, and obviously, access to dialysis services for our beneficiaries, it's critically important to have a highly trained nephrologist because of the obvious technical nature of hemodialysis and other dialysis modalities. So I'm very supportive of this, but I think we do need to keep our eye on this consolidation issue, as Jonathan laid out so superbly.

DR. CHERNEW: I was muted. We are going to go to Dana Safran, then Sue and Pat.

DR. SAFRAN: Thank you. I'm in full support of the Chairman's draft recommendations here and would just underscore the important points made by Marge about

beneficiary cost sharing and about the issue around consolidation. Having a sector where, you know, almost 100 percent of beneficiaries are in the care of two organizations really is something that deserves our attention, especially with the cost margins that we're looking at in this chapter.

So I appreciate the work, and that's all I have.

DR. CHERNEW: Dana, thank you. Sue and then Pat.

MS. THOMPSON: Thank you, Michael, and thank you, Nancy, for your ongoing work, not only on this chapter but on this entire set of subject matter.

I too am supportive of the draft recommendation. I really did appreciate Marge's comments and her recognition of the impact to the beneficiary and would love to see more information in response to her questions.

I do think the market consolidation in this particular segment is worthy of keeping our eye on. In a segment that has seen a 25 percent marginal profit, there's obviously something to watch here. But, nevertheless, given the work done in the analytics, I'm supportive of the draft recommendation.

Thank you.

DR. CHERNEW: Sue, thank you. We're going to do Pat and then Paul Ginsburg.

MS. WANG: I just want to --

DR. CHERNEW: So, Pat?

MS. WANG: Yeah. Thank you, Mike.

I just want to reiterate what others have said, the importance of access to dialysis when -- I thought that the chapter did a great job and a sobering job of describing the demographics of Medicare dialysis beneficiaries disproportionately younger African American men. It's just a really, really big crisis, first in line to have COVID complications. It's really critically important that these services exist.

I think that we had a discussion at the last meeting or the one before about Medicare Advantage payment or improving, I guess, the way that Medicare Advantage payments might support the efficient delivery of dialysis services to the population. As Mike points out, it's a completely voluntary program, but for organizations that want to take care of these people, I think it's important to continue that work. And I think that there was some good discussion about that last time in terms of statewide

averages and that sort of thing.

The recommendation makes a lot of sense, and, Nancy, sort of the way that you parsed it between current margins, the margins are expected to go down 8 percent, 4 percent, and so 1 percent update seems completely reasonable. I guess I don't disagree with it.

But I do really -- think back to the conversation about the hospitals, I mean, there's an 8 percent Medicare margin, 25 percent overall margin, and we're recommending 1 percent update factor. It is hard when you think about the chapter or the discussion that we just had about hospitals and the small overall margins and the negative Medicare margins that yielded some healthy debate about whether a 2 percent update was appropriate.

I don't know what the answer is to this dilemma, but others have raised it. It does feel like there's -- we're talking about two different worlds here when we talk about hospitals versus these other sectors, which are largely for profit. This one is unbelievably consolidated. They are making very healthy overall margins and very healthy Medicare margins, very critically important services for beneficiaries, but it really does feel like a

completely different conversation to the one that we just had about hospitals when we were fighting about 2 percent update.

So I support the Chairman's recommendation. I think it's justified within the parameters that MedPAC uses to evaluate this, but I do want to note that.

Thanks.

DR. CHERNEW: Pat, thank you.

Paul Ginsburg, and then we're going to Larry and Brian.

DR. PAUL GINSBURG: Okay. Very, very wise comments from Pat. I wanted to say they make a lot of sense to me.

This presentation, as the two previous ones, really well done, really being very thorough and taking care of a complex topic.

I do support the recommendation.

DR. CHERNEW: Okay. Larry?

DR. CASALINO: I'm okay with the recommendation, although what Pat just said really made me pause.

I think there's a more general principle. It would be -- it's not always clear. The chapters are great

and very precise, but then how we get from what we say in the chapter and that generally beneficiary to access quality, satisfaction, and all that is good. How get from that to zero percent or 1 percent or 2 percent or 3 percent is not exactly clear to me at least. The general principle that we used is -- or how the calculations are made in a specific case.

Pat made me think twice about that. Otherwise, I was just going to say yeah, I support the recommendation.

Thanks to Marge for raising the issue that she raised.

About consolidation, I'd just like to say that I think it would be great if the staff has time to do something about are there -- is there anything in Medicare dialysis policies that encourages the consolidation? I don't see it, but I don't know that much about the area.

Certainly, another area of an unintended consequence of Medicare policies has been to encourage various kinds of consolidation. The dialysis concentration is the most striking of all, and I think it would be worth at least thinking a little bit about is there anything Medicare is doing or not doing that has encouraged that

consolidation or could encourage it to become even more consolidated in the future.

DR. CHERNEW: Thank you, Larry. That's useful.

We're going to go to Brian and then Karen.

So, Brian, you're up.

DR. DeBUSK: Thank you.

I echo Jonathan's earlier point. This kind of payment area is testament to the effect of packaging, and I really, really hope that we acknowledge the benefit of the package brought to dialysis [inaudible].

I do agree with the Chairman's proposal as written. I struggle to pick a number here for two reasons. Number one, the LDOs are highly vertically integrated. They make their own equipment. They provide -- supply some of their own drugs. So my compliments to the staff for trying to get your hands around this area. It seems like it's very complex. It's very vertically integrated, but it's also probably a sign of things to come, because I think a lot of these payment areas are going to be increasingly vertically integrated.

The final thing I want to mention is I hope we keep our eyes on the TDAPA policy. That was the other

wildcard, as I was reading through this payment update, is with the right sequence of drugs coming down the pipeline until the end of this TDAPA policy, I mean, you could see very dramatic increases in dialysis payments over the next few years.

So that was the one other wildcard, but again, the 1 percent seems reasonable to me. So I do support the Chairman's recommendation as written.

Thank you.

DR. CHERNEW: Brian, thank you.

We're going to go to Karen, then David Grabowski, then Betty.

DR. DeSALVO: Great. Thank you.

I'll be brief because I support the Chairman's recommendations. I want to thank the Commissioners for raising some important issues about the dimensions of access.

I wasn't really aware of the workforce challenges in nephrology. So I appreciate that being raised and probably worthy of something for us to make sure we understand.

I also appreciated, Nancy, how much you all are

thinking about some of the dynamic changes in technology and the offerors of those technologies and how that might affect the accessibility of quality services for diverse populations going forward. So thank you for a great chapter. Thank you for really thinking through a very dynamic space and for helping us keep an eye on some of the potential challenges there, especially if consolidation continues.

Thanks.

DR. CHERNEW: Okay. I think we have David and then Betty, and then we'll go to Jon Perlin.

DR. GRABOWSKI: Great. Thanks.

Super discussion and really appreciate, Nancy, your presentation and your chapter.

I'm also supportive of the Chairman's draft recommendations. I just want to underscore three points that really resonated with me during this discussion. The first was Marge's points around cost sharing. The second were Jonathan's around consolidation. That's always concerned me or interested me about this sector, and then finally, Wayne's point about workforce is something we need to keep our eyes on, but overall supportive of the draft

recommendation.

Thanks.

DR. CHERNEW: Thank you, David.

Betty, and then we're going to go to Jon Perlin.

DR. RAMBUR: Thank you. Thank you very much to the staff and the comments from my fellow Commissioners.

I support the recommendation and also will pile on with the support of Marge's opening thoughts and others on the cost-sharing element and also the consolidation.

The other thing, Wayne pointed out or perhaps it was Brian, the lessons about bundling, and I think that there's something -- I think there's something important there for us.

Finally, Pat brought this up, and perhaps others were aware of this, but I was not aware of how differentially this particular service hits younger African American men, and so I think it's really important to pay attention to all the pieces around that, including the workforce development.

Thank you.

DR. CHERNEW: Betty, thank you.

Jon Perlin and then Bruce.

DR. PERLIN: Yeah, thanks.

Let me thank also the staff for a terrific chapter.

I just want to put on a clinician's hat for a moment. End-stage renal disease is just a really crummy disease. A five-year survival is 35 percent once on dialysis. If you have diabetes as well, that five-year survival goes down to 25 percent. So this is a very challenging disease.

I think one of the things we're most sensitive to is the question of access and our payment policy thought. It's really reflected in Slide 11 that we know that there are challenges that disproportionately affect certain categories of beneficiaries based on whether there's access in urban environments or whether there's access in rural environments.

Indeed, with respect to the Chair's recommendation, I support the policy; however, I think there are also ways to address this issue of access. Other concerns have been raised around consolidation, and I think endorsement of the End-Stage Renal Disease Treatment Choices Model, which both promotes home dialysis as well as

destination to transplant is tremendously important. I think it has very positive both fiscal and clinical benefits. The ultimate access for those beneficiaries who are able is home, and it may redress some of the areas where we disproportionately focus on Slide 11 to try to elevate the whole thing but really with the interest of elevating a particular quintile with limited access.

So with that proviso that we might really offer a full-throated support for the Treatment Choices Model, I support.

DR. CHERNEW: Thank you, Jon.

Next up is Bruce, and then we're going to go to Jaewon. And, Amol, you will be bringing us to lunch.

Bruce?

MR. PYENSON: Thank you very much.

I was just really excited to hear the other Commissioners' thoughts, and coming in towards the end of discussion, I benefitted a lot from that in these comments.

On Marge's issue on cost sharing, I'd point out that dialysis, according to the draft, is only about a third of the spending, but I think it's the A and B spending. So there's cost sharing far beyond dialysis for

these patients, and I think a place to look would be accounting for bad debt by the dialysis organizations perhaps in their cost reports because it's not clear if the dialysis organizations sue people who don't pay cost sharing or what happens there to that. But the MA plans do have the ACA's out-of-pocket, member out-of-pocket cap as a benefit.

Wayne's comment about workforce made me wonder if the dialysis organizations are also the dominant employers of nephrologists in the U.S. and what that might mean of the future of both the professional societies as well as the labor force.

Just a thought, although cost reports, that although we do have cost reports and for dialysis organizations and we don't have them for ASCs, I'm not sure that it's being all that much comfort because of the potential for transfer pricing with some of the organizations that also manufacture or have very strong relationships with suppliers.

So I'm not necessarily convinced that we have that bit of information nailed down, especially. The chapter talked about questions about the audits of dialysis

organizations.

Finally, I think Pat raised several great issues, but raised the issue of the comparison to other updates, and that led me to think that in this case, given some of the other findings, I would support a zero percent increase, as we do for ASCs. I'm not sure that dialysis organizations look to me to be that different from ASCs.

But, again, my compliments. This chapter is really terrific. Thank you.

DR. CHERNEW: Jaewon?

MS. MARJORIE GINSBURG: Okay. May I just make one comment with regard to what Bruce's statement --

DR. CHERNEW: Absolutely, Marge, and then we'll do Jaewon, and, Amol, you will be after Jaewon.

Marge?

MS. MARJORIE GINSBURG: Just back to the issue of cost sharing, Bruce, you're right that with MA plans there is an out-of-pocket max. However, they vary dramatically from $1,000 to $8,000. The people who buy the low-cost plans don't always pay attention to what the out-of-pocket max is. So it's a partial way to deal with it but probably not completely satisfactory, but thanks for mentioning it.

MR. PYENSON: Well, thank you.

DR. CHERNEW: Jaewon?

DR. RYU: Thanks.

I'm also supportive of the draft recommendation, and I agree with a lot of the comments that were already made.

The only comment I was going to make is on Slide 10. I was struck and didn't realize how much and to what extent the TDAPA really drives profitability in this space. I think it may have been Brian that said earlier -- and I would agree -- that keeping our eyes on the TDAPA policy and its impact, I think, would be the right move going forward.

DR. CHERNEW: Jaewon, thank you.

Amol?

DR. NAVATHE: Great. I have the unenviable spot of keeping everybody from their lunch, so I will be quick.

Thank you, Nancy, for the great work. I think a nice distillation of a lot of complexities.

I support and echo a lot of the comments of the Commissioners who made comments before. I thought Pat's comments, in particular, were fantastic and captured a lot

of my own thinking.

I think, as Karen pointed out, there's a lot of dynamic elements here. So it's not a, necessarily, simple decision on how to synthesize all this MA and ESRD stuff that Marge brought up. We talked about success of bundles and TDAPA's impact, workforce and equities. Those are sort of my recaps of echoing what people have said.

But I support the Chairman's draft recommendation, and let's go eat.

DR. CHERNEW: Well, actually, I'm going to be the one to keep you all from lunch. I will say something for just a minute to answer a few questions.

First, I'm glad the issue about transplants was raised. That matters. I think there's some efficiency in some other policies unrelated to payments that might do that.

No one mentioned the issue of the prices that are being charged to MA plans, which is an issue -- or at least I didn't catch that, which is an issue that we have talked about in the past and one that is actually quite concerning.

Again, the challenge in so many of these things

is to try not to conflate a whole bunch of different issues and to address the issues that we need to face appropriately. In other words, if we're worried about prices charged to MA plans, that's an issue for how we deal with that pricing and not necessarily an issue for what we do with just particular updates.

All of that being said, several of you have mentioned issues about connecting the dots. So I will say something simply about connecting the dots, and then I'll let Jim comment as well, if he wants, on this.

There is no magical formulaic way that any of these recommendations come up. All of the sectors are different, and they all have the unique situations. We are trying to be appropriate within a sector. We obviously want to apply similar frameworks in thinking across the sectors, and in that case, I think we do. But there are unique situations in all of the sectors.

So with the question of balancing where we see the margins and the cases where we don't have margins, where we see entry, there's sometimes issues. The ASC is an example where they're providing a select set of services to a select set of patients in ways that are perhaps unique

than what you would see in other sectors. But, again, we could discuss each particular sector.

The framework -- and this is sort of where I'll leave it for now -- that I have is, is there an update that would cause me serious concern about future access and quality, and if we were to change the update, make it more generous, for example, would I resolve that concern? And if we went lower in the update recommendation, would I worry a lot about access and quality?

Some of the sectors that you see that are quite profitable -- and just to be super clear, there will be some Chairman recommendations that are on the south side of zero going forward. We are concerned, I am concerned about the heterogeneity of providers within those sectors. We have the unenviable task of one update recommendation and very heterogeneous sector. So we worry about what happens in some places, and in some ways, for lack of a better word, nibble down as opposed to slash. So that some of these may feel like slashes to in some of the sectors.

Nevertheless, the point of this whole ineloquent speech is there is not a magic number that we are shooting for. We are trying to provide an update factor that will

allow efficient providers to provide high-quality care and good access to our beneficiaries, and that is typically a sector-by-sector assessment. And the reason why this meeting is so important and why it's so important to have this meeting in public is, of course, what we are asking you is for your opinions about where to shape the recommendations, and I think we will see, in some cases, there's a lot of consensus. In other cases, the hospital discussion is one. There are several of you that made relatively strong statements in different directions, and so, as I said, we will work on trying to strive for that balance, but I really -- as my first December meeting and having to do with virtual, which is a challenge, I really appreciate the time and thoughtfulness and, frankly, the conciseness of your comments, and as a reward, you get 20 more minutes for lunch.

So we will come back at 2:00. I think we're going to start off when we get back with the physician chapter, and again, to the staff, outstanding presentations, and as always, I still thought outstanding chapters. And so, again, I'll see you all in a little more than an hour.

Jim, do you want to add anything?

DR. MATHEWS: Nope. All good.

DR. CHERNEW: That's good. All right. See you soon. Thanks so much.

[Whereupon, at 12:56 p.m., the meeting was recessed, to reconvene at 2:00 p.m. this same day.]

AFTERNOON SESSION

[2:01 p.m.]

DR. CHERNEW: Hello, everybody, and welcome back to the Thursday, December 3rd, MedPAC meeting. This afternoon we're going to continue our discussion of payment updates, and we will conclude with a discussion of Medicare Advantage. In any case, we are going to start with the physician payment system, so I'm going to turn it over to you, Ariel. The floor is yours.

MR. WINTER: Good afternoon. In this session, Rachel, Jeff, and I will go over our assessment of the adequacy of Medicare's payment rates for physician and other health professional services. We will also present the Chair's draft recommendation for updating payment rates for 2022. The audience can download a PDF version of these slides in the handout section of the control panel on the right-hand of the screen.

A key difference from prior years, both for clinicians and all other sectors, is the coronavirus pandemic, which has had tragic effects on beneficiaries and the health care workforce, and material effects on providers. As in past years, to recommend payment updates

for the upcoming year, we start with indicators of payment adequacy based on the most recent available and complete data, which is generally 2019 for this year. We then consider preliminary data from 2020 and evaluate current law and expected environmental changes to develop the Chair's draft update recommendation for 2022.

Given the broader environmental and policy changes this year, we will continue to closely monitor these changes and whether their effects are likely to be temporary or permanent. To the extent the coronavirus effects are temporary, or vary significantly across providers, they are best addressed through targeted, temporary funding policies rather than a permanent change to all providers' payment rates in 2022 and future years.

With that introduction, I will now provide some background information on the clinician sector.

The fee schedule for physicians and other health professionals includes about 8,000 billing codes, for services delivered in a wide variety of settings, including doctors' offices, hospitals, and nursing facilities. In 2019, Medicare paid $73.5 billion to 1.3 million clinicians for these services.

Under current law, there is no update to base payment rates for 2022, but clinicians can potentially receive a positive or negative performance-based adjustment to their payment rates if they are in the merit-based incentive payment system, also known as MIPS, or they can receive a 5 percent bonus on payments for their professional services if they are in an advanced alternative payment model, or A-APM.

We don't know how many clinicians will get MIPS adjustments or A-APM bonuses in 2022, but this slide should give you a sense of what past trends have looked like. In 2021, almost 800,000 clinicians will receive a positive MIPS adjustment of up to 1.79 percent, based on their performance on measures in 2019. Almost 200,000 clinicians will receive 5 percent bonuses for being in an A-APM.

The rest of this presentation will focus on our assessment of the adequacy of current Medicare payment rates, based on these three topics. First we will present what we know about beneficiaries' access to care. Next, we'll talk about the quality of care clinicians provide to beneficiaries. And then we'll review data on payments received by clinicians and their costs.

And now I will turn things over to Rachel.

MS. BURTON: To determine whether beneficiaries have good access to care, the Commission looks at three main measures. First, we look at beneficiary feedback, collected through our annual focus groups conducted in several cities across the country, our annual telephone survey of 4,000 elderly Medicare beneficiaries and 4,000 individuals age 50 to 64 with private insurance, and CMS's Medicare Current Beneficiary Survey, which is a larger in-person survey.

Our second measure of access-to-care is the number of clinicians participating in Medicare. Our third measure is the volume of services provided by those clinicians.

Overall, Medicare beneficiaries' access to care is comparable to that of privately insured individuals. The vast majority of beneficiaries have a usual source of care, say their usual care provider spends enough time with them, and do not forego care. Despite the pandemic, there was no statistically significant increase in 2020 in the share of beneficiaries waiting longer than they wanted for appointments, or foregoing care. This may, in part, be due

to the availability of telehealth, which many beneficiaries used during the pandemic.

Compared to privately insured individuals, higher shares of Medicare beneficiaries report being satisfied with their overall care. It is worth noting that our telephone survey was conducted from April to October of 2020, and our virtual focus groups occurred in June and July, so most of the results on this slide are from the midst of the pandemic. Although access to care was relatively good according to these data sources, we will continue to monitor access during the pandemic.

As in past years, our phone survey found that among those looking for a new doctor, more reported problems finding a new primary care provider than finding a new specialist. We find that a small share of beneficiaries looked for a new doctor in the past year, shown in white in the middle two bars. Among these subsets, only 60 percent reported no problem finding a new primary care provider, shown on the left. In contrast, 79 percent reported no problem finding a new specialist, shown on the right.

In addition, Commissioners' mailing materials

describe a few small differences for urban and rural beneficiaries, and for beneficiaries of different races and ethnicities. Larger differences existed for non-elderly beneficiaries, who reported more difficulty accessing care than elderly beneficiaries. Non-elderly beneficiaries tend to be disabled and have lower incomes than elderly beneficiaries.

We next looked at the supply of clinicians billing Medicare's fee schedule. We found that from 2018 to 2019, growth in the number of clinicians billing the fee schedule outpaced growth in the number of beneficiaries enrolled in Medicare. However, over the same period, growth rates varied by the type and specialty of clinician. In particular, we saw rapid growth in the number of APRNs and PAs; we saw steady growth in the number of specialists, who now make up over three-quarters of the supply of physicians in the U.S.; and there was a small decline in the number of primary care physicians.

And 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.

Our next measure of beneficiary access to care is the number of encounters per beneficiary with clinicians, which we found grew by an average of 1.3 percent per year from 2014 to 2019. Beneficiary encounters with specialist physicians accounted for nearly 60 percent of all encounters.

Similar to our analysis of the number of clinicians billing the fee schedule, we found that the growth in the number of encounters per beneficiary varied by the type and specialty of clinician. For example, from 2014 to 2019, encounters per beneficiary with primary care physicians decreased by an average of 2.4 percent per year, while encounters with APRNs and PAs increased by an average of 11.5 percent per year. We are concerned about the decline in encounters with primary care physicians and will be monitoring this closely in the future.

I will now turn things over to Geoff.

MR. GERHARDT: Next we'll talk about the quality of clinician care in fee-for-service Medicare. First I'll touch on rates of ambulatory care-sensitive hospital use. Then I will discuss the prevalence of low-value care, which

are services that have little or no clinical benefit or care in which the risk of harm from the service outweighs its potential benefit.

We are reporting these population-based measures using fee-for-service claims and not MIPS results, because of the numerous flaws in the MIPS program. In March 2018, the Commission recommended the elimination of MIPS.

We measured risk-standardized rates of ambulatory care-sensitive hospitalizations and ED visits for certain conditions that may have been avoided with access to high-quality ambulatory care. Using these measures, we see substantial variation across different geographic markets, with rates in some areas twice as high as rates in other areas, which signals opportunities to improve ambulatory care in those areas.

We also found substantial use of low-value care, as indicated by 31 measures developed by researchers. Using both broad and narrow versions of the measures, we found that between 22 percent and 36 percent of beneficiaries received at least one low-value service, and Medicare spending for these services ranged from $2.4 billion to $6.9 billion.

We assess payments and costs for clinicians using the following indicators: (1) Medicare payments per beneficiary; (2) the change in clinicians' input costs; (3) the ratio of commercial payment rates to Medicare's payment rates; and (4) physician compensation from all payers.

Medicare payments and clinician input costs have been growing. Based on analysis of Medicare fee-for-service claims, we found that allowed charges for clinician services grew by 3.7 percent per beneficiary between 2018 and 2019, which was faster than the average annual growth rate between 2014 and 2018, of 1.3 percent.

Growth in allowed charges per beneficiary between 2018 and 2019 varied by type of service. It ranged from 2.6 percent for anesthesia services to 5.6 percent for other procedures. Allowed charges for evaluation and management services grew by 2.9 percent.

There continues to be an increase in the Medicare Economic Index, or MEI, which measures clinicians' input costs. The MEI increased by 1.5 percent in 2019, and CMS projects it will increase by 1.8 percent in 2022.

Next, we found that in 2019, commercial payment rates for preferred provider organizations were 136 percent

of Medicare fee-for-service rates for clinician services, up slightly from 135 percent in 2018. The ratio varied by type of service. The growth in commercial prices could be a result of greater consolidation of physician practices and hospital acquisition of practices, which gives physicians more leverage to negotiate higher prices with commercial plans.

Finally, we look at physician compensation from all payers. From 2015 to 2019, median total physician compensation across all specialties grew by 3.3 percent per year and reached $315,000 in 2019. Median compensation was much lower for primary care physicians than physicians in surgical specialties and radiology. Physician compensation from all payers reflects the structure of Medicare's fee schedule because many private insurers use relative value units similar to Medicare's RVUs.

Therefore, the difference in compensation between specialties partly reflects Medicare's underpricing of ambulatory E&M visits relative to other services.

CMS will increase E&M RVUs and create a new add-on code for certain E&M visits starting in 2021. These changes will increase Medicare payments for primary care

physicians and other physicians that furnish a high number of E&M visits. But since these changes must be made in a budget-neutral manner, specialists with few E&M visits will experience payment reductions.

I'll now turn things over to Ariel to wrap up.

MR. WINTER: To summarize our analysis, payments appear to be adequate. Most beneficiaries report good access to care, even during the pandemic. The number of clinicians billing Medicare is increasing, and the number of clinician encounters per beneficiary is also growing.

Our findings on quality of care show opportunities for improvement. There is wide geographic variation in the rates of ambulatory-care-sensitive hospitalizations and ED visits, and there is substantial use of low-value care.

In terms of payments and costs for clinicians, Medicare payments per beneficiary are growing, the MEI continues to increase, the ratio of commercial payment rates to Medicare rates for clinician services grew slightly, and physician compensation from all payers has been rising, although there are still substantial disparities between primary care physicians and certain

specialties.

In terms of the impact of the pandemic on clinicians thus far we see little to no impact on access to care, according to our summer phone survey of beneficiaries. It will likely be difficult to assess the quality of care during the pandemic because 2020 will be an outlier year. We saw large drops in the use of services and payments to clinicians in the early months of the pandemic. But Medicare increased its coverage of telehealth services and began paying for them at higher rates, and Congress has appropriated hundreds of billions of dollars to providers.

In recent months, spending for clinician services has strongly rebounded, and our most recent data suggest that utilization is close to baseline levels. However, we are entering a new phase of the pandemic, and circumstances may change by January. Also, the pandemic may be having different effects in different parts of the country. We will continue to monitor the impact of the pandemic, and we will come back to you in January with the most up-to-date data.

To sum up, our standard indicators of payment

adequacy are positive, and we don't see anything in the landscape that would change our assessment.

This leads us to the Chair's draft recommendation, which reads: For calendar year 2022, the Congress should update the 2021 Medicare payment rates for physician and other health professional services by the amount determined under current law.

As I said earlier, current law calls for no update in 2022, but currently about a million clinicians receive positive adjustments of up to almost 2 percent under MIPS, or get 5 percent bonuses for being in an A-APM.

In terms of implications, there would be no change in spending compared with current law, and this should not affect beneficiaries' access to care or providers' willingness and ability to furnish care.

This concludes our presentation, and I'll turn things back over to Michael.

DR. CHERNEW: Ariel, thank you. That was terrific. I'm going to make a comment first. Then we're going to start with Amol and then Marge.

So first let me say this is a remarkably complex area, because there's so many different things going on,

and it's particularly challenging because it's an area in which current law has very low, basically no fee increases, and that's in nominal terms, and that's scheduled in current law for quite some time.

So we're about to jump into discussion and I just want to say, for the record, that this is an area that I am worried about going forward, and we are going to, as was said, continue to have to monitor this. The strongest motivation for the recommendation, in terms of this sticking with current law, is where we seem to be right now, in terms of where we expect access will be and what we're getting from the survey, which was particularly challenging this year.

But we are very, very much paying attention to where this is, and it will stay on our radar, because I'm not sure what this is going to look like as time evolves.

So with that I'm going to turn it over to Amol, and then to Marge.

DR. NAVATHE: Great. Thanks, Mike. So great work. Obviously a challenging sector here and a lot of data to pull together to get to this.

So I have a few sort of comment-like questions,

or question-like comments, depending on how you want to view them, and then just some general comments as well.

First, let me formally say I support the approach of the draft recommendation. I'm certainly keenly interested in seeing how you guys update between now and January, as more data becomes available, so, of course, that will be an important input. But I'm generally supportive of the direction that we are headed here.

I think a couple of the comment-like questions, or vice versa, you know, one thing that strikes me is in the surveys we do have a reference point of private insurance, in terms of things like access. We are looking for changes, which is great. At the same time, I feel like sometimes the way that we've framed this is there is no change and we are doing okay relative private insurance for our beneficiaries, so, you know, we're good on the access piece.

And I wonder if we really want to think about it that way, particularly, you know, you guys showed some data around the primary care access piece relative to acquiring a specialist physician or getting access to specialist physicians. And we also know that there has been, and you

guys have presented data very nicely today, that shows that there is generally a shift in the primary care sector, where we are seeing some decrease in primary care physician visits and more in the NP PA world. And I think that's great, in general, for the efficiency of the system, but, you know, beneficiaries may also have preferences, and we don't know to what extent some of those trends are in concordance with beneficiary preferences versus perhaps not.

And I wonder if we can understand a little bit more about access also specifically, for example, in the context of COVID, this coronavirus public health emergency, access to COVID care itself, for beneficiaries versus private insurance, privately insured folks, and then getting a little bit more texture in terms of access to the type of primary care practitioners, if that's truly where we want to be.

So I just want to put that out there. I don't -- you guys are welcome to comment back, but I don't necessarily expect you to comment back. We can keep that as more of a rhetorical question point.

My other thoughts. So this is a challenge. As

Mike said, this one is challenge -- right? -- because there's a lot of moving parts here, and I think there's also some guardrails that we want to stay within given some of the historical congressional work here and legislation.

It strikes me immediately that even relative -- you know, every vertical that we're looking at here has a lot of variability, and we see that. And if you look at physicians and other health professionals, I feel like the variability here blows everything else out of the water, which makes it really hard to understand what is a perfect payment update to offer here.

There's also, you know, relatively less data, for example, on the cost side of things. I don't think we necessarily know the financial health and how that variation exists, for example, for efficient versus non-efficient. So I think that makes this a little bit harder.

The other thing I would say is, you know, we are seeing big changes in care models in part because of the public health emergency in terms of telehealth and seeing how that's affecting things.

We also want to see some of these shifts, as I mentioned, towards NP and PAs. The care model, we probably

want to see a shift in the context of value-based payments, alternative payment models, and so that's probably a good thing in general. But then we have these other countervailing effects which is we probably also want to maintain or support independent practices as much as we can. We want to try to hopefully, you know, reward primary care in terms of the value that it provides relative to specialists, and we know that there's a big gap that you guys have highlighted. And I feel like to some extent here we're stuck between a rock and a hard place because the Commission has said -- and I fully support -- we want to move towards value, value, value. And then in this space, what we have largely as value, as kind of default value is MIPS, and the Commission has already said that, you know, we would rather have an alternative to MIPS. And so that feels very frustrating, I think, knowing that we're kind of pegged to a particular statutory update here of zero, I think that can also feel frustrating relative to the other sectors.

So I just wanted to acknowledge that. As a physician myself, I feel like -- I feel that for my colleagues very personally. At the same time, I think it's

a tough position, and I do support the broad directions. I just wanted to highlight a number of the dimensions that make it complex, but then say that I look forward to the additional data that you guys bring out in January and support the general direction.

Thank you.

DR. CHERNEW: Okay. We're about to go to Marge, but let me say sometimes these discussions are analytical. This one may seem a little bit more like therapy, but, nevertheless, we're moving ahead. Marge, you're up.

MS. MARJORIE GINSBURG: Yes, thank you. Great report, comprehensive, easy to follow. You know, what's not to love?

My question or comment has to do with the part about low-value care, and I found it interesting that this was actually costed out. We have a number applied to it. So my specific question is: Does Medicare ever, in fact, deny payment for an intervention that has been clearly defined as low value? Do they reject them? And if so, is that figure capturable? If they don't reject them, is there really nothing we can do about this except continue to identify those interventions that have been shown to be

low value and try to reward physicians who avoid that?

So that's sort of the broad question, but I wonder if staff can talk a little bit more specifically about what, if anything, is ever done about claims that clearly were low-value interventions? Thank you.

MR. WINTER: I'll try to speak to that. So the measurements we use were developed by a team of researchers -- Michael was among them -- first published in 2014, and they shared their measures and their algorithms with us, and we've been using them for several years, going back to 2012, I think, to estimate the number of low-value services per 100 beneficiaries, Medicare spending for those services, and the share of beneficiaries who get at least one low-value service. And these 31 measures are on services that are commonly provided and paid for by insurers, Medicare as well as commercial plans, but have been flagged either by groups like Choosing Wisely or the medical literature or by the U.S. Preventive Services Task Force as potentially low value. And because it's difficult to define and identify low-value services using claims data, which lack a lot of clinical context, they've created two different versions of the measure -- a broad measure

that's more sensitive and a narrower measure, a narrower set of measures that are more specific. And that accounts for why we kind of bracket the spending estimate by a high -- with an upper and a lower bound.

In terms of how this intersects with Medicare coverage policy, so Medicare covers services that are deemed reasonable and necessary, and they tend to give a lot of discretion to providers. And so I think that's why you see Medicare paying for a lot of services that many experts and outside groups would deem low value. This is a problem that the program has been dealing with for a long time, and it's something we discuss in a lot more detail in our June 2018 report to Congress.

In terms of quantifying how much Medicare -- in terms of quantifying claims that are denied by Medicare because the service is low value, that would be difficult. We can look into that. It's probably very difficult to ascertain because there are lots of reasons why a MAP would deny a claim. They don't specifically -- I'm not sure the claim indicates great detail why it was denied. So it might be difficult for us to get an estimate of that. And I believe you also asked what tools Medicare might have

available to it to control, reduce the use of low-value care, and in that June 2018 chapter, we did discuss several potential policies Medicare could use, whether it's through coverage policy that is denying coverage, no longer paying for low-value services, whether it's on revisiting coverage decisions periodically to make sure that they're still appropriate decisions. It could be tools like increasing or adjusting beneficiary cost sharing, so cost sharing is higher for low-value services but lower for high-value services, and Michael has done a lot of work in this area. It could also be encouraging advanced APMs like ACO-type models where providers have accountability for both cost and quality. And there's some evidence in the literature that two-sided risk ACOs have been able to have lower spending on low-value care, low-value services, than fee-for-service Medicare.

So let me pause there and see if that -- does that help with your questions?

DR. MATHEWS: Actually, Ariel, let me see if I can take a stab at this. Marge, to answer your question a little more succinctly, there is no limitation of Medicare coverage or payment for the services that we have defined

as low value for this analysis.

MS. MARJORIE GINSBURG: Thank you. I mean, yes, that answers the question, and thank you for reminding me about the June 2018 report on this, which it has been awhile since I've looked at it. This may or may not be something we want to pursue with more vigilance in the future. But, anyway, thank you.

DR. CHERNEW: All right. So as you know, low-value care is something I've been interested in a while, and the administrative and operational reasons to do this when there's nuance in value is hard. But we're going to put that aside because right now it's really all about the update recommendation, so we're going to go to Paul and then I have Wayne on my list. So, Paul.

DR. PAUL GINSBURG: Basically, Amol stated a lot of my thinking very well, so I'm not going to repeat what he said. What I want to do is I've been thinking ever since our hospital discussion this morning about this issue of site differentials in payment. I realize that, you know, we have a current law, you know, baseline, which updates hospital outpatient rates, you know, roughly according to an input price index, but for the past 15

years, and a projection of, you know, a lot longer, we've had almost zero physician updates.

So in a sense, you know, the magnitude of the site differentials keeps increasing year by year. And, of course, you can either pay physicians more in their practices, or you can pay hospital outpatient departments less. It's just something we need to be thinking about in the future, and it's really a concern when in a sense the policy parameters are, you know, driving to exacerbate a problem that we've thought a lot about and are very concerned about its effect on consolidation, efficiency, patient choice, et cetera. So I just wanted to raise that concern again.

DR. CHERNEW: Thank you, Paul. I agree with that, and certainly we will think through, and what's clear is site-neutral -- there's so many different sites. There's a lot of neutrality and there's a lot of economies of scope that the different services and the different groups provide, and sometimes there's payment differentials. So this is a much bigger topic for us to think about and one that we, of course, have thought a lot about already. There's certainly more to do. But for now

I think I'm going to go to Wayne and then Pat. So, Wayne.

DR. RILEY: Well, thank you. Again, you know, great comments by Amol and others around this issue. You know, as an internist -- and many of us are internists on the Commission who are physicians -- you know, I worry about the disincentive for primary care, the attractiveness among medical students because in part the Medicare fee schedule and how it then is sort of all-encompassing in terms of even third-party payers, et cetera. So I hope that, you know, this continues to be a focus area for the Commission, and Paul's points are again relevant here, not much update in many years.

You know, the other thing I worry about is that this is based on sort of a phone survey and if that phone survey, you know, is really the most rigorous way to get to the data around this issue. So a very important issue. I'm glad MedPAC looks at it, and, again, as worried about the primary care physician workforce and attractiveness of primary care to future physicians, this is important for us to continue to keep focus on.

DR. CHERNEW: Wayne, thank you. We're going to go to Pat, then Dana, then Jaewon. So, Pat.

MS. WANG: Thanks. You know, I think that the Chairman's recommendation is where we have to land, and I agree with the observations that others have made about the importance of figuring out a better way going forward.

A couple of things I just wanted to note in the paper, which was, as usual, just phenomenal. I think it's good that more doctors are in advanced APMs. It looks like there was a significant increase, like doubling of the number over the course of two years, so I think that we take that as a positive sign, I think.

On Slides 7 and 8 -- and this goes to the information about access, satisfaction, things of that nature -- I wonder whether we've ever considered going a little finer than over the age of 65 and looking at age cohorts, because I suspect that, you know, folks who have just turned 65 are going to have a different expectation and a different experience with the health care system than folks who are 85. And I just throw it out there as a possible additional source of information to maybe detect problems with -- you know, I mean the population is getting older, obviously, and we worry about the old old having access to care perhaps a little bit more than folks who are

65 who run around, you know, on the subway and bus and find doctors as they need to. So that would be a suggestion.

The other suggestion -- and this goes to Wayne's comment about the focus groups. Again, I don't know if it's feasible, whether we've ever considered basically mimicking the CAHPS survey that Medicare Advantage plans use uniformly in the Stars program to see whether -- I mean, you know, there are very specific questions around access. It's all subjective. You know, did you have to wait too long in your opinion for an appointment? Did you have to wait too long in the waiting room? Did your doctor explain your care? Did you feel like your doctor's office was coordinated in their care? It's pretty detailed, and it might give a better feel around the access issue since that instrument is being used, you know, very widely now for a very large portion of the Medicare population, those enrolled in MA.

Like some of the others, I am concerned about the decline in the number of PCPs that corresponds to the beneficiary responses around more difficulty finding a PCP. I think that that's really a warning bell, and it's probably just the tip of the iceberg, again, something that

we should think about for payment policy.

And the last just question I had -- and perhaps I missed this. On Slide 17, in the description of the quality assessment of the sector, I don't remember seeing ambulatory care sensitive conditions and sort of ED use. And I was a little bit confused by seeing it here for fee-for-service physician payment as an assessment of quality. They're more population health measures, I think. I mean, high ACS, ambulatory care -- avoidable admission phenomenon might be as much due to a lack of access as it is to an individual clinician's performance, and the same thing with ED visits. I may be misunderstanding how those things were assessed, but I was a little confused to see that in the context of fee-for-service practice.

DR. MATHEWS: So, Geoff or Ledia, do you want to take a stab at answering that question? And I can loop back and talk a little bit about, you know, finer gradations of our survey.

MS. TABOR: Yeah, and I would also like to add, thinking about the gradations of the survey, we did this year with our focus groups try to get older beneficiaries, and it is just really challenging to recruit them. That's

something that we can keep trying to do, but I think in particular, this year, since we had to do virtual focus groups, it was even harder to get kind of older beneficiaries.

And then regarding the CAHPS survey, CMS actually does collect a fee-for-service CAHPS survey on the fee-for-service population. That's the same as the MA CAHPS survey, and this year we were not able to report out those results because CMS wasn't able to finish collecting the surveys because survey collection was happening right at the start of the pandemic. So we do hope next year to be able to report out those fee-for-service CAHPS results again.

And then thinking about the ambulatory care measures, you know, we struggle with being able to kind of report out the quality of individual clinicians. So for the past couple years, we have been using this measure just to have a general sense of the quality of ambulatory care in different market areas. And we're happy to kind of explore other measures, ideas of things that we can kind of look at to try to capture clinician quality without looking at individual clinician results.

DR. CHERNEW: So --

DR. MATHEWS: On the question --

DR. CHERNEW: I'm sorry. Go on, Jim. I was going to make a comment, and Paul also has a comment on this point. But go ahead, Jim.

DR. MATHEWS: Yeah, so just one finer stratifications of our survey, I would just point out that the survey that we currently conduct is one of MedPAC's biggest ticket research items in our line items in our budget. And this is for a survey of 4,000 beneficiaries, 4,000 private insured, and we are about pushing the limits of our ability to make finer gradations within the two groups that we sample.

It's also getting harder and harder with each passing year, as is the case for all surveys, to get the requisite number of respondents that we are looking for. So if you wanted to do finer gradations, you're talking about a lot more money and a lot more people and a lot more effort.

So it's something we can consider if there is an appetite for this, but as it is, this consumes a big chunk of our research budget already.

MS. WANG: Okay. Thank you.

DR. CHERNEW: So, Paul, I'm going to go to you in a second. I just wanted to add one point, which is I very much share the concerns about primary care, and there are certain things like the E&M rule and other changes about relative fees that may impact that. But simply paying more money may actually exacerbate the primary care shortage because the update gets applied to all services, specialists and otherwise. So it's not clear to me that increasing an update or doing something else solves the primary care problem at all. It strikes me as something that is probably best dealt with other recommendations, many of which I think have been longstanding interests of MedPAC and having related recommendations about that. But it's much more of a relative fee schedule change than a change to the overall level.

That being said, Paul, you had a response you wanted to give before we go on.

DR. PAUL GINSBURG: Yes, this was stimulated by Pat's comments. I've always had an informal model of what is happening as far as physician access in Medicare, particularly for primary care, just based on discussions

with physicians, is that there are some physicians that, you know, do not accept new Medicare patients to their practice. They do accept their existing patients as they transition to Medicare, and the implication is that whatever access problems there are probably are concentrated on beneficiaries whose physicians retire or beneficiaries who move to a different area.

The problem is that, you know, some of the comments Jim made about sample size, that would take an enormous sample size to really dig into, and I'm not really sure how we can deal with it. But I think it's very important that we keep looking, you know, be sensitive to this issue, because I've heard about that pattern for a long time.

[Pause.]

MS. KELLEY: Mike, are you still with us?

[No response.]

Mike, can you hear us?

[No response.]

MS. WANG: I don't think he can hear you, Dana.

DR. DeBUSK: I don't think he can hear us, but I hear all of you well.

DR. CASALINO: Yes, I do too, Dana.

MS. KELLEY: I'm sorry. I have a message from Mike. I think he's telling me that Dana Safran is going next.

DR. SAFRAN: Well, okay. I'll dive in, then. Thanks, Dana.

So I too have been supportive of the Chairman's draft recommendation. I do have a few comments and questions.

One is that, like others, the decline in primary care is of concern, and there was a bit of a -- I don't know -- implication in the evidence about PAs an APRNs, that that could be the reason, but I think we know that a big share of the PA and NP work force are in specialty care. So I just want to call that out and ask if there's a way to differentiate those clinicians who are working in primary care versus specialty care settings. That would be a valuable way to really tease out our patients losing access to primary care clinicians or, in fact, our PAs and NPs being sort of substituted for primary care physicians but now for primary care clinical care.

A second point that I wanted to make kind of

flows through many of the statistics about utilization. This was the first year that I noticed, anyway, that when we talk about utilization rates per beneficiary, we're doing it across all beneficiaries, regardless of whether they are receiving any care, and maybe that is a useful metric. But I also think that we should be understanding whether care is getting more concentrated in a subset of beneficiaries. So I would like to see us looking at the metrics that look at number of encounters per beneficiary and growth rates of allowed charges per beneficiary on the subset who are using care and then to really have some information about who are those who are not using care. What are their characteristics? How is that changing over time? Because I think as we try to assess access, that's really important to our having a good handle on that question.

Then just last two things, on quality, I had a very similar reaction to Pat's. I feel that the measures that we're looking at are good measures for physicians who are in accountable care contracts, where they really are trying to do population health management and avoiding the use of hospital for unnecessary ED or ambulatory care

sensitive, but I'm not so sure that those measures are a good measure for quality of physician care to tell us whether payment rates are adequate. So I would just ask that we really give some thought there. I'm happy to work with you offline, Ledia and others, on that question.

I was happy to hear that CAHPS has fielded to Medicare fee-for-service population. I don't think I was aware of that and just wanted to add in that if Health of Seniors Survey could also be done there. That starts to get us some interesting data that we've been wanting a long time to compare fee-for-service and Medicare Advantage.

Then my final question or comment was realizing that so much of physician practice is still in smaller solo settings, the lack of any discussion about access to capital and sort of issues around consolidation just seems like an important difference to the other chapters and maybe something that could find a place here.

So thanks. Those are my comments.

DR. CHERNEW: Thanks, Dana.

I'm sorry. I lost cell phone service. Now I'm back on the computer audio. I hope you can hear me. In any case, I think we'll go to Jaewon, and then I have Larry

next on my list.

DR. RYU: Thanks, Mike.

I too am comfortable with the draft recommendations. I echo many of the comments already made. I think one thing that did strike me as being a little bit of a surprise at least to me was Slide 8, the beneficiaries who tried to find a new doctor. I would have expected that more of them were in the market, so to speak, for a new physician, and I would have also guessed that those that were in that new market for a new physician, that more of them would have reported a problem or a challenge getting a new physician to take them. But I just thought that number was lower than what I would have guessed, but I suppose it's reassuring.

Then the other is several have commented on the disparate impact, potentially, between the independent practices and the employed physicians. I do think it's worth either a mention or some glimpse into how that would potentially cut. I don't know.

I think it was Slide 4 where we had the A-APM and the MIPS. I don't know how many physicians out there don't actually tap into either and are on the sort of the penalty

side of things, but that would be good to know as well. And I suspect that group, there are probably disproportionately more on the independent group side or the smaller group side. I don't know that, but that was another question.

Thanks.

MS. BURTON: It's usually a very small number that get negative adjustments. I actually don't know the number off the top of my head, but it's very small. And this year, we actually believe that no clinicians got negative updates due to a special pandemic-era policy that was put in place.

DR. CHERNEW: Rachel, I believe -- and, again, I could be wrong -- it's supposed to be budget-neutral in MIPS. So numbers of physicians aside, if there's half of many people getting negatives and positives, they have to pay twice as much in, because I think the money is supposed to balance, ignoring the pandemic adjustment.

Is that right, Rachel?

MS. BURTON: This year, the updates are entirely funded by the $500 million available for exceptional performance.

DR. CHERNEW: Okay. And that extends for how many years, the exceptional performance part?

MR. WINTER: It ends in 2024, and that's on top of any budget-neutral adjustment. So that's additional money that goes into the MIPS pool.

DR. CHERNEW: Right. I understand.

Okay. So I forget who I said. I think it was going to be Larry and then Jonathan is the list that I have.

DR. CASALINO: Yes. Thanks, Michael.

Two points. First, I think in terms of -- it's hard not to support the recommendation in the current context because we have MIPS, we have MACRA, and it's kind of heavily set in current law for years to come.

That said, it's pretty uncomfortable, I think, for the Commission to be in the place of saying, not so long ago, we strongly opposed MIPS and then basically making a recommendation that is, okay, yeah, let's go with MIPS, and for the non-A-APM physicians, we'll rely on their MIPS bonus, to give them a bit of an update.

I don't know what to do about that, but it is kind of a weird position to be in, I think, for the

Commission, and it might be worthwhile to call out again the opposition to MIPS, which not everybody knows, actually.

And I just think just a side point on this, I think the optics of the lack of any update for years, for quite a few years, for most physicians, whatever logical arguments may be made or databased, the optics of that to the physicians are very, very bad. They think we're working harder every year and we get no update. We actually get kind of negative with inflation. So it just doesn't look good.

In any case, under the circumstances, I suppose the recommendation, but I just think we should call out our previous opposition to MIPS.

The second thing that I have to say and last is I want to bring up site-specific. Again, Paul and I seem to do that a lot. I think our site-specific policies are actually a great example of what I referred to this morning, which is unintended consequences of CMS policies that lead to potentially very high levels and I think probably harmful consolidation.

So in the chapter, we see that for hospital-

employed physicians, we see a $52 professional fee and $116 facility fee for -- I think that's for 99213 in the visit, $52 versus $116.

Hospitals have higher costs than independent physician practices. There's no question about that, but no one is putting a gun to a hospital's head and saying you have to employ physicians. And the fact that some hospitals choose to do so, even though their costs for physician practices are much higher than independent practices, why that should be subsidized, I'm not sure. We don't do that in other industries or even in other sectors of health care.

But I just want to draw a conflict with ASCs. I think Bruce was very eloquent on pointing out the advantages of ASCs for certain categories of patients, but I think we do need to have hospital outpatient surgery departments because there are patients -- there's plenty of them -- who might not be that safe to do in an ASC or safer to do in a hospital outpatient surgery department.

So hospitals need to have those. It's a social good, and paying the higher cost to hospitals as opposed to higher amounts to hospitals around the ASCs, because of

hospitals' costs, makes sense to me because we need hospitals to have outpatient surgery.

We don't need hospitals to have physician practices, and that's why it doesn't really make sense to me to pay these very large facility fees, which drive consolidation enormously, which so far every study that's come out has shown higher cost, higher prices, and quality that's as best equal.

So I'll stop with that.

DR. CHERNEW: So, Larry, thank you.

Jon Perlin wanted to jump in. So I'm going to let Jon do that, and then we will go to Jonathan Jaffery. I can't seem to get away from hospital factor. Go ahead, Jonathan.

DR. PERLIN: Well, thanks. I'll comment on this and just in the interest of time make a couple general points, but first, excellent chapter. I support the recommendations.

I would generally agree with Larry, but I have to note that it is impossible in an 185-hospital system to get coverage in certain specialties -- neurosurgery, neurology, orthopedics, trauma coverage, emergency without employing

certain physicians.

Our organization's preferred approach is not to employ. We employ as a last resort, and actually, because of the inability to attract, which leads me to my two general comments. One is that, as Amol said, there are lots of moving parts, and when you change one part, there are unintended consequences.

As an example, the physician fee schedule obviously redistributes the health care dollar, but if you have already entered into a contract with a provider -- and this gets to many discussions in fixed versus variable costs -- that is axed and that provider is now on a specialty that's been reduced, you're still obligated to pay the difference between that contract and the reduction.

So it just becomes problematic because it's difficult then to have to renegotiate, and that's in the context of what I believe that there is actually a gun to the hospital's head to employ physicians in particular specialties where coverage is needed. But at the same time, it's this interlinkage of complexities that leads to some of the consolidation.

There are certain specialties today where the

cost -- and this gets into a different issue of whether physicians are overly compensated or not, but we know what they're compensated. And we know that the aggregate of reimbursement in particular subspecialty areas like emergency or hospital medicine is actually less than the cost of providing the employment. That's why some of the large physician staffing companies, as an example, which do hospitalists in ER, were in dire straits during the earlier peak in the pandemic. All the structures and supports fell because they're systematically subsidized by the hospital. So I think this notion of interaction between the pieces has to be considered.

The second point I wanted to make was really that I think -- I asked this question about the survey and the stratification of different ages last year, and I'm going to say that time very personal, as my father who had fallen to the older old was searching for a new physician. And what he reported to me demonstrated that there was a, essentially, credentialling of how many patients of a certain degree of complexity different providers would take.

And it may be beyond the capacity of MedPAC to do

that survey. On the other hand, not only do we have fee-for-service caps, but it may be an opportunity to recommend that a set of questions be added to fee-for-service caps that would allow us to have the details to provide the sort of stratification between older old, younger old, different demographics, et cetera.

Let me stop there. Thanks.

DR. CHERNEW: Thank you.

Larry, you wanted two sentences or so. I'm going to give you two sentences.

Jonathan, I'm sorry I keep pushing you off for Commissioners that send me messages that they want two sentences.

Larry?

DR. CASALINO: No, that's it. Two sentences.

Jonathan, I oversimplified in the interest of time. I agree with you. Certain specialties have to be employed, but those are not the specialties where site-specific payments are an issue really -- anesthesia, ER, hospitalists. Yeah.

DR. CHERNEW: Okay. Jonathan Jaffery.

DR. JAFFERY: Great. Thanks, Michael.

So I, like many others, sort of reluctantly accept that this is the right thing to do now but feel concerned about the long-term impact of no updates and then out-years -- I think it's 2026 and beyond -- of having these differential updates for different -- for providers in advanced APMs versus not, which I think -- I don't have an issue with the differentials. I think that it makes some sense, but I'm concerned about what .75 versus .25 really means in perpetuity and think that we should be thinking about these things now because, obviously, we have conversations about this every year, and we know that it's not like we'll come up with a recommendation in 2025 and have it picked up by 2026, just like that. So laying the groundwork for that would make some sense.

I also -- I really want to echo what Pat and Dana said about some of the quality metrics and whether ambulatory-sensitive conditions are exactly the right metric here and wonder if those -- you know, if there are differences in characteristics of hospital service areas that play as much, if not more, of a role and what that means.

One main point I wanted to make had to do with

encounters as a measure of access for us, as particularly thinking about primary care. A lot of the work that we're doing with providers, particularly in the context of HCOs, is to try to move away from always having to bring people in and find alternative care models that will help manage patients without having them come in. It's obviously accelerated recently and with the pandemic actually able to capture some of those things a little bit differently.

But it does feel like we're sort of working against ourselves if my primary care providers and my ACO did all the things that we hoped that they would do, it would look like the access fell quite a bit, and that's not necessarily the outcome. So I think we need to think about that.

Finally, the last comment I'll make, thinking about the MIPS and advanced APM bonuses, just to point out to everyone that while the MIPS is designed to adjust the payments going forward, the bonus payments actually have this two-year delay. So I'm not sure how that impacts people as they're thinking about when they're getting this payment and how that really connects to the work they're doing when it doesn't come for another two years and on a

time schedule that's not always entirely clear in advance.

So thank you.

DR. CHERNEW: Thanks, Jonathan. I saw a message in the chat. I'm sorry. I lost my connection for a minute so I may be a little bit behind my normally inefficient self. But I think, Brian, you wanted to get in, if you have not made your comment, and then we'll go to David Grabowski and Karen DeSalvo.

DR. DeBUSK: Thank you, Michael. First of all I do agree with some of the earliest comments that Amol and Paul were making. I completely agree with your mindset, not to revisit all that. And I also support the recommendations as written.

I think part of what makes this payment area so difficult is physician compensation is so much more complex than just the payment update that we would recommend or that's set in law each year.

But I do want to take a moment and say something that I think dovetails with some of Larry's and Jon Perlin's comment about physicians and physician employment, in general. Since the volume and intensity of the services that physicians can provide aren't constrained, you know,

there's a path here for them to either provide more services or to leverage their services more through mid-levels, or -- and I'm still fascinated with this shift inside of service effect, because, you know, we focus a lot on what happens when a physician becomes part of an outpatient provider department and sheds their practice expense, and then Medicare takes on the increased expense of the APC.

But I'm also looking at that from the other direction, which is, as a physician, if I can shed all of my practice-related costs and focus entirely on the physician work and collecting that physician work, there may be a path to increasing my income, and certainly de-risking, de-leveraging my business by shedding all that expense and that risk.

And the reason that I bring this up, and I know we've talked about it, I'm concerned in the absence of meaningful annual updates and these three mechanisms for physicians to continue to receive increases in income, I'm afraid what we're creating are some really powerful incentives for physicians to become employed and to lose autonomy. And I don't think it's explicit. I just think

that we aren't providing a Plan B or an alternative route here.

And so I'm concerned about the unintended consequence of increased physician employment and lost physician autonomy, unless we can go back and look at other mechanism for them to increase their income over years.

Thank you. That's all.

DR. CHERNEW: So I'm going to go to Betty in a second, but let me just say this holistic approach is unbelievably important. It's not just with other types of services, ASCs and hospital outpatient, but also between the A-APMs, and Medicare Advantage would be another example. I actually think some of the consequences you're talking about, Brian, were quite explicit in trying to encourage people into A-APMs as way out of some of the problems that are really a symptom of this somewhat fragmented fee scheduling. You can see us spending a lot of time tied in a knot about how to deal with broader policy issues when we're faced with updates than work through separately defined fee schedules.

So this is obviously a great interest and passion of mine, but I'm going to put that on hold for now and then

move ahead and let Betty jump in.

DR. RAMBUR: Thank you, all. Thank you very much to the staff, and I appreciate the comments of the Commissioners.

A comment about MACRA and MIPS. I was not on the Commission when you made the recommendation about MIPS, but I have to say that I have really seen this a bit differently than how I hear some of you. To me, the message is providers, one way or another, you're going to take on financial risk, and you can do it, you know, sort of all at once, and being in a qualified alternative payment model, or over time. And so that was one of the things that I actually really liked about it and had concerns about the voluntary recommendation when it came out.

It leads to thoughts about low-value care, and I know the devil is in the detail. But there was an article whose title I just lost that came out of Canada. They found an effective but underused strategy for decreasing low-value care, and that was to stop paying for it. And so to the extent that we really start to think about that and we really think about taking on accountability for outcomes

and cost, that's part of the mix for me.

I wanted to talk, or just mention a few thoughts about the shift of more and more nurse practitioners and PAs delivering primary care. My own opinion is that regardless of what we do payment-wise, this is going to continue and perhaps accelerate. And there is a question in here about the number of -- I don't know the PA world, but the nurse practitioners. Many nurse practitioners, most are prepared as family nurse practitioners for adult gero nurse practitioners, but they often then go into specialty practice because it's more lucrative. So that same issue riddles it. And I can say for myself, I worked as a family nurse practitioner and then in an otolaryngology clinic, and it was easier in a specialty clinic. And maybe you all don't agree with me, those of you who are primary care providers. I think it's challenging work.

The National Forum of State Boards of Nursing Workforce Center, or something like that -- and Jim and crew, I'll get you folks the name -- do have states that are gathering minimum data set on nursing, so they would know about where people are employed.

And the other thing that I hope we don't forget about is the Macy work in primary care nursing, in that really reconfiguring how we think about primary care, to take some of the burden off of the demand for physicians. Because so much of what we need is around care coordination, other kinds of things, that are really not exactly the medical piece that physicians are so skilled at and trained to do.

So I think more attention to how we think about paying attention to the primary care workforce in ways that MedPAC can do or recommend. And this certainly also reminds me of a conversation on GME.

So those are my thoughts. Thank you so much.

DR. CHERNEW: Great. We're going to go to David Grabowski, then Karen.

DR. GRABOWSKI: Great. Thank you, Mike. Like others I am supportive of the Chair's draft recommendation.

I wanted to raise a point that isn't directly related to the recommendation itself but I do believe is very related to access to primary care services for some of our most vulnerable Medicare beneficiaries.

Geoff made the point, on the bottom of Slide 16,

that CMS will increase RVUs for E&M office visits in 2021. As was noted, due to the budget neutrality restrictions, CMS can't raise those E&M payments without making cuts elsewhere.

Unfortunately, those physicians who provide services in nursing homes and assisted living facilities or delivery home-based primary care will see major cuts to their rates, and this is in the context, obviously, of nursing homes and other long-term care facilities being basically pummeled during the public health emergency.

The 2021 fee schedule contains cuts ranging from 8 to 10 percent to the family of CPT codes that are typically billed for non-office services delivered in the home or at the long-term care facilities. These are services that are scheduled for this payment cut that are delivered to some of our most vulnerable beneficiaries. They have greater levels of chronic illness, more medical complexity, and they are more likely to be dual eligible.

My colleagues and I published many studies suggesting physicians and other primary care clinicians are often missing in action in nursing homes and other long-term care settings. This Commission has obviously talked

about policies in the past that could help address this issue. I'm thinking about work on integrated care models for dually eligible beneficiaries. This Commission has also talked about the shortage of geriatricians and policies that may increase the supply of geriatricians for our beneficiaries.

CMS should not be cutting payments for care delivery in these settings. I believe these cuts are only going to lead to further shortages and access issues above what we see today.

So in summary, I think this is a case where payment adequacy may look -- you know, it's complex at a high level, it may look okay at a high level, but when you drill into some of these areas I think there's some real area for concern. I'm very worried, going forward, about clinical services or long-term care beneficiaries, and especially during and after this public health emergency.

Mike, I apologize. I just kind of got outside of our recommendation, but I thought it was too important not to raise, and I do hope that we're going to consider this going forward. Thank you.

DR. CHERNEW: I'm glad you raised that, and as a

general point we have to deal with relative prices in a way that's somewhat different than we do with average prices, and this, unfortunately, is the discussion about, in some sense, average prices, or some weird version of that, because we work with the parameters we have.

Karen, you're up.

DR. DeSALVO: I like the economist's answer to the question. I'm really not even 100 percent sure what you just said, but I will be looking it up.

First of all, I just want to thank the staff, because my sense is that year over year you guys pay another turn of the crank or a little more attention to understanding the disparities in access, not only to the type of care, primary care, but also to the populations that may be at increased risk. And it's helpful as we begin to think about whether or not we have tools or opportunities to see that communities of color or low-income beneficiaries are disparately impacted and if there are ways that we could be helpful there. So thank you for continuing to provide this information.

I think the second thing has been raised but I want to just bundle it what I'm thinking about how we're

defining success. On Slide 17 there's this sort of middle panel about increasing volume of visits that means thing are positive, and I think as we've all said, what we really want is to see better value care, better outcomes, better experience with care, and not just the numbers and the volume. And that relates, I think, on the flip side of that, to low-value care. So just getting a lot of care isn't necessarily what I think all of us want to see people get to. We want them to have better outcomes. So over time, thinking about how we can define success, and not just about access to visits but access to what kind of quality care, and I appreciate staff continuing to dig into it. I hope we'll have a chance to talk about that.

Two more things. Because it hasn't been mentioned, I do want to say physicians have been hammered in the pandemic, and I don't know quite how to articulate what it feels like for them on the front lines, not having tools to protect themselves and others. Maybe the physicians get PPE, but the nursing or respiratory staff don't, so they're making tradeoffs all the time. They're exhausted. People don't believe that COVID is a thing. And I just want to take a moment to give a shout-out to

them being heroes in the way that we talked earlier about how hospitals have really stepped up to the plate. Because I think this is just critically important that we don't lose sight of the fact that there's a particular history and moment going on and people have really stepped up to the plate.

So all that, the last thing is just that I have a -- I reluctantly support the Chairman's recommendations. Some of the others have mentioned that we need to pay attention to the trajectory in the next few years of what's going to happen to physician payment, and some of the complexities of MIPS and maybe the rebalancing the fee schedule that CMS is undertaking. But I certainly understand why we're making the decision this year, but I hope that we can spend a little more time on it in the next year, to understand if we're setting the right course to make sure that people, particularly vulnerable populations, have access to great, high-value primary care and that we're recognizing the value-add of this portion of the health care system. Thanks.

DR. CHERNEW: Right. We are going to go to quickly to Sue, and then we're going to close out with

Bruce. Sue?

MS. THOMPSON: Thank you, Michael, and I don't know that I can -- it's tough to follow Karen. I absolutely appreciated everything she had to say about physicians and their heroism during this pandemic. And my comments were really covered nicely by Betty.

I was struck by the reading where the supply of clinicians continues to grow. You know, we're growing numbers of clinicians, but we are seeing reduction in the number of primary care providers, and yet we're suggesting that we have adequacy here. I really -- and I can't help but reflect on conversations we've had in other chapters, whether it be the primary care workforce or the role of the nurse practitioner and PA in providing primary care. And really, I just had a real appetite for understanding what's happening here in terms of perhaps unintended consequences to our reluctance to do something with payer updates here. And I just want to call that out.

There is a growth in nurse practitioners and the role they play in all kinds of care. And we may be perfectly fine with that, but I'm not sure we really completely understand what's happening to the numbers of

physicians that we have available to care for our Medicare beneficiaries, who have the most complex medical diagnoses. So I just want to draw light to that workforce issue again. Thank you.

DR. CHERNEW: Thank you, Sue. And Bruce.

MR. PYENSON: I think Betty had a comment.

DR. RAMBUR: May I make this one sentence? I just want to add to Karen's so eloquently said thank-you and acknowledgement of the heroism of the physicians, but also just want to mention the nurses, the nursing students, and the other workers as well. They are there at the bedside with great cost. And I really especially want to give a shout-out to the nursing students. We need you. And it's not always like this. It's not always like this.

DR. DeSALVO: Betty, if the physicians are heroes, the nurses are the superheroes.

DR. RAMBUR: Well, it's not a contest. I just wanted to make sure --

DR. DeSALVO: I'm glad that you raised it, because there are a lot of people working hard every day, all across the health care system. So I totally agree. And I agree with you too. I don't want this to scare away

really great, well-intentioned people who want to come into the workforce.

DR. RAMBUR: Thank you.

DR. CHERNEW: Absolutely, and for those of you who can't see the chat there's a lot of agreement.

Bruce?

MR. PYENSON: Thank you. I just wanted to add a point about how little we know about the economics behind or the finances behind what are the physician practices or the corporation, the employee physician practices. We don't have visibility into incident to billing, and we address that from a billing standpoint, what Medicare pays, but that also has a profound impact on underlying costs, as does telehealth and other structural changes. So the traditional way of looking at that has been the MEI, Medical Economic Index, but that's based on weights that are very old, before these structural changes.

So it's hard for me to know whether, for the super groups or the physician, multi-specialty practices or others, whether actually costs are increasing or they're decreasing. So I think better visibility into that is something I welcome, or at least some discussion of some of

these underlying weaknesses. But that said I support the Chair's recommendation.

DR. CHERNEW: Thank you, Bruce. I'd like to say more broadly but I'm not going to. We're going to move to hospice. This raises a number of issues, largely about the relative reimbursement for selected groups, and I think we will continue to work on that as we go forward and say more about it when we come back in January.

But for now I'm turning it over to Kim to take us into a discussion on hospice services.

MS. NEUMAN: Good afternoon. Can you hear me?

DR. CHERNEW: Yes.

MS. NEUMAN: Great. For the audience, you can download a PDF of the slides at the right-hand side of your screen.

So today we're going to talk about the hospice payment update for fiscal year 2022 and discuss the Commission's March 2020 recommendation to modify the hospice aggregate cap.

First, we'll discuss some background on hospice. Then we'll walk through the payment adequacy analysis. Then we'll talk about the hospice cap. And we'll conclude

with the Chair's draft recommendation.

Before we begin, I also want to note that as follow-up to our discussion of hospice at the October meeting, we have included in the paper a text box on potential directions for future work on hospice payment policy. I won't walk through that now, but I'd be happy to discuss on question.

So, first, background. 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 of less if the disease runs its normal course.

There is no limit on how long a beneficiary can be in hospice as long as a physician certifies that the he or she continues to meet this criterion.

When hospice was added to the Medicare program, it was thought that it would reduce net program expenditures. The evidence on hospice's effects on Medicare expenditures is mixed. But hospice has important other benefits for beneficiary. Hospice offers terminally ill patients a choice of what type of care they'd like to receive. It focuses on quality of life and less invasive

care and makes it possible for patients to die at home or in another place according to their preferences.

So now some background on the hospice payment system. Medicare pays hospices a daily rate for each day a beneficiary is enrolled.

Medicare's payments to hospice providers are wage adjusted, and there is also an aggregate cap that limits the total payments a provider can receive in a year, which we'll discuss later.

This daily rate structure, as we've discussed before, has made long stays in hospice quite profitable.

In 2009, the Commission recommended that the payment rate for routine home care, the most common level of care, be modified from a flat payment per day to one that is higher at the beginning and end of the episode and lower in the middle to better reflect the hospice visit patterns during an episode.

In 2016, CMS made changes that move in that direction. Medicare now pays a higher rate for days 1 to 60 days and a lower rate for days 61 and beyond, with some additional payments for visits at the end of life. This has had some effect, but long stays remain profitable.

So a few key statistics on hospice. Medicare spent $20.9 billion on hospice services in 2019.

Over 1.6 million beneficiaries, including more than 51 percent of decedents, received hospice care in 2019 from over 4,800 providers.

As we consider hospice payment adequacy, we'll use the same framework as you've seen in other sectors.

One difference, though, is that we'll present margin estimates for 2018 instead of 2019. This is because the data needed for the aggregate cap calculations lags.

So first we have data on provider supply. The total number of hospice providers has been increasing for many years, as you can see by the orange line in the chart.

In 2019, the total number of providers increased by 4.3 percent from the prior year.

All of the net growth in provider supply in 2019 was driven by for-profit providers.

Next we have data on hospice use. You'll notice that these numbers are slightly different from your mailing materials. The slide has been updated based on a new data file we just received from CMS.

Hospice use continues to grow. Both the share of

beneficiaries who use hospice before death and their average length of stay grew in 2019.

The share of decedents using hospice reached 51.6 percent in 2019, increasing by one percentage point from the prior year.

Average length of stay among decedents increased about two days between 2018 and 2019, reaching 92.6 days as of 2019.

Underneath average length of stay is substantial variation across beneficiaries. Many beneficiaries have short stays, while a small share of beneficiaries have long stays. But as shown in the mailing materials, beneficiaries with long stays accounted for nearly 60 percent of hospice spending in 2019.

Another indicator of access to care is marginal profit. In 2018, marginal profit, the rate at which Medicare payments exceed providers' marginal cost, was 16 percent, and this is a positive indicator of access.

Next, we have quality. Hospice has a limited set of quality measures. There are seven process measures that gauge whether hospices appropriately performed certain activities at admission. Performance on those measures is

very high, and the measures are topped out.

Performance improved slightly on a measure of whether hospice patients received at least one nurse or clinician visit in the last three days of life.

The hospice CAHPS survey -- a bereaved family member survey -- showed stable performance.

It is also notable that a study by the OIG looking at data on deficiencies and complaints identified a subgroup of poor performers.

So next we have access to capital. Hospice is less capital intensive than some other Medicare sectors.

Overall access to capital appears positive.

We continue to see growth in the number of for-profit providers, which increased about 6.5 percent in 2019, suggesting that capital is accessible to these providers.

Reports from publicly traded companies and private equity analysts also indicate generally favorable financial performance as of third quarter 2020. These reports also suggest that the hospice sector is currently viewed favorably by the investment community, and that is anticipated to continue in 2021.

We have less information on access to capital for nonprofit freestanding providers, which may be more limited. And provider-based hospices have access to capital through their parent providers, which generally appear to have adequate access to capital.

Next we have margins. The aggregate Medicare margin in 2018 was 12.4 percent, similar to 12.6 percent in 2017. In 2018, freestanding hospices had strong margins -- 15.2 percent. Provider-based hospices have lower margins than freestanding hospices.

The chart also shows margins by type of ownership. For-profit hospices have substantial margins -- 19.4 percent. The overall margin for nonprofits is 3.8 percent. But looking at just freestanding providers, the nonprofit margin is higher -- at 7.6 percent.

Next, we show what's underlying some of the margin differences across providers that we just saw.

This chart shows the relationship between length of stay and hospice margins. Providers with longer stays had higher margins in 2018, as we have seen in other years.

So next we have our margin projection, and we start with our 2018 margin of 12.4 percent.

The 2021 projection takes into account several things. First, revenue increases based on net updates of 1.8 percent in 2019, 2.6 percent in 2020, and 2.4 percent in 2021. It also takes into account the suspension of the sequester in the first quarter of 2021.

As far as cost growth, in 2021 there will still likely be some effects of the pandemic with added costs related to items such as personal protective equipment and testing. At the same time, certain regulatory flexibilities granted during the public health emergency -- such as greater use of telehealth -- may yield some offsetting cost savings.

For our 2021 margin projection, we assume a rate of cost growth similar to the market basket, which means we're assuming slightly higher cost growth than what we've historically seen in the hospice sector.

Taking all this into account, our 2021 margin projection is 12 percent.

So, to summarize, based on the data we have available for 2018 and 2019, indicators of access to care are favorable. The supply of providers continues to grow, due to entry of for-profit hospices.

Hospice use rates and average length of stay increased. Quality data are limited. Access to capital appears good. The 2018 aggregate margin is 12.4 percent, and the projected 2021 margin is similar, at 12 percent.

While the payment adequacy indicators we just discussed are positive, the data mostly predates the pandemic. I want to discuss what we know about the pandemic's effect on beneficiaries and hospice providers.

COVID-19 has had tragic effects on beneficiaries' health this year. Beneficiaries have died from COVID-19 and from illnesses unrelated to the pandemic during this period. Social isolation associated with the pandemic has been particularly difficult for beneficiaries facing the end of life and their families.

The pandemic has also had effects on providers' volumes, revenues, and costs. What we know with respect to hospice comes mostly from publicly traded companies.

These companies report that patient volumes declined initially but generally rebounded to near or in some cases above pre-pandemic levels.

As some nursing facilities and assisted living facilities are restricting access to outside providers,

hospices have reported that they are seeing fewer patients in these settings. At the same time, patient referrals from other sources like community physicians has reportedly increased.

Company reports vary in terms of changes in length of stay.

From a cost perspective, as we just discussed, the pandemic has resulted in some additional costs for items like personal protective equipment and testing. Federal grants and loans received by some hospice providers and temporary policy changes have helped ease the public health emergency's impact.

We don't anticipate that the pandemic will substantially alter the cost structure of hospice providers in a permanent way. To the extent that the effects are temporary or vary significantly across individual providers, they are best addressed through targeted temporary funding policies rather than a permanent change to all providers' payments in 2022 that will also affect payments in future years.

That said, there is uncertainty as we are entering the winter with increasing cases and the potential

for a more intense phase of the pandemic. We will monitor available new information and update you in January as warranted.

So now switching gears to talk about the hospice aggregate cap. The hospice cap limits total payments a hospice provider can receive in a year. The cap is an aggregate limit, not a patient-level limit.

If a provider's total payments exceed the number of patients served by that provider multiplied by the cap amount, the provider must repay the excess to Medicare.

Currently, the cap is about $30,684, and it is not wage adjusted even though provider payments are wage adjusted.

Hospices that exceed the cap have long lengths of stay and high margins.

In 2018, we estimate 16.3 percent of hospices exceeded the cap. Their margin was about 22 percent before and 12 percent after the return of cap overages.

Last year, in March 2020, in lieu of an across-the-board payment reduction, the Commission recommended the cap be wage adjusted and reduced by 20 percent.

These recommended changes to the cap would make

it more equitable across providers and would reduce Medicare expenditures.

Overall, our simulation of this cap policy using historic 2018 data suggests it might reduce aggregate payments by about 3 percent. It would do so by reducing payments to providers with disproportionately long stays and high margins, while payments to the majority of providers would be unaffected.

Congress has not acted on this recommendation, so it could be contemplated again as part of this year's recommendation.

So this brings us to the Chair's draft recommendation. Given the margin in the industry and our other positive payment adequacy indicators, the analysis suggests that hospice aggregate payments exceed the level needed to furnish high-quality care.

It is important to acknowledge hospice is a valuable service for beneficiaries, but being high value is not a rationale for excessive payments.

In other sectors, in this situation the Commission has generally considered across-the-board payment reductions, but in this case, the hospice cap

policy we just discussed provides an opportunity to focus payment reductions on a subset of providers with high margins and disproportionately long stays.

So the Chair has put forward the following two-part draft recommendation. It reads: For fiscal year 2022, eliminate the update to the 2021 Medicare base payment rates for hospice, and wage-adjust and reduce the hospice aggregate cap by 20 percent.

This draft recommendation would keep payment rates unchanged in 2022 at their same 2021 levels, while modifying the aggregate cap to make it more equitable across providers and focus payment reductions on providers with high margins and long stays.

In terms of implications, the recommendation would decrease spending relative to the statutory update.

In terms of beneficiaries and providers, we expect that beneficiaries would continue to have good access to hospice care and that providers would continue to be willing and able to provide appropriate care to Medicare beneficiaries.

So that concludes the presentation, and I turn it back to the Chair.

DR. CHERNEW: Kim, thank you so much. That was a wonderful presentation.

I think I'm going to start with David Grabowski, and then we'll go to Dana Safran.

DR. GRABOWSKI: Great. Thanks, Mike. And, Kim, thank you for this great work. I'm supportive once again of the Chair's draft recommendations.

In thinking about this area, and we have made prior recommendations around cuts to hospice, I think those cuts and getting at some of the long lengths of stay and overutilization is a good thing. But I think that's just part of a broader sort of solution or step forward we need to take as a Commission. I really believe we need to worry about kind of value across the sort of spectrum here. So, yes, we have some low-value long length of stay. It's very easy to kind of limit that longer length of utilization, but how can we kind of step forward and make certain that we're not just sort of cutting one part of the distribution but, rather, being a little bit more thoughtful. And I think this sort of maybe gets to my second comment, and this is something that we raised earlier in the cycle that in many regards, you know, hospice is playing different

roles. There's sort of some blurriness with hospice into home health care. There's some blurriness with hospice and home care that might be delivered with coverage via Medicaid or paid out-of-pocket. And we need to think going forward both about how hospice fits in with these other benefits and how we can encourage high-value hospice. Hospice is an incredibly important benefit. I'm not trying to diminish that, only that we're looking at one part of the distribution, where I think we should be looking more holistically.

I'll stop there, Mike, and once again, supportive of the recommendations and look forward to kind of our further work, because I think hospice is an area where we can really work to encourage greater value. Thank you.

DR. CHERNEW: Thank you, David. I'm going to go to Dana Safran and then Karen DeSalvo.

DR. SAFRAN: Thank you, Mike. Really excellent chapter, and I am in support of the draft recommendation. I have only a few comments and questions.

One was that there was some interesting information about the increase, quite dramatic increase in hospice availability in California and Texas, and I was

just curious what we know about why that was, and also why no evidence about the relationship between the supply and use of hospice by markets. So I would like to get an answer to that while we're having this discussion, if that's possible, but I'll just quickly go through the rest of my comments and then hand it off.

I think I was also wanting to understand whether the cap, as we have proposed it, would disproportionately affect the care of those with certain diagnoses and what we know about that.

So those were the two questions I had about the content of the chapter. Overall I felt it was very strong, and I felt comfortable with the recommendation.

DR. CHERNEW: Thank you, Dana.

MS. NEUMAN: Should I respond?

DR. CHERNEW: Sure, Kim, go ahead.

MS. NEUMAN: Yeah, I wasn't sure if you wanted me to address those questions now?

DR. CHERNEW: Absolutely. Go ahead. Anything you know is always useful.

MS. NEUMAN: Okay. So there's been a long-term trend in entry of hospices in California and Texas, and the

entry of these providers, it looks to be smaller providers, and there's some concern sort of of what that kind of entry of large numbers of providers year after year might be signaling. We have not done a sophisticated analysis of those providers, but we could look at them and come back to you potentially with some more information. So that's point one.

And then the second thing you asked was whether different kinds of patients would be disproportionately affected by the cap policy. The cap policy is not a limit on a particular patient's care. It's a limit on how much Medicare will pay a given provider. And it's true if a provider enrolled patients with a certain diagnosis and then enrolled that group of patients early in the disease trajectory, so if you -- it's possible that that would bring them over the cap. But we have many hospices that are enrolling a wide range of patients with a wide range of diagnosis who are well below the cap. So it should not pose a problem for access for any group of beneficiaries.

DR. SAFRAN: Thanks, Kim. That's really helpful. And I personally do think that some examination of what's going on in California and Texas would be valuable.

DR. CASALINO: Kim, if you thought that you were -- if you were only halfway through the year and you looked like you were going to go over the cap, you don't think that might influence which patients you would admit to the hospice?

MS. NEUMAN: I think that a provider that is close to the cap may take into account who they admit. I think that that is entirely plausible. But I don't think that it should affect admitting practices of the broader group of hospices.

DR. CHERNEW: So, Larry, I'm about to ask for Karen's comments, but, again, you're very small on my screen, so I can't exactly read your face. That's why we should all be in person. But if you want to jump in here now, I'm giving you the opportunity.

[Pause.]

DR. CHERNEW: But you can't be muted. That's the one rule.

DR. CASALINO: Thanks, Michael. No, I was just following up on what Dana was asking. It just might be worth a little bit more thought for the hospices that have risk of going over the cap, is that going to systematically

affect certain groups of patients, whether maybe by disease or by demographics or whatever. It might be something to think about a bit more going forward.

DR. CHERNEW: Yeah. So I agree with that. I'll come back to you later, Larry. But I will say the cap, in general, does systematically address high, long length-of-stay patients systemically in some diseases over others. The question is sort of how we feel about that, because, I mean, the core problem for the entire day is we want a scalpel and we're working with a sledgehammer. And so that's just a fundamental problem. And thank you, by the way, for all of your service on MedPAC. Welcome, so having a sledgehammer, not a scalpel.

But nevertheless, I do think that's a relevant question to ask, to see if we can do a better job. But I'll come back, Larry, and look to see when you want to get in the queue, but for now I want to go to Karen.

DR. DeSALVO: Great. Well, again, thank you for the opportunity to learn more every time we read about hospice. I know we've had some deep discussions about this area, and I very much appreciate how the staff continues to try to tease apart what's going on under the hood. Because

I do sense that there are a couple of things going on. One is there's two benefits packages happening here. One is what we think is hospice and the other is some other kind of long-term care benefit that people are leveraging hospice for. And I do worry that that's clouding the numbers, particularly maybe because there's more for-profits in that space and their margins might be better.

But over time I also would really like to understand more about the quality and service for the beneficiaries. So I hope we'll continue to work towards getting a feel for whether the margins are coming at the cost of the kinds of care and supports that we want beneficiaries and their families to receive towards the end of life, in that traditional model of hospice benefits, and then also I hope that the Commission can find some space to think about whether there is some other kind of long-term care program that we should be considering, given the aging of the population and the prevalence of conditions that are arising, like dementia or other neurologic complications.

But given the context of what you have, I think you've done an amazing job, Kim, of coming up with the right narrative, and I very much appreciate that on the

part of the staff. So I support the Chairman's recommendation, but I do hope that we will continue to begin to tease this apart and think about whether this is all one thing or if we can begin to really understand how we'll provide great quality and service in the hospice program, and support it financially in a way that really supports beneficiaries but then also understand if there's another kind of benefit at play. Thank you.

DR. CHERNEW: Thank you, Karen. So we're going to go to Marge and then Jon Perlin.

MS. MARJORIE GINSBURG: Okay. I don't have anything new and different to add. I think most of the people who have responded so far have captured my view of this. It's a great chapter. I know we discussed this topic in depth, I think it was last month, and I think the staff has done a formidable job in capturing the issues and presenting their recommendations in ways that I fully support. So thank you.

DR. CHERNEW: Terrific. So we'll go to Jon Perlin and then Betty.

DR. PERLIN: Well, thanks. I'm really aligned with so many of the comments of the prior Commissioners.

I think this really reveals to us that we have an unfulfilled clinical need for patients with a different set of diagnoses. And you're right, within the constraints or the context of how hospice was originally envisioned, it's not work in that regard, and that's important. But I do think we have to ask ourselves, as David Grabowski said, how hospice and home health are sort of more together. I remember last year when this came up, Karen said that, you know, when we think of home health in the context of the MedPAC conversation as post-acute, rather than what it could really be for which is preventive of the hospitalization. And I think we need to think of this more holistically, as David encouraged us.

I think we have sort of suspicions about certain types of patients, dementing as an example. And that's going to be a larger challenge for the Medicare program. So within the limited context, you know, support it within the broader term text, I think we have some serious work to do ahead to figure out the needs and how some of these services can be used more appropriately, more effectively. Thanks.

DR. CHERNEW: Jon, thank you. We'll have Betty

and then Brian.

DR. RAMBUR: Thank you very much. I appreciated this chapter and the comments. I certainly support the direction, and I have to sort of pile on with these thoughts about the broader issue.

It's sort of interesting, as a clinician, to be reading this, as a person who's been very concerned about overtreatment at the end of life, to also hear of these excessive stays. And so my thought is how do we really design this. I mean, I'm very concerned about overtreatment at the end of life, as I'm sure many people are. And I'm recalling another study, again, that was in Ontario, where they found that there was no reduction in overtreatment at end of life in the single payer system. So it really suggested to me it's what we pay for and how we pay for it, not how it's financed.

So I don't have a solution. I have a concern. I certainly support this, but how do we think about other kinds of models of care that really support people in the least restrictive environment, so that they can die where most people want to die, which is at home?

DR. CHERNEW: Betty, thank you. And now it is

Brian, and then we will be with Bruce.

DR. DeBUSK: Well, thanks to the staff for what I thought was a very well-written chapter. I do support the recommendations as written. I also just want to echo support for what numerous other Commissioners have said -- David, Karen -- just talking about trying to tease apart -- and Betty, as a matter of fact -- just trying to tease apart the different roles that hospice may be playing. Because it is unclear where hospice ends and home health care begins.

I also want to support reducing the cap. I like the really surgical approaches to trying to manage payments in hospice, as opposed to raising or shrinking the entire payment area. I really like this surgical approach, even to the point where I would love to see perhaps a second or even third tier, where we try to identify hospices that aren't demonstrating the values and the behaviors that we want to see, and see something very targeted there where savings from the program could come from those specific providers, as opposed to coming from the group in aggregate. So I really like the surgical approach.

My one final comment, I know we have a

recommendation or are working toward using the wage index to adjust hospice. I just want to remind everyone, I really think the wage index is more U-shaped. It isn't perfectly linear. So I would take a look at what would happen to the most rural hospices when we make those types of adjustments.

Thanks. Those are my comments.

DR. CHERNEW: Brian, thank you. Bruce, and then we will have Pat.

MR. PYENSON: I support the recommendation and really the comments of the other Commissioners are really terrific. I really don't have anything to add, so thank you.

DR. CHERNEW: Bruce, thank you. That gets us quickly to Pat. And then we will have Jaewon.

MS. WANG: I'll be really quick as well. I support the Chair's draft recommendation and the comments that have been kicked off by David and echoed by others about understanding more about what is being provided in hospice benefit. I think it's really quite important to see whether or not there are other services or provider types that we should be looking to, to provide some of

these benefits or even other payment programs.

So I'll just echo those. I don't have anything to add. I support the recommendation.

DR. CHERNEW: Thank you, Pat. I have Jaewon and then Wayne.

DR. RYU: Thanks, Mike. I also support the recommendation. Just a couple of quick comments. I like the idea of reducing the caps but I do wonder if that has any dampening effect on enrollment. I think several people mentioned earlier, is it likely to dampen enrollment and who would it dampen that enrollment with? I would also throw in the question of when that enrollment happens. I've always thought, and perhaps wrongly, that hospice enrollment tends to happen later than we'd ideally like, and I wonder if the caps could inadvertently push that even later. So I think we need to keep our eyes on that.

And then as far as the uptake of the service, I think the materials said about 50 percent end up using it. I think that number has climbed nicely over the last couple of decades, but I think the other question I would ask is what do we believe is the right level that we should be shooting for?

DR. CHERNEW: Jaewon, thank you very much. So then we're going to Wayne and then Paul.

DR. RILEY: Yeah, thank you. Very interesting conversation about something that those of us, clinicians, both nurses and physicians, have had to wrestle with families about and counsel them on palliative care and hospice care. And you're right. Sometimes, you know, it happens way later than it probably should have, which is an excess cost to the Medicare program. So I, too, don't want to have the Commission inadvertently exacerbate that problem.

It is interesting. I had no idea that the decedents' stays, that 10 percent of the decedents' stays were over 260 days. That strikes me as very surprising. So maybe we can look at the data on that and see sort of what are the most common diagnoses that somebody who falls into that 10 percent are admitted to, just as a thought experiment, to see if there's anything we need to do to focus in on those admissions.

But generally I'm very supportive of the thrust of the recommendations.

DR. CHERNEW: Okay. Terrific. And that brings

us to Paul.

DR. PAUL GINSBURG: Okay. Yeah, really great work on your part, Kim, and other staff, and a lot of terrific comments by my colleagues. I support the recommendation. I particularly liked the fact that it's not an attempt to try to be surgical and try to pay efficiently rather than just varying the amount we pay. And I'm pleased that we keep trying to do this. I realize that hospice is something very complex, a situation we come into often in Medicare. The delivery system is fragmented. You know, we come up, or Congress comes up with a benefit, and it changes over time as the fragmented system tries to, for better or for worse, take full advantage of it.

DR. CHERNEW: Thanks, Paul. So let's go to Amol and then to Jonathan.

DR. NAVATHE: Thanks, Mike. So Kim, fantastic job. Really nice summary and synthesis. I agree with a lot of what the co-Commissioners have said thus far, and let me first say that I support both aspects of the recommendations here from the Chair.

While I think of course we want another impact I think I'm a little bit less worried about the cap in terms

of impact on extending the time to referral, if you will, for shorter stays, but more worried about, as Karen and Jon Perlin talked about, the different type of patients that requires a very long stay.

That being said, before we jump into that, I thought it was worth us taking a step back and to saying it's interesting to me that the hospice program does not seem to have generated savings for the Medicare program, and not that it has to generate savings, in the sense that as a lot of other benefits, and I think we should feel good about what hospice does do. But when we look at other parts of the health sector, and other insurers, even work that I've done with specific health insurance, has shown that hospice does seem to save money and be good for patients. And to the extent that hospice within Medicare fee-for-service to do that, that would be a net benefit.

The other things that I will say is if we look, to some extent, to the most comparable population that we might have, the Medicare Advantage side, I think there is quite a bit of a push to try to increase hospice utilization as well as move toward earlier palliative care for serious illness. And I think that, in part, may speak

to the multiple types of populations that perhaps a different care model that hospice right now is serving, in some sense, a dual care model. Perhaps one of the reasons that we end up in this situation of a lot of hospices going above the cap is that the payment model does need to be a little bit more refined, or surgical, if you will, than the sledgehammer that we have right now.

And one thing that I would urge us, again, I agree with the recommendation, based on what we've seen thus far, but I would urge the Commission to consider taking up, going forward, because it does feel like a really important area, and the types of populations who end up needing longer stays end up putting us towards the cap, for example, or those very long stays, outside of perhaps some small minority of circumspect type of hospice providers, or a population that is relatively vulnerable and that we might want to really care about clinically.

So again, to recap, I agree with a lot of what Commissioners said, and would push up to see if we could try to expand some work in this space of what's happening in hospice, palliative care, and serious illness within Medicare fee-for-service, but I support the recommendation.

Thanks.

DR. CHERNEW: Thank you, Amol. So I will go to Jonathan, Sue, and then Larry.

DR. JAFFERY: Thanks, Michael, and again, Kim, echoing, this is a great chapter. I really appreciate the other fellow Commissioners' comments. I support the recommendations and really love our ability to try and take a more targeted approach to policy-making.

Just a couple of things to comment on. Amol just was talking about maybe the lack of savings that we've seen relative to maybe some other payers, and work he's done. I think this may have been in the chapter, or I've seen it in other places, talking about they may see some savings in patients with cancer diagnoses but then not some of the other areas. This may, again, speak to some of the things that Karen and others have talked about, in terms of substituting for long-term care or the things where perhaps some of the commercial payers or whatnot, it's more focused on some of those oncology treatments perhaps.

One thing I wanted to mention is, like Jaewon, I was surprised, and perhaps this was in previous years and I missed it in the discussions, but surprised to see how high

a percentage of decedents actually utilize hospice services. And also I'm sort of pleased to see that, but also wondering, how do we know what the right number is exactly? But I do -- and again, this may be in the report; I couldn't find it quickly -- there are some disparities that exist in terms of people of color utilizing these services, and I think that's something for us to keep an eye on as it grows, in general, what's happening there. And also do any of the policies that we suggest, including things like wage index adjustment or whatnot, impact that either in a positive or a negative way? Thank you.

DR. CHERNEW: Jonathan, thank you. Sue?

MS. THOMPSON: Thank you, Michael, and Kim, thank you very, very much for this chapter. I think when we did talk about hospice a couple of months ago I made some rather impassioned comments about my feelings for high-value hospice and the importance of this piece of the continuum. And I really enthusiastically support these recommendations. I love how you were able to focus on where we see some of the issues to be. Whether that's a surgical approach or a rifle approach, or whatever metaphor we want to use, I appreciate that, and I think you did a

really nice job. I want to call that out, and I feel really good about that.

I, too, like Jonathan and I think a couple of others, have mentioned a little bit of a surprise about the fact that we're not seeing cost savings as it relates to the utilization of hospice in comparison to what otherwise might be end-of-life interventions for the same diagnoses. I think that's an area I have a great deal of interest in, and I just want to call out my surprise about that. But nevertheless, as it relates to payment update, I'm enthusiastically supportive of this recommendation.

DR. CHERNEW: Sue, thank you so much, and that leaves us with Larry.

DR. CASALINO: Yeah, I really don't have anything to add. I quite enthusiastically support the recommendations also. Great job, Kim, and very good comments from the other Commissioners.

DR. CHERNEW: Okay. Deep breath, everybody. We should do some calisthenics.

So we're now going to move on. We have a little bit of extra time. I fear we may need it, but, nevertheless, for a somewhat different type of chapter. So

we're now going to move to the Medicare Advantage discussion. Just to remind everybody, unlike the sessions we've been through today where we are working towards a vote in January, this will come back as a draft recommendation. We're not even at the recommendation stage quite yet. You'll see a draft recommendation in March, and our hope is, as this discussion goes forward, to get to a vote in April. So that's sort of the pathway that we're on, and I'm going to turn it over to -- Luis, are you going first?

MR. SERNA: Yeah, I'm going first.

DR. CHERNEW: Okay. Perfect. You're up.

MR. SERNA: Good afternoon. This presentation updates our findings on the status of the Medicare Advantage, or MA, program. The audience can download a PDF version of these slides in the handout section of the control panel on the right side of the screen.

I'm going to present our analysis of MA enrollment, plan availability, and payment for 2021. Then Andy will give you an update on MA risk coding intensity. Finally, we continue our discussion of a new benchmark approach that builds on the Commission's public discussion

of MA benchmarks this past October. We will not present any recommendations today, but there may be recommendations in the spring related to benchmarks.

Forty-three percent of Medicare beneficiaries with both Part A and B coverage are now enrolled in MA plans, up from 26 percent in 2011. The ACA established changes to MA payment rates, essentially phasing in a reduction of MA payment rates by 10 percentage points between 2011 and 2017.

Despite some initial projections that the decrease in MA payment rates would coincide with enrollment declines, MA enrollment has continued to grow rapidly, more than doubling since 2011. In 2020, MA enrollment great 10 percent to nearly 24.5 million enrollees. The 10 percent growth rate, equivalent to last year, is among the highest in the last ten years, coinciding with an increase in the number of plans bidding.

Medicare beneficiaries have a large number of plans from which to choose, and MA plans are available to almost all beneficiaries. For 2021, 99 percent of Medicare beneficiaries have at least one plan available. Ninety-six percent have a zero premium option that includes the Part D

drug benefit, up from 93 percent in 2020. The average Medicare beneficiary can choose from 32 plans in 2021, up from 27 choices in 2020.

I'll now briefly go over the MA payment system. Plans submit bids each year for the amount they think it will cost them to provide Part A and B benefits. Each plan's bid is compared to a benchmark which ranges from 115 percent of fee-for-service to 95 percent of fee-for-service in the highest-spending counties. Quality bonuses can increase plan benchmarks by as much as 10 percent.

For nearly all plans, Medicare pays the bid plus a rebate, calculated as a percentage of the difference between the bid and the benchmark. The rebate percentage ranges between 50 percent and 70 percent, depending on quality scores. Plan rebates may go toward lower beneficiary cost sharing for A and B services, supplemental benefits, premium buy-down, or enhanced Part D benefits. Plan rebates may include administrative expenses and profit related to reducing A and B cost sharing and providing supplemental benefits.

The average rebate that plans have available for extra benefits in 2021 has increased to $139 per member per

month -- a record high. The efficacy of rebate spending is unknown, and the relative value of rebate increases is questionable. MA rebate dollars can be used to provide cost-sharing reductions as a means of competing with Medigap coverage. However, as MA rebate levels have increased, plans have allocated smaller shares of rebate dollars toward reducing beneficiary cost sharing, indicating that many MA plans do not want additional rebate dollars for this benefit beyond medical inflation.

As rebates have increased, MA plans have allocated the largest share of additional rebate dollars toward other supplemental benefits. Coverage for these supplemental benefits varies widely by plan, and data on their use is unavailable, obfuscating the relative value for both beneficiaries and the Medicare program.

The level of rebates, now at 14 percent of total payment, reflects MA plans' ability to reduce their bids relative to payment benchmarks. However, because benchmarks have been much higher than fee-for-service spending, lower plan bids have not translated to overall Medicare savings. In 2021, before accounting for coding differences between MA and fee-for-service, we estimate the

benchmarks, represented by the blue line, will average 108 percent of fee-for-service spending. Payments, represented by the green line, will average 101 percent of fee-for-service spending.

Quality bonuses account for about four to five percentage points of MA benchmarks and account for two to three percentage points of payments. As Andy will discuss later, overall payments to MA plans will be about 4 percent higher than fee-for-service after accounting for our most recent estimate of coding practices by MA plans that result in higher risk scores. This is represented by the dotted line in red.

When we look at overall bids relative to fee-for-service, represented by the white line, we see a slight decline from 88 percent in 2020 to 87 percent in 2021.

Next we show how the level of fee-for-service spending in a plan's service area impacts its bid. As expected, plans bid lower relative to fee-for-service in areas where fee-for-service spending is high. However, even in the lowest spending areas, most MA plans bid below their local fee-for-service spending.

Let's look at the left-most column, circled in

yellow, which shows the bids for plans concentrated in the lowest spending quartile. We see that the median bid is 94 percent of fee-for-service. This means that for the third consecutive year, most plans concentrated in high benchmark counties are bidding below fee-for-service. However, the relative reduction of plan bids in these areas has not produced Medicare savings. For 2021, Medicare is still paying an average of 109 percent of fee-for-service spending in these areas. This is due to benchmarks in those areas averaging 116 percent of fee-for-service spending with quality bonuses.

Now I turn it over to Andy.

DR. JOHNSON: We're now going to turn to risk adjustment and coding intensity in Medicare Advantage. Your mailing materials explain how risk scores adjust payments to MA plans to account for health status of plan enrollees. Today we're going to focus on risk adjustment's biggest flaw: differences in diagnosis coding.

Given a significant financial incentive, MA plans document more diagnoses than providers in fee-for-service Medicare, leading to larger MA risk scores and greater Medicare spending when a beneficiary enrolls in MA. Our

analysis of 2019 data found that MA risk scores were about 9 percent higher than fee-for-service beneficiaries with comparable health status.

The Secretary is mandated by law to reduce MA risk scores to account for the impact of coding differences. The 2019 adjustment of 5.9 percent only partially offsets the full 9 percent impact. The remaining difference caused MA risk scores to be more than 3 percent higher and generated about $9 billion in payments to MA plans in excess of what Medicare would have spent for the same beneficiaries in fee-for-service Medicare.

This bar chart tracks the impact of coding intensity over time. The dark portion of each bar shows the mandatory minimum coding adjustment, and the green portion shows the excess payments to MA plans. Our analysis since 2007 shows that greater coding intensity inflates MA risk scores by about one percentage point per year relative to fee-for-service.

Two factors temporarily limited the divergence in MA and fee-for-service risk scores. The black arrows represent the implementation of new risk score model versions that were less susceptible to coding differences.

The gray arrows represent two years of faster fee-for-service risk score growth following the implementation of ICD-10 diagnosis codes. Since 2017, however, the prior trend of faster MA risk score growth has resumed. Over the next few years, we expect excess MA payments to increase as risk model changes are likely to exacerbate coding differences, but the minimum coding adjustment will remain at 5.9 percent.

Not only does the current coding adjustment fail to adjust for the full impact of coding intensity, the adjustment generates inequity across MA contracts. In this chart, the 2019 coding adjustment is shown by the red line. Each gray column shows one MA contract's coding intensity relative to fee-for-service. As you can see, coding intensity varies significantly across MA contracts. Because the coding adjustment reduces all MA risk scores by the same amount, contracts on the left with the dashed line are penalized by the adjustment, and contracts on the right are overpaid despite the adjustment.

In 2016, the Commission recommended a three-part approach that would make the coding intensity adjustment more equitable across MA contracts and would account for

the full effect of coding differences.

The Commission's strategy for addressing coding intensity focuses on the underlying causes. Health risk assessments are disproportionately used by MA plans, and the recommendation would remove them from risk adjustment. Using two years of diagnostic data would improve fee-for-service Medicare coding and reduce differences with MA coding.

Since this recommendation, the Office of Inspector General has quantified the impact of another underlying cause of coding intensity. Diagnoses identified in patient medical records through a chart review are not included in fee-for-service Medicare data, but chart reviews have become a common way for MA plans to boost risk scores.

For 2017, the OIG found that MA payments were inflated by $6.7 billion due to chart reviews and in a separate analysis by $2.7 billion due to health risk assessments. We compared these results to our estimate of coding intensity for 2017 and conclude that chart reviews and health risk assessments accounted for more than 60 percent of all MA coding intensity.

Eliminating chart reviews from risk adjustment would better align the fee-for-service and MA sources of diagnostic data used for risk scores and would be consistent with the Commission's strategy of addressing the underlying causes of coding intensity.

We now turn to a summary of quality in Medicare Advantage. Through Carlos' work over several years, the Commission has concluded that MA quality cannot be meaningfully assessed through the current system, and it should not be the basis for distributing bonus payments. Your mailing material cites prior Commission reports explaining the many flaws of the QBP, which include assessing quality for large contracts with dispersed enrollment, using too many measures, and not allowing beneficiaries to assess the quality within their local market.

Despite these issues, the MA quality bonus program now accounts for about $9 billion in annual bonus payments to MA plans. In the June 2020 report, the Commission recommended replacing the quality bonus program with an improve value incentive program that would focus on local markets, use a smaller number of measures, and

distribute plan finance rewards.

Before we conclude our summary of the MA program's status, we considered the impact of the coronavirus pandemic. The pandemic has had tragic effects on beneficiaries and the health care workforce and material effects on providers. As payers of medical services, the impact on MA plans has been very different from providers in fee-for-service Medicare. Reduced utilization in 2020 has resulted in lower plan medical expenses while plan revenues remain at normal levels. Plan payment rates are established prior to the start of the calendar year and are based on prior-year data.

Public plan sponsors report that relative to their revenues, medical expenses reached record lows in the second quarter and increased but remained lower than normal in the third quarter of 2020. Uncertainty about future expenses continues to be a concern, especially as infections and hospitalizations are rising yet again.

Early in the public health emergency, CMS allowed plans to make a mid-year change to their benefit packages, and many plans lowered premiums, further reduced cost sharing, and expanded telehealth benefits. We will

continue to track the impact of the pandemic on MA plans and enrollees.

To summarize, the MA plan is extremely robust. Enrollment continues to grow, plan offerings continue to increase, and for the fifth year in a row, extra benefits are at a historically level, now valued at about $1,700 annually per enrollee.

However, there are significant flaws in the payment system. The Commission has recommended changes to the coding intensity adjustment and the quality system, but the MA benchmark system remains flawed. Plans continue to demonstrate greater efficiency through declining bids, yet payments to plans rose one to two percentage points over the past year, in part due to the MA benchmark system. MA plans now cost the Medicare program 4 percent more than fee-for-service.

Now I'll turn it to Luis to discuss an alternative benchmark policy option to address these issues.

MR. SERNA: Over the course of multiple public meeting discussions, attributes of a benchmark alternative that Commissioners have generally favored are: one,

eliminating benchmark cliffs; two, bringing benchmarks closer to fee-for-service spending in the 115 percent and 107.5 percent quartiles; three, putting at least some additional pressure on some benchmarks in the 95 percent quartile; and, four, an immediate change in benchmarks that is not overly disruptive to basic supplemental coverage.

In October, we presented an alternative system for establishing benchmarks that conforms to these improvements and immediate replaces the current quartile structure. This system removes the quartile-based payments by blending local area and national fee-for-service spending. It achieves savings by applying a discount factor to benchmarks. We simulated benchmarks and payments for this alternative relative to current policy.

Building on Scott Harrison's work last year, we compared simulations with 2020 base benchmarks which do not include quality bonuses and are an estimated 103 percent of fee-for-service. A blended benchmark alternative would also include prior MedPAC recommendations which we have incorporated into our simulations where applicable. We simulate a blended benchmark with a 75 percent rebate. More detail in the underlying assumptions used for our

simulations can be found in your mailing material.

First we turn to the weighting of local and national fee-for-service spending. We focused on comparing current base benchmarks as seen by the gray line with pervasive peaks and valleys, with blended benchmarks under a 50/50 weighting structure. We also modeled other local and national weights, which are detailed in your mailing material. Overall, a 50/50 blend was the option that moved benchmarks in the lowest-spending areas much closer to fee-for-service while also applying some but not tremendous additional pressure on the highest-spending areas.

One related consideration is whether Medicare should set benchmarks in the lowest spending areas above fee-for-service spending in perpetuity or gradually decrease benchmarks closer to 100 percent of local fee-for-service in these areas.

Now we turn to the level of savings that the program should target through a discount rate. Without applying a discount rate, the program is unlikely to share in plan efficiencies and achieve savings. We simulated a discount rate of 0 percent compared with 2 percent. Lowering all blended benchmarks by 2 percent yields savings

of 2 percent. While a blended benchmark structure would remove the payment quartiles, we examined payments by quartile with fee-for-service spending to compare with current policy. As seen in the cells on the right-hand side, circled in yellow, a 2 percent discount rate helps ensure modest savings of 1 percent in the two highest quartile areas.

We also simulated plan availability under a 2 percent discount rate. Assuming no change in 2020 bids, which is likely conservative given that bid levels have since decreased, nearly all beneficiaries which continue to have an MA plan available with enough rebate dollars to cover 2020 levels of cost sharing. Even beneficiaries in the lowest-spending quartile would have access to an average of five different plan sponsors offering 12 plans that could provide 2020 levels of cost sharing.

During the October 2020 meeting, Commissioners generally favored the elements of a benchmark alternative that: one, uses a 50/50 blend of local area fee-for-service spending with standardized national fee-for-service spending; two, uses a rebate of at least 75 percent; three, integrates a discount rate of at least 2 percent; and,

four, applies prior MedPAC MA recommendations, including using geographic markets as payment areas.

Additional Commission feedback is required for two aspects of a benchmark alternative.

First, does an alternative benchmark structure warrant a phase-in? And if so, how long?

Second, in October, the majority of Commissioners expressed preference for additional financial pressure beyond 2 percent. How should additional financial pressure be applied over time?

In addition to the four elements that the Commission discussed in October, we welcome feedback on two additional elements of a benchmark alternative that is phased in over three years and gradually applies a benchmark ceiling of 100 percent of local fee-for-service spending.

For your discussion, we would like your reactions to the basic alternative benchmark structure. In particular, we are seeking guidance on the two open questions regarding a phase-in and additional financial pressure. The four elements from October and the additional two elements of a blended benchmark alternative

are listed here. If the Commission finds consensus on the elements of a benchmark alternative, we would return in March with a draft recommendation.

We look forward to your discussion, and now I turn it over to Mike.

[Pause.]

MS. MARJORIE GINSBURG: Can't hear you, Mike.

DR. CHERNEW: I am still going to start with Pat, but before I do I want to say what I said before, that Andy and Luis, that was terrific. I know Pat will have some important thoughts, so Pat, let's get right to it.

MS. WANG: No pressure there. Okay, thanks.

So it was a great chapter and a very comprehensive report. I just wanted to, on the background chapter, I guess just confirm a couple of things. So Slide 6, which talks about rebates reaching a historic high in 2021, includes the quality bonus?

MR. SERNA: Yes.

MS. WANG: Okay. Is it possible to know what percentage, or even from a dollar perspective, you think is being provide by the quality bonus?

MR. SERNA: We haven't simulated what rebates

would be without the quality bonus. It's possible for us to estimate that, though.

MS. WANG: Okay. Because as you point out in the deck, the prior MedPAC recommendation was to essentially eliminate the quality bonus, or at least eliminate it as an additional payment and instead have it self-funded from within the payment rates. I just note that.

On Slide 7, around the bids, I think that you just confirmed that the benchmarks, 108 percent as well as, I guess that this is payment relative to fee-for-service also includes the quality bonus. Just, you know, there's a lot of moving pieces to what you did, which was, you know, all appropriate. Just sometimes it's hard to disaggregate what we're really looking at.

The other thing that I also wanted to emphasize, I guess, to your point, the MedPAC estimate about payments being above fee-for-service, this may be true, and noted, Luis, that in the lowest fee-for-service areas, where the benchmark currently is well above the fee-for-service level, that could well produce that result. But I don't want it to like go past without noting that in the two highest fee-for-service spending areas the program has

gotten savings, by definition. It's 95 percent, and 100 percent is the benchmark level, which, as you point out, results in a lower than fee-for-service level payment.

So I just want to note that. It was in the paper also. There are plan types, like HMOs, there are payment quartiles that are saving the program money and producing, I think the program is hugely popular among beneficiaries, as shown by the growth in enrollment. But that, you know, there is a lot to parse underneath these overall figures.

So I guess before we talk about the benchmark section, on Slide 12, when you talked about coding intensity, I just wanted to note -- and I was in favor of the MedPAC recommendations around encounter submission, two years' worth, et cetera, et cetera, the peering of the application of the across-the-board cut in risk scores. I just want to note a thing here, that there's always going to be a difference between MA risk scores and the comparable fee-for-service, just because of the rules around coding. MA plans rely on diagnosis codes for risk scores. That is not the way providers code in order to get billed. The bill procedure codes, right?

And so this idea of chart review, which seems

like it's some kind of insidious trick, is really more about providers don't necessarily code diagnoses, because they don't require that to get paid. And so when plans are processing claims, the millions of claims that they process every year, that run through their systems, which drive the vast majority of their risk score, it's just whatever comes through on the claim. And it's sometimes over-coded, sometimes it's under-coded, because that's just not the way that providers bill.

The purpose of chart reviews, in the right sense, is, you know, you know that your member has a condition, and it has not come through. I'm going to make an extreme example. You know that your member has lost a limb. They had lost a limb last year. They were lacking a limb. Risk scores have to be confirmed every single year. And so when you see that, you will go into the chart to say, "I think the member still lost a limb. I want to confirm the risk score." That's kind of how chart review works. It's on a small proportion of members, generally speaking.

My only point here is that I think that the overall recommendations around risk scores are very, very sound, that MedPAC has made, but there's always going to be

a difference. I don't want people to think that if all these things get done that MA risk scores will match fee-for-service. I don't know what to do about it. I don't know whether, with the advent of ACOs it would be a good thing for fee-for-service providers to start coding diagnoses as a condition of getting paid. I'm not sure. But as long as there are two different sorts of coding systems that drive payment there is just going to be a gap, which is kind of weird.

Going to the benchmarks, so I guess I was not part of the coalescence that was described in the paper, that the Commissioners coalesced around this, because I'm really not quite there yet and I'll tell you what my concerns are, and some of these have to do with questions. I see that you, and I appreciated the sort of change in some of the descriptions of the proposal and the background for the proposal. I think that some of the explanations work better for me in the text.

There was also a change in what was being used as the national fee-for-service sort of per capital amount, a difference in the methodology, the idea being you take that, you blend it with the local, and this presents the

new sort of stream of benchmarks. I don't really understand what the formula was to develop that. I guess I have a curiosity about whether it differs from the current sort of national average fee-for-service estimate, which is called a USPCC.

The one thing that I was interested in, in the footnote description, was in the new approach that you guys took. You removed wage differences, geographic practice differences, some of the special payments, but you also removed DSH, and I am not sure that I ever heard that the USPCC removes DSH. Because these things, my understanding from the concept of using this national -- now this never gets adjusted. It's sort of like the stripped-down fee-for-service spending per capita. It never gets adjusted for wages. It never gets adjusted for geographic practice in the adjustments, and so forth.

But the DSH part confused me a little bit, because DSH is a component of hospital operating costs. It's part of the DRG. And I just was confused about taking that out completely, to sort of say this is the average spending. It get it for like the GME payments, because those are passed through. Plans don't pay those. But DSH,

plans do pay, and I don't really know why that wouldn't be included in an estimate of the average per capita spending.

And this gives rise, I guess, to part of my sensitivity or concern about the blending, because at a high level the numbers look very straightforward, but I suspect, and I am sure, that there's quite a lot of individual stories underneath that high level -- the payment gets cut by 3 percent, or the payment gets cut by 2 percent, or whatever it is. And part of the issue for me I can describe as related to this national average amount. You know, I think that depending on where you are, since today the way the benchmarks are set is there's the national average estimate. Then it's adjusted for things like local area wages and so forth and so on, and it does include DSH. It does reflect, or is set to emulate the local fee-for-service spending level, and then the benchmarks are set. That's my understanding, 95, 100, 107 1/2, 115, I guess.

Under this proposal, that kind of per capita amount never gets adjusted, and it gets blended with the local that will reflect all those things like wage index, local costs. And I guess DSH. And I don't want to overly

focus on DSH, but I just cite it to illustrate that local areas will have different characteristics of the delivery system and of the population. So what I'm calling the stripped-down national amount, I fear that in specific markets is going to be really way too low and have quite an impact on the plans that may serve residents of those areas.

I'm not going to pick on Brooklyn because he's sitting here, but if I look at the Bronx, for example, every hospital there gets huge DSH payments. So now only 50 percent of a plan's rate that is serving members in the Bronx is going to reflect those characteristics. So that's what makes me nervous, and if this was the approach I would ask you to kind of look at the DSH issue, in particular. I understand you're not putting local wages and so forth back in, but I'd ask you to look at the DSH issue. It makes me lean towards a blend that favors, or that weighs more heavily for local costs.

Now I realize that it doesn't produce the elegant result that your analysis did at 50/50, and I don't know what to do about that because there's so many things going on there that you guys did. But I think it's appropriate

to lean more heavily towards a blend which has more local costs and a smaller share of national costs.

In the paper, and I can't remember what page it was on, 32, you included this time a paragraph on the impact of SNPs, which I thought was terrific, because the other analysis apparently excludes SNPs, and I think that's really important. I would ask you whether you can give us a little bit more information on the analysis, what you found was under your 50/50 blend with a 2 percent discount, SNP bids would be 91 percent to 96 percent of the new benchmarks, the produced benchmarks. I wonder whether you could translate that into the way that you presented Slide 19, which is what that would mean in terms of payment differences between the current system and this updated system. Because I can tell you, 91 percent of the benchmark may sound like a lot, 96 percent may sound like a lot. It's really not. It's really tight.

You know, SNPs provide, in my opinion, extremely important benefits to their members who are lower income, and the extra benefits are of tremendous use to them. But before you even get to the transportation, the dental, the hearing aids, many MA SNPs use rebate dollars to buy down

the Part D LIS benchmark premium. And so I just want to throw that out there, because I know you've been sort of using cost-sharing reductions as kind of like the rule or the standard or the value to evaluate is there enough money, can the plan provide cost-sharing reductions? There are other things that SNPs do with rebate dollars, and I just want to put that out there, because 96 percent, getting 96 percent of benchmark is -- I don't know if that plan stays in existence. So more information about SNPs would be really helpful.

MR. SERNA: Pat, could I address a couple of these questions before I forget? So on the national blend, it is one national standardized amount, and from our perspective, it seems CMS would obviously have the leeway to apply local wages, so use that national standardized amount which is equivalent to kind of a national service use measure. And they could apply local wages to that national amount and include DSH in there, as you say.

I think the overall distribution of the benchmarks relative to local fee-for-service spending would be similar. It wouldn't be a completely smooth line, but it would be a little bit more jagged. But the results that

we presented would generally be the same overall, and by quartile. So that's definitely something that we could put in the paper, that CMS would have the option to do. So it's not as if you have to have one standard rate. But I think the bottom line is that the results would be quite similar.

DR. CHERNEW: Pat? We don't have that much time to go much longer, so I'm happy to have broader, other conversations.

MS. WANG: Let me just say one last thing about why I'm not part of the coalescence yet. MedPAC also has a proposal to remove the quality bonus, and so if you put those two proposals together, the new benchmarks would be self-funding the new quality program. And I realize that these came out in two separate chapters, but I don't think that I can think of them separately. I need to be thinking about -- and maybe that's something that we can discuss. But, you know, if this was written in one big chapter, you'd see a lot of cuts to the MA program. I mean, for an individual plan, when you put these together, you could be taking 8, 10 percent of the premiums they're getting today. So that's the other concern that I have, and I'll stop

there. Thank you so much.

MR. SERNA: I'll just also just quickly clarify that the simulations looking at benchmark and payment do include SNPs. We added the paragraph below plan availability, because, of course, when we talk about plan availability we talk about plans that are available to all beneficiaries. So we included SNPs separate there, but the simulations on payment of benchmarks do include SNPs.

MS. WANG: Got it. Thank you.

DR. CHERNEW: Thank you, Luis and Pat. Bruce, and then we will go to Marge.

DR. JOHNSON: Can I quickly respond to two of the earlier comments?

DR. CHERNEW: Sure, Andy. Go ahead.

DR. JOHNSON: I can send a little bit more information, but in our June 2020 report on the Quality Bonus Program and replacing it with the Value Incentive Program, we did discuss some of the impact on the sides of rebates, from eliminating the quality bonuses. And it gets somewhat complicated because it depends on how the plans bidding behavior changes. But overall the changes tended to be up to reductions that were similar to the increase in

overall rebates over the last year or two, and the last five years there has been an increase every single year. So it's still maybe going back a couple of years, but those would still be relatively high benchmarks.

And on the chart reviews, I think that a good point about the fact that payment accuracy requires coding at a level that is similar to the fee-for-service program, which is not perfect coding. And so I think the discussion in the chapter now reflects sort of the framework that says in order for payments to MA plans to be accurate it has to meet the standard, and it isn't a perfect coding standard, but that's what is necessary for accurate payments. Thank you.

MS. WANG: And I saw that and I thought that was a good discussion in the chapter. Thanks.

DR. CHERNEW: Okay. We are on to Bruce, and then we're going to go to Marge.

MR. PYENSON: Thank you. Overall, I support the package that's being presented, and I think it actually does a good job taken altogether of balancing the need for supporting the MA industry as part of the Medicare options, saving Medicare program money, and also putting pressure on

what might be characterized as the bad players in the industry, in almost the surgical way as we had discussed with hospice. I want to go through some of that. But I think the MA industry has been one of the success points of the Medicare program in attracting a lot of people to integrated care and integrated delivery in a variety of styles and fashions, and that's been a success over a number of years.

Ah, and let's not lose sight of that. But I think the material has identified some important issues that need to be fixed. And I think the framework we have presented does a good job of creating a platform that will fix it.

We spent a lot of time on risk adjustment just like in the past we spent a lot of time on Stars, and I think the bottom line that we've seen with risk adjustment is it is a lot easier for plans to optimize diagnosis coding than it is to actually manage care of patients, of individual people, patients, that interact with the complexity of their physicians and hospitals and providers and so forth. It's a lot easier and the rewards are a lot bigger of optimizing risk scores.

So moving to the two-year or maybe even three-year source for risk scores and other things along those lines really does a good job of taking away the incentive to manipulate that. So I like that as part of the package.

The slide on page 18 really convinced me that in this simulation that the 50/50, which wasn't my preference, actually does a good job of balancing the need to more closely represent the fee-for-service costs in the low-cost area but put pressure on the high-cost areas. I wonder if we could jump to Slide 18.

I'm not sure who's -- I guess we're having trouble moving the slides, but the point I'm making is that the high-cost areas, there's pressure put on the plans in the high-cost areas off to the right, and on the left there's not too much penalty going on in the low-cost areas.

As an actuary, my preference was to have a credibility scale so that the weights were more for fee-for-service in the low-cost areas and more for national average off to the right. But I think this does a good job of balancing and moves all of this in the right direction.

I would point out that the current situation with

rebates and supplemental benefits is actually, in my opinion, more a result of the effects of Medigap and supplemental coverage than the kinds of things we've been talking about here. So I believe MedPAC estimated something like 15 to 20 percent of Medicare spending is induced because of Medigap and supplemental insurance. I think that was work that maybe was done ten years ago or so.

That's a bigger issue than the kinds of changes we're talking about, but that induced utilization and that extra cost flows into the benchmark as part of the fee-for-service base, and, therefore, the benchmark for the base benefits of Medicare is inflated, which creates a higher premium payment to the plans that they can then use for supplemental benefits. So that's an issue that we're not addressing in the proposal but I think will have to be addressed at some point. But that I think helps put into perspective that the kind of changes we're talking about are actually relatively small compared to what it could be if we started to look at the induced utilization, fixing that.

I do want to say that the success of Medicare

Advantage is really stunning and isn't lost on the capital markets, and the growth of Medicare Advantage plans and the investment in them I think is also being expanded by the opportunity for the direct contracting entity, you know, the new ACO models that will allow Medicare Advantage plans to actually build ACOs off of their networks. So that's another opportunity for Medicare Advantage plans that, you know, in effect the MA program that we've been talking about has created a platform for.

So we're not -- there's a number of other -- my point is there's a number of other opportunities potentially for MA plans to do business and make money other than what we've been discussing.

One of the challenges that I do want to point out is the need to protect smaller MA plans and startups, and I think we haven't quite figured that out. Some of what we've talked about would help that by stabilizing the market, but I think that's an important issue because the market is rather consolidated, not as much as the Part D market, but that's an issue we want to be cognizant of.

But, overall, I think we have a good balance of the need to save Medicare money, maintain the success of

the Medicare Advantage plan, and a stable platform, a relatively simple platform to move off of. Hopefully next steps will include a move away from the annual bid cycle to a two-year or a three-year bid cycle, since the proposal will stabilize benchmarks.

So I think this is a great start to a new future for Medicare Advantage. Thank you all. Back to you, Mike.

DR. CHERNEW: Thanks, Bruce. I'm going to go to Marge, but I will just say for the record it is clear from the academic work and from the other work that has been done that Medicare Advantage plans can provide higher-quality care at a lower price than otherwise, and the challenge for this whole chapter is how to sort of promote that level of efficiency and do it in a sort of fiscally effective way.

So with that, Marge, we're going on to you.

MS. MARJORIE GINSBURG: Okay, good. Thank you. My remarks will be very short, and they're sort of at the 3,00-foot level. When I was new to the Commission about three years ago and I saw what we were paying for MAs versus Original Medicare, I asked Jay why we were paying so much, and he explained that the philosophy of the

Commission was that there should be parity in what MAs were paid compared to fee-for-service.

This chapter, my gosh, you guys really went out to pull all of our -- push all of our buttons here, because I read it almost as if you came this close to saying that that parity should no longer exist. That's how I read this chapter. And I just wanted to say I completely support the fact that there should not be parity, that what we, what taxpayers pay for MA plans should be less than what the government pays for fee-for-service. And this chapter's great. It's on its way to getting there. We've got to deal with the quality bonus issue. That will help us move it along. But I don't know -- I would be curious, and I guess I'm asking the staff, did you come as close to saying there shouldn't be parity as I read into this? Or was I just dreaming this?

My only other comment -- and it actually is very close to Bruce's, and that's the issue about the supplemental benefits. I have concerns about the supplemental benefits offered by MA plans, and I know this is going to be a topic for the future, so I won't say anything more now except to reinforce Bruce's comment about

it, that this is something that we may need to look at a little more closely.

But I would ask the staff to respond to my question. Did you come close to saying that parity should not exist, that our philosophy is that parity is no longer on the table?

Thank you.

DR. MATHEWS: So I'm going to take a run at answering that question. I wouldn't say we deliberately made a run at saying parity should not exist, but there is a subtle reorientation or potential reorientation of the philosophy here, which is similar to the financial pressure that we applied on fee-for-service providers by making relatively austere payment updates. The question that we started thinking about that led to this body of work was, given the fact that MA bids continue to decline relative to fee-for-service over time, indicating a level of efficiency, and given all of the other indicators that we're looking at are positive -- high levels of enrollment, high levels of extra benefits, high levels of plan availability -- should the Medicare program more directly apply fiscal pressure to this sector in a way that

generates financial benefits to the program and the beneficiaries and taxpayers that finance it? That's how I would answer your question. I've sidestepped answering it directly, if you missed that.

DR. CHERNEW: I'm new, so I wasn't part of any prior coalescing, but I'll give you my quick answer. I don't think it's a question of parity or not parity, although it is certainly true there's a tone that we shouldn't pay more for fee-for-service, particularly to a sector we think is more efficient than fee-for-service overall. But I think the way I think about this and many other payment areas is if there's an opportunity to spend less without giving up a lot in terms of what the beneficiaries are getting access to, we should look to see where we might be able to do that. And I think if you look through the analysis on the bids, for example, and the tone of the discussion, I think there's a belief that we're not necessarily trying to save money for saving money's sake. I think we're very, very cognizant of the valuable role that MA plans play in, for example, financing benefits particularly for disadvantaged populations, for example. But we believe that, given where the bids are and given the

efficiencies that we believe that in MA exist, we believe there's room to pay less without sacrificing a lot in terms of the benefits they're getting from MA, and that's sort of the spirit of this. And the question -- I heard you say this very loudly, Marge. Again, I can't see Bruce quite so well just because of the size, but his lighting is spectacular. I think Bruce also voiced the point that you believe that there is that kind of room, and I think Pat appropriately mentioned the benefits and the costs, and that's the needle we're trying to thread or the balance we're trying to strike.

But luckily I have a whole bunch of other Commissioners to make their comments on how well we're doing, and the first of those is going to be Brian, and Brian is going to be followed by Dana.

DR. DeBUSK: Thank you, Michael. First of all, I want to echo Bruce's comments in acknowledging that the MA program has been very, very successful. I think you can see from the tremendous growth in enrollment, even just in this last year, it's remarkable.

It does speak to the power of enrollment, and I hope we don't get away from that, because I do think that

part of what MA is teaching us is that enrollment and being able to do care coordination and move beneficiaries toward value is important, if not absolutely critical to moving where we want to go with payment reform.

I want to talk a little bit -- I do support the proposals overall. I think the blended 50/50 rate with the 2 percent cut is -- I think it works really well. The numbers look good. I want to comment, though, a little bit on the risk scoring. I would love to see us continue to increase our sophistication in being able to tease apart the good and bad actors here. I've really admired the work that the staff has done in the past with using matched cohorts and looking at how their scores change over time. I think there's some really good policy in there because I think it would give us the ability to tailor penalties or incentives for programs to code correctly -- not to undercode or overcode, but to code correctly.

So I do hope that we will continue to invest in more sophisticated methods. I also hope that we will explore options for fee-for-service beneficiaries to be coded more adequately as well. I think sometimes we look at just the overcoding -- or not over, the thorough-coding

in MA, and we ignore the fact that we need these fee-for-service beneficiaries coded properly if we're going to treat them. If we're going to do the care coordination and the value-based care that we want to move to in the fee-for-service platform, I think we're going to have to understand more about their underlying medical conditions and ensure that they, too, are properly coded.

I have a question for the staff. They don't have to address it today, but I would be curious to see how some of the changes in the telehealth benefits over the last couple of years could potentially impact risk scores. I know we don't like the health risk assessments. I know we're talking about chart reviews now. My concern is, as of a year or two ago, the MA telemedicine benefits could be added to the base package of MA anyway. And I'm wondering, with the right combination of waived cost sharing or other incentives for their enrollees to participate, I'm just wondering if the advantages gained by health risk assessments and by chart reviews could be recaptured through very simple telemedicine-based E&M visits.

The final thing -- and I want to also mention something that Bruce mentioned in my final comment, which

is I do hope we explore Medigap more. I think there's some real learning around how the balance between how much cost sharing induces volume versus at what point are you doing so much -- are you moving so much cost sharing to the beneficiary that it discourages participation. And I think there's some real learning in the $63 per month that MA is spending on average on cost-sharing reductions. You know, you contrast that to, say, a Medicare supplemental plan. Those plans can run up to $180, $186 a month.

So I really think that there's some learning here. There's a titration we can do in looking at what is the appropriate level of cost sharing, and I think that MA may be pointing the way for us to learn how better to address Medigap as well.

Thank you.

DR. SAFRAN: Michael, am I up?

DR. CHERNEW: Yes. I'm sorry, Dana. I was talking to you, but I was muted. I'm going to turn it to Dana; then I'm going to turn it to betty and then Amol.

DR. SAFRAN: Great. Thank you. So I think what I would start with is, you know, a couple of my colleagues have commented on how successful MA has been, and, you

know, as I reflected on these materials, I would struggle in some ways to characterize it that way, though maybe MA has been successful, but we have questionable success with how we've handled MA, because to have a program that has never had savings relative to fee-for-service and it's unclear whether the quality is better, partly because we have no ability to compare quality, does leave me wondering. And yet I am struck by the value that beneficiaries are getting in many ways, including from the extra benefits that they get. So there I think, you know, is something very important.

As almost an aside, but I do think it's worth mentioning, I did find myself struck by some of the content in this chapter that had us realizing that when those benefits are offered, beneficiaries really have no way to know how good the benefit is or not, the vision, the dental, et cetera. And maybe there's some opportunity for us to do similar work in those spaces, as has been done to kind of standardize Medigap plans so that beneficiaries could really know what they're getting when they're getting those extra benefits.

Another point that I haven't heard anyone mention

but that I'll mention is we never talk about the networks that MA plans contract. In my three years to date, I haven't heard us talk about that. And this is, you know, such a key part of how MA plans do their work, and are we completely blind to the contracted rates that MA plans have? And is that okay? I just throw that out as a question for us to consider.

Like Bruce -- I think it was Bruce who said this -- I had not been necessarily sold on the 50/50 until I read the chapter and also found some of the content there as well as the visual in the slide deck to move me more in that direction of comfort with the 50/50. I'll say prior to that I had really been leaning toward something that at least for the lower-cost areas would weigh more heavily to local payment rates.

But I've gotten myself comfortable with the 50/50.

I do feel, to the question that you asked on the slide about the gradual phase-in around a ceiling of 100 percent, I don't really have a particular comment on the time frame for that, but I absolutely feel that we should have a ceiling of 100 percent.

And then I think the last area of comments I had is around the coding differentials. And, you know, to me -- well, I have one and a half more comments. So on the coding differentials, it really got me thinking about our ACO program, right? And the ACO program also has the incentive to code beneficiaries as thoroughly as possible. And so if that is maybe getting up to 30 percent on the ACO program and 43 percent on the MA program, we might be getting to where we have fairly completely view of beneficiary case mix, and that would be a good thing.

But until that point, I did find myself wondering whether we should be comparing MA coding to ACO coding, and that really does bring me to my final point, which is that -- and I know I've said this in prior conversations, maybe as recently as the last meeting -- I still do not understand why we are holding MA and ACOs to different standards. We have so much criticism of the ACO program for not delivering savings, not delivering sufficient savings. Here we have a decades-old program that's never delivered savings.

So I find myself wanting us to really start to purposefully, every time we write about MA, comparing kind

of how we're thinking about benchmarking and everything else to how we're thinking about it on the ACO side, because fundamentally, these are both programs that are trying to manage cost and cost growth while getting better quality and outcomes. And so I would think we should really be trying to align the policies and structures we use to try to drive that, or be very deliberate where we're not aligning them. Thanks very much.

DR. CHERNEW: So, Dana, I agree with you completely, and, by the way, I'm a big fan of ACOs. So in case you think we talk about them like they're not successful, as I've said before I think they are, and again, like everything else, we can make them more successful.

There are differences. There's some flexibilities that plans have that ACOs don't regarding benefits, and that ACOs have that plans don't, because they don't have, for example, a capital requirement. But your basic point about being deliberate is one that I 100 percent endorse.

So we are going to carry on now. Betty, I think you're next, and then we're going to have Amol.

DR. RAMBUR: Okay. Thank you very much. I can be brief. So in reading this chapter, my first thought was how amazingly complicated our health care system is, and how just this one piece, how did it get to be this way? And so I'm still reading and taking it in.

I do strongly agree with the thought that we should be expecting MA to deliver savings, so I feel very strongly about that. And I support Dana's comment about the clarity on the extra benefits. So if people -- this program is growing, do people know what they are getting and its value to them, and do we understand it?

In reading the materials, I have become also more comfortable with the 50/50, with a 2 percent cut. And Pat, I heard your comments and I'm taking those under consideration. But my read of it, and the elegance of the presentation help me feel more comfortable.

And then finally, to go to Brian's comment about the cost-sharing and what we might learn, you know, I think we can learn something, but I guess that's maybe a separate conversation. But I do worry about moral hazard and the issue of incentivizing low-value care. So wherever that line is in incentivizing things that make a difference and

not those that don't.

So I will continue to study this, and I look forward to insights from other Commissioners.

DR. CHERNEW: Thank you, Betty. We are going to go to Amol, and after that will be Wayne.

DR. NAVATHE: Okay. Thank you. Great discussion so far. Fantastic job. This is very complicated and you guys did a great job in distilling it down to something that was digestible.

So I wanted to voice support for a few different things, I think generally support the recommendations, and I'll go through some of that in a little bit more detail. But, you know, I think it is worth echoing some of Dana's comments. You know, the MA program should save taxpayers money. There's a considerable amount of tools. There's been a considerable amount of time now and experience. And I think there are a lot of us who are big fans -- and I count myself in that camp -- of the Medicare Advantage program. I think it does amazing things and there is great flexibilities that are then afforded in benefits. At the end of the day, the taxpayer should also be seeing value from that, so I think that's important.

A couple other points. So on that point, relatedly, the supplemental benefits piece, you know, obviously I feel a little bit conflicted about this one, because I feel, in a very pragmatic way -- and, Michael, at one point you had said that we have to be careful about how we think about the future of bidding because we don't want supplemental benefits to go away -- I totally agree with that in the short- to mid-term. But I think as we look long-term, thinking about the way that we have benchmarks and bidding in this current structure as a way to "finance," quote/unquote, supplemental benefits, seems to me to be a very indirect way. If we really want supplemental benefits then let's have plans that offer supplemental benefits, and they could even bid based on those supplemental benefits. Or, I think economists in general would probably say that the current structure of getting supplemental benefits is perhaps inefficient, particularly inefficient for the government, for the taxpayer, and for the broader Medicare program.

So that being said, again, I think it is worth being pragmatic here, and the general approach to the Commission is taken and I'm very supportive of, given that

we probably need to make course corrections that cannot be that large.

I think that does mean that -- I think I've said this previously, but I support the broader work on Medicare Advantage going forward, to think about how we might re-imagine the way that benchmarks are determined, and so I support that work.

Another point that's related to the benchmark piece, so I think the reading materials do a very nice job of pointing out that as Medicare Advantage uptake rapidly increases, you could see, in certain areas, that there would be so much uptake that it may no longer be an appropriate comparator to look at MA versus fee-for-service beneficiaries.

And so I think that paradigm is actually really important to internalize, because that could happen in a number of smaller geographic areas pretty quickly, and that would threaten, to some extent, the whole validity of our current benchmark system. And that's sitting on top of some concerns that academic folks have already articulated around some favorable effects, in terms of the types of populations that are able to opt in to MA versus end up in

the fee-for-service world.

So I think if we take the long-term view here we should be thinking about a program design that doesn't have this core vulnerability, which is we want the MA program to grow, and if it does grow then it ends up undercutting our entire basis for how we finance the Medicare Advantage program with integrity for both the plans and for the taxpayers, going forward.

I agree with Dana's point, also, about aligning with ACOs. I recognize, Michael, you pointed out that there are differences between what we require of ACOs and the flexibilities that we give MA, and I think those are really important. But I think, philosophically, the way that we try to incentivize, to some extent, the standards that we at least are espousing and trying to achieve change, perhaps not levels but at least changes, those should be philosophically aligned, I think, across ACOs.

And to that point I think, for example, the idea of having a discount rate of at least 2 percent seems to create some alignment there with other APM programs that exist on the fee-for-service side, and I appreciated that. I thought that was a nice parallel, in addition to the

quantitative analysis that was done.

I'm supportive, in general, of a three-year phase-in. I would say I don't know that it needs to be three years. I think it could be shorter, perhaps, but I'm not opposed to three years, if that's what the Commission generally thinks.

I'm also in favor of the gradual benchmarks 100 percent of the local fee-for-service spending, as was discussed in the reading materials.

So before I close I wanted to just highlight a somewhat more minor issue, which is in the status report document there is a Figure 5, I think, on page 41, which I found to be confusing, at best, and I wanted to submit to you, Luis and Andy, if you might consider just removing that. It has to do with encounter data and the way that encounter data is used in coding, and basically because of the incomplete way in which encounter data is kind of mixed in there, I think actually it does more harm than good, personally, so I wanted to just mention that to you guys.

So to recap, I'm just very supportive of this entire line of work, including the recommendations at this point, or suggestions at this point, and hope to see this

work go forward. Thanks.

DR. CHERNEW: Thanks, Amol. So we can go to Wayne and then Jonathan Jaffery. Wayne? Can you hear me? Wayne?

DR. RILEY: Can you hear me?

DR. CHERNEW: Yes, now I can hear you. Yes, I can hear you, Wayne.

DR. RILEY: So great discussion --

DR. CHERNEW: And then we'll go to Jonathan.

DR. RILEY: Okay. Great. Sorry about that. Great discussion on the Medicare Advantage. Obviously it's something, as a new Commissioner, I've learned a lot about listening to all of you and the reading, the excellent work, the staff work.

One of the things that has surprised me about Medicare Advantage, and Amol just alluded to it, and anecdotally I've noticed it in some of my own family members who opted into Medicare Advantage, is the velocity of enrollment growth, year over year. And I may have missed this, but, Jim or the staff members, has there been any projections over 10 years of the likely growth of it, growth of enrollees?

DR. MATHEWS: Luis, Andy?

DR. CHERNEW: Can you hear me?

DR. MATHEWS: Yeah. I do not have anything at the top of my head on projections. Luis or Andy, do CBO or OACT have anything we can draw on?

MR. SERNA: So OACT's projections tend to be more on the conservative side, at least, which is understandable. It's been a while since I've seen CBO projections. There have been outside groups that have projected that within five years MA enrollment will be over 50 percent of all Medicare, if that's any indicator.

DR. RILEY: Yeah.

DR. CHERNEW: Go ahead, Andy. Okay. We're having a hard time now. Can people hear me?

DR. RILEY: Yes.

DR. CHERNEW: Okay. So I was going to say, Wayne, although predictions are important, take them with a grain of salt. After the Affordable Care Act, when MA rates were actually touched quite a bit in a variety of ways, the projections were that the program would collapse. And now we're talking about a straight success. In fact, there's evidence that when the benchmarks went down the

plans also went down, although not dollar for dollar. So the plans have been quite good at performing. I don't know exactly where the -- Andy, you may want to add -- where the forecasts are going, but the recent trends have suggested that the MA plans are quite able to be resilient and successful, and we've seen that in the enrollment. Just some nuances there with the stars program and other things. But we can get into that part later.

Andy, do you want to add anything?

DR. JOHNSON: I don't have anything to add, no.

DR. CHERNEW: All right. Back to you, Wayne.

DR. RILEY: No, that was my final --

DR. CHERNEW: Okay. Wayne, I'm having a hard time hearing you. Yeah, it's either me or you, Wayne, but I'm having a hard time hearing you. So the next in the queue is Jonathan, and if you have something you can go to me in the chat. But I can't hear you quite well.

DR. JAFFERY: Yeah, and Wayne was going in and out for me too, so I suspect it's on his end.

So I'll try and be brief. I think perhaps, not surprisingly, the comments that Dana made about, what do we call it, parity, trying to parity with ACOs really

encapsulated my thoughts. And Michael, the comments you made to add on, that talked about some of the different tools that MA plans have that ACOs don't, and some of those differences that we want to think about, that really captures how I'm feeling about this. I think we really want to make sure that we are able to compare those two things and think about that kind of parity.

One specific comment I'll make, thinking about risk adjustment, I think there are some opportunities to start to compare how MA plans have used risk adjustment, and ACOs are, but we need to think about that and be careful, because not all the ACO programs, over time, have had the ability to use risk adjustment. MSSP, traditionally, the original MSSP programs did not, and even the ones that do have a limit, a percent limit, that MA doesn't, and it's not the same way.

So there's an opportunity there but they're not necessarily completely apples to apples. But I think as we go forward, when we're talking about ACO programs and MA programs, we do want to kind of bring in these various comparisons whenever we can.

Specific to the discussion questions, I do also

support both of these things. I think gradually getting to a ceiling of 100 percent of local fee-for-service spending I think is a good idea, and, in general, I do favor phase-insurance for this and different ways to do it, a three-year phase-in or a multi-year phase-in. But I'm supportive of that overall.

And so thanks very much.

DR. CHERNEW: Great. Thank you very much, Jonathan. I think now it's going to be Jaewon and then Karen.

DR. RYU: Yeah. Thanks, Mike. I think I'm generally in favor. I would call it cautiously coalescing, maybe. I think on the coding intensity pieces, whether it's the chart review or the health risk assessment, I think those are reasonable things to look at.

On the benchmark alternative, the 50/50 blend and the discount of 2 percent, I think there are a couple of elements of that that give me some pause. I think the first is on Slide 19. It seems like the most disruptive counties, or the counties that have beneficiaries that potentially would be most disruptive would be those who are already in the lowest quartiles of fee-for-service

spending. And, you know, whether or not you believe that there should be supplemental benefits and how rich they should be within Medicare Advantage, I think it feels like, out of notions of equitable, or equity, I should say, it seems like it should fairly evenly be disrupted, if you will, and to have the lowest quartile spending areas be the areas where beneficiaries are least likely to have as rich of benefits, or put it differently, where they're more likely to have their supplemental benefits disrupted, I think that feels -- there's something about that that feels off.

And maybe it's also tied to the second point that gives me a little pause, and that's 100 percent caps. Similar concept, similar hesitation there. Obviously, if you're starting from a lower spending point it's tougher to generate savings in that environment, and I think that would mean that those folks are less likely to have access to those supplemental, enriched benefits, which doesn't quite feel like the right outcome either.

I'm not sure I have a solution for it, which I why ultimately I think it's as reasonable as maybe a solution gets, because I do agree, the MA program should

generate savings relative to fee-for-service, but those two elements feel a little off to me still.

DR. CHERNEW: Jaewon, thank you. I will just pick up on one thing you alluded to, and then we're going to go on to Karen. But there is an issue that I wanted to emphasize about what I would call, broadly speaking, geographic equity, to some extent. In areas that are very efficient, in general, in fee-for-service, their beneficiaries, or, therefore, it's harder to say, their beneficiaries are afforded some amount of rebate by the way we have structured it now. And even though the high-spending areas are getting less, relative to fee-for-service, it's really, as the one chart shows, flattening out a little bit, seeing this geographically.

We can discuss the numbers -- you saw the picture -- but I think if I were in a highly low-spending fee-for-service area I would argue why give all the benefits to the places that are much more inefficient, where the MA plans can save a lot more? And that is one of the things that we are trying to balance, some sense of -- I don't want to use the words "geographic equity," although I guess I just did. So it's late in the day and I'll deny it later. I guess I

can't because it's recorded.

Nevertheless, I think the point you raise about that and the cap is something we are worried about, and we will continue to do that type of analysis when we come back in March and look at this. But thank you for your comments, and I think they pick up on that theme.

So it's going to be Karen and then Sue Thompson.

DR. DeSALVO: Super. Thank you.

Maybe just shape this in kind of three broad areas, the first of which is that not only does the Commission want to see beneficiaries linked to an accountable entity who is at risk financially for their care but also has some longitudinal relationship to support preventative care and really have some accountability for overall health, and MA purportedly or theoretically should offer that.

It seems like we think that it does. It seems that beneficiaries are really interested in the program, and so the more we can do to make sure we understand what are the true benefits, not just only financially, but what are the other services and offerings that are part of the Medicare Advantage program or ways of working or system-

ness, opportunities for coordination and collaboration that are programmatic lessons that we could learn not only to begin to expect more broadly of the Medicare Advantage program, but perhaps if we're going to still have other types of the Medicare program.

I think what I'm trying to say is health is more than an office visit or a hospitalization, and there's a lot of wrap-around things that Medicare Advantage programs seem to be offering, more than gyms, Marge, that are attracting folks to those programs. And I think it's worthy of trying to understand it and, where appropriate, support it.

The second is about equity. It's come up in some of the Commissioners' comments. I think equity is a principle here. It reflects not just geographic equity but also thinking about vulnerable beneficiaries, low income, beneficiaries of color, beneficiaries that are dually eligible because maybe they have severe mental illness.

Pat speaks eloquently about some of these concerns, and one of them is structural. And it relates to the deep relationship that some of the smaller regional MA plans have with networks of providers and social care

organizations that can really address the needs of some of these highly vulnerable populations.

I know the staff is working on balancing policy that won't drive consolidation and will really create some opportunities, though, for us to have programmatic savings. I just want to underscore that Pat's deep thinking and advice on this is worth us heeding because I know, from having practiced on the front lines, more than anything, that not all health plans necessarily are created equal when you really get down to especially vulnerable populations.

The third thing has also come up, but I want to underscore it, which is that we just got to be able to make accurate comparators. I still don't fully understand, as we're thinking about spend, how we're risk adjusting. I raised this the last time we had an MA chapter. I just want to make sure that I understand if we're comparing apples to apples, as Jonathan said, that I don't think that we can really compare MA to ACOs because, for example, they're not prospectively accountable for the same population. They're not held to the same responsibility with the beneficiaries.

On the other hand, I do think that we need to expect some transparency from the Medicare Advantage program so we have the data to really understand and assess quality and make comparators in the way that the Commission has been working and the staff on trying to create aligned quality programs so we can begin to get a glimpse of that, but just the quality outcomes is a piece of it. I think we have to understand if we're comparing spend similarly and if the structures and expectations and accountability of, say, an MA or an ACO are sufficiently aligned so that we can really make a comparison.

Thank you.

DR. CHERNEW: Thank you, Karen.

So for Sue and then to Larry.

MS. THOMPSON: Thank you, Michael, and to the staff who prepared this chapter, great work.

I'm going to be pretty brief. I just want to call out several things I've heard that may be are a bit tangential to this chapter but that I think are really important. First and foremost, Pat, your comments were outstanding, and I especially created your comment on the sort of sense on coding and risk scoring, that there was

something askew going on in terms of the work of MA looking to do this sort of retrospective chart review to pull out the diagnoses. I appreciate that sentiment, and I think it's important because, somehow, I think every time we get into this discussion about coding risk scoring -- and maybe it's just me, but I feel like there's this inference. There's something not appropriate going on, and if that's true, then I think we need to call it out and understand it and name it. So I just really appreciate that comment that if that's an issue, then let's name it, let's get after it and understand it.

On the impact of MedSup or the Medigap plans and the impact they have on utilization, again, tangential to this discussion about MA, but in the context of the full Medicare program, I think that's another question that is intriguing and one that I think important.

Then last but not least, Dana, your comments on holding MA accountable similar to ACOs in expectation of cost savings, a number of folks have underscored that comment. Jonathan, you did a great job. I think, again, calling out Dana's comments here, I just want to add to the chorus of that particular sentiment.

We tend to talk about MA in the MA box and fee-for-service in the fee-for-service box, but as we take the Medicare program and work to move to value, there's a transformation going on here. And there's such opportunity to connect so many dots outside of just a box of MA, and certainly, MA is complicated enough. But I think the opportunity here to reconcile it somewhat with ACOs, understanding there are differences, but then the opportunity that it's coming out with our direct contracting entities and the role that the MA plans can play in creating a new platform or a new segue for ACOs to reconcile and move into direct contracting with the federal government, there's enormous transformation opportunities here. I just think it's important we connect all these dots in these discussions.

Thank you.

DR. CHERNEW: Sue, thank you very much. I agree there is so much going on. It's almost overwhelming, and harmony is ultimately going to be a goal.

Larry and then David Grabowski.

DR. CASALINO: Thanks, Michael.

Well, first of all, although I feel enormously

ignorant compared to Pat, at this point, I do agree with the recommendations, and I think a three-year phase-in is too long, at least for the bigger plans. But, in general, I agree with the recommendation.

My second point is for quite a bit of this hour and a half, more than an hour and a half now, we've referred to the MA program as successful, and I was glad to hear Dana and somebody before that too kind of question the meaning of the word "success."

If you look back for a moment, yeah, the industry has grown remarkably. It's popular, but this is a quote from page 34 of our written materials: Over a 35-year history, the many iterations of full-risk contract with private plans have never, never yielded aggregate savings for the Medicare program. Never, not once, not in any year.

If any ACO program had been around for 35 years and hadn't once generated savings, I can't even begin to imagine what people would be saying, and yet because of the financial success of the Medicare Advantage, not surprising success for every year for 35 years, we've paid plans way more than we would have paid for fee-for-service, to me,

that's not that successful from the point of view of Medicare or the country.

I think the evidence on quality is quite equivocal at best, and in fact, in the report, the staff said several times we really can't compare quality in Medicare Advantage versus fee-for-service.

So I think we need to step back a little bit and think about how we can actually save some money for Medicare and for the country through Medicare Advantage and not go more years after these 35 losing money instead of saving money with MA.

The last thing I'll say is just to repeat what I said in a different context earlier. I think any recommendation we make, we want to think about what could be the unintended consequences and particularly the unintended consequences on consolidation.

I think we had quite a bit of discussion about this after Pat's reaction to MA recommendations or MA discussion last year. I think we do want to think twice before we make recommendations that would pretty clearly lead to further consolidation and further domination by the largest plans and the loss of some or all of the small

regional plans which, as Karen said, can have some real advantages.

Right now, you can count on one hand the nationally dominant plans in Medicare Advantage. With overpayment year after year, they've gained enormous political and economic power in the biggest industry in the United States, and I don't know if we want to reinforce that.

I don't know how many people noticed. If you look on the very last page of the report and you look at the lawsuits about basically upcoding -- and not appropriate upcoding but, at least as alleged by the government, fraudulent upcoding -- it's like a roster of big names in Medicare Advantage plans. So I do think we want to try to avoid things that will kill small regional plans and lead to further consolidation of the dominant entities.

DR. CHERNEW: Larry, thanks tons.

David, you're up, and then we have Jon Perlin.

DR. GRABOWSKI: Great. Thanks. I'll be brief. I have a very short comment and then a question for Andy and Luis.

My comment, I support this package of reforms. I really like the way this is coming together, so great work, and I look forward to seeing where this goes.

My question, as Dana suggested earlier, it's really hard to know what we're getting in terms of quality here relative to original Medicare without better quality data. The MA encounter data have such potential in this regard. They could really be a game changer of sorts. However, it was noted in the chapter, these data are incomplete and not yet ready for prime time.

So, Andy and Luis, I know we've talked about this issue before, but I felt it was worth pushing you a little bit on an update. Do you feel that adequate steps are being taken at CMS to ensure that accurate and completely encounter data are being generated? Are we keeping with the expected timeline that we discussed in prior years? I just would love to hear any thoughts you have in this regard.

Thanks.

DR. JOHNSON: So, as you know, we have a recommendation from a couple years ago about applying a withhold for encounter data -- well, first -- sorry --

establishing some benchmarks for what encounter data completeness looks like and then establishing a withhold for plans that don't meet those thresholds.

As far as I can tell, I think the system of collecting encounter data is in the same situation it was the last time we talked, which is that there's incremental improvements year over year but still not quite to the level of where we would be able to use the encounter data to assess total numbers of utilization for a given service type and compare that to fee-for-service with confidence.

DR. GRABOWSKI: Mike, if I could just quickly follow up on that. I wonder if we want to revisit this, continue to sort of beat this drum. I don't know what else can be done here, but I really think it's important that we continue to push on this. I don't know. Maybe there's not much else to be done in the short term, but I feel like this is so important.

I don't know, Andy or Luis or Jim or others, if there are thoughts here.

Thanks.

DR. CHERNEW: Okay. We'll follow up on that. Certainly, I think I speak for the researcher in me and

maybe the researcher in you. Having better encounter data sure would be nice for a bunch of reasons, not just policy. We'd be able to answer a lot of better questions. So I'm completely supportive.

Jon Perlin and then Paul. Jon?

DR. PERLIN: Well, thanks. Let me thank the staff for a particularly illuminating chapter and my colleagues for a particularly illuminating discussion.

You know, earlier, Mike, you said that the challenge of MedPAC is that we have a bludgeon, not a scalpel. And because I think about this issue, you know, we want to have appropriate pay in high-cost areas and for high-cost patients and not overpay in lower-cost areas and lower-cost patients. The problem is the average, is that it's likely to be unfair at the extremes.

My colleagues have mentioned -- let me first talk a point about quality comparison, that we don't have the quality data, and when we just agreed categorically with the need for that. But, you know, it's hard to compare on the basis of cost unless you calibrate those cost comparisons for what you're getting.

On the one hand, you know, when we look at fee-

for-service, I don't think we're looking at a fully loaded cost, and admittedly, Medicare has remarkably low administrative overhead. I believe it's 2 percent, but even if it's 1 percent, that would make it roughly, quote, "comparable."

And, you know, second, I've heard the philosophical misgivings about induction through Medigap, but putting that aside, there are a series of additional benefits. And it makes me wonder whether the actual comparison isn't the slate of benefits of Medicare fee-for-service plus Medigap.

Operating in the other direction is that one of the things that attracts us to MA, attract us to ACOs is the coordination, and, my goodness, I think any of us who are clinicians, frankly, family members have seen what happens from the lack of coordination in human terms. But I fully understand that there is a financial cost to lack of coordination, and so I think we need to be more complete in terms of telling what the puts and takes are in terms of comparing the cost.

Confounding this is obviously the risk adjustment model, and I support the multiyear. Mike, I get your

point. I appreciate Brian's comment on whether you have a telehealth E&M coding call. I wondered about that last time, given the costs overall, whether to do something like that, or, my goodness, as we now have mandated electronic records, whether we can't, in fact, infer risk based on electronic records of patients.

All that said, blending the national rate seems to be an appropriate way to achieve generally the desired effects, and I do have one caution, which is that the conjunction of changes to the risk assessment model and the new payment scheme could change access in the form that we don't want, which is cherry-picking patients with lower risk. The other alternative is that we could actually induce more stinting on services because of pressure there.

So I overall would agree with the general direction here, but I think there are some general cautions that we have to attend to as we iterate going forward.

Thanks.

DR. CHERNEW: Jon, thank you. That was very useful.

And, Paul?

DR. PAUL GINSBURG: Oh, thanks, Mike.

First, I also believe the work was just outstanding that got us here, and I'm very supportive of it in general.

I want to make some comments on a few points. One is on savings. I was engaged somewhat, involved somewhat of the discussions that launched the original -- I guess it was competitive medical plans, whatever they called it, predecessor of Medicare Advantage. And it was clearly a plan that there would be savings, and that the savings would be shared, 75 percent to the beneficiaries, 25 percent to the trust funds, which actually sounds very much like the 75 percent rebates.

Many of my colleagues have mentioned that it's never been achieved. I think there is some reason it's never been achieved because as this has always generated -- I think in recent years always generated savings. It's just that the beneficiaries got some and the trust funds never got any of it. So, in a sense, it makes it politically difficult to threaten the savings that the beneficiaries have achieved.

We need to think long term about savings. Let's not worry too much about what we're going to ask, 2 percent

discount now, 3 percent discount. The key thing is that the plans have done very well when pressured to do their job better, and this is what happened with the ACA cuts. The plans actually made some excellent changes. MA became a better program as the result of those cuts, and in a sense, there were more savings to capture. So if we start out with 2 or 3 percent, given a few years, there may be more savings to take a piece of.

I'm not as concerned as Pat is about when the Commission has come up with multiple ideas to save money in MAs, such as the quality bonuses, benchmarks, et cetera. I don't think we need to concern -- and we've come up with these ideas over a number of years. I don't think we have to worry that Congress is going to, all of a sudden, decide, "Oh, let's do them all at once." Congress isn't like that. They are very strong on phase-ins. Some of our ideas, they may like; others, they won't like. So I think that's their problem rather than our need to hold back if we have a lot of good ideas, because if you add them all on top of one another, it wouldn't be feasible on an implementation basis.

I'm really glad that Bruce brought up the issue

about Medigap and its huge budgetary impacts. I want to remind people -- and this, we talked about before -- it's also a major barrier to alternative payments if we're talking about engaging beneficiaries, which I think in the long term, we really want to do.

I'm really glad that Amol brought up this issue of the vulnerability of the benchmarks in areas where the share of the MA in the market is very large. We are getting there very quickly and the projection of 50 percent nationally in 5 years, which would imply much higher percentages in many local areas. So I think this has to be an issue that the Commission starts working on because I don't think we can continue this benchmark system, even refined, that much longer without leading to more dire consequences.

I think that it's been a great discussion.

DR. CHERNEW: Wow. Not only was it a wonderful day substantively, Paul ended exactly on time, which hopefully will end up being a hallmark of the next few years when I am the Chair.

So I am going to say nothing else to keep us on time and just say thank you, thank you, thank you for all

of your time, everybody, and thank you for the public for listening. I should have said at the beginning, I will now say now, there's many ways to reach out to us if you're listening to this. You can contact the staff. You can send messages. You can go to the website. We very much do want to hear from the public. This is a public meeting, and we do regret not being able to be there in person.

So, again, thank you for all those who have listened. Thank you to the Commissioners for an outstanding if not somewhat long day, and we will start again bright and early tomorrow. So I'm signing off exactly on time.

Jim, do you want to say anything besides goodbye?

DR. MATHEWS: Nope.

DR. CHERNEW: Thanks, everybody.

[Whereupon, at 5:46 p.m., the meeting recessed, to reconvene at 9:30 a.m., on Friday, December 4, 2020.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

VIA GoToWebinar

Friday, December 4, 2020
9:32 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
PAUL GINSBURG, PhD, Vice Chair
LAWRENCE P. CASALINO, MD, PhD
BRIAN DeBUSK, PhD
KAREN B. DeSALVO, MD, MPH, Msc
MARJORIE E. GINSBURG, BSN, MPH
DAVID GRABOWSKI, PhD
JONATHAN B. JAFFERY, MD, MS, MMM
AMOL S. NAVATHE, MD, PhD
JONATHAN PERLIN, MD, PhD, MSHA
BRUCE PYENSON, FSA, MAAA
BETTY RAMBUR, PhD, RN, FAAN
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AGENDA PAGE

P R O C E E D I N G S

[9:32 a.m.]

DR. CHERNEW: Welcome, everybody, to the Friday session of our December meeting. We're going to continue our discussion of payment adequacy for a range of different services. We're about to start on SNFs. I hope to say this at the end, but should I forget, I will say it now. There are many ways that you can interact with MedPAC and give your comments for this public meeting. You can go to the website. You can contact the staff or any other mechanism like that. We do very much want to hear from the public and regret not being able to see you all in person.

With that, I want to jump right into it because we have a lot of material to cover and the time is tight, so, Carol, I'm going to turn it over to you to talk about payment adequacy for skilled nursing facilities. Carol.

* DR. CARTER: Good morning, everyone.

The audience can download a PDF version of these slides in the handout section of the control panel on the right hand of the screen.

And before I start, I wanted to thank Bhayva Sukhavasi and Carolyn San Soucie for their help with this

chapter.

This presentation will assess the adequacy of Medicare's payments for skilled nursing facilities, or SNFs.

As you've seen in the other presentations, we'll review four categories of indicators listed on the slide and conclude with the Chair's draft recommendation regarding the update to base payment rates for fiscal year 2022.

A key difference from prior years is the coronavirus public health emergency, which has had tragic effects on beneficiaries' health and health care workers and material effects on providers.

As in past years, to recommend payment updates for the upcoming year, we start with indicators of payment adequacy based on the most recent and complete data, which this year is 2019. And when possible, we then consider preliminary, newer data from 2020 and evaluate the current law and expected changes in the environment for 2020, 2021, and 2022 to develop the Chair's draft update recommendation for 2022.

Given the larger environmental and policy changes

this year, we will continue to closely monitor these changes and whether those effects are likely to be temporary or permanent.

To the extent the coronavirus effects are temporary or vary significantly across providers, they are best addressed through targeted temporary funding policies rather than a permanent change to all providers' payment rates in 2022 and in future years.

Let's start with an overview of the industry in 2019.

There were about 15,000 providers, most of which also provide long-term-care services.

About 1.5 million beneficiaries, or about 4 percent of fee-for-service beneficiaries, used SNF services.

Program spending totaled almost $28 billion.

Medicare makes up a small share of most nursing homes' volume and revenue -- about 9 percent of days and about 16 percent of revenues.

Access to SNF services is adequate. Supply was stable at about 15,000. Eighty-eight percent of beneficiaries lived in counties with at least three SNFs.

Between 2018 and 2019, covered admissions per thousand fee-for-service beneficiaries declined 4.8 percent. SNF stays were shorter, so total days declined 5.4 percent. These trends are consistent with the growing presence of alternative payment models that encourage shorter stays or avoiding the setting altogether, and with decreased hospital use.

In 2019, occupancy rates were down slightly from 2018, but remained high, at 85 percent.

The marginal profit, a measure of whether providers have an incentive to treat Medicare beneficiaries, was high, about 20 percent, another positive indicator of patient access.

Turning to quality measures, this year we've shifted to reporting measures that are uniform across the post-acute care settings. We most recently discussed these in October during the SNF value-based purchasing session. The discharge measure counts the rate of discharges to the community without a hospitalization or death in the next 30 days, and higher is better. The hospitalization measure counts unplanned hospitalizations and observation stays during the stay, and lower rates are better. Both measures

are risk adjusted and use a higher minimum count of stays than previously reported measures to ensure that they are reliable.

You can see that both measures show small improvement from 2015. On the left, the rates of successful discharge increased, and on the right, the hospitalization rates decreased.

This year we have dropped measures of provider-reported functional improvement in our assessment of quality. We realize that maintaining and improving functional status is a key outcome of post-acute care but are sufficiently concerned about the integrity of this information that we are not sure it is a good indicator of provider performance.

Because the vast majority of SNFs are also nursing homes, we assess the adequacy of capital for nursing homes.

Merger and acquisition activity slowed in 2020 during the public health emergency but is started to rebound, with capital reported to be widely available in many markets. The activity reflects several trends that are noted on the slide. HUD is a key lender, and its

financing increased substantially in 2020.

The total margins in this setting are low (0.6 percent), and this reflects the low payments from other payers, notably Medicaid. The low total margin is not an indicator of the adequacy of Medicare's payments Medicare is a preferred payer. Capital is expected to remain adequate in 2021. Demographics and SNFs' lower cost relative to other institutional post-acute care favor the setting, and government financing is seen as relatively stable.

In 2019, the average margin for freestanding facilities was 11.3 percent, and this was the 20th consecutive year that the average was above 10 percent. These margins illustrate why Medicare is a preferred payer.

Across facilities, margins varied substantially. One-quarter of SNFs had margins of negative 0.9 percent or lower, and one-quarter had margins of at least 21.3 percent. There continued to be more than a 10-percentage-point difference in Medicare margins between nonprofit and for-profit facilities.

Variations in Medicare margins reflect several factors including differences in economies of scale.

Nonprofit facilities are typically smaller and have higher costs per day. Also, for the past several years, nonprofits have had higher cost growth compared with for-profit facilities. In addition, high-margin providers have a greater share of their cases assigned to the highest rehabilitation case-mix groups, which are the most profitable case-mix groups. With the new case-mix system, we expect the differences across providers to shift.

As required by law, we consider the costs associated with efficient providers. Efficient providers are those that perform relatively well on both cost and quality measures, and the measures we use in this analysis are: standardized cost per case, rates of successful discharge to the community, and hospitalization rates. In 2019, 9 percent of the SNFs included in the analysis were relatively efficient.

Compared to other SNFs, relatively efficient providers had community discharge rates that were 15 percent higher and hospitalization rates that were 21 percent lower. Their standardized costs were 7 percent lower than other SNFs, and their payments were 6 percent higher, in part reflecting their higher share of the most

intensive therapy case-mix days. The combination of lower costs and higher revenues per day resulted in a median Medicare margin of 19.2 percent, another indication that Medicare's payments are too high relative to the costs to treat beneficiaries.

We also look at the average payments per day that some MA plans pay for SNF care. In three publicly traded companies that own SNFs, fee-for-service payments per day averaged 24 percent higher than average MA payments per day. A survey of over 1,500 SNFs conducted by the National Investment Center for Senior Housing and Care found a similar difference: 22 percent.

Our analysis of the characteristics of MA and fee-for-service users found that differences between the two groups would not explain the differences in payments.

The publicly traded PAC companies with SNF holdings report seeking managed care business, suggesting that the lower MA per day payments are attractive.

SNFs have been especially hard hit by the coronavirus, with their staffs and residents bearing the emotional and health tolls of the pandemic. Weekly case counts and deaths continue to increase, and while supplies

and testing are more available and surge pricing has abated, SNFs continue to face challenging conditions.

Facilities benefitted from the provider relief funds and the other federal programs that included almost $10 billion targeted to nursing facilities. We estimated that these funds helped offset lost revenue and increased costs for between 8 and 10 months.

The overall occupancy rates remain about 10 percentage points below their pre-COVID levels and remain in the low 70 percent range. We expect volume to be slow to recover in 2021. The pandemic's effects continue to evolve, and we are monitoring its effects on nursing homes.

Turning to Medicare, the declines in Medicare volume were tempered by the temporary waiver of the prior hospital stay requirement. Costs increased in 2020 as a result of higher costs for cleaning, personal protective equipment, and COVID-19 testing. Payments increased due to the elimination of the sequester. And unrelated to the pandemic, the new case-mix system increased payments relative to payments in 2019, and because it does a better job considering the clinical conditions of patients, it is better able to capture the complexity of COVID-19 patients.

Combining 2019 data with the policy and environmental changes, we project SNF margins to decrease in 2021 but to remain high, at about 10 percent. This estimate is based on many assumptions that we outline in the paper regarding costs for PPE, testing, and cleaning, lower volume, and the effects of the new case-mix system that began in fiscal year 2020. Larger changes from those we estimated would raise or lower the projection.

We expect margins to decrease because volume is expected to decline and the per case costs will increase.

Facilities will incur higher cost per day due to PPE, testing, and cleaning supplies. Some of these costs have been offset by the relief funds this year, but some costs are going to be long-lasting.

Higher per day costs may also stem from fewer cases over which to distribute the fixed costs.

The new case-mix system and the update will increase payments but not enough to offset the effects of volume and higher cost per case.

In summary, our indicators are generally positive. Beneficiaries' appear to have access to services. SNFs made small improvements in the two quality

measures, and they appear to have access to capital, and this is expected to continue. The low total margins reflect low payments from other payers, not the adequacy of Medicare's payments.

Medicare margins remain high, and the margin for the efficient provider is even higher -- both indicating that Medicare's payments are too high relative to the cost of care. And the Medicare margin is expected to remain high in 2021.

In considering how payments should change for 2021, the summary indicators are positive. Even with increased costs associated with the coronavirus that we expect to become part of SNFs' operations, the projected margin is expected to remain high.

While Medicare's payments are more than adequate, nursing homes may need additional financial support in 2021. An update to Medicare's per day payments in fiscal year 2022 would be a poor approach because assistance would not begin until October 2021 and funds would not be targeted to facilities in need. Instead, additional financial support should be separate from the annual update and targeted to facilities that have been especially

affected by the coronavirus.

This brings us to the Chair's draft recommendation. It reads: For fiscal year 2022, the Congress should eliminate the 2021 update to the Medicare base payment rates for skilled nursing facilities.

The high level of Medicare payments indicates a reduction to payments is needed to more closely align aggregate payments to aggregate costs. However, the effects of the coronavirus and the impacts of the case-mix system are uncertain. Therefore, the Commission will proceed cautiously in recommending reductions to payments. A zero update would begin to align payments with costs while still exerting some pressure on providers to keep their cost growth low.

In terms of implications, spending would be lower relative to current law. The current law update is projected to be 2.3 percent. Given the high level of Medicare's payments, providers should continue to be willing and able to treat Medicare beneficiaries.

And with that, I'll turn things back to Mike.

DR. CHERNEW: Carol, thank you so much, and it goes without saying that this is such a hard factor to deal

with for a range of reasons, and the COVID pandemic really weighs heavily on our mind in a range of ways in this setting. But I will save my comments and turn it over to start with Brian, and then we're going to go to David.

DR. DeBUSK: Well, first of all, thank you for a great presentation, Carol, and I do support the recommendation. I think it's very consistent with our thinking in prior years that we shouldn't be subsidizing other payers through abnormally high Medicare payments.

Carol, if you could take us back to Chart 12, this is where I had a question. Please, page 12 of the presentation?

MS. KELLEY: Hang on, Brian. We'll get there.

DR. DeBUSK: Oh, sorry. Thank you.

You know, this is consistent -- you know, a Medicare margin of around 10 to 11 percent and with an efficient provider margin around 20 percent is consistent with prior years. But I'm having a little bit of trouble reconciling that because if the PBPM resulted in 7 percent higher average daily payments but that was in the face of a 2.3 percent update, it looks like there ought to be about 5.3 percent in there that we can't -- that should -- these

margins should be higher in our projection, I would think.

Could you walk me through some of that and help me reconcile it, please?

DR. CARTER: Yes. So when I was projecting the revenues for 2021, what I did was I took the updates, and then I added the additional payments for the new case-mix system, but I also considered the reductions in volume. So that, you know, would raise the revenues and then lower them based on revenue.

And then on the cost side, as outlined in the paper, I increased the costs for testing and PPE and cleaning, and that does offset some of the increase in the revenues there.

And I did assume a cost growth of about 2 percent, and here's -- I don't have the numbers on what the fixed and variable cost split is in this setting. I assumed a 2 percent increase. That might be about right or not. We've noticed in prior years, when volume goes down, costs are pretty sticky, and they don't go down. They just have smaller increases. And so the reductions in volume, because, I guess -- I mean, the fixed cost gets spread over fewer cases, so we don't see reductions in, say, employment

or what the BLS statistics during the years where we see reductions in service, and you don't see -- you see some declines, but not commensurate with the declines in service use.

DR. DeBUSK: Almost an inexplicable amount of fixed cost, huh?

DR. CARTER: Well, you know, I think the staffing is pretty lean, and they're not flexing in the same way that hospitals can flex. So you'll see some flexibility on the therapy side. There are much lower drug and device costs than you would have, say, in hospitals that can flex based on volume. You don't have that in this setting. So I think that the cost reduction is stickier here than maybe we're used to seeing in other settings.

DR. DeBUSK: And I guess our recommendation -- and, Michael, this may be a question for you. Our recommendation doesn't take into account the possibility that CMS may do an across-the-board adjustment as a result of the PBPM. Correct?

DR. CARTER: So I could speak to that just a second. In the final rule this year, CMS noted that because of the pandemic, [inaudible] didn’t feel like it had good

information for making that adjustment.

And just reading tea leaves, if this public health emergency is not clearly in our rearview mirror, it's going to face the same situation this coming year, where it may have indications that revenues are running high. But because of the effects of the COVID, it may again feel like the data are going to be hard to interpret.

I know from my own work, I've wanted to look at how the new case-mix system is working, and except for the first couple of months, the data are so -- you know, it's going to have the combined effect of COVID and the new case-mix system, and those are going to be hard to tease apart.

DR. DeBUSK: Okay. Thank you.

DR. CARTER: Yep.

DR. CHERNEW: Jon Perlin, did you want to jump in before David?

DR. PERLIN: It was just a quick clarifying question, if I might.

On page 11 -- Carol, thanks for a great presentation -- increased infections, increased mortality volume dropped 10 percent, in trying to get at the last

thread on the relationship of cost to volume, fixed cost, do we expect that capacity to come back, or in fact, is that capacity that's being reserved to isolate patients for resilience against COVID?

My sense is that even though there's potential capacity, the singles rather than doubles, et cetera, and all of the other maneuvers are done to be more resilient, and so I'm not sure that their fixed costs are going to change for the next couple of years. I'd appreciate your thoughts on that. Thanks.

DR. CARTER: Yeah. I mean, that was one of the things also I struggled with is this year may not look like next year, and the need for isolation may be lower.

Right now, I think you're right. There is the need for setting up single rooms. Some SNFs have multiple occupancy, not just doubles, and so the virus has really required facilities to isolate in a way that maybe other providers haven't had to deal with. But I don't know what that's really going to look like next year.

That's part of the difficulty in this exercise is trying to imagine what next year is going to look like not what this year is looking like.

DR. PERLIN: Right. Well, I think it's hard to imagine that they're going to robustly go back to double or multiple occupancy quickly, and just parenthetically, you know, one indication is the difficulty in placing patients with post-acute needs, which is the sort of signal we attend to. But, structurally, they would appear to be constrained for a period of time.

This is one of those vexing areas where I agree entirely with the underlying philosophy of separating the durable policy supports from those things that we certainly hope to be transient, but there's an interplay that may change the basic assumptions about the fixed cost of operation.

Thanks.

DR. CHERNEW: So, yeah, actually two things. The first thing is, Jon, I'm trying to avoid a Round 1, Round 2. We simply don't have the time to go through that. So if you want to say more, now is probably the time.

The second thing is this issue about how to deal with the durable versus non-durable effects of the pandemic is admittedly a challenge. We are shooting here for 2022. I'm not sure how to do it. At the end of the day, the most

important feedback is where we are on the number that's sort of in front of us and how it should be shaded one way or another. That's kind of the question.

The good news is that a lot of people that now want to jump in. So were you done, Jon?

[No response.]

DR. CHERNEW: Okay. So, Paul, you wanted to say something right about this, and then I promised I will get to David. And then I'm going to get to Larry. I'm working very hard on a complicated set of requests.

DR. PAUL GINSBURG: I just wanted to reinforce how challenging it is to project what 2022 is going to be like because when you think of the isolation, you know, isn't it likely that many or most residents of nursing homes will be vaccinated by January, this coming January? So it might be very different environments in the nursing home area.

DR. CHERNEW: Yeah. So let me say this recommendation could have been more negative, if you will, if we weren't worried about some of these particular things that were going on. I don't think there's any magic way to know what the right recommendation is.

Paul, again, I'm not sure I'm going to get back to you. So do you want to say something more about that? I'm going to go on to David, then Larry.

DR. PAUL GINSBURG: No, I'm fine with that issue.

DR. CHERNEW: Okay. David, then Larry.

DR. GRABOWSKI: Great. Thank you, Mike, and, Carol, thank you, as always, for this great, great work.

First, I just want to recognize what a challenging period this has been for skilled nursing facilities. It's obviously been hard for their residents but also for the staff. We hard yesterday about the heroism of physicians and nurses, and that's very much deserved. But I also wanted to add all those certified nurse aides or CNAs that work at nursing homes, many of whom make close to minimum wage. They're doing the bulk of the direct care needs in these buildings, and they've had a high death rate themselves during the pandemic. So we very much need to thank them and recognize the incredible work they're doing.

I'm very supportive of the Chair's recommendation. This is a really hard one, given where the sector is today and trying to forecast out where it's going

to be in the coming years. So I really appreciate the cautious approach that Carol mentioned.

I just wanted to highlight two issues quickly. The first, we've known this for a long time. SNF payment has been broken, and I think the pandemic highlighted just how much. Medicare pays double-digit margins for short-stay care, but Medicaid is paying basically a negative margin for the majority of the long-stay residents. And that just doesn't work.

Once elective surgery stopped and Medicare admissions fell at nursing homes, at SNFs, the bottom fell out in terms of their finances.

So I think, longer term, we really need to think about -- obviously, we can't control Medicaid, but Carol has had that great textbox every year in this chapter. Carol, it came through this year in that every year we've highlighted just how broken it is, and this year, unfortunately, the pandemic really showed that.

The second point I wanted to make really gets to what John Perlin and others were pushing on, and that's really what happens to this sector going forward. I think for me, thinking about does volume actually come back in

2021 and 2022, or is this kind of a longer-run phenomenon? Will the marginal patient go to a skilled nursing facility, leaving a hospital, or will he or she opt for home health?

We know our beneficiaries have always preferred to be in the home. I think at the margin, we're going to see some shifting there. So really thinking about what volume looks like going out to 2021 and 2022 and going forward, even in the post-pandemic, I think it's going to be challenging to model exactly what volume looks like.

We're going to see -- and I think Carol highlighted this in the chapter. We're going to see some closures. We may even see some consolidation among SNFs.

It's hard to make a recommendation, but I do think we want to keep our eyes on this sector. I'm supportive of the Chair's recommendation, but a lot is going to change, I think, with skills nursing facilities in the next one to three years.

Thanks.

DR. CHERNEW: David, thank you very much.

Larry and then Sue Thompson.

DR. CASALINO: So, yeah. I'd just like to add to what David said and Karen yesterday. It's not only nurse's

aides, physicians, and nurses, but it's also the people who clean the rooms and the people who bring the food into the rooms, who are taking public transportation, risking their lives if they are to get to work and then further risk within the SNFs. They don't get called out much, but they are as heroic as anybody else.

I also support the recommendation, although I would like to hear what other Commissioners have to say. I have one quick point and one question. The quick point is in the discussion of SNFs, because they've been hit so hard, we seem to be sliding a little bit into thinking about, well, should a recommendation take into account the pandemic when we're already especially saying that we're not doing that and the pandemic should be dealt with separately, so I just point that out.

My question is for Carol. Carol, 85 percent, I think, occupancy is the figure you put out, and that sounds like there's plenty of room for access, but I think anecdotally, as Jonathan mentioned, it's not necessarily so easy to get access, especially to the more desirable SNFs.

With the admissions, discharge, and the other kind of thing, 85 percent certainly in an acute hospital

setting, it doesn't actually leave that much slack.

But, again, this is an area I don't know that much about. Did you have any comment on that?

DR. CARTER: Well, right now, the occupancy rates are running about 10 points below that. So they're in the low 70s, but you're right. And we've talked about this in prior years, and I'll make sure the chapter emphasizes this. You could be in a market where there isn't a bed available, because occupancy rates vary by market, and they certainly vary by facility. My guess, although I haven't looked at this recently, is that higher-quality homes have higher occupancy, and so it's going to be tougher to get into them.

So you're right. Even with mid-70s occupancy, that doesn't mean every facility is going to have capacity.

DR. CASALINO: I'm done. Thanks, Carol.

DR. CHERNEW: Larry, thank you.

Sue Thompson and then Betty.

MS. THOMPSON: Thank you, Michael.

I too want to extend my support for these recommendations and add to the chorus of recognition of the work done by individuals who have been the family extenders

to the individuals who live in skilled and long-term care facilities during this pandemic, just a word on behalf of the beneficiary themselves and the isolation that has been very much a part of their lives for the last many months.

You know, the tone of our voice here this morning, again, it's much like we started yesterday, just filling this enormous tension of wanting to do so much and yet being very much disciplined about keeping our eye on the horizon. But I think of all of our continuum of health care, of the folks that have been the families. The extended families to these beneficiaries need enormous recognition and our support.

But I do support these recommendations.

I have one more thing I do want to say, and that's to Carol and all the great work you have led in the post-acute setting, Carol, and this must be an especially difficult time for you. So I want to say thank you. It's been a pleasure to listen to your leadership here throughout the many years, thank you, Carol.

DR. CARTER: Thank you.

DR. CHERNEW: Sue, that was very well said. I echo all those sentiments, and just as an aside, I think

many people here on the Commission are dealing with related personal issues. So I think this is really heartfelt sentiments.

I will add, just in response to something Larry had said, that this is one area where we're spending a lot of time worrying about the durable effects of the pandemic, which we are actually trying to deal with in various types of -- it's this issue of what is the world going to look like ongoing. We're having a hard time sorting through in this particular case, which is complicated because of the reason that David said about the interplay between the role of Medicare and Medicaid, which has been vexing us since my first time on the Commission. It makes it just really, well, in some sense, a lose-sleep kind of discussion.

But apart from my little therapy concerns, we'll go to Betty and then, I think, Marge.

DR. RAMBUR: Thank you so much, and thank you to the staff. And I also echo the sentiments that were given for the workforce.

I support the recommendations completely, and I have a few thoughts or questions that are really sort of in the parking lot and not particularly conceptually elegant,

but I'll share them, nevertheless.

When we think about the future, of course, we're thinking about vaccines, but I'm also thinking about what is called the "long haulers," the people that have ongoing, relatively serious, perplexing conditions and how might that impact the need for these services, and we don't know that yet.

I was very interested to look at the rural-urban piece, and as I was reading this material, I was particularly thinking of frontier counties of less than six individuals per square mile. It was sort of interesting to see that the lowest and highest median occupancy is in states with substantial amount of frontier counties, Montana and Alaska. So it was very interesting. So, obviously, that's not a monolithic group, nor would we expect it to be, but I think it's a population that needs attention.

I don't know how to do this, but I would also like us to continue to think about how we accelerate those small improvements in quality to moderate or substantial, and I don't have strategies for that.

Then, finally, as it's stated in the materials,

the pandemic lifted the three-day requirement for hospitalization as has next-generation ACOs, which is my understanding. Perhaps it's just me, but I've never really understood the requirement for the three days' hospitalization. So I'm absolutely certain it's intending to address a challenge or a problem or an unintended consequence, but is it the right strategy, given that we're trying to have less payment silos? Because, obviously, payment silos create treatment silos.

So thank you so much for this important work.

DR. CHERNEW: Carol, do you want to say something about the three-day rule that I think had to do with the moving of people from nursing homes and hospitals and back and the payment implications of that very quickly? And then we'll go on to Marge.

DR. CARTER: Yeah. Just very quickly, that has been in statute since the beginning of the program, and it was trying to target Medicare-covered services for the post-hospital-stay patients. And so Medicare clearly does not cover long-term care, and this was sort of one way of ensuring that was to bolt it, if you will, to a prior hospital stay.

DR. CHERNEW: So we're going to go on to Marge and then Amol.

MS. MARJORIE GINSBURG: Wonderful report, and I really appreciate the work that's gone into this.

Actually, one comment about the last reference to the three-hospital stay. That really does sound antiquate now with so much ambulatory care surgery and other things that are done. I know we don't want to take it up just now, but in terms of reducing unnecessary costs, I'd love to dig our teeth into the three-hospital stay in the future.

My one comment about this and my one concern about the recommendations is I notice a tremendous difference between for-profit and not-for-profit profit margins, and I know this is typical. It seems like this is true in every domain that we look at, but it seems particularly stark here. And I always worry when we are targeting our recommendations towards the for-profit because that really does seem to be what we're doing, and whether these recommendations will sort of be the final effort or the final step towards nonprofits closing.

I wonder, Carol, whether we have any information

about SNFs that have closed. Are they predominantly nonprofit? I know we don't target our recommendations for nonprofit or profit. I spent my whole life in the nonprofit industry. So I'm very much attuned to that.

But I wonder if we have any other information about whether nonprofits are more inclined to be the ones that are closing than for-profit.

DR. CARTER: I can look into that and get back to you. Okay, I don't have that information right in front of me.

MS. MARJORIE GINSBURG: Okay. Thank you.

DR. CHERNEW: All right. We're going to go on to Amol and then Pat.

DR. NAVATHE: Thanks, Michael. I'll be brief. I will say that I will echo a lot of the comments the Commissioners have made today. I think this is an incredibly complex issue. Carol, I appreciate the way that you've laid this out and your leadership in this space, for sure, that recognizes the complexities COVID has obviously hit very hard here.

I agree with the approach of trying to sort of maintain a little bit of discipline around separating out

the COVID impacts, recognizing that there is a complex interplay here nonetheless.

I support the Chairman's recommendation and look forward to that additional work that we've been doing on the value-based purchasing side of PAC payments and the like that I think will be necessary going forward. But again, I support the Chairman's recommendation. Thanks.

DR. CHERNEW: Thank you, Amol. We're going to go to Pat and then Wayne.

MS. WANG: Okay, thanks, and I would simply echo again the other Commissioners. Hats off to folks who have worked in nursing homes and are still working in nursing homes throughout all of this. I think it's just been -- I mean, we feel that way about every frontline health care worker and facility, but nursing homes have been under-resourced, under-prioritized for PPE. The mortality rate, I think it's just been a terrible, terrible time for folks who staff the SNFs, and my hat is off to them with a lot of gratitude, and they're still going through it.

I support the recommendation. This is one of those things where you have to kind of use the information that you have to try to leap forward into, you know, a

period of time where certainly the reality that we think is going to exist is going to be different.

The thing that I wanted to raise, though, and maybe this is the third rail and we just can't do anything about it, but, you know, every sector is different and has its peculiarities. The thing about SNF and nursing homes that we know is true is that they are payer mix is so binary. So the issue, Michael, that you alluded to, you know, the issue of Medicaid underpayments and the fact that Medicare is floating the boat. You know, it's 16 percent of revenue overall, and it's the only reason that there might be a break-even, or slightly positive margin.

You know, I feel like it's a very blunt instrument to try to kind of just have these blinders on, and say I'm just kind of trying to make sure that Medicare payment for Medicare beneficiaries is adequate, because as Carol pointed out in the paper, you can overshoot because places that have more Medicare and seek that business are going to have much higher profit margins, and those that have a smaller share of Medicare, because of the community they serve or what have you, are going to be struggling. It's just never going to be enough. At what point does

this issue become an access to care for Medicare beneficiaries if sort of higher Medicaid share nursing homes can't make it because the Medicare portion is not big enough?

I mean, Carol, you alluded to, in your paper, that this should -- and I agree -- be a separate topic of conversation that policymakers should tackle. I just ask whether it's something that we think that we should tiptoe into, or at least write about or observe, in terms of the profit margins of SNFs, for example, according to their payer mix and what happens. And it might suggest that policymakers take a look at whether something can be done for the high Medicaid share nursing homes, whose Medicare beneficiaries are at risk because they don't have enough of them to maybe provide the same level of services as a place that has a high share of Medicare.

It's the elephant in the room and it's such a huge reality that this tiny sliver of business for a nursing home is kind of, you know, pulling the entire train for everybody who's getting care there.

DR. CHERNEW: So I'm really sensitive to this issue and I think these comments suggest that I need to be

-- we need to be a little more aggressive. I'm not sure how to be more aggressive. I'll say two things, none of which I want anyone to take particularly seriously, although at least now while I'm using I do mean them.

One of them is I understand that our goal is to make payment recommendations for Medicare. I wouldn't be opposed if we said something strongly about what Medicaid should do, recognizing that we are not MACPAC. The other thing, of course, is we can talk to MACPAC more directly and see how this plays out. I think states and states budgets have their own set of pressures that is not really in our purview of doing analysis. And just as I think MACPAC should focus on the MACPAC issues, I think we should focus on the Medicare issues. But this is one where the interplay, as we all point out, is really, really strong, and it does affect the beneficiaries who we care about.

So I think I'll go back and we'll put on the agenda, and I'll talk with Jim and Carol about strategizing about how to deal with this issue.

But for now, given our time, we have about 15 minutes left, I want to go to Wayne and then Bruce.

DR. RILEY: Thank you. Great discussion, and I

too join with all the other Commissioners to express our profound gratitude to the staff of nursing homes over the last nine months, who have really been at the front lines of this pandemic. As many others have pointed out, these are black and brown fellow citizens of many of our communities, they are woefully underpaid, and they have really been hammered by this. So again, my heart and my kudos go out to all who have worked so valiantly in nursing homes.

I'm supportive of the Chairman's recommendation. I do agree that knowing the guardrails that Michael just mentioned, in terms of the interface between Medicaid and Medicare with regard to nursing homes, I think this is something that we can contribute to the dialogue about this by looking at that interface in some way, Mr. Chairman, that doesn't wander off from our responsibilities to Medicare, et cetera.

So I'm supportive and I want to thank Carol for her great leadership in this. This is terrific work.

DR. CHERNEW: Terrific. So we're going to go to Bruce and then Jonathan.

MR. PYENSON: Yeah. Thank you, Carol. I also

support the Chair's recommendations and echo the sentiments of the fellow Commissioners.

I wanted to suggest that in future work that the Commission could look at not just nursing homes but assisted living facilities, which, of course, are outside of Medicare payment policy, except that Part D treats people in assisted living facilities differently than in nursing homes, than in the community. And in the tragedy of COVID, about half of the deaths are in nursing homes or assisted living facilities, so the issues appear to be similar, even though Medicare is not directly paying.

So as we think about the characteristics of the patients and their socioeconomic circumstances and how they go about their lives, I think a view of assisted living as well as nursing homes may make sense. Thank you.

DR. CHERNEW: Great. So now we have Jonathan and Dana.

DR. JAFFERY: Great. Thanks, Michael, and thanks, Carol. This is a great report and a great discussion, and I too echo fellow Commissioners' comments. I'm supportive of the Chair's recommendation. I'm also glad that you brought up the three-day waiver. I think

that is something that we should think about in the future. There's also the observation stays at the hospital that make it sometimes even a bigger challenge, and I think this kind of builds on some of the discussion we were having yesterday about hospice and how we have a long-term care problem in this country and how we finance that. I appreciate what the waiver's intent was but there may be some better policy ways to approach that over time.

One other comment I wanted to make, I'm following on David's comment of some of the long-term trends that we should think about, particularly in light of COVID and the public health emergency. We're already seeing some trends towards having more care for people in the home as opposed to nursing homes and SNFs. There are a lot of reasons for that. Some of the value-based care work we're promoting has helped facilitate that. Beneficiaries tend to want that and families want that.

I think the other thing that we're going to see now, in addition to an increase in beneficiaries wanting to do that because of inherent reasons and because of the risk of infection, but we're also seeing health systems increasingly build their capacity and skills in caring for

people in the home pretty quickly. And given CMS's recent waiver opportunity around acute hospital and home programs, it's going to help systems have more of those capabilities. So there could be some long-term consequences, potentially, to that sector as well.

Thanks for the opportunity to comment.

DR. CHERNEW: Great. So we're going to do Dana, Karen, and Jaewon, I now see you. Before I wasn't seeing you but now I can see your smiling face. So great. Dana, then Karen.

DR. SAFRAN: Thanks, Michael. I am in full support of the draft recommendation here and, you know, like my colleagues really just want to commend to you, Carol, for ongoing thoughtful, important work in this area and across the whole long-term care spectrum. And, you know, I also recognize the gravity of the situation, both for the residents, the staff, and the institutions themselves.

That said, you know, I think one of the things that I found most striking about the content here was, I believe it was 20 sequential years with margins at 10 percent or higher, and that really does tell us something.

And as we said yesterday and today, our job isn't to address, through our payment policy recommendations, the impact of COVID. Those need to be dealt with through targeted relief. And so all of the uncertainty and trepidation that we all express notwithstanding, I think the right thing for us to do is what's reflected here in the draft recommendation. So I fully support that. Thank you.

DR. CHERNEW: Dana, thank you. Karen and then Jaewon.

DR. DeSALVO: Thank you, Mike. Honestly, I would just say plus one to what Dana said, and I want to just thank all of the workers on the front lines, but acknowledge that their special COVID relief is a way to address the COVID situation, and I think that the Chairman's draft recommendation makes a lot of sense. I think it is the -- Carol, just as everyone has said, you've done an amazing job of navigating a difficult space and helping us think about a rational approach to payment.

I do hope that we'll continue to think of ways that we can not only improve quality overall but close the gap where there may be some significant differential, and I

think Pat's comments about understanding what some of the impact is on the high Medicaid facilities is really critically important, and I do hope we will have a chance to work with MACPAC on this, not only in this sector but in some other sectors going forward. Thank you.

DR. CHERNEW: Great. And Jaewon.

DR. RYU: Yeah, I agree as well. Consider me another plus one. I think the COVID impact, and the durability of the impact, I do believe there's some durability here, which remains to be unseen, or unknown. So there's some uncertainty there, but I think what was most compelling for me was Slide 7, where Medicare is actually one of the preferred payers, if not the preferred payer, in this space. And I think that's atypical for most of the other sectors, and given that the recommendation makes sense.

DR. CHERNEW: Terrific. So I really appreciate all the time and work here, and I think it's clear, both the enormous concern we have for not only the beneficiaries that rely on this but also the workers that are working at this, either employed by them or otherwise going into SNFs. And I think this has just been an unbelievably challenging

time for them, and we are very aware of that. It's really frustrating how it interplays with other types of policy issues that we will continue to think through.

But again, I appreciate all your time, and I think what we should do now is move on to our next section, which is going to be home health. So I think I'm going to turn it over to Evan.

* MR. CHRISTMAN: Good morning. Next we will review home health. Before I begin I just want to note that the slides for this presentation are available on the control panel on the right-hand side.

As an overview, this presentation will cover the basics of the benefit, the current issues the Commission has identified, and the bulk of it will review the payment adequacy framework and present the draft recommendation.

As an overview, Medicare spent $17.8 billion on home health services in 2019. There were over 11,300 agencies, and the program provided about 6.1 million episodes to 3.3 million beneficiaries. And home health accounts for about 4 percent of fee-for-service expenditures in 2018.

As in prior years, MedPAC assesses the adequacy

of fee-for-service Medicare payments with our four categories of payment adequacy indicators, and this is a similar framework to what you have seen in other settings.

In terms of the payment system the Commission has noted two problems. The first issue is the high level of payments. Medicare has overpaid for home health since the PPS was established. The fact that home health can be a high-value service does not justify the excessive overpayments. As discussed in the paper, Medicare margins have averaged better than 16 percent in the 2001 to 2018 period. These overpayments do not benefit the beneficiary or the taxpayer. And for many years the Commission has recommended payment reductions to address these overpayments.

The second issue we have noted was an incentive in the payment system. Prior to 2020, the PPS used the number of therapy visits provided in an episode as a payment factor. Payments increased as more therapy visits were provided. This trend, and the fact that more profitable agencies tended to favor therapy episodes, raised concerns that financial incentives of the payment system may be influencing the type of care provided, and

the Commission recommended the removal of therapy as a payment factor in 2011.

In 2018, the Bipartisan Budget Act mandated the elimination of therapy as an adjustor, and this change went into effect at the beginning of 2020. The Bipartisan Budget Act also required a new 30-day unit of payment for home health, and CMS also implemented a new case mix system and payment adjusters in January of this year.

These are the most significant changes to the PPS since it was implemented in 2000. These changes are intended to be budget neutral but will redistribute payments among providers. Estimates of the redistribution have some uncertainty because agencies have a history of changing coding and operational practices when the PPS is altered. But based on current patterns, CMS expects that non-profit, facility-based, and rural agencies will see an increase, and for-profit, freestanding and urban agencies will see a decline.

Next we turn to access and supply. As in previous years, the access to home health appears to be very good. Eighty-six percent of beneficiaries live in a ZIP code served by five or more home health agencies.

Ninety-nine percent live in a ZIP code served by at least one home health agency.

Turning to supply, the number of agencies was over 11,300 by the end of 2019. There was a slight decline of about 1.7 percent in 2019, relative to the prior year, and supply has been slowly trending down since 2013. However, in 2002 to 2013, the number of agencies increased by over 80 percent.

The recent decline is concentrated in a few areas, such as Texas, Florida, and Michigan, and have been the targets of efforts to reduce fraud. These areas also experienced rapid growth in prior years, and we do not expect these declines to affect access significantly.

Turning to volume, episode volume has been declining since 2011. On a per capita basis, the number of episodes per beneficiary in 2019 is 13.7 percent lower than the 2011 level, indicating that volume has declined even after accounting for changes in fee-for-service enrollment.

The recent decline has been concentrated in five states -- Florida, Louisiana, Illinois, Texas, and Tennessee -- that experienced the most growth prior to 2011. Many of these states also experienced a decline in

the supply of agencies I mentioned on the prior slide.

And home health agencies reported a marginal profit of 18 percent. This indicates that providers had an incentive to serve additional beneficiaries.

Our next indicator is quality. This year we are using two new measures of quality. These measures were developed by MedPAC, and they use a common definition and risk adjustment model to measure quality in each of the PAC settings. This slide presents the results for home health on these common measures.

The graph on the left shows the share of home health spells in which the beneficiary was discharged to the community with no hospitalization in the 30 days after discharge. It shows gradual improvement from 2015 to 2019 -- that is, the share successfully discharged without a subsequent hospitalization is rising.

The graph on the right shows the share of stays that had a hospitalization occur during the home health spell. The share of stays with a hospitalization during the spell increased from 2015 to 2018 and decreased slightly in 2019.

This is our first year reporting these quality

measures. This year we have dropped measures of provider-reported functional improvement from our review of quality. While we recognize that maintaining and improving functional status is a key outcome for post-acute care, the Commission has expressed concerned about the accuracy of this data and noted it may not be a reliable indicator of provider quality.

Next we look at capital. It is worth noting that home health agencies are less capital intensive than other health care providers, and relatively few are part of publicly traded companies.

However, overall, financial analysts have concluded that the publicly traded agencies have adequate access to capital. I'll say more about COVID later in the slide, but I would just note that during the emergency, the large publicly traded agencies have generally reported positive financial outcomes. And I would note finally that the all-payer margin equals 5.9 percent in 2019.

Turning to Medicare margins for 2019, we can see that the margins for this year were 15.8 percent. The trend by type of provider is similar to what we have found in previous years, with for-profit agencies having higher

margins than nonprofit and urban agencies having higher profits than rurals.

I would note that the overall margins for home health have been 15.3 percent or higher since 2015, so these findings are consistent from prior years.

This year we again have examined the performance of relatively efficient home health agencies. We use a similar definition to what you have seen in the other sectors. Providers have to be in the best-performing third on measures or quality for a three-year period. In addition, they can never be in the worst-performing third of either the cost or quality measure in any single year during the three-year period. Based on these criteria, about 14 percent of agencies met this standard.

Compared to other home health agencies, efficient providers had lower hospitalization rates. They typically had higher patient volumes, and their standardized costs were 14 percent lower than other home health agencies, likely reflecting the economies of scale from their larger size. And the relatively efficient providers had median margins in excess of 23 percent.

We estimate that margins for 2021 will equal 14

percent, a slight decline from the 2019 level. This is a result of several payment and cost changes.

First, on the payment side, the home health agencies will get market basket updates in 2020 and 2021. In addition, the base rate in 2020 was lowered in anticipation of nominal case-mix growth due to the new payment system, though we assume some of this reduction is offset by changes in coding by home health agencies.

We also expect cost growth in 2020 to be 3 percent, higher than the recent trend because of some changes, such as the expansion of telehealth and the need for more personal protective equipment. However, we did not assume that all COVID-related costs in 2020 carried over into 2021, reflecting that factors like surge pricing of personal protective equipment will be mitigated in the future.

There is more detail in your paper, but the net impact of these changes is that home health margins in 2021 will be well over 10 percent.

Similar to other sectors, the pandemic affected the delivery of home health care. Information about the impact to home health is limited and comes mostly from

reports by publicly traded companies. I would note that this information summarizes what we know about the pandemic to date and should be interpreted carefully because the emergency is ongoing.

That said, these companies reported that patient volumes declined initially but generally rebounded within a few months to near or at pre-pandemic levels. During the spring, when volume was most affected, home health agencies reported that they were providing fewer in-person visits and more telehealth.

Home health agencies have faced some additional costs associated with the pandemic, such as personal protective equipment and testing, while federal grants and loans have been helpful in offsetting these costs. Home health agencies also may have other tools to manage the impact. For example, many providers pay the staff on a per visit basis. So when the volume of services drops, as it did in the spring, their labor costs naturally adjust. As a result, they may be better positioned to mitigate the biggest impacts of the pandemic.

Finally, I turn to the summary. Overall, our indicators are positive: 99 percent of beneficiaries live

in an area served by at least one home health agency; volume has decreased, but this appears to be unrelated to payment; positive marginal profits of 18 percent.

The rates of successful discharge have increased. We've seen a small decrease in hospitalizations.

In terms of access to capital, agencies have positive all-payer margins, and the large for-profits continue to have access.

And in terms of payments and costs, Medicare margins for 2019 were 15.8 percent, and the projected margin for 2021 is 14 percent.

Next, we turn to the Chair's draft recommendation for 2022. For calendar year 2022, the Congress should reduce the 2021 Medicare base payment rate for home health agencies by 5 percent.

The spending implications are that this would lower payments relative to current law, and the beneficiary and provide implications is that access to care should remain adequate, should not affect the willingness of providers to serve beneficiaries, but may increase cost pressure for some providers.

This completes my presentation. I look forward

to your discussion.

DR. CHERNEW: Evan, thank you very much. That was really useful, another very important sector. We're going to start with Jaewon and, Karen, I'm going to ask you to go second. Jaewon.

DR. RYU: Thanks, Mike, and thank you, Evan. I did have a question on this one. On Slide 9, you mentioned the folks getting discharged to hospital and the folks getting discharged to community following the episode. What makes up the remainder? It's probably, I don't know, 8 to 10 percent in that remainder. What are the other destinations that people might be going to?

MR. CHRISTMAN: I think, if I'm following your question correctly, it's important to note that these two measures follow different periods of time.

DR. RYU: Okay, okay.

MR. CHRISTMAN: The one on the left looks at the 30 days after a patient is discharged, and the one on the right measures what happens while the patient is in home health care.

DR. RYU: Okay. Okay, that explains it. Sorry. That's a helpful clarification. But, no, I think all in

all I am supportive of the recommendation. I think if I'm looking at my reference grid here, it looks like this sector has the highest overall 2019 Medicare margin, so I think there's good rationale in light of the other dimensions, whether it's access or access to capital or other dimensions that we look at to evaluate adequacy.

And here, too, much like the prior discussion with the nursing homes, it looks like Medicare remains essentially a preferred payer, if I'm interpreting Slide 10 correctly. And so given those things, I'm supportive of the draft recommendation.

DR. CHERNEW: Jaewon, thank you. I think we had Karen next, and then we're going to do Paul and Dana.

DR. DeSALVO: Great. Thank you. Evan, thanks for your work on this, and again, like all the other sectors, they're not only in a dynamic state given COVID-19, but given consolidation and a change in the role of home health in the orbit of the care continuum, and it's going to be an interesting few years as we continue to understand whether home health is one sector or if it's evolving into one that is post-acute care, and then there's another piece of it, which is -- or maybe there's multiple

pieces, a portion that's about prevention and primary care and then, of course, the hospital at home movement and successes that we're seeing starting in the VA and then expanding into the private sector are giving us a new sense of what's possible to do in the home.

But given all of that, I support the Chair's draft recommendation and look forward to continuing to understand this sector as we talk in years to come. Thanks.

DR. CHERNEW: Okay. Let's do Paul and then Dana, and then we'll go on from there to, I think, Larry. Paul.

DR. PAUL GINSBURG: Thanks. Yeah, I have a question for Evan. Evan, I may have missed it, but do you have any information about what Medicare Advantage plans pay for home health in comparison with fee-for-service Medicare?

MR. CHRISTMAN: Only anecdotally, and my understanding is that it is generally less. You know, the numbers that people throw out are [inaudible]. Sometimes I hear things like 10 or 20 percent, and they do other things like manage, you know, sort of prior authorization or they only authorize like four visits or ten visits at a time and

require re-auth. So they do sometimes manage it a little differently. But, in general, my understanding is that Medicare Advantage pays less than fee-for-service.

DR. PAUL GINSBURG: Yeah, thanks, because I've found that, you know, the various services we focus on, you know, the ones that Medicare Advantage pays less than Medicare tends to be consistent with our own sense of when Medicare might be overpaying, and to me this is -- you know, just the fragments you have are in support of that. I support the Chairman's recommendation.

DR. CHERNEW: Great. So thank you, Paul. Dana.

DR. SAFRAN: Yeah, I have nothing more to add other than to say I support the Chairman's recommendation on this. I think everything I would have said has been said by my colleagues. Thanks.

DR. CHERNEW: Terrific. So Larry and then Betty.

DR. CASALINO: A quick question for Evan. Actually, before I do that, I just want to call our home health workers as well. We shouldn't just do it for nursing homes. These people also are in many ways risking their lives every day to get to work and going into people's homes, and they are not paid very well, and you

don't really hear too much about them, and they tend to be, of course, from racial and ethnic minorities.

Evan, in your two quality measures and in identifying the most efficient hospitals, are those risk-adjusted in any way, those measures?

MR. CHRISTMAN: Yes, they are. They use, you know, the data that we have on patient characteristics, and they are risk-adjusted.

DR. CASALINO: Okay. And just a broader question on the same lines for Jim or for you. I assume that's true in the presentations we had yesterday as well; when we're seeing the quality measures, they are risk-adjusted. Okay, great.

Well, you know, for the reasons others have given, I also support the Chair's recommendation.

DR. CHERNEW: Larry, thank you. So Betty is next and then Jonathan.

DR. RAMBUR: Thank you very much. I agree with everything that has been said, and I won't repeat it. I do have one question on the written materials, and it might be that I'm confused. So on page 4, the second paragraph talks about Medicare requires that a physician certify

patient eligibility for home care and the patient receiving services be under the care of a physician. Then it talks about encounters, and it talks that an encounter with a nurse practitioner or a PA can satisfy that, and that the CARES Act has expanded the authority for ordering and supervising home care to include nurse practitioners, clinical nurse specialists, and physician assistants.

So am I correct in reading this that that certification for home care for NPs and PAs is only temporary for now?

MR. CHRISTMAN: Oh, no. That should be clear that it's permanent, Betty. We can take a closer look at that paragraph. I think the correct reading is that basically everything a physician used to be required by a physician in terms of ordering and supervising can now be done by NPs and PAs, and obviously state scope-of-practice acts may determine, you know, how far that can go. But no longer is Medicare law an implement -- in the hospital, but we can look at that paragraph.

DR. RAMBUR: Yeah, I thought it was a little unclear, and it's clear about the state practice laws, but the other pieces I think reads a little bit unclear. That

was my only comment. Thank you so much, and I support the recommendations, and thanks for the great work.

DR. CHERNEW: Terrific. So we'll go to Jonathan and then Amol.

DR. JAFFERY: Thanks, Michael. Thanks, Evan. Great chapter. I'm supportive of the Chair's draft recommendation. I don't actually have a lot to add. I would like to just really emphasize what Larry said, and I really appreciate the efforts of home health workers, and it's hard to imagine how difficult that must be in some of these settings to keep doing the work they're doing.

And then the other thing, I'd really like to spend some time thinking about some of the comments Karen had made about, you know, what are the different tracks that home health does. Is this sort of thinking about this as a lumper or a splitter? Are there multiple things that home health does, or is it home health has an increasingly large set of capabilities? But either way, there's a lot of opportunity here. So thank you.

DR. CHERNEW: Great. Thank you. Amol, and then after Amol, we will have Bruce.

DR. NAVATHE: Great. Thanks, Michael. So I

certainly agree with a lot of what the Commissioners have said who preceded me here. I appreciate the work, and like Larry, certainly all of us appreciate the work of the home health care workers as well.

So I think one of the interesting challenges of home health is that it seems to be evolving into multiple types of care, and I think the paper actually did a very nice job of teeing that up and kind of outlining that this is happening. I think also we've heard already that there's developments in hospital to home. Many of the A-APM models like bundled payments are to shift patients from SNF to home health, which perhaps means that the acuity of patients in the home health care setting is also evolving to some extent. Then we also have, you know, trends in hospice where we have longer lengths of stay. That might be also sort of intersecting, if you will, with home health.

So I think that, you know, I support the Chairman's recommendation here. The indicators obviously are what they are, which, again, I think I recognize how we're viewing this. In the broader sense, I think it would be helpful for us to take a deeper dive and start to look

at what's actually happening in the home health sector, because I think it is textured and nuanced, more so than perhaps we have looked at -- the Commission has looked at previously.

And another piece that I think intersects that we haven't really talked about is my understanding is that if you meet the requirements of the beneficiary, there's no cost sharing for beneficiaries. And there might be some preference sensitivity here as well, and particularly for clinicians and practices that are not in APM, alternative payment models. There's, you know, a little friction, if you will, for how to meet those types of preferences.

So what I also wondered alongside a broader point, not particularly the Chairman's recommendation per se, is to think about whether as we uncover different types of services within home health, it also makes sense to revisit the benefit design of home health and think a little bit more, if there's different types of home health, would that, therefore, have different types of benefit design?

I just wanted to put that out there because I think it's important that we think about this sector

evolving overall. But, again, I support the Chairman's recommendation. Thanks.

DR. CHERNEW: Great. Thank you, Amol. We have Bruce and then Jon Perlin.

MR. PYENSON: Thank you. I don't have anything to add other than my support for the Chair's recommendations. Thank you.

DR. CHERNEW: Bruce, thank you. So then we have Jon Perlin and Wayne.

DR. PERLIN: Let me again add, of course, thanks for a terrific chapter. I support this. I also endorse my colleagues' comments that we have a recurring issue of the way in which some of our programs are being used versus what they might have been designed for. We see that with dementia patients and the hospice program, and I think Amol's and others' points about the different roles of home health, whether it's for coordination, whether it's for pre-acute care, whether it's to avoid acute care, or whether it's actually post-acute care, we need to have in that deeper dive that was suggested a taxonomy and then really see if our instruments are the right instruments in 2023 for the needs of the beneficiaries.

But notwithstanding that, I support it for all the reasons said previously. Thanks.

DR. CHERNEW: Jon, thank you very much.

Wayne and then Pat.

DR. RILEY: Yes. I'm in favor of the Chair's recommendation. Nothing further to add.

DR. CHERNEW: Wayne, thank you so much.

Pat?

MS. WANG: I also support the draft recommendation.

I just wanted to pick up on Paul starting the conversation before about how MA plans might pay for the services and seeing some comparison to the SNF world. The couple of observations I would offer about this that may affect how MA plans pay more or less for certain services is, first, supply and demand. The supply of nursing homes in a particular market, it's extremely possible that an MA plan would find that they really just need a subset of nursing homes to meet the needs of their members, and so that sets up sort of a contracting dynamic that could well result in lower rates.

And for home health, the observation, I guess,

would be not capital intensive, definitely lots of supply. The pop up easily, and so what a plan might be looking for, some plans might be looking for is the highest quality ones that will work with the plan in a certain way because the plan may want to direct what kinds of services they're looking for as opposed to take the standard package, if I could say it that way.

The final thing is that in contracting -- because plans might be -- they would contract for the skilled portion of home health, but then it slides into the non-skilled personal care, which Medicare fee-for-service does not pay for. So you might wind up having a blended rate, recognizing that at some point, it's going to convert from skilled to non-skilled and more like supports and services are home.

I think all of those things go into a contracting discussion, and I agree with Evan's observation about, perhaps, tighter UM on the sort of non-preferred agencies to keep track and no UM, perhaps, on the agencies recognized to deliver the best quality.

So the point is there's just a lot more flexibility, I think, in this sector, unlike provider types

where -- I mean, an inpatient hospital service is -- you know, you really -- you don't have alternate settings for that. And we have talked about dialysis centers, and there, you've got a situation where supply is controlled by a couple of national organizations in that sense, but totally different dynamic. So I just wanted to offer that perspective.

But to Karen's point, in home health, in particular -- and I think it's happening with SNF -- there are lots of different ways to deliver these services. So not only are providers competing with like providers, home health agency with home health agency, but home health agency might be competing with SNF. New modalities are competing with both. So you have a lot more -- I think there's just a lot more options that a private plan might be looking at to meet the needs it identifies.

Thanks.

DR. CHERNEW: Pat, thank you very much. That is true. In fact, it always struck me that we have a number of these sectors which can overlap, which its challenges are site-neutral sensibilities. There's case-mix differences that are hard to get a handle on, and

obviously, there is -- I have to call out MA plans. There's a flexibility that MA plans have, not just in how things are done, but also market-specific things that they can take into account that's really challenging for us.

I think some of this whole discussion in much of today emphasizes the real challenges we set in the national upset, which we do across all these sectors, given the heterogeneity within, between all the sectors. It's a really challenging path, but I appreciate now more than ever.

Luckily, there's a bunch of views and comments on how we're doing, and so that's going to turn to Sue Thompson and then Marge.

MS. THOMPSON: Thank you, Michael.

I agree with the recommendations, and, Evan, thank you for your good work. I know you have heard me in years past. Yes, this is a high-value care, and I have always worried when we make recommendations to cut fees here. But I cannot argue with the kind of Medicare margins that we see here, but I do support these recommendations.

Again, I think this is another part of our continuum that is going to play an enormously important and

even more impactful role in care delivery as we come out of this pandemic. I think we only need to go back to the last 24 hours and listen to the various conversations we've had.

In this chapter, certainly around Hospital at Home, Hospital at Home has been literally a life saver in our system as we have used this program to decant patients who have low-intensity chronic illness with exacerbation of symptoms, moving them to the home with monitoring equipment to make beds for patients that are in our emergency room.

So not surprising, folks like to be at home, and the fact that an organization will invest in monitoring equipment to keep a patient at home as opposed to being in a hospital bed where we have limited visiting, I anticipate we're going to have a demand for this kind of a service going forward.

Secondly, I think the conversation we just had in the long-term care chapter; we are not going to see folks running to get into nursing home facilities. So the demand for home care to help us keep people in their home and live high quality of life, I predict, is going to go up.

So I'm just very bullish on home care. I think it's going to be such an important component in our

continuum as not only for the beneficiary and living a great quality of life in our Medicare years, but also to the overall cost of care to the Medicare program. So I'd just say keep an eye on it because it's such an important component of our continuum, and the folks who have been working in this arena during the COVID deserve a great deal of our appreciation.

So thank you very much.

DR. CHERNEW: Sue, I echo all of those comments and will add that one of the merits of alternative payment models, apart from how much they save, a lot of times, we critique those models because we don't think they have saved enough.

But, of course, one of the big advantage is they allow this type of flexibility. So with new innovative programs like Hospital at Home are introduced, they're just much easier to think through in a world in which we're paying broadly in a world we have to figure out how does a Hospital at Home program interact with our hospital payment, our SNF payment, our home health payment, or rehab payment, all of those payments and how the different patients that are Hospital at Home might differ in a case-

mix sense from patients that aren't quite good candidates for Hospital at Home. All of that is so, so challenging in the existing model that I actually think the biggest reason why we want to have these more flexible payment models is to allow exactly that type of innovation, and we will worry about having bigger savings later. But I think they promote that type of innovation in organizations like yours are doing, and I know that there's others. In New York, we saw some, and the VA, it was mentioned, other places. It's an unbelievable important thing that our payment models be structured to promote this type of innovative site placement for people, and I'm not so sure we do that so well now.

So I know it was a little bit more of a speech, but we're well, well ahead of schedule. So I feel like I could be more verbose than is normal. For those of you that know me, I'm actually normally quite verbose.

Nevertheless, I'm going to stop now and turn to Marge and then Brian.

MS. MARJORIE GINSBURG: Okay. Thank you, and thank you, Evan. This is, once again, a fabulous report with great information.

I'm completely supportive of the recommendations.

I'm intrigued a little bit by some side-bar conversations about the role of MA, and I hope I'm not sounding like a One-Note Charlie here, since I seem to focus a lot on MA, but as the MA tends to increase its domination in Medicare and the numbers are going up and I think will continue to go up, this to me just reinforces what I think is our need to start understanding a lot more about what MAs are paying and the actual quality of the care they're getting for their clients, other than the quality indicators that we already have.

We haven't talked all that much about that in the past because our entire focus really is on original Medicare, but I just want to sort of put a note in that perhaps there may be a way that we can start looking at and getting a lot more information from the MA plans, including their work in home health.

Having said that, great report, strong recommendations, and I completely support them.

DR. CHERNEW: We're going to go to Brian and then to David Grabowski.

DR. DeBUSK: Thank you.

I do support the Chairman's draft recommendations as written, but I also agree with all my fellow Commissioners on some of their comments.

I really want to hone in, though. Pat and Sue made comments about just the fluidity and how patients are moving. The practice patterns are shifting, say, from SNF to home health. I want to take a moment just to endorse and say I hope we're continuing to push forward on a unified PAC Model because I think ultimately, while this payment adjustment appropriate, I think the real goal here is to move to that unified PAC platform.

And just to make one highly technical comment on this, as we begin modeling the unified PAC, I know we have a dichotomous variable for home health that remove some of the costs, basically a payment adjuster just because home health is a lower-cost post-acute care venue.

I hope we as a Commission look at that, get a chance to look at that variable closely, because I'm less interested in making sure that it accounts for every penny of savings that we could produce in home health and more interested in how altering that or adjusting that could actually induce volume to shift from higher-cost settings

like LTCHs and IRFs and SNFs and actually incentivize home health, taking those higher and higher acuity patients.

So I think there's a real opportunity here for payment policy to drive better practices, and I hope all of that gets taken into consideration as we talk about the appropriate levels of payment for home health.

Thank you.

DR. CHERNEW: So that's absolutely true, and let me add again -- I know I just said this beforehand. I'll say it again. I think the appropriate place for a lot of that discussion is the alternative payment model chapter in discussions we had before about how CMS can set up a portfolio of payment models that work together as opposed to separating them out more piecemeal.

So I think we need to think through, for example, how a post-acute alternative payment model would fit with broader payment models like ACOs because there's obviously been a lot of research and a lot of evidence that one place that ACOs get a lot of their savings turns out to be from post-acute and largely in how they direct post-acute patients across different post-acute settings.

So we have to be careful that we don't create

other sort of post-acute silos as opposed to other broader payment models and how it interacts with MA.

So I could not agree with your sentiments more, Brian. I hope you hear the passion in my voice when I say that. It's just I think the appropriate recognition of that is in how we think through our strategy of moving toward alternative payment models. There's only so much we are going to be able to do in fee-for-service, and certainly, the existing systems that are so fragmented really do place challenges in our December and you will soon see January meetings.

All of that said, if there's anyone who personifies post-acute -- I say that as a bit of a joke and to a friend -- it's David. So, David, you get the last post-acute word.

DR. GRABOWSKI: Great. Thanks, Mike, and thanks, Evan, for this great work.

I'll start by saying I support the recommendation.

Similar to Sue, I'm really torn here. On the one hand, I think home health is the future. There's a real opportunity here to kind of grow this area. On the other

hand, it's really hard to argue with the huge margins that home health agencies have been associated with and going forward. I'm very supportive of the recommendation.

Mike teed this up as all of my interest in post-acute. I did want to highlight an issue. Most home health is actually not post-acute. About two-thirds of this is delivered to beneficiaries without a preceding hospital stay. Evan discussed that in the chapter, but I do think going forward, we should think about post-acute home health and non-post-acute and what those two types of services look like, who's using them. Should they be treated any different from a cost-sharing perspective or from just kind of a program oversight perspective? Both may be high value, but thinking about kind of what they're doing and how they're serving our beneficiaries, I would like to unpack that.

We typically place home health here in the post-acute kind of framework, and it's an important part of that continuum, but that's not all it is.

The second area I wanted to touch on is just this evolution of home health, and several other Commissioners already discussed this.

We saw this big payment change this year that Evan mentioned is going to be really hard to tease out kind of what are the short-term impacts of moving from a very therapy-driven payment system historically to one that's now based largely on patient characteristics, very similar to the new SNF payment system.

Home health is very much using a similar payment model. Unfortunately, this happened right during the pandemic. So it's really hard to kind of see what changes are due to the pandemic versus what's happening with the payment system, but I do think we'll want to monitor that going forward and get a sense.

To Brian's point, this new payment system for home health and for SNFs very much fits with our movement towards unified payment in that we've moved away from paying based on therapy to paying based on patient characteristics. We've now gotten our two biggest post-acute care sectors -- SNFs and home health -- paying based on patient characteristics. Can we begin to unify this going forward? I think this is kind of a great step forward in that regard.

I'm really glad that Paul raised Medicare

Advantage. I think this is a really important part of that. That's another part of this evolution of home health in that more and more they're doing -- they're receiving Medicare Advantage payments versus traditional Medicare.

As Evan already noted and the data I've seen very much agree with that, MA plans pay less than traditional Medicare. It seems like if we can control for the selection across the two programs, it does look like for a given condition, it seems like MKA beneficiaries also use less home health care, and I think that's an important part of this as well.

Then, finally, they do seem to contract with lower-quality home health agencies.

I hope going forward, we'll pay more attention in all of our sectors to kind of what MA versus traditional Medicare looks like, but especially for the post-acute care sectors, it's a very different story relative to hospitals or dialysis or other parts of the program.

Final point I wanted to make is just this idea -- and I think this is probably close to Mike's heart -- how do we continue to encourage high-value home health care? As I said at the outset and very much agree with Sue's

point, this is the future, but ACOs and others are beginning to figure out how to encourage that, that high-value mix of services.

I think home health is really prime to take a bigger role, but I don't know that it's home health as we've historically configured it that's been this therapy-heavy set of benefits. Just like the discussion we had yesterday on hospice, where hospice is kind of doing a lot of things for different beneficiaries, I think home health is also sort of doing a lot of different things, and my sense is there's this opportunity for high-value home health care as we transition individuals out of skilled nursing facilities into home health. That's kind of the goal a lot of us have for this high-value home health care, yet that care really rests on as lot of other supports that an individual previously would have received in a skilled nursing facility but now needs to kind of build themselves. Maybe those are family caregivers that are assisting with all the other care, when the home health agency isn't there. Maybe that's a paid set of services, a home care agency that's coming in and providing services alongside of home health.

I'm very bullish on home health yet really weary that we constructed this very, kind of narrow benefit that's very therapy-driven to kind of meet some of our beneficiaries' needs in the home, yet not really provide that full package of care that they might get in a skilled nursing facility. So how do we find that beneficiary that's appropriate to move out of institutional care into the home? How can we kind of craft this set of services?

I actually think home health is only one part of that broader sort of mix of services they need. I'm both excited but also a little weary of the way we pay for home health historically.

So I'll stop there. Once again, Mike, I'm supportive of the recommendation, and you said I'd like to talk about post-acute. So I talked about post-acute, and I could keep going. But I'll stop there in the interest of time. Thanks, Mike.

DR. CHERNEW: I'd appreciated your subtle calling out when I labeled home health post-acute when I realized it's much more than post-acute. So that was certainly appropriate. That's true.

There's a few other things that I'll say before

we move on. We're about to go on to IRFs, but one of the things you pointed out that I think is true is there's also this very complicated interaction with informal caregivers in a range of ways. And I think given our demographic trends and where people are living relative to their parents and a bunch of things like that, this issue about how we provide care for folks is going to be increasingly really, really important.

The problem which is always the case -- and I said this yesterday, so I'll say it again for those of you who weren't here yesterday and people listening who weren't here yesterday -- we do not have a scalpel very well. It's very hard for us in our fee-for-service world to come up with levels of payment that deal well with the vast amount of heterogeneity in terms of type of patients, type of providers, geographic differences, innovative programs like Hospital at Home. It's very hard for us to deal with that, and never is that more clear to me than when we're doing these sector-to-sector fee update recommendations.

So we will continue to do the best we can with the updates but recognizing that as we modernize Medicare payments, it's not simply a matter of figuring out what the

update factor should be.

Again, I say that with great enthusiasm. It's time to talk about another update factor.

At this time we are going to move to rehab facilities. So Jamila, I think you are up and I look forward to your presentation. Thank you.

* DR. TORAIN: Thank you, Mike. Good morning. Before we start I will outline today's presentation for inpatient rehabilitation facilities, also known as IRFs. The audience can download a PDF of these slides in the handout section of the control panel on the right-hand of the screen.

First, I will briefly review Medicare's payment system for IRFs. Next, I will give a quick overview of some continuing concerns we have about the payment system. Then I will present our payment adequacy analysis and recommendation. In general, we see a continuation of trends we observed last year, when, you will recall, we recommended a 5 percent reduction in the IRF payment rate. As applicable, more details about the impact of the COVID-19 public health emergency on IRFs will also be presented.

After illness, injury, or surgery, many patients

need intensive rehabilitative care including physical, occupational, or speech therapy. Sometimes these services are provided in IRFs. Per-case payments to IRFs vary depending on patients' condition, level of impairment as measured by the IRF, age, and comorbidity.

To qualify as an IRF, facilities must meet Medicare's conditions of participation as well as several additional requirements. For example, the 60 percent rule is a Medicare facility criterion that requires each IRF to discharge at least 60 percent of its patients with 1 of 13 qualifying conditions. In addition for a stay to be covered there are certain patient requirements that must be met that are outlined in your paper.

In 2019, Medicare accounted for about 58 percent of IRFs' discharges, the average length of stay in an IRF was 12.6 days, there were 1,152 IRFs, and about 363,000 beneficiaries had 409,000 stays. Medicare spent about $8.7 billion on IRF care provided to fee-for-service beneficiaries.

In past research, the Commission has identified two major payment issues. We have talked about provider coding extensively and we have also identified that some

cases types may be more profitable than others. This year, with the Urban Institute, we compared payment-to-cost ratios of different case types and found substantial variation. For the purposes of this presentation, I am only highlighting two conditions because of their relevance to previous findings. Please refer to your paper for a complete list of conditions. Overall, the average payment-to-cost ratio was 1.11, that is, payments were 11 percent higher than costs for the average IRF stay.

Other neurological cases which includes non-stroke neurological conditions such as multiple sclerosis, Parkinson's disease, polyneuropathy, and neuromuscular disorders, was the second most frequently occurring case type and among the most profitable, with a payment-to-cost ratio of 1.2. By contrast, the most frequently occurring case, stroke, had a comparatively low payment-to-cost ratio of 1.07.

These findings indicate that some case types are more profitable than others. Beyond this observation, due to the subjective nature of the assessment of IRF patients, there may be a coding effect that is playing a key role in IRF provider profitability. We will provide more detail on

this payment issue in the fall of 2021.

Now I will review our assessment of payment adequacy for IRFs. We have used our established framework that you have seen in earlier presentations today. We will start by considering access to care which includes analysis of the supply of providers, volume of services, and marginal profit.

In 2019, there were 1,152 IRFs nationwide, a slight decrease from 2018. However, despite this decline in number of facilities, the total number of IRF beds edged up slightly with almost 38,000 beds in 2019. There was an increase in the volume of Medicare cases and the number of cases per fee-for-service beneficiary. If we look at marginal profit, we see a robust 40 percent for freestanding IRFs, and 19 percent for hospital-based IRFs, meaning that both sets of providers have an incentive to serve additional Medicare beneficiaries assuming that they qualify for IRF-level care.

This year, we looked at the quality of care furnished in IRFs, using risk-adjusted cross-PAC measures developed for MedPAC. Overall, our quality measures have remained relatively stable since 2015. The average risk-

adjusted rate of all-condition hospitalizations within the IRF stay was 7.8 percent in 2019, and the share of patients successfully discharged to the community rising slightly from 64.6 percent in 2015 to 65.5 percent in 2019.

As Carol mentioned earlier, this year we have dropped measures of provider-reported functional improvement from our assessment of quality.

Turning now to access to capital. As I noted in your paper, about three-quarters of IRFs are hospital-based units, which access needed capital through their parent institutions. As you heard yesterday, hospitals maintained good access to capital.

As for freestanding IRFs, over 40 percent of the providers in the freestanding IRF category are owned or operated by one large chain. Market analysts indicate that this chain has good access to capital. The company has continued its pursuit of vertical integration by expanding its business to include the purchase of home health care agencies and hospice providers and entering joint ventures with acute care hospitals to build new IRFs. The all-payer margin for freestanding IRFs is a robust 10.4 percent.

Differences in per case costs and payment growth

led to a steady rise in aggregate margins for IRFs, which have been over 11 percent since 2012. Financial performance continued to vary widely across IRFs. For example, in 2019, the aggregate margin for freestanding IRFs was 24.6 percent. In contrast, hospital-based IRFs had an aggregate margin of 2.1 percent. We also see wide differences in margins of for-profit and nonprofit IRFs as most freestanding IRFs tend to be for-profit and most hospital-based IRFs are non-profit.

The primary driver in these differences in margins is costs, which tend to be lower in freestanding and for-profit providers.

So, why do we see such a disparity between hospital-based and freestanding margins? We think there are several factors. First, hospital-based IRFs are more likely than freestanding IRFs to be nonprofit, and so they may be less focused on reducing costs to maximize returns to investors. Also they have fewer economies of scale. Hospital-based IRFs tend to be much smaller than freestanding IRFs, and they have fewer total cases. Their occupancy rates are also somewhat lower, 61 percent versus 69 percent in freestanding IRFs. In addition, hospital-

based IRFs may assess and code their patients differently, contributing to differences in payments for similar patients.

Finally, hospital-based IRFs tend to have a different mix of cases. It is not clear why this is the case. As I mentioned earlier, other neurological cases are among the most profitable cases, which may contribute to higher margins for facilities that admit larger shares of those cases. Hospital-based IRFs consistently have a lower share of these cases compared to freestanding IRFs.

Next, we will move on to our analysis that examines relatively efficient IRFs. In 2019, 17 percent of the IRFs included in the analysis were relatively efficient. Compared to other IRFs, relatively efficient providers had hospitalization rates that were about 12 percent lower and community discharge rates that were about 6 percent higher than other IRFs. Their standardized costs per discharge were 13 percent lower, leading to a large difference in the median Medicare margin, which was 15.8 percent for the relatively efficient group compared with 4.6 percent for other IRFs.

This year, because of the change to our cross-

sector quality measures, we observed a change in the pattern of the type of relatively efficient IRFs. Specifically, more hospital-based nonprofit IRFs were relatively efficient than freestanding for-profit IRFs. I am happy to provide more information about this pattern change, upon request.

With that we will move on to discuss our projected Medicare margin for IRFs in 2021. We expect that payment growth is likely to exceed cost growth in 2020 and 2021, and so we've projected that the aggregate margin will increase to 16 percent in 2021. This is driven by substantially higher payment rate updates in 2020 and 2021 due to the expiration of statutory reductions in IRF updates required by the Affordable Care Act in each of 2010 through 2019.

On the environmental front, since early 2020, the coronavirus has had a devastating global impact. It has also affected the IRF landscape. However, we don't have complete data on Medicare volume for all IRFs in 2020. At the time this report was written, publicly traded IRFs reported reductions in volume from March to May relative to pre-COVID volumes, largely due to the cancellation of

elective surgeries in acute care hospitals. In addition to the effect on volume, publicly traded IRFs also reported that the COVID-19 public health emergency also affected cost by requiring IRFs to use more personal protective equipment and increasing the price of equipment.

However, as states began to ease restrictions in acute care hospitals and surgery centers resumed performing elective surgeries, the largest publicly traded IRF company reported that volume began to slowly recover, reaching at least 95 percent of pre-pandemic levels by late June. Though, they also reported that the remaining lag in volume is largely due to COVID-19 related challenges in certain geographic markets and to the decrease in the number of orthopedic and lower extremity joint replacement cases compared to the same period in 2019.

Some of the impact of volume reductions and increased cost have been offset by a concurrent increase in net revenue per discharge due to the temporary suspension of sequestration and higher acuity patient mix resulting from the pandemic. While we do not anticipate any long-term changes to the IRF landscape that will persist past the end of the public health emergency, there is still

uncertainty as things are changing rapidly on a daily. We continue to track changes as the environment may be different even when we come back in January.

In summary, we found that the IRFs payment adequacy indicators were positive. With regards to beneficiaries' access to care, IRFs continue to have capacity that appears to be adequate to meet demand. With regards to quality of care, our risk-adjusted outcome measures have remained relatively stable since 2015. With regards to IRFs' access to capital, IRFs maintain good access to capital markets. The all-payer margin for freestanding IRFs is a robust 10.4 percent. With regards to Medicare payments and IRFs costs indicators they were positive. In 2019, the aggregate Medicare margin was 14.3 percent. We project a margin of 16.0 percent in 2021.

So to summarize, we observe capacity that appears to be adequate to meet demand and that providers should have an incentive to take more Medicare beneficiaries that qualify for IRF level care given the strong marginal profits for both freestanding and hospital-based facilities.

And so that brings us to the update for 2022.

Because the circumstances in the IRF industry remain consistent and the indicators were positive in 2019, it reads, for 2022, the Congress should reduce the fiscal year 2021 Medicare base payment rate for inpatient rehabilitation facilities by 5 percent.

To review the implications, on spending, relative to current law, Medicare spending would decrease. Current law would give an update of 2.5 percent. On beneficiaries and providers, we anticipate no adverse effect on Medicare beneficiaries' access to care. The recommendation may increase financial pressure on some providers.

This recommendation would be accompanied by a reiteration of our March 2016 recommendations to the Secretary to conduct focused medical record review and to expand the outlier pool to increase outlier payments for the costliest cases.

With that I will close. I am happy to take any questions. Thank you.

DR. CHERNEW: Sorry, I was muted. Thank you so much, Jamila. That was terrific. We are going to start with Jonathan Jaffery and then go to Brian. Jonathan?

DR. JAFFERY: Great. Thanks, Michael. Thanks,

Jamila. This was a great presentation. Super clear. Great report. I will start off by saying, in general, I'm very supportive of the recommendation. I actually don't have any specific questions or a lot additional to weigh in here. I think this is very consistent with what our recommendations have been for the last couple of years, as I recall, and as conditions, despite the public health emergency, those conditions seem to be pretty consistent, and I think, again, keeping in line with what our philosophy has been in that we all address updates for the long term and address issues around the public health emergency with more targeted type interventions.

I'm very supportive of this, so thank you.

DR. CHERNEW: Thank you, Jonathan. Let's go to Brian and then David Grabowski.

DR. DeBUSK: I'm also supportive of the Chairman's draft recommendation. In reading through the chapter I was a little intrigued by the nuance of for-profit versus not-for-profit IRFs, particularly around potential coding differences, potential case mix issues. I realize today we're talking about the aggregate update, and I do support the reduction, but I also hope, as we move

towards the PAC PPS that we try to tease some of that out, because it's hard for me to understand how much of that is an intrinsic difference in for-profit versus not-for-profit IRFs versus how much of it is some type of arbitrage in how we pay. Thank you.

DR. TORAIN: Thanks for that comment, Brian. I think part of what we're doing in the IRF space right now is looking under the hood of the case mix system. Part of what you saw today, with the payment-to-cost ratios, is just a very first step into looking at whether payments align with expected costs, and it was just a first look. It gives us more incentive to look at more analyses in that area.

And so we plan on doing that work this coming year and presenting more on that work in the fall. But I do agree that it's really hard when you look at the disparity, and we don't have a specific factor right now that tell us what is driving that variation.

DR. DeBUSK: Thank you.

DR. CHERNEW: Great. Thank you very much. David, and then we're going to Amol.

DR. GRABOWSKI: Thanks, Mike, and thanks, Jamila,

for this great work. I am also supportive of the draft recommendation.

I'm just going to go ahead and say it. These margins are offensive, the biggest margins. We see these every year. This is ridiculous. We're in kind of this period where we know, across the board, a lot of our providers are struggling. This is an area where I think low-value care is rampant, however. There's a lot of good evidence that skilled nursing facilities are able to provide similar outcomes at a lower cost, relative to inpatient rehab. Medicare Advantage plans don't pay for this care. When I first got on the Commission I wanted to visit an IRF and get a better sense of what they do, and that was one of the questions I asked the IRF is, well, what about MA? And they said, "We haven't had an MA patient here in years." And I think it's the sense that MA plans just won't cover it.

So I think the recommendation is great, but I hope that we're going to take a stronger look at this sector, and, in particular, we're going to have a discussion in a little while on long-term care hospitals, where we had similar concerns about low-value care. And

when you actually move to this dual payment rate structure I think it's really worked in a lot of ways and encouraged much greater value in that program.

And I wonder what the answer is here, with inpatient rehab. Is it some sort of similar dual-payment rate structure where we tighten up even further the kinds of conditions? We obviously have rules, and Jamila did a nice job on the chapter of talking about those, but do those guardrails need to be strengthened? Do we just need to pay less across the board? What's kind of the answer here?

So, Mike, this is, I think, a start, but it's just that, a start. This is an area where I think we should really dive in and think about why do we keep coming back to these, not just even double digits but massive double-digit margins. And unlike some of the other sectors we've discussed, they're not cross-subsidizing Medicaid. So this is a very different sector relative to skilled nursing facilities and even home health.

So I'll stop there, Mike, but I think there's a lot of work left to be done here, even though I'm very supportive of the draft recommendation. Thanks.

DR. CHERNEW: David, thank you. We're going to Amol and then Pat.

DR. NAVATHE: Thank you. So I'm very supportive in general of the Chairman's draft recommendation here and the direction that we're headed. I just had one question, Jamila, before I jump into a couple comments. Do we have an understanding -- it struck me that SNF cases, I believe, in volume is going down as a secular trend, take away 2020 here for a second, but that's not true of IRF cases. And I was wondering if we have any sense of why that might be happening.

DR. TORAIN: So one thing that I've considered in terms of cases switching from different settings is that in IRF from 2018 to 2019 the case-mix index actually decreased slightly. And so one of the things that I was thinking about in terms of these payment policy-driven things that we're observing, in the LTCH space there's this approach to have patients paid under the LTCH PPS, which is a more acute patient. And so I thought that possibly some of the non-qualifying cases may be coming over and being admitted to

IRF. I don't think that it's the other way around because

there's the requirements in IRF for a patient to tolerate three hours of therapy, so I don't think that IRF patients are going to the LTCHs, but I do think it is possible that some of those non-qualifying cases are coming over to the IRF space.

And if you look at the actual number of cases that increased from 2018 to 2019 in IRF, it's low. So I do understand there's not a lot of cases in general in LTCH, but we're talking about like the difference between 1,000 cases. So it's possible that that could be it.

DR. MATHEWS: But if I could jump in here, Amol, also recall that the decline in SNF utilization is tracking a parallel decline in inpatient admissions, which are a prerequisite for a Medicare-covered SNF stay. So to the extent there is still an ambient demand for post-acute care, there is an artificial break on that demand in the SNF sector that doesn't exist in home health or IRF.

DR. NAVATHE: Thanks, Jim, and thanks, Jamila. That's helpful. I think it's -- to me I think it's a little hard to integrate all those pieces together, because I tend to think of IRF and SNF to some extent on the continuum of severity and intensity, as you were kind of

alluding to, and so it made me wonder a little bit because I think, you know, as David highlighted, there's other contextual factors around Medicaid and what have you on the SNF side that don't necessarily exist on the IRF side. And so I wonder about appropriateness. I wonder about, you know, how IRFs are actually being used, particularly, Jim, given that you're highlighting also that they don't have some of the requirements on the sort of post-acute side. So, you know, something perhaps worth looking a little bit more deeply into.

I think more generally speaking, I agree with the comments that have been made earlier. I think the financial numbers speak for themselves. I think it would be worth looking a little bit more deeply into policy design, payment policy designed solutions a la LTCH, for example, or two-tier -- you know, other ways that we might set up the right incentives here, because the profitability certainly is particularly striking. So thanks, and in summary, I do support the Chairman's draft recommendation.

DR. CHERNEW: Amol, thank you. We're going to go to Pat and then Sue.

MS. WANG: Thanks. Jamila, thanks. As usual,

it's really, really clear and enlightening.

You know, I would echo Brian's questions about the shift that is happening in this sector, as in so many other sectors, from not-for-profit hospital-based to for-profit freestanding, except they're starting from a much higher, at least at this time, concentration in the not-for-profit hospital-based IRF. You know, there's more as opposed to some of the other sectors where it's kind of disappeared and it's primarily for-profit at this point. So I'm just very interested in the comparison that you made around the types of cases that the hospital-based IRFs tend to take, which are less profitable, differences in coding, what have you. I think it would be very good to continue to explore that.

The margin differences I assume are -- does a hospital-based file a separate cost report or is it included in the hospital's big cost report? I'm just curious about allocation of overhead that might --

DR. TORAIN: They have their own cost reports for freestanding and hospital-based IRFs.

MS. WANG: Okay, so they're not absorbing overhead from the mothership hospital?

DR. TORAIN: They are. They still --

MS. WANG: They are.

DR. TORAIN: Yeah.

MS. WANG: Okay. So the margins are -- the margin comparison might not be apples to apples because there's quite a disparity between the hospital-based and so forth.

I'm supportive of the draft recommendation. I'm glad you're going to keep looking at differences in -- case-mix service does seem to be a slightly different population that is being attracted to the different settings. And I would say that, you know, to David's comment, I'm sure what you're looking at in the aggregate is correct about -- it was based on your own interviews about MA plans not using IRFs. Some MA plans do use IRFs, and some MA plans would not send certain members, patients, to a SNF for the care they need. The IRFs -- there's definitely a continuum, but when you look at, you know, Jamila's information for stroke, TBI, the more complicated, you're not sending those people to SNFs. It's just -- you're not doing that. IRF is -- it's an inpatient facility, and so the care that is delivered there,

particularly in the case of stroke, for example, where the two weeks post-stroke, post-event, are so critical and the amount of therapy and so forth can make the difference, you know, in the permanent situation of the patient. So I realize -- this is also hard to discern. And then you have LTCHs, which are geographically concentrated. They don't really exist in every market. So every market seems to have figured out how to fill the need for a certain kind of service with different provider types. So it makes it more complicated to come up with a unified view of where people should go.

My last question, I guess, or curiosity is just about teaching programs in hospital-based IRF. The ones I'm familiar with have full teaching programs for physiatrists and rehab specialists and so forth, and it seems like it's an important site of training. Do freestanding IRFs entertain training programs of that nature?

DR. TORAIN: I know that they're mostly in hospital-based IRFs, and the actual share of IRFs that are teaching status is about 14 percent, but -- and most of them are hospital-based, but I don't know for certain if

there are freestanding IRFs that have training programs as well. But that's something I can look into.

MS. WANG: Do IRFs get IME and GME payments?

DR. TORAIN: They do get IME payments.

MS. WANG: Okay, and is that included, again, in the mothership sort of count, or do they have their own --

DR. TORAIN: That's included in all of their payments. The payment is adjusted for the teaching status and DSH.

MS. WANG: Thank you. I support the draft recommendation. Thanks so much.

DR. TORAIN: And I also wanted to add, just to speak on MA, in our largest publicly traded company, they do have a share of about 10.4 percent MA, and it has increased during the pandemic because of the waiver of the prior authorization. Medicare's still the primary payer, but it is there.

DR. CHERNEW: Jamila, thank you, and, Pat, thank you. So Sue Thompson and then on to Wayne.

MS. THOMPSON: Thank you, Michael, and thank you for a very clear chapter, Jamila. I don't have anything to add to the conversation except to say I strongly support

the recommendation and would agree with David, the current Medicare margins are obscene. So thank you very much.

DR. CHERNEW: Sue, thank you. Wayne and then Karen. Wayne, I think you're muted.

DR. RILEY: Excellent presentation and excellent chapter. Thank you. I support the recommendations. It is eye-popping, the margin. You know, this is my first rodeo looking at some of these payment margins, and this one is one of the other eye-popping ones. So I fully support the recommendation. Great work.

DR. CHERNEW: Wayne, thank you. So Karen and then Marge.

DR. DeSALVO: Thank you, Mike. Thank you, Jamila. Great presentation, and I particularly appreciate your responses to the questions. It's wonderful to hear how much you've been thinking about the challenges in this space, and I look forward to learning more from you as we go forward on the journey.

I support the Chairman's draft recommendations also. I appreciate as well that this seems to be a little bit of a black box space that we needed some more understanding of the use and benefit for the beneficiaries,

but given the positive indicators that you have for the adequacy indicators, I think you all land in a good spot, and I support the draft recommendations.

DR. CHERNEW: Karen, thank you. Marge and then Paul.

MS. MARJORIE GINSBURG: Okay. Great, Jamila. Wonderful job on this report. Thank you so much. And I support the recommendations, and I want to echo what others have said about being concerned about the profit margin in this group and how important it is that we get to it, and also the issue of if MA plans are not using IRFs or are using them sparsely, why is that? And what are the differences that we're seeing in terms of treatment for MA beneficiaries versus Original Medicare? And I think in this category it really does warrant greater exploration of this, because I don't recall any other category that we've looked at where there has been a question that it's predominantly used by those in Original Medicare but not those in MA. And that raises all sorts of sort of red flags for me about what is the value of this particular service and what is our role in assuring that beneficiaries and taxpayers are getting the bargain and the quality that

they're looking for.

Thank you.

DR. CHERNEW: And hopefully this recommendation will help move us in that direction. We will see. That's certainly the intent. Paul and then Larry.

DR. PAUL GINSBURG: Thanks, Mike. I support these recommendations enthusiastically, endorse my colleagues' points about the terrific work by Jamila to get us here, how outrageously high the margins are, and add something that, you know, our discussion today has really shown the potential to -- by observing how MA uses its management tools in the various types of post-acute care, it really sheds a lot of light on where our unmanaged fee-for-service Medicare program is most efficient, particularly most profligate in its spending. And I think we can make use of that information to rethink some of our fee-for-service policies in this area.

DR. CHERNEW: Paul, thank you. Larry and then Dana.

DR. CASALINO: Yes, Jamila, terrific job and great answers to the questions. I too support the recommendation for the reasons other people have already

given. I just want to raise one issue, which does not alter my support for the recommendations, but just to ensure I sound like a broken record.

I do think that we should always think about potential effects of policies on consolidation, and I do suspect that a 5 percent cut will probably lead to more consolidation. That's more of a concern perhaps in this sector since we have one company that owns more than 40 percent of the freestanding facilities. So, you know, increased financial pressure clearly is needed in this area. But it probably will lead to more consolidation. I don't really know what to do about that. And just to finish off, you know, why should we ever care about consolidation? Well, obviously you can raise prices in the commercial sector and possibly for MA, and that has indirect effects potentially on what traditional Medicare winds up paying in the long run.

Then, of course, there's the economic power of large consolidated entities. We saw last year with surprise billing how large physician management companies were able to spend a lot of money and block bipartisan legislation that looked like was certainly going to go

through.

And then, finally, there's the issue of quality, and there's pretty good data in a variety of sectors that decreased competition leads to decreased quality, leaving prices aside. I know that's an issue for traditional Medicare as well. So I don't really see what we can do about that in this situation, but I do think that we should increase financial pressure. I do think that will increase consolidation, which when we already have pretty big consolidation adds somewhat of a worry.

DR. TORAIN: Thanks for your comment. One thing I wanted to say is part of the reason why we include the additional recommendation to expand the outlier pool from 3 to 5 percent -- we've been doing that for the last few years -- is to really focus in on those providers, specifically hospital-based nonprofit IRFs, who do have the costliest cases. In 2019, they're 82 percent of high-cost outlier payments, so I recognize what you're saying, and part of the reason that we include that recommendation is to try to have that in as a safeguard.

DR. CHERNEW: Thank you, Jamila. You're set, Larry? Okay. I got the thumbs up from Larry. So we're

going to go to Dana and then Bruce.

DR. SAFRAN: Thank you, Michael. Jamila, this is a really excellent piece of work, as my colleagues have said, and I'm look forward to thinking together with you about how we bring this into the broader post-acute care reform that we're focused on.

So I very strongly support the Chairman's draft recommendation here without hesitation. I have only two comments. One is that, like others, I find the relative lack of use -- you've corrected us, Jamila, to show there is some use by MA, but the relative lack of use by MA something that I would just like to understand better so that, you know, understanding where patients that under fee-for-service would end up in an IRF, where do those cases go in MA? Obviously, ideally, we would know and how do the outcomes compare, but I understand our data there are going to remain quite limited. But I think that could be very instructive to us.

Similarly, you know, what kinds of use of IRFs are the ACOs making? That would be very valuable to know.

My other comment is much more a personal one, and that is to say, you know, in my own experience with an

inpatient rehab facility, it was in the final months of life, of my father's life, and, you know, so I have a sort of n of 1 experience with one facility, which was owned by one of the dominant companies in this space; and, similarly, an n of 1 experience with a long-term acute-care hospital where my father was before there. And from a family member's perspective, this facility seemed a world better than a kind of frighteningly poor resourced and kind of dark, old, dingy feeling LTCH attached to a hospital compared to a kind of well-outfitted and seemingly really broadly capacity facility with lots of different, you know, ability to handle speech and physical aspects and swallowing and all of that.

And so I say that only to say that, you know, so much of the post-acute care facilities that beneficiaries have access to can often seem kind of rundown, poorly resourced, and at least my own experience with an inpatient rehab facility was that it felt more solid and new and modern, and that had some value as a family member. And so I say that only because I hear us questioning the value of these facilities, and, unfortunately, we don't have good quality or outcome data to tell us their value or their

relative value. But it would be to my mind very useful for us as we continue to think about reform in this whole area of post-acute care to consider how we preserve what's good about them and not end up losing this sector as we seek the reforms that we're seeking.

So thanks. Those are my thoughts.

DR. TORAIN: Thanks for sharing that, Dana. I wanted to say, to your point about what you experienced in the inpatient rehab, I think one thing that I want to do is also explore some of this, quantitatively, of course, but qualitatively. I think that is always important to explore things qualitatively, to provide more context. So that's something that you also want to do with this work around the case mix profitability in IRF.

DR. CHERNEW: Great. And you're set. So we're going to go to Bruce and then to Jaewon.

MR. PYENSON: Thank you, Michael. I support the Chair's recommendation, and Jamila, this is terrific work.

The only thing I want to say is that I think the IRF connection or overlap with SNF is an ideal case for unified PAC work, and the importance of continuing that work, I think, is not just on the payment side but not

being trapped by the historical and licensure distinctions that are perhaps today not very relevant.

Just this morning we are spanning topics from inpatient rehab, hospitalization at home as part of home health, and, of course, SNF. So from a continuity of patient needs, a lot of the distinctions that we're talking about are old and perhaps no longer relevant. That's what we have to deal with from a payment policy. But a unified PAC approach is, I think, a way of overcoming that legacy.

So I would just urge us to find a way to bring into our recommendation a way of mentioning the unified PAC work that we had done.

DR. CHERNEW: Bruce, thank you very much. Jamila, I think we're good. Yeah, okay. So we're going on now to Jaewon and then Betty.

DR. RYU: Yeah, I don't think I have anything to add either. I'm supportive of the recommendations for all the same reasons folks have been mentioning.

DR. CHERNEW: Thanks, Jaewon. So Betty, and we'll close with Jon Perlin.

DR. RAMBUR: Thank you so much, Jamila. Thank you for this fabulous report and also your thoughtfulness

in terms of next steps.

This is an area that was new to me, and I have to say reading this I was stunned at the margins. And perhaps, like David mentioned, my initial impulse was that I need to go to one of these, because I haven't had any recent experience there.

So I really support the importance of a closer look under the microscope, and as we looked at some of the margins and the differences I was also sort of struck that there seemed to be no improvement in quality over time, and, you know, a lot of margin there. And I was also very curious about workforce differences in some of these different settings.

And I'll just close by saying, Dana, I really appreciated your comments. It was really, I think, important for us to remember that in the end there are very local effects on individuals and families. So I thank all the Commissioners for your comments but I appreciated hearing that voice as well. Thank you so much.

DR. CHERNEW: Betty, thank you. Jon Perlin.

DR. PERLIN: So let me start by also thanking Jamila and Kate for terrific work and taking something

that, as a clinician, I thought I fully understood and making it far more complex. You know, this is the old in theory and theory in practice are the same. In practice, they're not. I operated with a mental model that there was a gradation of complexity from home health to SNF to IRF to LTCH. But, in fact, I think the thread of this conversation together suggests that there are SNFs that are highly skilled, and, in fact, may be preferable to certain IRF environments, that across IRFs there are differences in capabilities and certainly patient acuity. And we've already crossed that Rubicon in the LTCH.

So while I support this I do think that, you know, this really does lend itself to a more coherent conversation, not about trying to identify the facility type but trying to identify the patient type and the services they need as the entrée into understanding.

What makes this especially complex is what is that availability in a particular community at a particular time, and that is the one factor that always, even if we have an optimal continuum of what the environments are, gets crossed with the reality of need at a particular moment in a particular community.

So I appreciate it, support it, and I think further work to do in terms of delineating the sort of patient archetypes as we move toward a concept of unification across this bucket of what we're calling post-acute. Thanks.

DR. CHERNEW: Yeah, so thank you, Jon, and in a moment we'll move to LTCH, but I'll summarize quickly that while there is support for this general recommendation there really is -- and I think this is a broader point -- interest in what I would call thinking about patient-centered aspects of payment. We have a provider-centric payment system, for obvious reasons, and you can just hear, through a whole range of comments, the patient-centricness, both in terms of getting people to the right side of care, making sure the site that they go to is providing appropriate quality, and a whole slew of things like that, so we can get some sort of flexibility. And I agree with that, by the way. It is a hard task but certainly one that MedPAC has moved forward in thinking over the past several years.

So I appreciate all of those comments, and now we're going to move on to the LTCH session, and Kathryn

will lead us in that conversation. So Kathryn, I am turning it over to you.

* MS. LINEHAN: Great. Thank you. Yes, good afternoon -- it is afternoon on the East Coast. A reminder to the audience that a PDF of the slides is available in the handout section of the control panel.

I want to thank Carolyn San Soucie and Stephanie Cameron for their help with this chapter.

Our last session is about how payments to long-term care hospitals should be updated for fiscal year 2022. I will begin with some background on LTCHs and the dual-payment rate system, proceed to our framework, and conclude with the Chair's draft recommendation for the 2022 update.

To qualify as an LTCH under Medicare, a facility must meet Medicare's conditions of participation for acute care hospitals, and must have an average length of stay for certain Medicare cases of greater than 25 days.

Starting in 2016, Medicare has paid LTCHs according to a dual-payment rate system. The LTCH PPS standard payment rate applies only to qualifying LTCH stays that had an acute care hospital stay immediately preceding LTCH admission and for which either the acute care hospital

stay included at least three days in an ICU or the case received mechanical ventilation services in the LTCH for at least 96 hours. Cases meeting the LTCH PPS criteria are paid under the LTCH PPS. All other stays are paid the lower site neutral rate.

I want to take a minute to orient us to the timing of the dual-payment rate system phase in 2019 and beyond, because it is important context for our interpretation of our payment adequacy metrics. It also provides a rationale for why we condition some of our analyses on LTCHs with a high share of cases meeting the LTCH PPS criteria.

Starting in 2016 and through 2019, non-qualifying cases receive a blended payment of 50 percent of the higher standard LTCH PPS rate and 50 percent of the lower site-neutral rate. In 2020, blended rates were to be phased out and the full site-neutral rate phased in. Finally, in 2021, site-neutral payments were to be fully in effect for the entire year for all LTCHs.

However, as discussed in the paper, the CARES Act temporarily waived certain provisions relating to site neutral payments during the coronavirus public health

emergency to allow for expansion of inpatient capacity.

Now some summary data on LTCHs in 2019. Care provided in LTCHs is relatively expensive. The average Medicare payment per case was about $41,000 across all cases, and $47,000 across the cases meeting the LTCH PPS criteria. LTCHs are also infrequently used. Fee-for-service Medicare beneficiaries had about 91,000 stays. Total Medicare spending on care furnished in 361 LTCHs was approximately $3.7 billion in 2019.

To determine the update recommendation for fiscal year 2022, we review payment adequacy using the framework you've seen for all the other sectors.

To begin, we will focus access to care where we examine use, provider capacity, and occupancy. When considering access to care in LTCHs, it is important to note that many beneficiaries may receive similar services in a short-term acute care hospitals or some skilled nursing facilities.

The number of LTCH cases for fee-for-service Medicare beneficiaries has been declining since 2012, but most of the reduction came from site neutral cases, the blue bars. As a result, the share of LTCH cases meeting the

criteria, the green bars, has increased. In 2019, 75 percent of LTCH cases met the PPS criteria, a sign of some success of the dual payment rate system in reducing the number of site-neutral cases.

Between 2018 and 2019, the number of LTCHs decreased 3.5 percent. Since the dual-payment rate system began through 2020, 78 LTCHs have closed. Closures were expected with the phase-in of site-neutral payments. These closures were primarily in markets with multiple LTCHs.

In 2019, occupancy was unchanged from 2018, averaging around 63 percent. This suggests that LTCHs had ample capacity in the markets they served.

LTCHs' aggregate marginal profits suggest that LTCHs with available beds continue to have a financial incentive to increase their occupancy with beneficiaries who meet the criteria. The average LTCH marginal profit on original Medicare cases was about 15 percent. For LTCHs with a high share of Medicare cases meeting criteria, marginal profit was 17 percent.

We examined two sets of quality measures for LTCHs. The first are the new risk adjusted measures we used in all PAC settings that you have seen earlier today.

For LTCHs we find rates of hospitalizations, admissions and readmissions, were 5.3 percent in 2019. This rate was generally consistent with prior years of the dual-payment rate phase-in. By contrast, average rates of successful discharge to the community have trended down. Higher rates are better in the period. In 2019, 22 percent of stays resulted in successful discharges to the community. Rather than being an indicators of Medicare payment adequacy, this likely reflects changing patient acuity in the period.

The second set of measures are unadjusted mortality rates for Medicare cases that we have reported in prior years. Unadjusted mortality, both in-LTCH and 30 days after discharge, were unchanged from prior reported trends in 2019, for qualifying and not qualifying cases.

Moving on to access to capital. Given a decade of policies that have limited industry growth and the implementation of the dual-payment rate system, the availability of capital has been limited across the industry during this period. We expect this to continue until after the dual-payment rate system is fully phased in at the end of the public health emergency.

LTCHs' access to capital also depends on their

all-payer profitability, which was 2 percent in 2019. LTCHs with a high share of Medicare cases meeting the PPS criteria had an aggregate all-payer margins of 3.2 percent in 2019.

The final element of our payment adequacy framework is payments and costs for Medicare cases. Year-over-year cost per stay growth in the dual-payment rate system phase-in period was variable among all LTCHs, in blue, and those with a high share of qualifying cases, in green, as LTCHs adapted operations to the dual-payment rate system and due to declining volume.

For the cohort of LTCHs that have achieved a high share of LTCH-PPS qualifying cases by 2019, the green row, costs per stay increased 4.1 percent between 2018 and 2019. This is an uptick from the previous two periods and reflects a transition to greater shares of higher-acuity LTCH PPS qualifying cases and declining volume overall.

In 2019, the aggregate Medicare margin for all LTCHs, in blue, fell to −1.6 percent as providers' costs grew more than Medicare payments. For-profit LTCHs, which accounted for about 80 percent of all LTCHs in our cost report analysis, had higher margins than nonprofit LTCHs.

To understand the performance of providers under the LTCH PPS, we focus the subset of LTCHs with a high share of qualifying cases, in green. Among these providers in 2019, we find a higher and positive aggregate margin of 2.9 percent. Here again, we see higher margins among for-profit LTCHs.

This slide compares LTCHs in the top quartile for 2019 Medicare margins, an average of 16 percent, with those in the bottom quartile, who had average margins of -29 percent. Looking at the characteristics of cases, the teal segment, or I guess the blue segment, high-margin LTCHs had more cases and higher occupancy rates, so they likely benefit more from economies of scale. They also have a higher Medicare share, higher mean case mix index, and greater share of cases meeting the LTCH PPS criteria. Finally, as shown in the lime green segment, high-margin LTCHs had standardized costs per case that were almost 40 percent lower than low margin LTCHs.

So, higher acuity on average and lower costs per case among the high-margin LTCHs illustrate profitability under the dual-payment rate system.

As in previous years, our projection of the LTCH

margin focuses on LTCHs with a high share of cases paid under the LTCH PPS. We project that the Medicare margin for these LTCHs will decrease in 2021 to 1.2 percent. This projection is based on average historical levels of cost-per-case growth for these LTCHs in the dual payment rate system phase-in period that exceeds increases in Medicare payments.

While we expect growth in cost per case after the phase-in period is over to stabilize at a rate closer to pre-dual payment rate system levels, we expect recent historical levels to persist into 2021.

On the environmental front, since early 2020, the coronavirus has had tragic effects on beneficiaries and health care workers. As noted earlier and discussed in the paper, it has also affected Medicare payments for all provider types, including LTCHs. Specifically for LTCHs, CMS waived the 25-day average length-of-stay requirement when an LTCH admits or discharges patients to meet the demands of the public health emergency.

The CARES Act also temporarily waived Medicare policies to allow for expansion of inpatient capacity. All Medicare cases are paid the LTCH PPS standard rate. The

CARES Act also gave LTCHs access to additional funding sources.

While we don't have complete data on Medicare volume for all LTCHs in 2020, the largest provider of LTCH services reported a 2 percentage point increase in occupancy from 2019 through the end of the third quarter of 2020. Public health emergency-related payment policy changes will likely affect volume, case mix, payments, and costs for all LTCHs in 2020 and 2021 due to relaxed site-neutral policies.

In sum, occupancy rates across the industry were steady in 2019. Although volume of LTCH services continued to decline, this is in large part due to reduction in non-qualifying cases. In terms of quality, unadjusted mortality rates appear to be stable as were risk-adjusted rates of hospitalization. Risk-adjusted rates of discharge to the community declined slightly between 2018 and 2019. The effect of fully implementing the dual-payment rate system, will continue to limit industry growth and access to capital in the near term. The aggregate margin for LTCHs with a high share of cases meeting the LTCH PPS criteria was 2.9 percent in 2019. Our projected margin for

these LTCHs in 2021 is 1.2 percent.

Medicare payments to LTCHs are not updated in statute, so our recommendation is made to the Secretary. The Chair's draft recommendation reads, For fiscal year 2022, the Secretary should increase the 2021 Medicare base payment rate for long-term care hospitals by 2 percent.

CMS typically makes the update based on market basket and productivity forecast which are currently 2.7 and 0.1 percent. A 2 percent recommendation is expected to reduce federal program spending relative to the expected regulatory update, given the current projections. We anticipate that LTCHs can continue to provide Medicare beneficiaries who meet the LTCH PPS criteria with access to safe and effective care.

And with that, I will turn it back to the Chair.

DR. CHERNEW: Great. Thank you so much. That was really helpful and another wonderful presentation.

I'm going to start with David Grabowski, actually, and then go on to Wayne and Bruce.

David?

DR. GRABOWSKI: Great. Thanks, Mike, and thanks, Kathryn for this great work.

So I'll start by saying I'm supportive of the draft recommendation. I should acknowledge I've been pretty critical even at these meetings in the past of LTCHs. I've been quite suspicious about whether they actually offer high-value care and where they fit into this post-acute care continuum. However, two issues have really changed my perspective and had led me to being much more supportive of a rate increase here.

First, I'll sort of echo what Kathryn said during her presentation and in the report as well. I believe the dual payment rate structure has been successful. It led to some closures and some reconfiguring of local markets, but it's also led to more appropriate care. So I do think it's been successful and encouraging higher-value care.

I'll just put in a plug now, and this isn't really what I was asked to speak about. But I believe post-pandemic, we should go back to the dual payment rate structure that was working before, and we should continue to take steps towards the full implementation of that dual payment rate structure.

The second reason that I'm, I guess, very supportive of this rate increase is just I think LTCHs have

shown to be a really important piece here during the pandemic, and I realize this was hopefully a once-in-a-generation event. But it did show kind of a role for LTCHs that I really wasn't -- I hadn't been thinking of prior to this.

A colleague and I published a Health Affairs blog on this, but we kind of outlined three roles for LTCHs that were really quite helpful. I think, first, LTCHs served as specialized providers of COVID care, so allowing hospitals to discharge individuals. Many skilled nursing facilities weren't able to do this care safely. LTCHs were much better positioned, given single rooms and better infection control, and they were able to take these cases.

We saw an LTCH here in the Boston area, for example, specialize in COVID care. In other markets, a second issue we raised in this blog was that they became kind of a relief valve, if you will, for hospitals in some markets where they weren't taking COVID patients, but they were taking the non-COVID patients. And they were able to do that.

Then, finally, we raised the issue of tele-ICU and just the capacity and work that LTCHs had in this area

and they were able to apply in some markets during the pandemic.

So I do think going forward, LTCHs don't just have -- I think we're paying them more appropriately, but they also, I think in my mind, have a more defined role in our continuum, and I think I saw some real advantages to this model during the pandemic. So I'm hopeful we won't have this again, but I do think they serve an important function there.

So I'll stop there, Mike, and just say that, once again, I'm supportive of the draft recommendation. Thanks.

DR. CHERNEW: David, thank you.

In a moment, I'm going to go to Wayne.

Just for people who may be listening at home or wherever you happen to be, there's another thing you might read, if you don't commonly read the journal Econometrica, but there's a great article on this area in Econometrica by Liran Einav from Stanford, Amy Finkelstein from MIT, and Neale Mahoney who is now actually also now at Stanford, was in Chicago.

So I think that's an article worth reading. It certainly has informed a lot of my thinking, but in lieu of

that, let's go to Wayne and then on to Bruce and then Brian.

DR. RILEY: Thank you, Mr. Chairman. That's not a journal I often see at Barnes & Nobel or in the medical library here in Brooklyn. So maybe --

DR. CHERNEW: Thank God.

DR. RILEY: -- we'll have to buy -- give us just a reprint.

But I want to second what David just said because during COVID, I too basically had undervalued the contribution of LTCHs to the continuum of care pre-COVID, and as David just laid out superbly, LTCHs were a safety valve that proved to be very, very helpful to acute care hospitals like mine in Brooklyn that was designated by the governor as entirely COVID only, but for the fact that we had access to LTCH transfers and dispositions, we would have had more difficulty with our patient care mission.

So I think this is a moment for the LTCH industry to really highlight its value, and so, therefore, I am in support of this payment adjustment.

DR. CHERNEW: Wayne, thank you.

Now we're going to go to Bruce and then Brian.

DR. PERLIN: Thank you, and, Kathryn, terrific work. Thank you.

I was struck by Figure 6 that shows that for qualifying cases, the mortality rate is about 30 percent within 30 days of discharge or within the hospital stay, and that's not as high as the mortality rate in hospice. But it does suggest that there's a high portion of people entering LTCH who are at extremely high risk of dying, and it's unclear. Of course, we don't have the data on what portion of them were expected to be terminally ill.

But this is, I think, an issue that has been persistent. The numbers haven't really changed since 2015. Perhaps they will look different in 2020 because of COVID. But it raises questions that I think other Commissioners have raised in the past about the nature of patients going into LTCH and to what extent are LTCHs inexpensive and not high-quality way of treating terminally ill patients.

I respectfully disagree with my fellow Commissioners. I suspect that LTCHs are probably not the most efficient way to provide surge capacity to our health care system. I'm glad we had it, but perhaps that's not the context for looking at reimbursement policy for 2022.

So I'm less comfortable about the rate increase, and consistent with our stated policy of making adjustments where they're needed on a special case basis, I don't see the surge capacity that LTCHs provided in the public health emergency as a justification for the rate increase.

Thank you.

DR. CHERNEW: Bruce, thank you. Those are important comments.

Brian. And then after Brian, we will go to Paul Ginsburg.

DR. DeBUSK: Well, thank you for a very well-written chapter.

I do support the Chairman's recommendation of an increase here. I also want to echo some of David's and Wayne's comments about LTCHs in general.

I do also agree, however, with Bruce in that I think appreciating the importance of having surge capacity doesn't necessarily mean that we should design Medicare around a worst-case scenario. While I support the increase in the update, it isn't really due to the surge issue as much as it is watching our thoughts around LTCHs evolve.

When I joined the Commission in 2016, there was a

tremendous amount of skepticism around LTCHs and what value do they offer and what quality do they deliver, and I believe the implementation of this case criteria and LTCHs responding as well to the case criteria is really -- it's a lesson in how we can tighten the qualifications for what it took for a beneficiary to enter an LTCH, how the providers responded appropriately, and at least for me personally, a lot of my confidence in LTCHs has been restored. So I'm excited this year to be part of recommending a payment, an update, a favorable update, because I think some of our confidence in LTCHs has been won back in how they responded to this case criteria.

Thank you.

DR. CHERNEW: Thank you, Brian.

Paul, you're up.

DR. PAUL GINSBURG: Sure. I'm glad I followed Brian because I really support all the things he said. He said them very well, and as a key thing, I support the recommendation.

DR. CHERNEW: That went so quick, I wasn't able to give Pat a heads-up.

Pat, you are next, and you are going to be

followed by Amol.

MS. WANG: Okay. Thank you.

I am fine with the draft recommendation, and I really appreciate the Commissioner's comments about a newfound appreciation for LTCHs because of the role that they play in the pandemic. They're very well suited. They do bench care. They have single-patient rooms. They are accustomed to taking care of extremely ill patients, but like Bruce, I do not see that as any way, shape, or form connected to support for the draft recommendation.

If I felt that way, I would have voted for increases to other sectors as well. LTCHs are not unique in stepping up in a unique way.

It's just funny. It goes back to the earlier discussion. LTCHs are not uniformly, geographically available, and the system develops itself to kind of find a way to provide the services with different provider tacts and we just finished the discussion of IRFs. At least I'm aware of hospital-based IRFs in my market that took COVID patients and got turned into COVID wards and stepped up and played that role. so I think that there are many different ways to -- many different provider types stepped up to

help.

Bruce, the one thing that I would say, your observation about the 30 percent mortality rate, my feeling about LTCHs and the value of LTCHs is that that is -- I doubt very much that those patients or their families believed that their loved ones were terminally ill when they were admitted to an LTCH. I think the mortality rate is more, perhaps, an indication of just how sick they were, because LTCHs really do -- you know, I think the value of LTCHs, that does have to be appreciated, like what David Grabowski was referring to before about the overlap between what an IRF should do and what a SNF could do. You know, there's a similar discussion perhaps for LTCH, and there are certainly cases that LTCHs take that require their specialization and in vent care, in particular. So I think that they do provide important value there.

But bottom line, I support the draft recommendation based on the analysis, the great analysis that Kathryn did, and irrespective of the role that they may have played during COVID.

Thanks.

DR. CHERNEW: Pat, thank you.

We're going to go to Amol and then Sue.

DR. NAVATHE: Thank you.

I agree with a lot of what the previous Commissioners have noted.

If I just reflect upon my own experiences as a clinician, I have certainly taken care of many patients with spinal cord injuries who reside primarily in LTCHs, and then I've cared for them in the hospital. And understanding their experience, I would say that LTCHs do play a fairly important role here for well-defined and sick populations. So I think we should be mindful of that as we think about LTCHs' place overall in the broader post-acute and overall health care delivery system.

And I agree with what many of the Commissioners have said about both giving more posit about them in the concept of dual payment system but also in their general contributions to supporting care in the pandemic.

So with all that said, I would say I certainly support the Chairman's draft recommendation here, and I don't have anything else to add other than what the Commissioners have already said.

Thank you.

DR. CHERNEW: Amol, thank you.

So we'll go to Sue and then to Marge.

MS. THOMPSON: Thank you, Michael, and I will be brief.

I think this has been a very rich conversation. I also agree, I do think LTCHs do play a very important role in care of long-term patients, especially those with ventilators. Many times, it can be difficult to find placement of those patients. So for reasons well stated by previously made comments by my Commissioners friends, I do support the recommendations of the Chair regarding LTCHs.

DR. CHERNEW: Sue, thank you.

So now we'll go to Marge and then Jaewon.

MS. MARJORIE GINSBURG: Thank you.

Actually, I have nothing more to contribute than what my colleagues already have, and I support the recommendations.

Thank you.

DR. CHERNEW: Then we will go to Jaewon and then Karen.

DR. RYU: Yeah. I support the recommendation as well and also agree that LTCHs probably play a role for a

very specific subset of patients, but I continue to believe that it's a smaller role and a smaller subset than what we're still seeing, although I think the dual payment approach probably helped to hone in on it a little bit. But all of that being said, I do support the recommendation.

DR. CHERNEW: Jaewon, thank you.

We'll go to Karen and then Dana.

DR. DeSALVO: Thank you.

I do support the Chairman's draft recommendation. I appreciated your comments, Bruce, to make sure that we're doing this consistent with our principled approach to provide surge funding as one time and then consider the payment updates as the baseline, so just probably incumbent on all of us to give that one more good look and make sure that we're having a principled approach to all the payment updates.

And I would ask that we continue to think about how we're assessing quality in this context. We have had some pretty robust conversations maybe a couple years back thinking about the challenges of defining what optimal outcomes are for this very sick population.

So I don't think we ever solved it, but we had some ideas. And I would welcome the opportunity to be able to talk about it again because I think this is one of these places where these are difficult conversations, really complex beneficiaries. On the other hand, we want to make sure they're getting the best care possible.

DR. CHERNEW: Thank you, Karen.

So that takes us to Dana, and then we'll go to Larry.

DR. SAFRAN: Thank you, Michael.

My comments are almost exactly what Karen has just outlined. So just very briefly, yes, I'm in full support of the Chair's draft recommendation. Like Karen and Pat, wanted to voice my appreciation for Bruce's points about even as valuable as LTCHs have been during the public health emergency, their surge capacity shouldn't be the reason for our rate increase.

And then, as Karen said, what I've been sitting and thinking a lot about is when can we revisit the issue of measuring quality and outcomes for this population and patient experience, if that's not already considered to be subsumed under the quality or outcomes piece.

So I look forward to being able to discuss that at some future time. Thanks.

DR. CHERNEW: Dana, thank you. Larry and then Jon.

DR. CASALINO: Yeah. I'm not sure that I have anything new to add, maybe just a little nuance. I think the comments from David and Wayne were very interesting and moving, but I agree with Bruce that logically it's not our job, I don't think, to consider where service capacity can come from, although one does wonder whose job it is, because I'm not sure, going forward, that's going to be a job that gets done too well. But I think Bruce is right. It shouldn't really be a factor in what we're considering.

I think the nuance I can add, and Amol and Sue alluded to this, is looking at this from the point of view of a clinician in the hospital who wants to discharge a patient and needs a place to send them. It does seem that most of the kind of patients who are going into LTCHs now are not patients we would be comfortable sending at least to the vast majority of SNFs, and probably they wouldn't be appropriate, by and large, for IRFs.

So I think there is a role for LTCHs, and as long

as we're paying them appropriately and the margins are not extreme, which they clearly are not, it seems like a reasonable thing to do. So I support the recommendation.

I just also want to reinforce Dana and Karen's comments. I do think that some form of patient and family experience measure of quality would be important. I think with people who have been so sick and maybe are going to be very sick for the rest of their lives, their experience and the experience of the people who love them and who are coming to visit them in the hospital I think are very relevant measures, if those can be obtained.

DR. CHERNEW: Larry, thank you. Before we jump on to Jon, who will be followed by Betty, I will say that the surge issue was not a factor in the recommendation that we made, just for record. That was not what we were relying on. And, frankly, if you were to read the paper that I read, that I talked about before, the Einav, Finkelstein, and Mahoney paper, you would see that they leveraged, in part, the areas of the country where there actually are no LTCHs. So what certainly seems to be true with the existing non-LTCH payment rates, we are able to run a health care system without demonstrably worse

outcomes, in markets that don't have LTCHs in them. I think that would be my characterization. Kathryn or Jim may want to make a broader comment about how we think about it on paper but how we think about those areas.

I think the issue that underlies the recommendation is much more that we have moved towards this other dual payment system and there are some changes going on, and I think the idea of letting that play out a little bit is very useful, based on where we think we are now. And that, I think, is probably, at least in my thinking, the view of how we ended up where we ended up. The sector, in part because of the changes, has actually been shrinking some.

So, Kathryn, if you want to add anything to that, that would be interesting, or Jim, you might as well. Then we will go to Jon Perlin.

MS. LINEHAN: No thanks. That's exactly right, and the recommendation is based on our usual framework and the factors that we reviewed in the paper. So thanks for clarifying.

DR. CHERNEW: Jim, do you have anything? That's a no. Jon Perlin.

DR. PERLIN: All right. Well, actually in conjunction with Larry's comments and Kathryn's chapter they really lead into what I want to say. I support the recommendation. I actually don't see this as a COVID response but really a response there, that the policies that we've been working with the past couple of years seems to, in fact, be working, as demonstrated by the complexity of the patients that are there now.

And, you know, whether or not it's in LTCH, there clearly is a category of patients that need this level of acute services. And that leads me back to ditto to our conversation with respect to IRFs, Mike, your terrific comments. I think we have an opportunity to move from a taxonomy that is provider centric to a taxonomy that's patient centric, supported on a foundation of capabilities that provider institutions, environments, including the home, might have in place. I hope that characterizes some of our work going forward.

As a parentheses, I realize that surge is not, in a sense, our technical problem in a particular domain, but overall it's kind of our problem. There is a question. How tightly do we want to the whole system to run? Don't

get me wrong -- I'm not pressing back against needed economies, but if you look at some of the areas where we said, okay, there are efficiencies that don't impact patient care, is that really true? Just-in-time inventory and supplies is a perfect demonstration of that.

So I just note that as an aside, another point we had talked to, but in this instance I support the recommendations and it's rewarding to see the policy attempt actually coming to fruition. Thanks.

DR. CHERNEW: Jon, thank you. We have Betty, and we're going to close with Jonathan.

DR. RAMBUR: Thank you so much. Thank you, Kathryn and staff for a great report, and thank you to the fellow Commissioners. This has been very illuminating to me.

As a new Commissioner, looking at this, really at this level for the first time, I have really been persuaded by all of your arguments and I'm very pleased to hear that the surge piece, although it ended up being beneficial to all of you, or to many of you, is not the deciding issue. So I support this recommendation.

I do have to say I am sort of stunned thinking

about the work of today, building on what Jonathan said, about needing to get to a more patient-centric kind of flow of things. Because we have all these different payment models that can't help but create some kind of payment silos. And so I really hope we can focus on that work.

And just in closing, I keep thinking of Einstein's formula, E=mc2 explains like the whole universe, and we have like 1,000 pages for one delivery site. And to get to some greater elegance that can really support providers and patients and taxpayers I think is a really worthy long-term goal.

So thank you so much for all your insights.

DR. CHERNEW: So a few comments on that. The first is that of course alternative payment models, particularly ACOs, and even MA, in some sense, are, by definition, patient centric. That's how they work. One alternative, of course, is an episode-centric version. So again, I would be remiss if I didn't want to call out the connections between how we spend our December and January and how we think about some of these other payment models. I think we actually have the mechanisms already in the system to think about that. We just have to continue the

work we've been doing on that.

And I was going to say it at the end but I'll say it now, just because your comment gives me a chance to say this, Betty. It may seem like 1,000 pages. It's not quite. But that's really a tribute to the incredible thoroughness that the staff has done. And though I'm saying this now, in the LTCH session with Kathryn, this really is something I should say at the end of the meeting, in recognition of all the staff and all of the chapters. It is an enormous amount of work to prepare for this meeting and then to prepare for the January meeting, and the level of thoroughness and expertise that the staff has across the board on all these things is really remarkable, given the details of these programs. So I really do appreciate that. And that's why the chapters are so thorough.

In any case, I'm sorry, that's a bit of a digression. I'm going to now go to Jonathan to see if he has any comments on LTCHs.

DR. JAFFERY: Yeah, thanks, Michael, and first off I want to echo your appreciation to the staff's expertise and thoroughness. Actually, Kathryn, I want to

start off with a question that I think builds a little bit maybe on the comment that Jaewon made about sort of how do we continue to narrow in on what the right patient population might be.

Do you have any sense, or do you think we have the ability to take a look at some of the outcomes that you looked at under the PPS system a little more granularity based on the two different criteria, the 96 hours of ventilation versus 3 days in ICU? I sort of preface that, I've made this comment in some previous meetings, where my sense is that while the ventilator criteria is pretty clear-cut, three days in an ICU can be a lot of different things, depending on what hospital and a variety of other factors.

MS. LINEHAN: I can look into it. I don't know off the top of my head. But we're always constrained in this sector by the low volume of patients, but I will get back to you and see what's feasible.

DR. JAFFERY: Okay. Thanks. And that was sort of the crux of my wondering how big a volume you had in each of those versus the whole.

So with that said, I guess I am sort of more in

the Bruce camp on this, of being concerned about, still not totally clear about how much value I think we have here as a sector. And again, this is something I've said before. I continue to struggle with where LTCHs fit in a post-acute care continuum versus actually part of acute care, and I think this conversation sort of reinforces that for me a little bit, thinking about how, to the extent that it did supply surge capacity under the public health emergency, it was for acute care hospitals, largely.

And so I do wonder, as we focus more and more in on what the right patient population is, I feel like our dual payment system has been very successful. This policy has been very successful towards getting what it was intended to get. But I'm still not sure if that's the most effective and efficient way to manage what could be a narrower and narrower subset of very sick patients.

I guess one of my big concerns about that is predicated on my own experience, which is about a decade's worth of rounding in an LTCH and seeing a fair bit of disruption for beneficiaries, for patients and families, as they go from one facility to the next and often back again. And I wonder if, in the long term, there aren't better ways

for patients to get their needs met in these very, very sick subsets of the population, including additional outlier payments in acute care hospitals and things like that.

So again, I think that the policy has been great to what we wanted to get to, but I do have some of those longer-term concerns and I look forward to additional discussions on this matter.

DR. CHERNEW: Yeah, this is certainly going to be an area where as things play out we will have continuing discussions on this particular point. I think that is spot on and a fine way to end this session.

I don't have a lot of broad summary comments about this session. Paul, I think you wanted to make a comment I think more generally, so I'm going to turn it over to you for a minute.

DR. PAUL GINSBURG: Thanks, Mike. You know, you had started the process of general comments when you praised the staff for the really outstanding and really important work they do for this session and all of our sessions, and they are an important part of the Commission's success.

I also wanted to point out that there are two staff, Jim Mathews and Dana Kelley, who do very important work behind the scenes that makes the staff work we see so valuable, and I just want to give a shout-out to them for their contributions.

And finally, Mike, I just want to praise you for the leadership you've made during this meeting, but other meetings and between the meetings. Thanks.

DR. CHERNEW: Thank you, Paul. I must say that this is a daunting task, in general, particularly daunting to be virtual, particularly daunting because many of you have actually never had the pleasure of meeting in person, and I hope we can do that. But I will say that I am soothed by being in this with such a wonderful group of Commissioners, and in general, when you tell people you're involved in MedPAC, the modal comment is, "What a great group of Commissioners," and that is certainly true. And I appreciate all the seriousness with which you take each of these topics.

So again, the appreciation goes both ways. I am really grateful.

So we have gone through our last session. I will

say to the public that it is very important to MedPAC institutionally, it is very important to me personally, to be able to hear feedback from you. We have a mechanism by which that happens when we are able to meet in D.C. We have put in place mechanisms to enable that feedback while we do this virtually.

And so in a moment I'll ask Jim to say more, but I would encourage you to give comment through the website or to otherwise reach out. They are taken seriously, and you should know that the staff does report back to me and the Commissioners who they have spoken with and the nature of those interchanges in the Executive Session. So we do take seriously the views of the public writ large and appreciate all of the attention to folks that have been joining us for these virtual meetings.

So that's going to be my closing remark, and thanks. Jim, do you want to add anything?

DR. MATHEWS: No. You did good.

DR. CHERNEW: All right. It has been a productive if not long two days. Thank you, everybody. Please stay tuned. We are obviously going to pick up on all of these topics again in January, and we look forward

to hearing from you.

Again, thanks again. Have a wonderful and particularly safe weekend, and happy holidays to all.

* [Whereupon, at 12:48 p.m., the meeting was adjourned.]