MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, December 12, 2024
10:32 a.m.

COMMISSIONERS PRESENT:

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1 P R O C E E D I N G S

2 [10:32 a.m.]

3 DR. CHERNEW: Hello, everybody, and welcome to
4 the December MedPAC meeting. As is the norm for the
5 December MedPAC meeting, we are going to be discussing the
6 update recommendations for a range of different Medicare
7 fee schedules. And we are going to start with one that
8 attracts a ton of interest, which is the physician and
9 other health professionals fee schedules, the PFS, as we
10 call it. And we will start with Geoff. So Geoff, take us
11 through it.

12 MR. GERHARDT: Thanks, Mike, and good morning to
13 everyone.

14 In this session, we'll assess the adequacy of
15 payments for physician and other health professional
16 services,
17 and present the Chair's draft recommendation of how to
18 update payment rates for 2026. We want thank our
19 colleagues, Rachel Burton, who couldn't be here today, and
20 Ledia Tabor for their assistance with this work.

21 For those watching online, a copy of these slides
22 is available in the Handouts section of the webinar's

1 control panel, on the right side of the screen.
2 Our presentation will begin with a quick overview
3 of use and spending under Medicare's physician fee
4 schedule, and we will recap a recent policy that has
5 resulted in the conversion factor declining in recent
6 years. We'll give an overview of the indicators we look at
7 when assessing the adequacy of payment rates, and then dive
8 into our findings regarding beneficiaries' access to care,
9 the quality of their care, and we'll also discuss how
10 clinicians' revenues compare to their costs. We'll end
11 with the Chair's draft recommendation, and your discussion.
12 We start with some background.
13 In 2023, approximately 1.4 million clinicians
14 billed Medicare's physician fee schedule for 666 million
15 clinical encounters with 28.2 million beneficiaries in fee-
16 for-service Medicare. The Medicare program and fee-for-
17 service beneficiaries paid a total of $92.4 billion for fee
18 schedule services.
19 An important contextual fact to keep in mind when
20 thinking about payment rates for clinician services is the
21 recent revaluing of evaluation and management visits. In
22 2021, CMS increased the payment rates for many office and

1 outpatient E&M visits, an example of which is shown in the
2 left graph. This increasing the payment rate for these
3 services required a minus 6.8 percent budget neutrality
4 adjustment to the fee schedule's conversion factor, since
5 CMS's changes to the values of individual codes are
6 required to be budget neutral.
7 To prevent a cut to the conversion factor of this
8 size in a single year, Congress enacted a series of one-
9 year-only increases from 2021 to 2024, which had the effect
10 of gradually phasing in the budget neutrality adjustment,
11 as shown in the right graph. As a result, while it is true
12 that the conversion factor has declined in recent years,
13 it's important to remember that the payment rates for
14 office visits, which are the billed frequently by many
15 types of clinicians, have increased substantially.
16 In 2024, payment rates for certain office visits
17 were further increased when a new add-on code was added to
18 the fee schedule, as shown by the dotted line in the left
19 graph.
20 Turning to assessment of the adequacy of
21 Medicare's current payment rates, this slide shows the four
22 domains that the Commission looks at when formulating our

1 recommendations about update payment rates this year.
2 These domains can be hard to directly measure, we so we
3 look at a number of different types of data to come up with
4 an overall assessment of whether current payment rates are
5 adequate or need to be increased or decreased.
6 In the case of clinicians, we explore
7 beneficiaries' access to care and the quality of their
8 care. Unlike other presentations you'll see today, we do
9 not assess clinicians' access to capital due to data
10 limitations, but we do examine growth in clinicians'
11 revenue and costs.
12 Our assessment of the various indicators on this
13 slide inform the Chair's draft recommendation for physician
14 fee schedule service rates in 2026.
15 Now for our findings.
16 One of the main ways we assess beneficiaries'
17 access to clinician care is through a short, quick-
18 turnaround survey we have fielded annually for over 20
19 years. We survey Medicare beneficiaries ages 65 and over,
20 as well as a comparison group of privately insured people
21 ages 50 to 64. In our 2024 survey, Medicare beneficiaries
22 continued to report access to care that was at least as

1 good as that reported by privately insured people. On most
2 questions in our survey, Medicare beneficiaries actually
3 reported better access to care.
4 As shown here, higher shares of Medicare
5 beneficiaries reported being satisfied with their ability
6 to find providers that accepted their insurance, and
7 satisfied with their ability to find providers that had
8 appointments when they needed them. Higher shares also
9 said they "never" or only "sometimes" had to wait longer
10 than they wanted to get an appointment for routine care, or
11 to get an appointment for an illness or injury.
12 In response to special interest in the topic of
13 wait times among Commissioners and Congress, we added new
14 questions to our survey this year. We found that among
15 people who tried to get a new primary care provider in the
16 past year, waits reported by Medicare beneficiaries and
17 privately insured people were comparable with each other,
18 and in some cases Medicare beneficiaries had shorter waits.
19 The circles show that Medicare beneficiaries were more
20 likely to be seen by a new primary care provider in 1 to 2
21 weeks, and less likely to be seen in 3 to 5 weeks, compared
22 with privately insured people.

1 We saw a similar pattern when we asked about
2 waits for appointments with a new specialist. Medicare
3 beneficiaries were more likely to be seen by a specialist
4 in less than 1 week, and less likely to wait 6 weeks or
5 more, compared with privately insured people.
6 Once beneficiaries find a new clinician and
7 establish a care relationship with them, subsequent
8 appointments seem to be easier to schedule, according to
9 our analysis of CMS's 2022 Medicare Current Beneficiary
10 Survey. CMS's survey, unlike our survey, groups together
11 appointments with new and existing clinicians. Their
12 survey finds that among Medicare beneficiaries who recently
13 had an office visit scheduled after the beneficiary reached
14 out to a doctor's office to set it up, 39 percent were seen
15 in less than 1 week and 34 percent were seen in 1 to 2
16 weeks. These are much shorter wait times than those
17 reported in our survey, which focused only on wait times
18 for a beneficiary's first appointment with a new clinician.
19 One subgroup of Medicare beneficiaries that
20 report having relatively more difficulty accessing care are
21 low-income beneficiaries. As shown on this slide, the
22 Medicare Current Beneficiary Survey indicates that

1 beneficiaries with incomes low enough to receive Part D
2 low-income subsidies have more difficulty accessing care
3 compared to beneficiaries with higher income. This could
4 be for a variety of reasons, including that fact that most
5 state Medicaid policies result in clinicians receiving less
6 revenue when caring for dually enrolled beneficiaries than
7 when caring for non-duals.
8 In 2023, the Commission recommended creating add-
9 on payments for services delivered to low-income
10 beneficiaries, which could help improve their access to
11 care.
12 Another key indicator of beneficiaries' access to
13 care is the share of clinicians who accept Medicare.
14 According to surveys of clinicians, the share who report
15 accepting new Medicare patients is relatively high, and
16 comparable with the share who report accepting new
17 privately insured patients.
18 For example, the 2021 National Ambulatory Medical
19 Care Survey found that among the 94 percent of non-
20 pediatric office-based physicians who were taking new
21 patients, 89 percent accepted new Medicare patients, and 88
22 percent accepted new privately insured patients. A 2022

1 survey by the American Medical Association included
2 physicians who work in other settings besides offices, and
3 found that an even higher share accepted Medicare and
4 private insurance.
5 Another indicator of beneficiaries' access to
6 care is the number of clinicians billing Medicare's fee
7 schedule. From 2018 to 2023, the total number of
8 clinicians billing the fee schedule grew by an average of
9 2.2 percent per year. Because the number of beneficiaries
10 in fee-for-service Medicare decreased over this time, the
11 ratio of clinicians per fee-for-service beneficiary
12 increased from 2018 to 2023.
13 Over the same period, growth varied by the type
14 and specialty of clinician. Specifically, we saw rapid
15 growth in the number of advanced practice nurses and
16 physician assistants. We saw modest growth in the number
17 of specialist physicians, who account for over three-
18 quarters of the physicians billing Medicare. And there was
19 a modest but steady decline in the number of primary care
20 physicians. We are concerned about the decline in primary
21 care physicians and are monitoring this closely.
22 Consistent with past years, nearly all clinicians

1 who billed the fee schedule did so as participating
2 providers, meaning they accepted Medicare rates as payment
3 in full and did not balance-bill beneficiaries.
4 Our next measure of beneficiary access is the
5 number of encounters per fee-for-service beneficiary in a
6 given year. An encounter represents an interaction between
7 a beneficiary and clinician for which one or more fee
8 schedule services were billed.
9 For all clinicians, the number of encounters per
10 FFS beneficiary grew by 4.3 percent from 2022 to 2023.
11 Similar to our analysis of clinicians billing the fee
12 schedule, we found that changes in the number of encounters
13 per FFS beneficiary varied by the type and specialty of
14 clinician. For example, between 2022 and 2023, encounters
15 per fee-for-service beneficiary with primary care
16 physicians decreased by 0.1 percent, and encounters with
17 specialist physicians increased by 2.7 percent. Encounters
18 with APRNs and PAs increased by 10.1 percent.
19 I will now hand things over to Brian.
20 MR. O'DONNELL: Turning to our assessment of
21 quality of care, the quality of care provided by individual
22 clinicians is difficult for us to assess for two reasons.

1 First, Medicare does not collect much clinical information,
2 like blood pressure and lab results, or patient-reported
3 outcomes, such as improving or maintaining physical and
4 mental health, at the fee-for-service beneficiary level.
5 Second, CMS measures the performance of
6 clinicians using MIPS, which, in March 2018, the Commission
7 recommended eliminating because it is fundamentally flawed.
8 For example, clinicians select a small set of quality
9 measures to report from a catalog of hundreds of different
10 measures. This makes it harder to compare physicians since
11 only a few clinicians may report a certain measure. Also,
12 many clinicians are exempt from reporting quality data for
13 MIPS so there is portion of clinicians where CMS has no
14 quality information.
15 Taking these limitations into account, we report
16 on the quality of the ambulatory care environment for
17 beneficiaries in fee-for-service Medicare by looking at two
18 sets of measures. We use outcome measures that assess
19 ambulatory care-sensitive hospitalizations and emergency
20 department visits. And we look at patient experience
21 measures from the fee-for-service CAHPS survey. This
22 approach is consistent with the Commission's principles for

1 quality measurement to focus on quality measures tied to
2 clinical outcomes and patient experience.
3 The 2023 risk-adjusted rates of ambulatory care
4 sensitive hospital use continued to worsen from 2021, but
5 remained below pre-pandemic levels. We continued to see
6 geographic variation in these rates, which signals
7 opportunities to improve. Rates of ambulatory care-
8 sensitive hospitalizations were about twice as high in some
9 hospital service areas than others, and rates of ambulatory
10 care-sensitive ED visits were more than twice as high.
11 Patient experience scores were also relatively
12 stable with CAHPS scores of 83 out of 100 for
13 beneficiaries' rating of fee-for-service Medicare, and 85
14 out of 100 for their rating of their health care quality.
15 Finally, we turn to clinicians' revenues and
16 costs. On a per beneficiary basis, total fee schedule
17 payments grew at a substantial rate. We found that allowed
18 charges per beneficiary for all clinician services grew by
19 4.2 percent between 2022 and 2023. This was higher than
20 the average growth rate from 2018 to 2022, although that
21 period includes 2020 when aggregate payments for most
22 services declined due to the effects of the pandemic.

1 The 2023 growth in payments per beneficiary
2 varied by type of service. It ranged from minus 0.1
3 percent for major procedures to an increase of 7.2 percent
4 for treatments. Allowed charges for evaluation and
5 management services per beneficiary grew by 4.2 percent.
6 In 2023, growth rates for all broad service categories were
7 higher than they were over the 2018 to 2022 period.
8 In this slide, we compare private insurance PPO
9 rates with fee-for-service Medicare rates. We compare
10 private insurance rates with Medicare rates because large
11 differences could create an incentive for clinicians to
12 focus on patients with private insurance. We found that
13 commercial PPO payment rates were 140 percent of fee-for-
14 service Medicare rates in 2023, up from 136 percent in
15 2022.
16 Despite lower rates, providers may accept
17 Medicare patients for several reasons. A substantial share
18 of many clinicians' patients are covered by Medicare, and
19 if these clinicians opted to accept only commercially
20 insured patients, they might not be able to fill their
21 patient panels, and as we've heard in our annual focus
22 groups, many clinicians have a strong desire to treat their

1 patients regardless of their insurance status.

2 Fee-for-service Medicare is also a prompt payer,

3 as it's required to pay clean claims within 30 days. And

4 private payers generally impose more administrative

5 burdens, such as prior authorization, which can decrease

6 the amount of time clinicians have to see patients

7 In this slide, we discuss all-payer clinician

8 compensation. While it's an imperfect measure, we use

9 compensation as a rough proxy for all-payer profitability.

10 In 2023, we saw typical growth in physician compensation,

11 after rapid growth in 2022.

12 According to SullivanCotter's latest clinician

13 compensation surveys, from 2022 to 2023, median

14 compensation grew by 3 percent for physicians and by 6

15 percent for advanced practice providers such as NPs and

16 PAs. Over a four-year period, from 2019 to 2023, median

17 compensation grew at average rates of 3.3 percent per year

18 for physicians, and 4.4 percent per year for advanced

19 practice providers.

20 In this slide, we shift to the costs clinicians

21 incur to treat patients. The Medicare Economic Index, or

22 MEI, measures clinicians' input costs and is adjusted for

1 economy-wide productivity. MEI growth was 1 percent to 2
2 percent per year for several years before the coronavirus
3 pandemic. MEI growth then increased and peaked at 4.4
4 percent in 2022. MEI growth slowed in 2023 and is
5 projected to moderate further in the coming years,
6 increasing 3.3 percent in 2024, 2.8 percent in 2025, and
7 2.3 percent in 2026
8 In this slide, we take a longer-term view of how
9 clinicians' input costs compared to fee schedule updates
10 and fee schedule spending per beneficiary. Over more than
11 two decades, MEI growth consistently exceeded fee schedule
12 updates. From 2000 to 2023, the cumulative increase in fee
13 schedule updates, the bottom line, totaled 14 percent
14 compared with MEI growth of 52 percent, the middle line.
15 However, as the top line on the figure shows,
16 Medicare fee schedule spending per fee-for-service
17 beneficiary grew by 101 percent over the same period, far
18 outpacing MEI growth. And as noted earlier, the
19 Commission's full set of access measures suggest that
20 beneficiary access to care has remained similar to or
21 better than individuals with commercial insurance.
22 The fact that our beneficiary access measures

1 remained similar to the commercially insured population
2 while fee schedule payment rates have not kept up with MEI
3 growth suggests that increasing fee schedule rates to
4 closely reflect inflation has not been necessary to ensure
5 beneficiary access to care. Instead of hindering access,
6 relatively low payment rate updates appear to have been a
7 tool to slow the rapid increase in spending on clinician
8 services, which benefits both taxpayers and beneficiaries.
9 To summarize our analysis, most indicators
10 suggest that payments have been adequate, but relatively
11 high growth in input costs are a concern.
12 In terms of access, beneficiaries report access
13 to care that is comparable with, and in most cases better
14 than, the privately insured. Comparable shares of
15 clinicians accept patients with Medicare and private
16 insurance. The total number of clinicians billing Medicare
17 is increasing, although the mix of clinicians is changing.
18 Clinician encounters per FFS beneficiary increased
19 substantially
20 In terms of quality, it is difficult to assess
21 quality of clinician care, because Medicare does not
22 collect much clinical information, and CMS currently

1 measures clinician quality using MIPS which is
2 fundamentally flawed.
3 In terms of clinicians' revenue and costs, MEI
4 growth has outpaced updates, but MEI growth is expected to
5 slow to 2.3 percent in 2026. The ratio of private
6 insurance to Medicare payment rates increased slightly.
7 Clinician compensation continued to grow in 2023.
8 Taking a step back, we note that, in totality,
9 our payment adequacy indicators are generally similar to or
10 better than those that the Commission published in its
11 March 2024 report.
12 And before we get to the Chair's draft
13 recommendation, I'll review the key objective of the draft
14 recommendation and some considerations that go into its
15 development.
16 The key objective is to maintain beneficiary
17 access to quality care without unnecessarily high payment
18 rates, which create financial burdens for beneficiaries and
19 taxpayers. In terms of considerations, our beneficiary
20 access indicators are relatively positive, suggesting that
21 payments are currently adequate. However, clinicians face
22 high input cost growth relative to current law updates and

1 there are concerns that some clinicians may not be able to
2 absorb those costs.
3 And third, low-income beneficiaries report worse
4 access to care than other beneficiaries.
5 To help improve access to care for low-income
6 beneficiaries, the Commission recommended establishing add-
7 on payments for all fee schedule services furnished to low-
8 income, fee-for-service beneficiaries. We defined low-
9 income beneficiaries as fee-for-service Medicare
10 beneficiaries who are also enrolled in Medicaid or are
11 enrolled in the Part D low-income subsidy program. We
12 targeted services provided to this population since they
13 report worse access to care than other beneficiary
14 populations, and clinicians do not always receive the full
15 amount of Medicare cost-sharing due to Medicaid payment
16 policies.
17 Under our safety net recommendation, when
18 treating low-income beneficiaries, primary care clinicians
19 would receive a 15 percent add-on to their fee schedule
20 payment rates, and all other clinicians would receive a 5
21 percent add-on. The add-on payments would not result in
22 increased beneficiary cost sharing and would not be paid

1 for through offsetting payment cuts elsewhere. We also
2 called for safety net add-on payments to be excluded from
3 Medicare Advantage benchmarks.
4 This brings us to the Chair's draft
5 recommendation for 2026, which reads:
6 The Congress should, for calendar year 2026,
7 update the 2025 Medicare base payment rate for physician
8 and other health professional services by the projected
9 increase in the Medicare Economic Index minus one
10 percentage point, and enact the Commission's March 2023
11 recommendation to establish safety net add-on payments
12 under the physician fee schedule for services delivered to
13 low-income Medicare beneficiaries.
14 In this slide, I'll walk through the estimated
15 impact of the Chair's two-part draft recommendation,
16 relative to the 2025 base payment rate.
17 CMS currently forecasts a 2.3 percent increase in
18 the MEI for 2026, so MEI minus one percentage point yields
19 an update of 1.3 percent that applies to all clinicians.
20 This update would replace current law updates that are set
21 at 0.25 percent or 0.75 percent, based on whether a
22 clinician participated in an A-APM.

1 Also, enacting the Commission's safety net
2 recommendation would increase the average clinicians' fee
3 schedule payments by an additional 1.7 percent, but the
4 effect varies by the number of low-income beneficiaries
5 treated and clinician specialty. Primary care clinicians
6 would see an average increase of an additional 4.4 percent,
7 and all other clinicians would see an average increase of
8 an additional 1.2 percent.
9 In terms of implications, this draft
10 recommendation would increase spending relative to current
11 law. It should maintain beneficiaries' access to care and
12 maintain or improve low-income beneficiaries' access to
13 care.
14 In addition, the recommendation should maintain
15 clinicians' willingness and ability to furnish care and
16 should maintain or improve clinicians' willingness and
17 ability to treat low-income beneficiaries.
18 And with that, we look forward to your questions,
19 and I'll hand it back to Mike.
20 DR. CHERNEW: Brian and Geoff, thank you. This
21 is a really important topic, and that's a remarkably
22 thorough analysis. And I will just add, the wait time

1 stuff, which you guys all asked about I think is really
2 terrific. But I'll let others say that. So we will jump
3 to the queue, and Dana, I think if I'm right, Stacie is
4 first in the queue.
5 DR. DUSETZINA: Thank you. Great work, and I
6 will just say, as Mike was just alluding to, the additional
7 questions on wait times I think are super, super important
8 and helpful here. And that's the part I had a question
9 about.
10 So in the graphics shown, I assume that the MA
11 and fee-for-service beneficiaries are both reflected. And
12 I think in one of the footnotes I saw it was that they had
13 similar reported wait times when they were looked at
14 separately. It might not be that they were looked at
15 separately for all of the figures.
16 But I guess my question would be, did you check
17 to make sure that people in MA and fee-for-service have
18 similar wait times, and if you did and then combined them,
19 can you add footnotes to each of the figures to just
20 emphasize those points.
21 MR. O'DONNELL: Yeah. And I just want to give a
22 shout-out to our colleague, Rachel, who is not here, but

1 who manages this. So I'll give an answer and then if I
2 mess it up, we'll come back in January.
3 But I think the general kind of perspective is
4 that for our surveys that we field we generally can't break
5 it out MA versus fee-for-service. So you see some wait
6 time data that we reported, and that's generally not broken
7 out by MA and fee-for-service.
8 We also report wait time data from MCPS, which is
9 a little bit bigger survey, and they can break out wait
10 time data for MA versus fee-for-service. So that's a case
11 where it's just a kind of fee-for-service population, and
12 so that's kind of the groundwork.
13 And I think, in general, we can add some of those
14 notes to make that more clear.
15 DR. DUSETZINA: Yeah. I think that having a
16 footnote about who's included in each one and when it's
17 aggregated or disaggregated. I will also put in a plug for
18 future work to disaggregate the wait time issue, because I
19 think looking for clinicians' time built in could
20 potentially make it a little bit longer of a process for
21 someone in MA versus fee-for-service. That's a future wish
22 list.

1 MR. GERHARDT: Yeah, and I'll just say, and this
2 was discussed last year, our survey is not only small but
3 it basically just asks people these questions. And their
4 memory or knowledge about what type of program they're in
5 is not always reliable. MCPS has a little bit of a
6 different perspective. They're more beneficiaries and they
7 cross-check people against the Medicare enrollment data,
8 just so they know what program they're in, as opposed to
9 just relying on people's memory.
10 DR. CHERNEW: And that's a separate issue.
11 MS. KELLEY: Cheryl.
12 DR. DAMBERG: Thanks for this chapter. I just
13 want to echo what Stacie said, and I do think, moving
14 forward, if you have some ability to collect separate
15 information for MA versus fee-for-service I think that
16 would be particularly illuminating.
17 I had a couple of other questions around access.
18 When do you do the comparisons to private insurance do you
19 know what type of private insurance people have? Like are
20 they in HMO plans versus PPO plans? Because my guess is
21 it's probably lumped together.
22 MR. O'DONNELL: So we can follow up on that. I

1 think the stipulation we do know is that they are kind of
2 ESI, so commercial insurance, and there's a small amount of
3 directly purchased insurance. But I'd have to follow up
4 with you whether we can break out by HMO or PPO, but I
5 don't believe so. But I'll follow up to make sure.
6 DR. DAMBERG: Yeah, because my guess is, at least
7 on the commercial side, there's probably a lot of
8 variability between the HMO and the PPO side, in terms of
9 people's access.
10 And then my other question was related to some of
11 the differences that you're seeing, say, for low-income
12 folks. I know you noted that copayment and the inability
13 to collect that 20 percent might be a factor. But do you
14 have any sense to what extent these individuals may be
15 living in what I would call an ambulatory care desert? And
16 I don't know if you have the ability to look at that.
17 MR. GERHARDT: I don't think that was something
18 that we looked at when the safety net policy was first
19 developed. I guess we could go back and see whether that's
20 a contributing factor.
21 MS. KELLEY: Robert.
22 DR. CHERRY: Yes. Thank you. It's a very nice

1 presentation. I just also had a question around the access
2 survey. You know, it's two different age groups. It's 50
3 to 64 among the private insured, but you have Medicare,
4 which is 65 and older. And the challenge with that is that
5 there's a difference between a 55-year-old and a 75-year-
6 old. And I wonder if the survey should more closely
7 approximate the ages in future years. Like for example, 62
8 to 67 in each age group might be potentially doable and
9 perhaps reduce the complications of having a patient
10 population that may be more acute, simply because they're
11 of a more advanced age. So something to think about later.
12 But I don't know if you've considered it before,
13 but that would be sort of my recommendation around future
14 surveys.
15 MR. O'DONNELL: Yeah. We can follow up with a
16 more comprehensive answer, but I do think one of the things
17 that we're limited by is that the firm that we retained to
18 do the survey, they have a panel of folks from which we
19 draw, and we're always looking to increase the number of
20 responses. Initially we got about 5,000 responses from the
21 private insured. And as you narrow it down, you said 62 to
22 67, we might face some challenges with just number issues.

1 So that's my first kind of guttural response. But I hear
2 the generalized concern.
3 MS. KELLEY: Larry.
4 DR. CASALINO: Geoff and Brian, really nice work
5 and great set of slides. I especially liked the table on
6 page 39 that shows -- I don't think we've had one that's as
7 comprehensive as this before -- shows not only the annual
8 updates and MIPS and APM bonuses but also, crucially I
9 think, the one-time payment increases and annual
10 sequestration. Very useful to see all that, so that was
11 great work.
12 Two questions. One is does the new G2211 code --
13 I should know this but I don't -- does it affect the
14 conversion factor?
15 MR. GERHARDT: Yes.
16 DR. CASALINO: It does. Okay.
17 MR. GERHARDT: It was an addition that was also -
18 - the conversion factor was adjusted to make it budget
19 neutral.
20 DR. CASALINO: Based on some estimate of what the
21 additional spending would be?
22 MR. GERHARDT: Correct. Correct.

1 DR. CASALINO: Yeah. It might be worth tracking
2 that, although maybe this is for GAO rather than MedPAC.
3 But it's interesting that, for example, glaucoma patients
4 are specifically mentioned as people for whom that might be
5 an appropriate code. And, you know, I think that the
6 average glaucoma patients, most visits are probably 5
7 minutes. Then there will come a time when there's
8 something really important to discuss, like should the
9 patient have surgery or not, and the ophthalmologist might
10 spend quite a bit of time on that visit. And I could
11 provide lots of other examples, in primary care and for
12 specialists.
13 But I do wonder whether the code is going to be
14 used like for every visit for a glaucoma patient, for
15 example, which would be very expensive and not really the
16 intent of the law, I guess.
17 And then the last question is, is it my
18 imagination or in past years did you guys have some data on
19 medical school applications?
20 MR. O'DONNELL: So we had those data in our
21 November presentation, which was focused on the long-term
22 update to the fee schedule. It's not a routine thing that

1 we do for our kind of March chapters, but we have the data
2 and have looked at them.
3 DR. CASALINO: It might not hurt to put it into
4 this, as well. Thanks.
5 MS. KELLEY: Amol.
6 DR. NAVATHE: Geoff and Brian, thanks. Thanks
7 for this. I have a question related to Slide 25, which is
8 Figure 7, I think, in the paper. In the reading materials
9 you pointed out that when we look at the spending in the
10 PFS, that in some sense it is understated in the context
11 that as there's been a shift from office setting to HOPD,
12 that the PFS payment actually goes down because there's a
13 facility fee on the HOPD side.
14 So I was wondering if we knew what this 101
15 percent number looks like if we either factor in the
16 facility fee or, alternatively, if we pretended as if that
17 care didn't shift into the HOPD setting and we used a full
18 clinical PFS rate.
19 MR. O'DONNELL: So we don't precisely, but
20 obviously that number would be bigger than 101 percent.
21 And we can look at that type of simulations, and we issued
22 a report in 2019, that basically for that kind of middle

1 period where that line is flat, we ran simulations holding
2 the place of service constant to say how would this have
3 changed. And we did it by type of service.
4 So we did that for a five-year trend, and it
5 varied by service type. But it was substantial. So it
6 could underestimate a lot of charges by a percentage point
7 a year for some services. So even though that sounds
8 small, that accumulates over time. So we ran that for a
9 five-year period, just to get kind of sense of what
10 happens. But that's what it would tell you.
11 DR. NAVATHE: Okay. That's helpful. I mean, I
12 think in the context of the broader discussion that happens
13 here in terms of volume intensity and such, I know there's
14 a lot of work that's being done, so they differ in terms of
15 the sequencing or the prioritization. But I think that
16 would be a helpful fact to help understand kind of how the
17 services and the PFS and volume intensity, all these
18 things, and site of service is another dimension here.
19 I would find that personally helpful and if other
20 Commissioners agreed that would be great. Thanks.
21 MS. KELLEY: Gina.
22 MS. UPCHURCH: Thanks so much. Great chapter.

1 Always very informative. Just two quick questions for you.
2 If you, talking about Cheryl's question about
3 Medicare Advantage, in fee-for-service can you break it
4 down -- I'm sorry if I've missed this -- in people that
5 have secondary coverage and not secondary coverage, having
6 access to providers and such. So either they have
7 Medicaid, employer, or Medigap policy or not. So is there
8 a difference that they have in being able to get
9 appointments?
10 MR. GERHARDT: So I do think, and again, it comes
11 to this. In our survey we are somewhat limited by kind of
12 asking them what they had insurance and their sample size.
13 So we do do a very rough cut on low-income, although that
14 income is defined somewhat differently. To get the kind of
15 things that you kind of wanted, we might go to the MCPS,
16 which is where they have better, more direct information on
17 those kinds of things.
18 But again, getting to that thing is really
19 difficult. We understand it.
20 MS. UPCHURCH: Yeah. It's getting a little
21 blurry, too, because the individuals who are eligible for
22 LIS may not have any sort of secondary coverage. They may

1 not even have Medicare savings programs, much less
2 secondary coverage. So that might be interesting.
3 The other thing is, I know in North Carolina we
4 expanded Medicaid and we received half for state-directed
5 funds, so that hospitals that see people with Medicaid are
6 now being paid commercial rates to see those expanded
7 Medicaid folks, the hospitals are. So my question is, and
8 this MEI adjustment in addition to the safety net sort of
9 adjustment, would that go to hospitals or just to providers
10 that are individual providers versus institutions? I'm
11 just curious.
12 MR. GERHARDT: I mean, the recommendation is
13 limited to fee schedule, physician fee schedule updates.
14 There are certainly cases where physicians are employed by,
15 work for the hospital, or their practice is owned by the
16 hospital, so the financial lines get a little fuzzier.
17 But, you know, these conditions are limited to the 9,000
18 fee schedule codes built by clinicians.
19 DR. CHERNEW: So basically, we're not changing
20 the flow of money, so the recommendation money would flow
21 the same way the general physician fee schedule money
22 flowed, which typically, if you were employed it would flow

1 to the organization.

2 MS. UPCHURCH: Right. Okay. Thank you.

3 MS. KELLEY: That's all I have for Round 1,

4 unless I've missed anyone.

5 DR. CHERNEW: We should move on to Round 2,

6 because just to remind everybody, there is a queue, which

7 we'll go through, but then I want to make sure if you're

8 not in the queue, just very quickly, give a sense of where

9 you are, because that's what I like.

10 MS. KELLEY: I have Larry first.

11 DR. CASALINO: First of all, again, thanks, guys,

12 for the time and the really conscientious effort that you

13 put into this every year.

14 I want to provide quickly a bit of context for

15 those watching the webinar, and remind you, at least, on

16 what MedPAC is trying to do when it makes its

17 recommendations about the physician fee schedule.

18 It's important to realize that our job as MedPAC

19 staff and Commissioners isn't to decide whether physicians

20 are paid too much or whether they're paid too little.

21 That's not what we're here today to do.

22 Our job really is three-fold. First, we want to

1 recommend policies that result in Medicare not paying more
2 for care to physicians or hospitals or any other sector
3 than is necessary in order for beneficiaries to have
4 excellent access to high-quality care. Obviously, this is
5 critical to the survival of the Medicare program. So
6 that's our first job.
7 Second, we want to recommend policies that will
8 actually improve beneficiaries' access to care, or at least
9 not make it worse. Same thing about quality, for the third
10 point.
11 Just to be clear, I don't believe that in the
12 short term a percentage point or two above or below
13 inflation in the physician fee schedule will have much
14 effect one way or the other on beneficiary access to care
15 or on the quality of care, and the data you show I think
16 probably supports that view.
17 But I do believe that over time the cumulative
18 effect of annual payment increases that are less than
19 inflation are very likely to affect both beneficiaries'
20 access to care and the quality of care, primarily because I
21 think that over time it sends an extremely negative message
22 to physicians, although also over time it will provide less

1 money for organizations in which physicians work to invest
2 in improving quality.
3 I think it's important to recognize, and I've
4 said this before, that when we make a recommendation about
5 the physician fee schedule it's different from making a
6 recommendation about hospitals or all the other sectors in
7 which the recommendation is really about organizations.
8 The fee schedule is understood by physicians very
9 personally, as individuals. And no one lines to be told
10 that their annual pay each year, indefinitely, year after
11 year, is not going to keep up with inflation. Over time, I
12 think that's likely to affect the moral of physicians and
13 other clinicians, and that this can't help but result in
14 worse access and lower quality of care.
15 In fact, physician morale, at least, is measured
16 by burnout rates in some other kinds of surveys. It's
17 pretty bad, and it's decreased over time. I don't think
18 that payment rates are the main reason, the main thing
19 affecting physician morale now, but I do think the message
20 that, "Okay, guess what, guys? We're going to pay you
21 every year less than inflation" is not going to be useful
22 for morale.

1 So I'm struggling to balance the need to control
2 Medicare spending with the need to maintain or improve
3 access and quality. For that reason, if our recommendation
4 for 2026 -- and I'm almost done here -- if our
5 recommendation for 2026 was simply MEI inflation minus 1
6 percent, I wouldn't vote for it. But I do think that the
7 two prior recommendations that the Chair has made is quite
8 reasonable. That's the MEI minus one percent and the
9 higher payment rate for care for low-income patients. I
10 think that's very smart. It accomplishes multiple goals,
11 and I do support it.
12 And then just before I stop talking, I do want to
13 note that I know that staff are working on how to deal with
14 the physician fee schedule going forward. I think the bump
15 in inflation over the past few years kind of really raised
16 this as an issue -- what are we going to do about inflation
17 and the fee schedule?
18 You know, for the reasons I've just said, I think
19 I'd be reluctant to vote for a recommendation in the
20 future, a few months from now maybe, that the fee schedule
21 would be updated by MEI minus 1 forever, basically. I
22 could see it for a couple more years because there's been a

1 very substantial increase in payment for E&M visits, and
2 then we'll see what the new G2211 code does.
3 So I don't think it would be unreasonable to
4 recommend MEI minus 1 for, say, 2027 and 2028. But after
5 that I think it would be much more reasonable to recommend
6 an update that's equal to inflation.
7 So I look forward to hearing what the staff and
8 colleagues on the Commission have to say about these
9 things.
10 MS. KELLEY: Greg.
11 MR. POULSEN: Thank you. Let me second the
12 appreciation for the really thoughtful work that was done.
13 I know there's a ton of work that goes into this.
14 I am in broad agreement with what Larry just
15 said, but interestingly for slightly different reasons.
16 For me, an important point, and I really would suggest that
17 we look at a sentence on page 4 of the report, where it
18 reads, "Providers are increasingly consolidating into
19 larger organizations to improve their ability to negotiate
20 higher payment rates from private insurers," and then in
21 parenthesis, "and some other things too."
22 I think that is maybe truer than it used to be,

1 but I think that it may still give a slightly incorrect
2 impression. As we've looked at some studies -- and oh, by
3 the way, it mentions the studies have indicated that, the
4 studies that were in the footnotes, the AMA study, came
5 from 2023, and the McKenna study for Medscape in 2022, I
6 think actually can be read slightly differently than that
7 statement was.
8 And I think as we look at the reasons for
9 consolidation, which the consolidation is clearly
10 happening, I think what we're seeing is that at least from
11 what I'm interpreting and as based on the data that I've
12 seen and the information that we have directly, EMR issues,
13 coordination of care, and other things are incredibly
14 important and difficult in today's world. Insurance
15 travails, especially coding and documentation, which have
16 to gotten right or claims get denied or care is not
17 approved. Negotiating reasonable relationships regarding
18 those kind of things. Managing a practice and personnel,
19 where there are increasing labor shortages and increased
20 labor costs. Those are all really difficult things.
21 And so I think that certainly in the minds of
22 physicians who are making those decisions about where

1 they're going, sort of the idea of having a reasonable
2 life, a reasonable approach to care, and a reasonable
3 capability to do what they like to do, practice medicine as
4 opposed to manage minutiae, I think is equally and maybe
5 more important than those. And I think that should be
6 reflected, because as we contemplate the concern, which I
7 think the majority of the Commission group has, and the
8 staff, regarding consolidation, we need to understand
9 what's driving it, and it may not just be increased
10 negotiating capacity.
11 So as we put that together I think that's
12 important. And it leads me to, as I said, it's very much
13 the same idea that Larry had, which is we need to make sure
14 that those who are in the physician group, at least, who
15 are most likely to be negatively impacted by payment lower
16 than their cost increases, will lead to consolidation. And
17 as a couple of studies have shown, the increasing area of
18 consolidation is in private equity kinds of consolidation
19 as opposed to into health systems, where I think you can
20 make an argument within health systems that that brings
21 them together in a way that allows them to improve the
22 value of care, and that's not quite so true in the other.

1 So for those reasons I tend to agree with the
2 point that Larry made.
3 DR. CHERNEW: The key thing, Greg, is -- and I'm
4 sorry, there was a lot there -- how do you feel about the
5 recommendation?
6 MR. POULSEN: I would go with Larry, which is I'd
7 be comfortable doing this as long as we are not viewing it
8 as something that carries on into perpetuity.
9 DR. CHERNEW: Okay. So --
10 MR. POULSEN: So this year.
11 DR. CHERNEW: Right. So for the recommendation
12 we're discussing now, there's no perpetuity. That's not a
13 statement on perpetuity. There will be perpetuity. But
14 for what we're doing now, it's just for 2026. We will have
15 a longer-run discussion later, as Larry pointed out.
16 MR. POULSEN: Yeah, and we always do. But it's
17 always, I think, important when we say here's what I'm
18 comfortable with for next year to say it's relative to what
19 would go on beyond that. So thanks.
20 MS. KELLEY: Cheryl.
21 DR. DAMBERG: Again, thanks for all the great
22 work here. In terms of my support, I think the Chair's

1 recommendation is directionally correct. I too share some
2 of the concerns Larry has raised. But I'm also mindful
3 that the current updates seem low, given increases in input
4 costs.
5 And I too, similar to Larry, really support the
6 idea of this being paired with the Medicare safety net add-
7 on payment. I think that's a critical factor, and I hope
8 that policymakers will seriously consider that piece of it
9 as they weigh the payment updates.
10 Because, I mean, it's clear that what we see in
11 some of this data around access issues for low-income
12 beneficiaries is really spotlighting the need to do more
13 targeted payments to this group of physicians.
14 I am concerned about access to primary care, and
15 I think we're seeing, so while access has generally been
16 good, I was concerned about the 52 percent who reported
17 problems finding a new primary care physician, even though
18 that group as a whole represents a small proportion of the
19 total Medicare population.
20 And I know that we're going to continue
21 discussions in thinking about physician payment reform and
22 trying to figure out, you know, there are supply issues

1 around primary care and what are the best mechanisms to try
2 to increase the number of primary care physicians in the
3 market. And I think payment is one signaling aspect of
4 this, and I think that's why I'm in favor of the Chair's
5 recommendation.
6 MS. KELLEY: Brian.
7 DR. MILLER: First of all, huge kudos for adding
8 a quantitative measure of access. Made my day to see that.
9 I also want to say access for many benes is
10 objectively terrible. I just want to say that.
11 Objectively, access for many Medicare beneficiaries is
12 terrible.
13 Why do I say that? I was looking at these tables
14 and facts we had on page 13. One-third of Medicare benes
15 had to wait 3 to 8 weeks, and another 18 percent had to
16 wait more than 18 weeks to get a new PCP. I think we can
17 all agree that's pretty terrible. If you are 75 and you
18 have a lot of health problems, that's a long time to wait
19 to get prescription refills, establish with a new doc to
20 try and get things done.
21 Half waited 3 to 8 weeks to see a specialist.
22 Now, many of us may sort of pooh-pooh that. It's a

1 mistake. If you have a new diagnosis of cancer, if you
2 fractured something and are in a sling, waiting for your
3 post-hospital follow-up to see an orthopedic surgeon, and
4 discharge instructions tell you to see someone within 14
5 days, and half have to wait 8 weeks, that's objectively
6 terrible, just on a clinical basis.
7 I think if we take the standard of a patient or
8 practicing physician will get to that realization of that
9 standard, it's terrible. If we look at it just from
10 numbers, it doesn't seem bad, but we are the patient or we
11 are the clinician, it's not good. It doesn't matter if
12 it's similar or slightly better to private markets. It's
13 still objectively not good. We have a labor productivity
14 problem in health care, and I think that is something that
15 we should mention in here.
16 Because these access data actually tell us that
17 our access is a lot worse than we thought it is, I actually
18 don't support a differential add-on payment for low-income
19 fee-for-service benes that is different and lower for
20 specialists and more than primary care physicians, or
21 primary care physicians are 15 percent and specialists are
22 proposed as 5 percent.

1 If half of all Medicare benes are waiting almost
2 a month, or two months, to see a specialist, that actually
3 suggests that perhaps that add-on payment should be more
4 for specialists, or at the very least it should be equal.
5 Cheryl mentioned the challenge with primary care
6 physicians. I don't think medical students are
7 prioritizing going into primary care. I think we need to
8 be realistic. I support primary care, but it's primary
9 care clinicians. If we look at the data in there, that we
10 see in the chapter, there are a lot of nurse practitioners,
11 physician assistants. So I think we need to be realistic.
12 I think actually that MedPAC should spend time,
13 and I know Betty has mentioned this multiple times, and I
14 agree with her, that we should have a specific chapter on
15 the role of non-physician providers in the Medicare
16 program.
17 A couple of analytical concerns. We keep talking
18 about physician salary. I remain disappointed, not just
19 personally -- that was a joke about working in academia.
20 But if more than half of physicians are employed and
21 Medicare is a minority of practice revenue, salary doesn't
22 mean anything in terms of whether the fee schedule is

1 adequate. So we should really just stop having that
2 discussion. I mentioned that last year, and frankly, we
3 look ridiculous when we're talking about things that don't
4 actually affect the fee schedule.
5 The other thing I'd note is that we have this
6 wonderful graph, which I really liked, on page 51, talking
7 about changes in PFS spending versus MEI versus actually
8 payment updates. That gets to something that Amol hit on,
9 which is the volume intensity response. We need to talk
10 about that explicitly, because if anything, when I look at
11 that graph it tells me that physicians are responding,
12 physicians and non-physician providers are responding to
13 low payment rates by modulating volume and intensity. And
14 we can debate what the exact degree of that relationship
15 is, but that relationship exists.
16 I also noted on page 42, and appreciate it as a
17 giant nerd, that we spent an entire page debating the
18 conversion factor, and I had fun reading that. But it also
19 got me thinking, this whole exercise of what we are doing
20 today demonstrates the futility of the last 30 years of
21 Medicare payment policy. From an operations perspective,
22 CMS is a policy operator that is struggling to both operate

1 a fee-for-service Medicare plan, and as many of you have
2 mentioned, challenges in the Medicare Advantage
3 marketplace. CMS is also struggling to be a plan
4 regulator. It's trying to do two very hard jobs.
5 I think that we need to think differently, as a
6 Commission, about CMS, and the fact that we're having this
7 discussion every year about Medicare Advantage and also
8 about targeting Medicare payment rates.
9 When we look at the FDA, the FDA is a very
10 successful regulator, but the FDA is not manufacturing
11 drugs. The FDA can detect manipulation of data in pharma
12 development programs that are submitted, but it's not
13 manufacturing drugs. It's not doing drug development. So
14 we should, I think, collectively think as a group about
15 ways to help CMS become a market regulator of publicly
16 funded health benefits programs that are executed by the
17 private market, a public-private hybrid, because that's
18 where we are right now. And if you actually look at fee-
19 for-service Medicare, it's mostly executed by the private
20 market, and you have a limited staff at CMS who are helping
21 run it.
22 So we need to help modernize fee-for-service

1 Medicare and improve Medicare Advantage regulation in
2 tandem. And if we do that, as a Commission, we can
3 actually help Congress and the American population set
4 population health goals for Medicare within defined
5 population budgets, rather than worrying about someone's
6 quality metric for their LDL cholesterol being less than
7 70, or debating what the right payment level is for a 15-
8 minute E&M primary care visit, or spend an hour talking
9 about the blood deductible.
10 So I really think collectively we, as a group,
11 should be thinking about how we modernize Medicare. Thank
12 you.
13 MS. KELLEY: Stacie.
14 DR. DUSETZINA: Thank you again for this really
15 important work. I wanted to just follow up on a couple of
16 points that have been made, or plus-ones to some of the
17 things other Commissioners have said. One is related to
18 the spending MEI and the inflation growth chart; I think
19 that Amol's points are spot on about thinking through how
20 that shifts across outpatient care and other things that
21 are contributing. Because to Brian's point, the volume and
22 intensity pieces are important there.

1 It makes me a little bit less concerned about the
2 recommendation on like the MEI-related growth when I see
3 that overall spending is increasing more. So like if
4 practices are able to make ends meet or, you know, make
5 money because of increasing volume and intensity, then I'm
6 a little bit less worried about an MEI minus 1 type of
7 update. So I think that type of work would be really
8 useful.
9 I also wanted just to say thank you so much for
10 the excellent work on breaking out the lower-income
11 individuals and their experiences and then also really
12 highlighting the Medicare Safety-Net Index pieces of this.
13 I think it's critically important. So plus-one to Cheryl's
14 comments there, and also Larry's comments about the
15 importance of the two-part recommendation. Because I think
16 targeting more updates to the lower-income individuals
17 through Safety-Net Index is really important.
18 And I'd like to just say, going back to the
19 points that Brian made about the wait times, I agree that
20 the long wait times are concerning for people. But I think
21 that it's important to recognize that relative to
22 commercially insured people, a piece of this is that

1 Medicare beneficiaries aren't necessarily waiting longer
2 than commercially insured people, and in some cases a
3 little bit less.
4 And so there is a question of how much more
5 payment fixes that versus this is really a market
6 constraining issue that I think is a problem for everyone
7 who needs health care services. So yes, important that
8 people are waiting long times, but it's not clear how much
9 this recommendation would shift the needle there.
10 So in summary, I am supportive of the Chair's
11 recommendations, and I absolutely fully endorse the
12 addition of the second part around the Safety-Net Index.
13 Thank you.
14 MS. KELLEY: Tamara.
15 DR. KONETZKA: Thanks, Geoff and Brian, for this
16 great work. So I'll start by saying, lest I forget, that I
17 support the Chair's recommendations, both of them. I think
18 the safety-net part, for reasons already mentioned, I
19 support, so I won't talk more about that.
20 I do differ a little bit with some of my
21 Commissioners on the MEI minus 1. I agree with the
22 recommendation, but I see it as more of kind of an upper

1 bound on a payment increase that I'd be in favor of, maybe
2 in the long run. And I'll mix up the long run and this
3 decision in this discussion, because I find them very hard
4 to separate, but for the following reasons I'd be skeptical
5 about sort of greater increases this year or moving
6 forward.
7 One is, I think I mentioned in our discussion
8 last time, we don't really know if the current payment
9 rates are sort of the right payment rates that need to keep
10 up with inflation over time. I think especially in this
11 sector, we don't really know what the right price should
12 be.
13 Second, as Stacie just mentioned, and others, I
14 think it's difficult to separate the actual payment rates
15 per service from the volume and intensity response. We
16 don't actually know how much of that is behavioral and how
17 much of that is just due to underlying demand and
18 demographics, et cetera. But I think that the fact that
19 volume and intensity seems to make up for payment rates
20 that don't keep up with inflation to me signals that maybe
21 we don't need to worry about the payment increases as much.
22 And then finally, one can look at the access data

1 in different ways. When I look at that I think I agree
2 that there's no real evidence of access problems.
3 Certainly access problems, I agree with Stacie on this,
4 that we're sure that payment rates could fix, right. And
5 so to me it remains a really hypothetical problem, and I'm
6 really reluctant to support spending a lot more taxpayer
7 and beneficiary money to solve a problem of physician well-
8 being or morale in the future, that we're not really sure
9 is a problem yet.
10 And so I think I come down on being a little bit
11 more conservative about how much we want to increase the
12 rates. And one suggestion I would have there, I know that
13 people are concerned that if we don't increase rates or
14 don't keep up with inflation that all of a sudden this
15 problem of access will emerge, and then it will be sort of
16 too late to solve.
17 I think we should sort of couple a conservative
18 approach with -- I'm wondering if we can sort of drill down
19 on access in slightly different ways. So for example, we
20 might assume that providers that are heavily dependent on
21 Medicare are not going to all of a sudden stop taking
22 Medicare patients. But if access problems emergent, it

1 might be among certain kinds of providers or certain areas.
2 So providers where Medicare is a smaller portion of their
3 patients, where they might be able to survive on just
4 commercial insurance or something else. Or it might be
5 areas where populations are younger and Medicare is just
6 not as big a player in that area. So there might be more,
7 but I think maybe we could drill down on our access
8 measures and try to sort of get out ahead of it in a sense
9 of like really looking for changes where we might expect
10 them most, such that we could sort of adjust in the future
11 and see if --
12 [Audio interruption.]
13 DR. CHERNEW: All right. Are we back live? All
14 right. I'm sorry, everybody. We obviously had some
15 technical difficulties, but we seem to have finally
16 resolved our technical difficulties. So we are going to
17 pick up where we were, which is with Robert.
18 DR. CHERRY: Thank you very much. That's the
19 most excitement we've had in quite a while. So I'll just
20 start at the very beginning, since you missed all seven
21 minutes of that.
22 [Laughter.]

1 DR. CHERRY: But I think I was starting off
2 mentioning that I was somewhat conflicted by the MEI minus
3 1, because it turns out that it's a total growth of 1.3
4 percent in terms of physician payments. And I agree with a
5 lot of the points that Larry made. You know, ultimately,
6 1.3 percent growth rate, or just continuing on below
7 inflation, is really not sustainable, over the long term,
8 if we want to maintain a viable position workforce for the
9 next generation.
10 I think we could be explicit about the need to
11 keep up with inflation and still balance that with the
12 needs for an add-on for safety-net providers, as well. I
13 don't think they're necessarily mutually exclusive.
14 Because even those individuals, if you're keeping up with
15 inflation, still safety-net providers do have extra
16 efforts, extra costs involved with taking care of a
17 vulnerable population that may have additional
18 comorbidities as well.
19 So I'm kind of on the fence a little bit with all
20 of this.
21 You know, in terms of other comments regarding
22 the presentation, I think it's also just a little

1 frustrating sometimes to see just one slide on quality of
2 care, and it's no fault of the staff. It's just the
3 challenges with abstracting the information and then trying
4 to make sense whether the dollars that are invested in the
5 Medicare program is actually providing value.
6 We talked about it a lot of times, but I do think
7 we have to be much more thoughtful and purposeful about
8 trying to not burn the ocean but trying to get some
9 discreet variables that tell a story about the care that's
10 being provided. So like in primary care, if there's some
11 sort of integration with the electronic medical record that
12 says something about blood pressure or how hemoglobin A1C
13 is being managed and BMI, so just a few things that says,
14 you know, is the population going in the right direction in
15 terms of primary care.
16 And then in terms of procedural, particularly
17 surgical specialties, in terms of post-procedures, are
18 patients still on antibiotics, or are they still requiring
19 narcotics, for example, or are there codes for ongoing
20 wound care management. I think those things can be helpful
21 too in terms of trying to develop sort of wraparound best
22 practices, depending on what you're seeing.

1 In addition, I think one concern that I have is
2 this comparison of the Medicare payments with the PPO
3 payments, because you can interpret it as one of two ways,
4 one that you're providing value, because we're keeping
5 costs down. But on the other hand, many private practice
6 physicians that depend on fee-for-service, they need those
7 PPO payments as way, in some circumstances, cross-
8 subsidizing Medicare, because it may be a loss to them, as
9 well. So I think we have to balance those two issues.
10 And then finally, I think, to Brian's point, for
11 employee physicians, if you're getting a 3 percent or 6
12 percent increase in payments in a particular year, it
13 doesn't necessarily translate into their salaries because
14 the organizations that hired them are making very difficult
15 decisions around how to allocate their resources to meet
16 the needs of the community that they serve. So that
17 doesn't necessarily mean that those payments are being seen
18 in physician salaries.
19 Otherwise it's a good report. It's not
20 unreasonable to make this recommendation, but like I said,
21 I'm conflicted because I'm not sure, year after year after
22 year, this is really a sustainable model for us. Thank

1 you.

2 DR. CHERNEW: I just want to say, and again for

3 the folks at home, the vote we're going to have is not for

4 year after year after year. The vote we're going to have

5 is for 2026. We're considering a recommendation we would

6 vote on in April for what we would do year after year after

7 year. But this recommendation is separating that out, per

8 our normal course of business.

9 MS. KELLEY: Scott.

10 DR. SARRAN: Okay. I'll try to be super brief,

11 recognizing we've chewed up some time with the technical

12 issues. First, the important parts. Yes, I support the

13 draft recommendations, particularly the tandem

14 recommendation of the update of MEI minus 1 as well as

15 combined with the safety-net add-on. And the other

16 important part is kudos again to the team. You guys do a

17 really great job of taking a lot of data and synthesizing

18 it into an actionable story.

19 Four very brief comments. I can't help but be

20 reminding us all that the entire fee-for-service

21 architecture is in conflict with the needs of both the

22 population and payer. The population, of course,

1 increasingly needs and expects coordinated care,
2 coordinated both between physicians and non-physicians and
3 coordinated between primary and specialty physicians. The
4 needs of the payer, essentially Medicare, again should be,
5 or are not being met by fee-for-service system because we
6 care about outcomes and not about what -- and widgets is a
7 pejorative term, but units of service.
8 Second comment. I think our various attempts to
9 put our thumb on the scale, if you will, in terms of
10 primary care weighting is appropriate I think because
11 primary care docs, by definition, are substantially chronic
12 care oriented, and again, that's the need of the
13 population. Specialists may or may not be.
14 The other thumb on the scale, low income, I think
15 as many others have pointed out, the needs of low-income
16 patients are multiple, complex, and not always easily
17 recognized or addressed or measured.
18 And the third sort of thumb on the scale is the
19 polychronic or complex, single chronic disease beneficiary,
20 and pay more for that because that is very challenging
21 care. And it's ACO work, of course, and it's the G2211.
22 So I think those sort of are continued bodies of work on

1 our part and are appropriate.

2 The third comment. Though the drivers of
3 workforce dissatisfaction and consolidation are not going
4 to be easily remediated and certainly not substantially
5 addressed by more appropriate, if you will, update in the
6 PFS, I think the messaging -- and Larry, you said it quite
7 well -- the messaging is important and it's directionally
8 appropriate in terms of those issues.

9 And the last comment is the access challenges I
10 think we have to recognize go way beyond the PFS. And the
11 issues and drivers and ultimate resolution if we achieve
12 such, of access challenges I think are the same as what we
13 see in terms of the increased charges per beneficiary over
14 time. And really what they reflect is the increasing
15 complexity of care choices that are available. I mean,
16 there are many more options available to take care of
17 beneficiaries with complex chronic illnesses, and we should
18 celebrate that but also recognize that that drives up the
19 work involved in care.

20 And there's also, I think, and I think we should
21 celebrate this, there's an increased expectation from
22 beneficiaries for high quality care that addresses their

1 needs and allows them to lead continued, fruitful lives.
2 So thanks again for the great work, guys.
3 MS. KELLEY: Lynn.
4 MS. BARR: I don't know if you ever get tired of
5 hearing how great you are, but I really appreciate your
6 work.
7 I am yes on the recs, but I also have some
8 concerns. And I'm going to sneak a Round 1 question into
9 Round 2, because one of the things I've been thinking about
10 is a couple of years ago, when Jim and I were fighting
11 about these updates, he said, well, we're doing all these
12 updates to the physician fee schedule to pay primary care
13 doctors a lot more, and we've got to let that work out
14 through the system.
15 So I was just wondering, can you show us, like
16 when we're having this next conversation, how did that
17 really impact primary care payments? Or I don't know if
18 you already know the answer to that. I know we have an
19 expectation, and because of that expectation we have not
20 bumped the primary care doctors for quite a while because
21 we think we've got it. And I just want to make sure we
22 did, and that they don't need more. I wouldn't be

1 surprised if they did.
2 I know this is for another conversation, but
3 sometimes what we do becomes fixed in people's minds, you
4 know, even though we say, oh, we're just doing it MEI minus
5 1 this time, but then we're going to do something else.
6 People are like, oh yeah, we'll just do MEI minus 1. But
7 if inflation is 10 percent, that's one thing. If inflation
8 is 1 percent, you know, that's a whole other thing. So I
9 don't want us to get used to a minus 1 number when the
10 inflation number could be anywhere from 0 to whatever. So
11 I think that's kind of a dangerous -- I just want to make
12 sure that people don't expect to see a fixed number in the
13 future. That just wouldn't make any sense to me.
14 We have talked a lot about quality, and I think
15 that we struggle to measure quality. But I'm wondering,
16 you know, the ultimate measure of quality is life
17 expectancy and quality of life. And life expectancy has
18 been declining, right. So I don't know whether we have
19 quality of life measures that we can look at for our senior
20 population, but I think that's our true, true measure of
21 quality as the ultimate outcome, which is how long do you
22 get to live and how much do you get to enjoy it. That's

1 what we really want out of our health care system. So I'd
2 like to see if we can look at that sometime in the future.
3 And the SNI is incredibly important, and it's
4 disappointing that I think this is some of the best work
5 that MedPAC's come up with, and I think everyone around the
6 table probably would agree with that, and it's very
7 disappointing that Congress has not adopted this, because
8 this is really speaking to the disparities of care. And we
9 say we really care about that. We really need to look hard
10 at the safety-net index and make sure that we are taking
11 care of all beneficiaries. Thank you.
12 MS. KELLEY: Betty.
13 DR. RAMBUR: Thank you. I also very much
14 appreciated the chapter and also the questions and comments
15 from the other Commissioners.
16 I concur with the recommendation and I very
17 strongly support the second part. I mean, optimally, a
18 stronger primary care system would create a need for less
19 specialists, so I think it's really appropriate.
20 I align with Tamara, though, on it being an upper
21 bound. I'm not confident that money is really going to fix
22 the dissatisfaction in the health care system. It's the

1 working conditions. And I'm not surprised we see more
2 nurse practitioners, because nurses are fleeing the bedside
3 to do things like primary care, which actually,
4 paradoxically, is less disheartening than working in an
5 understaffed facility.
6 So I just have to also say I think it's important
7 that everybody recognizes that caring for low-income people
8 is part of the culture of nursing. Very many nursing
9 programs, at the master's level, the doctorate level,
10 looking to recruit nurse practitioner students, have to
11 write an essay about their interest in serving rural and
12 serving underserved. So it is something that we are
13 marinated in.
14 So going back to Brian's comment, I think it's
15 actually really important that we recognize that this is a
16 workforce that's here and, frankly, ready to do more,
17 enabling physicians to do what only they can do.
18 A number of you mentioned the volume and
19 intensity piece, and I just want to plus-one on that, or
20 plus-five, whatever it's up to.
21 And although I know this is a focus
22 recommendation, I remain struck by a nation writing in pain

1 at the cost of care and pleas for enhanced reimbursement,
2 as we're also having declining mortality and quality of
3 life.
4 So in my penultimate year I just have to make a
5 plea that MedPAC redoubles its efforts, workstream, focused
6 on payment reform. I agree with Scott that we can't -- at
7 least I think this is what he said -- in a reactive fee-
8 for-service system we simply can't really meet the needs
9 of society, and it's simply too comfortable to stay there,
10 so we end up doing these kinds of things. And then, as
11 Brian said, modernizing Medicare.
12 But I greatly appreciate this work, and I support
13 the recommendations. Thank you.
14 MS. KELLEY: Amol.
15 DR. NAVATHE: Geoff, Brian, and in absentia,
16 Rachel, fantastic work, as always. It's always astounding
17 how much information you all are able to generate and then
18 pack into these materials, so thank you for all your
19 efforts.
20 I also want to voice support for the
21 recommendation, both parts of it. I think the safety-net
22 part certainly is very important.

1 And then I wanted to offer two other comments.
2 So I think that access data is striking. The number of
3 different ways I think there are certainly concerning
4 elements. Larry, Brian, Robert, I think some others have
5 also mentioned, aspects that are concerning. I think it's
6 meaningful the statistics and the data that's been added,
7 so I appreciate the additional efforts that have gone into
8 giving us that data.
9 And I also, I think simultaneously, very much am
10 hearing the Commissioner comments around, you know, is this
11 fundamentally about adding dollars to the system? Is that
12 really going to solve the problems? And I think this is
13 very, very clearly a highly multifactorial problem, and I
14 think we want to be fairly compensating physicians for the
15 care that they provide, as well as for the complexity of
16 the care they provide, and how, for some patients, the
17 needs, the volume of care vary relative to others.
18 I was very particularly struck by the access
19 issues on the mental health specialty side. I think the
20 statistic was something like 62 percent of beneficiaries
21 experience challenges or problems I think in accessing
22 mental health services. What's striking to me there, at

1 least kind of in a very speculative way, is that I would
2 have to believe that is a gross understatement of the
3 access challenge, because I can only imagine there are
4 several thousand, millions of beneficiaries who have tried
5 to access the system and at some point have given up.
6 Therefore, are they even recording their challenges?
7 So that strikes within the access bucket as the
8 piece that really bothers me the most. Just on the record,
9 I don't think that physician updates are going to be the
10 way that we solve that problem. But I think it's very,
11 very striking data, and I really appreciate that you all
12 have brought that forward.
13 The other comment I wanted to make was with
14 respect to the safety-net work, which I agree with the way
15 Lynn characterizes it. I think one of the best pieces of
16 work that I've seen since I've been on the Commission,
17 which has been wonderful.
18 The one piece that I wanted to offer here, a
19 comment on, is based on some emerging data that suggests,
20 so certainly there's a subset of clinicians that tend to
21 take care of a disproportionate number of DLIS benes. But
22 even at the hospital and otherwise, what's interesting

1 about that is that the providers that seem to take care of
2 the hospitals and clinicians, that seem to take care of the
3 vast majority of beneficiaries that might fall into a
4 safety-net population, based on income or based on the
5 geographic indicators of their area or otherwise, tend not
6 to be the ones who fall into the high share of DLIS. In
7 some sense, the majority of DLIS benes are seeking care
8 from provider group, whether clinicians or hospitals, who
9 are not heavily concentrated in their patient panel, if you
10 will, of DLIS benes.
11 So the reason that's important, I think, is
12 because, one, it supports the approach that we've taken,
13 which is add-on payments, because the dollars follow the
14 benes and don't go to the providers based on the share.
15 But the other piece is to the extent that think, in quotes,
16 that we are "targeting dollars" to organizations that might
17 have lower margins or may have poorer financial metrics,
18 because of the way that the sorting is happening here,
19 comes to the numbers, we're probably not actually going to
20 be boosting margins or groups that are disproportionately
21 caring for, within their panels, a high share of DLIS
22 benes.

1 So I think that's just a tradeoff that we should
2 be thinking about, and a lot of it depends on what is our
3 objective. I think if our objective is just
4 straightforward for benes who are in the safety-net, then I
5 think the way we've been structuring the add-on payment
6 totally makes sense. But I thought I would just add that
7 fact, sort of, as we contemplate physician updates and
8 safety-net and other things down the road. Thank you.
9 MS. KELLEY: Kenny.
10 MR. KAN: Thanks for an excellent chapter. I
11 agree with Amol and many of my fellow Commissioners. This
12 is a multifactorial problem that we cannot solve in one
13 year.
14 I enthusiastically support the Chair's two-part
15 draft recommendation.
16 MS. KELLEY: Josh.
17 DR. LIAO: Thank you again, and also to Ledia and
18 Rachel for their contributions. I appreciate my fellow
19 Commissioners and their comments so far. I think it's
20 highlighted the number of considerations, macro and
21 specific to this conversation today. But recognizing the
22 task at hand, 2026, versus out years, the things that we

1 need to address in the health care system but then the
2 subset that may be affected by payment, and then within
3 that, what can be affected in an update like this. I would
4 just say, bottom line on top, I'm supportive of the two
5 recommendations.
6 Just to give color, kind of from my perspective,
7 I tend to agree with Larry that maybe year-to-year, any one
8 given change may not move behavior that much. I also agree
9 it's multifactorial. At the same time, I think we are
10 here, and Figure 7 speaks the way Figure 7 speaks because
11 of the cumulative nature of that. So I think even for one
12 year, to start framing it that way, for a robust discussion
13 for year-on-year later, I think is the right move
14 directionally.
15 I'm also a primary care trained general
16 internist, and I think a lot about developing and
17 recruiting primary care clinicians alongside advanced
18 practice professionals, as well. In that I think we can --
19 and I look forward to the opportunity to debate, what are
20 the factors, major and minor. But I think not making some
21 of these changes is not going to help. I think that's
22 fairly clear to me. It doesn't help morale, and I'm happy

1 to talk more about that in future discussions.

2 The last thing about the MSN, the safety-net, I

3 agree for many of the reasons that my colleagues have

4 mentioned. I acknowledge Brian's and others' points about

5 specialty care. You know, there are data out there that

6 suggest that dual eligible individuals, for example, have

7 more comorbidities, but they have fewer visits to the

8 specialty care. I think that's an issue we need to

9 address.

10 At the same time, I don't want to pit it as a

11 primary care versus specialty care as if one is more

12 important. I would just say that, in general, I believe

13 that primary care fills a lot of functions that coordinates

14 with specialty care, whether through co-management or

15 different types of arrangements. So if we think there are

16 multiple chronic conditions, as Scott has mentioned, if we

17 think that there is a bigger body of work, I do favor

18 something that addresses both primary and specialty care.

19 That's directionally how I feel. Whether it's the 15

20 versus 5, I think that's something I'm less sure about.

21 MS. KELLEY: Gina.

22 MS. UPCHURCH: When I came on the Commission, one

1 of the things I care about a lot is trying to keep it
2 simple and transparent, particularly so that people can
3 plan. And I want to be supportive of this recommendation
4 for those reasons.
5 I also just want to put out there that if the RUC
6 would value primary care more it might help us in many ways
7 with these workarounds that we create. So just put that
8 out there.
9 I also appreciate Tamara's concerns and
10 conservativism, because there has been an increase in
11 volume and intensity. So it's hard to know ultimately
12 whether the income of primary care providers or any
13 specialist has been dramatically hurt, but not keeping up
14 with inflation or somewhere near to inflation does not make
15 sense if we want providers to stay engaged with Medicare
16 beneficiaries.
17 So I support both parts of the recommendation,
18 and I want us to keep an eye on primary care, not just for
19 people with limited incomes, but just primary care, in
20 general. I think code 2211 is going to be helpful to them,
21 but I do think supporting primary care and team-based care
22 settings I think is something we want to do if we're going

1 to be looking at quality of care for older adults. So it's
2 supporting team-based care moving forward in primary care.
3 But thanks for the great work in the chapter, and
4 Rachel in absentia.
5 MS. KELLEY: Mike, that's all I have in the
6 queue.
7 DR. CHERNEW: And if I have this right, Wayne, I
8 think you're -- oh, you moved. That just shows you.
9 DR. RILEY: I'm usually there.
10 DR. CHERNEW: Wayne, I have you last.
11 DR. RILEY: Yes. Thank you, Chairman, and I do
12 support the recommendation. I appreciate the excellent
13 discussion we've had sort of laying out the cognitive
14 dissonance we have about doing one year, thinking about the
15 out years. So that is something I think, directionally, we
16 deserve to have a fulsome discussion on, because it does
17 affect, in the aggregate, as Josh says, sort of the
18 atmospheric around primary care. I, too, Josh, as you
19 know, was a primary care general internist. I worry about
20 the cumulative effect down the road in terms of getting
21 young men and women to pursue primary care, internal
22 medicine, and advanced practice nursing, et cetera.

1 So I think this discussion has really distilled
2 where we need to think about this going forward. But Mr.
3 Chairman, I support the recommendation as presented.
4 DR. CHERNEW: Okay. Given our technical
5 difficulties we're a little bit behind, so I'm going to
6 just sum up. And again, I'll start with thanks to the
7 staff -- Geoff, Brian, Rachel, and others, Ledia. I think
8 the quality stuff you've done has also been really helpful
9 here, so thank you.
10 To folks at home, in case I forget later, please
11 reach out to us with your comments. I'm sure you will have
12 some, meetingcomments@medPAC.gov, or through the website or
13 other ways to reach us. But we really do want to hear from
14 all of you at home about your thoughts on this chapter.
15 A few just very quick bullet points summary
16 things. First, as I have said, and I will say again, our
17 charge for now is just 2026, and I fully understand the
18 concern that what we've done the past has not been things
19 that people want going forward, and as a result we have
20 responded by having a separate work stream to think about
21 broader recommendations, which we talked about last month
22 and we will talk about in March and maybe vote on in April,

1 depending on how all these conversations go. So that's the
2 first point.
3 The second point. I was surprised, and it came
4 up in a few comments a little bit, but I will just
5 emphasize, higher payments to providers of any type mean
6 higher premiums to beneficiaries and higher cost sharing
7 for folks. So if you're actually concerned about access,
8 which is a reasonable thing to be concerned about,
9 understand that there's a demand and a supply side thing
10 going on. And so when we pay more, we really have to think
11 about what we're getting for that. And while I understand
12 the desire for physicians and others to get paid more, we
13 also have to understand that in doing that the cost is
14 ultimately borne by beneficiaries and taxpayers and others.
15 And so it is a balancing effect.
16 There is this question about what the right
17 number should be, and first of all, I think, as I've said
18 before, the details of the number are less important.
19 Congress will do what they ultimately want to do. But I
20 will point out that all the other fee schedules since the
21 ACA have an update that's less than inflation, as the
22 productivity adjustment. So current law is less than

1 inflation for every sector. You can debate the number, but
2 that is not the case that other sectors have current base
3 equal to inflation, for better or for worse.
4 One thing to say about the formula, MEI minus 1,
5 and again, I don't think this matters at the time. The
6 reason why it is that way -- and again, we can discuss.
7 You can send me email separately -- is if you did half of
8 MEI, which is what we had in the previous rec, if inflation
9 is 10, you get 5. So this gives you basically an increase
10 with inflation as it varies, but then we will talk about
11 this again. It's a bigger issue in the long run, so we had
12 a floor on where it would be. But at least now it's moving
13 consistently with inflation.
14 So there's a lot of discussion about primary care
15 and specialists, and so let me say, in general, we think
16 both are important. I think we need primary care doctors.
17 We need specialists. I think that's acknowledged in the
18 second part of the recommendation, for example. We don't
19 say specialists, zero. We just say less. And the reason,
20 just so you know, is we are really struggling to get people
21 into primary care positions. Specialists -- and I don't
22 want to deny the challenges they face -- but there are more

1 people going into specialty. And as an aside, related to
2 that, an average update dollar-wise actually supports the
3 specialist more, because they're starting at a higher base.
4 That's just the mathematic version of changing with the
5 update, if you were concerned about that.
6 But in any case, to a comment that Lynn made, it
7 is not the case that we believe, or I don't think we
8 believe, or maybe I just stick for me, I don't believe that
9 it's inherently true that the primary care increase that
10 happened was necessarily enough, and that I think is
11 reflected in the second part of the recommendation. We
12 continue to be concerned about access to primary care and
13 the number of people choosing primary care, the
14 distribution of primary care. That's again not to say that
15 there's not real problems with access to specialty care, as
16 well. I think Brian's basic point is correct, that access
17 is actually not that great in a lot of cases. I accept
18 that.
19 I think the material about the access differences
20 should be viewed relatively. So if access is bad for
21 commercial people, and it's bad for Medicare. In fact,
22 it's a little bit less bad for Medicare. So the problems

1 are probably much more workforce-y problems, the number of
2 physicians, a bunch of other things. And I do think that
3 some holistic discussion of that is valuable, but in the
4 update world we're probably not going to solve that
5 particularly easily.
6 And the last point I'll say, and I just say this
7 because Brian said this several times and I just want to
8 make sure it's clear, there was a concern about the salary
9 data. And I understand that the salary is reflective of a
10 lot of things and it doesn't necessarily pass through.
11 There is great work by Josh Gottlieb and a whole bunch of
12 other colleagues, Maria Polyakova and others, and I
13 apologize to the others that may be listening for me not
14 giving their names. But that, in fact, it does pass
15 through, just not one-for-one.
16 But the broader point is there are a lot of
17 people that do believe the salary data is interesting, and
18 so we present the salary data. And there will be people
19 for all of the data that we present, including me, that
20 find some pieces of information more interesting than other
21 pieces of information. So I just ask that you understand
22 that other people may like things that you might not like,

1 and so we still present it, and it doesn't play necessarily
2 directly into what the recommendations are. So our
3 recommendations, for example, are not trying to target any
4 particular salary number for anybody, but it does speak to
5 some of the others issues that you guys raised.
6 So again, I really appreciate the staff work. It
7 is quite comprehensive, and it is getting more
8 comprehensive over time. I think that's message one. And
9 I hope that folks at home can send us their comments.
10 Again, meetingcomments@medpac.gov. And we are going to
11 adjourn now for what will be a shorter lunch than otherwise
12 scheduled, and we will be coming back at 1:15, and we will
13 be talking about the hospital sector.
14 So again, thank you all, and we'll see you soon.
15 [Whereupon, at 12:25 p.m., the meeting was
16 recessed, to reconvene at 1:15 p.m. this same day.]
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1 AFTERNOON SESSION

2 [1:16 p.m.]

3 DR. CHERNEW: Hello, everybody. Welcome back to
4 our Thursday December meeting, and we are going to continue
5 our discussions of updates to various fee schedules. And
6 we are going to start now with the hospital inpatient and
7 outpatient services fee schedule with a bit on the rural
8 emergency hospital mandated report. And to start us off I
9 believe we're going with Alison.

10 MS. BINKOWSKI: Thank you, Mike, and good
11 afternoon. The audience can download a PDF version of
12 these slides in the Handout section of the control panel on
13 the right-hand side of the screen.

14 In addition to the staff listed on the slide, I
15 would like to thank Stuart Hammond, Pamina Mejia, and
16 Nathan Graham for their assistance.

17 In today's presentation we will cover several
18 topics. First, we will provide an overview of hospital use
19 and spending under fee-for-service Medicare. Then, to
20 assess the adequacy of fee-for-service Medicare payments to
21 hospitals, we will summarize results from four categories
22 of payment adequacy indicators: beneficiaries' access to

1 hospital care, quality of hospital care, hospitals' access
2 to capital, and the relationship between fee-for-service
3 Medicare payments and hospitals' costs.
4 Based on these indicators, we will present
5 Chair's draft recommendation on how to update fee-for-
6 service Medicare base payment rates to hospitals in 2026.
7 We will then transition to discuss one other
8 topic, a mandated report on rural emergency hospitals. We
9 will then turn it back to the floor back to Commissioners
10 for discussion.
11 To pay hospitals for the facility share of
12 providing services, fee-for-service Medicare generally sets
13 prospective payments rates under the inpatient and
14 outpatient prospective payment systems.
15 In 2023, over 3,100 hospitals were paid under
16 these payment systems, and these hospitals provided 6.6
17 million inpatient stays to fee-for-service Medicare
18 beneficiaries, for which the Medicare program and its
19 beneficiaries paid $102.6 billion, as well as an additional
20 $6.7 billion in uncompensated care payments.
21 These hospitals also provided $123.8 million
22 hospital outpatient services to fee-for-service Medicare

1 beneficiaries, for which the Medicare program and its
2 beneficiaries paid $49.6 billion, as well as an additional
3 $20.4 billion for separately payable drugs and other items.
4 Together, these payments totaled nearly $180
5 billion.
6 The following slides focus on assessing adequacy
7 of payments under these two prospective payment systems.
8 Each year MedPAC assesses the adequacy of fee-
9 for-service Medicare payments by looking at four categories
10 of payment adequacy indicators: beneficiaries' access to
11 care, the quality of that care, provider's access to
12 capital, and the relationship between fee-for-service
13 Medicare payments and providers' costs. The goal of this
14 exercise is to determine what update to fee-for-service
15 Medicare payments would achieve access to high quality care
16 for beneficiaries and good value for taxpayers.
17 The specific set of indicators used to assess the
18 adequacy of fee-for-service Medicare payments to hospitals
19 are enumerated on this slide. For each set of indicators,
20 we start with the most recent available and complete data,
21 which this year is generally fiscal year 2023, and include
22 preliminary data for 2024 when possible. We also project a

1 fee-for-service Medicare margin for 2025.
2 Based on these indicators, the Chair develops a
3 draft update recommendation for hospital base payment rates
4 in 2026.
5 Our first category of fee-for-service Medicare
6 hospital payment adequacy indicators is beneficiaries'
7 access to hospital care. We found that hospital capacity
8 increased and hospitals maintained available capacity in
9 2023.
10 Specifically, hospital employment increased to
11 4.7 million full-time equivalent employees, a 3 percent
12 increase from 2022; inpatient beds increased slightly to
13 674,000; hospitals maintained available inpatient capacity
14 in aggregate, with 69 percent of beds occupied; and
15 hospitals maintained adequate emergency department capacity
16 in general, with only about 2 percent of patients leaving
17 the ED without being seen. Within these aggregates, there
18 continued to be substantial variation in hospitals'
19 available capacity.
20 Another indicator of beneficiaries' access to
21 hospital care is the supply of hospitals. As shown in the
22 figure on the left, the supply of hospitals was relatively

1 steady in 2023, decreasing by 0.2 percent. In both fiscal
2 year 2023 and 2024 about 10 more hospitals closed than
3 opened, with low volume being the most common cited reason
4 for closure, and about 15 hospitals converted to rural
5 emergency hospitals, a new designation which we will
6 discuss more later in this presentation.
7 Another indirect indicator of beneficiaries'
8 access to care the volume of fee-for-service Medicare
9 services. Both inpatient stays and outpatient services per
10 capita increased in 2023.
11 As shown in the left figure, from 2022 to 2023,
12 the number of inpatient stays per capita increased 1.5
13 percent, up to 205 stays per 1,000 fee-for-service Medicare
14 Part A beneficiaries, below the 2019 level.
15 As shown in the right figure, from 2022 to 2023,
16 the number of hospital outpatient services per capita
17 increased 2.4 percent, up to 5.2 services per fee-for-
18 service Medicare Part B beneficiary. Most outpatient
19 services largely rebounded to 2019 levels, except for
20 emergency department services which remained lower.
21 Our final indicators of beneficiaries' access to
22 care is a comparison of fee-for-service Medicare payments

1 to hospitals' variable costs. Hospitals have a financial
2 incentive to provide services to fee-for-services Medicare
3 beneficiaries if Medicare's payments exceed hospitals'
4 variable costs of providing those services.
5 In 2023, aggregate fee-for-service Medicare
6 payments were 85 percent of hospitals' aggregate costs of
7 providing those services. Meanwhile, we estimated that
8 hospitals' variable costs, that is, the costs that varied
9 with hospitals' annual volume changes, were lower, at
10 between 75 percent to 85 percent of hospitals' costs.
11 As fee-for-service Medicare payments exceeded
12 hospitals' variable costs, hospitals had a positive fee-
13 for-service Medicare marginal profit, and a financial
14 incentive to serve fee-for-service Medicare beneficiaries.
15 Our second category of hospital payment adequacy
16 indicators are those related to the quality of hospital
17 care. In 2023, these hospital quality indicators were
18 mixed, both relative to 2022 and pre-pandemic levels.
19 Specifically, fee-for-service Medicare beneficiaries' risk-
20 adjusted mortality rate was 7.6 percent in 2023, a slight
21 improvement.
22 However, our other two quality indicators were

1 mixed. Fee-for-service Medicare beneficiaries' risk-
2 adjusted readmission rate was 15 percent, worse than in
3 2022 but still an improvement relative to 2019, and most
4 patient experience measures improved from 2022, but almost
5 all remained at least one percentage point lower than in
6 2019.
7 Our third category of hospital payment adequacy
8 indicators is hospital's access to capital. Hospitals'
9 primary source of capital, operating profits, increased in
10 2023. As shown in the orange solid line in the figure,
11 hospitals' aggregate all-payer operating margin increased
12 to 5.1 percent in 2023, well above the relative low of 2.7
13 in 2022. This 2.4 percentage point increase was driven by
14 growth in operating revenues.
15 Within these aggregates, there continued to be
16 considerable variation, as shown by the light gray shaded
17 area in the figure indicating the margin among the middle
18 half of hospitals.
19 While there was variation among each group of
20 hospitals, as shown in the right bullets, in aggregate, the
21 2023 all-payer operating margin was substantially higher at
22 for-profit hospital than nonprofit hospitals, and higher at

1 hospitals in urban areas than in rural non-micropolitan
2 areas.
3 In addition to operating profits, hospitals also
4 access capital in ways, and these indicators were mixed in
5 2023. Hospitals' all-payer total margin, which includes
6 investment and donation income, increased to 6.4 percent,
7 and hospitals borrowing costs increased 4.4 percent in
8 fiscal year 2023, but by less than the borrowing costs of
9 the general market.
10 While we only have complete cost report data
11 through fiscal year 2023, we can gain insight into
12 hospitals' 2024 and 2025 all-payer operating margin and
13 other indicators of access to capital by looking at
14 financial statements from large hospital systems. These
15 preliminary data suggest that hospitals' all-payer
16 operating margin improved by about 1 percentage point in
17 2024. For nonprofit hospitals, this is consistent with
18 rating agencies projected outlook.
19 I will now turn it over to Betty.
20 DR. FOUT: The fourth and final category of
21 hospital payment adequacy indicators is the comparison of
22 fee-for-service Medicare payments and hospitals' costs. As

1 shown in the dotted orange line in the figure, hospitals'
2 aggregate fee-for-service Medicare margin exclusive of
3 relief funds was -13 percent in 2023. The margin was
4 stable between 2022 and 2023, and reflected offsetting
5 pressures on hospitals' margins, including downward
6 pressure from the reinstatement of Medicare sequestration
7 and upward pressure from an increase in profitable
8 separately payable drugs.
9 Within these aggregates, there continued to be
10 considerable variation, as shown by the light gray shaded
11 area in the figure show the margin among the middle half of
12 hospitals.
13 There was variation among each group of
14 hospitals. As shown in the right bullets, in aggregate,
15 the 2023 fee-for-service Medicare margin was substantially
16 higher at for-profit hospitals than nonprofit hospitals,
17 and higher at hospitals in rural non-micropolitan areas
18 than in urban areas.
19 Each year, the Commission examines the median
20 fee-for-service Medicare margin for a group of hospitals
21 that performed relatively well on mortality and readmission
22 while keeping unit costs relatively low during a three-year

1 historical baseline period. We refer to these hospitals as
2 "relatively efficient" because they performed relatively
3 better on selected quality and cost measures. This method
4 does not seek to identify all efficient hospitals but
5 rather be one source of information about whether
6 Medicare's payments are adequate to cover the costs of
7 provided hospital care efficiently.
8 As shown in the first column of the table, in
9 2023, among the set of hospitals we identified as
10 relatively efficient, the median fee-for-service Medicare
11 margin was -1 percent when including relief funds and -2
12 percent exclusive of these funds. The all-payer operating
13 margin in 2023 for these hospitals was 7 percent. As shown
14 in the second column, both the median fee-for-service
15 Medicare margin and all-payer operating margin were
16 substantially lower among the other hospitals that were not
17 identified as relatively efficient.
18 The relatively efficient hospital median Medicare
19 margin improved by about 1 percentage point compared to
20 what we found last year, for relatively efficient hospitals
21 in 2022. The all-payer operating margin improved by 3
22 percentage points compared to last year.

1 Similar to past years, relatively efficient
2 hospitals were spread across the country and included
3 different categories of hospitals. Among for-profit and
4 nonprofit hospitals, the shares of hospitals categorized as
5 relatively efficient were similar. Although for-profit
6 hospitals tended to have lower costs, nonprofit hospitals
7 tended to have higher quality metrics.
8 For 2025, we project the fee-for-service Medicare
9 margin to be similar to the levels in 2023 exclusive of
10 coronavirus relief funds. Specifically, we project the
11 aggregate fee-for-service Medicare margin in 2025 to remain
12 at about -13 percent, and the median fee-for-service
13 Medicare margin among relatively efficient hospitals to
14 remain near -2 percent.
15 More details on our projections are in your
16 mailing materials.
17 While there is more uncertainty for 2026, we
18 expect that fee-for-service Medicare margins in 2026 to be
19 similar to our 2025 projections.
20 In summary, across our four categories of
21 indicators of the adequacy of fee-for-service Medicare
22 payments to hospitals, we found that beneficiaries' access

1 to care is positive, the quality of care is mixed,
2 hospitals' access to capital is positive, and fee-for-
3 service Medicare payments relative to hospitals' costs is
4 negative.
5 In considering how to update fee-for-service
6 Medicare payments to hospitals, the Chair's draft
7 recommendations aims to balance several objectives. These
8 include maintaining payments high enough to ensure
9 beneficiaries' access to care; maintaining payments close
10 to hospitals' cost of providing high-quality care
11 efficiently to ensure value for taxpayers; maintaining
12 fiscal pressure on hospitals to constrain costs; minimizing
13 differences in payment rates for similar services across
14 sites of care; limiting the need for large, across-the-
15 board payment rate increases by directing a portion of the
16 increase in Medicare payments to Medicare safety-net
17 hospitals treating higher large shares of vulnerable
18 Medicare patients.
19 Last year, we balanced those objectives by
20 recommending a small, across-the-board update above current
21 law to all hospitals and a larger and a more targeted
22 increase to some hospitals based on their Medicare safety-

1 net index.

2 As a reminder, in June 2023, the Commission
3 recommended replacing existing Medicare safety-net payments
4 with the Commission-developed Medicare Safety-Net Index, or
5 MSNI, which identifies hospitals that serve large shares of
6 low-income Medicare patients.

7 For each hospital, the MSNI is calculated from
8 three components: the share of Medicare volume for
9 beneficiaries who are low-income, uncompensated care costs
10 as a share of all-payer revenue, and Medicare's share of
11 all-payer volume, which is divided by two.

12 Higher values of the MSNI indicate greater
13 financial vulnerability and greater reliance on the
14 Medicare program.

15 In addition to the MSNI targeting hospitals that
16 treat larger shares of low-income Medicare beneficiaries,
17 our prior analysis also found the MSNI was better predictor
18 of hospitals all-payer margins and risk of closure than
19 those used for current Medicare safety-net payments, which
20 are composed of disproportionate share of hospital and
21 uncompensated care payments.

22 As shown in the figure on the right, in 2023, the

1 all-payer operating margin continued to be lower for
2 hospitals with higher MSNI values. The all-payer operating
3 margin was 7.6 percent among hospitals in the lowest
4 quartile of the MSNI compared to 3.7 percent for hospitals
5 in the highest quartile of the MSNI.
6 As recommend in our prior work since 2023, the
7 current disproportionate share hospital and uncompensated
8 care payments should be replaced with payments distributed
9 using the MSNI and, if needed, the MSNI could also be used
10 to target new funds to hospitals most in need of additional
11 Medicare dollars because they are serving a
12 disproportionate share of low-income Medicare
13 beneficiaries.
14 More details on the MSNI are in your reading
15 materials.
16 We now turn to the Chair's draft recommendation
17 for 2026. Given that the payment adequacy indicators are
18 slightly improved relative to last year, the Chair's draft
19 recommendation for 2026 is slightly less than the
20 Commission's recommendation in 2025, but otherwise remains
21 the same.
22 The Chair's draft recommendation reads:

1 The Congress should:
2 For fiscal year 2026, update the 2025 Medicare
3 base payment rates for general acute care hospitals by the
4 amount specified in current law plus 1 percent, and
5 redistribute existing disproportionate share hospital and
6 uncompensated care payments through the Medicare Safety-Net
7 Index (MSNI), using the mechanism described in our March
8 2023 report, and add $4 billion to the MSNI pool.
9 The implications of the Chair's draft
10 recommendation is an increase in spending above current
11 law. We expect this recommendation will help maintain
12 hospitals' willingness to treat fee-for-service Medicare
13 beneficiaries and maintain beneficiaries' access to care by
14 improving the financial stability of hospitals serving
15 large shares of low-income Medicare beneficiaries.
16 Before turning to our discussion of the Chair's
17 draft recommendation, we will discuss one additional topic,
18 a mandated report on rural emergency hospitals, or REHs.
19 The creation of the REH designation was a
20 response to changes that occurred in rural areas over many
21 years. Rural hospitals were traditionally inpatient-
22 centric organizations and rural Medicare payment policies

1 often focused on increasing payment rates for inpatient
2 services as a mechanism to support rural hospitals.
3 However, in recent years, some rural hospitals had almost
4 no inpatients, but still had active emergency rooms.
5 To address these changes in rural patients'
6 needs, the Commission recommended the creation of an
7 outpatient-only hospital. Medicare would support the
8 hospital with a fixed annual payment that would help cover
9 stand-by emergency room costs plus traditional fee-for-
10 service payments for each unit of service.
11 Broadly consistent with the prior MedPAC
12 recommendation, the Consolidated Appropriations Act of 2021
13 created this new REH hospital designation.
14 REHs must provide 24/7 emergency care but cannot
15 maintain acute inpatient bed or swing beds. REHs also have
16 the option to furnish other services, including distinct
17 part SNF services and other outpatient services beyond ED
18 services.
19 To support REH's, the Act required Medicare to
20 pay a fixed monthly payment to help cover standby costs.
21 In 2025, that fixed monthly payment will be about $286,000.
22 REHs also receive 105 percent of OPPS rates for all OPPS

1 services and standard rates for other services.
2 The Act also mandated MedPAC to annually report
3 on payments to REHs. In our March 2024 report to Congress,
4 we reported on the structure of the program in detail. In
5 your mailing materials, we provide an update on the number
6 of REHs and their Medicare payments in calendar year 2023,
7 which shows that 21 hospitals converted to REHs in 2023,
8 and these REHs received about $10 million in fee-for-
9 service Medicare payments for outpatient services, and also
10 received about $30 million in fixed payments from Medicare.
11 REHs continued to grow in 2024. The Commission
12 continues to monitor the implementation and uptake of the
13 new REH designation.
14 We'll now answer any questions you have and take
15 your feedback, and we'll turn it back to Mike.
16 DR. CHERNEW: Great. Thanks, everybody. As
17 always, a lot of important information for an important
18 sector that we've worried a lot about. I think we're going
19 to jump into Round 1, and if I'm right, Cheryl is the first
20 Round 1 question.
21 DR. DAMBERG: Yes. All right. Thanks for all
22 the great work. A lot of meat in this chapter.

1 Table 3.4, I really like the content of that
2 table. But I was also potentially interested in seeing it
3 stratified by rural versus urban, just in terms of the
4 number of closures. That was one question, and I'm
5 assuming you have the data to be able to do that breakout.
6 MS. BINKOWSKI: Yes. We described it some in the
7 text.
8 DR. DAMBERG: Great. And then I had a question
9 about the quality measures. We have few more quality
10 measures here than in some of the other sectors. But I was
11 curious why we're not looking at some of patient safety
12 measure, because I know some of those have been more
13 problematic since COVID.
14 MS. BINKOWSKI: We can consider adding them in.
15 DR. DAMBERG: Okay, great. Thanks. And then
16 another was some text around health care consolidation, and
17 I was not sure whether you've been tracking how many merged
18 or were acquired. And I think it would be helpful to have
19 some of that information.
20 MS. BINKOWSKI: We do have some of that
21 information. Again, it becomes difficult in the precise
22 definition of mergers, but we can add some flavor around

1 that.

2 MS. KELLEY: Lynn.

3 MS. BARR: A great chapter. Always enjoy reading

4 about what's happening with hospitals.

5 My Round 1 question. So you mentioned that only

6 6 percent of the hospitals are relatively efficient. I

7 don't remembers seeing that number before. Is that

8 something that you've been reporting out and I've just been

9 missing it?

10 DR. FOUT: We do report that every year.

11 MS. BARR: You do report it?

12 DR. FOUT: Yes.

13 MS. BARR: But I guess, is there a thought about

14 like if only 6 percent of the market is relatively

15 efficient, maybe they're not really relatively efficient.

16 They seem to be like super high performers, right? I mean,

17 it doesn't seem like that's a credible, you know -- do you

18 see what I'm saying? I'm just confused about that. I

19 don't know. Am I getting into Round 2? I don't know.

20 I'll leave that for Round 3. That's Round 2. But I would

21 think that relatively efficient would be the top half, you

22 know. So if we're only taking 6 percent saying this is

1 where everybody should get to, and 94 percent can't, I
2 don't understand that.
3 DR. STENSLAND: Historically it's been closer to
4 12, and we can look to see what happens. I think one of
5 the key things is we require them to be consistently
6 relatively efficient in every year. Like one bad year
7 throws you out. So when we have some sort of volatility
8 like we've had during the COVID times, there might be
9 different things that could cause you to have one bad year
10 on quality or one bad year on cost, and either one of those
11 things could throw you out. And that might be one of the
12 reasons why we're seeing 6 percent now when before we saw
13 maybe something closer to 12.
14 MS. BARR: Got it. Got it. Yeah, okay, good.
15 Thank you, because I was thinking I'd lost my mind. I
16 appreciate that.
17 On page 19 of your slide deck, can you show on
18 that -- do you have that chart that shows, I don't know if
19 you want to pull it up, that shows the projections, you
20 know, all-payer margins by MSNI quartile. Could you also
21 show the companion chart of how that relates to DSH?
22 Because I think that's what makes the point, right, is this

1 program is actually not at all -- and we need to reinforce
2 that over and over, because they haven't adopted this MSNI
3 thing yet, and I really don't understand why they haven't.
4 And then as far as ownership of REHs, is that
5 something that will be -- so that was a concern last year
6 was who is converting, and is it all, you know, systems, or
7 is it more individuals? So could you just break that out
8 of one versus the other?
9 DR. STENSLAND: We can do that in the next round.
10 It's a variety of different types of hospitals.
11 MS. BARR: Well, that's good news. All right.
12 Thank you.
13 MS. KELLEY: Brian.
14 DR. MILLER: Thank you. A couple of questions
15 and also just a brief tidbit. I agree with Cheryl on
16 including mergers, and the FTC actually publishes an annual
17 report that you can find, so you can see at least what
18 mergers have qualified for HSR filings with the Federal
19 Trade Commission Premergers Notification Office.
20 So a couple of clarification questions.
21 Apologies if I missed this. I saw that we recommended
22 current law plus 1 percent, but what is the current law

1 update?

2 MS. BINKOWSKI: So the current law update will

3 not be finalized until the summer of the coming year, but

4 the projections at this point are slightly over 2 percent.

5 It varies some between inpatient and outpatient because of

6 the start at 0.5 percent offset.

7 DR. MILLER: Net, we're recommending about 3

8 percent then?

9 MS. BINKOWSKI: About 4.2.

10 DR. MILLER: About 4.2 percent. So we should

11 specify that in the recommendation, that we are

12 recommending a 4.2 percent increase to the hospital

13 industry.

14 MS. BINKOWSKI: But it will be different when

15 current law changes, or if it might change when it's

16 finalized over the summer.

17 DR. MILLER: Still, 4.2 percent is a significant

18 number. I saw on page 18 that patient experience regarding

19 communication, quietness, and responsiveness and

20 understanding was sort of concerning in around the 60 to 70

21 percent range. Was there any correlation of the scores

22 with the number of hospital beds?

1 [Inaudible.]
2 DR. MILLER: Okay. That would be good to know,
3 because that could tell us if there's any economies or dis-
4 economies of scale.
5 MS. KELLEY: Let me just say that one more time
6 for the record, Brian. We're not sure offhand, but we can
7 get information.
8 DR. MILLER: Okay. Thank you.
9 MS. BINKOWSKI: And I misspoke. It should be
10 about 4.6 percent, but we can still add some flavor to
11 that.
12 DR. MILLER: That would be helpful, just to give
13 us context as Commissioners, because current law plus 1
14 percent means something different to us when that is 4.6
15 percent.
16 One thing that I've always wondered about, and I
17 think is important, and I was curious about and here we
18 talked about the costs of running a hospital. It's not
19 easy being a hospital CEO. There's no mention of
20 compliance costs of regulatory burdens for conditions of
21 participation. When we talked about fixed and variable
22 costs, have we quantified the compliance costs for

1 hospitals?

2 MS. BINKOWSKI: We have not. This was looking

3 purely at the extent to which hospitals total costs for

4 fee-for-service Medicare services varied with annual

5 changes in volume, and it's really difficult to parse out

6 specific compliance costs.

7 DR. MILLER: So I think that, for the hospital

8 industry, could be a valuable line of analytical work,

9 because regulatory costs do drive costs, which drives up

10 price. And I think we should be cognizant of regulatory

11 burdens driving administrative costs, which then increases

12 prices for patients.

13 The other thing which I was hoping for

14 clarification on is on page 14 we noted that we can't use

15 cost accounting to determine marginal variable costs to the

16 patients served in an acute care hospital. And as someone

17 who has unfortunately had to take a lot of accounting

18 classes, I paid very close attention to managerial and

19 financial accounting. My MBA professors are rejoicing

20 right now.

21 I also noted that when, in the IRF where the

22 impatient rehabilitation facility chapter, we noted that we

1 were able to determine the marginal variable cost of a
2 patient served. So can you explain to me this
3 inconsistency in methodology between inpatient rehab
4 facilities and general acute care hospitals?
5 MS. BINKOWSKI: I can start on that. To clarify,
6 the cost accounting is the cost accounting using the
7 hospital cost reports that are submitted, and one of the
8 differences between hospitals and other sectors is the
9 amount of costs that are categorized administrative and
10 general. And given the really large share of that and how
11 it varies across hospitals makes it even more complicated
12 to say these certain cost centers that are reported on
13 hospital cost reports represent fixed versus variable
14 costs.
15 And that's why this year we've begun our periodic
16 methodological review of various aspects, and one of them
17 was the hospital marginal profit. And we started with that
18 since that's the sector that has the only materially
19 negative fee-for-service Medicare margin.
20 There is also some uncertainty in the other
21 sectors, and we may revisit that, moving forward. But it
22 is, I would say, a positive profit, it's less sensitive.

1 DR. MILLER: So you're saying because you're
2 uncertain how to allocate indirect costs you therefore did
3 not determine variable costs. Am I understanding
4 correctly?
5 DR. STENSLAND: So there are two ways you can do
6 it. One, you could try to go through the cost reports and
7 say, oh, this is a variable cost, this is a fixed cost.
8 And you quickly get to some point of saying, okay, we're
9 going to have to determine how much of this administrative
10 cost is variable and how much is fixed. We're certainly
11 not going to say all labor is fixed or all labor is
12 variable. So we can make those judgment calls, and we've
13 done that before and tried to make those judgment calls.
14 But I don't want to pretend like it's precision.
15 Like I'm not going to go to Mass General and say I know
16 exactly how many of your employees are fixed and how many
17 are variable. You know, we're going to make an adjustment.
18 So then in addition to the cost accounting thing,
19 what we primarily did, is we did this many years ago.
20 We've done some regressions and said when your volume goes
21 up and down, how much does your cost go up and down. And
22 then we can see how much of your costs are variable by

1 actually looking at what happened. When your volume went
2 up by 10 percent, how much did your costs go up? When your
3 volume went down by 10 percent, how much did your costs go
4 down?
5 And when we went through that exercise there was
6 kind of a range, and it was an average of about 20 percent.
7 And so this year we did it again, and Dante, he was here,
8 who is just a Cracker Jack econometric person, did our
9 analysis. So we ran some more regressions, and we added a
10 couple of different ways. We added an instrumental
11 variable regression for some reasons, and we can say why,
12 and we all said, oh well, that's regression. And we looked
13 at all of it and we said, well, what's the confidence
14 interval here of how much is variable, and it came down to,
15 you know, something in the range of close to 75 to 85
16 percent, is like the 95 percent confidence interval from
17 the regression.
18 So that's kind of the long story of saying how
19 we're pretty confident in the range, because we did it the
20 same way, doing it many different ways over many different
21 years. I don't think we're going to say it's precisely
22 20.2 or 20.4 percent of the costs that are fixed.

1 DR. MILLER: I guess what I'm saying is if we
2 have to model what indirect versus direct variable costs
3 are for an industry that is spending several hundred
4 billion dollars in taxpayer funds to deliver care to
5 Medicare beneficiaries, perhaps part of our annual payment
6 recommendation should be an improvement in the Medicare
7 cost report to make that clearer, so that we can get better
8 estimates, and move it mor towards gap accounting. Because
9 that way we could better assess the operations and
10 profitability of the industry and better target payments.
11 So I would stress that as part of our payment
12 update that we consider that, not just in hospitals, but in
13 other markets that use the Medicare cost reports. That way
14 we can get better data. Thank you.
15 MS. KELLEY: Scott.
16 DR. SARRAN: Great work, again, summarizing a lot
17 of different aspects into very cogent discussion.
18 Three brief questions, and I'll put them all out
19 there. First is, somewhat building on Lynn's point,
20 efficient versus nonefficient hospitals. I'm just
21 wondering how much granular information we have about what
22 drives the difference. Because ideally -- and where I'm

1 coming from is ideally what we would glean from that are
2 things that would be informative to further public
3 discussions and potentially actionable on the part of the
4 less-efficient hospitals. So the question is again around
5 how much granularity we have to understand the underlying
6 operational drivers of that delta of efficient versus
7 nonefficient.
8 Second question is, am I thinking about this
9 correctly that the cost of our recommendation would be
10 essentially 1 percent of $180 billion plus $4 billion?
11 And then the third question, and I'll just get
12 these all out there, is, the redistribution that we
13 describe in our recommendation, do we have a good tutorial
14 that shows how that redistribution would impact various
15 types of hospitals, how much of a winner-loser change does
16 that create?
17 DR. FOUT: Sure. I'll address the first
18 question. Right now we define relatively efficient with
19 the two measures, mortality and readmissions, and we look
20 at standardized costs and CAHPS measures. I think you're
21 asking about other factors we could use to look at the
22 differences between the two, and we are happy to take a lot

1 at other factors if you have some things in mind. I mean,
2 we have looked at a host of variables that we didn't report
3 in the presentation.
4 I think number three I'll address, which is
5 looking at the winners and losers, MSNI. We certainly have
6 looked at that data ourselves, and there is variation by
7 different types. For example, rural hospitals do really
8 well with the MSNI, in terms of Medicare margins -- oh
9 sorry, all payer margins and their improvement and revenues
10 from redistributing the MSNI with the current payments.
11 MR. MASI: People are pointing to me, so I should
12 say something. Thank you, Scott. I think you also asked
13 about the cost of the recommendation. And when we come
14 back in January, we'll have kind of broader budget
15 information from CBO that we'll report at that point.
16 But I think you're thinking about it in roughly
17 the right way. There will be other effects, like
18 interactions with Medicare Advantage benchmarks that will
19 also tend to increase federal spending. So that's another
20 thing not to lose track of.
21 MS. KELLEY: Larry.
22 DR. CASALINO: Yeah, a couple of quick things.

1 One is your responses to the questions about fixing
2 variable costs. If we want a demonstration of the level of
3 detail that the staff get to and the level of knowledge
4 they have, that was a good demonstration.
5 So two comments/suggestions. One is I think I or
6 other Commissioners said this once or twice in the past.
7 This is a very picky point, and not to MedPAC, but
8 sometimes there are very, very small percentage changes,
9 and actually within relative terms that you guys call
10 better or worse, and don't really differentiate it much.
11 I'm not asking for looking for statistical significance.
12 But, for example, I'm reading this and I think if
13 I got the data right there was change. You say it got
14 worse. And readmission rates when from I think 14.6
15 percent to 15 percent. So that's 0.4 difference in
16 percentage points and a 2.7 percent change. And so whether
17 it actually says that's worse or not or broadly similar but
18 has been getting worse the last three years or whatever, I
19 think anybody writing this kind of stuff up has its
20 problems, not unique to you.
21 But maybe more thought might be given to it,
22 because I think it might decrease our credibility a little

1 bit if people are reading through reports and constantly
2 reading that things are better or worse when they might, in
3 some cases, be better said to be similar.
4 So I'm not sure I know really the best way to
5 deal with this, but I think it's worth just a little bit
6 more thought.
7 And the last point is, I hadn't thought about
8 what Lynn said previously, but I really agree that limiting
9 relatively efficient to 6 percent, or even 12 percent,
10 maybe devalues a little bit the usefulness of the category.
11 Anyone could argue about, well, what percent would we like
12 to see as relatively efficient, but maybe 20 percent. And
13 I think you could jigger your way of identifying the
14 relatively, like if you have four or five things that you
15 measure, and right now to be relatively efficient they have
16 to do well on all three of them in all three years. You
17 could maybe change the standards a little bit so that it
18 would come out more to 20 percent than 6 percent or 12
19 percent, something like that. I think that might make the
20 measure more useful. There's no reason that that couldn't
21 be done, I take it. Is that right?
22 MS. KELLEY: Gina.

1 MS. UPCHURCH: Yeah, thanks for all this
2 information. Great chapter. Just a quick question. On
3 page 12 you have something that says, "Medicare's fixed
4 monthly payments to REHs are included in MA benchmarks,"
5 even though MA plans are not expected to pay that. Do we
6 know what percentage -- if we think that we're paying 22
7 percent more to Medicare Advantage plans than traditional
8 Medicare, do we know paying this REH payment what
9 percentage that would be of the 22 percent? It’s not
10 necessarily relevant to this work, but I'm just curious.
11 Thanks.
12 DR. STENSLAND: That number was created before
13 the REH program data occurred. So in our historical data,
14 when we made those, there was no REH. And REHs are small
15 enough now that there's, you know, $3 million times 32 I
16 think is the most recent number. So it's not going to be a
17 big effect. Certainly nationally it's not going to really
18 move the needle at all. It might have a little effect on
19 these individual counties, and I think if you're a county
20 where you're getting this money, it could give the MA plan
21 an advantage in that concept.
22 MS. UPCHURCH: So just a follow-up question then.

1 Do we know if -- and this might be through interviews that
2 you had -- that Medicare Advantage plans in rural
3 communities want to support those hospitals more so that
4 they can decrease spending over time for those individuals?
5 Or, I mean, there's no interest. There's no payment that's
6 coming from them to support the emergency hospitals. Yeah.
7 DR. STENSLAND: Yeah. We asked the hospitals, is
8 there any support, like fixed payment from the MA plans,
9 and they kind of just look like a blank, like "what are you
10 talking about?" It's not happening.
11 MS. UPCHURCH: Okay. Thanks.
12 MS. KELLEY: That's all I have for Round 1. Oh,
13 I'm missing someone?
14 DR. CHERNEW: I think it's like the second Round
15 1 that you could've interpreted a typo as meaning Round 2?
16 MS. KELLEY: Lynn.
17 DR. CHERNEW: Apparently, it's a Round 1 -- no.
18 MS. BARR: It's Round 1 1/2. Sorry. I just
19 wanted to follow up on how you were calculating fixed costs
20 for hospitals. And I'm really glad, you know, in your
21 methodology of looking at, oh, they go up 10 percent, they
22 go down 10 percent, how do their costs change.

1 There is a constant drumbeat from rural providers
2 that insists they have 75 percent fixed costs. And we say,
3 no, it's 20, right. Could you run that analysis on the
4 rural hospitals so we could just end that argument once and
5 for all and you can tell me?
6 DR. STENSLAND: We did this before, when we first ran it,
7 and we can send you the appendix to that chapter, where we
8 broke it out for the smaller rural versus the larger, and
9 the 20 percent is more for your typical PPS. But if you
10 look at the small rural it is larger. I think it was about
11 50 percent. But we can send you that appendix that looks
12 at the small rural and what share is fixed versus variable.
13 DR. CHERNEW: So we're going to go around to
14 Round 2 in a minute, but I just want to say something as we
15 do. First, remember, I'm interested in how you feel about
16 the rec, and in particular, could you live with it or not,
17 or some version of that. You certainly might want it to be
18 slightly different one way or another, which is worth
19 saying, because we will consider that. But there are going
20 to be different opinions, so knowing what you could live
21 with is going to matter.
22 The second thing I'll say with regards to this

1 discussion, and just so you all know, and I don't think we
2 should belabor this now, but we can talk about it
3 separately. I am actually not a huge fan of the fixed-
4 variable cost decomposition, and in the thinking through of
5 the update it plays very little, if any, role in my
6 thinking anyway. And the reason is because it implies a
7 notion that we should somehow just cover variable costs.
8 And I actually don't think that's fundamentally true, I
9 think, for a whole range of reasons, on investments.
10 So you all can comment on that one way or
11 another. We have been reporting that. As I said last
12 session and I'll say again, there are people who find a few
13 pieces of information interesting so we report it. But in
14 the grand scheme of things that I have been influential, at
15 least in my personal thinking about the updates, I don't
16 want to give the impression that our goal is to just cover
17 variable costs. If that were the goal, there would be a
18 very different update than, in fact, we're doing, and I
19 actually think, by and large, our charge is not to push
20 down to variable costs. And that being said, and
21 estimating it is, of course, quite complicated, both on
22 average and otherwise.

1 So I appreciate all the comments, but in the
2 grand scheme of things that I am hung up on, I'm not that
3 hung up on that issue, because that issue is not
4 definitive, or even that impactful, in where I think at
5 least in my mind was driving a recommendation. So you guys
6 can take that for what you want. You can tell me
7 separately or otherwise, in person, or, by the way, through
8 meetingcomments@medpac.gov, any way you want to, your
9 thinking on that. But that's my view of the variable-fixed
10 cost rate, which is a notoriously hard thing to do.
11 But that being said, I believe Stacie is number
12 one in Round 2.
13 DR. DUSETZINA: Okay. Thank you very much.
14 Thank you for this excellent work, you guys. I'll start by
15 saying I support the Chair's recommendations. And also a
16 big plus-one to the Medicare Safety-Net Index for this
17 recommendation, as well.
18 I wanted to plus-one on Lynn's comment about the
19 comparison of the MSNI and payer margins, and then having
20 that broken out so we could see that figure in the chapter,
21 sort of the way it's represented on the slide, which I
22 thought was really compelling. And the DSH versus payer

1 margin. I think that would be a really helpful comparison
2 for thinking about how it would look different under the
3 Medicare Safety-Net Index.
4 The one substantive piece that just keeps sitting
5 with me is the experience measures from patients, and I
6 know there wasn't much of a change over time. But some of
7 those are terrible. Like half of people don't understand
8 what they're supposed to do when they leave the hospital.
9 It's like 52 percent how. That's terrible.
10 And also, I noticed that understanding and
11 communication about medications was particularly low, and
12 that was like it had gotten worse than some of the other
13 measures over time. You know, I get that we're kind of
14 thinking about updates year-to-year, so it hasn't changed
15 much, but I don't know what we can do to help make that
16 better. Because it seems like if you're confused leaving
17 the hospital about what's supposed to happen next then
18 that's a higher risk for readmissions. That's a higher
19 risk for poor outcomes. And maybe we need to be thinking
20 more about how to have higher bar for those activities.
21 But thank you very much for this excellent work.
22 MS. KELLEY: Kenny.

1 MR. KAN: Thanks for an insightful chapter. I
2 appreciate the framework that we apply to evaluate the
3 payment update for hospitals. I worry that the approach
4 may not be sufficiently dynamic to mitigate forecast
5 variances, given that all-payer margins have doubled from
6 2022 to 2023, with 2024 shaping to be much better than
7 2023.
8 Thus, while I like the MSNI portion of the
9 recommendation, I struggle mightily with the base payment
10 update. Thank you.
11 DR. CASALINO: Struggle and so you would like it
12 to be less.
13 MR. KAN: Yes.
14 MS. KELLEY: Brian.
15 DR. MILLER: Thank you. A couple of things.
16 One, it sounds like if the current recommendation is
17 current law plus 1 percent, I was seeing that in the chat,
18 there's an additional 1.2 percent for MSNI. So our total
19 recommendation, it sounds like, is a 5.8 percent increase.
20 DR. CHERNEW: No. I think it's 4.6. I think
21 it's basically --
22 DR. MILLER: Because the table says current law

1 plus 2.2, that giant table with the small --

2 DR. CHERNEW: The 2.2 is including -- I think

3 that's including both the MSN and the 1.

4 DR. MILLER: So the total is 4.6?

5 DR. CHERNEW: So you're adding 1.2 twice.

6 DR. MILLER: Okay. So it's 4.6, which is about

7 twice the rate of historical CPI over the 20th century.

8 So a couple of thoughts. One is I think access

9 is pretty variable. So hospitals are like malls with a

10 variety of service providers. While we noted that

11 occupancy as an aggregate at 69 percent is adequate, we

12 also saw that ED wait times, if you look at CMS data

13 online, are, on average, 163 minutes, and in some cases

14 exceed 400 minutes. That, to me, seems like access is

15 perhaps more varied than we would suggest. And then

16 follow-up, of course, being a significant regulatory burden

17 on hospitals, requiring them often to have their emergency

18 rooms function as primary care clinics, in addition to

19 being an emergency room.

20 So I think that some of that access granularity

21 is probably beneficial for us to include.

22 I'd also like to note that the hospital quality

1 metric system is completely broken. We have required
2 hospitals to report a lot of medical process or outcomes
3 metrics that are not necessarily meaningful and may, in
4 fact, cause patient harm. The classic example, of course,
5 being the Hospital Readmissions Index, which came out of a
6 handful of academic papers and transformed what is
7 functionally an operational metric into a quality metric
8 tied to finances, with a penalty bonus system, which does
9 not make sense.
10 And if we actually look at our readmissions data
11 that we show on page 16, for the past five years, hospital
12 readmissions are flat, which suggests that the quality
13 incentive programs like the Hospital Readmissions Reduction
14 Program, don't work. And if they don't work, they're
15 definitely increasing burdens and increasing costs, and we
16 should eliminate them.
17 I'd also like to note that in terms of our
18 analysis of the hospital industry, that MedPAC's piloting
19 its own practice standards and cultural norms. We, first
20 of all, are analyzing -- and I pointed this out last year
21 and I'm pointing this out again -- we are mixing IPPS and
22 OPPS services together, and doing a combined update. We

1 don't do this in any other market. We're not looking at
2 SNFs and IRF updates together in the same chapter and
3 coming up with a unified recommendation for post-acute
4 care. We're not combining IRFs with home health and coming
5 up with a combined recommendation for them. So it makes
6 absolutely zero operational and analytical sense in the
7 real world for us to combine OPPS and IPPS service updates.
8 And, in fact, I think it's sort of silly that we do that.
9 It doesn't correlate with reality.
10 What does this mean? Well, I'm not sure because
11 I'm not the analyst. But I'd wonder if perhaps the IPPS
12 update is too low, and maybe hospitals need a higher IPPS
13 update. I think it's definitely likely that the OPPS rates
14 are too high, and in fact, MedPAC is ignoring its own prior
15 support of site neutrality for 57 APCs.
16 And so we should be analyzing IPPS and OPPS
17 separately. OPPS should be compared to ASCs and the
18 physician fee service, as is appropriate for those
19 services. And IPPS should be analyzed separately, so that
20 way we can appropriately reimburse or recommend
21 reimbursement for hospital services and outpatient
22 services. Acute care hospitalization is different than

1 outpatient care. Every clinician knows that. All of our
2 patients know that. So it makes zero sense for us to
3 combine these together, and in fact, we are not just
4 shortchanging the hospital industry, potentially, but we
5 are actually being a terrible advisor to Congress in the
6 process.
7 So because I think our methodology is completely
8 wrong in this space and that we are mixing two service
9 markets and we should not, we are not comparing our
10 outpatient service market to the appropriate service
11 market. And despite our show of supporting the precedent
12 we are actually not supporting the precedent because we're
13 not supporting our own prior site neutral recommendation
14 that we made a year ago, I do not support the Chair's
15 recommendations for this marketplace. Thank you.
16 MS. KELLEY: Betty, did you have something on
17 this point?
18 DR. RAMBUR: I was just going to say that I
19 appreciate your perspective. I am going to argue the other
20 piece, in that penalties for readmission haven't been high
21 enough to make a difference, and I'll talk a little bit
22 about that.

1 I'm sorry. That the penalties for readmission
2 haven't been high enough to really change behavior, and
3 that's why they aren't working.
4 In terms of the other piece, I also hear what
5 you're saying about the two types. I also appreciate the
6 different lanes the staff has to run down, and I'm not sure
7 that a specific recommendation versus a quadrant of
8 direction, is worth the extra effort.
9 DR. MILLER: On point response, if we're not
10 separating IPPS and OPPS we're being mealy-mouthed in our
11 recommendation and support for site neutral as a policy.
12 DR. CHERNEW: So I think we'll go around, and I
13 will then speak to that once we hear what everybody else's
14 view is. But I won't do it now because I want to make sure
15 everyone gets to say their piece.
16 MS. KELLEY: Greg.
17 MR. POULSEN: Thank you. Yeah, my list of things
18 to add is adding up, so I'll try and be brief.
19 To a couple of the early points, I do think that
20 it would be good, and I actually kind of like having the
21 small group of highly efficient or highly effective,
22 whatever we want to call that, but I do think we need to

1 call it out that this is a pretty elite group. And I think
2 that's great. But it makes it a much higher hurdle to
3 assume or hope that we could see other people behave that
4 way, and I think that's great if we do that. I think
5 there's nothing wrong with that. But I think the
6 terminology could or should be identified that this is a
7 high hurdle to expect the other 94 percent of the folks to
8 aspire to. So I think that's okay.
9 I just have to talk about the fixed variable
10 thing, because the more you know about that -- sorry, Mike,
11 but I think I'm going to say the same thing you did, which
12 is -- the more you know about fixed and variable, the more
13 you realize that it's impossible to define it in a solid
14 way. Irrespective of whether this was an easier industry
15 than hospitals to look at, it's still just about
16 impossible.
17 And what we find is that fixed and variable are
18 defined by what time horizon you look at. If you look at
19 the next 20 minutes, almost all the costs are fixed. If
20 you look at the next 20 years, all the costs are variable.
21 And so to try and dig in precisely to what is the fixed and
22 variable cost is impossible to do.

1 So I like the idea of having it, in general. I
2 don't think we should abandon it. But I think we should
3 also be humble about assuming that we know what it is and
4 how precisely it can be defined. And I'm grateful that
5 what we're not charged with doing is identifying the
6 variable costs and making sure we're paying at least that,
7 because then it would become important to define it
8 precisely, and I'm glad we're not trying to do that.
9 But the people should keep in mind that it is not
10 only tricky to define, it's impossible to define without
11 some additional assumptions.
12 Okay. That said, I would jump in and say I do
13 like the recommendation as it's there, for a number of
14 reasons. The first one is I think it seems like a
15 reasonable middle ground when costs are very volatile, and
16 to live in this world you realize the cost structure is way
17 more variable than it was for the 20 years prior to COVID.
18 If we look at it, and even in the last few weeks, some of
19 you are aware of the IV fluid expenses, the impacts there.
20 Those have hit hospitals more than you would realize. It
21 seems like a small line item, but it's been significant
22 impact on costs, not just the cost of the fluids themselves

1 but the cost on the operations of the hospitals and how
2 they have to deal with those things. So just an example of
3 volatility.
4 Broadly speaking drugs and other devices that
5 fall within the DRGs are unpredictable and higher than they
6 have been. Software and other digital systems, I mentioned
7 there's a lot of enthusiasm within the hospital industry
8 for AI, or AI-type systems to replace human resources over
9 time. Those are big investments right now. The payoff is
10 not yet, and when it will be is unpredictable. So again,
11 you've got costs that are hopefully investments, but we
12 aren't seeing the investment outcomes yet, so that's
13 another unpredictable factor.
14 But, of course, the biggie is labor. And Betty
15 probably knows better than any of the rest of us, but I
16 think we all recognize that our labor force in the
17 hospital, particularly the skilled labor among nurses and
18 technicians and technologists, if you put those people all
19 in a big group, they look more like us than they look like
20 a bunch of college students. And that's not a good thing
21 for the labor market, and the cost of the labor that's
22 going into it.

1 So just keeping in mind that we've got a lot of
2 variables that are in play and that are difficult to
3 understand and analyze makes me believe that what we've got
4 is a nice middle ground that we're approaching, and we need
5 to keep our thoughts clear in terms of where it's likely to
6 be in the future. But in the short term I think we're on
7 the right path.
8 And while I don't fully disagree with what Brian
9 said, I think that the difficulty of carrying out the cost
10 that goes into an outpatient versus an inpatient service, I
11 don't think it's unwise to be doing it the way that we're
12 recommending doing it here.
13 So thanks very much.
14 MS. KELLEY: Lynn.
15 MS. BARR: Thank you. I know fixed versus
16 variable is not supposed to be on the agenda, but I'm just
17 going to --
18 [Laughter.]
19 DR. CHERNEW: Whatever you guys want. You know,
20 spend your time how you want.
21 MS. BARR: I will make a brief comment. I'm just
22 trying to illustrate the fact that it's different in rural

1 and urban, probably by an order of magnitude, and that we
2 don't take that into our calculations. And I've had
3 conversations with many Commissioners, and many
4 policymakers, that believe that the fixed costs in rural
5 are the same as urban hospitals. So I just think it's
6 important for us to be clear about that, because there's a
7 lot of policy implications of that.
8 I support the recommendation. You know, as I
9 look at the Medicare margin, going from -8 to -12, I mean,
10 we really shouldn't be cost shifting. And so, you know, we
11 should at least try to pay our way. And so, you know, the
12 total margin is going down because we're paying less,
13 right, or on a relative basis, than commercial payers. So
14 I definitely support the recommendation, and thank you.
15 DR. CHERNEW: Good work.
16 MS. KELLEY: Robert.
17 DR. CHERRY: Thank you. I'm going to be very
18 careful what I say for fear that the microphones might go
19 out again.
20 [Laughter.]
21 DR. CHERRY: The first thing I want to say, I'm
22 supportive of the Chair's recommendation, so hopefully that

1 will buy me a little bit of time.
2 I feel more comfortable with this one because I
3 think there's a good faith attempt to really keep up with
4 inflation here. So I think current law plus one is a
5 little more clear to me, as opposed to physician payments
6 was. I was struggling more with that effort.
7 I think there are a couple of cautionary tales in
8 the material I think that everyone should keep in mind. We
9 talked about network adequacy in terms of hospital supplies
10 and bed capacity, but there's a wide variety of geographic
11 variation out there. So we shouldn't think that because
12 we're looking at this aggregate data that everything is
13 fine in certain parts of the country. Certainly rural
14 areas struggle, inner-city areas struggle. That's part of
15 the reason why we have the Medicare SNI, as well.
16 What we don't get at the heart of is actually
17 certain service lines that are highly impacted in different
18 parts of the country. So pediatrics, obstetrics,
19 behavioral health are still challenges, and we're not
20 really kind of unpacking that here in any kind of detail.
21 The other thing I would caution about is just
22 looking at margins alone to think about whether facilities

1 are relatively efficient or not. Because you do need a
2 healthy margin to keep up with appreciation, replacing
3 equipment, repairing equipment, and the inflationary
4 pressures, particularly around pharmaceuticals and things
5 like that. I think not-for-profit hospitals do need some
6 sort of margin to be able to keep up with all of that.
7 You know, the other complexity here too, and I
8 think to a certain extent Brian is alluding to this, is
9 that funds flow in a very complex way within hospitals. So
10 inpatient versus outpatient is sort of one way of looking
11 at it too. But it's also highly dependent on the payer
12 mix. So if you have a certain sufficient commercial payer
13 to cross-subsidize other areas, like your physician
14 payments or to offset other governmental payments, like
15 Medicare and Medi-Cal, you might look relatively efficient
16 if your payer mix is a little bit different, or you have a
17 strong fundraising program that you can reinvest in your
18 community that helps kind of stabilize your resources.
19 That creates a certain efficiency, as well.
20 So there is some complexity to how dollars kind
21 of move around within hospitals, and we often take a look
22 at this in a silo. You know, a bucket of money flows into

1 Medicare, and therefore we're looking at a margin, when in
2 fact there are different revenue streams going into
3 facilities that cross-subsidize the entire model. There's
4 not a really easy way of unpacking that, but I think we
5 have to keep in mind that there is a lot of cross-
6 subsidization that is really going on within hospital
7 facilities, in particular.
8 Otherwise, I'm very supportive of the Chair's
9 recommendation.
10 MS. KELLEY: Cheryl.
11 DR. DAMBERG: Thank you. I'm going to start with
12 the Medicare Safety-Net Index. I definitely support
13 redistributing DSH and uncompensated care payments through
14 that mechanism. I think, as we previously discussed, it's
15 better targeting the dollars to Medicare beneficiaries who
16 have greater health needs and therefore costs associated
17 with managing those health care needs.
18 And then going back to the first bullet around
19 the update, the -2 percent margin for the relatively
20 efficient hospitals caught my attention, and the fact that
21 fee-for-service payments are lower than aggregate costs.
22 And so I would support this, but I am ever mindful of

1 trying to balance these increases with pressure to
2 constrain costs.
3 MS. KELLEY: Scott.
4 DR. SARRAN: Okay. I'll take the two parts of
5 the recommendation separately. In terms of the first part
6 about the current law plus 1, yes, I support that,
7 particularly given that the, as others have commented on,
8 the Medicare margins for even the very efficient hospitals.
9 And as others have pointed out, that is truly an elite
10 group, as we've defined it, that even those very efficient
11 players have a negative Medicare margin and we should not,
12 as others have commented, we should not be a free rider on
13 the costs shifted to the commercial sector.
14 So I support it for that reason, as well as
15 Greg's comments about how it is truly a more volatile time
16 these last few years for hospitals trying to manage their
17 costs, particularly labor, but also supplies. And I don't
18 think anybody believes that volatility will return to pre-
19 COVID levels any time soon. So I think that's a very
20 appropriate, prudent action.
21 In terms of part 2, I'm provisionally supportive
22 of it, but I would like to see details, at least at a

1 somewhat high level, of the implications of the increased
2 funding and the redistribution in terms of showing how that
3 plays out to different types of hospitals. So conceptual
4 and instinctually I'm sort of there with you, but I'd like
5 to see us at least get some information about how that
6 increased money, and the redistribution of those two
7 actions together create some incremental new winners, new
8 losers, if you will.
9 And I can't help but reinforce Stacie's earlier
10 point about what I think, as someone with a long career
11 built around geriatric principles, that to me the
12 disappointing performance on the care transition measure.
13 I know it's hard to get people that rank something in the
14 top percent or top quartile, whatever, when they may be
15 just experiencing a painful, traumatizing illness to
16 themselves or their family member, if they're filling it
17 out for a family member. So I get that.
18 But the goal should be 100 percent, right. One
19 hundred percent of people and their support groups, whether
20 it's family or significant other, whatever, should leave
21 the hospital understanding fully the care transition needs.
22 I mean, it's archaic in this year, this day and age, to

1 think that a hospital's responsibilities cease at the
2 doorway out of the hospital, when we increasingly have
3 beneficiaries -- and I know I'm preaching to the choir, et
4 cetera -- but we increasingly have beneficiaries who leave
5 the hospital with complex, ongoing care needs.
6 So again, I recognize I'm preaching to the choir
7 and all that, but I think we should continue to highlight
8 that that is an area that continues to be ripe for
9 improvement.
10 MS. KELLEY: Betty, did you -- okay, go ahead.
11 DR. RAMBUR: Thank you. I really appreciated
12 this chapter and the comments, and I just want to talk
13 about the efficient versus the effective. I have been
14 concerned about the operational definition of efficient for
15 a long time, which is not a criticism. I understand why
16 it's done. It seems like a good brass ring.
17 But here's how I think about it. Robert
18 mentioned the robust fundraising. That's more likely to be
19 in more affluent communities, I would assume. But if you
20 think about it in the most kind of, you know, kind of gross
21 terms, high volume versus low operating creates a more
22 efficient hospital, right. And the largest part of the

1 operating is the staff, but unfortunately staff are not
2 revenue generating. They're labor costs. So to manage the
3 costs you keep the labor down.
4 And if you look at Table 9.3, those metrics are
5 all about people. And you can see in here that we're doing
6 the discharge planning, the people aren't understanding it.
7 So we're doing it. We're filling the box, but we're not
8 planning it.
9 So in terms of the penalties for readmission,
10 they're not high enough to really change in behavior.
11 They're really not high enough to create an incentive to
12 actually kind of have the care that we would want in many
13 places.
14 And I know that efficient seems like the brass
15 ring from the 20,000 view, but if you're at the working
16 surface with a terrified person who is alone and dying,
17 thinking about being efficient is really probably not what
18 you would want if you were that person.
19 And there is more and more in the literature
20 about the problems with mixed care, which is when you focus
21 on one person and you're not able to deal with the others,
22 and then they have all kinds of adverse events. And it

1 also creates a lot of moral stress among nurses, and I'm
2 sure other staff.
3 So I don't have an answer for this, but I really
4 think we need a more robust, fresh thought about what it
5 means, because it's efficient when you're actually working
6 with people who are really sick is very different thing
7 than trying to keep the volume high and the staffing low.
8 So I think that would be really important, and maybe some
9 of it is more robust payment policies.
10 I think I had one other thing that I wanted to
11 say, that I don't recall.
12 DR. CHERNEW: Betty, I think you were going to
13 say what you feel overall about the recommendation.
14 DR. RAMBUR: Thank you. I knew there was another
15 thing. Thank you.
16 DR. CHERNEW: I don't want to make too much on
17 selective relistening.
18 DR. RAMBUR: I support the recommendation. I
19 have some sympathy for Kennedy's position because we
20 haven't always seen that the resources that we give
21 actually go to increasing the staffing and those kinds of
22 things, and things that directly impact patient care. I

1 appreciate Brian's sense of wanting to tease them apart,
2 but I also agree with what Greg said. I think it's just
3 too complicated for now, and I solidly support the
4 recommendation.
5 MS. KELLEY: Amol.
6 DR. NAVATHE: Thank for this fantastic work.
7 I'll try to be relative brief with my comments.
8 So I think sort of a couple of comments. I think
9 top line is that I agree with the recommendation,
10 particularly the safety-net portion. But in general the
11 approach here of looking at the overall margin as opposed
12 to trying to piece it out into different types of costs I
13 think overall makes sense, especially as organizations are
14 most likely making decisions around, for example,
15 participation in Medicare at an organizational level across
16 the different service lines, across the different types of
17 services, not piecing out we're going to do one thing and
18 not do the other. I think that's an important vantage
19 point as we're considering the implications of Medicare
20 payment updates.
21 In terms of where the numbers have actually
22 landed, as we look at the chart and as well as when we look

1 at the numbers in the slides, as well as the reading
2 materials, I guess I would very much echo what Greg said,
3 that this is kind of a middle-ground approach of
4 recognizing that the relatively efficient hospital, just as
5 one metric, is in a negative space, just south of zero. At
6 the same time, we have done a lot of work to show why the
7 safety-net population and the hospitals that particularly
8 serve the safety-net for Medicare patients are particularly
9 in need.
10 So I think the way we've kind of constructed
11 this, to me, checks a number of these boxes of trying to be
12 judicious and fiscally responsible while also trying to
13 address the core parts about what we're trying to address
14 with respect to access, and access, in particular, to high-
15 quality care.
16 So thank you so much.
17 DR. CHERNEW: So I think that's the end of the
18 queue that I have, so I want to just go around. There are
19 several folks that I just -- if you just want to say you
20 support, you don't, whatever it is. So we're just going to
21 go around. Tamara?
22 DR. KONETZKA: I support the Chair's

1 recommendations, both of them, for reasons that other
2 people have discussed. I think that when you look at a
3 negative margin for even the most efficient hospitals
4 that's sort of alarming.
5 And the other thing I'd say about the relatively
6 efficient hospitals, again, echoing what a few other people
7 have said, what Robert and Betty were both talking about, I
8 think that in many ways we shouldn't really expect
9 hospitals -- we want them to be fiscally responsible and
10 efficient as possible. But, you know, minimizing costs is
11 not really what we, as a society, or as Medicare, expect of
12 hospitals. The cost subsidization that Robert was talking
13 about is something we actually expect them to do. We don't
14 want hospitals to get rid of their psych departments and
15 their unprofitable departments, right. And similarly at a
16 patient level, what Betty was talking about.
17 So, you know, I'm not sure that's like our most
18 important metric, but even those hospitals that seem to be
19 lower in cost but have negative margins, I think that
20 recommendation seems reasonable. Thanks.
21 DR. CHERNEW: So I think Larry.
22 DR. CASALINO: Yeah. I strongly support the

1 Medicare Safety-Net Index recommendation. I think that's
2 great. And I do support the first recommendation as well,
3 current law plus 1 percent. Scott was quite eloquent in
4 discussing the reasons for that, one of which is the one
5 Tamara just emphasized.
6 I will say, though, that Brian's point about IPPS
7 versus OPPS is something that might bear more thinking
8 about, if not now then in the future. It is a little
9 inconsistent, I think, to say on the one hand we think
10 hospitals get more money than they ought to because of the
11 lack of site neutral payments for certain outpatient
12 services. And on the other hand, we'll give them the same
13 update for OPPS as IPPS.
14 Other people may have thoughts about that, that I
15 haven't thought of, but that actually seems to me a pretty
16 important point.
17 Nevertheless, for this year I can go with the
18 recommendation as is, but it would be nice to see more
19 thinking about that going forward.
20 DR. CHERNEW: Gina.
21 MS. UPCHURCH: I also support the Chair's
22 recommendation. I do like the idea of looking a little bit

1 more at the Safety-Net Index and trying to figure out how
2 that compares, I think it was Cheryl's comment, with what's
3 in place now, with disproportionate share and uncompensated
4 care, to see the winners and losers, to Scott's comment, to
5 understand that a little bit more. But I do appreciate
6 that, going that direction.
7 Also, the current law plus 1 on the hospital
8 increase, I also support that. One of the things that is
9 concerning is, though, how does that relate to the quality
10 of care that people are receiving in the hospital, as
11 Stacie and others have alluded to or mentioned.
12 So I don't know. You know, we're talking a
13 little bit in skilled nursing facilities and stuff, looking
14 at staff turnover or staff satisfaction in working there.
15 I think that could be very telling about quality of care
16 you get in a hospital. So I'm just curious if, over time,
17 we might even look at that hospital turnover and what that
18 may mean in terms of the quality of care.
19 I'm very discouraged by so few people leaving the
20 hospital understanding the medications, understanding what
21 they can do to take care of themselves, and just being left
22 out in the cold. So I think we need to look at how we can

1 improve that.

2 But I do support hospitals might, you know,

3 continuing to have negative margins and being subsidized by

4 others. Thanks.

5 DR. RILEY: I support the recommendation.

6 DR. LIAO: Ditto Wayne.

7 DR. CHERNEW: So first of all, Paul wants to say

8 a few things, and then I'm going to say a few things, and

9 then, well, we have about five more minutes left so we'll

10 see. Paul.

11 MR. MASI: I will be quick but not that quick.

12 This is very good feedback. Thank you very much. It is

13 appreciated. And I also appreciate the robust discussion

14 around the relatively efficient hospital, and we'll be

15 happy to continue looking at that.

16 And I did just want to clarify for folks

17 listening at home that that methodology includes

18 considerations of both cost as we're able to measure as

19 well as quality. And as always, we're happy to continue

20 getting feedback from Commissioners on both of those. But

21 just wanted to make that clear that there are both cost and

22 quality considerations in the methodology.

1 DR. CASALINO: I'll just jump in. The use of the
2 word "efficient" would be read by a casual reader, quickly
3 going, is really only about cost, which is, I think, partly
4 why you made the comment you just made, Paul. So maybe
5 some more thought as to whether there is a better
6 terminology, wouldn't give that false impression.
7 UNIDENTIFIED VOICE: I agree.
8 DR. CHERNEW: Yeah. I would just point out the
9 economic efficiencies of cost and quality. But yes,
10 understood. So luckily there are people watching at home
11 and will clarify that.
12 But I do think that's right. Were you done,
13 Paul.
14 MR. MASI: Yes.
15 DR. CHERNEW: So a few things. Just so you know,
16 it's one recommendation. There are different parts of it,
17 like the physician part of it, and we're not going to have
18 separate votes. Just so you know.
19 So I very much appreciate a lot of comments, and
20 I will spend most of my time on this issue of OPPS versus
21 IPPS. But beforehand let me say, in response to some of
22 this variable-fixed cost thing, as I sort of said before,

1 our goal is to pay for both. And so while we can discuss
2 the decomposition, and I do believe there are differences
3 and challenges of doing it, and there are policy
4 differences on how you do it, and I think there are
5 economies of scale in ways that are important. I agree
6 with all of that. But at least for this somewhat
7 prescribed activity, our goal is to sort of capture both,
8 so the disaggregation between them is mildly less important
9 in the grand scheme of things.
10 And certainly in the rural case we spend a lot of
11 time worrying about what to do in rural areas, and there
12 are some other issues in rural areas, like other programs.
13 This is IPPS. So just for people following along, there
14 are critical access hospitals and other types of programs
15 that are intended to deal with some of those issues that
16 are a little bit outside of this.
17 I said that kind of quickly. I'll try and say
18 this more slowly.
19 So first of all, this exercise, what we're doing
20 here, and then we will do in January, is a very prescribed
21 activity of applying criteria to different sectors. And we
22 have a bunch of criteria. You've seen them in all of the

1 chapters.

2 It turns out if you were to separate out IPPS and
3 OPPS, it is just analytically very challenging to go
4 through and do those activities. It's not that you
5 couldn't conceptually do it, although I have to say it
6 would be hard. And so I will take the blame for whatever
7 version of mealy-mouthness I have been. It's me, not
8 anybody else. And the reason is because certain things
9 like access to capital I view as inherently hard to
10 separate. Access, I view as a fundamentally cross-sector
11 issue, with ASCs, physician offices, for example.

12 And so applying some of the criteria across the
13 sectors is just analytically challenging to do, and
14 frankly, I don't think it's worth the time to try and do
15 that in the grand scheme of things.

16 That being said, and this might be the most
17 important part, I fully, and I think the staff, and I
18 suspect most of the Commissioners, really, really, really
19 do understand that there are complicated cross-sector
20 issues for outpatient care. I think maybe it's the case,
21 Brian, you weren't named to the Commission early enough,
22 but this, of course, is the motivation behind all of our

1 site neutral work. And for those of you that were here you
2 understand that was quite complex to do that analysis, and
3 many of you I spoke to on vacation and in other places, to
4 try and figure out how we could get through balancing
5 between ASCs, PFS, OPPS, and what to do, and how we went
6 about doing that. And it is really, truly, honestly,
7 genuinely something that I think we worry about.

8 The key point that I want to make is, we worry
9 about that in a broader, complex set of analyses, as a
10 cross-sector sort of analyses. We do that in the context
11 of applying these particular criteria. So it is
12 conceivable, and it's certainly reasonable to believe that
13 our IPPS, our site neutral work, did not approach that in
14 the right way. A whole bunch of people could say that. We
15 forget, but we did that in a service-specific way.

16 So we made a decision, for better or worse. We
17 made a decision that we were going to think through site
18 neutral in a service-specific way as opposed to an update-
19 specific way, and we dealt with it in a service-specific
20 way and not an update-specific way. You could think that
21 we should've dealt with that in an update-specific way.
22 That's not an unreasonable intellectual thing to say. It's

1 just not what we did, and if we were going to change the
2 way we thought about it, we would do it holistically and
3 readdress all those issues.
4 But for a bunch of case mix issues and other
5 types of service issues, it seemed much harder to do it in
6 an update-specific way as opposed to a service-specific
7 way. So again, for better or worse, we dealt with that
8 issue in a separate work cycle, in a service-specific way.
9 And again, let me emphasize, it is because exactly that we
10 understood the connection across the sectors and the
11 complexity of those connections that we did it in a
12 separate work cycle, and now we are doing a narrower thing,
13 which is not to revisit that.
14 But just as we're not revisiting it doesn't mean
15 that we ignore it or we're inconsistent or any other type
16 of thing is going on. I think we are actually quite
17 cognizant of it, and I'm certainly willing to listen to
18 people say, you know, we should revisit what we're doing
19 for IPPS/OPPS. And if that were the case, which is true,
20 we would do that in a different work stream, that we tried
21 to think through how it works across multiple sector
22 things. Because fundamentally, in this update exercise, we

1 are trying to do this loosely speaking within sort of
2 sectors.
3 So that raises this issue that Brian raised,
4 which is well, the OPPS and the IPPS should be treated as
5 separate sectors. That's not a crazy thing to do. There
6 are separate fee schedules. But it turns out the criteria
7 that would be necessary to separate or to do that I think
8 is just analytically not worth the exercise because I think
9 going through the how is the OPPS access to capital and
10 other things, it's just a much more complicated thing than
11 I think we should spend our time doing. And again, that's
12 a me thing, and I guess there was some sort of broad
13 support for that. I think that fits in, for example, to
14 some things Greg said, and these sort of complex cash flow
15 things that Robert said, is exactly why we don't want to
16 have to go through all of this analysis to separate out
17 where the cash flows are going to attribute to things.
18 And I do want to say two other things, but I will
19 say we did try our best to go through doing that around
20 margins, if you will, and there are ways you could do the
21 allocations across margins. I actually am quite
22 dissatisfied with the attempt to go through the cost

1 reports and work through how to allocate the fixed costs.
2 You could do that, but if you do that the way the staff
3 tried to do it, you actually get margins that are kind of
4 similar, which has reinforced my view that going through
5 the exercise separately, to then try and figure out, okay,
6 well now we're going to figure out how access to care for
7 just HOPD services are, when the bad access to HOPD
8 services may be great access to ASC services, just seemed
9 like more.
10 So that is basically reason one. The second thing
11 I will say, just respond to it being inconsistent with our
12 IRF and SNF thing -- and again, I think the key point here
13 is data -- the big difference between, say, OPPS and IPPS
14 versus SNF, which actually are different types of services,
15 more so than certain post-acute services, SNF and IRF, in
16 many markets the SNFs are providing IRF services. So in
17 some ways you could think of them as actually more closely
18 related than IPPS/OPPs.
19 But there's one crucial distinction for this
20 particular exercise, which is we can actually measure
21 access to capital. We can measure margins. We can measure
22 the things that we need to measure for this exercise

1 separately for those sectors. So the reason we deal with
2 them separately is because we actually have the ability to
3 apply our criteria separately for those sectors.
4 And again, we will be talking. So I hope those
5 of you -- I'm not even sure where to look to see those of
6 you at home. Anyway, I hope those of you at home tune in,
7 because in a moment we will go to the SNF sector.
8 Okay, I'm almost done, Scott, for your comment.
9 But I think that the motivation for this exercise
10 is, at its core, the boundaries are we have a set of
11 criteria. Can we apply that set of criteria to come up
12 with a recommendation. And for SNF and IRF and hospice and
13 home care, physicians we can try and do that. But to go
14 through the exercise of trying to do that for OPPS and IPPS
15 is, I think, challenging in a December/January context.
16 And we will come back in April and talk about what you guys
17 want to talk about next year, and if you think revisiting
18 our site neutral work or trying to reframe our site neutral
19 work in different ways, that is fine. But until the site
20 neutral work is or isn't adopted, or whatever it is, I
21 think we will reserve that for sort of that type of
22 discussion and not do it in the update discussion. And

1 that is a me thing.

2 And so for those at home,

3 meetingcomments@medpac.gov. For those here,

4 meetingcomments@medpac.gov, or chernew@acp.harvard.edu,

5 whatever you want. I am perfectly fine to take the heat on

6 that decision.

7 But I do want to just emphasize, it's not that we

8 just ignored it or decided we want it to be inconsistent,

9 because the exercise we were doing doesn't lend itself to

10 that type of disaggregation. At least that's my

11 assessment. And again, we can talk about why that misses

12 certain things but I don't think that's crazy. It does

13 miss certain things. But to the extent that it does, I

14 think we would deal with them, at least my preference would

15 be to deal with them elsewhere. So that's sort of the

16 broad plan.

17 That was a lot. Thank you for your patience.

18 Scott.

19 DR. SARRAN: Yes. Just very briefly, to the last

20 point, in fully supporting, Mike, your very clear and well

21 thought out conclusion that we can't quickly dive in, in a

22 meaningful way, to the OPPS versus IPPS. So this is about

1 sort of planting and watering the seed for future work.
2 And what's driven me to continue to move on this
3 is what we want from a public policy perspective, and how
4 it's different on the impatient versus the outpatient, we
5 need, in every market, vigorous, robust, accessible,
6 inpatient capacity. We don't need every single acute care
7 hospital to be a vigorous, robust, effective, competitor
8 against every type of ambulatory service component, two
9 ambulatory players, sort of pure ambulatory players that
10 may be very high quality, very efficient, very high service
11 delivery.
12 And yet when we sort of subsidize with one lump
13 sum, as we do, and we need to do for the foreseeable
14 future, absent more granular data, we enable hospitals to
15 do what any prudent hospital would, if their margins in
16 some types of ambulatory service are much higher, for
17 example, than some other types of inpatient service, which
18 is they'll over-invest so they can be a robust competitor
19 against already present ambulatory pure players, and
20 they'll under-invest in the low-margin inpatient services.
21 Which, by the way, are typically with populations that have
22 low access and low quality today, which are frail elderly

1 patients with comorbid, behavioral, et cetera, et cetera.
2 So just, again, planting and watering the seeds.
3 DR. CHERNEW: So again, I don't mean to belabor
4 this point. I have not dispute with the notion that we
5 need to think through what we're paying with IPPS and OPPS
6 and how to balance out the OPPS stuff, so the OPPS stuff is
7 collectively not accessibly profitable and/or the
8 inefficient site. Again, I completely understand that. We
9 had a very long, very rich discussion about how to go about
10 doing that. So it’s not like this is a new seed or some
11 new issue. It's just we went down that path, in a very
12 somewhat contentious way, by the way, to try and address
13 those issues.
14 So I'm happy to revisit. It's just I think
15 revisiting it in an update chapter recommendation is well
16 outside of the scope of the update chapter work. It is
17 completely in the scope of what MedPAC or Medicare should
18 think about. That is totally true. And again, had we not
19 done site neutral when we did site neutral, I think this
20 would say, well, you really need to think about how to
21 balance the payments for outpatient services, and for that
22 matter, worry if we think inpatient services are somehow

1 being under-invested in or some other various things.
2 Again, I totally agree.
3 But just to repeat, in the update chapter
4 structure, the way that we apply our criteria and the
5 recommendations we make, it is simply not flexible enough
6 to have that level of work in this particular exercise, in
7 my view, because the criteria we apply, whatever you're
8 going to do there is not going to be driven by access to
9 capital. It's going to be driven by this cross-sector
10 comparison, as our site neutral work, just to be clear, was
11 driven by cross-sector comparison.
12 Anyway, I'll bet after listening to me we all
13 need a break. We probably need a longer break than we're
14 going to get, but we all need a break. So let's take five
15 minutes. We'll come back at roughly 2:55, and we're going
16 to talk about skilled nursing facilities.
17 So again, to the staff, thank you. To those at
18 home, thank you.
19 [Recess.]
20 DR. CHERNEW: Okay, everybody. Welcome back.
21 We're continuing our march through the fee schedules, our
22 December march through the fee schedules. And we're going

1 to start our discussion of SNFs with Carol.

2 DR. CARTER: Yes. Good afternoon, everyone. We

3 are here to present our work assessing payment adequacy and

4 updating payments for skilled nursing facility services.

5 Webinar attendees can download a copy of these slides from

6 the Handout section of the control panel on the right-hand

7 of the screen.

8 In today's presentation, we will cover seven

9 topics: An overview of SNF use and spending in 2023, then

10 the four domains of payment adequacy indicators --

11 beneficiaries' access to care, quality, access to capital,

12 and fee-for-service Medicare payments and SNF costs. We

13 will then present the Chair's draft recommendation for your

14 discussion. And finally, we will present some information

15 on the new staffing rule for nursing homes.

16 This slide provides an overview of the SNF sector

17 in 2023. That year there were about 14,500 SNFs, most of

18 which also provide long-term care that makes up the bulk of

19 services in this sector.

20 The median Medicare share of total facility days

21 was 8 percent. In 2023, there were 1.6 million fee-for-

22 service Medicare-covered SNF stays, and the program paid

1 $27 billion for care in SNFs and SNF care provided in swing
2 beds.
3 Each year MedPAC assesses the adequacy of fee-
4 for-service Medicare payments by looking at four categories
5 of payment adequacy indicators, shown on this slide. To
6 assess the adequacy of Medicare payments, we start with the
7 most recent year of data available, that's complete, which
8 this year is generally 2023, and include preliminary data
9 for 2024 when possible. We also project a Medicare margin
10 for fiscal year 2025, using current law and other expected
11 changes. Based on these indicators, the Chair developed a
12 draft update recommendation for Medicare's base payment
13 rates to SNFs in 2026.
14 Turning to our measures of access. The number of
15 SNFs declined about 1 percent in 2024, consistent with the
16 reduction last year. Given that Medicare is a small share
17 of most nursing homes' businesses, it is unlikely that the
18 closures reflect the adequacy of Medicare's payments.
19 After falling during the pandemic, the median SNF
20 occupancy rate has steadily recovered to almost the level
21 prior to the public health emergency, at 84 percent,
22 indicating some available capacity in the aggregate, though

1 not necessarily in every SNF or in every market.

2 For some facilities, workforce challenges have

3 limited admissions. Between 2022 and 2023, SNF admissions

4 and days per fee-for-service beneficiary decreased 12 and 8

5 percent, respectively, reflecting the reinstatement of the

6 prior 3-day hospital stay requirement that had been waived

7 during the pandemic. The trends are now back in line with

8 levels that have slowly declined since 2010.

9 Given the level of Medicare's payments, as we'll

10 see later, the declines in the number of SNFs and service

11 use do not reflect the adequacy of Medicare's fee-for-

12 service payment rates.

13 Another indicator of access is the Medicare

14 marginal profit. In 2023, the aggregate marginal profit

15 was 31 percent. SNFs with available capacity have a

16 financial incentive to serve fee-for-service Medicare

17 beneficiaries.

18 Now shifting to indicators of quality.

19 We assess the quality using four measures: two

20 claims-based outcome measures. risk-adjusted rates of

21 discharge to the community and potentially preventable

22 readmissions after discharge, and two staffing measures,

1 risk-adjusted registered nurse hours per resident day and
2 total nursing staff turnover rates. There is more
3 information about these measures in your paper.
4 As shown in the top left table, the most recent
5 data from the fiscal year 2022 and 2023 period show that
6 the median facility discharge to the community rate
7 improved slightly from the earlier two-year period, and the
8 median rate of potentially preventable readmissions was
9 unchanged. In the bottom left table, we see that the
10 median facility RN hours per resident day and total nursing
11 staff turnover rates in 2022 and 2023 were identical.
12 The rates for the four measures varied across
13 facilities. Nonprofit facilities and hospital-based
14 facilities had better rates than other facilities for all
15 measures.
16 Ideally, we would also present data on other
17 outcomes and patient experience, but significant gaps in
18 the data persist. First, patient experience data are not
19 uniformly collected for SNFs. Second, restoring and
20 maintaining patient function is a key outcome. However,
21 because provider-reported function data are also used to
22 adjust payment, the Commission has raised concerns about

1 their accuracy.

2 In fiscal year 2027, CMS will start to validate

3 the function information, and we will then begin to examine

4 changes in function.

5 Because the vast majority of SNFs are also

6 nursing facilities, we assess the access to capital for

7 nursing facilities. The number of publicly reported

8 transactions indicate strong investor interest in this

9 sector. During the first six months of this year, there

10 were more transactions than in the past few years.

11 HUD is a key lender in the nursing facility

12 sector, financing mostly renovations and improvements

13 rather than new construction. In fiscal year 2024 HUD

14 financed more projects compared with 2023.

15 In 2023, the all-payer margin, reflecting all

16 lines of business, all payers, and investment income, for

17 nursing homes was 0.4 percent. This was an increase from -

18 1.3 percent in 2022, and fewer providers had negative

19 margins.

20 Because the all-payer margin includes Medicaid-

21 funded long-term care, the overall financial performance of

22 this sector is heavily influenced by state Medicaid

1 payments to nursing homes.

2 Brian will now talk about our estimates of

3 Medicare margins.

4 MR. KLEIN-QIU: The aggregate fee-for-service

5 Medicare margin in 2023 was about 22 percent, as shown in

6 the orange bar. This year we updated the adjustment we

7 always make to account for the complexity and costliness of

8 beneficiaries in a Medicare-covered SNF stay. The fee-for-

9 service margins calculated under the old adjustment are

10 shown in the dark blue bars, and you can see that this

11 update raised our estimates by about 4 percentage points.

12 I'll go into a little more detail on this in the next

13 slide.

14 The fee-for-service Medicare margin decreased

15 about one percentage point from 2022, largely due to a 4

16 percent growth in ancillary costs in 2023. This was the

17 first year that ancillary costs grew since the

18 implementation of the new case-mix system in fiscal year

19 2020. PHE emergency funds are not included in any of these

20 margins.

21 Fee-for-service Medicare margins varied

22 considerably across providers. For-profit facilities had

1 much higher margins compared with nonprofit providers, and
2 high-volume providers had much higher margins than low-
3 volume providers. Urban and rural facilities had similar
4 margins
5 Beneficiaries in SNF stays are more complex and
6 costly to treat compared to the average nursing home
7 resident. Cost reports apportion nursing labor costs
8 between fee-for-service Medicare and other payers, but SNF
9 beneficiaries are generally more costly to treat than
10 nursing home residents, and the apportionment does not
11 account for this. Therefore, we adjust the fee-for-service
12 Medicare nursing labor costs upwards every year, by taking
13 the nursing weights of the Case mix classification system,
14 and determining the ratio of these nursing weights between
15 fee-for-service Medicare and all other payers. Fee-for-
16 service Medicare nursing weights are higher than for other
17 payers, and so this ratio is greater than 1.0, meaning
18 applying this ratio raises the fee-for-service Medicare
19 costs relative to other payers.
20 This year, we updated the ratio using the case-
21 mix weights of the new case-mix system. The difference in
22 the nursing weights between fee-for-service Medicare and

1 other stays is smaller using the new case-mix system than
2 with the old case-mix system. The smaller ratio lowers the
3 fee-for-service Medicare costs and thereby raises the
4 Medicare margin.
5 However we should keep in mind this still lowers
6 fee-for-service margins compared to if we did not adjust
7 nursing labor costs on the cost report at all.
8 Because the adjustment is all about apportioning
9 facility costs between payers, the updated estimate does
10 not change the all-payer total margins.
11 We project that SNF fee-for-service Medicare
12 margins will increase in 2025 to 23 percent.
13 In our estimate of costs, we used CMS's most
14 recent estimates of the market baskets for 2024 and 2025.
15 We also factored in additional staffing costs that urban
16 facilities may incur in 2025, to raise their staffing
17 levels to comply with the new staffing rule in 2026. This
18 had a small effect, less than a point, on the projected
19 fee-for-service Medicare margin because fee-for-service
20 Medicare is a small share of the nursing home business, and
21 because the staffing rule is phased in over time.
22 On the payment side, we assumed that payments

1 will increase by the amounts in the final rules for 2024
2 and 2025, including positive forecast error corrections in
3 both years. We also accounted for the adjustment of the –
4 2.3 percent that CMS applied in 2024, to adjust for
5 overpayment resulting from the implementation of the new
6 case mix system in fiscal year 2020. Margins could be
7 higher or lower if changes in costs or payments differ from
8 these assumptions.
9 In summary, our access indicators show that
10 supply of facilities and volume declined, but neither
11 reflects adequacy of fee-for-service rates. Occupancy rates
12 increased to about their pre-pandemic levels.
13 The high Medicare marginal profit indicates
14 providers had a strong incentive to treat fee-for-service
15 Medicare beneficiaries if capacity was available. Measures
16 of quality show little or no change.
17 SNFs have adequate access to capital and the
18 sector remains attractive to investors. The total margin
19 improved compared to 2022, and in continuation of a now
20 decades-long trend, the average Medicare margin in 2023 was
21 high. Factoring in expected changes to payments and costs,
22 the projected margin for 2025 is even higher at 23 percent.

1 So this brings us to the Chair's draft
2 recommendation. The recommendation reads:
3 For fiscal year 2026, the Congress should reduce
4 the 2025 Medicare base payment rates for skilled nursing
5 facilities by 3 percent.
6 In terms of implications, spending would be lower
7 relative to current law. We do not expect adverse effects
8 on access to care due to continued provider willingness and
9 ability to treat fee-for-service beneficiaries.
10 Now we shift our attention to the new minimum
11 staffing requirements for nursing homes. Nurse staffing is
12 an important measure of the quality of care in nursing
13 homes. Labor staffing is also a very high share of a
14 facility's overall costs, and thus staffing requirements
15 are an important financial consideration for nursing
16 facilities. Additionally, nurse staffing remains an area
17 of Commissioner interest. Therefore, we have looked into
18 the new CMS staffing requirements, and try to contextualize
19 them here.
20 CMS finalized a rule updating minimum staffing
21 requirements in nursing facilities that will begin in May
22 2026 and represents large changes from the current federal

1 requirements. The new requirements spell out staffing
2 levels for total nurse staffing, registered nurses, and
3 nurse aides, and require an RN on-site 24/7.
4 Starting May 2026, urban facilities must comply
5 with the total nurse staffing minimum and the 24/7 RN on-
6 site requirements. Other facilities and requirements begin
7 in 2027 and beyond. Facilities can apply for exemption
8 from specific requirements if they are located in an area
9 with a labor shortage relevant to the requirement.
10 Note that our analyses are informational and that
11 the Commission has not taken a position on these staffing
12 requirements.
13 We estimated the shares of providers that would
14 meet the requirements, and the shares of facilities that
15 were close to meeting them based on 2024 data. In this
16 chart, we show the shares of facilities that met the
17 requirement, which are the dark blue bars, the share of
18 facilities with staffing levels above 90 percent of the
19 requirement, which are the orange bars, and the share that
20 were above 80 percent, which are the gray bars. For each
21 requirement, we excluded facilities that could apply for an
22 exemption from that requirement.

1 On the left we show just over half of nonexempt
2 facilities currently meet the RN hours per resident day,
3 but 69 percent have ratios above 80 percent. The bars in
4 the middle show that just 29 percent of nonexempt
5 facilities would meet the nurse aide requirement, but 69
6 percent had ratios above 80 percent of the requirement. On
7 the right we show that the majority of nonexempt facilities
8 would meet the total nurse staffing requirement, and 94
9 percent were above 80 percent of the requirement.
10 To get a sense of the impact of the first year of
11 the rule, we looked at the requirements that will affect
12 urban facilities in 2026. On the left is the total nursing
13 staff hours per resident day. The middle bars show
14 facilities that had 24 total hours of RN care per day, and
15 on the right is both. The dark bars show the share of
16 facilities that would meet the requirements based on 2024
17 data. The orange bars show the share of fee-for-service
18 days these facilities treated.
19 We estimated that of Urban facilities not
20 exempted from the total nursing hours per resident day
21 minimum, 60 percent of these facilities already met the
22 requirement. As a share of fee-for-service Medicare days,

1 these facilities represented 68 percent of days.

2 We approximated the share of facilities meeting

3 the 24/7 hours of RN care requirement by calculating the

4 share of facilities that provided 24 hours of total RN care

5 per day. Because this could include concurrent RN shifts,

6 leaving some portions of the day uncovered, the share of

7 facilities meeting the rule could be lower than shown here.

8 We found that 84 percent of non-exempted facilities

9 currently provide 24 total hours of RN care per day, and

10 these facilities represent 91 percent of fee-for-service

11 Medicare days.

12 For urban facilities that are non-exempt for both

13 the total nursing staff hours per resident day and 24-hour

14 RN requirement, 53 percent currently meet both standards.

15 These facilities represent 63 percent of fee-for-service

16 Medicare days. We will continue to monitor nurse staffing

17 levels.

18 This concludes our presentation, and we look

19 forward to the discussion. With that we turn it back to

20 Mike.

21 DR. CHERNEW: Great. Thank you, Brian and Carol.

22 In the interest of time we'll move right along, and I think

1 Tamara is number one in Round 1.
2 DR. KONETZKA: Okay. I have three clarifying
3 questions. First, thank you for this great work. I always
4 appreciate your depth of knowledge in this area.
5 So first question, and this may just be confusion
6 about how it was written in the text, but want to make
7 sure. When you're talking about closures of facilities, in
8 the text it says a number of SNFs and swing beds
9 participating in the Medicare program declined 1.2 percent.
10 And I think there was a different footnote elsewhere that
11 kind of said this is like closures, or maybe change of
12 ownership. Could you try to break those out, and I guess
13 the most important question is, I can't imagine there's
14 actually a SNF that stayed in business and decided to just
15 not do Medicare anymore. That's probably not what we're
16 talking about there.
17 DR. CARTER: Yeah, that's right. So these
18 would probably be facilities that changed ownership and
19 changed their provider number. Having looked at this a
20 couple of years ago, some of the facilities that were
21 reported as closed, some of them actually had closed and
22 others had not actually closed. And unless we kind of do

1 web searches, the data don't indicate whether a facility
2 actually closed. It just indicates whether it's
3 participating in the program.
4 DR. RAMBUR: [Inaudible.]
5 DR. CARTER: I'm sorry, Betty? Oh we can't
6 distinguish between facilities that actually closed,
7 because that isn't the way the data are reported. So if
8 somebody changed their provider number, you know, that
9 facility would've closed under one provider number but they
10 popped up as a new provider number. I think Tamara is
11 right that we're not going to see facilities getting out of
12 the Medicare business.
13 DR. KONETZKA: Yeah. Just as we, with 1.2
14 percent it probably doesn't matter, but as we monitor, an
15 actual closure has much more impact on access than just a
16 change of ownership.
17 DR. CARTER: And in the paper, I think Brian
18 calculated, if a provider looked like it had closed, what
19 were the travel times involved, in the different, urban to
20 rural.
21 DR. KONETZKA: Okay. Second question. On the
22 potentially preventable readmissions measure, again this

1 might just be a text issue. But it's saying 30 days after
2 discharge. Do you mean discharge from the hospital?
3 DR. CARTER: No. We mean discharge from the SNF.
4 DR. KONETZKA: Okay. That, to me, was very
5 confusing, because mostly like the way that nursing home
6 care compare measures and --
7 DR. CARTER: [Inaudible.]
8 DR. KONETZKA: -- discharged from the hospital.
9 And so if you're measuring discharge from the SNF means
10 that the SNF provides poor quality care if people get
11 rehospitalized while they're in the middle of their SNF
12 stay, then they're not counted in that measure?
13 DR. CARTER: Right. Right.
14 DR. KONETZKA: Okay. So I might just say we
15 should consider these other measures that other people have
16 used that include the SNF stay maybe 30 days from the
17 hospitalization. Because to me it's just basically a
18 subset of the community discharge measure, right?
19 DR. CARTER: Yeah.
20 DR. KONETZKA: -- go back to the hospitals.
21 DR. CARTER: Yes. The reason we used to look at
22 that measure, and the reason that we didn't really like it,

1 is if you count 30 days from the hospital discharge, for
2 some SNF stays you've captured the whole SNF stay, and then
3 a little bit of community-based care, wherever they went.
4 And for other SNF stays they're going to stay 60 days, and
5 you're only seeing the first 60 days. So it seemed like it
6 was a mixture of a during-stay measure and a post-stay
7 measure. And the actions of how a provider would improve
8 those rates would be quite different, right. If you're
9 trying to improve the within-rehospitalization rate, that's
10 one set of actions a provider might take. But if you're
11 looking at trying to improve your after you've discharged a
12 patient, you know, good discharge instructions, maybe
13 arranging home care, that's a different set.
14 So they seemed differently actionable, so we kind
15 of preferred separating those measures.
16 DR. KONETZKA: Okay. Yeah. To me I think the
17 actions after discharge are already sort of part of the
18 discharge to the community. So I think I might prefer the
19 other measure. But we can talk about that more, or maybe
20 think about doing something comparing them.
21 DR. CARTER: And I noticed that [inaudible] move
22 to within-stay measure, which is cleaner.

1 DR. KONETZKA: Okay. And then third clarifying
2 question. This updated methodology to calculate the fee-
3 for-service margins, so if I understand correctly the point
4 is that costs for a SNF post-acute stay are very different
5 than costs for like a long-term stay, in that there should
6 be some additional adjustment for that. What I was
7 confused by is that basically the ratio that's created to
8 do this adjustment is based on sort of Medicare fee-for-
9 service versus all else. And what's in that "all else" is
10 Medicare Advantage post-acute stays. And I think Medicare
11 Advantage post-acute stays are much more, in terms of cost,
12 much more like a fee-for-service stay than like a long-term
13 stay.
14 And so I worry that we're sort of systematically
15 sort of down-weighting costs for facilities that have a lot
16 of MA.
17 MR. KLEIN-QIU: I think that is probably right.
18 We are allocating an all-payer margin between fee-for-
19 service Medicare and all other payers. So I think what
20 you're saying would be a problem if we were trying to
21 present a margin on Medicaid specifically, or Medicare
22 Advantage. But because we're doing this for fee-for-

1 service Medicare relative to all other costs, including
2 Medicare Advantage, as far as fee-for-service Medicare
3 margin is concerned, I don't think it would be too much of
4 a distortion. So is your question more about 10 facilities
5 with different payer shares?
6 MR. MASI: And if I could just add on to what
7 Brian said, I think we hear your point, Tamara, and that's
8 a great observation. Brian, is it right, this has to do
9 with a data limitation, where we aren't able to
10 specifically point to the kinds of Medicare Advantage post-
11 acute stays that we would like to be able to for this
12 adjustment. Is that correct?
13 MR. KLEIN-QIU: It's correct. In this round of
14 the exercise we were not confident about identifying MA
15 benes on the fee-for-service ones.
16 MR. MASI: That's a great point, and we'll keep
17 this in mind to see if we can further refine this
18 adjustment in the future.
19 MS. KELLEY: Brian.
20 DR. MILLER: Thank you for this work. This is a
21 hard market to take apart.
22 Two quick questions. I saw that we used CMI here

1 as an adjustor. Is there a reason why we used CMI here and
2 not in other service markets, where CMI is also salient?
3 MR. KLEIN-QIU: I think our justification is that
4 for nursing facilities as opposed to others, nursing labor
5 is such a core component of the facility costs, and it's
6 really kind of a low-hanging fruit in this sector, where
7 it's kind of easy to get from the MDS for fee-for-service
8 Medicare, compared to all other payers. And we know that
9 in theory Medicare fee-for-service beneficiaries are more
10 costly than long-term stay residents. So there's really a
11 good reason to use the ratio here, and it's easy to do so,
12 and that's why we did it.
13 DR. MILLER: I'm not criticizing using it here.
14 I'm wondering if we should also be consistent across other
15 markets where CMI is relevant, because, as you said, it's a
16 good indicator of labor burden and cost.
17 MR. KLEIN-QIU: I don't want to speak for the
18 other sectors, but nursing facilities are also unique to us
19 in the fact that payer share is so different compared to
20 other sectors.
21 DR. MILLER: Understood. I guess I'm saying I'm
22 pushing for consistency across markets where salient. And I

1 was hoping, because I read the section and appreciated it.
2 But I was hoping you could walk us through a high level of
3 the methodology for calculating margins for SNFs, in about
4 four or five steps, and how you made decisions, or
5 methodologic decisions.
6 MR. KLEIN-QIU: Sorry. You're asking how we
7 calculated margins?
8 DR. MILLER: How and the why, just briefly.
9 MR. KLEIN-QIU: How and the why of why we're
10 calculating SNF fee-for-service Medicare?
11 DR. MILLER: Why you made the analytical choices
12 that you did when you calculated SNF margins.
13 MR. KLEIN-QIU: Oh, are you talking about the
14 ratio --
15 DR. MILLER: Amongst others, yes.
16 MR. KLEIN-QIU: Okay. I think the fee-for-
17 service Medicare margin is a good indicator of how much a
18 facility can profit off of Medicare patients.
19 DR. MILLER: Pardon the interruption. Not that
20 you did calculate the fee-for-service margin, but can you
21 walk us through the methodology you used to calculate the
22 Medicare fee-for-service margin for SNFs.

1 MR. KLEIN-QIU: Okay. We take the costs and
2 payments from the cost report. And we are able to see the
3 labor allocations that the cost report already does between
4 fee-for-service Medicare and other payers. So what we do
5 is we take the MDS assessments and we check the MDS
6 assessments for the nursing CMIs. We do that for the
7 specific facility, and for that specific facility we
8 estimate the ratio of nursing CMI for fee-for-service
9 Medicare compared to other payers, and we apply that ratio
10 to that specific facility's nursing labor cost component.
11 DR. MILLER: Thank you.
12 MS. KELLEY: Robert.
13 DR. CHERRY: Thank you for the report. I also
14 learn a lot just from the discussions, as well, and I
15 really appreciate your depth of knowledge.
16 I just have a couple of questions. One, this
17 question has been asked before, and it has to do with the
18 Nursing Home Care Compare. And I think it's been suggested
19 before, could we use that as maybe the true north in terms
20 of quality measures. So I was wondering why it wasn't used
21 in this particular report. Are there some limitations that
22 we're not aware of?

1 DR. CARTER: Well, the Nursing Home Compare,
2 those are interesting, like the staffing component of
3 Nursing Home Compare. But it is for the whole facility,
4 and here we're trying to measure the quality of the care of
5 the short stay beneficiaries. And there are short stay
6 measures, like in the quality reporting, so you could zero
7 in on the short stay measures. But the care measures of
8 quality are a mix, and we're trying to focus just on the
9 SNF population.
10 DR. CHERRY: Okay. And then the other question
11 has to do with patient function, because it was mentioned
12 that CMS is starting to validate patient function measures
13 in fiscal year 2027. I just wondered; do you know why it's
14 that far out? It seems like 2027 is a long ways away.
15 DR. CARTER: It's being done in conjunction with
16 when that measure is being added to the value-based
17 purchasing program. And so they're going to start moving
18 money around based on that measure, so they wanted the
19 validation starting coincident with that.
20 DR. CHERRY: I see. Okay.
21 MS. KELLEY: Gina.
22 MS. UPCHURCH: Thanks for this important work.

1 Just one quick question. At the top of page 28, it says
2 "the continued expansion of enrollment in Medicare
3 Advantage, with its lower payment rates, also factors into
4 total margin. One study of payments and costs from 2017 to
5 2019 found that MA penetration in a county increased the
6 total margin. As that increased, the total margin
7 decreased."
8 So I get a little confused here because Medicare
9 Advantage, I know consumers pay differently if they're in
10 Medicare Advantage plans. But I thought they had to pay as
11 much as traditional Medicare. Does that mean because
12 there's froth, or things are denied, or on the back end
13 something was done, but it doesn't get paid in full? So is
14 that what that means?
15 DR. CARTER: So managed care needs to offer the
16 same set of benefits and coverage.
17 MS. UPCHURCH: Right.
18 DR. CARTER: We don't have comprehensive
19 information, but I would guess that the MA payments, in
20 general, are between 20, 25 percent lower than fee-for-
21 service Medicare payment rates.
22 MS. BARR: On this point, please.

1 MS. UPCHURCH: Okay.
2 MS. BARR: Wouldn't it also relate to when MA
3 moves into town that they use prior auth on skilled nursing
4 and they don't -- so the utilization rate on those
5 beneficiaries would be much lower in an MA plan than in
6 fee-for-service? Wouldn't that account for --
7 MS. UPCHURCH: Well, that's in addition to, I
8 think, the actual payments, is what you're saying.
9 DR. CARTER: Well, the payment reflects who
10 actually was in the four walls. So I guess what you're
11 saying is the mix of what is in the total payer margin
12 could vary by market.
13 MS. BARR: Right. Yeah, I'm losing all those
14 lucrative Medicare patients because they're sending them to
15 home health and other places. But I think that's probably
16 the main driver. Thanks.
17 MS. KELLEY: Lynn, you're next for Round 1.
18 MS. BARR: Great. Two quick questions. On page
19 7 and Slide 7, Slide 15, would you be able to break those
20 out by rural versus urban? Because of ongoing questions
21 about, first of all, what does the data say about what's
22 going to happen to the rural facilities when they go into

1 these new staffing models? And I think they're going to be
2 really different, and that might be informative for folks.
3 And then looking at, on page 7, sort of the same thing, as
4 we talk about quality.
5 DR. CARTER: You're talking about the quality
6 measures. Correct?
7 MS. BARR: Yes.
8 DR. CARTER: So the charts, Figures 6.2 and 6.3,
9 break out rural and urban. But I don't see, it's
10 interesting, I think on the staffing, I think they were
11 similar enough that we didn't include them. Is that right?
12 MR. KLEIN-QIU: That's it.
13 MS. BARR: They were similar. That's really
14 interesting, because that's not what the rural folks are
15 saying at all. They're saying there's no way they're going
16 to be able to do that. That would be shocking.
17 MR. KLEIN-QIU: For a little bit of context on
18 that, for this specific measure that's shown there, it's
19 pretty similar for rural and urban. But for other
20 components of the rural it is very different.
21 MS. KELLEY: Amol.
22 DR. NAVATHE: Brian, Carol, thank you for this

1 work. So in Figure 2 of the reading materials, which is
2 page 17, this is the risk-adjusted rates of discharge to
3 the community in fiscal year 2022 and 2023. The hospital-
4 based rate of discharge to the community, the median is 60
5 percent, and for all SNFs is 50.9 percent.
6 And so I was just curious if you could give us a
7 sense of why we see the hospital-based rate of discharge to
8 the community higher and how that relates to the
9 characteristics of the patients that are in hospital-based
10 SNFs versus other SNFs, particularly free-standing.
11 DR. CARTER: So I haven't looked at that
12 specifically. Many years ago when we did look at the
13 differences between hospital-based and freestanding SNFs we
14 did find that the patient mix could be different. And so
15 this could reflect a little bit the differences in how well
16 the risk adjustment model works for these two different
17 types of facilities, because I think that there are
18 differences in the patient mix between hospital-based and
19 freestanding.
20 DR. NAVATHE: I see. So I guess a follow-up
21 question, because I guess typically my instinct would be to
22 think that the patients who are in the hospital-based SNF

1 are more likely to have comorbid conditions and perhaps
2 likely to be sicker. At the same time, my understanding is
3 that oftentimes hospital-based SNFs, the way that they use
4 the SNF is way to actually shorten length of stay in the
5 inpatient setting. And so part of my question here, in
6 part, is kind of related to that might lead us, actually to
7 discharge less sick patients since they're less complex
8 patients, quicker to the hospital-based SNF. And I was
9 wondering if there's a clear directionality there, or maybe
10 there's not a clear directionality, and it has to do with
11 other things like the way that things are coded and how
12 risk adjustment works, or what have you.
13 DR. CARTER: I think there is some of what you're
14 talking about in terms of hospital-based units being used
15 to really improve the throughput on the inpatient hospital
16 side, which would mean, I think, that their case mix would
17 be lower. But we haven't done that analysis. I wouldn't
18 want to say that uniformly true.
19 DR. NAVATHE: Okay. Thank you.
20 MS. KELLEY: That's all I have for Round 1.
21 Ready to go to Round 2?
22 DR. CHERNEW: And I believe Tamara is first.

1 DR. KONETZKA: Yes. Great. So I tried to pick
2 and choose here a few things that I want to bring up.
3 First of all I wanted to say I really appreciated
4 a lot that you've added to this chapter. I appreciate the
5 additional effort to adjust for case mix. We know that
6 raises some of the issues we were just talking about, so I
7 appreciate that additional method was added, to try to
8 adjust for PAC versus long stay.
9 I appreciate the detailed analysis of the
10 potential effect of the new staffing rule. I think you
11 added some nuance to that analysis, specifically in like
12 how close facilities are to meeting it, that I haven't
13 really seen in other analyses of this. So that was super
14 helpful.
15 And also, I appreciated that you added the
16 staffing measures to the quality measures we consider, the
17 RN staffing and the turnover, given how fundamental
18 staffing is to quality. Anyway, all that was so responsive
19 to comments you received earlier, and I appreciate that
20 you've added all of that.
21 So it is now a very long chapter, but I will say,
22 still, to me the elephant in the room here is the MA part

1 of this. We know that there are spillovers, right. When
2 facilities have a lot of MA there's spillovers to length
3 stays. There's probably spillovers to rehospitalizations,
4 et cetera.
5 And so if there's room or time in this already
6 long chapter, I'd love to see maybe a few of those tables
7 broken out by high MA and low MA, or just a paragraph on
8 context. And you had a little bit in that, a couple of
9 sentences. It would be good to have a little bit more
10 about that, because I think especially in this sector it
11 looms very large in what we're seeing in terms of both
12 margins and quality.
13 On the analysis of the new staffing regulations,
14 that assesses meeting the cost of the new minimums, I guess
15 I just wanted to not lose sight of several related issues.
16 A lot of the analysis you did on sort of non-exempt
17 facilities, but a couple of comments about those that go in
18 different directions, really. One is that being exempt
19 because of workforce shortages doesn't mean that the role
20 is costless, right. Those facilities still have to apply
21 for the exemptions and have to sort of demonstrate ongoing
22 attempts to hire, et cetera.

1 So there's a lot of sort of costs that is not in
2 here, I think for good reason. But I just don't want to
3 lose sight of that.
4 And the other part of that is, you know, the
5 chapter really focuses on the cost implications. I think
6 appropriately so. But what we also shouldn't lose sight of
7 is hopefully this is really going to turn into differences
8 in quality, right, where the exempt facilities, yeah, they
9 may be exempt but they're also not going to have higher
10 staffing ratios. And then for other facilities, the cost
11 hopefully will be outweighed by improvements due to having
12 higher staff. So I just don't want to lose that in that
13 sort of context of this analysis.
14 And I want to mention two things that that are
15 peripheral to this chapter. I'm just going to throw them
16 out there because I think the Commission has probably had
17 many conversations about these before my time on the
18 Commission. But I think indirectly some of this work
19 raises the issue of the copay that starts on day 21. And,
20 so the way it work is Medicare covers SNF care for 20 days
21 fully, and then there this sort of cliff where the copay is
22 now going to be $210 a day, I think you said in the

1 chapter.

2 So sometime, whenever we have time, I think we
3 should revisit that, whether that's the appropriate way to
4 sort of structure the payment for this. I mean, in the
5 chapter there's this amount, sort of $5 billion in
6 beneficiary liability for SNF care, which is not nothing.
7 And research does show that people disproportionally,
8 especially those low socioeconomic status, they're much
9 more like to be discharged on day 20 because of that. And
10 similarly, I'd love to revisit the three-day stay.

11 But those are sort of an aside. I just wanted to
12 put those out there.

13 Finally, to the actual recommendation, as
14 acknowledged repeatedly by Mike and others on this
15 Commission, there is this well-accepted fact that high
16 Medicare margins for SNF care cross-subsidize low or
17 negative margins from other payers, specifically Medicaid.
18 And that presents this challenge because the people in
19 nursing homes for long stays are also Medicaid
20 beneficiaries. But as I said last year, and I'll say it
21 probably every year that I'm on the Commission, I continue
22 to agree with the arguments that I think you spelled out

1 very well in this chapter, that we, in recommending
2 Medicare policy, shouldn't be perpetuating this really
3 inefficient cross-subsidization.
4 So I do agree with the recommendation. I agree
5 with the general sense that we should signal that lower
6 payment rates to SNFs would be appropriate and sort of
7 disregard the cross-subsidization issue. And so I agree
8 with the Chair's recommendation.
9 I'll just mention two caveats to that, well not
10 really caveats but addendums. Because of the broader
11 market forces in the SNF market right now, because of the
12 uncertainty around the new staffing rule, because of
13 continued fallout from the pandemic, I think the
14 recommendation of a sort of small reduction, the -3, makes
15 sense, because I think it signals the right direction and
16 does not do anything that's too drastic, given uncertainty
17 in the industry. I do still worry about sort of closure
18 and the access issues moving into the future.
19 And the other thing I would say is that even
20 though I don't support the cross-subsidization, I would
21 hope that, and I think we are, I would hope that instead of
22 just stating that we continue to work on ways that we could

1 sort of get rid of that conundrum, and to figure out how to
2 sort of modernize Medicare to sort of soften this
3 distinction between post-acute and longer-term care needs
4 of Medicare beneficiaries. Thanks.
5 MS. KELLEY: Stacie.
6 DR. DUSETZINA: Thank you very much for this
7 excellent work. I also support the Chair's recommendation.
8 Following up on some of Tamara's comments, I also worry
9 quite a bit about access to skilled nursing outside of the
10 setting for the parts that Medicare currently doesn't
11 cover, and what that means for the ability for people to
12 get into care, even when they're paying cash or going to
13 eventually be paying with Medicaid.
14 And I'll just say, anecdotally, I had my own
15 Secret Shopper experiment with this with a family member
16 who needed skilled nursing care, as a cash-paid person, and
17 could not get into any high-quality nursing homes at all.
18 It was like waitlist or documenting hundreds of thousands
19 of dollars in cash to be able to cover expenses.
20 So I would just put a plug in for, I think it
21 would be helpful for us to consider some form of these are
22 still Medicare beneficiaries. Are there access to care

1 problems if you were paying cash and trying to get a bed,
2 in which case I would be worried a little bit about
3 underpaying or any kind of people closing, or negative
4 margins overall, because our beneficiaries still need these
5 services even if we're not paying for them.
6 Excellent work, and thank you both very much.
7 MS. KELLEY: Lynn.
8 MS. BARR: Thank you. I think I kind of agree
9 with Stacie here. A, I support the recommendation, but I'm
10 concerned about the fact that there's not enough money for
11 these nursing homes to be a reasonable place to go, and I
12 think we've all been in nursing homes that we would never
13 go to.
14 And I'm sort of struggling with the moral issue
15 of it's okay for commercial payers to subsidize Medicare,
16 but Medicare can't subsidize Medicaid. So we're like,
17 we're okay with negative margins, or very close to it, but
18 our patients are being subsidized. And like you said, this
19 is a population that is almost all Medicare eligible, so it
20 seems like if there was a place where we could cost
21 subsidize, it might not be the worst thing. But I support
22 your recommendation.

1 MS. KELLEY: Brian.

2 DR. MILLER: Thank you. I just wanted to clarify
3 something from a prior discussion, which is that SNFs and
4 IRFs are clinically very different and have different
5 populations. I also note that one of the things that I
6 think is a challenge for us is I don't believe that there's
7 anyone on the Commission -- and I could be corrected -- who
8 has owned or operated a chain of SNFs. And I think that we
9 all collectively would benefit from learning from their
10 experience, even if we disagree or agree with it.

11 I also wanted to mention that I think Scott's
12 push for us, building off Lynn's comments, to look at the
13 Medicare long-term care population is an important one, so
14 I'm glad we're undertaking that work.

15 Sort of three things I wanted to mention. One is
16 the staffing rule. The capture share mentioned that about
17 a quarter of non-exempt facilities would meet the SNF
18 staffing requirement, which to me -- I agree that there are
19 staffing challenges -- sort of shows how ridiculous the
20 rule is operationally in the real world.

21 I'll note that as a Commission that we looked at
22 a proposed rule in September 2022. We usually don't look

1 at CMS proposed rules, and that was a little unusual. This
2 rule was just finalized, and based upon our analysis,
3 pulling some numbers from the chapter, we said that urban
4 facilities are required to have 3.48 hours of nurse
5 staffing per resident day by 2026.
6 Now, 3.48 seems a little arbitrary. I'm not sure
7 what half. You know, are we going to fractions of minutes
8 and seconds, on average? It sort of shows how ridiculous
9 this rule is in terms of specifying operational
10 requirements.
11 We all have agreed that the clinical models for
12 SNFs are, shall we say, have opportunities for
13 improvements. Why would we want to have a rule that
14 enshrines that clinical operational model as a regulatory
15 requirement?
16 The rule also is functionally serving to regulate
17 an industry and say what akin is the barista to customer
18 rations at Starbucks is, or prespecifying the number of
19 mechanics available in a county. So I think it's a little
20 unusual that we are doing this.
21 I also think that post-acute care policy in SNFs
22 has long been ignored. The three-day stay requirement, we

1 have not addressed that, and I think that as a Commission
2 we should. That rule is from half a century ago, when the
3 average length of stay was 13.78 days -- I looked it up. I
4 think that we can all agree that the average length of stay
5 is nothing like 13.78 days, so that three-day stay
6 requirement is not reasonable, especially if you're a
7 patient under observation stay. If you fall at home and
8 you're too weak to get up, you don't meet requirements for
9 inpatient hospitalization, and then you're admitted and
10 you're stuck in this no man's land, in an acute care
11 hospital, frequently large academic medical center, or
12 cautionary care hospital, and you can't get discharged.
13 I also agree the prior rec, that we should
14 collect patient experience data.
15 And then I think there was a data point in there
16 that should make us think carefully about the consequences
17 of our recommendations. We noted that the implementation
18 of the patient-driven payment model resulted in a 23
19 percent decline in the minutes of therapy delivered per
20 stay in the first three months. This is like exercising
21 less. I'm not sure that this is a good idea.
22 And then I think, collectively, as a group, we

1 should ask has Congress ever implemented our SNF payment
2 recs, and have they implemented our recommendations for
3 other services? With the advent of DOGE, we should be
4 grading our performance year-over-year, reflecting how
5 effective we are at advocating for Congress for policies,
6 and then adjust accordingly.
7 So I would like to see a summary table at the end
8 of each chapter with the prior five years of
9 recommendations, and then the update that Congress took,
10 and then at the end of each annual report I would like to
11 show the prior several years of recommendations
12 collectively that we made and whether Congress has adopted
13 them, and then score ourselves. Thank you.
14 MS. KELLEY: Scott.
15 DR. SARRAN: Thanks for the very good work. It's
16 not an easy space, as we've been discussing, to get our
17 hands around, given the disparate lines of business, or
18 separate lines of business that the nursing facilities work
19 under and their corporate complexities. So good work.
20 I'm comfortable directionally with the
21 recommendation. I'm still kind of noodling on whether I
22 think it may be going a little bit too far quantitatively,

1 but directionally I'm comfortable. The reason I'm not sure
2 I'm comfortable with how far it goes is not the Medicare
3 versus Medicare issue, because I think you've done a very
4 nice job of trying to incorporate case mix adjustment to
5 account for that, and kudos on that.
6 It's the MA issue that others have brought up,
7 that I think we all know that as MA penetration in a given
8 geography increases, and as that increases, their market
9 clout increases, and they become increasingly able to exert
10 their influence on both rates and utilization, to Lynn and
11 Tamara's points. So they push down both the dollars per
12 day and the number of days, and again, it increases, like
13 such a dull whammy, the MA plans become increasingly strong
14 and capable of doing that as they grow. So it's sort of an
15 accelerated effect.
16 So that's part of why I'm just not totally
17 comfortable with the 3 percent.
18 And then a couple of just very brief comments. A
19 reminder, and we've tackled this, or we've noted it before,
20 the need for increasing transparency in terms of reporting
21 of intercorporate relationships and transfers of dollars,
22 because that makes it very difficult for us to really be

1 certain about what their true margins are. We all know, at
2 least anecdotally, some nursing facilities report very
3 negative margins, or SNF negative margins. But really,
4 there's a related corporate entity that's doing fine, and
5 the nursing facility entity is doing poorly. And yet the
6 owner is over both, doing okay.
7 Again, that's an anecdote, but the solution to
8 that is more detailed reporting requirements of those
9 relationships.
10 The access, I think it might make sense to do
11 some qualitative interviews at some point of hospitals
12 discharge planners and hospitalists, because I think there
13 are at least some significant pockets of access issues,
14 particularly for medically complex patients that we don't
15 really get at in the overall data. So that's planting a
16 seed for further exploration in that area.
17 And the last comment, in terms of the staffing
18 requirements, yeah, it's a clumsy tool -- and yeah, we're
19 not weighing in on an opinion but just a comment -- yeah,
20 it's a clumsy tool but the understaffing, I think, is a
21 persistent problem. So I understand the instinct on CMS's
22 part to address that with their regulation. But on the

1 other, other hand, it is also a classic unfunded mandate.
2 So if we were giving an opinion on it, I'm not sure what my
3 opinion would be at this point in time.
4 So again, thanks for the very good work.
5 MS. KELLEY: Gina.
6 MS. UPCHURCH: Thanks again for this work. I
7 know CMS is still considering it, but this idea of not
8 having patient experience data I think is very concerning,
9 and we need to keep that in the forefronts of our minds.
10 Staff turnover, if the small agency I run had 53
11 percent turnover I would be fired. So I think it's just
12 horrendous, because I think so much is about relationships,
13 especially if it's your short-term or long-term residents,
14 and getting to know people. And I'm going to come back to
15 that in just a second.
16 I agree with Tamara about the 20-day cliff being
17 a concern, especially for people with limited incomes or
18 that have a very small nest egg, that that's just a real
19 big constraint. And what happens at 20 days? It's shut
20 off. And the three-day, during COVID that got waived, the
21 three-day hospitalization before you have skilled nursing
22 facility coverage. You know, Brian's point, that's a

1 really old rule, so just looking at that again, because it
2 really does limit people's access to skilled nursing
3 through Part A.
4 So I support the recommendation, but I do hope in
5 the future we'll think about targeting and just some ideas
6 about targeting where the money goes and who gets more of
7 it and who gets less of it. And I know we aren't to
8 oversee long-term care or skilled nursing facilities. I
9 know that Medicaid primarily and private pay issue. But
10 all of us have been in the skilled nursing facilities, and
11 you know nice ones, right. You know that they're mostly
12 private pay and they have very few Medicaid beds long term,
13 and they're getting Part A SNF when they can.
14 But I'm just wondering, could we regard those
15 that do Part A? Could we pay higher amounts for people who
16 take Part A patients if they open up more Medicaid beds,
17 you know, as opposed to just private pay? Is that a way to
18 target it? I mean, they have less staff turnover. Could
19 we target better pay to those groups that have less staff
20 turnover? But just a way to target those funds moving
21 forward.
22 But I am in support of the recommendations, not

1 because I think they need less money, but because I think
2 Part A is subsidizing lots of what's happening. Thanks.
3 MS. KELLEY: Cheryl.
4 DR. DAMBERG: I'm going to plus-one on Tamara's
5 comments about all the good additions to this chapter from
6 earlier comments the Commission has made.
7 I just want to spotlight, I very much liked the
8 breakout that you did on Figures 6.2 through 6.5, by
9 subgroup. I thought that was illuminating. I also liked
10 the analyses of the new staffing rule. I thought that was
11 particularly helpful information.
12 And I also like, although the numbers are
13 concerning, around the staffing problems and turnover
14 rates. I think it's good that we continue to spotlight
15 that issue and try to think hard about what we can do to
16 try to affect that.
17 The other thing, related to the occupancy rates,
18 84 percent seems high, and I want to plus-one on Scott's
19 idea that doing some interviews to really try to better
20 understand access problems that people are facing. I think
21 that could be particularly rich information to kind of
22 inform our thinking in this space.

1 I also want to plus-one on the MAPs, that we
2 really aren't sort of looking at the whole picture here, so
3 it's hard to really judge what's going on, particularly
4 related to spillover effects.
5 And then lastly, I do support the Chair's
6 recommendation. The Medicare margin is large, on this one
7 it's the marginal profit. So it seems that the payments
8 are more than adequate for caring for Medicare
9 beneficiaries. But I too struggle with some of the issues
10 that others have flagged here about cross-subsidies and how
11 to ensure the health of this particular sector.
12 MS. KELLEY: Kenny.
13 MR. KAN: Thanks for a great chapter, especially
14 the analytic enhancements. Though I struggle with some of
15 the cross-subsidy issues, I support the Chair's draft
16 recommendation. Thank you.
17 MS. KELLEY: Betty.
18 DR. RAMBUR: Thank you. I also appreciated the
19 chapter very much, and also the comments of my colleagues.
20 I just wanted to underscore a few points.
21 Stacie, I really resonate with your comments about trying
22 to find long-term care. It disproportionately falls on

1 women as providers. It falls on women as daughters, as
2 partners. And at least in many of these settings,
3 disproportionately women of color. And I think it's really
4 an important issue that this nation has to face, but I
5 don't think we can fix it through Medicare, so I'm not sure
6 we have our hands on that wheel.
7 I liked Gina's idea about targeting, because if
8 more money is being put some places, let's make sure it
9 goes so it really makes a difference.
10 This has may been said, but I just want to
11 underscore, these turnover rates are not just management
12 issues. For the person who's in this facility having a
13 constant parade of different people, and they're trying to
14 figure out what's going on, and for the family members,
15 it's really, really a challenge. And as you've heard me
16 say before, obviously the nursing staffing problem is in
17 part because it's always a labor cost.
18 And so, respectfully, I don't see this as
19 mandatory baristas. I see it as air traffic controllers.
20 And I really have come to support this because I don't
21 think it's going to happen any other way. I know that's
22 not in our lane, but the data on RNs and patient outcome

1 safety is very, very clear.

2 So I support the recommendation, and I wish we
3 could do more. I don't know what we can do from this lane.
4 Thanks.

5 MS. KELLEY: That is all I have for Round 2.

6 DR. CHERNEW: I'm going to go around. I think
7 for the folks that haven't actually spoken I'm going to try
8 and start over there, but I might not get this exactly
9 right. Josh?

10 DR. LIAO: Great conversation, and thank you
11 again for the great work. Many things have been said, and
12 said well, so I just want to underscore a few things I
13 think I share, and look forward to maybe ways to look at
14 the data in trying to get a full picture. I recognize this
15 is not in this activity, so maybe in future work. And the
16 cross-subsidization is something that I'm still cogitating
17 on, but it is a concern, as well.

18 I think applying even imperfect tools
19 consistently, though, based on everything, I support the
20 recommendation, as stated.

21 DR. CHERRY: Yes, I support the recommendation,
22 as well. I think it's very prudent and rational, given the

1 margins that the SNFs currently hold.

2 DR. NAVATHE: I support the recommendation.

3 DR. CHERNEW: Wayne. Thank you for raising your

4 hand. It really does help me as I'm trying to look at

5 different things. I really do appreciate that.

6 DR. RILEY: I, too, support the recommendation.

7 It's a tough analytical area with excellent staff work, by

8 the way, on this, so I support it.

9 DR. CHERNEW: Greg.

10 MR. POULSEN: Yeah, I'm in support, as well. I

11 was hoping to duplicate Wayne's prior sterling example, but

12 I do want to just add one thing. I think Gina's idea is

13 really worth contemplating in terms of should there be a

14 differential payment for SNFs that accept Medicaid patients

15 versus those who do not. I'd rather see us go down that

16 path than an explicit subsidization. Yeah, I don't like

17 the idea of us paying more than we should in order to keep

18 people afloat who aren't taking good care of other folks,

19 but I don't dislike the idea of saying there's a

20 differential payment if you accept Medicaid patients versus

21 those who do not.

22 DR. CHERNEW: We never get applause. Larry, I

1 think.

2 DR. CASALINO: I hadn't thought about what Greg

3 and Gina just said, but it's an interesting idea that bears

4 more thinking, I think.

5 I support the recommendations. I'd just like to

6 mention two things. One is, you know, Medicare is not just

7 subsidizing Medicaid in SNFs. It's also subsidizing

8 Medicare Advantage, which is really perverse. And that

9 really should stop. So more attention to that would be

10 great.

11 And then the other thing is just, it's wired in

12 us so we may have forgotten, but Scott was talking about

13 ownership transparency, really, and how that might play

14 into cross-subsidization. Because I think we're also

15 cross-subsidizing real estate investment trusts, which are

16 not exactly poor entities.

17 And just to enlarge on that a little bit, so one

18 of these trusts comes in, buys a nursing home, makes a

19 very, very favorable contract for the trust with the SNF.

20 Very high rent, management fees, this, that, and the other

21 thing. They scarf up the money, and this is money that

22 Medicare is paying, and the facility can go bankrupt or not

1 have enough staff or whatever. The REIT doesn't really
2 care. In fact, it's good if it goes bankrupt because then
3 they can sell the land, which is more valuable than the
4 home.
5 And so the facility could actually look like it
6 has a really poor Medicare margin and all-payer margin,
7 because it's paying such high rent, for example, and other
8 things that the REIT team can collect.
9 So I think that might be worth looking into, as
10 well. I think the MA parts of this are extremely
11 important, and something where we might be able to have
12 more leverage than we would have on the issues of cross-
13 subsidizing Medicaid.
14 DR. CHERNEW: Okay. Because of time I'll be
15 quick. We're going to take a brief break in a minute, but
16 let me just say it's nice to see that everybody's concerned
17 about the same things I'm concerned about. That is
18 soothing. I do think there are a lot of other issues here.
19 This is, in many ways, why we have the whole workstream
20 that we've kicked off on long-term services and supports in
21 a whole bunch of ways.
22 I think the key point here is that these issues

1 are complex, for a range of reasons. Like, sometimes the
2 REITs might be owned by the nursing homes, so it's not
3 paying to another entity. The integration issue is
4 actually quite complicated. And the MA issue is actually
5 also quite complicated because it's not clear you want to
6 raise fee-for-service rates to compensate for Medicare
7 Advantage behaviors, so thinking about that all matters.
8 But the key point is when things seem that
9 complex, and I agree with everything that was said, we
10 typically try and deal with that through broader types of
11 workstreams, which just for those at home, we have indeed
12 kicked off.
13 So Brian and Carol, thank you very much for all
14 of your work. I think there's widespread appreciation for
15 that. And we're going to take a quicker break than usual
16 because we're coming into our home health session, I think.
17 IRF session. We're coming into our IRF session, and I want
18 to make sure we have time for that.
19 [Recess.]
20 DR. CHERNEW: Okay. Welcome back. We're going
21 to now jump in, as we finish up our day, with Laurie. I
22 think Laurie is starting. Okay. IRFs.

1 DR. FEINBERG: Good afternoon. Before we start,
2 I would like to acknowledge Alison Binkowski for her
3 contributions to the chapter and this presentation. The
4 audience can download a PDF version of these slides in the
5 Handout section of the control panel on the right-hand side
6 of the screen.
7 In today's presentation, we will start with
8 background on Inpatient Rehabilitation Facilities, which I
9 will refer to by the acronym, IRFs, and review our usual
10 payment adequacy indicators, listed on the slide.
11 We will conclude with Chair's draft
12 recommendation on how to update fee-for-service Medicare
13 IRF payment rates in 2026.
14 After illness, injury, or surgery, some patients
15 need intensive rehabilitative care including physical and
16 occupational therapy, or speech and language pathology
17 services. These services can be provided in IRFs. Fee-for-
18 service Medicare pays IRFs for providing inpatient services
19 with a prospective payment per discharge described as the
20 inpatient rehabilitation facility prospective payment
21 system.
22 In 2023, there were about 1,200 IRFs, and 69

1 percent were hospital-based and 31 percent were
2 freestanding hospitals. They served about 358,000 fee-for-
3 service beneficiaries who had 404,000 stays. The total
4 payment for IRF care was about $9.6 billion, including
5 payments by fee-for-service Medicare and its beneficiaries.
6 Fee-for-service Medicare accounted for about 51 percent of
7 IRFs' total discharges.
8 Now I'll review our assessment of payment
9 adequacy for IRFs using our established framework you've
10 seen in earlier presentations.
11 We'll start by considering access to care.
12 In terms of the supply of IRFs, in 2023, there
13 was an increase of 2 percent in the number of IRFs compared
14 to 2022. The number of IRF beds increased by about 3
15 percent. The majority of IRFs that opened were
16 freestanding and for profit, and most closures were
17 hospital-based nonprofit units. In 2023, the number of IRF
18 stays increased by 7 percent, reaching pre-pandemic levels.
19 On a per fee-for-service beneficiary basis, Medicare stays
20 increased by about 10 percent, and the aggregate occupancy
21 rate of the facilities was stable at 69 percent.
22 Overall, IRF indicators of access suggest that

1 capacity is more than adequate to meet demand for IRF
2 services.
3 The fee-for-service Medicare marginal profit of
4 hospital-based IRFs was 18 percent and 40 percent for
5 freestanding IRFs, indicating that both sets of providers
6 have a strong financial incentive to serve additional
7 Medicare beneficiaries.
8 Our second category of IRF payment adequacy
9 indicators is related to quality.
10 The two quality measures we tracked, facility-
11 level risk-adjusted discharge to community and potentially
12 preventable readmission, were both stable from the prior
13 period. The median rate of successful discharge to the
14 community was 67.2 percent in fiscal year 2022-2023. The
15 median rate of potentially preventable readmissions was 8.8
16 percent during the same time.
17 Ideally, we would also consider measures of other
18 outcomes, but significant gaps in the data persist. We
19 continue to have concerns about the validity of the
20 function data submitted on the assessment instrument.
21 A patient experience survey is available to IRFs
22 but not required under the IRF Quality Reporting Program.

1 Our third category of IRF payment adequacy
2 indicators is IRFs' access to capital. Sixty-nine percent
3 of IRFs are hospital-based units which access capital
4 through their parent institutions. As you heard earlier,
5 acute care hospitals' access to capital improved in 2023.
6 Access to capital for freestanding IRFs remained
7 strong in 2023. Overall, the all-payer total margin for
8 freestanding IRFs is 10 percent, up from 8 percent in 2022.
9 In addition, new construction of freestanding IRFs reflects
10 positive financial health.
11 Forty-four percent of freestanding IRFs are owned
12 or operated by one large corporation. Their investor
13 reports indicate that this corporation had good access to
14 capital. In 2023, the company opened 8 new IRFs and added
15 beds to existing IRFs, for a total of about 440 new beds.
16 The company continued to open IRFs and new beds in 2024.
17 Our fourth and final category of payment adequacy
18 indicators is how fee-for-service Medicare payments compare
19 to IRFs' costs.
20 As shown by the middle orange line, the aggregate
21 fee-for-service Medicare margin has been over 13 percent
22 since 2019. In 2023, the Medicare margin increased to 14.8

1 percent, which is in line with pre-pandemic levels.
2 Financial performance continued to vary widely
3 across IRFs. For example, in 2023, the aggregate Medicare
4 margin for freestanding IRFs was about 24 percent, as shown
5 by the top dark blue line. In contrast, hospital-based
6 IRFs had an aggregate Medicare margin of about 1 percent,
7 shown by the bottom light blue line.
8 These differences in profit margin by provider
9 type have persisted over time, and we continue to monitor
10 these differences.
11 We will move on to discuss our projected fee-for-
12 service Medicare margin for IRFs. In 2023, the margin was
13 14.8 percent. For fiscal year 2025, we project that IRF
14 margins will increase to 16 percent. This is because we
15 expect payments to increase more than costs.
16 Margins for 2025 could be higher or lower if
17 changes in costs or payments differ from the projections.
18 In summary, our four categories of payment
19 adequacy indicators for IRFs are mostly positive. First,
20 in terms of fee-for-service Medicare beneficiaries' access
21 to care, IRFs' volume and capacity increased while
22 occupancy rates remained stable.

1 Second, in terms of quality of care, in 2023, the
2 median facility-level risk-adjusted rate of potentially
3 preventable readmissions and the median facility risk-
4 adjusted rate of discharge to the community were both
5 stable.
6 Third, for access to capital, all-payer operating
7 margin among IPPS hospitals improved in 2023, indicating an
8 improved access to capital for their IRF subunits. The
9 all-payer margin for freestanding IRFs also increased in
10 2023, indicating freestanding IRFs maintained good access
11 to capital markets.
12 Fourth, fee-for-service Medicare payments and
13 IRFs cost indicators were positive. In 2023, the aggregate
14 Medicare margin was 14.8 percent. We project a margin of
15 16 percent in 2025.
16 And so that brings us to the Chair's draft
17 recommendation for 2026.
18 The chair's draft recommendation reads:
19 For fiscal year 2026, the Congress should reduce
20 the 2025 Medicare base payment rate for inpatient
21 rehabilitation facilities by 7 percent.
22 To review the implications, on spending, current

1 law would give an update of 2.6 percent, so fee-for-service
2 Medicare spending would decrease with this recommendation.
3 We anticipate no adverse effect on Medicare
4 beneficiaries' access to care. The recommendation may
5 increase financial pressure on some providers.
6 With that I will close. I am happy to take any
7 questions.
8 I now turn it back to Mike. Thank you. And I
9 tried to make this efficient because this is your last
10 talk.
11 DR. CHERNEW: And both thank you and great job,
12 Laurie. We are now going to go to Tamara for Round 1.
13 DR. KONETZKA: Thanks for this work. Very
14 interesting. My question is about the expansion in the
15 number of IRFs, like 10 percent growth among for-profits.
16 Do we know where that growth happened? I guess we know
17 that there are markets that don't have IRFs at all, there
18 are markets that have IRFs. Was that more IRFs and more
19 beds in markets that already have them, or does it expand,
20 potentially increasing access to markets that didn't have
21 one at all?
22 DR. FEINBERG: We obviously have identified the

1 individual facilities, and we could do that analysis. But
2 I think it was mostly expansion in existing markets, but I
3 would have to do the analysis.
4 MS. KELLEY: Gina.
5 MS. UPCHURCH: Thanks so much for this
6 information. So you have a statement in here that CMS has
7 developed an IRF experience of care survey for public use,
8 but did not currently include the survey in the quality
9 reporting program, as it has not collected the results. Do
10 we know why that is?
11 DR. FEINBERG: A little bit. I've asked CMS. I
12 think there are some methodological concerns. The survey
13 itself has 58 questions, which is kind of lengthy. And so
14 they are still considering what to do about it. So that's,
15 I think, the reason why they told me they weren't
16 implementing it. But the plan, we think, is coming. Who
17 knows.
18 MS. UPCHURCH: So I know this is Round 1
19 questions, but we would weigh on wanting to know what
20 people's experience is.
21 And then secondly, and I'm sorry if I missed
22 this, but just falls off the conversation we just had about

1 SNFs, for IRFs. Is fee-for-service subsidizing Medicare
2 Advantage with IRFs?
3 DR. FEINBERG: I don't know the answer to that.
4 MA is about 15 percent of IRF admissions. I know that the
5 distribution of their cases is somewhat different, much
6 higher in the area of actually stroke. But I'm not sure we
7 have done the cost information that you asked about.
8 MS. BARR: Just that you know, I believe almost
9 all MA plans do prior auth on post-acute care, and if
10 somebody needs an IRF, they're going to put them in a SNF.
11 If they need a SNF, they're going to move them into home
12 health. So I wouldn't imagine that there's many patients
13 that go to IRFs unless they can't find a SNF bed anywhere
14 else.
15 DR. FEINBERG: There was a Senate report this
16 summer about prior authorization that had some nice data.
17 MS. KELLEY: Kenny.
18 MR. KAN: Thanks for a great chapter. Can we go
19 to page 9 please? So two quick questions on the graph.
20 DR. FEINBERG: Okay.
21 MR. KAN: Any conjecture on why the hospital-
22 based margin is a lot lower than the freestanding? And

1 then also, what caused the spike in 2021?

2 DR. FEINBERG: My impression in 2021 had to do

3 with the pandemic.

4 MR. KAN: So government payments, maybe?

5 DR. FEINBERG: Yeah. I'm not absolutely sure,

6 but it was consistent. I think that there are several

7 factors. My impression is that there are differences in

8 cost allocations. And there are actually some differences

9 in the kind of patients they see. There are a lot of

10 factors that go into why they report lower costs.

11 MR. KAN: And I won't go down the cost allocation

12 rabbit hole, in the interest of time.

13 But anyway, I support the Chair's draft

14 recommendation.

15 MS. KELLEY: Scott.

16 DR. SARRAN: Just building off Kenny, that's what

17 I was going to ask. Is our data sufficient to even do some

18 drill-down on the types of categories of cost? Because

19 it's so striking, and it may lead us in a different

20 direction in terms of recommendation, you know, staff

21 versus real estate versus square foot charge, that kind of

22 thing, as well as how much is case mix index difference.

1 DR. FEINBERG: So I'm relatively new. I don't
2 believe we've looked at cost allocations. But when we look
3 at sort of distribution of things like ancillaries, which
4 you can pick up off the cost reports, there doesn't seem to
5 be a lot of difference between the freestandings and
6 hospital-based. But clearly there could be more research
7 to be done.
8 DR. SARRAN: It's so dramatic.
9 DR. FEINBERG: And it's been that way for years.
10 If it had suddenly changed it would be more concerning, I
11 think.
12 MS. KELLEY: Brian.
13 DR. MILLER: Thank you. I just wanted to respond
14 to Lynn's comment briefly. I think we should avoid
15 generalizations about a 30 million member Medicare
16 Advantage marketplace segment that they dump, which would
17 be IRF patients, in this instance IRF patients into home,
18 when we don't really have data to suggest that. It seems
19 imprudent.
20 My question about this work in Round 1, I looked
21 at the table on page 17, Table 8.4, which suggested
22 economies of scales with IRFs, so increasing efficiency and

1 increasing profitability, which I realized from a, you
2 know, the thing about payment levels is, of course, oops,
3 right. On the other hand, that actually does show a good
4 thing, in that this is one of the few parts of the care
5 delivery business where normal business operational
6 expectation is implied, suggesting that they have systems
7 and processes. And I think that there is something that we
8 can pull from that. I'm not sure what that is, but that is
9 a good thing to see, from an operational perspective.
10 I also saw that hospital-based versus
11 freestanding are sort of different, and my question is
12 that, which was not listed, is can we perhaps add some
13 statistics that differences in size, staffing, or other
14 features of hospital-based versus freestanding IRFs, to
15 help enumerate that?
16 DR. FEINBERG: I believe there's some data on
17 size. I believe there is no staffing data.
18 DR. MILLER: Even size or diagnosis differences
19 would be helpful.
20 MS. KELLEY: I do think there is a discussion in
21 the paper currently about some of the underlying factors
22 that could be contributing to differences in cost between

1 freestanding and hospital-based. And size is one of those,
2 Brian, I think you're absolutely right.
3 DR. MILLER: Right. And it would be good if we
4 could just add that into the table. It's a great table, I
5 understand. We could make it even better by adding that
6 in.
7 DR. FEINBERG: Occupancy is also different.
8 There are some, not huge differences, but like 4 or 5
9 percent, which adds up.
10 DR. MILLER: Thank you.
11 MS. KELLEY: Robert.
12 DR. CHERRY: Thank you. I wonder if we can go to
13 Slide 6, by the way. Right now, freestanding IRFs have
14 about twice the margin of hospital-based IRFs. So if we
15 reduce by 7 percent, assuming all things being equal,
16 right, then you would have 11 percent of margin for
17 hospital-based IRFs and then a 33 percent margin for
18 freestanding. So now we go from twice the margin to now
19 freestanding facilities now having three times the margin
20 as hospital-based. I'm just looking at the straight
21 numbers here.
22 So I don't think that was the intent, and I kind

1 of wonder whether some differential should be considered.
2 I think this is more of an R1 question for you, though.
3 DR. CHERNEW: Yeah. That might be more of an R2
4 question, but I will try and answer it, just so we go
5 through. What you're all picking up is the obvious
6 elephant in the room, is there are big differences between
7 freestanding and hospital-based IRFs. It's different, and
8 that may have implications for what the recommendation is,
9 obviously. And guess I would say in the absence of
10 information, for example, the hospital-based IRFs are
11 dramatically serving different people, providing some other
12 version of that, you could tell a story that some of these
13 differences would explain it. So you might not want to say
14 subsidize.
15 So in some sense this recommendation is timid.
16 We're not going to bring the margins down across the border
17 of the sector. In other ways it would be challenging if
18 you thought you were a hospital-based IRF and you needed
19 all the hospital-based IRFs. But sometimes there aren't.
20 So we just haven't gotten there. But what I've
21 taken from the Round 1 questions is we will spend more time
22 trying to understand what's going on there. Because of the

1 exercise we're doing now, we're not in the position to say
2 here's the update for IRF freestanding, here's the update
3 for hospital-based. That wouldn't be a crazy thing to
4 think about in the grand scheme of things, but that would
5 be outside of our update work, because that would require
6 us to do some analysis that we haven't quite done in our
7 standard update analysis.
8 But there are a series of providers, we used to
9 do LTCHs, as well, that are very complicated to get our
10 head around. They're not everyplace. It's hard to know
11 what to make about the different things.
12 So I think as Laurie said, it is a valuable
13 comment to think through other extra research we can do.
14 But right now we're just trying to sort of signal the
15 sector as a whole seems to be doing quite well.
16 Paul's going to add something.
17 MR. MASI: This is a very helpful conversation.
18 I just wanted to provide a little historical context. In
19 general, the Commission has focused on what level of
20 Medicare payment is necessary in order to support the
21 efficient provision of care in a different payment setting,
22 and taken a position that we're kind of agnostic as to how

1 the market should organize in terms of buildings and
2 structures and instead focused on what is the Medicare
3 payment level to support efficient provision of care and
4 then let the market work it out from there. So I just
5 wanted to add that context to this conversation.
6 DR. CHERRY: I wonder if we should be agnostic,
7 though. It's probably for like a future conversation, but
8 I think it's probably worth studying and looking at and
9 seeing whether we should start to differentiate a little
10 bit more of these margins.
11 Sorry for the R3 comment.
12 DR. CHERNEW: Since that's the theme it's worth
13 getting out in the open. Thank you.
14 MS. KELLEY: Larry.
15 DR. CASALINO: Pretending that I just heard what
16 Robert said but didn't hear what our Chair said, but very
17 quickly a question. Have we done any interviews in five
18 years or so with hospital-based IRF administrators to try
19 to find out more about how they allocate input, you know,
20 financial input and cost? Because the difference is
21 striking. And there probably are a lot of explainable
22 reasons. It's hard to believe there aren't some reasons.

1 There may be some strategic reasons that hospitals put some
2 things in and keep other things out.
3 It's well-known that when hospitals buy a medical
4 practice, which is making money or breaking even, all of a
5 sudden they'll tell the physicians, "Now we're losing
6 $100,000 per physician per month." And a lot of that, I
7 can tell you, from experience, is cost allocation. It
8 might be worth knowing that, just because there's such a
9 dramatic difference.
10 I think five or ten interviews would be
11 sufficient to try to find out if there are strategic moves
12 where they allocate things.
13 DR. FOUT: I'll just say we haven't interviewed
14 them recently on cost allocation. But I can say that you
15 can know from the cost reports how hospitals are
16 allocating, and hospital-based IRFs are always pretty
17 small. So if you look at the table that Brian was talking
18 about, they're going to fall in that 5- to 10-bed much more
19 frequently, and that's part of it. But also if you're
20 allocating based on square footage, you might think that an
21 IRF needs more square footage for some of their therapy. I
22 mean, this would have to be confirmed, but that could lead

1 to more allocation for IRFs.

2 So I think, I mean, it's reasonable that some of

3 the cost is an allocation issue. We can look in the cost

4 report.

5 DR. CASALINO: And the question is do they have a

6 reason to allocate more or less square footage, for

7 example, to the IRF.

8 DR. FEINBERG: Well, for example, their gyms are

9 usually rather spacious, something that an acute care unit

10 would not have. The rooms actually often are larger

11 because they want the patient to have room to learn how to

12 do ADLs. So you don't want the bed with just room for the

13 nurse. So probably if you were to walk into an IRF it

14 would look more spacious. So that would be one of the

15 reasons why they have more square feet.

16 DR. CASALINO: That's true for both kinds of

17 IRFs, not just hospital-based.

18 DR. FEINBERG: Well, yeah, it is, but the for-

19 profits sort of built the freestanding ones, that's all

20 they have. They don't have any of the other allocation

21 things that go on in an acute care hospital. Rarest is an

22 operating room. Even radiology suites may or may not be

1 there in a freestanding. I could go on.

2 DR. CHERNEW: The core sort of question is we're
3 not going to have an answer to, and I think we're going to
4 move on. I think we're ready to start Round 2 in a minute.
5 Is that right? But let me just say is essentially the
6 substitutability between the freestanding and the hospital-
7 based. If you thought they were substitutable, you would
8 want people to substitute to the more efficient sector. If
9 you thought they weren't because of case mix issues or
10 other things -- we've had this discussion -- then you would
11 worry about a lot more.

12 And I think it's a little bit of both, which, of
13 course, limits what we do in terms of the recommendation.
14 But on balance I don't think that we've found evidence that
15 they're obviously serving completely segmented,
16 unsubstitutable markets. It seems largely the case that
17 there is a lot of substitutability, and I say that in part
18 because there are markets that don't have IRFs, and they
19 seem to do things like. And there are a lot of people that
20 get some of that type of care in SNFs.

21 But the core in all of these settings is this
22 complicated issue of substitutability, and to the extent

1 that we pursue this it might be we can pursue some of that
2 in an update rec kind of thing. But it might be we need a
3 separate broad set of work to understand that, and then
4 come back and try and think through a more nuanced rec.
5 But at least the stage of where the analysis is now, I
6 don't think we have the underlying information to claim,
7 with any type of certainty, one way or another.
8 So we're sort of, I don't know, and I apologize
9 to the folks at home that are listening, because this is
10 not going to sound the way I mean it, because I really do
11 understand the importance of giving people high-quality
12 rehab. But given the sort of decision in front of us and
13 the information in front of us, we're kind of trying to
14 balance, to some extent, what's going on. And I do agree
15 with the themes here, which is we could do a better job,
16 because it is really important.
17 My grandfather had a stroke. I think rehab
18 actually, in general, turns out to be a really important
19 thing, and the people that are doing it are important, and
20 the people who have access to it are important. That being
21 said, we do want to make sure they've provided an efficient
22 sector in a particular way. So that might just be one of

1 these examples where our update work has to follow other
2 work, because right now we're in this more prescribed
3 setting.
4 Anyway, we're going to start with Round 2, I
5 think, Dana, and if I'm correct we are again going to go to
6 Tamara. Maybe when we do all of these sectors, I should
7 just say we're now going to start with Tamara.
8 DR. KONETZKA: Just the post-acute ones. Okay.
9 So I'll just start with saying that I am supportive of the
10 Chair's recommendation. I'm kind of agnostic about the
11 exact number. I think that even among hospital-based IRFs,
12 you know, a -7, that leaves them at 10 percent, still seems
13 to me adequate in terms of access. So I'm fine with the 7
14 percent, although I think one could change that a little
15 bit and I'd still be fine. So I'm supportive of the
16 recommendation.
17 I think what I want to raise here is sort of a
18 broader concern and really a suggestion to keep monitoring
19 this. I was struck by the rapid rate of growth of the IRF
20 sector. I mean, it's pretty small, but it's really been
21 increasing quite quickly, and mostly through one company,
22 right.

1 And so I worry about this in the context of
2 things we've talked about before, and that is the context
3 of the IRF and SNF comparison. We know that some portion
4 of people who go to IRFs really are different than people
5 who go to SNFs, and we know that there's probably some
6 degree of overlap. But I think we've concluded that the
7 research just isn't there to really tease out that
8 selection bias well and know what we're getting when we pay
9 more to IRFs.
10 So that sort of gray area, in conjunction with
11 this growth and these really high margins among
12 freestanding facilities, just makes me really worry that
13 Encompass Health, in particular, but whoever else is also
14 growing in this space, has really found this niche where
15 we're really overpaying for IRF care. And they've found
16 exactly those conditions that perhaps should be going
17 elsewhere, or we don't need more IRF beds.
18 So I think this just reinforces this idea that I
19 think we have to continue to monitor that and to sort of
20 try to -- it's hard, but to try to keep getting at better,
21 more rigorous estimates of the IRF-SNF comparison, in
22 particular.

1 And a couple of specific suggestions. I think in
2 the chapter, I don't remember where now, I also read that
3 there's this growth, but there's also a decreasing length
4 of stay over time, slightly decreasing length of stay. And
5 so this might be consistent with sort of expansions of IRFs
6 into markets where the patients are a little bit less sick,
7 and maybe the IRFs are more profitable among those
8 particular patients.
9 So you have the distribution of diagnoses by
10 freestanding and hospital-based, but I'd love to see if
11 that's changing over time. Like do we see that the
12 distribution of diagnoses is moving toward sort of a
13 marginally less sick patient over time, especially among
14 the IRFs that are sort of new expansions.
15 Yeah, I think I'll leave it there. I'm really
16 concerned. I think it's super interesting that especially
17 there's this one company that is really expanding. I'd
18 love to see some analyses that, if possible, even look at
19 what's happening in this one company, given that it's, what
20 was it, 40 percent of IRF stays right now is incredible --
21 oh, freestandings.
22 DR. FEINBERG: It's about a third of stays.

1 DR. KONETZKA: Yeah, so that's huge. I'd love to
2 just see more analysis drawing down on exactly which
3 patients they're serving, in which markets also, like if
4 it's markets where IRFs already exist, or are they just
5 sort of skimming off the less sick people in those markets
6 and we're not really increasing access, or are they sort of
7 serving a new market that's just tapping into an unmet
8 need. Thanks.
9 MS. KELLEY: Brian.
10 DR. MILLER: So thank you for doing this.
11 First some quick questions. One, there was discussion
12 about IRF coding and acute care hospital coding, functional
13 status. I agree that there are concerns about differential
14 coding. My question is how accurate do you think hospital
15 claims are coded? And I'm asking as someone who sees a lot
16 of hospital diagnosis coding, and it's challenging.
17 DR. FEINBERG: Based on other experience looking
18 at things for an FDA study, it varies quite widely. It
19 turns out that on a stroke study that was done for FDA, it
20 was about 85 percent of cases were coded correctly, and
21 those were dually.
22 But that's pretty expensive research to do. I can

1 report on what FDA did.

2 DR. MILLER: Yeah. I guess what I'm saying is
3 agree that it's a reasonable proxy, but knowing how
4 terrible many of us hospital medicine folks are at
5 diagnosis coding, and as someone who is constantly asked by
6 my colleagues. I used to teach diagnosis coding. There is
7 a lot of room for improvement.

8 So I value that discussion, but we just might
9 want to qualify that a little bit.

10 The other question I had, before I get to
11 comments, is on page 10 there's a comment about other
12 neurological conditions being more profitable. And some of
13 the ones listed included Parkinson's, neuromuscular
14 disorders, which I presume include Guillain-Barré and
15 others, and polyneuropathy.

16 DR. FEINBERG: The neuromuscular includes disused
17 myopathy.

18 DR. MILLER: Gotcha. So perhaps I think a little
19 more granularity on that would probably help us, because my
20 brain went places that were different than yours.

21 So then some comments. For methodology I thought
22 it was nice here that we had a profit discussion focused on

1 variable costs, but then IRFs are also a capital-intensive
2 industry, just like acute care hospitals. The acute care
3 hospitals we consider more of those fixed costs, but then
4 we didn't do that for IRFs. So that's not knocking our IRF
5 methodology at all. It's more so saying here we have two
6 very capital-intensive, residential, human care delivery
7 industries, and our methodology is pretty different. So
8 that is a concern that should be addressed.
9 I also share others' concern that we can't really
10 answer the MA question here.
11 And then I had two thoughts about policy
12 improvements. One is I agree with everyone that patient
13 experience data would be a huge win, so always important.
14 At some point we're all going to be patients, and we all
15 want that experience to be valued.
16 And then the 13 qualifying conditions. So that
17 list is about 20 years old, I think. It might be 18 years
18 old. So there are probably more than 13 qualifying
19 conditions. I think we should think about IRFs a little
20 different than perhaps we are. Right now we're saying it's
21 interchangeable with SNFs, and for some patients it may be,
22 but for a lot of patients it isn't. An IRF is like a

1 supercharger on your rehab.

2 So functional status is arguably one of the most
3 important things to Medicare beneficiaries. It's can I
4 drive to the grocery store? Can I cook? Or if I can't
5 cook, can I operate the microwave? And basic ADLs. Can I
6 put on a sweater? Can I bathe myself? Can I toilet
7 myself? Can I comb my hair?

8 So that is functionally the type of things that
9 IRFs are addressing if something bad has happened to you.
10 If you've had a stroke, you've had a spinal cord injury,
11 whatever it is.

12 So if anything, I actually wonder, especially
13 when I think about Medicare Advantage and post-acute care,
14 prior authorization, if perhaps the expansion of IRF beds
15 is not necessarily a bad thing and might be a good thing.

16 And I'm going to add just another wrinkle on
17 that, which is with the rise of the use of GLP-1s, which I
18 think on the whole is a good thing. You do lose lean mass
19 in addition to fat mass, and we all know that in the
20 Medicare population, just based upon age, it's harder to
21 gain lean mass back. It's not easy. I think of stat, say,
22 for a hospitalized patient you lose half a pound of lean

1 mass per day, for every day in your length of stay in an
2 acute care hospital.
3 So I actually think, if anything, we might need
4 IRFs more than we think we will in the future. So I would
5 caution us about being concerned about the growth of IRF
6 markets writ large. We could be concerned about the
7 profitability, but I don't think we should be concerned
8 about the growth of IRF physical beds. And if we broaden
9 that list of 13 qualifying conditions, which hasn't been
10 updated in nearly two decades, that might some of the
11 profitability question while expanding access appropriately
12 to Medicare beneficiaries with positive downstream effects
13 of allowing them to live at home, with less support, more
14 independence, and frankly, more happiness.
15 DR. CHERNEW: So I know we're going to go.
16 Brian, thank you for that. There was a lot there. But the
17 one thing I didn't really pick up was what you feel about
18 the recommendation.
19 DR. MILLER: Generally supportive, but do think
20 that we need to address the methodologic concerns across
21 two capital-intensive industries that we are now treating
22 very differently.

1 DR. FOUT: I'll just say that, as we've talked
2 about, we first worked on the hospital setting and
3 improving our marginal profit methodology there. This one
4 still does use our old methodology, which is the 20 percent
5 fixed cost and 80 percent variable, which is pretty similar
6 to what it was in the hospitals.
7 MS. KELLEY: Scott.
8 DR. SARRAN: Thanks for the great work. I
9 unambiguously support the recommendation.
10 In terms of what we're talking about and trying
11 to understand the profound differences in margins between
12 freestanding and hospital-based, in the ideal world I think
13 we'd try to get a sense of a pie chart with three pieces
14 that explain the delta, and one piece would be the case mix
15 index difference, so how different are the patients, one
16 versus the other. The second would be the direct staffing,
17 how nurses, PT, OT, all that. And the third might be all
18 other costs.
19 And look, I kind of get the sense we're not going
20 to be able to do anything precise around that, but if
21 directionally we could sort of get a feel for that, I think
22 it would be really helpful, not so much for this year's

1 recommendation. I think probably it's going to be solid.
2 But for continuing to better understand this space.
3 Thanks.
4 DR. FEINBERG: To the extent that we've looked at
5 case mix index, it's pretty constant, and if anything,
6 slightly improving as the freestandings report a slightly
7 higher case mix than the hospital-based. But what I would
8 say is there is a certain amount of variability within all
9 the things that we use for case mix, so I would be hesitant
10 to just depend on case mix alone, and I think there's more
11 research to be done.
12 DR. SARRAN: To your point, if that's reasonably
13 close then the key question is are the margins much better
14 at appreciating IRFs because they staff less, or is it all
15 about the hospital-based ones and their cost allocation.
16 That's a big difference in take-home message, right?
17 MS. KELLEY: I think it's important to remember
18 the work that Betty and others have done in the recent and
19 more distant past, looking at coding in IRFs, where we had
20 a lot of concerns about the accuracy of the coding. And I
21 think our sense has been, although this is just a sense,
22 that the interrater reliability within the IRF case mix

1 system may not be what we would like to see.

2 And then the other thing I'll add, and I think

3 Betty or Laurie said this already, we don't have very much

4 information on staffing. So our ability to get under the

5 hood here I think is somewhat limited.

6 DR. SARRAN: So maybe just calling out that,

7 gosh, these differences in margins do raise some questions

8 that we cannot reasonably answer with what we all believe

9 is the required or optimal level of detail.

10 MS. KELLEY: Gina.

11 MS. UPCHURCH: Well, thank you, Scott. I was

12 following right on that. I think there might be a third

13 thing. So you've got case mix, you've got staffing. What

14 about payer mix? So if I'm somebody who has, a lot of

15 people who are in fee-for-service and they've got secondary

16 coverage, particularly not just Medicaid but it's employer

17 coverage, or if it's a Medigap policy, is more of that

18 happening in the IRF versus the hospital, which is maybe

19 trying to offload some of its beds, and you meet those

20 requirements most of the time to be someone who could leave

21 an acute hospital setting and go to an IRF?

22 And you're trying to -- what do they call it? --

1 you're trying to decrease your acute care hospital numbers
2 and put somebody in an IRF, and maybe you don't care as
3 much about what the payer mix is. So I'm just curious what
4 the payer mix would be, as another.
5 But I want to be on the record as supporting this
6 recommendation and being concerned about the incredible
7 disparity in profits.
8 Does payer mix essentially matter?
9 DR. FEINBERG: I think the data I've seen says
10 that a higher percentage of Medicare actually gives you
11 higher profits.
12 MS. UPCHURCH: Higher percentage of fee-for-
13 service Medicare?
14 DR. FEINBERG: Yes.
15 MS. UPCHURCH: Yeah. Well, and that's 80 percent
16 of the allowable, right? So if you've got --
17 DR. FEINBERG: No. It's done differently. It's
18 paid per day.
19 MS. UPCHURCH: That's right. It's part A. Never
20 mind. I'm sorry. Yeah, so that's less critical versus
21 fee-for-service or Medicare Advantage. Thank you. Thanks.
22 MS. KELLEY: Cheryl.

1 DR. DAMBERG: Thanks for this very good chapter.
2 I am also curious, as the other Commissioners have noted,
3 about the differences between the hospital-based and the
4 freestanding, and recognize you don't have all that
5 information. But I do think it's something that if we an
6 opportunity to explore, that would be great.
7 And I just want to go on record as saying I
8 support the Chair's recommendation.
9 MS. KELLEY: Greg.
10 MR. POULSEN: Thank you. We've had a lot of
11 comments that have asked for additional information, and I
12 know we're really burdened. I guess I would suggest there
13 may be a way to streamline the understanding of the
14 differences, the big margin differences. And that would
15 simply be to ask a group of discharge planners, if the
16 hospital-based IRFs closed tomorrow, how would that impact
17 you. If they said, "No big deal. We'd send them to the
18 freestanding down the street," that gives you a very
19 different answer than if they said, "Oh my goodness. We'd
20 be in big trouble because there's a whole series of
21 patients that we wouldn't know what to do with."
22 So I think we could do something like that. I

1 think that would tell us more than trying to get in under
2 the covers and figure out what the differences in
3 populations were, the differences in the coding was, the
4 differences in the cost structure was. Because I think it
5 gets to the point that Mike made, which is if these cost
6 more but really are providing the same difference, why
7 should we subsidize it? On the other hand, there
8 substantively a different capability that's beneficial to
9 Medicare patients, our accountability, we could and should
10 know that, I think. I think that would be an easy way to
11 short-circuit that analysis.
12 And then let me say I support the recommendation.
13 DR. CHERNEW: Thank you for that. The other
14 thing that I think makes that complicated is the other type
15 of providers. If, in your thought experiment stuff, IRFs
16 went away, the other type of providers would adjust in some
17 particular way. So it's challenging to understand.
18 MR. POULSEN: Only the hospital-based went away,
19 not the freestanding.
20 DR. CHERNEW: I understand if the hospital-based
21 went away. Anyway, sorry. Dana.
22 MS. KELLEY: Stacie.

1 DR. DUSETZINA: Thank you very much for this
2 work. I just want to go on record saying I support the
3 Chair's recommendation.
4 MS. KELLEY: Amol.
5 DR. NAVATHE: Thanks. First, I'll just mention
6 that I also support the Chair's recommendation here.
7 So just some musings a little bit related to the
8 challenge of some of the clinical complexity here and the
9 comparability across different care.
10 I think it's actually quite challenging to tease
11 out exactly the dimension of comparability and how the
12 specifics around quality for IRFs versus SNFs across
13 different settings and such end up playing out, probably
14 very extensively by condition, by the characteristics of
15 the population.
16 So there are a few nuances here. I think, Greg,
17 you highlighted very nicely that IRFs are paid more, right.
18 That's important to recognize. IRFs are paid more than
19 SNFs. The reason for that is likely most tightly related
20 to the intensity of the care, and particularly the skilled
21 rehab care. So in some sense IRFs are much more focused
22 than SNFs. SNFs have a much wider acute care population

1 that can have a lot of complex medical and nursing needs,
2 and those staff populations would not really be appropriate
3 for an IRF, because to be appropriate for an IRF you have
4 to be able to participate in very intensive physical
5 therapy.

6 So on one hand I think phenotypically they can
7 look really different, but then we do know that there are a
8 lot of markets that don't have IRFs. SNFs certainly can
9 provide physical therapy, and so a lot of patients end up
10 going to SNFs who could have otherwise gone to IRFs. And
11 this is, at least, partially recognized in our payment
12 system through this notion of a qualifying and non-
13 qualifying condition at IRFs.

14 So one of the points I just wanted to raise is
15 that Brian highlighted the importance of functional status
16 and what IRFs are doing physical therapy, and that's very
17 different for some population within a SNF and overlapping
18 with other populations.

19 It's actually been very hard to tease out what is
20 the contribution, the outcomes associated with causally
21 going to an IRF or going to a SNF, if you're the same
22 patient. I think others like Tamara may correct me, but I

1 haven't seen any evidence around that.
2 I've seen good clinical evidence that if you have
3 what we would probably consider an obvious qualifying
4 condition, like you have a stroke and you're able to
5 participate, that outcomes are very good coming out of
6 IRFs. So they definitely have clinical benefit in those
7 settings. And there have been some comparisons, again with
8 some methodological limitations, that suggest that patients
9 who really meet that criteria specifically for IRFs may do,
10 in fact, better in functional recovery at IRFs than SNFs.
11 But the challenging part here is that IRFs are
12 also allowed to admit non-qualifying patients, for whom
13 they are paid more than if that patient went to a SNF.
14 So I'm just highlighting that I think even if we
15 try to put blinders on and say that IRFs are more intensive
16 and they do better for some clinical population, we know
17 that might be true. But when we zoom out, it's actually a
18 much more complicated picture. I think in some sense we
19 are in a world where we would ideally have better evidence.
20 I don't know that we're in the position to really
21 provide that evidence, because I am aware of efforts across
22 a number of different research groups in clinical as well

1 as health economics and policy literature that have tried
2 to address this, and it has been very challenging to
3 actually get this sort of precise comparability between the
4 settings, intersected with this interactive, at this point,
5 of qualifying and non-qualifying, because that's really
6 important. And that's actually potentially quite difficult
7 to observe for a researcher, for MedPAC, or for somebody
8 from the outside.
9 So I just wanted to offer that point, and I think
10 from that perspective, when we take a step back and you
11 look at, from a payment system-wise, what we're seeing
12 across, whether it's hospital or we're seeing IRFs, again I
13 think there are challenges in figuring out what exactly is
14 happening there. I think that provides a good kind of
15 backdrop for, well, this is directionally sound, based on
16 what we understand, recommendation. But I don't think the
17 point here is that we precisely know exactly what the puts
18 and takes are, because I think it's very challenging to
19 actually disentangle that. Thank you.
20 MS. KELLEY: Robert.
21 DR. CHERRY: Yeah. So I'll say right at the
22 outset that I'm supportive of the recommendation.

1 Hopefully you'll listen for the rest of my comments.
2 But I will say it will be nice if we can figure
3 out, in a simple way that may not be easy at all, to
4 understand exactly what we're deciding upon because of
5 these differences in profitability. And there is some
6 complexity to it, because I imagine a major motivator for
7 hospitals in getting into this business is trying to manage
8 the total cost of care, which I think Greg is alluding to.
9 And so if they can move the patient from a higher-cost
10 environment to a lower-cost environment and backfill those
11 acute care beds with more patients that they can serve,
12 then that all works out.
13 But there are some interesting complexities too.
14 Like you mentioned the square footage, being smaller in
15 terms of the rooms, and the gym sizes in hospital-based
16 clinics. You know, not all IRFs are the same. Some have
17 specialty care around spine rehab or brain trauma. And so
18 I imagine that those patients going to hospital-based
19 clinics, particularly if they're smaller sizes, are
20 probably for less complex reasons.
21 So how to tease all this out I'm not quite sure,
22 but if there is an easy way so that we can make some better

1 decision-making for next year, that would be great. Thank
2 you.
3 MS. KELLEY: Lynn.
4 MS. BARR: I too support the recommendation.
5 I was thinking about, Betty, you can help me out
6 because I remember this maybe came up here in MedPAC a
7 couple of years ago. But we were talking about how I think
8 hospital-based IRFs treat basically a wide variety of
9 things, right, and that there are these neurological, like
10 there's stroke, or the freestanding are more specialized.
11 I'm just wondering if part of the efficiency is
12 you're dealing with a more limited menu. Is that not
13 correct?
14 DR. FEINBERG: Not that I'm aware of. I think
15 the most efficient freestanding facilities often treat a
16 fairly wide range.
17 MS. BARR: Because they're larger.
18 DR. FEINBERG: Actually, the optimal size is in
19 the 40 to 60 bed range. The largest IRFs may actually be
20 the ones treating the super-complex patients.
21 MS. BARR: Interesting. All right. Thanks.
22 MS. KELLEY: Betty.

1 DR. RAMBUR: I support the recommendation, and I
2 have one quick question as I reflect on this. I think
3 about, and this might be a regional thing, that in my
4 experience younger people, pre-Medicare age, were more
5 likely to go to freestanding clinics. Do you have any data
6 on that? No.
7 DR. FEINBERG: I don't have any non-Medicare data
8 on who's there.
9 DR. RAMBUR: You know, it's an answer to it
10 really. But I just want to support the idea of dissecting
11 out, to the extent that we can, hospital-based versus
12 freestanding, as many people have talked about. And until
13 we can do that in the future, I think Scott's comments
14 about at least reflecting it in there that we don't know
15 would be very helpful.
16 Thank you for the great work. I appreciate it.
17 MS. KELLEY: I think that's the end of the queue,
18 unless I missed anyone.
19 DR. CHERNEW: It's not the end of the discussion.
20 I don't know if I've really thought through. You know
21 what, Wayne, I'm going to start with you, because I didn't
22 see you there. And then we're going to go around.

1 DR. RILEY: Support.
2 DR. CHERNEW: Okay. I'm not doing it in reverse
3 alphabetical order from my list. So Josh.
4 DR. LIAO: Dittoing.
5 DR. CHERNEW: It's a double dittoing. Kenny?
6 DR. NAVATHE: Kenny supported it in Round 1.
7 DR. CHERNEW: Oh right, in Round 1. I'm sorry.
8 I didn't get that right. Larry.
9 DR. CASALINO: Support. I was trying to think of
10 a quicker way to say it.
11 DR. CHERNEW: Paul wants to make a comment, and
12 then we'll wrap.
13 MR. MASI: I love this enthusiasm for more work.
14 [Laughter.]
15 MR. MASI: Particularly now that the sun has gone
16 down. No, thank you for this conversation. This is very
17 helpful. We really appreciate it.
18 I just wanted to talk for a moment about setting
19 expectations. We will take all of this back. We will work
20 very hard to incorporate as much as we can for the January
21 chapter that you'll see in January. As you know, January
22 is quite soon, and so we will have to do our best to both

1 incorporate what we can now and then to the extent to which
2 some of this conversation has contemplated some broader
3 either methodological changes or exploring really good,
4 meaty issues, some of those will be in the conversation for
5 future work planning.
6 So I just wanted to say that, to make sure that
7 Betty and Laurie do come back tomorrow and that they're
8 employed in a civilized way.
9 DR. CHERNEW: Okay, so ditto.
10 So first of all, thank you, Betty and Laurie, for
11 your work. I do want to emphasize that I, and I think the
12 Commission, the staff, really does understand the
13 importance of rehab work. I do agree with what Brian said,
14 that functional status and related things are really
15 fundamental to what we're trying to accomplish broadly with
16 our recommendations and what we do.
17 As you all pointed out, there's a lot of analytic
18 questions, some of which will be challenging to answer, for
19 data reasons and a slew of other reasons. So we will take
20 those under advisement and move at the pace that we can end
21 up moving, given the data that we have.
22 But in any case, for those of you at home that

1 want to reach out and give us comments on this, please, at
2 meetingcomments@medpac.gov. We really do want to hear from
3 you. And that said, again, thank you to all the staff that
4 presented today, and in advance to those that will present
5 work tomorrow.
6 But for now, thank you at home for joining us.
7 We will come back in the morning, and I think we're going
8 to start with home care, and then we will do hospice and
9 dialysis tomorrow. But we are now going to adjourn, and
10 we'll continue then.
11 So again, thank you, everybody.
12 [Whereupon at 5:09 p.m. the meeting was recessed,
13 to reconvene at 8:45 p.m. on Friday, December 13, 2024.]
14

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, December 13, 2024
8:49 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
AMOL S. NAVATHE, MD, PhD, Vice Chair
LYNN BARR, MPH
LAWRENCE P. CASALINO, MD, PhD
ROBERT CHERRY, MD, MS, FACS, FACHE
CHERYL DAMBERG, PhD, MPH
STACIE B. DUSETZINA, PhD
KENNY KAN, FSA, CPA, CFA, MAAA
R. TAMARA KONETZKA, PhD
JOSHUA LIAO, MD, MSc
BRIAN MILLER, MD, MBA, MPH
GREGORY POULSON, MBA
BETTY RAMBUR, PhD, RN, FAAN
WAYNE J. RILEY, MD, MPH, MBA
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1 P R O C E E D I N G S

2 [8:49 a.m.]

3 DR. CHERNEW: Good morning, everybody, and
4 welcome to our Friday morning MedPAC meeting. We are going
5 to spend this morning continuing our discussion of our
6 recommendations on conversion factor updates, and we're
7 going to start with home health care services. And that
8 means, of course, we're going to start with Evan.

9 MR. CHRISTMAN: Thanks, Mike. Good morning.
10 Next, we will look at payment adequacy for Medicare home
11 health agencies. The audience can download a PDF version
12 of these slides in the Handout section of the control panel
13 on the right-hand side of the screen.

14 In today's presentation I will cover our payment
15 adequacy indicators, and we will also review the Chair's
16 draft recommendation.

17 Before turning to our payment adequacy
18 indicators, here is a brief overview of home health care in
19 Medicare fee-for-service.

20 In 2023, there were about 12,000 agencies
21 participating in the program. Those agencies served 2.7
22 million fee-for-service beneficiaries, and delivered 8.3

1 million 30-day periods of home health care, and total fee-
2 for-service payments in 2023 equaled $15.7 billion.
3 Now we turn to the payment adequacy indicators.
4 They are similar to what you have saw for other sectors
5 yesterday, so I will not run through them in detail. But
6 in general, we assess these factors to determine a payment
7 recommendation for the upcoming payment year, 2026.
8 The four indicators are beneficiary access to
9 care, quality of care, access to capital, and Medicare
10 payments and costs.
11 Our first category of payment adequacy indicators
12 is access to care. We find that access to care is
13 generally adequate. Similar to past years, over 98 percent
14 of fee-for-service beneficiaries lived in an area served by
15 at least two home health agencies, and 88 percent live in
16 an area served by five or more. We recognize that the
17 number of agencies active in an area may not be a complete
18 measure of access but include this as one of our measures
19 because it provides a baseline of how the supply of
20 providers is distributed relative to the Medicare
21 population.
22 The number of agencies increased by about 3

1 percent in 2023, though this trend is heavily influenced by
2 an increase in Los Angeles County, California. Excluding
3 this county, the number of agencies declined by 2.8 percent
4 in 2023. That said, agencies vary widely in size and
5 capability, so the number of agencies is an important, but
6 limited, indicator of access, and it should be considered
7 with the context of other data.
8 We also reviewed data on the share of services
9 that were reported by agencies as being initiated in a
10 timely basis, which was 96.1 percent in 2023. Though this
11 measure has some limitations as noted in our paper,
12 beginning home health promptly after it has been ordered is
13 important to beneficiaries. The rate has been steady in
14 recent years, indicating that agencies are not reporting
15 significant delays in the initiation of care.
16 The per-capita utilization of home health
17 services declined by 3.9 percent in 2023 relative to the
18 prior year, consistent with a long-term trend that predated
19 the pandemic. This decline reflects that the share of
20 beneficiaries using home health care declined slightly,
21 though the number of 30-day periods per user held steady.
22 I would also note that home health utilization

1 was slightly lower in rural areas in 2023, averaging 21.9
2 periods per 100 fee-for-service beneficiaries compared to
3 24.4 in urban areas. While the rural rate is lower, like
4 other health care services there is variation within urban
5 and rural areas, and low-use and high-use areas can be
6 found in both categories.
7 As another indicator of access, we also looked at
8 the share of inpatient hospital stays that were followed by
9 a home health or SNF stay. This chart shows the trend
10 since 2019.
11 As you can see from looking at the blue line, the
12 share of discharges to home health increased at the onset
13 of the pandemic, surpassing the share discharged to SNF.
14 Since 2020, the share to home health has remained high but
15 trended downward as SNF has trended upward.
16 From a broader perspective, this graph provides
17 an indicator for assessing overall access. Though home
18 health utilization after discharge has fallen in recent
19 years, it appears that beneficiaries needing post-hospital
20 home health are able to access it at a rate that is
21 actually higher than before the pandemic.
22 Shifting now to indicators of the quality of home

1 health care, as shown in the top left table, the most
2 recent data show a discharge to the community rate of 80.6
3 percent, a 1.3 percentage point increase over the prior
4 periods. The average rate of potentially preventable
5 readmissions was about 3.8 percent. Due to a change in the
6 way this measure was calculated, we can't compare the rate
7 to the earlier period.

8 The Home Health CAHPS measures of patient
9 satisfaction did not change significantly compared to prior
10 years, with the rates on these measures showing most
11 patients had favorable views of their home health care.
12 For example, 85 percent of patients rated their agency
13 highly, and 78 percent said they would recommend their
14 agency.

15 Next, we look at access to capital. Home health
16 care is less capital intensive than other sectors. That
17 said, we note that the all-payer margin was 8.2 percent,
18 indicating that agencies can yield profitable returns for
19 investors.

20 The number of home health acquisitions has
21 fluctuated in recent years, with big increases in 2021 and
22 2022 but a slower pace in 2023 and 2024. But even with

1 this slowdown, some local and regional operators continue
2 to acquire additional agencies, suggesting they have access
3 to capital for expansion.
4 Turning to Medicare fee-for-service margins for
5 2023, we can see that the margin for this year were 20.2
6 percent. The trend by type of provider is similar to prior
7 years, with for-profits having higher margins than
8 nonprofits, but margins for urban and rural were relatively
9 comparable.
10 The 2022 margins remain above 20 percent, higher
11 than the long range average of 17.1 percent since 2001.
12 These margins indicate Medicare fee-for-service continues
13 to pay well in excess of cost.
14 This brings us to our margin projection for 2025
15 for Medicare fee-for-service. We project that margins will
16 decrease in 2025 to 19 percent. This is because we assumed
17 costs will increase more than the payment rate increases.
18 On the payment side, our estimates include CMS's
19 payment updates for 2024 and 2025, which are detailed in
20 the paper. And we assumed a cost increase equal to average
21 that agencies experienced in 2021 to 2023.
22 So this brings us to a summary of our indicators,

1 which are generally positive. Ninety-eight percent of
2 beneficiaries live in a ZIP code with two or more home
3 health agencies. The fee-for-service Medicare per capita
4 volume decreased, and the share of hospital discharge to
5 home health is higher than the pre-pandemic level. For
6 quality of care, we noted that fee-for-service, risk-
7 adjusted discharge to community increased slightly, and the
8 patient experience measures remained high and stable.
9 For access to capital, the all-payer margin was
10 8.2 percent, and we note that acquisitions have slowed but
11 some firms continue to expand. And for payments and costs,
12 we noted that Medicare margins in 2023 were 20.2 percent,
13 and the projected margin for 2025 is 19 percent.
14 This brings us to the Chair's draft
15 recommendation.
16 The recommendation reads:
17 For calendar year 2026, the Congress should
18 reduce the 2025 Medicare base payment rates for home health
19 care services by 7 percent.
20 We expect that this would be a decrease relative
21 to current law and spending. There would be no adverse on
22 access to care, and we expect continued willingness and

1 ability of providers to treat fee-for-service
2 beneficiaries.
3 This completes my presentation. I look forward
4 to your questions.
5 DR. CHERNEW: Evan, thank you so much. Very
6 good. Very concise. We're going to start with Round 1,
7 and I think that's going to be Lynn.
8 MS. BARR: Thank you, Evan. This is a great
9 report. I really enjoyed it.
10 So I'm going to just ask about the rural issues a
11 little bit more, and I think I ask you this every year, but
12 I think we're getting closer. So thank you for including
13 the rural data. So that was 10 percent less home health in
14 rural, right, which is significant, I would suggest.
15 I was wondering if you could break that down by
16 isolating micropolitan from the rest of rural, because I
17 think where we're in the micropolitan areas we have a lot
18 more access. And so that might help continue to illuminate
19 where we might have to think about policy. Thank you.
20 MS. KELLEY: Tamara.
21 DR. KONETZKA: Thanks, Evan. Great chapter.
22 Just a couple of questions about measurement. First, in

1 terms of your definition of timely initiation, I know you
2 put in some limitations and stuff in the chapter. But
3 first question about that, so that mixes post-acute use of
4 home health and community initiated?
5 MR. CHRISTMAN: Which definition?
6 DR. KONETZKA: Oh, the timely initiation of care.
7 So the 96 percent seems high to me, relative to some work
8 we've been doing in the data. So it mixes the two of
9 those. Do you have a sense of whether the post-acute
10 timely initiation is different from the community
11 initiated?
12 MR. CHRISTMAN: No, we don't, and I should be
13 very clear about what's in that measure. Because of the
14 way CMS reports it, it's actually sort of, we'll use the
15 term patients instead of beneficiaries. So it's MA, fee-
16 for-service, and any Medicaid home health care they do. So
17 it's sort of all of those rolled together, because that's
18 the way CMS collects it.
19 DR. KONETZKA: They include Medicaid? Okay.
20 MR. CHRISTMAN: When it is the Medicaid home
21 health benefit, not HCBS.
22 DR. KONETZKA: Okay.

1 MR. CHRISTMAN: That's what agencies are supposed
2 to be reporting.
3 DR. KONETZKA: Okay. All right. So that's
4 mixing a lot. So you don't have those broken out.
5 MR. CHRISTMAN: No. It doesn't break out that
6 way. I mean, I guess the rate's so high, it's expected to
7 be relatively high for most broad categories. Now if you
8 start to look at specific categories of patients in terms
9 of conditions, you might see some differences, and you
10 might see some differences across geography. But that's
11 been a relatively high rate.
12 DR. KONETZKA: And so in the community, a
13 physician orders it and then that's the date --
14 MR. CHRISTMAN: Right.
15 DR. KONETZKA: -- from what you measure timely
16 access, right? For the post-acute, it's from hospital
17 discharge. So if they order it in the hospital, it's
18 hospital discharge, but if they get discharged and the
19 physician puts in the order a few days later, is it from
20 that physician's --
21 MR. CHRISTMAN: I believe it's the later of the
22 two. So when the order is made, if the order comes after

1 the discharge. You know, it does have some fuzziness
2 there. And we do mention that in the paper. It's around
3 precisely when the order is booked. Basically it drives
4 this number.
5 I think one of the reasons we include it is that
6 this is the only directly collected data about this that I
7 know of, that you get from home health agencies. There are
8 other sources out there, and that's one piece of it. The
9 other piece of it is that whatever limitations this measure
10 may have, CMS includes it in the star ratings. And so I
11 think people feel like it's telling them something. It's
12 sort of like keeping an eye out to see if people propose
13 changes to it.
14 But you're right. The advantage of this measure
15 is it's the most direct measure we get from agencies about
16 the timely initiation of care. The disadvantages are like
17 anything we get from Oasis, coding practices and whatnot
18 may affect it.
19 But to this point, if this is a problem, then the
20 star ratings are a problem.
21 DR. KONETZKA: Yeah, no, I think it's a very
22 important measure. I just want to understand what goes

1 into it.

2 And so the final question about that one is, you
3 noted that there's the limitation that if somebody gets
4 discharged from a hospital and the discharge destination is
5 home health, but they actually never get home health,
6 that's not in the measure at all, right? Do you have a
7 sense of what proportion that is?

8 MR. CHRISTMAN: Well, the answer to that question
9 is yes, and it's complicated. If you look at the claim,
10 the claim has a discharge destination indicator, and people
11 have used that to look exactly for what you're talking
12 about. And when you just take the existing data as it is
13 available, people sometimes get rates between 20 and 30
14 percent of people who are ordered home health and don't get
15 it.

16 Now there's a lot that goes on around that
17 number. The first thing to understand is that for that to
18 be coded that way on the hospital claim, the beneficiary
19 doesn't have to have accepted the service. And that's just
20 a long way of saying there are a lot of reasons that can go
21 into that gap.

22 The second issue is, and forgive me, this has

1 been a part of my life so now I get to show it off.
2 DR. KONETZKA: I love that.
3 MR. CHRISTMAN: That field on the claim is taken
4 as what the hospital coded as discharge, but in many cases,
5 CMS goes in after the fact and edits that field. So it may
6 not even be what the hospital discharged, and you have to
7 ask for a specific audit trail of the inpatient claims, and
8 go back and find what the hospital discharge quoted. So
9 both comparisons have some challenges.
10 The second piece is that if you just do the
11 analysis the way it's been done, taking those codes as is,
12 there are hundreds of thousands of discharges that were not
13 coded as getting home health that do get it. There are
14 errors in both directions, if you take the discharge
15 destination indicator as truth.
16 So I am, among my many projects, endeavoring to
17 better understand that field and get closer to what the
18 hospital coded and think about what that field is telling
19 us.
20 But yes, there is some population that is coded
21 as getting the service, doesn't get it, and this can range
22 from supply problems, or it can be someone not wanting the

1 service, or that the agency determines that the individual
2 doesn't qualify.
3 So the issue is that, in terms of describing that
4 population, you know, we can describe them using
5 administrative data, but there's nothing that directly goes
6 and asks them, "Hey, you were coded this way. Why didn't
7 you end up getting the service?"
8 So I think in trying to understand what those
9 analyses are telling us, when we talk with people there's a
10 lot of speculation about what's in that group. And also,
11 I'm nervous with the way people interpret the discharge
12 destination field as always being what the hospital coded,
13 because it is in many cases, but it's not always.
14 So I don't know, forgive me.
15 DR. KONETZKA: No, that's great. Thank you.
16 It's very helpful, and I really appreciate your detailed
17 knowledge of this. It sounds to me like, I mean, to me
18 that would be a really important data point conceptually,
19 but it sounds like there are a lot of problems with looking
20 at it.
21 My other clarifying question is much quicker, and
22 that is the hospital admission measures, similar to my SNF

1 question yesterday. I was a little bit confused in the
2 text. Is that hospital readmission from start of care or
3 from discharge from home health?
4 MR. CHRISTMAN: I believe that is after
5 discharge. They're the same measures. They're just
6 applied to the same setting. So I believe that the PPR --
7 I get this confused. I believe the PPR is a post-discharge
8 window.
9 DR. KONETZKA: Okay. I think to me there was
10 conflicting information in some of the footnotes versus the
11 text, so maybe just clarify that.
12 MR. CHRISTMAN: Okay. I'll take a look at that.
13 DR. KONETZKA: If it's after discharge I have a
14 sort of similar issue that, you know, it's like
15 hospitalizations within the frame of care seem important to
16 measure.
17 MR. CHRISTMAN: And yeah, and to your point,
18 Carol and I actually talked about that yesterday, and it's
19 the same basic point. Yes, the biggest difference is the
20 discharge to community measure captures all cases, and the
21 rehospitalization measure captures people came to home
22 health from the hospital. And I think there is definitely

1 some overlap there.

2 I mean, the measures kind of underwent a lot of

3 changes in the last three or four years, and we can take a

4 look at see what else is on the shelf, and we might be able

5 to find some measures that cover a broader range of things.

6 But we want to be able to give them time so we have a time

7 series, and things like that. But we can look at that.

8 DR. CASALINO: In case anybody wonders whether

9 MedPAC staff know their subjects --

10 [Laughter.]

11 MS. KELLEY: Cheryl.

12 DR. DAMBERG: Thanks, Evan, for a great chapter.

13 I was trying to make sense of the market basket,

14 and in the text it says under current law fee-for-service

15 Medicare payment rates to home health agencies are

16 increased annually, based on the projected increase in the

17 HHA market basket, less an amount for productivity

18 improvement.

19 But then in another place in the chapter it talks

20 about HHAs keeping cost growth lower than inflation

21 projected in the market basket.

22 And I guess what I'm trying to figure out is, is

1 the market basket actually reflecting the right inputs?
2 MR. CHRISTMAN: So, yes. I guess I would try and
3 answer this question as concisely as possible, for
4 something I've lived for 20 years. But I would say that
5 prior to the pandemic, when we looked at the growth and
6 cost per what was an episode, it averaged between 0.5 and 1
7 percent. You know, it bounced around.
8 And now, you know, obviously with the pandemic,
9 and there's been a lot more inflation, and things have kind
10 of bounced around recently too. But the averages come out
11 like around 1 percent.
12 And so the long-term question has always been why
13 does this end up looking like this, and there's sort of two
14 answers I think of, and one is that, in general, over time,
15 the number of visits in a period or episode has gone down.
16 And that's just been a secular trend under PPS. That's one
17 thing. The other thing is that this is also just a classic
18 situation where the market basket is a fixed weight price
19 index, and when they move things between categories they
20 can beat inflation.
21 And so I think the actuaries and the folks who
22 develop the wage index can say with 100 percent certainty

1 that these are the categories and the weights the agencies
2 report for their costs, and these are the price proxies we
3 use for them, economy-wide price proxies.
4 But yeah, you know, it's always an estimate. I
5 think if I had to tell you why exactly they've had that
6 long a success I couldn't point to any one thing. I think
7 the decline in visits is one factor, but sometimes I think
8 the agencies will report finding efficiencies, changing how
9 they pay for home health staff, or other things. I think
10 that's kind of the long run story.
11 But the market basket is just trying to measure
12 inflation, assuming nothing changes about the product. And
13 so when things change about the product, you can end up in
14 the situation that we're in.
15 DR. DAMBERG: No, that's super helpful, because
16 it seems like under current law is definitely going to
17 overshoot. So thank you.
18 MS. KELLEY: Go ahead, Betty.
19 DR. RAMBUR: We were just talking about paying
20 staff differently. Is there any evidence that changing the
21 staffing mix is part of this scenario?
22 MR. CHRISTMAN: Yes, that could be in there too,

1 and that hits in there too. One of their two broadest
2 categories is when permitted they can use an LPN instead of
3 an RN in some cases, and they can use physical therapy
4 aides instead of a physical therapist. You know, there are
5 rules about supervision and every other visitor, some
6 interval of RN or a full PT needs to provide the service.
7 But yeah, that's another piece of it.
8 MS. KELLEY: Robert.
9 DR. CHERRY: Yeah, thank you for the excellent
10 report. You know, I noticed with the margins in terms of
11 the ownership categories that the for-profit had a 21
12 percent margin versus not-for-profit about a 13 percent
13 margin. None of that is actually surprising.
14 When you look at the quality section in the pre-
15 read materials it was specifically mentioned that there was
16 no difference in readmission rates between profit and not-
17 for-profit. But the other quality indicator --
18 [Audio interruption.]
19 MR. CHRISTMAN: Hi. We're back. So I think
20 Robert asked about the performance of nonprofit agencies
21 relative to for-profit agencies and quality measures. And,
22 you know, I think in general there are lot of measures

1 where the nonprofits do better, and we can take a look at
2 the CAHPS data and adding some of that granularity there.
3 DR. CHERRY: And the discharge to the community,
4 as well.
5 MR. CHRISTMAN: And the discharge to the
6 community.
7 DR. CHERRY: Thank you.
8 MS. KELLEY: Kenny.
9 MR. KAN: Thanks for a great chapter, Evan. On
10 page 10, I'm just curious. Why are the urban and the rural
11 margins similar, given that there is a divergence of
12 profits between nonprofits and for-profits, to the extent
13 that you may ascribe for-profits to more of an urban
14 setting and possibly nonprofits to a more rural setting, if
15 that's a reasonable assumption?
16 MR. CHRISTMAN: I mean, a lot of this industry is
17 heavily for-profit, and there are a lot of for-profit
18 active in rural areas. I'd had to take a little bit of a
19 closer look. But let's see, this is 2023. There wasn't a
20 substantial rural add-on in place in that year. It wasn't
21 like there was a policy thing. They've drifted a little
22 closer.

1 Again, the general thing that often relates the
2 margins is their cost per visit. I would have to take a
3 look. There are differences across those markets, and it's
4 sort of a question of who has more wage pressure, for
5 example. Some improvement in that area might have narrowed
6 the gap between the two areas that's been there in the
7 past. That difference has drifted around over time, and
8 it's a little closer than it has been.
9 But I guess there are a lot of states, like
10 Texas, where there are a lot of rural areas, lots of
11 utilization, and substantial numbers of for-profits. But
12 there are 2,000 rural counties, so the circumstances vary
13 widely.
14 So I can take a little bit of a look at that, but
15 that would sort of be my thinking.
16 MR. KAN: Second question. I support the
17 recommendation.
18 DR. CHERNEW: That's how you save time in Round
19 2.
20 MS. KELLEY: Gina.
21 MS. UPCHURCH: Yeah, thanks so much, Evan, for
22 your deep knowledge of the subject and for this chapter.

1 So I do have a question. It looks like Los
2 Angeles County dramatically increased its home health. Do
3 we know why those services dramatically increased?
4 MR. CHRISTMAN: I guess the short answer is I
5 don't think there was an access problem that people thought
6 needed to be solved. It's a little bit of an aberration in
7 that Los Angeles County is a high-use county, but the
8 growth was a few years ago. It's just like at a real high
9 level now.
10 So what these additional agencies are doing, it
11 would take a deeper dive. But I guess I would say that to
12 my knowledge, I don't think there was a low number before.
13 MS. UPCHURCH: Okay. So do we think there's
14 abuse of the system?
15 MR. CHRISTMAN: There could be. There’s
16 potential. I think there has been some work around the
17 hospice in L.A. County that has raised concerns. I think
18 it gets complicated. Remember that agencies will get
19 Medicare certification so they can work with other payers.
20 I know that my understanding is that the Medi-Cal program
21 has had fraud issues. So I can't really speak to exactly
22 what's going on there, but I guess the pattern is

1 suggestive that there could be some program integrity
2 concerns. But it's hard to tell. We can simply see the
3 changes in utilization. That doesn't provide the
4 granularity sometimes to sort of really identify anything
5 that's truly illegal.
6 MS. UPCHURCH: Okay. So on behalf of Medicare,
7 who pursues that?
8 MR. CHRISTMAN: Well, it's an alphabet soup.
9 It's the Center for Program Integrity at CMS, and then the
10 folks at DOJ are sort of the two arms. And sometimes this
11 get into some complicated issues of jurisdiction, whether
12 it's state or local. But those are sort of the things.
13 I think people are aware of it. I think there's
14 always a question of just resources and things like that.
15 MS. UPCHURCH: And just another quick. Cheryl,
16 did you want to ask something related?
17 DR. DAMBERG: Oh, I was just kind of wondering
18 whether part of it is a shift in the distribution of where
19 these agencies are doing business. L.A. County is massive,
20 and so maybe they've moved into other areas where there
21 wasn't a presence. I don't know whether you can sort of
22 map that.

1 MR. CHRISTMAN: You know, we could think about
2 that. I think the work done by the states suggests that a
3 lot of these were, you know, they found one building with,
4 I forget, it was like 200 hospices in it, and you could
5 look at some of this stuff. We can think about that.
6 MS. UPCHURCH: Just two other quick questions
7 here. Sorry. Home health is unusual because the
8 beneficiary doesn't have any cost sharing. We pay for it
9 Trust Fund Part A, and we pay for it via Part B. Do we pay
10 differently, or is it the same amount, the same amount
11 whether it's A or B?
12 MR. CHRISTMAN: It is the same amount. That
13 simply is sort of a bookkeeping entry on the federal
14 government side.
15 MS. UPCHURCH: Gotcha. Okay. Thank you. And
16 then the second question is, there's a 35 percent decline
17 in the use of home health aides over the few years. Do we
18 think that impacts quality of a person's experience?
19 MR. CHRISTMAN: Well, this is a major concern
20 among some individuals, and I think some stakeholders. And
21 I would say sort of the following things. From the
22 perspective of Medicare payments, the aide visit is the

1 cheapest visit to provide. It's the least expensive. And
2 so from the perspective of Medicare's rates, I guess we
3 have a hard time seeing the connection.
4 We hear different things. There's been a lot of
5 discussion around this, you know, things like these are
6 workforce issues and things like that. I mean, it's
7 challenging because I think on the one hand the aide
8 workforce, if you look at the nationwide BLS employment
9 numbers, the home health aide is the like largest category
10 of employment in numbers, but I think a lot of those folks
11 are in the HCBS world or serving other categories.
12 So I think the benefit has changed a lot. In the
13 '90s there were a lot of aide visits. When they switched
14 to PPS it became very heavy on nursing and therapy. And
15 there are different narratives that some people attach to
16 that. But yeah, about 10 percent of periods had any aide
17 visits, and it has been noted that the beneficiaries have
18 complained that it's difficult to get an aide for them.
19 MS. KELLEY: Lynn.
20 MS. BARR: Thank you. So we were just talking
21 earlier about maybe carving out micropolitan as a subset
22 and then looking at the rest of rural for beneficiary

1 usage. As I was thinking about that, and again, if you
2 don't have time to do this, but maybe next year we can keep
3 working on trying to understand why there is widely
4 reported disparities in rural, but the data doesn't show
5 it. And I think that the micropolitan issue might help
6 clear things up.
7 Also, I know that there's been certain areas of
8 the country that have been particularly active in home
9 health. Like there's been some concerns about parts of the
10 country. And maybe if we can back those out of the number
11 somehow, as well. Because like, for example, if there were
12 a bunch of rural providers in a state that were doing a lot
13 of home health, and it was a large state, it would sort of
14 wipe out all the other numbers. I'm convinced there's a
15 problem there, but we've just never been able to get at it.
16 And so it would be great, too, if you can figure
17 out, just breaking out micropolitan from the rest of rural
18 I think will help. But also looking at, in addition to the
19 utilization, looking at profitability and the discharge
20 indicators and quality indicators of making that subset of
21 urban, micropolitan, and rest of rural, to see if there's
22 just any way of starting to uncover what people are talking

1 about and find a way to validate that in the data, if it's
2 not too much to ask. Thank you.
3 And I support the recommendation.
4 MS. KELLEY: Scott.
5 DR. SARRAN: Yeah, very nice presentation, Evan.
6 You certainly know this space. So you painted a picture of
7 a very robust sector, performing quite well from a
8 financial, access, clinical perspective. And so as we move
9 down the road towards recommending a cut -- and I'll pre-
10 empt my Round 2 by saying I support the recommendation --
11 I'm just wondering whether there are any pockets of
12 providers where a cut would prove deleterious to
13 beneficiaries, whether we have any qualitative information,
14 and maybe, Lynn, this builds off yours, whether there are
15 particular geographic areas or particular beneficiary types
16 in terms of clinical needs, et cetera, where there is a
17 small number of providers, and they are struggling.
18 MR. CHRISTMAN: So I think that's something that
19 I'm always thinking about, and I think in the context of
20 the Commission's current agenda you might recall in October
21 we talked about a home health mandated report, where we
22 will be looking at changes in home health utilization

1 before and after the implementation of the new payment
2 system in 2020.
3 And I think we're taking that as an opportunity
4 to look at changes in utilization, odds of getting home
5 health care, and the amount of home health care you get,
6 and looking at that on the basis of patient
7 characteristics, and looking for -- I guess the shorthand I
8 use is vulnerable populations. Are there pockets of
9 vulnerable populations where the current payment system may
10 not be adequately paying for it. And the idea there is
11 that certainly in the case of home health, if there are
12 problems that need to be addressed, we can solve them by
13 redistributing the money that's in the system better. And
14 that's the goal with that work.
15 I think one of the things I'll say is that under
16 the new payment system that went in effect in 2020, people
17 get grouped into, for example, 12 clinical categories. And
18 the share of patients in those categories has been
19 extremely stable.
20 You know, I don't want to say there aren't
21 pockets of individuals that need exactly what you're
22 talking about, and we would want to find them and better

1 target dollars towards them. But I would say that when we
2 look at the system so far, and I saw that the intensive
3 nursing category was just dropping through the floor, that
4 would give me some alarm.
5 But I think at this point we don't really see
6 that yet. But I certainly think that across the 2.7
7 million beneficiaries, there certainly may be pockets that
8 hopefully we can identify, to redistribute funds to. I
9 think that's kind of the way I'm thinking about it.
10 Does that kind of follow your question?
11 DR. SARRAN: Yeah, thanks. It sounds like you
12 really are doing the best job anyone can do about thinking
13 ahead in terms of that potential implication, so thanks.
14 MS. KELLEY: Amol.
15 DR. NAVATHE: I pulled back my comment, my
16 question.
17 MS. KELLEY: Oh, I'm sorry. All right them. I
18 think we're ready for Round 2 then.
19 DR. CHERNEW: Perfect. Again, please all be
20 cognizant of time, but in any case, we're going to Brian, I
21 think is first in Round 2.
22 DR. MILLER: I'm supportive of the Chair's

1 recommendation. A couple of quick questions.
2 One, I love this table that we have, summarizing
3 the recommendations. It's very helpful, even with the
4 small font size. Is there any way that we can make this
5 public so that people who are watching can more clearly
6 follow our recommendations? I think that would be helpful.
7 I realize this is a draft, but people sorting through the
8 PowerPoint deck, it would be nice if they had this
9 summarized table.
10 One of my questions is if we have a 20 percent
11 aggregate margin, the current law update of 2.4 percent,
12 how did we come up with the number, a decrease of 7
13 percent, versus, say, 20 percent? And I'm not saying that
14 we should cut the aggregate margin to zero.
15 DR. CHERNEW: Yes. So that's kind of a Michael
16 question, unless you want to take that.
17 MR. CHRISTMAN: As far as I'm concerned, they can
18 all be Michael questions.
19 [Laughter.]
20 DR. CHERNEW: So in general, this will come up in
21 other sectors, as well, typically speaking there is
22 variation in how organizations are doing. We worry a lot

1 about disruption. We understand that these services, home
2 care we're talking about now but others, are actually quite
3 important. So we tend to try, I tend to try to avoid
4 particularly large recommended cuts because of the
5 potential disruption.
6 I think what we would do, my general policy view
7 would be there would be some cut. We would then come back
8 and look and see where things played out. Then we might
9 make another cut. But I think the idea of having a large,
10 the 20 percent cut, for example, probably would be too
11 disruptive to, admittedly, a very important industry.
12 So then the question is, well, why 7 and why not
13 5? Or why 7 and not 4 or 6 or 9? I could say more numbers
14 but I don't have time. The answer is there's no reason.
15 DR. MILLER: So we didn't look at distribution,
16 or model of sensitivity --
17 DR. CHERNEW: I am not trying to mathematically
18 out some optimal level of precision because I understand
19 that Congress is going to holistically look at a lot of
20 things beyond that. So I view this as much more of a
21 signal, and the signal is basically we think Medicare --
22 and I want to emphasize the Medicare program is probably

1 paying more than cost, so a reduction is probably
2 worthwhile. We understand the importance of the sector, so
3 we're not targeting to get it to zero margin, per se.
4 So we're just sort of signaling to Congress that,
5 you know, this is an area where you might be able to cut.
6 But if Congress said we're going to cut 10, we would say,
7 you know, I can see why you would do that, and that's a lot
8 but we could say why could do it. If they said, you know,
9 we're only looking at 4, we'd say, yeah, I understand, this
10 is an important sector and you're worried, all right.
11 So we're just not that level of precision when we
12 get to this. There's a lot of indicators. So that's
13 basically how we came up with 7. But as I said, it's just
14 not a mathematical thing.
15 DR. MILLER: Gotcha. So the next question is, do
16 you know what our home health recommendations have been for
17 the past five years?
18 MR. CHRISTMAN: So I'm not going to be able to
19 pull them all off the top of my head.
20 DR. MILLER: Ballpark.
21 MR. CHRISTMAN: I'd say prior to 2020, the
22 margins were not quite as high as they are now, and they

1 were about -5. And then the margins went up, and that's
2 sort of when we wandered into -7 territory.
3 DR. MILLER: So our recommendation in the past,
4 say, three or four years has been similar to this.
5 MR. CHRISTMAN: Yes.
6 DR. MILLER: Has Congress implemented our
7 recommendations?
8 MR. CHRISTMAN: No.
9 DR. MILLER: Okay. I think that we should add a
10 table to this chapter nothing the past couple years of
11 recommendations, what they were and whether Congress
12 implemented them, especially, as I said, with DOGE going
13 around looking at the effectiveness of various government
14 agencies. And we should be grading ourselves so that we
15 can do a better job. Thank you.
16 MS. KELLEY: Larry.
17 DR. CASALINO: Yeah. You know, it's an
18 interesting idea, Brian. I think grading ourselves,
19 whether to do it and how best to do it, is probably not
20 something that could be discussed probably not right this
21 minute. But the idea of trying to say, look, we've
22 recommended 5, 5, 7, 7, 5 cuts over the last six years and

1 nothing has been done, is not such a bad idea. I mean,
2 because that raises interesting questions like, well, why
3 has nothing been done. Are there good reasons why nothing
4 has been done or is it a matter of, you wouldn't think home
5 health agencies would have such powerful lobbyists, but
6 maybe at the state level at least they do. I don't know.
7 So it is kind of interesting to note, when we
8 repeated make recommendations and nothing happens, I think
9 that is worth knowing, not as a way of necessarily
10 evaluating our performance but just for the subject matter
11 it's worth knowing.
12 DR. MILLER: I have a quick thought. This idea
13 came from the FTC Office of Policy Planning, which writes
14 letters to state legislatures in response to requests for
15 input on legislation regarding certificate of need,
16 telehealth, scope of practice, licensure issues. And the
17 Federal Trade Commission in fact does grade the
18 effectiveness of its recommendations and adjusts
19 accordingly if they don't meet their own performance goals.
20 So it's not necessarily as a way to penalize or
21 reward. It's more so to be reflective and say what is
22 being effective, and if we are not being effective, what do

1 we need to do differently.
2 MS. KELLEY: Lynn.
3 MS. BARR: I support the recommendation.
4 MS. KELLEY: Tamara.
5 DR. KONETZKA: Thanks. I also support the
6 recommendation.
7 Just a couple of quick suggestions. Evan, I
8 really appreciate in response to prior suggestions how
9 you've broken out community-initiated versus post-acute in
10 more of these tables. I guess we're going to continue to
11 push on that, in that I think you demonstrated in the
12 chapter well, that even though it's the same benefit and
13 there's overlap in this population, in some ways they are
14 pretty distinct. The community-initiated do tend to have
15 more cognitive impairment, lower incomes, et cetera, and
16 maybe different kinds of needs, and tend to use those home
17 health aides more.
18 So there are certain things like the quality
19 measures on Figure 7.1. That's the discharge to the
20 community. It would be great to see those broken out by
21 those two populations, as well. Also Table 7.2, if
22 possible.

1 Following up on some of my Round 1 questions,
2 I'll just summarize. It would be great to try to capture
3 people who don't get home health at all after a
4 hospitalization. It sounds like there are data limitations
5 to that. But if feasible, it would be great to continue
6 exploring that, even if it's not a completely reliable
7 number.
8 And then it would also be great to capture
9 within-state hospitalization if we're not already capturing
10 that.
11 And then finally, this is sort of following up on
12 Scott's point, and it sounds like you're going to explore
13 some of this anyway for future reports and not in this
14 chapter. But I find this sort of basic inconsistency or
15 sort of puzzling fact that there's this declining rate of
16 home health use and of aide visits, especially in that sort
17 of community population. You know, we know there's
18 increasing rates of cognitive impairment and probably
19 temporary skills needs.
20 So it's sort of puzzling to me when our margins
21 are so high and supply seems good, that we have these
22 declining rates. And I know there are all these reasons,

1 right. There are fewer people going to hospitals and
2 getting discharged and needing that kind of care. There's
3 probably workforce issues somewhere.
4 I think to the extent you can, I'd love to see
5 you continue sort of trying to explore why there's these
6 declining rates in home health use, by the type, by
7 community-initiated versus post-acute. Maybe exploring
8 whether geographic difference and workforce may be a
9 factor, or whether it's something else, because I think
10 there might actually be some sort of underutilization or
11 unmet need here. Thanks.
12 MS. KELLEY: Betty.
13 DR. RAMBUR: Thank you. A few points. First of
14 all, Evan, I want to thank you for the report, and I really
15 appreciate your expertise.
16 I want to double down on Lynn's request about
17 disaggregating rural, to the extent that we can. For
18 example, in frontier counties of less than six individuals
19 per square mile it's got to be very different. But because
20 it's so few people, it gets aggregated in. And maybe it
21 can't be the same in a frontier area because of the low
22 population density. But to the extent that we can

1 understand that, without sort of it being too heavy of a
2 lift, I think it would be great.
3 I wanted to follow up on Robert's comments about
4 for-profit and not-for-profit, and it links, I think, to
5 what Tamara was saying. I'm particularly interested in
6 understanding, to the extent that we can, the relationship
7 between staff and staffing mix and the patient and family
8 experience, et cetera. Because obviously one way to
9 increase your profits is to decrease your staff. So trying
10 to understand that better I think would be really helpful.
11 I can't help but comment about reporting our past
12 recommendations. To the extent that it puts an exclamation
13 point on the importance of the recommendations, I think
14 that's really valuable. To the extent that it suggests we
15 haven't done our job, I'm very concerned. I can give an
16 example.
17 The FTC, I think in 2015, promulgated a white
18 paper about the problem with states having restrictive
19 practice laws for nurse practitioners and PAs, and that
20 it's anti-competitive and they testified all over. The
21 fact that not all states have adopted that I don't think
22 means that the FTC was ineffective in that role. And I

1 really see the signaling piece as being really important,
2 because I think our work has a lot of different avenues
3 that it takes, in terms of scientists and others.
4 So to the extent that we think we've made this
5 recommendation, we think it's important, and I'll throw
6 another one in, incident-to billing. You know, we think
7 that's really important. But there are some very powerful
8 lobbies who want to keep some of that, and we have to
9 recognize that that's not within our control.
10 So sorry to go on a diatribe here, but we have
11 one set of responsibilities. Congress has a different set
12 of circumstances. So I just have to throw that in there.
13 Thanks.
14 MS. KELLEY: Cheryl.
15 DR. DAMBERG: I want to go on record as
16 supporting the Chair's recommendation.
17 I also want to note that in terms of the
18 scorecards the Commissioners get, to me that's an interim
19 document for internal guidance, and I don't think that it
20 necessarily makes sense to publish that, given that this is
21 still work in progress. So I would not be in favor of
22 that.

1 I also, to Brian's comment about grading
2 ourselves, I see our role as advisory to Congress, and
3 Congress has to weigh many different factors in coming up
4 with their specific set of actions. And I also kind of
5 view a lot of the work that the Commission does, this is a
6 long game, and agencies have to step back and reflect on
7 what they can do, within what period of time, given sort of
8 a range of political forces and resources available to take
9 on various factions.
10 So despite the fact we would like to see change
11 happen tomorrow, I don't think that's sort of the reality
12 of how our government works.
13 MS. KELLEY: Josh.
14 DR. LIAO: Evan, thank you. I agree with the
15 recommendation.
16 MS. KELLEY: Stacie.
17 DR. DUSETZINA: I would say I also plus-one on
18 everything that Cheryl just said, for the record, about
19 scoring ourselves and advising Congress and the context
20 there.
21 Evan, fantastic work. This was an excellent
22 chapter. And I also am supportive of the recommendation.

1 MS. KELLEY: That's all I have for Round 2, Mike.
2 MR. MASI: Betty, did you want to get in here to
3 get something on the record?
4 DR. RAMBUR: I neglected to say that I support
5 the recommendation. Thank you.
6 DR. CHERNEW: For those of you that haven't
7 spoken in Round 2, can you just say quickly how you feel
8 about the recommendation? We'll just go around. Wayne?
9 You actually have to say it.
10 DR. RILEY: I support the recommendation,
11 Chairman.
12 DR. CHERNEW: Okay.
13 DR. CASALINO: I'm in support.
14 MS. UPCHURCH: I'm in support of the
15 recommendation, and a plus-one on Cheryl's comments.
16 DR. NAVATHE: I support the recommendation.
17 DR. CHERRY: I support the recommendation.
18 DR. CHERNEW: I hope I got everybody, but we'll
19 go from there.
20 All right. Let's take a five-minute break, and
21 we're going to come back and we're going to talk about
22 hospice. So thank you all.

1 [Recess.]

2 DR. CHERNEW: Okay, everybody. Welcome back.
3 We've had our break, and we are going to power through with
4 Kim talking about hospice. So Kim.

5 MS. NEUMAN: Thanks, Mike. Good morning. The
6 audience can download a PDF version of these slides in the
7 control panel on the right-hand side of the screen.

8 Next, we are going to talk about the hospice
9 payment update for fiscal year 2026.

10 Like other presentations, we will cover six
11 topics today. First, I will provide an overview of hospice
12 in Medicare. Then, we will review results from four
13 categories of payment adequacy indicators: access to care,
14 quality of care, access to capital, and the relationship
15 between fee-for-service Medicare payments and hospice's
16 costs. And then, we will conclude with Chair's draft
17 recommendation.

18 First, we have a slide on the Medicare hospice
19 benefit You've seen this before so I'm just going to
20 highlight a few points.

21 Hospices provides palliative and supportive
22 services for beneficiaries with terminal illnesses who

1 choose to enroll. To qualify, a beneficiary must have a
2 life expectancy of six months of less if the disease runs
3 its normal course. There is no limit on how long a
4 beneficiary can be enrolled in the hospice as long as a
5 physician certifies that the patient continues to meet this
6 criterion. Fee-for-service Medicare pays for hospice for
7 both beneficiaries enrolled in fee-for-service and Medicare
8 Advantage.
9 Next, we have background on hospice payment
10 system. Medicare pays hospice providers a daily rate for
11 each day a beneficiary is enrolled, regardless of whether
12 services are furnished.
13 There are four levels of hospice care. Routine
14 home care is by far the most common level of care. There
15 are three other levels, including general inpatient care,
16 continuous home care, and inpatient respite care.
17 As we've discussed before, under the daily
18 payment rate structure, long stays in hospice have been
19 profitable because more services tend to be provided at the
20 beginning and end of a stay and less in the middle.
21 The hospice payment system includes an aggregate
22 cap that caps the total payments a provider can receive in

1 a year. Because the cap is applied in the aggregate
2 across the provider's entire patient population and not at
3 the stay level, a hospice can furnish a substantial amount
4 of long stays and remain under the cap.
5 Before turning to our payment adequacy
6 indicators, here's a snapshot of hospice use and spending.
7 In 2023 there were over 6,500 hospice providers.
8 These providers furnished care over 1.7 million Medicare
9 beneficiaries, including more than half of decedents. This
10 involved 138 million days of hospice care, and
11 beneficiaries on average received 3.9 visits per week from
12 hospice staff. Total Medicare payments in 2023 equaled
13 $25.7 billion.
14 As we consider hospice payment adequacy, we'll
15 use the same general framework as you've seen in other
16 sectors. One difference, though, is that we'll present
17 margin estimates for 2022 instead of 2023. This is because
18 the data needed for the hospice aggregate cap calculations
19 lags.
20 First, we have provider supply. The number of
21 hospice increased substantially in 2023, by over 10
22 percent. As shown in the chart, the growth in overall

1 number of providers entirely reflects an increase in number
2 of for-profit providers. A few states had very large
3 increases in the raw number of providers such as Arizona,
4 California, Georgia, Nevada and Texas.
5 It notable that for four of these five states CMS
6 announced in August 2023 it was implementing an enhanced
7 period of program integrity oversight for new hospices in
8 the states.
9 Next, we look at hospice use rates among Medicare
10 decedents. In 2023, the overall share of Medicare
11 decedents who used hospice increased to 51.7 percent, up
12 more than 2 percentage points from the prior year. The
13 overall 2023 use rate was similar to the pre-pandemic high
14 that occurred in 2019.
15 Looking at hospice use by decedent
16 characteristics, the hospice use rate increased in 2023,
17 within all subgroups examined such as age, race, and rural
18 and urban location.
19 Now looking at wider set of access indicators,
20 they are positive. As discussed, the share of decedents
21 using hospice increased. The number of hospice users and
22 total number of hospice days also increased. Among

1 decedents, average length of stay increased and median
2 length of stay was stable. Average visits per week was
3 generally stable.
4 Our final indicator of beneficiaries' access to
5 care is fee-for-service Medicare marginal profit. The 14
6 percent fee-for-service Medicare marginal profit indicates
7 that hospice providers with available capacity have a
8 strong financial incentive to serve Medicare beneficiaries.
9 Next, quality. The first set of data comes from
10 the Hospice CAHPS survey, which surveys the patients'
11 family members after their death. Performance on the
12 Hospice CAHPS measures were stable. Of the eight measures,
13 seven were unchanged and one declined slightly.
14 Performance on a composite measures of seven processes of
15 care at admission improved slightly, but was topped out for
16 most providers.
17 Finally, how much time hospice staff spend with
18 patients at the end of life is also thought to be a measure
19 of quality. Between 2022 and 2023, measures of hospice
20 nurse and social worker visits at the end of life were
21 stable or increased slightly. But nurse visit frequency
22 remained slightly below the 2019 level.

1 So next we have access to capital. It is
2 important to note that hospice is less capital intensive
3 than most other Medicare sectors.
4 Overall access to capital remains positive. In
5 terms of for profit providers we continue to see
6 substantial entry of new providers. Also, reports on
7 publicly traded hospice companies indicated generally
8 strong financial performance thru 3rd quarter 2024. While
9 we have seen slower merger and acquisition activity in the
10 last couple years, financial analysts report the hospice
11 sector continues to be viewed favorably by investors.
12 In terms of nonprofit hospices, we have less
13 information on their access to capital. Provider-based
14 hospices have access to capital through their parent
15 providers.
16 Next, we have margins. As I mentioned before,
17 different from other sectors, we have historical margin
18 data through 2022.
19 First, looking at the chart on the left, the fee-
20 for-service Medicare margin in 2022 was strong at 9.8
21 percent. The 2022 margin declined from the prior year
22 about 3.5 percentage points. The decrease in 2022 largely

1 reflected cost growth exceeding the 2022 payment update and
2 the reinstatement of sequester mid-year.
3 On the right side of the chart, we have margins
4 by type of hospice for 2023. Freestanding hospices had
5 strong margins at 12 percent. Provider-based hospices had
6 lower margins than freestanding hospices.
7 Margins vary by ownership. For-profit hospices
8 had substantial margins at about 16 percent. The overall
9 margin for nonprofits was 0.3 percent. The margin for
10 nonprofit freestanding hospices though was higher at about
11 5 percent. Urban and Rural hospices both had favorable
12 margins.
13 Next, we have our margin projection. For 2025 we
14 project a margin of about 8 percent. We arrive at that
15 projection by starting with the 2022 margin and making
16 several assumptions. We take into account statutory
17 payment increases, historical cost growth trends,
18 reinstatement of the sequester, and the increase in the
19 penalty on hospices that don't report quality data.
20 To summarize, indicators of access to care are
21 favorable. The supply of providers continues to grow.
22 Hospice use among decedents increased. Other utilization

1 measures increased or were stable. Marginal profit was 14
2 percent. Quality indicators, including CAHPS data, process
3 of care at admission, and visits at the end of life, were
4 generally stable.
5 Access to capital remains positive.
6 The 2022 aggregate Medicare margin was 9.8
7 percent, and the 2025 projected margin is 8 percent.
8 Based on our positive payment adequacy indicators
9 and the projected margin, the Chair offers the following
10 draft recommendation.
11 It reads:
12 For fiscal year 2026, the Congress should
13 eliminate the update to the 2025 Medicare base payment
14 rates for hospice.
15 In terms of implications, the recommendation
16 would decrease spending relative to current law. In terms
17 of beneficiaries and providers, we expect that
18 beneficiaries would continue to have good access to hospice
19 care, and that providers would continue to be willing and
20 able to provide appropriate care to Medicare beneficiaries.
21 So that concludes the presentation, and I turn it
22 back to Mike.

1 DR. CHERNEW: Kim, thank you very much, and we're
2 going to jump into Round 1, and I think Kenny is first.
3 MS. KELLEY: Kenny.
4 MR. KAN: Great chapter. Thank you. I support
5 the recommendation. Page 13, can we flip to page 13,
6 please, on the deck. Do you know why the hospital-based
7 margin is a lot lower than the home health base?
8 MS. NEUMAN: So there are a number of factors
9 that go into differences in margins across providers. So a
10 couple of things. One, hospital-based providers tend to be
11 smaller. They also tend to have shorter length of stay.
12 And then there's also issues with overhead from parent
13 providers. All of those things contribute to hospital-
14 based margins being lower.
15 MR. KAN: I'm not try to go down a cost
16 allocation rabbit hole, in the interest of time, but we
17 don't think it has much to do with cost allocation issues,
18 right?
19 MS. NEUMAN: I think that when we looked at this
20 in the past, we have seen that there has been elevated
21 costs that are sort of fixed kind of costs, from the
22 parent, relative to, say, a freestanding provider. So that

1 may contribute partly to the lower margins. But there is
2 more going on than just that.
3 MR. KAN: Thank you.
4 MS. KELLEY: Amol.
5 DR. NAVATHE: Thanks, Kim, for this great work.
6 I just had a quick question, which is in the reading
7 materials it mentions that there was a hospice model under
8 the MA-VBID demonstration. And I was curious if there's
9 any outcomes particularly around utilization costs,
10 caregiver experience in particular, that came out of that
11 demonstration.
12 MS. NEUMAN: So the MA-VBID? CMS has an
13 evaluation report out through the second year of the model,
14 and what that report says is that they didn't see effects
15 on utilization, generally, either election of hospice or
16 utilization of hospice, among those who utilized it.
17 DR. NAVATHE: Sorry. You mean they didn't see
18 effects, meaning differential from fee-for-service? Is
19 that what you mean? I just wanted to clarify.
20 MS. NEUMAN: Right. They didn't see differential
21 trends in utilization or election of hospice compared to,
22 say fee-for-service. It's possible that they included

1 Medicare Advantage beneficiaries who elect hospice but who
2 are not in VBID plans. That may have been in the control,
3 as well. I can go back and confirm that.
4 But in any case, no utilization effects. They
5 did find that there was a small CAHPS effect, and it seems
6 to be driven by responses in Puerto Rico, that that's where
7 they were seeing the CAHPS effect. So they reported that
8 specifically.
9 And at that point that was the main gist of the
10 findings.
11 DR. NAVATHE: And that CAHPS effect was
12 favorable?
13 MS. NEUMAN: Favorable, yes.
14 DR. NAVATHE: Favorable.
15 MS. NEUMAN: Yes, favorable, for respondents in
16 Puerto Rico.
17 DR. NAVATHE: Okay. And then did they report
18 anything on the aggregate spending, essentially, on hospice
19 then?
20 MS. NEUMAN: They did not, to my recollection. I
21 can go back and look.
22 DR. NAVATHE: Okay, great. Thank you.

1 MS. KELLEY: Gina.
2 MS. UPCHURCH: Kim, thank you so much for this
3 excellent work. A couple of quick questions. So somebody
4 is in Medicare Advantage and they need hospice, it's carved
5 out under Part A, traditional Medicare. I'm assuming
6 that's taken out of the bid projections, since Medicare
7 Advantage plans don't have to provide hospice services?
8 MS. NEUMAN: I don't believe it's in the bid.
9 MS. UPCHURCH: Okay. It shouldn't be, obviously.
10 Do we know in the CAHPS survey that
11 beneficiaries' families take -- because I know you could
12 have a recall problem, but also, I know we experience this
13 recently, and there was grief counseling that came with it,
14 and it lasted for a year afterwards. It was really
15 helpful. Do we know when that survey was taken?
16 MS. NEUMAN: There is a lag between the patient's
17 death and when the field the survey. And my recollection
18 is it's a couple of months. I think the bereavement
19 counseling continues to happen beyond when that survey gets
20 fielded.
21 MS. UPCHURCH: That seems like good timing,
22 because it's so dramatic, but you don't want to forget

1 things. So that actually seems like good timing.
2 This new Hospice Special Focus that began in
3 November, on poor-performing hospice providers, you know, I
4 think of carrots and sticks. It looks like it's a lot of
5 sticks for these underperforming groups. But is there
6 coaching or something to help these agencies that aren't
7 doing well, do a better job?
8 MS. NEUMAN: So the Special Focus Program, just
9 to clarify, was supposed to have begun in November, them
10 notifying hospices. I haven't seen anything publicly
11 available on that sort of notification and who those
12 hospices are, at this point.
13 That said, the main component of the program
14 itself is sort of more surveys, checking them out more
15 closely and seeing if things look okay on the surveys, or
16 if they continue to see indicators of concern.
17 I am uncertain about whether that program itself
18 has coaching associated with it, or potentially the MACs
19 may have like probe-and-educate kinds of things that happen
20 separate.
21 I could do a little bit more looking into that.
22 MS. UPCHURCH: That would be good to know. I'm

1 not saying it all could be helped, but maybe some of it
2 could be, if it truly is lack of knowledge of something.
3 And lastly, when somebody leaves the hospice
4 benefit alive and then potentially comes back, do they
5 start the higher payment again, the first 60 days at a
6 higher payment?
7 MS. NEUMAN: There is a 60-day gap. So if they
8 come back within 60 days, they stay at whatever payment
9 rate they were at. If the gap is larger than 60 days, then
10 they resize.
11 MS. UPCHURCH: Okay. Thank you so much.
12 MS. KELLEY: That's all I had for Round 1, Mike.
13 Shall we go to Round 2?
14 DR. CHERNEW: Absolutely, and I think it's going
15 to be Stacie.
16 MS. KELLEY: Yes, Stacie.
17 DR. DUSETZINA: Great. Thank you. Kim, this is
18 excellent work, and I'll start by saying I agree with the
19 Chair's draft recommendation regarding the payment update,
20 or eliminating the update.
21 I just had kind of one maybe broader comment
22 around hospice service, in general, and not necessarily to

1 make changes to this chapter but one that has been in some
2 other work I'm doing around cancer care. One of the things
3 that kind of keeps coming up is people delaying hospice
4 entry because of the need to disenroll from other active
5 treatment. And there are some treatments that are actually
6 palliative in nature that are expensive and too much for a
7 hospice budget.

8 And I think it's one of these things that
9 probably is something that is a one-off of hospice payment
10 overall, like blood transfusions people with certain
11 cancers, or even radiation for people for palliative
12 intent. But I think it would be worth considering in
13 future work, how do we think about incorporating those
14 payments so people can take advantage of hospice services,
15 which are absolutely critical and important for the patient
16 and their family members, but also still have some access
17 to these higher-cost services. That's just kind of for
18 future thinking. But excellent work.

19 MS. NEUMAN: Thank you. I just wanted to add
20 that we do have work underway looking at some of those
21 services that you mentioned.

22 DR. DUSETZINA: Great. Thanks, Kim.

1 MS. KELLEY: Cheryl.
2 DR. DAMBERG: Thanks, Kim, for a great chapter.
3 I want to go on record as supporting the Chair's draft
4 recommendation. And one thing that occurs to me, since
5 this is not the first time we've seen some of this
6 material, is the striking differences between short and
7 long stays. I don't know whether the Commission has given
8 thoughts about whether there should be two different
9 payment mechanisms for short versus long stays, but just
10 something to put in the back pocket for future thinking.
11 DR. CASALINO: What do you have in mind, Cheryl,
12 for the two different ways?
13 DR. DAMBERG: I don't have a fleshed out plan,
14 but it strikes me that --
15 MS. NEUMAN: Just to respond on that point. The
16 hospice payment system, the routine home care rate has two
17 steps in it now. It used to be flat. So now the first 60
18 days is a higher rate, about $225, and 60 days onward is
19 $175. We've done some work in our March 2021 report. We
20 had some additional ideas for further research, potentially
21 like tweaking those steps. Or another way you could think
22 about it is whether when stays get very long that they sort

1 of approximate a different kind of care, and maybe should
2 merit a different lower payment rate.
3 So we've got in that text box there a couple of
4 different ways that someone could think about making more
5 adjustments. So it's something we could think more about,
6 as well.
7 DR. CHERNEW: I just want to say one other sort
8 of somewhat related thing. There has been some academic
9 work out that some of you may have seen, talking about the
10 impact of hospice and long-stay hospice on overall
11 spending. And that's a complicated sort of dynamic so I
12 won't review my sense of where the literature is. But the
13 staff is exploring that in more detail, because as hospice
14 has moved to having some disease criteria that might not be
15 easy to predict life trajectories, it's less clear how to
16 think about how you want that to play out and what the
17 overall impact is.
18 And one of the challenges in all of these
19 sectors, they overlap in complicated ways, in a bunch of
20 things. So we are trying to do that, and there's some
21 other ongoing work that we won't delve into now. But I'm
22 happy to talk about it separately offline.

1 MS. KELLEY: Brian.
2 DR. MILLER: Thank you. A quick response to
3 that. I think there are some issues with MACs and how they
4 administer some of those disease criteria, which can cause
5 challenges in hospice.
6 So a couple of comments. I think Gina and I
7 talked about this last payment cycle update, in that there
8 are concerns that hospice not being part of the Medicare
9 Advantage benefit, and there are a lot of papers talking
10 about how patients go in and out of MA with hospice because
11 it's not part of the benefit. Maybe there's selection;
12 maybe there's not. It depends upon which paper you read.
13 I do think, as part of modernization, having
14 hospice be part of the MA benefit, in addition to having it
15 be part of the fee-for-service benefit, could help address
16 some of those concerns that I think we all have.
17 Obviously, I'm supportive of the Chair's draft
18 recommendation, which is why he's staring at me intently.
19 A couple other thoughts. Regarding transparency,
20 I'd note that the FDA publishes draft guidance documents.
21 CMS publishes notices of proposed rulemaking and draft
22 rules. Congress posts draft bills. I see no reason why we

1 at least can't post our graph summary table, especially if
2 we're not posting our draft chapters. The least we could
3 do is be considerate in that sense.
4 I wanted to also just look at our draft
5 recommendation. Looking at our table, we noted that the
6 2023 Medicare marginal profit was 14 percent, with the 2023
7 Medicare aggregate margin of 9.8 percent, and the 2025
8 projected Medicare aggregate margin of 8 percent. The
9 current law update is 2.5 percent, and our recommendation
10 is 0 percent, so no updates, eliminating the update. As I
11 said, I'm supportive of that update.
12 But I just want to clarify that we didn't have a
13 specific methodology for deciding, for certain margins, we
14 suggest a negative update and other margins we suggest no
15 update.
16 DR. CHERNEW: We do not have a mathematical
17 connection of margins --
18 DR. MILLER: Or principles -- do we have
19 principles?
20 DR. CHERNEW: Yeah. So let me answer your
21 question in sort of two ways. The first way is we
22 certainly have principles that when we think there is

1 payment above cost, in a range of ways, that we go into the
2 update discussion thinking that we're going to look for a
3 cut, potentially, and we're going to try and think about
4 reasons why that cut should be of varying magnitudes.
5 So for example, in the SNF chapter, we're worried
6 about the level of disruption. So there's less of a cut in
7 the SNF chapter recommended than might be in others.
8 In this particular case, I think there are some
9 complications with the overall interaction of hospice in
10 other ways. The margin isn't quite as big as some of the
11 other sectors.
12 But if your question is, is there a reason why we
13 got to eliminate the update, which is basically a 2 percent
14 cut if you were frame off of current law some version of
15 that, versus 5, versus 7, it's not that mathematically
16 precise. The way you should read this, and the way I would
17 encourage people at home to read this, is the margins in
18 hospice seem reasonably healthy, so we are leaning towards
19 less as opposed to more. You know, we could frame it
20 relative to current law or not. That's a little bit beside
21 the point. That's a semantic issue.
22 But there's nothing magic about the magnitudes

1 and there's nothing mathematical about the magnitudes.
2 DR. MILLER: Well, I guess my question is, if our
3 Medicare aggregate margin was 9.8 percent and we're
4 suggesting a 0 percent update, and then you look at, say,
5 IRFs, which have a 14.8 percent aggregate margin and we
6 suggest a 7 percent cut, that doesn't really make sense to
7 me why, if we're slightly higher, we're suggesting cutting
8 it by half versus 0 percent.
9 DR. CHERNEW: Well --
10 DR. MILLER: I'm saying I don't understand the
11 principle there.
12 DR. CHERNEW: It's not --
13 DR. MILLER: And then if we look at SNFs, where
14 we suggest a 21.9 percent Medicare aggregate margin, we
15 suggested a 3 percent cut. So we have increasing positive
16 margins, and then varying thoughts about whether the cuts
17 should be zero, more, or less negative, that don't seem to
18 reveal clear principles.
19 DR. CHERNEW: So again, the general approach is
20 we look to get a sort of directional sense of where we want
21 to go, and then we begin to think about the other factors,
22 in a non-mathematical way. So you get a judgment on how

1 big the disruption might be or what's going on. It's not a
2 mathematical issue.
3 So if you're asking for do we have a mathematical
4 connection where if the margin was X and the capital access
5 was Y and the quality indicators were Z, and we put it
6 through a machine, would we come up with a mathematical
7 connection? The answer is no. If you have a different
8 judgment, you think this one should be bigger. So if
9 you're advocating if we should cut hospice more or we
10 should cut IRFs less, or whatever it is, I'm all ears. But
11 the connection is not a mathematical one. It is really
12 based on sort of the discussion with the staff, concerns
13 about disruptions.
14 In all honesty, I think that because Congress is
15 going to have so many other considerations and what goes
16 on, it would be false precision to assume that we were
17 proposing to Congress some formula about what's optimal for
18 them to do. We are really just trying to signal to them
19 that there is room for a cut, in this case in the hospice
20 sector, and the magnitude, roughly 2, you could say 3. And
21 again, if you said it really should be 5, I wouldn't
22 quibble.

1 DR. MILLER: And as I said, to be clear I'm
2 supportive of the recommendation. I'm just trying to
3 understand how we're weighing various factors across
4 sectors, when I see different --
5 DR. CHERNEW: I think the uniqueness in hospice -
6 - so I'll answer it this way -- I think some of the
7 uniqueness in hospice is some concerns about underuse, some
8 concerns about spending offsets and a whole range of
9 things, it sort of pushed us marginally in a direction. If
10 I could tell you why it was pushed to a 2 percent marginal
11 direction or a 1 percent marginal direction, I would
12 probably need a little more therapy --
13 DR. MILLER: All right. I wasn't meaning to
14 quibble about the, say, 2 versus 3 percent. It's more so
15 that for other industries that have higher margins,
16 sometimes we're suggesting less cuts. Sometimes we're
17 suggesting more cuts. It's not clear how we weigh those
18 non-qualitative factors from looking at this from our
19 discussion entirely.
20 DR. CHERNEW: So the short version is -- let me
21 just emphasize the "we." You can all claim, one way or
22 another. A lot of it is not mathematical connections

1 between those things. If you think that there's some
2 reason why IRFs should be done more or less, that's fine.
3 Although I will say separately, we generally do these
4 sector by sector. We don't spend an enormous amount of
5 time going through across all the sectors, in part because
6 we don't take the recommendation numbers --
7 DR. MILLER: I wasn't talking about IRFs, per se.
8 I was referring to hospice, IRFs, SNFs, just saying --
9 DR. CHERNEW: No, I understand.
10 DR. MILLER: -- that we --
11 DR. CHERNEW: I understand, and I wasn't meaning
12 to pick IRFs, per se, either. You could've picked any of
13 the other sectors. We go sector by sector, and we begin to
14 ask the question within each sector, what do we think the
15 payment is relative to costs, in varying ways.
16 DR. MILLER: Right. I guess what I'm saying is
17 if we're in the business of making evidence-based
18 recommendations with judgment, the principles upon which we
19 decide to titrate up or down on our recommendations, the
20 principles should probably be more clear. I'm not
21 quibbling about the 1 versus 2.
22 DR. CHERNEW: No, I understand. So for people

1 listening at home, the principles -- and again, this is the
2 judgment part -- the principles are we recommend less of a
3 reduction if we're worried more about disruption in a range
4 of things. We make less of a reduction if we're worried
5 that maybe there's underuse in some cases, or there's big
6 offsets in other cases. So those are the principles.
7 But the question about how we go from those
8 principles to the numbers, and whether the principles map
9 to a number directly in a way that I would say is
10 transitive or mathematically connected, I'm happy to have a
11 discussion about any of these, but it's not as precise as
12 sort of the question implies.
13 But I would say, in each case there are
14 considerations about, in this case, for example, all right,
15 it looks like the margins are give or take, 2026, 8, 9.
16 You could pick whatever number you think it is, and have
17 been trending downward in this particular case. And so
18 then there will be an assumption, all right, we think we
19 should probably shade a little bit lower of an update than
20 current law. How much lower? And then there's a
21 discussion that's probably a little bit more like, well, it
22 seems ballpark this. That's sort of just like eliminating

1 the update, so we'll frame it that way.

2 I don't know if that's too -- Paul, do you want

3 to jump in? But that is sort of the transparent inside-

4 the-sausage-factory answer to your question.

5 MR. MASI: Yeah, I'll jump in real quick, and

6 then also keep an eye on the time. I want to make sure all

7 Commissioners have an opportunity to weigh in in Round 2.

8 I would agree that this is inherently a judgment,

9 and that's why Commissioners have been selected to be here

10 and to weigh the evidence and then reflect their own

11 judgments in the conversation.

12 DR. MILLER: One final quick question, and I

13 really appreciate this report because I know that hospice

14 is a challenging subject to write about. Have our

15 recommendations for the past five years been similar to our

16 current recommendation, or different?

17 MS. NEUMAN: So last year the recommendation was

18 a zero update. The past couple of years before that our

19 recommendation, instead of a change to the update, related

20 to changes to hospice aggregate cap, which had the effect

21 of pulling some money out of the system. And then I think

22 before that we may have had a negative update for maybe

1 2019, yeah, one year.

2 DR. MILLER: And has Congress implemented any of

3 our recommended updates or changes?

4 MS. NEUMAN: No.

5 DR. MILLER: Okay. Thank you.

6 MS. KELLEY: Lynn.

7 MS. BARR: I support the recommendation.

8 MS. KELLEY: Greg.

9 MR. POULSEN: And I actually find this one

10 complicated, and the reason is because of the connection

11 that it has with MA and the tricky combination there. I

12 think that I'm also torn because the difference between the

13 for-profits and particularly the provider-sponsored plan

14 implications, at least in the Mountain West, where I hang

15 out, primary care physicians and geriatricians dramatically

16 prefer the provider-sponsored hospice plans because they're

17 significantly better at hand-holding, they're better at

18 keeping people from reverting to going back in and getting

19 out of hospice services. I mean, there's a whole series of

20 things where the performance, which don't necessarily show

21 up in the metrics that we looked at, and maybe can't. I'm

22 not sure whether they can be made available or not. But

1 they are noticeably different.

2 And I think the recommendation would be fine for

3 the for-profits. I'm not so sure that we're not going to

4 encourage some of the others that are not financially doing

5 at all well under the current payment mechanism, won't be

6 ultimately driven out. So I'm concerned about that.

7 I'm also concerned, maybe outside of our ability

8 to recommend certainly as an update, but I think it might

9 be thoughtful for us to consider whether we should simply

10 include hospice care within the MA framework. I know

11 within at least a few MA plans, and ours would be one of

12 them, we would be happy to pay the higher rate within the

13 framework because it saves money overall and performs

14 better for the members in the MA plans.

15 So I'm caught a little bit, because I think this

16 is probably the right recommendation for the vast majority.

17 The majority of homes are in the for-profit world here.

18 This is probably the right one. But I think because of the

19 interesting dynamics in there I'm a little bit conflicted

20 on that. So I would vote yes, but with a big asterisk.

21 MS. KELLEY: Scott.

22 DR. SARRAN: A very nice job summarizing this

1 space and where we are. I concur with the Chair's
2 recommendation, and I want to build off largely Greg's
3 comments, I think, because I have major concerns, as well.
4 I think we need to acknowledge that there is a
5 lot of troubling data out there, some anecdotes, but some
6 real data, as well. The large increase in the number of
7 for-profit entrants I think speaks to, let's just call it
8 easy money to be made, and that's troubling in a space that
9 depends, at the end of the day, on a lot of human-to-human
10 hand-holding. I mean, that's what hospice is significantly
11 about, as well as very, very granular detailed, ground-
12 level clinical acumen and care. And those are, to some
13 extent, antithetical to the for-profit, drive-costs-down
14 mantra.
15 There are persistent quality problems. I'll call
16 that again what I believe should be considered "never
17 events," which is anything less than a top score on the
18 CAHPS measures related to providing timely help or helping
19 pain symptoms, and the score on both of those was below 80
20 percent, that again, to me that means we've got greater
21 than 20 percent "never events." That should not happen in
22 hospice. That is why hospice exists, is to provide timely

1 help and relieve pain and suffering at the end of life. So
2 I'm very concerned about that.
3 Other signals of quality, CMS has acknowledged
4 this, and then the Special Focus Program. The number of
5 live charges suggests some cherry-picking and things like
6 that.
7 And I shared Greg's concern, as well, about how
8 we're mixing two different populations of providers, and
9 the for-profits certainly seem capable, based on what we've
10 seen, of absorbing a flat increase with rising costs. But
11 the not-for-profits may well be servicing different pockets
12 of populations, and we could lose some of them. So that's
13 concerning.
14 What I'd like to see us start going down the road
15 towards, and it's analogous to some of the discussion we
16 had on IRFs, is understanding we don't have answers to
17 these questions. I'd like us to consider a text box that
18 says ideally, we want to understand the drivers of profit
19 margin difference between for-profits and not-for-profits
20 that break down into at least the following categories.
21 Again, I'm not suggesting we have the data to
22 answer these, but in my mind, these are all hypotheses that

1 at least we should call out. Difference in patient types,
2 different clinical types by diagnosis, different site of
3 service. That's a lot easier to do hospice in a nursing
4 facility or assisted living facility, where essentially
5 you're adding onto what the staff is already doing, than in
6 a freestanding community setting. I mentioned different
7 patient type. A second driver is difference in direct
8 costs, staffing ratios, which, by the way, to me raises
9 more concerns than it reflects appropriate efficiencies.
10 Third driver of differences is, and Stacie
11 mentioned this, the use of high-cost services, which very
12 often are truly appropriate and patient-centered in
13 hospice, such as palliative transfusion, palliative
14 radiation therapies, higher-cost pain medications when
15 lower-cost medications are not clinically appropriate.
16 Again, that gets very clinically granular. Differences in
17 allocated costs, and if that's a big driver, that's fine.
18 You know, if that's the case. And difference in length of
19 stay.
20 And so again, ideally we're trying to fill in a
21 pie chart with those different drivers. We understand the
22 data exists for some of those, to some extent, may not

1 exist for others, but we think from a public policy point
2 of view we want to, over time, be able to fill that in
3 because answering it will help address some significant
4 questions that are raised by what we are currently seeing.
5 So thanks.
6 MS. KELLEY: Betty.
7 DR. RAMBUR: Thank you. I very much appreciate
8 this important work, and I'm going to pile a little bit on
9 in the last couple of comments.
10 The excessive profits off the suffering of the
11 dying and inadequate pain management is really, really,
12 really disconcerting to me. And I wasn't really surprised
13 that the CAHPS are higher in rural areas, because it's
14 really neighbors taking care of neighbors.
15 And on Slide 11 that's on page 29 of our
16 manuscript we talk about the slight decrease in nurse
17 frequency of visit, and nurses is aggregated to RNs and
18 LPNs. I know we can't really dissect this, but I think
19 it's important to remember that most of the public,
20 including policymakers, don't understand the different
21 costs and skill mix of nursing assistants, licensed
22 practical nurse, associate degree RNs, baccalaureate RNs,

1 and then APRNs is a whole different thing. And to the
2 extent that we can always think about who the people are, I
3 think it's really helpful.
4 And why I think that's important is that this
5 work is all about people, and people are the cost but
6 people are also the service, the hand-holding that Greg
7 mentioned.
8 I've always been curious about the carveout for
9 Medicare Advantage, and before, wanting to understand where
10 that should go, I'd really like to hear more about how that
11 evolved. So for example, the inclusion of end-stage renal
12 disease in traditional Medicare, regardless of age. I
13 understand the politics around that and how that happened.
14 I don't really understand how that was a carveout, so I
15 would be very interested in learning more about that.
16 And I support this recommendation. I'm happy we
17 don't have an algorithm, because it's really about human
18 judgment. And you hear the different factors that play in,
19 so I'm pleased to support the recommendation. Thank you.
20 MR. MASI: Kim, did you want to get in for a
21 moment just on some MedPAC history?
22 MS. NEUMAN: Yeah, sure. On the MA carveout, in

1 2014, the Commission made a recommendation that the hospice
2 benefit should be included in the Medicare Advantage
3 benefits package, and CMS is testing that through the MA-
4 VBID, which started in 2021 and ends in 2024, and it's
5 voluntary.
6 DR. CHERNEW: But we have been on record of doing
7 that. It took a long time to do it.
8 MS. KELLEY: Larry.
9 DR. CASALINO: Yeah. So I'm supportive of the
10 recommendation, but I think that the remarks that we've
11 just heard from Greg and Scott and Betty are concerns that
12 I share. You know, hospice is, more than almost anything,
13 is an area where the actual details of the interaction are
14 so important, and I certainly, in my own experience,
15 witnessed great variation, from really despicable things
16 that hospice did to really wonderful.
17 So it is an area where I do worry a little bit
18 about for-profits, frankly.
19 I guess I wouldn't mind seeing in future chapters
20 more breakdown on the various, let's call them quality and
21 patient experience measures, by ownership. I think that
22 would be useful.

1 I was also going to mention MA. I mean, MA is
2 more than half of Medicare beneficiaries right now. It's a
3 pretty big deal to have hospice, except for this
4 experiment, excluded from what MA is supposed to cover.
5 And I know we did have that recommendation in 2014, but
6 that's 11 years ago now, and it was a lot smaller part of
7 the health care system then.
8 So I don't know if we have or are envisioning
9 more of a workstream on MA and hospice, but that seems like
10 a pretty important thing to do, actually.
11 And just for context I'll say, for the non-
12 clinicians, a median length of stay of 18 days is still
13 pretty short in my opinion. I mean, it's good that more
14 beneficiaries are getting hospice care than used to, but I
15 think -- I mean, you can say clinicians aren't doing their
16 job, but if it's only 18 days you could say families have a
17 really hard time giving up. But still, that's kind of
18 disappointing. It's not really something that I think our
19 recommendation about payment rates would affect. But just
20 to highlight that, 18 days is still probably very
21 inadequate use of the hospice benefit.
22 MS. KELLEY: That's all I have for Round 2,

1 unless I've missed anyone.

2 DR. CHERNEW: That's me, as well. So again,

3 because I've lost track, I have it here but it's too hard

4 for me to look at my list and then to look at the order.

5 If people just want to go around, maybe we could start with

6 Tamara. I just want to hear, sorry, your recommendation,

7 or anything else you want to say.

8 DR. KONETZKA: I support the recommendation as

9 well as the suggestions and the conversation that we just

10 had about breaking things down by ownership a little bit

11 more in the future, to monitor this.

12 MS. UPCHURCH: I also support the Chair's

13 recommendation and think we should look at it by ownership,

14 following in line with Greg's, Scott's, and Betty's

15 comments. Thanks.

16 DR. NAVATHE: I support the recommendation and I

17 also support some of the comments that Commissioners have

18 made about carving hospice into the MA benefit long term.

19 DR. CHERRY: Yes, I also support the

20 recommendation. It's one of the limitations of the update

21 is that we don't get sort of a holistic perspective of the

22 sector. So hopefully in future meetings we'll be able to

1 do that. Thank you.

2 DR. LIAO: I also support. I would add one

3 thing. As somebody who doesn't hang out in the Mountain

4 West but hangs out in the South, but leads and works with a

5 group of palliative medicine physicians, the details

6 matter. I share many of the concerns about profit status

7 and need for monitor.

8 DR. RILEY: I support the recommendation.

9 DR. CHERNEW: We got everybody?

10 So I'll say just two things. First, about this

11 theme of profit and nonprofit, I would say something a

12 little -- I don't disagree, but I'll say something I think

13 that in some sense is more bedeviling of this sector, is

14 quality is really important. It's very hard to measure

15 quality. So the challenge is understanding and separating

16 out where there's efficiency and where there's bad quality

17 and how that's differing.

18 And while profit status may, in some cases, be a

19 proxy for that, I don't believe that inherently, for-profit

20 is a proxy for bad quality and nonprofit is a proxy for

21 good quality, nor do I believe that for-profit is a proxy

22 for efficiency and nonprofit is a proxy for inefficiency.

1 I just think it's complicated.

2 And it's challenging because the measures of

3 quality of hospice is challenging because at the end of the

4 day people qualifying for hospice, you know, and having had

5 a number of relatives in hospice, several with multiple

6 stays, I understand. For a while what I said, I think this

7 is true, is I aspire to raise my kids to be as good people

8 as the hospice workers were to my relatives, because those

9 people were amazing, and my relatives were challenging, as

10 I plan to be.

11 But again, it is really challenging because

12 hospice, more than maybe many other sectors, and I think

13 this is true of all sectors, really does bring to fore the

14 human condition. And I will stop there for time.

15 The other thing I do want to say is it's come up

16 several times about managing how well we're doing based on

17 whether Congress adopts our recommendations. I'll just say

18 one thing for the audience, and we can continue the

19 discussion.

20 It is obviously something we are aware of, as to

21 how our recommendations go, and I wouldn't say that we

22 understand that the recommendations are not always adopted

1 and they're not always adopted in a timely way. Sometimes
2 it takes a while.
3 But more importantly, I think we conceptualize
4 our work as providing data and advice to Congress, but we
5 fully understand the role of Congress and what they decide
6 to do, and the considerations about whether they adopt our
7 advice. So the failure to adopt our advice I don't
8 consider to be a failure on our part, and in fact, I would
9 worry that if measuring Congress' adoption of our advice
10 was a measure of our success, it would push us to lobby in
11 ways that we just don't.
12 So we do not have a conversation that says we
13 want Congress to do X, and in order for them to do X we
14 need to manipulate the data in particular way to get them
15 to move in a particular way. We just try and provide the
16 most unbiased data we can, and if they respond, they
17 respond. If they don't, they don't.
18 And so the last thing I'll say, and a little bit
19 tongue in cheek but also true. Many of you make
20 recommendations about things that you think MedPAC should
21 do. Some of those things we do. Some of the things we
22 don't. I would discourage you from evaluating yourselves

1 on how many of your comments are adopted by MedPAC, and
2 would encourage you to continue to make those comments.
3 The success of your comments is not judged by
4 whether we adopt them, I guess, as many of you would
5 consider our failure to adopt them my fault, not yours.
6 And I'm perfectly fine if you do that.
7 So we can continue this discussion. I do think
8 it's important to track, but I do want to say I think that
9 our scorecard, my view of success is how well we anticipate
10 the type of information Congress needs and how good that
11 information is that we provide to them. And if we are
12 providing them important information that's accurate, in a
13 timely way, I think that's a success. If they decide to
14 act, however they decide to act, that's completely up to
15 their wisdom.
16 But we haven't changed how we behave in order to
17 get them, to manipulate them, or CMS, for that matter, in
18 any particular way. We are simply trying to provide the
19 best data we can.
20 Anyway, I wish we had more time to have that
21 conversation, and maybe we will. We're going to take a
22 break now.

1 DR. CASALINO: Michael, may I make a brief
2 comment, very brief, in response to what you just said?
3 DR. CHERNEW: Yes.
4 DR. CASALINO: Yeah. I think, again, more for
5 the public, because this is not something that we
6 necessarily get to see or hear. I agree with everything
7 you just said. But to me one measure of the value of what
8 MedPAC does is how interested congressional staff are in
9 the work and the level of interaction between MedPAC and
10 congressional staff. And my impression, from talking to
11 numerous staff members, is on both sides of the aisle the
12 interest in what MedPAC does, and actually asking, I think,
13 for help and ideas and data from MedPAC staff, is very
14 high. I think I'm correct about that.
15 DR. CHERNEW: And I have had the privilege -- you
16 know, I don't interact with the Hill staff as much as the
17 MedPAC staff does, but I have gone around with the MedPAC
18 staff and talked to the staff at the committees of
19 jurisdiction and some of the members. And I will say that
20 universally they are happy with our work, at least what
21 they've said. And my view is as long as they believe that
22 the information we're providing is useful, I believe the

1 information we're providing is useful, even when they may
2 not do what we say.
3 So anyway, I don't think this is worth
4 belaboring. We can have that conversation as much as we
5 want, but I think it's much more important for the purposes
6 at hand to talk about, we're about to talk about dialysis.
7 So I think we should all thank Kim for her
8 excellent work. We will continue to think about hospice
9 and what to do there, and we are going to move on to
10 dialysis.
11 [Recess.]
12 DR. CHERNEW: Okay. We're back, and to close us
13 out we're going to talk about the conversion factor update
14 for dialysis. And I think, Grace, you're going to start.
15 Go ahead.
16 DR. OH: Good morning. The audience can download
17 a PDF version of these slides in the Handouts section of
18 the control panel, on the right-hand side of the screen.
19 We would like to thank our colleague, Andy
20 Johnson, for his assistance with this work.
21 In this presentation, we will go over the
22 outpatient dialysis payment update for calendar year 2026.

1 We will begin with an overview of this payment system, then
2 walk through our payment adequacy analysis, and end with
3 the Chair's draft recommendation.
4 Outpatient dialysis services are used to treat
5 most patients with end-stage renal disease. Since 2011,
6 fee-for-service Medicare has paid dialysis facilities for
7 each treatment they furnish using a defined "ESRD bundle."
8 The bundle includes drugs, laboratory tests, and other ESRD
9 items and services. Medicare also pays an add-on payment
10 for certain new qualifying drugs, supplies, and equipment.
11 In 2023, there were roughly 262,000 fee-for-
12 service beneficiaries on dialysis, receiving, on average,
13 2.8 dialysis treatments per week, at around 7,700
14 facilities. Total fee-for-service spending for dialysis
15 services was about $8.1 billion.
16 While the Commission's payment adequacy
17 indicators pertain to Medicare's payments for dialysis
18 treatments provided to just fee-for-service beneficiaries,
19 the share of beneficiaries on dialysis enrolling in
20 Medicare Advantage has increased rapidly since 2021. In
21 2021, the 21st Century Cures Act permitted beneficiaries
22 with ESRD to enroll in MA plans without restriction.

1 Between December 2020 and December 2023, the
2 share of beneficiaries on dialysis enrolled in fee-for-
3 service declined from 73 percent to 48 percent as indicated
4 by the dark blue line on this graph. MA enrollment among
5 beneficiaries on dialysis, shown in orange, increased from
6 27 percent to 52 percent during this time.
7 Increasing MA enrollment by beneficiaries on
8 dialysis is likely linked to the same factors affecting MA
9 enrollment growth among beneficiaries without ESRD. These
10 include the availability of extra benefits, such as dental,
11 hearing, and vision services, and lower cost-sharing
12 liability.
13 In our payment adequacy analysis of Medicare's
14 payments for dialysis treatments provided to fee-for-
15 service beneficiaries, we look at the same indicators as in
16 all other sectors, including beneficiaries' access to care,
17 the quality of care, providers' access to capital, and fee-
18 for-service Medicare payments and provider costs.
19 One notable difference for this sector is that we
20 have more clinical information to examine quality of care,
21 including dialysis adequacy and anemia management, because
22 such data are reported on the claims dialysis providers

1 submit to CMS.

2 We assess beneficiaries' access to care by

3 examining the industry's capacity to furnish care as

4 measured by the growth in dialysis treatment stations.

5 Between 2022 and 2023, the capacity of freestanding, for-

6 profit facilities and those owned by the two large dialysis

7 organizations held steady. The 0.3 percent growth in in-

8 center treatment stations exceeded the growth in the number

9 of all Medicare beneficiaries on dialysis, fee-for-service

10 and MA, which declined by 1 percent per month during this

11 time.

12 Factors linked to the slowdown in capacity growth

13 in 2023 compared to 2019 to 2022, include excess mortality

14 among patients with ESRD during the COVID-19 pandemic, the

15 decline in the incidence of ESRD over the last decade, and

16 the increase in the use of home dialysis.

17 I will now turn it over to Nancy to go over the

18 remaining payment adequacy indicators.

19 MS. RAY: Another indicator of beneficiaries'

20 access to outpatient dialysis services is providers' fee-

21 for-service Medicare marginal profit. The 17 percent

22 marginal profit suggests that providers have a financial

1 incentive to continue to serve beneficiaries.
2 We also look at volume changes by measuring
3 changes in the use of ESRD drugs that are furnished to fee-
4 for-service beneficiaries on dialysis. We measure the
5 volume of ESRD drugs by holding price constant. Since the
6 PPS was implemented in 2011 and these drugs were included
7 in the payment bundle, providers' incentive to furnish
8 them, particularly erythropoietin stimulating agents, ESAs,
9 the black bar that treat anemia, has changed.
10 Much of the decline of ESAs, the black bar,
11 occurred in the early years of the PPS. The decline is a
12 function of factors that can include shifts to less costly
13 drugs within a drug group, changes in the share of
14 beneficiaries receiving a drug, and changes in the
15 prescription of a drug. Most recently, while use of ESAs
16 has remained steady, we see a shift to the use of epoetin
17 beta from epoetin alfa reference product between 2022 and
18 2023.
19 Competition for market share among drugs with
20 similar health effects is something that has occurred in
21 prior years, for ESAs as well as vitamin D agents, part of
22 the blue bar, and calcimimetics, the green bar. Under

1 prospective payment systems, providers have become more
2 judicious about the provision of services and, importantly,
3 CMS's monitoring program concluded no sustained negative
4 changes in beneficiary health status from the changes in
5 drug use over the years.
6 Quality is stable. Between 2022 and 2023,
7 measures of ED visits, admissions, readmissions, and
8 mortality held steady. The rate of hemoglobin levels and
9 blood transfusions, both anemia quality measures, also held
10 steady. An indicator that measures how well the dialysis
11 treatment removes waste from the blood, dialysis adequacy,
12 remained high in 2023.
13 And the rate of home dialysis among fee-for-
14 service beneficiaries on dialysis and the number of kidney
15 transplants across all patients increased. Home dialysis
16 has been linked to better quality of life and greater
17 independence than in-center treatment. And kidney
18 transplantation is widely regarded as a better ESRD
19 treatment option than dialysis in terms of clinical
20 outcomes and quality of life.
21 Regarding access to capital, indicators suggest
22 it is positive. The two large dialysis organizations have

1 reported positive financial performance related to their
2 dialysis business for 2023, including improvements in
3 productivity and earnings growth. In addition, both large
4 dialysis organizations are also vertically integrated,
5 suggesting good access to capital. The 2023 all-payer
6 margin was 15 percent.
7 Dialysis facilities' financial performance under
8 the ESRD PPS has been variable due to statutory and
9 regulatory changes as well as the use and profitability of
10 certain ESRD drugs. For example, between 2018 and 2020,
11 the green bars, the add-on payment for calcimimetics
12 contributed to the increase in the aggregate fee-for-
13 service Medicare margin.
14 Since 2021, cost growth has been variable, the
15 gray bars. In 2022, higher labor and capital cost growth
16 than historical trends contributed to a decline in the
17 aggregate fee-for-service Medicare margin, while in 2023,
18 cost growth moderated. Throughout these periods,
19 beneficiaries' access to care has remained positive.
20 In 2023, the increase of the fee-for-service
21 Medicare margin to -0.2 percent from -1.1 percent in 2022,
22 is linked to moderate cost growth and because the growth in

1 the fee-for-service payment per treatment exceeded the
2 growth in cost per treatment.
3 The fee-for-service margin varies by treatment
4 volume. Smaller facilities have substantially higher cost
5 per treatment than larger ones. The lower Medicare margin
6 for rural facilities is related to their capacity and
7 treatment volume. Rural facilities are, on average, smaller
8 than urban ones. They provide fewer treatments. In your
9 mailing materials, we highlight that cost per treatment is
10 highly correlated with treatment volume.
11 The 2025 projected Medicare fee-for-service
12 margin is 0 percent. We project the 2025 fee-for-service
13 Medicare margin to modestly improve compared to the 2023
14 aggregate margin based on statutory payment updates in 2024
15 and 2025, historical cost growth, and the small reductions
16 in total payments due to the ESRD QIP and CMMI's ETC model.
17 Factors not considered that may have a material, positive
18 effect on future margins include the potential effect of
19 the add-on payments for ESRD drugs, in 2024 and 2025.
20 Here is a quick summary of the payment adequacy
21 findings. Access to care indicators are generally
22 favorable. Between 2022 and 2023, capacity as measured by

1 in-center stations held steady, while the number of
2 Medicare beneficiaries on dialysis declined. Quality is
3 stable. For example, in 2023, dialysis adequacy continues
4 to remain high and home dialysis continues to increase.
5 The 2025 Medicare margin is projected at 0 percent.
6 And this leads us to the Chair's draft
7 recommendation, and it reads:
8 For calendar year 2026, the Congress should
9 update the 2025 Medicare end-stage renal disease
10 prospective payment system base rate by the amount
11 determined under current law.
12 This draft recommendation will have no effect on
13 spending relative to current law. Based on current
14 estimates, this would increase the base payment by 1.7
15 percent. We expect beneficiaries to continue to have good
16 access to outpatient dialysis care and continued provider
17 willingness and ability to care for Medicare beneficiaries.
18 That concludes the presentation, and we look
19 forward to your discussion.
20 DR. CHERNEW: Nancy and Grace, thank you so much.
21 I think we'll start Round 1, and that's going to be Gina.
22 MS. UPCHURCH: First of all, Nancy, your history

1 with this is super helpful, and Grace, welcome.
2 A couple of quick questions for you. I'm so
3 happy you talked about the maximum out-of-pocket and what
4 that means for people, particularly that are in Medicare
5 Advantage plans, that are potentially switching plans in
6 the middle of the year.
7 So when people switch to Medicare Advantage plans
8 in the middle of the year, and we experienced this some in
9 my area, not only does the MOOP, the maximum out-of-pocket,
10 shift, but your contracts with vendors all get shifted
11 around. You have to go through the prior authorization
12 again. So when people switch plans, it creates some havoc
13 other than just the maximum out-of-pocket.
14 So what we've come to learn locally is that
15 sometimes -- well, first of all, CMS has changed the rule,
16 and I just gave Nancy some information about this. So next
17 year, people in Medicare Advantage plans -- this is the new
18 CMS rule -- will not be able to switch to a different
19 Medicare Advantage plan quarterly. They will only be able
20 to go from Medicare Advantage back to traditional Medicare,
21 or they can switch Part D plans. But people with low-
22 income subsidy, unless they're going to fully integrated

1 Medicare Advantage plan. That's my understanding of the
2 new CMS rule.
3 And I think there was some switching around for a
4 couple of reasons, for people. One was agents calling
5 people because they get bonuses for people signing on.
6 That's one thing. And I think CMS -- I don't know why CMS
7 did this, but I'm assuming they did it to stop some of
8 that.
9 But the second reason a lot of people switch is
10 to get the extra perks that some with some of the Medicare
11 Advantage plans. So you can use the $1,000 dental benefit,
12 and then you go to another plan and get another $1,000
13 benefit in the same year. So they were switching insurance
14 companies potentially. We see it, so we know that it
15 happens, but just to put it out there. So CMS limiting
16 that ability for people to switch around will hopefully
17 keep those MOOP -- because a lot of the maximum out-of-
18 pocket ends up being the obligation, as you pointed out, of
19 the Medicaid program as the payer, and to Medicare,
20 obviously.
21 The other thing I would just say, when people
22 turn 65, you do have a right to get a supplement or Medigap

1 policy, because you have six months from starting your Part
2 B or when you turn 65 if you've had Medicare before. But
3 people don't know that. So I think there needs to be
4 better outreach for people, especially with end-stage renal
5 disease, that they do have these rights when they turn 65.
6 They can be pooled with a Medicare supplement and pay a lot
7 less, and they just don't know about it.
8 On page 17, you talk about the special pricing
9 that goes for drugs, the add-on pricing, versus devices.
10 And there's a higher bar for covering devices than it is --
11 let me see if I can get to page 17 of our writing here, so
12 I can pull it up.
13 So in the footnote it says, "Unlike for new end-
14 stage renal disease drugs covered under TDAPA, a
15 substantial clinical improvement standard is used to
16 determine, for DPNIS, which is devices and such, do we know
17 why there's a difference there?
18 MS. RAY: So CMS did that in regulation. So I
19 don't misspeak, I will come back to you in January and talk
20 more about that. But they have declined to do it for
21 drugs. That's correct.
22 MS. UPCHURCH: Okay. And the last question, and

1 this is a broader question, but we have these two major
2 firms, and they're vertically integrating with drug
3 development, device development, AI. You know, it raises
4 the potential of conflict of interest, obviously, in my
5 opinion. It's also, you know more about it so you're
6 developing things. So there's this tradeoff of, you know,
7 it's your field.
8 But I'm just wondering if there's a sense of
9 conflict of interest or if it's a positive sort of spin
10 that these companies are not just providing the service
11 for hemodialysis or peritoneal dialysis but they're doing
12 other things.
13 Conflict of interest for Medicare, in other
14 words, if you're giving somebody hemodialysis, you're
15 giving peritoneal dialysis, and there are these added
16 expenses with these new technologies, it could potentially
17 raise a conflict of interest in my mind. Just like an
18 orthopedic surgeon running a physical therapy clinic.
19 MS. RAY: Right. So certainly with the vertical
20 integration and one of the large dialysis organizations is
21 a manufacturer of drugs that maybe in the future would get
22 an add-on or device. There is certainly that potential.

1 MS. UPCHURCH: I think we just need to keep an
2 eye on that. Thank you for this great work.
3 MS. KELLEY: Robert.
4 DR. CHERRY: Thank you for the very clean
5 presentation. A very nice job on the report, as well.
6 Just to put some context to my question, I'm just
7 kind of thinking a few years ahead so there's no immediacy
8 here, just really more curious than anything else.
9 A large part of our decision-making is based on
10 the fee-for-service Medicare margin, but that's only 50
11 percent of the population. The other 50 percent is MA. I
12 was just wondering, in this particular sector, what is the
13 level of difficulty in obtaining the margin for MA
14 patients? I was just really curious to know. Because as
15 we start thinking in the future about how to collapse these
16 things, it's good to know what the data barriers are for
17 obtaining that information.
18 MS. RAY: So MedPAC has used the encounter data
19 to look at Medicare payments. And my colleague, Andy
20 Johnson, who did that --
21 DR. CHERRY: Come on up, Andy.
22 MS. RAY: -- is coming up.

1 DR. JOHNSON: Thanks, Robert. Can you say it
2 again was the question about what the data are?
3 DR. CHERRY: Yeah. I'm just curious. For the MA
4 patients, in particular, for this sector, what are the
5 barriers to pulling together a report that says something
6 about what the margins are for MA patients on dialysis?
7 DR. JOHNSON: So we have some information about
8 what MA plans pay to dialysis providers from the encounter
9 data, and we're working to update that analysis in the
10 future.
11 I guess the barrier to coming up with an MA-
12 specific margin would be to figuring out how to coordinate
13 that revenue information with the cost side for MA
14 patients, but I'm not sure if we can fully disentangle that
15 information from the cost reports.
16 MR. KAN: So on that point, MA plans typically
17 lose money on ESRD members.
18 DR. CHERRY: So how would MedPAC staff know that?
19 DR. JOHNSON: We did look at the bid information
20 that plans submit, and there are breakouts for the ESRD
21 population within a plan. And the year that we looked at
22 it was a few years ago now. And the revenue for the ESRD

1 population compared to the plans' costs for their ESRD
2 population, for the medical costs, was similar, but there
3 was a lot of variation. And we were not able to directly
4 include the administrative costs for those ESRD patients
5 because that's an average across the entire plan
6 population.

7 DR. CHERRY: Probably there are some health plans
8 that have greater data on this. Yeah, so thanks.

9 MR. MASI: And this is helpful to keep in mind,
10 and we'll keep this in mind going forward. Just to tease
11 out one thing Andy said, specifically when we looked MA
12 payment rates for beneficiaries on dialysis, I think we
13 found that differential was roughly 18 percent. Andy, can
14 you remind me?

15 DR. JOHNSON: 14.

16 MR. MASI: 14. That's why Andy's here and not
17 me.

18 DR. JOHNSON: The average MA payment rate
19 compared to fee-for-service was about 14 percentage points
20 higher.

21 DR. CHERNEW: This is an area --

22 DR. CASALINO: Higher. And the reason is that

1 because there's two dialysis companies.

2 DR. JOHNSON: Yeah.

3 DR. CHERNEW: This is an area where the fees
4 diverge between MA and fee-for-service, for reasons that
5 were discussed. But I think there's a separate risk
6 adjustment model for ESRD. But if I understand correctly,
7 it's calibrated on TM, which would mean it would have TM
8 prices in the risk adjustment model, and then it's applied
9 to MA. And whereas in most cases the prices are kind of
10 similar, here I think you would worry about that
11 difference. And maybe Andy can correct me. But that's, I
12 think, sort of explaining in part what's going on in this
13 context.

14 And again, that's an important issue. It's a
15 separate issue. I understand that issue. If I don't, tell
16 me. But in our update recommendations, I should say more
17 broadly, in every sector there's unique MA things, and with
18 the growth of MA we have started a whole series of work to
19 think about how we think through that, which I think is
20 important. That is a bit where we're going in this
21 particular case. The other cases might be different by
22 sector.

1 But our update recommendations are really focused
2 on the fee-for-service rates, and the MA nuance, which I
3 don't want to be dismissive of, is probably outside of our
4 update discussion, but it's not outside of our general
5 purview.
6 DR. CHERRY: Thank you. That was very helpful.
7 MS. KELLEY: Scott.
8 DR. SARRAN: Very nice. Very nice work, Nancy
9 and Grace. Do we have any insights into any pockets of
10 access geographically? Anecdotally, I heard that is the
11 case in some locations where, although we show overall that
12 there's capacity, that there may be challenges in some
13 locations.
14 MS. RAY: So can you say a little bit more about
15 this?
16 DR. SARRAN: And this is anecdotes, and Brian and
17 others would point out we don't want to make policy by
18 anecdotes, and appropriately so. I'm hearing concerns
19 sometimes from hospitals being able to place people upon
20 discharge who have gone on dialysis during a hospital stay,
21 and then need to be transitioned to an outpatient dialysis
22 center, similarly challenges with MA plans, securing

1 access.

2 So I'm just wondering if there's overall

3 information, overall data, showing adequacy reflects a mix

4 of some markets, and pockets of geography within markets,

5 where there's, yes, adequacy on one hand, but gaps on the

6 other?

7 MS. RAY: Right. So most of our measures are

8 done at the national level. I will say that roughly, in

9 2022, continuing in 2023 and 2024, in certain markets there

10 has been either closure of facilities or facilities

11 merging. And that's highlighted in the chapter,

12 highlighting what the two large dialysis organizations have

13 reported.

14 So I guess that is potentially one item that we

15 can look into further.

16 DR. MILLER: Just on point response and agree

17 with Scott on not wanting to make policy based on

18 anecdotes. I think the question is have we measured ESRD,

19 HD chair access in the post-acute care setting. For

20 example, in SNFs, IRFs, et cetera, like if the patient gets

21 discharged to those settings do they have access to HD, or

22 is that a barrier to discharge? Do they have that access

1 also in the long-term care setting, and what does that
2 access look like? And then what does that access look like
3 in rural settings, especially with drive time?
4 DR. SARRAN: And just to put a finer point on the
5 concern, in many other sectors -- home health, hospice, for
6 example -- it's really easy, as we've seen, for somebody to
7 enter the market as a provider. It can happen with little
8 capital investment and little time on the front end.
9 Dallas is very capital intensive. Hence, they're
10 only essentially the main place with only two players. And
11 if they've got all their chairs booked at a different
12 facility then expanding their capacity, even though they
13 clearly, the two big players, have access, expanding their
14 capacity isn't easy. It's as if the analogy would be if
15 every hospital were running at 100 percent capacity,
16 there's no flex, right.
17 MS. RAY: And so we certainly do report changes
18 in in-center treatment stations and facilities for urban
19 areas and three or four types of rural areas. And I think
20 the other thing to keep in mind, and clearly it is not an
21 option for all individuals on dialysis, but there is, of
22 course, the potential for home dialysis, as well. And

1 trying to accurately measure that capacity is a little bit
2 different than measuring the capacity of in-center
3 treatment stations, and how that home dialysis capacity
4 augments in-center in certain markets.
5 DR. SARRAN: Thanks very much. And I'm not
6 suggesting new work. I'm just asking a question. And your
7 last point, I think, is very valid, which is that as the
8 use case and the comfort with home dialysis increase, as
9 most people believe it will, that may make capacity issues
10 moot.
11 MS. KELLEY: That's all I have for Round 1, Mike.
12 Shall we go to Round 2?
13 DR. CHERNEW: I do, and I think --
14 MS. KELLEY: Before we start, I wondered if I
15 could just read Cheryl's Round 2 comment into the record,
16 which is that she supports the recommendation.
17 DR. CHERNEW: Thank you. And I think Brian is
18 the first one in Round 2.
19 MS. KELLEY: Yes.
20 DR. MILLER: And I'm just going to preface my
21 comments by saying that there are many challenges with the
22 dialysis market, including its duopoly structure. So my

1 comments should not be interpreted to disregard any of
2 those concerns.
3 I agree with Gina that more beneficiary education
4 is needed, but the financial costs of end-stage renal
5 disease and the associated hemodialysis have probably
6 driven beneficiaries into the Medicare Advantage
7 marketplace after the 21st Century Cures Act passed. MA
8 plans functionally, for an ESRD bene, are highly appealing
9 because they're offering more affordable Medigap coverage
10 and PDP coverage in exchange for a network and some
11 utilization review.
12 I agree that those tradeoffs need to be made
13 clearer to beneficiaries, which is why we need to improve
14 the Plan Finder and provide more information to
15 beneficiaries, which my colleague, Lisa Graber, who used
16 to work at CMS, has advocated for.
17 I also wanted to note that the issues of
18 conflicts in vertical integration aren't necessary as
19 simple as some of us would see. An orthopedic surgeon
20 owning a physical therapy clinic could actually promote
21 customized and integrated care. And it's confusing to me
22 as to why we think a physician should not be able to own

1 something, or a small physician practice, but it's okay for
2 a large hospital to own and require internal referral from
3 their employed orthopedic surgeon to their owned and
4 operated physical therapy clinic.
5 So I wouldn't necessarily presume to say that the
6 small physician-owned practice is somehow worse than that
7 tax-exempt, multibillion-dollar corporation. Nor would I
8 necessarily assume that the tax-exempt, multibillion-dollar
9 hospital corporation is worse than the physician-owned
10 enterprise. Rather to say that the concerns about self-
11 referral and the vertically integrated setting need to be
12 focused on patient outcomes, cost, and obviously medical
13 quality and beneficiary experience, which is something that
14 we traditionally, in health policy, have not focused on.
15 And I think that the dialysis market is
16 interesting, because the 21st Century Cures is a natural
17 experiment for us in patient selection. And we saw that
18 after 21st Century Cures passed, from data, that the ESRD
19 pot share that enrolled in Medicare Advantage rose from 27
20 percent -- so about a quarter -- to 52 percent, slightly
21 over half, in about three years, I believe, which is the
22 same share, if not 1 percent higher, than the general

1 Medicare Advantage share of the Medicare population.
2 I can say, as a physician, I don't know of a
3 healthy end-stage renal disease beneficiary. You don't get
4 end-stage renal disease. You know, you could have IgA,
5 anything from IgA nephropathy to uncontrolled diabetes.
6 All of those have effects.
7 This population is not profitable for the plans.
8 I don't think the plans are driving a combine harvester
9 through the dialysis centers looking to pick up profitable
10 ESRD benes. I think it's really the affordable Medigap and
11 PDP coverage which is driving them to enroll into this
12 marketplace, and I don't think that there's favorable
13 selection in this marketplace by MA plans.
14 Which actually suggests that our broader MA
15 analysis, that we do as part of our annual status report,
16 as I have mentioned multiple times before and written
17 about, does not pass the test for internal validity with
18 our own dataset, and is, in fact, fatally flawed.
19 From an access perspective, I agree with Scott's
20 concerns about access. I also realize it is not easy for
21 us to measure access. Access could be a post-acute care
22 access issue. It could be a rural issue. It could be an

1 urban issue. You have to get to dialysis. It's not
2 optional for you to go to dialysis. You have to go. And
3 if your dialysis chair times is during rush hour, that
4 network adequacy requirement is very different in the
5 middle of Manhattan versus, say, in suburban D.C. or rural
6 Virginia. Of course, rural Virginia could also be
7 challenging in the winter.
8 So I think that thinking about access for
9 dialysis chairs, for hemodialysis, is something that's
10 probably worthy of more analytical thought, and thinking
11 about how we measure occupancy is important. I also
12 recognize that clinically not everyone can participate in
13 home hemo, and PD or peritoneal dialysis is not an option
14 for everybody.
15 I think a couple of questions I have is, over the
16 past five years have any of our dialysis payment updates
17 differed from current law? And if you don't know, that's
18 okay.
19 MS. RAY: I don't think so. I mean, I'm not
20 willing to bet my house.
21 DR. MILLER: That's okay. I'm not going to bet
22 my house either. I like my house.

1 MS. RAY: Yeah, I like my house. I don't think
2 so.
3 DR. MILLER: Okay. And then what is the expected
4 CPI for 2024, or the 2025 CPI, consumer price index,
5 inflation?
6 MS. RAY: You mean the ESRD market basket.
7 DR. MILLER: No. Even before that I'm asking
8 what is the CPI for this year?
9 MS. RAY: I don't know that. I know what the
10 ESRD market basket is.
11 DR. MILLER: And what is the ESRD market basket?
12 MS. RAY: It was, for 2026, it's 2.3 percent, and
13 then there's the productivity offset of 0.6 percent.
14 DR. MILLER: Gotcha.
15 MS. RAY: And that's how I think we get to --
16 DR. MILLER: Oh, 1.7 percent? The CPI, I think,
17 is around 2.7 percent, and our expected projected Medicare
18 margin per our table for 2025 is 0 percent. Our 2023
19 Medicare margin is 0.2 percent. I realize we're
20 recommending the current law, which is 1.7 percent. I
21 don't have a final opinion on this as of yet, but I wonder
22 -- and again, I recognize there are a litany of challenges,

1 policy, operational, statutory, regulatory, with this
2 marketplace, anti-trust concerns too.
3 But I worry if that update is adequate, given
4 that we are projecting a margin of 0 percent for Medicare,
5 0.2 percent in 2023, and multiple Commissioners have
6 expressed concerns and questions about how we are measuring
7 hemodialysis chair occupancy, and whether there are
8 significant unmeasured access issues. Thank you.
9 MS. KELLEY: Scott.
10 DR. SARRAN: I support the draft recommendation
11 and just have one brief comment, and Gina kind of teed this
12 up.
13 I think we need to stay alert to the challenges
14 of understanding the true margins of duopoly players who
15 are increasingly vertically integrated. It's analogous to
16 the nursing facility discussion, where somebody owns the
17 nursing facility, somebody else owns the real estate,
18 they're all related entities, there's all sorts of
19 corporate transactions that occur, and it obscures the
20 ability for us to look and understand the true performance.
21 So I think we're going to see increasing
22 challenges where, for example, it is possible that a

1 duopoly player who is vertically integrated could easily
2 show that they're performing at a low or negative margin,
3 but that's driven by profits being pulled out by a related
4 entity who is selling supplies, these varies types of
5 supplies, drugs, or services to the actual corporate
6 dialysis provider. So we need to be alert to that.
7 MS. KELLEY: Kenny.
8 MR. KAN: Intellectually stimulating chapter.
9 Thank you. I am neutral about the recommendation for now.
10 I'm a strong plus-one on Robert's suggestion to strongly
11 consider that future payment update recommendations reflect
12 the 52-plus percent share, and growing, in MA.
13 MA plans typically lose money on ESRD members,
14 despite the differential rate, the risk model, and
15 payments. As Brian expressed, I am concerned that MA, plus
16 could actually be subsidizing fee-for-service on this.
17 So I'm still mulling what to do on this payment
18 update recommendation, but definitely for future years we
19 may have to seriously look at higher fee-for-service
20 payments above current law. Thank you.
21 MS. KELLEY: Larry.
22 DR. CASALINO: I do support the Chair's

1 recommendation, and just as a brief add-on comment, we've
2 had various discussions within the Commission about
3 consolidation and what role, if any, the Commission has in
4 dealing with it. And my take, at least, on where we stand
5 at the moment, or at least where I stand, is that we can do
6 or not do chapters on consolidation. We had one a few
7 years ago. But also, we can, or not, bring up
8 consolidation and impacts of consolidation whenever it
9 seems relevant, in any discussion we have.
10 And so I think it's great that you guys pointed
11 out here that MA plans pay 14 percent higher than fee-for-
12 service to ESRD providers, when we know that in most other
13 sectors they pay less than fee-for-service, or the same as
14 fee-for-service.
15 So you mentioned that, but I'd really like to see
16 it called out, and even in just a sentence, more
17 explicitly, that this is going on, and it's because there's
18 a duopoly.
19 And I'm using this as kind of an example about I
20 think what we can do. That's really kind of important that
21 they pay more than fee-for-service. And the reason for it
22 is obvious, and I don't think we should shrink from

1 stressing that.

2 And just one more editorial comment. I don't

3 think it's something that belongs in this chapter. It is

4 beyond me -- I mean, maybe not beyond me -- how the FTC

5 allowed this duopoly to come into existence. I imagine

6 it's because most of the acquisitions were below the Hart-

7 Scott-Rodino thresholds, and they could just keep gobbling

8 them up. The FTC has announced, during the last four

9 years, that they're going to look at serial acquisitions

10 like that, even if they're below the threshold, and their

11 effect, not just here but in other sectors, as well.

12 Whether that will happen now with new anti-trust

13 administrators, we'll see. Anyway, that's an editorial

14 comment.

15 But I think it would be easy to just add a

16 sentence or two, stressing that the reason they pay 14

17 percent more is there's a duopoly.

18 MR. MASI: So I think Brian wants to get in here,

19 but I would also encourage folks to keep the conversation

20 on the dialysis updates. I know there is an interest in

21 Brian getting in here, as well.

22 DR. MILLER: Just briefly, most of them did meet

1 the HSR threshold.
2 DR. CASALINO: They did?
3 DR. MILLER: They did.
4 DR. CASALINO: And less explicable how this could
5 happen, yeah.
6 MS. KELLEY: That's all I have for Round 2, Mike.
7 DR. CHERNEW: Right. So I know now how to
8 probably go around, because I can just look at my list
9 instead of trying to go in order for the room. It took me
10 like several sessions to figure that out. I'm a little
11 slow.
12 So if I go through, Larry, I think you just said
13 you were in support of the recommendation. So going
14 through, that leads us to Robert.
15 DR. CHERRY: Yes. So I support the
16 recommendation. I think eventually we need to figure out
17 how to produce operating margins for MA patients as well as
18 fee-for-service, but that's more long term.
19 DR. CHERNEW: Yeah. I'll say something about
20 that in a second. I'm just going to go down this list.
21 Stacie spoke, I think.
22 DR. DUSETZINA: Thank for this work, Nancy, and

1 welcome, Grace. I support the recommendation.
2 DR. CHERNEW: Kenny. Tamara?
3 DR. KONETZKA: I support the recommendations and
4 the suggestion to continue monitoring the duopoly,
5 especially how it actually affects these calculations.
6 DR. CHERNEW: Josh?
7 DR. LIAO: Thank you to both of you. I agree
8 with other workstreams for this activity. I support it.
9 DR. CHERNEW: Actually, so Brian, did you say how
10 you felt about the recommendation? I'm sorry if I --
11 DR. MILLER: I said I am uncertain.
12 DR. CHERNEW: Okay. You're also uncertain. And
13 Amol?
14 DR. NAVATHE: I support the recommendation.
15 DR. CHERNEW: Greg?
16 MR. POULSEN: Support.
17 DR. CHERNEW: Betty?
18 DR. RAMBUR: I support the recommendation. I
19 have just one quick comment. I do also hope that we can
20 look at the issue that Larry has raised and Tamara
21 supported, as well, and Scott's comments.
22 I just want to ask if we have any sense, in terms

1 of this paradox of excess supply and then gaps in supply,
2 if there is still overuse of dialysis at the end of life?
3 This was a personal experience I have. I know we don't
4 make policy by that. But if there's anybody looking at
5 that in terms of sort of supplier-induced demand, not for
6 this piece. But it's been my personal experience, so maybe
7 it's a regional piece, that people are offered dialysis
8 when their kidneys are failing because they're dying, and
9 it's not palliative.
10 So that's a concern to me. It creates suffering
11 at the end of life. And it's not really part of the update
12 but it is part of the supply and demand issue.
13 I support the recommendation. Thanks.
14 MR. MASI: And on that, I appreciate that
15 feedback. And Nancy, I think we have some work ongoing and
16 planned for the spring on the overlap between ESRD
17 beneficiaries and hospice.
18 DR. RAMBUR: Thank you.
19 DR. CHERNEW: Gina?
20 MS. UPCHURCH: I support the Chair's
21 recommendation. I did think of one other sort of more
22 Round 2 question. So we know that it saves money and it's

1 obviously better for people to have the transplant, a
2 living donor, potentially. And there was some legislation,
3 and I can't remember if this has been in our work before,
4 to support living donors, like paid time off, this kind of
5 thing. Can we include that, and maybe I missed it somehow.
6 Is that something that we're helping support, as a policy?
7 MS. RAY: So we can look into that. There is
8 also, I think, the recent CMMI model that's been finalized
9 on kidney transplants, that we can also, I think, include
10 it in the chapter, if it's not already in there. I don't
11 think it is in there.
12 MS. UPCHURCH: That would be great. We know too
13 many people that go through grueling -- I mean, it's a
14 grueling life, really, and a lot of exhaustion and stuff.
15 For quality of life purposes I would love to learn more
16 about transplants. Thank you.
17 DR. CHERNEW: Wayne.
18 DR. RILEY: I support the recommendation.
19 DR. CHERNEW: And Scott.
20 DR. SARRAN: Yeah, I support it.
21 DR. CHERNEW: You did. Sorry.
22 All right. So I'm going to wrap up in a second,

1 but first, lest I forget, for those of you at home, thank
2 you very much for joining us. You can reach out to us at
3 meetingcomments@medpac.gov, or in any other way. We do
4 want to hear from you. To Grace and to Nancy, thank you so
5 much for all this analysis. Beneficiaries that are using
6 dialysis services really do need to have access. The
7 consequences of not having access are really severe, and we
8 appreciate all the work that you've done in this space.
9 So two general things, just about where we are,
10 to think through. Thing number one, I do think the access
11 issue is a key. I think in order to justify more than a
12 current law or recommendation -- so the default is sort of
13 current law. Brian asked about principles, so we'll sort
14 of start at current law. We asked is there anything in
15 there that says more or less than current law. What would
16 be less than current law? A very high margin. We don't
17 have that here, so we wouldn't go below current law. What
18 would say more than current law? Some version of we have
19 real access problem and we need to pay more to induce that
20 access. So we would both have to see the access problem
21 and believe that the payment would solve it.
22 I appreciate your point that there might be some

1 issues of access, but at least I think, I'll go back and
2 talk with Nancy and Grace and the staff. But I think our
3 general sense is there's not access problems that are at
4 the level that we've considered an issue. And if there
5 was, that would be certainly a reason to pay more.
6 The other issue, which I think is also important
7 and has come up a lot, is the issue around Medicare
8 Advantage and how we think about the Medicare Advantage
9 market here. And I think that is actual crucial. And as I
10 said before, we are thinking about that across the board.
11 However, my general view is to the extent that the core
12 problem here is that the Medicare Advantage plans are
13 paying more than traditional Medicare, because of market
14 dynamics, if that's what we think the core problem is, the
15 solution strikes me as not we should just pay these
16 organizations more because they're exercising their market
17 power in fee-for-service. We should think through how to
18 deal with that in the Medicare Advantage market. And
19 again, I think that's actually quite important, so I think
20 it's worth doing that.
21 For the purpose of the date, I don't think the
22 sort of logic of, well, Medicare Advantage is losing and we

1 need to pay more is a logic that at least resonates with
2 me. But again, that would be a discussion we would have to
3 have in a separate cycle issue, which I think we're going
4 to continue to have to have, about how MA plays out.
5 So I won't claim to have thought through all of
6 the sort of policy options around how to think about what
7 seems to be some challenges in the Medicare Advantage
8 market for dialysis, but I will say, although there's a
9 bunch of other things that are terrific about MA, and I
10 think I've said repeatedly that I think MA provides care
11 and services less than overall, less than I think fee-for-
12 service does -- we could debate that, and I'm sure we will
13 next month. I think the broader point is in this case,
14 because of the price reason, if you just narrowly focus on
15 dialysis, it's probably more efficient to be in TM, because
16 the prices are just a lot lower. The MA plans, I do
17 believe in this market, are at a disadvantage for that
18 reason, which we had that discussion.
19 But anyway, I'm not going to belabor that because
20 I think that's a little bit outside of the update
21 recommendation. So I am going to conclude with a Happy,
22 Happy Holidays to everybody. Please be safe. Travel safe.

1 Otherwise be safe. I hope you enjoy whatever holiday
2 traditions you have. That goes for the Commissioners, for
3 the staff, and for those at home. And remember,
4 meetingcomments@medpac.gov.
5 With that we are adjourned, and we will come back
6 in January and see you all then.
7 [Whereupon, at 11:45 a.m., the meeting was
8 adjourned.]
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