MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[11:31 a.m.]

DR. CHERNEW: Hello, everybody, and welcome to the December MedPAC meeting. As is tradition, we will be having our initial discussions about the update recommendations which will appear in the March report. There are a lot of fee schedules, and so there's a lot to discuss this month, and so without further ado, I'm going to turn the stage over to Alison. Alison, go ahead.

MS. BINKOWSKI: Thanks, Mike, and good morning, everyone. The audience can download a PDF version of these slides in the handout section of the control panel on the right-hand side of the screen.

This presentation is in four sections:

First, we will provide an overview of MedPAC's payment adequacy framework, including the effects of the coronavirus public health emergency on our indicators.

Second, we will use this framework to assess the adequacy of fee-for-service Medicare payments for hospital services.

Third, we will provide results from a mandated report on modifying the low-volume hospital payment adjustment.

And, finally, we will present the Chair's draft recommendation for fiscal year 2023 updates to base payment rates for acute-care hospitals.

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

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

To assess the adequacy of Medicare payments, we start with the most recent available and complete data, which this year is generally 2020, and include preliminary data for 2021 when possible. We also project a Medicare margin for fiscal year 2022 using current law.

Based on these indicators, we develop the Chair's draft update recommendation for Medicare's base payment rates to acute-care hospitals, which for this year will be 2023.

A key difference from most prior years, both for hospitals and all other sectors, is the coronavirus public health emergency which has had tragic and disproportionate effects on Medicare beneficiaries and on the health care workforce.

From the perspective of assessing the adequacy of Medicare payments, the PHE has also had material effects on our payment adequacy indicators. Therefore, though analyzing 2020 data is important to understand what happened to indicators of beneficiaries' access to care, the quality of that care, providers' access to capital, and Medicare payments and providers' costs, it is more difficult to interpret these indicators than is typically the case. For example, mortality rates increased in 2020, but this reflects the tragic effects of the pandemic on the elderly rather than a change in the quality of care provided to Medicare beneficiaries or the adequacy of Medicare payments.

As another example, Congress provided substantial relief funds to health care providers, but the extent to which these funds were recorded in providers' cost reports varied based on their cost reporting period, and providers may still return some 2020 funds.

As the Commission stated last year, to the extent the coronavirus effects are temporary, even if over multiple years, or vary significantly across providers, they are best addressed through targeted temporary funding policies rather than a permanent change to all providers' payment rates in 2023 and future years.

The considerations on this slide apply to all the upcoming payment adequacy presentations.

Congress and HHS responded to the unfolding coronavirus pandemic by providing substantial support to health care providers through both all-payer funds and Medicare-specific policy changes.

In terms of all-payer relief, Congress provided two key types of support: over $178 billion in provider relief funds, which HHS has dispersed through a combination of general distributions to all providers and targeted distributions to certain types of providers; and approximately $100 billion in paycheck protection program loans to small health care providers.

Congress and HHS also implemented Medicare-specific changes to increase payments and beneficiaries' access to care, including: the suspension of the 2 percent sequestration on Medicare payments; sector-specific

Medicare payment increases, such as the additional 20 percent in payments for COVID-19 inpatient stays; and various sector-specific waivers to increase Medicare beneficiaries' access to care, such as flexibility for telehealth services.

As will be described in more detail in each of the presentations this meeting, collectively the federal support provided to date has generally maintained, if not improved, providers' financial performance in 2020, and more funds remain to be distributed in 2022.

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

FFS Medicare's payment rates for hospital inpatient and outpatient services are generally set under the inpatient prospective payment systems and the outpatient prospective payment system.

In 2020, about 3,150 hospitals paid under the inpatient PPS received over $104 billion for 7.5 million inpatient stays.

About 3,600 hospitals paid under the outpatient PPS -- all inpatient PPS hospitals and some specialty hospitals -- received $60.2 billion for 78.1 million outpatient visits.

Turning to our assessment of the payment adequacy, our first category of Medicare beneficiaries' access to hospital care.

One measure of beneficiaries' access to hospital care is hospitals' inpatient occupancy rate.

In 2020, hospitals continued to have excess inpatient capacity in aggregate, with an occupancy rate of 62 percent, indicating that about two-thirds of inpatient beds were occupied, consistent with prior years.

However, occupancy rates varied by state and month, including some states nearing their inpatient or intensive care unit capacity limits in certain months as COVID-19 cases peaked in their areas.

To help address hospital capacity constraints, CMS enacted numerous waivers for the duration of the public health emergency, including allowing hospitals to provide inpatient care in temporary expansion locations. Additional waivers are discussed in your mailing materials.

A second indicator of beneficiaries' access to hospital care is changes in the supply of hospitals.

The number of hospital closures declined substantially in fiscal years 2020 and 2021, falling from 46 acute-care hospitals ceasing inpatient services in 2019, to 25 in 2020 and 10 in 2021. The substantial federal support provided to hospitals during the coronavirus pandemic may have contributed to the significant decline in closures.

In contrast to the number of closures, the number of openings has been more consistent, including 18 in 2020 and 11 in 2021.

A third indicator of FFS Medicare beneficiaries' access to hospital care is the volume of hospital services per beneficiary.

Both inpatient stays per capita and outpatient services per capita declined in 2020, driven by a large drop in the spring of 2020 as many hospitals suspended non-COVID care, followed by a partial rebound as beneficiaries and providers continued to postpone some care because of the COVID-19 pandemic.

For example, in April 2020, hospital inpatient stays per capita declined 40 percent relative to 2019, while outpatient services per capital declined 50 percent.

By June 2020, hospital volume had partially rebounded, but remained 10 to 15 percent below pre-pandemic levels through June 2021, with the slower rebound in inpatient services in part reflecting the long-term trend in the shift of services from inpatient to outpatient settings.

Our final measure of Medicare beneficiaries' access to hospital services is hospitals' marginal profit on inpatient and outpatient PPS services. In 2020, hospitals continued to have a positive marginal profit of about 5 percent, which while lower than in prior years indicates that hospitals with excess capacity continued to have a financial incentive to serve FFS Medicare beneficiaries.

In addition, hospitals' rapid response to the coronavirus pandemic has demonstrated that at least some hospitals can substantially decrease their costs when volume declines.

Shifting gears to the second category of hospital payment adequacy indicators, the quality of hospital care, the coronavirus pandemic makes it difficult to assess the quality of care provided to FFS Medicare beneficiaries in

2020.

As mentioned earlier, the change in measures in 2020 reflect temporary changes and data limitations unique to the PHE rather than trends in the quality of care. Further, some of the Commission's quality metrics rely on standard risk adjustment models that use performance from previous years to predict beneficiary risk, and COVID-19 is a new diagnosis that is not included in the current risk adjustment models.

With those caveats that the changes in 2020 cannot be used to draw conclusions about trends in the quality of care provided to Medicare beneficiaries and its relationship to Medicare payment adequacy, in 2020 mortality increased, readmissions declined slightly, and most patient experience measures declined slightly.

Turning to our third category of hospital payment adequacy indicators, hospitals' access to capital, we found that hospitals' access to capital remained strong in 2020, but hospitals' all-payer total margin declined.

IPPS hospitals' aggregate all-payer total margin declined from a record high of 7.6 percent in 2019 to 6.3 percent in 2020 -- a level similar to the 15-year average.

This margin includes over $32 billion in federal support reported on hospitals' cost reports, primarily through the Provider Relief Fund. Without this support, and assuming hospitals' costs remained the same, hospitals' net income would have declined about $50 billion in 2020, substantially less than AHA's estimate of over $320 billion.

While hospitals' all-payer total margin declined slightly in aggregate, the margin for rural IPPS hospitals and critical access hospitals reached near record highs. Rural IPPS hospitals' all-payer total margin increased from 5.9 percent in 2019 to 6.6 percent in 2020 -- the highest in over 20 years. And critical access hospitals' all-payer total margin increased from 3.6 percent in 2019 to a record high of 6.4 percent in 2020.

These record high margins reflect the targeted provider relief funds rural hospitals received, as well as how small rural hospitals were eligible for paycheck protection program loans.

2020 was a particularly anomalous year for hospitals' financial performance, as it coincided with the start of the public health emergency, including dramatic drops in volume and substantial federal relief.

While the PHE continued into 2021, preliminary data to date suggest that hospitals' all-payer margin strengthened in 2021. In particular, among the six largest hospital systems representing over 20 percent of IPPS hospitals, 2021 operating profits reported to date exceed pre-pandemic levels.

Therefore, while the effect of the coronavirus pandemic on hospitals' finances varied substantially across hospitals, we have no evidence that it has had a negative effect on hospitals' aggregate long-term access to capital markets.

Turning to our fourth category of hospital payment adequacy indicators, Medicare payments and hospital costs, we found that both Medicare payments per service and hospitals' costs per service increased substantially in 2020, but that costs per service grew faster.

This faster growth in costs per service primarily reflects factors unique to the public health emergency, including spreading fixed costs over fewer services and an increase in the complexity of services and needed supplies.

In addition, the higher outpatient growth than inpatient growth reflects the continued growth in separately payable drugs.

Turning to hospitals' overall Medicare margin, in 2020 IPPS hospitals' aggregate margin remained negative, but increased slightly when including Medicare's share of federal relief funds.

Because provider relief funds and paycheck protection program loans were intended to help cover lost revenue and payroll costs, including lost revenue from Medicare patients and the cost of staff that help treat these patients, for each sector where we have the data to calculate a Medicare margin, we include a portion of these federal relief funds in our Medicare margin, generally based on FFS Medicare's share of 2019 all-payer operating revenue.

Using this method for hospitals, we allocated $6.4 billion of the $32 billion in federal funds that hospitals reported on their cost reports towards hospitals' care of FFS Medicare beneficiaries.

With these allocated funds, IPPS hospitals' overall margin improved slightly from minus 8.7 percent in 2019 to minus 8.5 percent in 2020, while without these funds, and assuming all costs remained the same, the margin would have declined to minus 12.6 percent.

Because hospitals vary in the extent to which they control costs and provide quality care, the Commission also examines overall Medicare margins among relatively efficient hospitals -- those with consistently high performance on quality and cost metrics over the prior 3 years.

In 2020, the median overall Medicare margin among the hospitals we identified as relatively efficient over the prior three years was 1 percent when including Medicare's share of federal relief funds.

The relatively efficient hospitals also had better patient satisfaction, with 72 percent rating the hospital a 9 or 10 in 2020, compared to 69 percent for other hospitals. In addition, while mortality rates increased in 2020 at both relatively efficient hospitals and other hospitals given the effects of the pandemic, the relatively efficient hospitals continued to have a lower risk-adjusted median mortality rate than other hospitals.

The relatively efficient hospitals' lower costs per inpatient stay -- 91 percent of the national median --

allowed them to generate better Medicare margins than the comparison group.

As the last piece of our assessment of the adequacy of fee-for-service Medicare payments to hospitals and to help inform our projected margin for 2022 and the Chair's draft recommendation for 2023, we review current law updates to IPPS and OPS rates and other environmental changes.

After annual updates to hospital payment rates of 1.35 percent in 2018 and 2019, the annual update increased to 2.6 percent in 2020, and then declined to 2.4 percent in 2021, and 2 percent in 2022. The final update for 2023 will not be set until summer 2022, but CMS currently projects it will be 2.0 percent, including an estimated 3.1 percent growth in hospital wages and benefits.

In addition to these annual updates, federal support and PHE payment changes which began in 2020 continued into 2021 and at least some will continue into 2022, including over $25 billion in provider relief funds.

Based on 2020 and preliminary 2021 data as well as policy and environmental changes for 2021 and 2022, we project hospitals' overall Medicare margin for 2022 to be about minus 10 percent, exclusive of any relief funds, and that the median Medicare margin among relatively efficient hospitals will be near 0 percent.

These projected Medicare margins assume that decreased relief funds and uncompensated care payments will be roughly offset by decreased COVID-19 costs and increased Medicare volume.

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

First, in terms of FFS Medicare beneficiaries' access to care, while capacity was stressed at times and volume declined sharply in spring 2020, hospitals maintained excess capacity in aggregate, fewer hospitals closed, and hospitals continued to have a positive marginal profit on IPPS and OPS services.

Second, we cannot draw conclusions about quality in 2020 as measure changes reflect the PHE rather than changes in quality or payment adequacy.

Third, hospitals maintained strong access to capital thanks to substantial federal support, including targeted relief funds to rural hospitals which raised their all-payer total margin to a near record high.

Fourth, while hospitals' overall Medicare margin remained negative, it remained steady when including Medicare's share of federal support, the median margin for relatively efficient hospitals increased to positive 1 percent, and we project hospitals' Medicare margin in 2022 to be minus 10 percent, exclusive of any relief funds.

Turning to the third section of the presentation, I'll briefly present results from the mandated report on the low-volume hospital payment adjustment. More details are in your mailing materials.

The Bipartisan Budget Act of 2018 temporarily extended and modified the low-volume hospital payment adjustment in the IPPS for fiscal years 2019 through 2022 and mandated that MedPAC report on the effect of these changes.

For context, in 2001 the Commission recommended creating a graduated adjustment to the IPPS for low-volume, isolated hospitals, as hospitals with low volume lack economies of scale, and for those in low-population-density areas, their low volume is beyond their control.

Congress subsequently created and modified an LVH adjustment. The original criteria were generally consistent with MedPAC's recommendation. However, Congress subsequently modified and substantially expanded LVH eligibility, most recently in the Bipartisan Budget Act of 2018, which switched the eligibility from Medicare inpatient stays to all-payer stays but retained expanded eligibility and a statutorily set adjustment.

We found that the BBA of 2018 modifications to LVH policy modestly increased the number of LVHs, the average number of fee-for-service Medicare inpatient stays per LVH, and the average LVH adjustment; shifted the LVH adjustment towards hospitals with lower all-payer volume; and other results discussed in the mailing materials.

The change to LVH eligibility based on all-payer volume is consistent MedPAC's prior recommendation, but concerns remain about the expanded eligibility and statutorily set adjustment.

Allowing the LVH modifications to expire and revert to the original 2005 criteria would preserve the BBA's basing the adjustment on all-payer volume and allow CMS to calibrate an adjustment to an empirically justified amount.

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

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

Furthermore, as we mentioned previously, to the extent the coronavirus public health emergency continues, any needed additional financial support should be separate from the annual update and targeted to affected hospitals that are necessary for access.

With that, the Chair's draft recommendation reads: For fiscal year 2023, Congress should update the 2022 Medicare base payment rates for acute-care hospitals by the amount determined under current law.

Maintaining the current law update would not change spending relative to current law.

In addition, we do not expect the recommendation to affect beneficiaries' access to care or providers' willingness to treat Medicare beneficiaries. Rather, we anticipates that a current law update to hospital payment rates in 2023 would be enough to maintain beneficiaries' access to hospital inpatient and outpatient care and keep IPPS and OPPS payment rates close to hospitals' costs of efficiently delivering high-quality care.

MS. BINKOWSKI: And with that I turn it back to Mike.

DR. CHERNEW: Great, Alison. Thank you so much. This is such a challenging year, both for our work, and I just want to emphasize for those listening that we are really very aware of the challenge that the delivery system has faced during the public health emergency, and really appreciative and recognize the importance of all of the work. That is true for all of the providers. I just wanted to say at the onset of this meeting that we are very aware of both the human toll and the challenges that everyone in the sector and more broadly has faced.

That said, we are now going to jump into

comments, and Dana, I am going to let you run the queue.
And I think, Brian, you are up first with Round 1.

MS. KELLEY: That's right.

DR. DeBUSK: Thank you, Michael, and thanks to the staff for an excellent report. I realize how difficult it would have to be this year to try to capture some of these costs and make an update.

I have a quick Round 1 question, then I'll save most of it for Round 2. But I know the actual market basket value will be determined -- I think the drop-dead date is September of 2022. And my two questions related to that -- or summer of 2022 -- how precise is that date? I know it corresponds with the comment letter and some finalization of the rule, but I'm curious. When is the drop-dead date on that market basket factor being finalized in summer of 2022, and how far back do they go on that date? I mean, would data as early as the spring of 2022 be available for calculating that market update, or is there a lag in that data as well?

Thank you. Those are my only questions.

MS. BINKOWSKI: I can start with that. It is finalized in the summer of 2022, and as of the date of the final rule, which does vary a little bit. It is based on the most recent quarter of available data as well as projections for the months or quarters that they have partial data on.

DR. DeBUSK: So would there be then a one-quarter lag, at most? What I'm getting at, and I'll do this in Round 2, I'm just curious as to how contemporary and how timely the market basket information is incorporated into the next year's update.

DR. STENSLAND: I think one important thing to remember is this is the economists' forecast of what the rate inflation will be. So in August of 2022, they may forecast that labor rates rise significantly faster than they did in the second quarter of --

DR. DeBUSK: Thank you. Jeff, thank you. That was exactly what I was curious about. Thank you.

MS. KELLEY: Lynn.

MS. BARR: Good morning, everyone, and thank you, staff. It was really a tremendous effort on your part to pull together recommendations for this year. I have three Round 1 questions.

One of them is, when you're looking at the margins, are you also including loans against -- you know, so the loans that they got against future billings to Medicare? I can't remember what those were called. But are there any repayable loans that are included in that margin?

MS. BINKOWSKI: So it does not include any of the advanced or accelerated payments from the Medicare program that do need to be repaid. It does include certain Paycheck Protection Program loans that have been forgiven to date. The extent to which some of those loans are forgiven and the extent to which hospitals may return certain provider relief funds could change moving forward, but they are only including forgivable amounts as of now.

MS. BARR: That sounds very reasonable. The PPP loans shouldn't be an issue.

One of the things that you mentioned in your report was there was a significant increase in the drive-bys of rural hospitals. I believe it went from 40 to 48 percent. Jeff, do you recall that in the report? And my question is, do we know why, you know, that there has been such a substantial increase? What are the drivers of that?

I'm curious because, you know, it could be that they have to pay more. It could be quality. It could be a lot of things. And I was just wondering, do we have insight, because it's bad for Medicare, if the volume goes down in those hospitals, costs go up, right? I mean, it's not good. So I was curious if we have any understanding of why that is happening.

DR. STENSLAND: This, I think, goes back to our rural report, and we did see a lot of bypass, and particularly with the closed hospitals, and over time we have seen more and more. And I can just talk on a few things that contribute to it, but I can't pinpoint exactly how it all adds up.

At one point, a long time ago, you used to see heart attacks treated in some of these small, rural hospitals with thrombolytics, and you just don't see that very much anymore. They are helicoptering people out to someplace that can do reperfusion.

You also have some difference, I believe -- and this is more speculative -- in the way a lot of these rural hospitals' emergency rooms are staffed. At one point it was the primary care physicians that largely staffed the emergency care room in the rural community, and more and more you have people coming in to staff, either some locums or sometimes you'll have ER doctors come from the urban area out to the rural area and then see those people. And I believe there is some anecdotal evidence, and we talked to some of the hospitals, that they feel these ER doctors from the outside might stabilize and transfer more people than the physicians used to themselves.

You know, I could see a primary care doctor having greater faith in their ability to manage that congestive heart failure than maybe this ER doctor who doesn't even know that primary care doctor. He might send them off to that urban hospital that he is used to working with. That's another factor.

And certainly when we did talk to people there was some, in some of the places at least, the closed ones, there was quality concerns. Some of the regional rural places have suggested that care is becoming more specialized and congestive heart failure and things like that people may want someplace that has a pulmonologist or a cardiologist and not just a primary care physician.

And all of that is kind of the speculation when we look at the actual data. The types of discharges really haven't changed much. It's just that over time now they seem to be getting a smaller share of the congestive heart failure discharges, a smaller share of the pneumonia discharges, and more bypasses.

So that is not a complete answer but that's a few bits of information.

MS. BARR: That's great. I mean, it would probably be beneficial if we got more granular on it, to see if there were things that we could do to shift that, because we're paying for the cost of this hospital either way. So if it's appropriate for the patient it would be good if they used it.

My third question is, in the hospital outpatient section you talked about a decrease nationally of hospital outpatient utilization, right, and I believe it was about 17 percent. Twenty percent of that was urban, 14 percent was rural. So one of the things, you know, because rural is cost-based reimbursement, I'm trying to figure out, are we talking about dollars or are we talking about units service? Are the units of service that different between the two, or are the dollars that different?

MS. BINKOWSKI: I'll let Dan chime in, but I think the section you're referring to is talking about decline in units of service, in particular separately payable services or outpatient visits. Dollars, I don't have those differentials off the top of my head.

DR. ZABINSKI: Yeah, it's units of service.

MS. BARR: Units of service. Thank you. I'm done.

MS. KELLEY: Okay. I have Jaewon next, with a Round 1 question.

DR. RYU: Thanks, and thank you, and I would echo the earlier comments. With the COVID dynamic, I think this just makes for exercises like this to be really, really more complicated, and I thought you all did a really good job taking all those factors into account.

My clarifying question is, I think it was Slide 5, you had 3,100 or 3,150 participating in the IPPS and 3,600 in the OPPS. It's a bigger gap than I would have guessed. Do we know what accounts for that? Are these freestanding ERs or what facilities are in the OPPS but not in that IPPS?

MS. BINKOWSKI: Specialty hospitals such as rehab facilities, long-term care hospitals.

DR. ZABINSKI: And I'll add children's hospitals.

MS. BINKOWSKI: Cancer hospitals.

DR. ZABINSKI: Cancer hospitals. But, you know, basically the only thing excluded from the OPPS are critical access hospitals and Maryland hospitals.

DR. RYU: Got it. Thank you.

MS. KELLEY: Pat.

MS. WANG: Thanks. Again, my commendation. I echo everything that the Commissioners have said. For every single report that was written analysis, a phenomenal job in a very challenging time.

I'm looking at Slides 15 and 18. I see, in the calculation of Medicare margin on Slide 15, for example, that you show the sort of before and after the inclusion of relief funds. I'm trying to track how you treated the 20 percent inpatient COVID bump and the suspension of sequester, both in projecting the overall Medicare margin in '22, in 2020, and then, on Slide 18, projecting the Medicare margin for 2022, because, you know, as you know, there is an assumption that there will be decreased relief funds, et cetera. Does that include the resumption of sequester and the elimination of the 20 percent inpatient

COVID bump?

MS. BINKOWSKI: So I can address those in turn. Starting with Slide 15 and 2020, the difference between those lines are the Federal relief funds, which are the relief funds and Paycheck Protection Program loans. The Medicare-specific payment changes, including the 20 percent bump for COVID-19 stays, and the suspension of Medicare sequestration are in that minus 12.6 already. We treated those separately, because they are Medicare specific payments relief.

Moving to 2022 in our projected margin, we based it on current law as of when we put together this presentation, so that includes the suspension of sequestration would resume and that the public health emergency would end as currently scheduled. To the extent that changes between now and January we will update the slides accordingly.

MS. WANG: Okay. So those revenue impacts are already reflected in here. Got it. Thank you.

And this is just a small question. The market basket update is obviously critical, and I think there have been questions around that with respect to labor costs.

And I'm curious about supply costs. You know, I think those are the two big items that people, thinking forward, feels like a bit of a jump fall based on current indicators of [inaudible] increased cost, but also the supply chain issues.

How does that get reflected in the market basket? If you could just talk about supplies, because I think you addressed Brian's question about labor.

MS. BINKOWSKI: Yeah, so supplies are treated the same way as labor, the same one-quarter lag that will be finalized in the summer. Right now they are projecting, for 2023, a 3.1 percent increase in labor costs and a -- I need to scan, but a smaller increase in supply costs. But again, that's subject to change, and we can follow up with you afterward with the specific point estimate. But it is the same process for all components, with labor accounting for slightly under 50 percent, or slightly over 50 percent, and supplies about 20.

MS. WANG: Thank you very much.

DR. CHERNEW: Jon Perlin.

DR. PERLIN: Let me add to the chorus of thanks for a very complex, informative chapter. Difficult under the best of times and obviously more moving parts this past year.

If you have access to Slide 18 I want provide a little depth and follow-up on some of Pat's comments there. This is all in. This includes the relief funds in terms of the relatively efficient hospital margin, if I recall, from page 3 of the reading materials. It would have been minus 3 percent for 2020.

Help me understand the extrapolation from 2020 to 2022 to the zero percent overall Medicare margin for relatively efficient hospitals. Tell me the mechanics of that.

DR. STENSLAND: Well, we expect to have reduction in COVID funds, but we also expect to have a reduction in the COVID costs, because they would expect to have fewer COVID cases. You also had a dramatic decline in volume in April of 2020, and that certainly had a reduction in the profitability for a short period of time for hospitals at that point in time. And we are not forecasting anything dramatic like that happening in 2022. Of course, this is forecast and it is not anything that is certain.

DR. PERLIN: Thanks. Those are difficult to project items.

As you look at the year 2022, and obviously focus our upcoming discussions on 2023, how recommendations for 2022, and if I recall correctly 2021 as well, included parsing the update into both something that was essentially a flat update based on market basket but breaking part of it out to the hospital value incentive program or to quality metrics. Given the suppression of measures and given some of the current measures, unless something changes in terms of the HVIP, there are a number of moving parts. First is the evolution of those measures. Second is the suppression of measures during periods of time where multiyear metrics would figure in. But third is just the idiosyncrasy of performance given the impact of COVID.

How are you figuring the revenues to hospitals in terms of what we recommended as a separation of the updates for 2021 and 2022 into performance space versus the general update?

DR. STENSLAND: I might have not fully understood your question, but the 2022 projection doesn't assume anything in terms of the HVIP being implemented, so there is none of that happening. And we are not expecting any aggregate change from 2020 in the overall pool of rewards or penalties going to hospitals.

DR. PERLIN: Okay. That makes it more confusing for me, because in 2020, because of the suppression of quality metrics because of the decrease in volume the program was essentially muted out. You know, hospitals essentially got back what they put into it, so there was nothing at risk.

DR. STENSLAND: Yeah, that is a good point. We can revisit that.

DR. PERLIN: Okay. I am just trying to figure out puts and takes in what will be a very complicated year. Thank you very much. I appreciate it.

MS. KELLEY: Bruce.

MR. PYENSON: Thank you. I second other Commissioners' compliments to the staff for this work.

I've got a question on Slide 16 and a question on Slide 18. On 16, there are columns, relatively efficient hospitals and the others, and there is an overall Medicare margin, a sizeable difference, a range from 1 to -6 points. But that really contracts a lot for the payer total margin, which includes commercial payers and others. And I'm wondering what the explanation for that is. There is presumably the cost efficiency of the relatively efficient hospitals might apply to the commercial payers as well, so what accounts for the narrowing of the difference there?

DR. STENSLAND: It would appear that the relatively efficient providers, while they are having lower costs, they also, on average, receive lower revenues from the non-Medicare payers, including the commercial payers. And kind of the intuition here could be that if you are especially a nonprofit hospital that receives very strong private payer payment rates, and so has more revenue, that might actually cause you to have higher costs. And that's something we didn't put in this year's paper but in the past we have noted that the providers that tend to generate bigger profits on their non-Medicare patients tend to have higher costs. So you're going to see some of that, like while you don't see such a big difference in the all-payer margin I think part of that would be the high-cost hospitals tending to be high-revenue hospitals.

MR. PYENSON: Thank you. I think maybe adding that to the report might be a good, helpful explanation. My question on Slide 18, the relatively small difference in overall Medicare margin between 2019 and 2020 is really what I'm asking about. I know early on in the epidemic there were a lot of concerns expressed that the most profitable patients were either inpatient surgery or outpatient surgery patients, most profitable for Medicare and commercial payers. And those often would be the ones who would be postponed because many times they were elective.

It seems as though that wasn't the huge impact or there were things that compensated for that. I wonder if you could comment on what you think went on with case mix and the interplay of the loss of highly profitable patients and increases in other types of patients.

MS. BINKOWSKI: I can start with that. I think the first clarification is one of the major offsets were federal relief funds, that minus 8.5 percent includes the provider relief funds and paycheck protection program loans. A second component, as we discuss more in the paper, is that while volume went down, average case mix did substantially increase, and there were also increases in outlier payments. So I think, on net, in aggregate across all hospitals, those came closer to canceling out as more patients with more severe cases remained in the hospital.

Do you have more to add there, Jeff?

DR. STENSLAND: I think that's it, and then there's also a little bump from sequester relief.

MR. PYENSON: Thank you.

MS. KELLEY: Amol.

DR. NAVATHE: Thank you. I also wanted to echo the comments from past Commissioners about the great work here and the challenging circumstances with all the moving parts.

I think I had a question, though, to some extent being one of Bruce's questions, a sort of two-part question. One part hopefully should be very, very simple, which is I just wanted to confirm, when we think of overall Medicare margin, we're thinking of all Medicare payments, we're including things like DSH, correct? Okay. So with that kind of confirmed, I was curious about this analysis about the relatively efficient hospitals, and I apologize if I don't remember from past papers. Has there been -- or do we have a sense of the characteristics? There's a nice analysis that's in the paper around hospitals that serve low-income patients and their margins, you know, not being any lower essentially, hospitals that have -- well, we didn't quite get to uncompensated care specifically, but I was curious basically, how do relatively efficient hospitals versus other hospitals stack up when it comes to things like the percentage of their payments that come from DSH, their magnitudes of uncompensated care, and these other factors that are essentially coming from the non-patient care revenue stream, if you will, from Medicare?

DR. STENSLAND: There is a pretty wide spectrum of hospitals in the relatively efficient group. The ones that are probably overrepresented tend to be a little bit larger hospitals because they have more stable performance and do a little better on the quality metrics. The ones that are probably underrepresented are the really small hospitals, partly because sometimes they don't do quite as well on the quality metrics, but also they just have a lot of variability in their performance due to their small numbers of observations, and we toss out folks that bounce around a lot.

In terms of the other characteristics, the DSH share, the share of poor patients, it's going to be fairly similar between the IPPS and relatively efficient hospitals. The relatively efficient hospitals get a little bit less in uncompensated care dollars as a share of their overall revenue, but it's not a huge differential. Part of that could be that they just -- the uncompensated care computation, the way it's done is it's based on your costs. So if you have higher costs, you get more uncompensated care dollars. So just because they have lower costs, they might have a little bit. But, otherwise, it's kind of a wide spectrum across the different types of areas.

We also intentionally, when we devised this, we said there's a couple of groups we didn't want to include, so we toss out hospitals that have the lowest share of -- the 10 percent that had the lowest Medicaid shares, and the rationale there is we didn't want to find a hospital that was really just cherry-picking patients, and we did find some cherry-picking in the past, in particular with some physician-owned hospitals, and we didn't want them to look particularly attractive just because they got the easy cases.

We also ended up tossing out some hospitals in markets where they just do lots of admissions, because in some cases if you're in a market where you just don't have high admission rates and maybe you tend to be more likely to admit people from the ER if they don't really need to be in your hospital, the concern was that could lead to lower costs per case, and so we tossed those out.

So because we've kind of trimmed out some of those outliers, what's left looks fairly similar. But I also want to caution that what we're looking at here is -- I would call it a sample of the relatively efficient hospitals. We're certainly not finding all the relatively efficient hospitals because we're tossing out these different categories that we're concerned about, and what we're saying is we're okay tossing out these broad categories of low Medicaid hospitals or really small hospitals because we're not trying to capture all of them; we're just trying to get a sample of the ones that are relatively efficient.

DR. NAVATHE: Thanks, Jeff.

MS. KELLEY: All right. That's all I have for Round 1. Mike, are we ready to move to Round 2?

DR. CHERNEW: Yeah, I think we should go to Round 2. I will save my comments. We'll see how Round 2 evolves. But, yeah, I think given time, we should go straight there.

MS. KELLEY: Okay. I have Brian up first.

DR. DeBUSK: Thank you. I'd like to build on Pat's comments and others' about labor and supplies and the market basket update. That's why I was particularly interested in the timing of the market basket update. I hope we watch labor, particularly nursing, very, very closely this cycle, because I do think that the nursing market has permanently changed. I think hospitals are simply going to pay more for nursing going forward. But I think that effect is going to be compounded by contract nursing. We really need to get our hands around contract nursing. It has been around for a long time, but what we're witnessing is the rapid growth of a very powerful new intermediary, and I think this new intermediary is going to have a material impact on hospital cost structures.

And the other thing, and this is a little bit beyond the 2023 payment update, but I would also encourage staff to look one step beyond that and look at the impact that contract nursing could have on the hospital wage index calculation, because I think what you're going to find is that increasingly a hospital's HWI is going to be influenced by its approach and posture toward contract nursing versus W-2 full-time nurses.

The other thing I want to focus on is medical devices. There's a bubble that's working its way through the system here that we really need to be mindful of. We missed this bubble in the 2022 market update window, and I think that's going to be a real problem. I think we're going to start -- you're going to start seeing hospitals reporting unusually high costs, again, not just in labor but also in supplies, starting as early as next year. And the background there, the medical device market has been essentially flat or even deflating over the last 10 to 15 years. Now, that has been offset by new products and new technologies, and they're always been, you know, sources of cost increases. But there have been a lot of categories that have simply decreased or at least stayed the same now for 10 to 15 years easily. And I think the pandemic and its subsequent supply chain effects have uncovered a tremendous amount of hidden risk in the medical device supply chain, because our chain currently is really based on what I would consider near ideal conditions for transportation, for raw material input cost, even for things like geopolitical risk. And a lot of these products are contracted on very short cycles, typically three years or less. And those short contracting cycles combined with a shift toward low-cost countries have really created an overreliance on the Asia Pacific region for supplies. And that risk is being unwound now, and it's manifesting itself as higher prices, but right now it's also manifesting itself as product unavailability. I mean, I've seen hospitals that have had to scale back their ICUs and their operating rooms, in some cases over products that cost less than $2.

So, historically, a lot of this risk has been implicit. It has been built into the contract but not stated. My favorite example is personal protective equipment. I mean, you could have a three-year signed contract for N95 masks or for isolation gowns at a very attractive price. But what the pandemic taught us is that that contract really isn't worth the paper it's printed on once the supply chain breaks down.

And so it's going to be unclear -- and, again, this is why I'm really focused on the timing and the analytics that go into the next market basket update. It's really unclear how we're going to balance all these implicit risks, because, remember, the taxpayers are going to pay for it either way. I mean, you can look at the provider relief funds and, you know, at the tremendous amount of money that's been dispensed to providers. We're going to monetize and capture that risk one way or the other. But I think it's unclear how long it's going to take to balance how much of that risk do we want to be implicit versus explicit.

And, you know, just as a point of reference, for example, professionally I've seen about a 102 percent increase in our resident crisis versus pre-pandemic levels. So, I mean, these are very material effects. So I guess my hope is that CMS will track this very closely, again, labor and materials, and let's make sure that these effects are captured in the 2023 rates because I do think that failing to get those incorporated into 2022 already will be disastrous for hospitals next year.

Thank you.

DR. CHERNEW: Yeah, so let me jump in for a second. Paul, I know you want to make a point, too, and we do have to be a little mindful of the time. This issue about understanding what's going to happen to costs is always complex. It's particularly complex at the juncture in time we find ourselves now.

One reason we've moved to a current law recommendation is because it will adjust for anything that happens between now and then. What I think is outside of what I would feel comfortable doing is projecting what we think CMS will project, deciding whether we think the CMS projection will be too high or too low, and then adjusting our recommendation for some perceived misperception or misforecasting and what actually happens in the rest of the system.

So I think the spirit behind your comments, Brian, are 100 percent spot-on and, in fact, motivated the nature of this recommendation now compared to some of our recommendations in the past, where all those features, to the extent that they're captured by the people that do that stuff, will be then consistent with our recommendations. We did not, for example, take the current law projection now and recommend that as a numeric update. We're recommending that the update be current law, which would change should those things change.

Paul, did you want to say something very quick on this point?

DR. PAUL GINSBURG: Yeah, Brian's point was really good, and I agree with your response, Mike. One thing I would say is that in a sense, you know, what Brian is saying means that the forecasts of the market basket are not going to be as accurate as they've been in the past because they're just more challenging, because this is a time of potentially real transition. And, you know, I think the best we can do is, as Mike said, switch to current law rather than a number because at least this gives us the ability to absorb changes in the market basket to diverge from today's forecast.

MS. KELLEY: I have Lynn next.

MS. BARR: Thank you. So just, you know, thinking about the rural hospitals, so, you know, probably the big difference between the closures prior to this year has been rural versus urban. So we were losing a rural hospital every three weeks, and we stopped losing rural hospitals. They stopped closing, you know, because of all the bailouts. But I asked about the accelerated payment program and repayment. Thank you, Alison, for sending the details on that. I hear a lot of magical thinking in the rural hospitals that they're not going to have to pay that money back, because they've already spent it. And so I'm a little concerned about a tsunami of closures, sort of like that pent-up demand that we've been talking about might actually be that pent-up demand of rural closures.

And so I don't know if there's any way the Commission can look at these repayments and what the potential harm could be, because, you know, I mean, there's a lot of rural hospitals that open up the checks every day and decide who to pay, and they got that money, and they don't have it anymore. And so I don't know what's going to happen. I'm very concerned about that.

The other comment I wanted to make quickly is my concern about the differences in utilization, right, so that the 14 percent drop in rural utilization of outpatient versus the 20 percent, when there's a drop in rural utilization obviously in critical access hospitals, then the cost per unit goes up. So they stay about the same in terms of reimbursement, but the cost per unit goes up because of that. And if there's a large difference in the experience of a pandemic between rural and urban situations, I just wonder how all of that plays into advanced payment model calculations, right? And so our costs went way up in hospital outpatient significantly this year, but a lot of that is just because of the payment model and because of the drop in utilization. So our unit cost went way up.

It's just something for the Commission to consider, how do the differences between how the pandemic has played out in rural versus urban and how that's going to affect many things, including the advanced payment models.

Thank you.

MS. KELLEY: Jon Perlin.

DR. PERLIN: Thank you. I really want to make three points. One is a note on equities, particularly in this instance addressing rural; second, you know, really tying together the cost that we pay versus the care that we want; and, third, and finally, a view from the front line.

I think this group knows that at least for the next 20 days or so, I'm a member of a very large health system and so have been living the experience of the effect of COVID.

Let me just turn to equity. I do think our chapter should overtly promote a commitment to equity. One of the areas among the many in which I think we could do better is in the area of the impact on rural hospitals and rural elders. You know, with the recommendation, if we return to the pre-ACA low-volume hospital, LVH, adjustment, I'm wondering how many hospitals might benefit. My recollection is that originally it was like 10 or 11, and that's a $300 million cut that's directly to rurals, you know, apropos of Lynn's point. So I just want to say that.

Second, this balance in terms of care that we want, I think we have to be very clear in terms of what we want to specify for surge capacity, and, you know, the greatest efficiency is not commensurate with the greatest capacity to respond to surge. And COVID certainly demonstrated the shortcomings.

Then, third -- and this is really in the view from the front line, but I want to just amplify on the great points that Brian and others made about the impact of inflation. So let's look at the perfect storm that's converging for 2023. The moratorium on the sequester we can anticipate to be expired, real terms minus 2 percent.

Although, you know, there are funds that were -- for which reimbursement will be forgiven, the recoupment of accelerated Medicare payments begins this coming year, and that's as much as 20 percent, if I recall, of garnishment on claims. So that's minus 22 percent.

Now, I know this doesn't affect all equally, but this gets pretty substantial. The 20 percent add-on is set to expire with the end of the public health emergency. So that's pretty substantial.

The cost of labor and the cost of supplies, there are a number of factors beneath the cost of labor. So, for example, when you look at the attrition -- and Betty probably could give us more detail than I do on this, but I can tell you our lived experience. The attrition of the nursing workforce has not been sort of equivalent across all cohorts. It has been the senior nurses, the most skilled nurses that have left. So the notion that there's one-for-one replacement doesn't work. I don't know what the factor is, but it's probably 1.1 or more in terms of that, but, you know, you can't parse the units of patient that there's cures for, so you end up with a rather substantial step function in labor.

What are the alternatives? I really don't like the term, but going to lower skill may render the same sort of effects that we have not appreciated in terms of COVID response in the skilled nursing environment. We will need, by necessity, to find different models, but the ideal models would have highly skilled individuals, supported by others, but we can't skimp on the highly skilled individuals.

I think Brian's points on supplies are also correct.

The market basket adjustment, obviously, includes health care but it is not exclusively health care. And so even if it's relatively timely it still will underestimate the magnitude of something that seems to be more sector-specific.

I would note that as one thinks about all-payer margins, one of the things that is also apt to hit is that many hospitals will have negotiated their contracts with payers for 2023 and underestimated the impact of inflation, so the cost of shifting this cross-subsidization that occurs will ultimately be less, you know, not just access to capital but fundamentally operating dollars.

So let me stop there, but simply note that if absent the relief funds most-efficient hospitals participated, you know, this year could have had a minus 3 percent margin, it is a pretty gloomy picture for the real-world conditions, and I think we are going to have to be agile. I endorse, obviously, the market basket update as written in this recommendation, but I think we have effectively parsed what we have sort of tried to describe as transient effects for fundamental policy, but the intersection of multiple transient activities are going to collide at a particular point that I think we have to be uniquely sensitive to in order to get the care that we want. I really endorse that we think about our measures of surge capacity, our measures of equity, and our measures of quality during this time.

Thanks very much.

DR. CHERNEW: So let me jump in again, and first of all, Jon, thank you for your wonderful comments. Second, thank you for saying that you support the current law update. Note that it is more generous than the one we had last year, for some of the reasons that have come up. And just for everybody writ large, understand that the most important information for me to take from this discussion is how you feel about where we are going. In January, there is going to be a vote, and so part of the purpose of this meeting is to understand all the factors going on. Part of this meeting is to get a sense of where you are on the recommendation.

I will say, I'm a little hesitant to say this, given the time and the queue, but I will point out we still are supportive of the HVIP recommendation. For a bunch of reasons we didn't put the HVIP recommendation in this. It wasn't literally in the recommendation we voted last year but it is still something that we are broadly supportive of. If, going forward, if Congress felt there was need for more, we would probably stick by the HVIP sort of philosophy of put the money in through HVIP, as opposed to raise the overall recommendation number.

The projections for the margins going forward to 2023 are around zero for efficient hospitals, even after the sequester stuff, Jon, just so you know.

And so that's where we are on this. So we have tried to come up with a recommendation that is flexible for uncertainty around all these supply issues, these labor issues, all of which are unbelievably important. So we've actually made a chance to make the recommendation more responsive to that concern. We've also made the recommendation more generous than it was last time, and we stick by the other things we've done.

So again, accepting everything that everybody said, I just wanted to get a chance to explain the rationale of where were so if there are strong objections that they get surfaced now. I will leave it there.

DR. PERLIN: Mike, I do want to clarify. I censored myself from going back and talking about splitting the 2022, but given the instability, and the instability performance measures, it's really hard to justify a split of that as much as someone with my background favors performance measurement. I just think --

DR. CHERNEW: A split of what?

DR. PERLIN: -- rocky road.

DR. CHERNEW: I'm not sure what you mean, Jon. I'm sorry.

DR. PERLIN: Unlike last year, I appreciate that the recommendation as raised thus far does not seek to split out that into an HVIP versus a base. First we have the instability of the quality measures and second, and perhaps more importantly, we have the instability of the system. But, you know, we need some fundamental work in quality measures, and thankfully we have Dana to do that, but, you know, given the instability of the environment it is hard to recommend that money go in, in a way that could exacerbate the instability.

DR. CHERNEW: Again, I want to make sure I understand what you're saying, but I think we're agreeing. Because we're not in person I can't see your face well enough to know, but I understand for that reason we've moved the recommendation up to current law. And I should add we are also doing a lot of work on safety net hospitals because we do believe there is room to support many of the things you said. Many of the equity points you make, for example, Jon, resonate very strongly, which is why we've started the safety net work and all the other things we've done.

So we are indeed trying to move in that process. We are not at the end of that journey. We are at the beginning of that journey, as you all know. But in the interim, given all of the stuff you said, we felt that we needed a recommendation that was current law as opposed to recommendations you saw in the past, which again I am glad that I am in an advisory role, or we are in an advisory role.

We aren't actually coming up with the actual projections, but don't think we will try and do a better job of projecting than the people who do that part for a living, and we, of course, per what you said, hope they do it as well as they possibly can, and we emphasize the challenges of their task. But our intent is to make sure that the update that happens in 2023 uses the best possible information, the best possible forecasting of what the market basket increase will be when it applies. And I think that is sort of the best we can do.

But again, we are having a public meeting so people can hear our thinking, and so I'm just trying to outline at least my thinking so we can uncover any problems. And again, for Lynn and Stacie, they are new, but for others as well, understand that we're going to come back in January with a recommendation and a vote. And so I really appreciate all of the feedback but keep in mind sort of the path we're on.

Sorry. Dana, let's go back to the queue.

MS. BINKOWSKI: Can I make one point of clarification, which is that the market basket for hospitals, the employment cost index that is used is hospital specific.

MS. KELLEY: Okay. Thanks, Alison. Bruce, you are next.

MR. PYENSON: Thank you very much. I have somewhat of a contrarian view to what other have said, and let me start by saying that the rather crude scissors we're using for hospitals of considering averages and not giving special treatment to specialty net hospitals, all of those are really important issues.

But from the standpoint of the Medicare program, the tragic death of about half a million Americans in 2020 associated with COVID has a disproportionate effect on Medicare. And that is a significant reduction of the Medicare population compared to what it would have been. And it's also tragically led to fewer people who are going to need hospital services, fairly significantly. Many of the people who died were older, were sicker, and more likely to use hospital services had they not died prematurely.

So looking ahead over the next several years, our expectation should be that there is going to be measurably lower demand for hospital services, because of COVID, after the public health emergency is over. The data suggests that 2021 might be as bad as 2020 in terms of the tragic loss of life for the Medicare population.

So if we are projecting ahead that there is going to be less demand for hospital services by Medicare, that says something different about the kind of planning and the kind of need for payment increases. In particular, it creates a situation where, because of capacity that we have, hospitals will be more likely to want to fill their beds.

So from that standpoint I don't want us to get into a situation that preserves the current status quo when it seems as though there is, just because of the loss of life we are in a very different situation going forward. So I think we need to think about what that means for the Medicare program and what it means for the hospital organizations and their costs and their sources of revenue.

MS. KELLEY: Jaewon.

DR. RYU: Yeah, I think Mike's question earlier around where do we stand and directionally are we okay with where things are going as far as the recommendation is concerned, I am. I think ultimately, at a high level directionally, I think the recommendation seems reasonable. But I do have a couple of areas of concern. I think one is that the readings mentioned quite a bit about we're trying to tease apart the more permanent or lasting effects of the pandemic and focusing on teasing out the impacts of the pandemic that may not be as lasting or permanent.

I think one of the items around total margin, to the extent that that is also incorporating investment income, I think that something that, by that same logic, I would be a little bit cautious in terms of feeling good about access to capital, because that number right now, with the financial markets and the performance I think is falsely elevated and could mislead us into thinking that there is better and durable access to capital versus what may be more of a steady state once we settle into that. So that's number one, understanding that it's something you can't predict how the markets are going to do.

Number two is, on this labor question, and I think both Jon Perlin and Brian earlier made a lot of really good points. But the only one that I would add to the mix is I actually think there's competition beyond just the health care industry now, and it may not necessarily be in nursing, although even there I would argue there is greater competition across not just within the industry but outside the industry. But definitely in other areas and other components of the health care workforce I think that dynamic, where I don't think that was as prevalent before.

And earlier we talked a little bit about skill mix and staffing mix. That gets to unlicensed areas of the workforce where I think there is greater competition with other industries that frankly have a different operating model, different revenue model. And so I do think we have to be a little bit cautious in keeping our eyes on that as that continues to unfold.

MS. KELLEY: Marge.

MS. MARJORIE GINSBURG: Great. Thank you. And my comment is, I think, quite different than everyone else's, and perhaps it doesn't fit in this chapter, but it's been nagging at me.

I think everybody knows inpatient falls under

Part A, outpatient falls under Part B. I assume you all know that the Part B premiums have jumped from $148.50 to $170.10, for 2022, the biggest jump in I don't know how many years, but a long time.

I just got a text from a friend who got a notice for their mother in Ohio, explaining the cost, and basically attributing it to COVID and to the potential increase in Part B drugs.

I raise this, and perhaps it doesn't belong in this chapter, but I know that one of our responsibilities is looking at financial impact on beneficiaries, and I'm wondering whether it's this chapter or the physician chapter, and maybe it's just a footnote, but some reference to the impact this has on beneficiaries' cost burden.

So that's it. Thank you. I don't think it was mentioned anywhere in this chapter, and I certainly understand if it wasn't, and I don't recall that we've ever talked about the financial impact on beneficiaries in terms of Cost B premiums. We've danced around Part D, because we don't have a lot of influence in Part D. But we certainly should have some influence in Part B premiums. So thank you.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks, Dana. So there are many points that my fellow Commissioners made earlier that I agree with but I will let their comments stand and not repeat them, for the same of time.

The one thing that I did want to elevate, because I don't think it was discussed in full, but we talked about it in the questioning, was further exploration, in some sense, of the efficient hospital designation that we use. I think it's clearly a very important part of the rationale of how we conceptually think about the payment updates, and it just strikes me that because of the rationale that we use, or really the logic that we use around being the upper third of performance along a number of different metrics, those are metrics that, in the course of the rest of the Commission's work, we oftentimes worry or are confounded by other factors, and particularly factors that are related to the underlying types of populations, social determinants of health, et cetera, et cetera.

And so I think it behooves us to do a little bit more work to ensure essentially that if we do vary some of the inclusion criteria, exclusion criteria, look at the sensitivity of our designations and, therefore, the margins that come out of the overall Medicare margins and other metrics that come out of that analysis, that there is some stability there. And if there is, then I think that will give us some more reassurance. They still never will be perfect aspirationally, but I think it is something that we can strive for.

So I just wanted to put a plug in for some additional examination, if you will, of the characteristics of those hospitals and potential some more sensitivity analyses, if you will, of the robustness. Thanks.

MS. KELLEY: Betty.

DR. RAMBUR: Well thank you, staff, for this great work on a very complicated and delicate issue, and also to the Commissioners. I really appreciate your comments.

I wanted to comment on the issue of relatively efficient hospitals, particularly related to nurse staffing mix. Pre-COVID there is a lot of data on the proportion of backordered, prepared, and above being associated with better patient outcomes, decreased failure to rescue, et cetera. But I wanted to underscore that that's not about the individual. It's about the aggregated skills of the team. And it is not only the RN workforce that we are really struggling with but the CRNAs, et cetera, who often can do better financially in other settings without taking the risk and the emotional strain of working in health care.

I just wanted to mention that just out this month there is a study that found that there are better outcomes in both generic BS program and AD to BS programs, including on value-based purchasing metrics. So there is something about education and skill mix that matters.

So when I think about optimization of the nursing workforce when we go forward, I'm really concerned about a couple of things. We have record enrollments in nursing programs throughout the country, but imagine if you were a nursing student and your junior and senior year have been these last two years. Think how different that experience would have been than a typical kind of experience.

And at the same time we're having an enormous exodus of boomer RNs, and I think of this concept of nurse-year as sort of the analogy to pack-year history of smoking, except in a good way. Going back to what Jon

Perlin said, we are going to be losing, we are losing, an enormous amount of nurse-years, and this extends also to the nursing faculty who are just disproportionately boomers.

So the nation's longstanding lack of attention to development of workforce outside of the MD is really hitting us squarely, and it's certainly going to be impacting Medicare expenditures, one way or the other.

I hear what Bruce said, and I have pondered that myself. So think about that piece of unknown and also the unknown about the workforce in terms of how this evolves, pending new information between now and when we have to vote I feel comfortable with the recommendation. Thank you.

MS. KELLEY: David.

DR. GRABOWSKI: Thanks, Dana. And thanks to the staff for this great work. I'll say at the outset that I'm also supportive of the Chairman's recommendation.

I just wanted to make two brief points. The first is the labor issue that has come up a lot. I imagine this issue is going to continue to come up over the next couple of days. I completely agree with Brian, Jon, Betty, and others that this is a huge issue for hospitals and obviously for other sectors as well. Everything we're hearing already suggests big staffing shortages, and as Jon noted, that's especially true among the most senior staff.

Kind of looking forward, I imagine this issue is only going to become magnified in the coming years. I'm already hearing a lot about the use of contract staff. That's going to inflate costs; that's going to be, I think, an issue that we're going to want to think about. This doesn't change anything about my support for the recommendation today but, rather, just to further flag this issue that this is something we're going to want to track.

The second point I wanted to make, and I think it's a point I make almost every year, so I just want to remain consistent here, but just to kind of stress that Medicare doesn't pay in a vacuum. When I look at this chapter and others, we're seeing all these metrics, and it's easy to have your eyes focus on just the Medicare margin. And I think here it's really important to sort of view the whole set of measures together.

Obviously, in this sector, Medicare pays alongside very generous commercial plans, and a lot of economics research suggests, you know, costs are not fixed, and that's going to drive up Medicare costs when you have a higher commercial payer.

So I'm very comfortable with the Chairman's recommendation because I'm looking and because I think we should look at the full set of measures and not just focus in on that Medicare margin in particular, because when I think you try to compare that to some of the other sectors, which I know is a mistake, this one looks a little off. But I think it's important to look at access and to look at quality and other metrics.

So, once again, thanks for this great work, and I'll stop there.

MS. KELLEY: Bruce, did you have something else to add?

MR. PYENSON: Thank you. I agree with fellow Commissioners on pointing out the risks to the industry and some of the challenges that they're facing. I would consider those to be often created by the public health emergency and could be treated with special efforts or special funding when needed.

I think the longer-term issues I'm pointing out suggest that one of the big drivers of reimbursement, which is ensuring access for Medicare beneficiaries, is not going to be a problem, and that has been of concern in the past. I don't think that's going to be nearly as much concern in the future. So, therefore, that's to explain my thinking a little bit better than I had earlier. I think that justifies a lower reimbursement for hospitals. We're simply not at risk of losing access for Medicare beneficiaries.

Thank you.

MS. KELLEY: Okay, Mike.

DR. CHERNEW: Okay. Yeah, I think that is the end of the queue. I will give a very quick summary.

Bruce's most recent comment aside, I hear a lot of support for the recommendation as it is and a lot of concern about the uncertainty going forward. My read from the tone of some of the comments is that several of you, although you didn't say it, can live with the recommendation, but might want it to be a big higher. Bruce seems to want it to be a bit lower. We will first think about all the issues you've raised. There's been a lot of general issues raised that aren't directly related to the recommendation per se in terms of whether you support it or not, but they're just important issues for us to keep in mind, which we will do. And we will then ponder all of those comments and what you've said and come back in January with some added thinking.

But I hear, just so you know, and if not, you know, send me a note if I misheard or say so now, but I hear broadly speaking acceptance of where we are. So I'm going to leave it at that. I'm going to pause -- actually, I will say to the population, the public who is listening, please send us comments. You can email us at meetingcomments@medpac.gov, or you can go onto the new revised website, which I encourage you to, go to Public Meetings, and then if you go to Past Meetings, you will see a link for how you can submit comments. Either way we do want to hear from the public.

So with that said, we're about to take our break. Any parting thoughts, Jim?

DR. MATHEWS: No. All good here.

DR. CHERNEW: You're good? Pausing for a second before saying good-bye to see if anybody wants to add.

[No response.]

DR. CHERNEW: Okay. Thank you all very much. We are going to come back at, I think it is, 1:45, and we're going to do the physician fee schedule. So, again, thank you and we'll see you and hopefully we'll see a lot of you from the public in 45 minutes.

[Whereupon, at 12:58 p.m., the meeting was recessed, to reconvene at 1:45 p.m. on this same day.]

AFTERNOON SESSION

[1:47 p.m.]

DR. CHERNEW: Hello, everybody, and welcome to the afternoon session of our update discussion. Again, we have a lot to cover this afternoon, so we're going to jump right in. We're starting with the physician fee schedule, and that's going to be Rachel. Rachel, take us away.

MS. BURTON: Good afternoon. In this session, my colleagues and I will go over our assessment of the adequacy of Medicare's payment rates for physicians and other health professionals' services. We'll also present the Chair's draft recommendation for updating payment rates for 2023.

The audience can download a PDF of these slides in the "Handout" section of the control panel, on the right side of the screen.

Similar to last year, we find ourselves needing to recommend payment rates in the midst of a global pandemic. The pandemic has had tragic effects on Medicare beneficiaries and has been a source of financial disruption and psychological burnout for many clinicians.

To assess the adequacy of Medicare's payment rates for clinicians, we examined data from 2020 and beneficiary surveys and focus groups from 2021.

The Commission contends that the temporary and highly variable declines in revenue that we've seen during the pandemic are best addressed through targeted, temporary funding policies rather than permanent changes to all providers' payment rates in 2023 and beyond. With that introduction, I'll now provide some background information on the clinician sector.

Medicare's fee schedule for physicians and other health professionals includes about 8,000 billing codes for a wide variety of services.

If services are delivered in certain settings, such as hospitals or skilled nursing facilities, Medicare makes separate payments under both the physician fee schedule and other payment systems that our colleagues will present on during this meeting.

In 2020, Medicare paid $64.8 billion to 1.3 million clinicians under the physician fee schedule. This is $8.7 billion less than was spent in 2019, before the coronavirus pandemic.

To offset any declines in revenue from Medicare and other payers during the pandemic, Congress has provided tens of billions of dollars in relief funds to clinicians, which we discuss later.

Under current law, there is no update to base payment rates for 2023, but clinicians can potentially receive a positive or negative performance-based adjustment if they are in the Merit-based Incentive Payment System, known as MIPS, or they can receive a 5 percent bonus if they are in advanced alternative payment models, known as A-APMs.

This graph shows the cumulative percent by which Medicare's base payment rates will increase under current law. The left side of the graph captures two temporary increases that have boosted clinicians' payment rates by almost 6 percent.

First, in response to the pandemic, Congress suspended the 2 percent sequester that normally applies to Medicare payment rates.

Second, in response to a rebalancing of fee schedule RVUs, Congress increased payment rates by 3.75 percent in 2021.

In 2022, these temporary increases will expire, and clinicians' payment rates will return to pre-pandemic levels through 2025.

In 2026, differential payment updates will begin for clinicians in A-APMs and clinicians not in A-APMs. Over time, as the difference between these two sets of payment rates grows, non-participation in A-APMs will become increasingly unappealing.

The rest of this presentation will focus on our assessment of the adequacy of current Medicare payment rates based on these three topics.

First we'll present what we know about beneficiaries' access to care. Next, we'll talk about the quality of care clinicians provide to beneficiaries. And then we'll review data on clinicians' revenues and costs.

To determine whether beneficiaries have good access to care, the Commission looks at three types of information.

First, we look at beneficiaries' feedback on their experiences accessing care, collected through focus groups in several cities in the summer of 2021, our annual phone survey of 4,000 elderly Medicare beneficiaries and 4,000 privately insured individuals ages 50 to 64 in the middle half of 2021, and the 2019 fielding of CMS' Medicare Current Beneficiary Survey.

Our second measure of access to care is the number of clinicians participating in Medicare. And our third measure is the number of clinician encounters per beneficiary.

In general, the Commission's 2021 phone survey found that Medicare beneficiaries' access to care was comparable to that of privately insured individuals and comparable to pre-pandemic years.

For example, among beneficiaries who received care in the past year, 93 percent were satisfied with the quality of that care. There was no statistically significant difference in satisfaction rates for Medicare beneficiaries and the privately insured, nor among rates for beneficiaries this year versus pre-pandemic years.

One change we did observe this year was higher shares of Medicare beneficiaries ages 65 and over reporting waiting longer than they wanted for an appointment compared to privately insured people ages 50 to 64.

Although beneficiaries reported forgoing some care in the early months of the pandemic, they likely caught up on this care in subsequent months, since our 2021 survey found that only 10 percent of beneficiaries reported forgoing care in the past year. This was not significantly different from pre-pandemic years, nor from privately insured people.

Finally, majorities of beneficiaries in our survey didn't experience problems finding a new primary care provider or a new specialist, and these results were not significantly different from the privately insured.

I'll now hand things over to Geoff.

MR. GERHARDT: We next looked at the supply of clinicians billing Medicare's fee schedule.

Over the 2015 to 2019 period, the total number of clinicians billing the fee schedule grew by an average of 3.3 percent per year -- outpacing growth in the number of all beneficiaries enrolled in Medicare. In 2020, the number of clinicians billing Medicare dropped slightly, but that decline may prove to be temporary as the effects of the pandemic subside.

Over the 2015 to 2020 period, changes in number of providers varied by type and specialty of clinician. In particular, we saw rapid growth in the number of advanced practice registered nurses and physician assistants. There was also growth in the number of specialists, who now make up three-quarters of the supply of physicians in the U.S. And there was a modest decline in the number of primary care physicians.

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

Our next measure of beneficiary access to care is number of clinician encounters per beneficiary, which we found grew by an average of 1.3 percent per year from 2015 to 2019. Encounters per beneficiary declined by 11.1 percent in 2020 due to beneficiaries delaying or forgoing services. The drop in encounters mainly took place during the spring, with volume largely rebounding by the summer and rest of the year.

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

For example, from 2015 to 2020, encounters per beneficiary with primary care physicians decreased by an average of 4.2 percent per year, while encounters with APRNs and PAs increased by an average of 8.3 percent per year.

We are concerned about the decline in encounters with primary care physicians and will be monitoring this in the future.

Next we'll talk about the quality of clinician care in fee-for-service Medicare based on ambulatory care-sensitive hospital use and patient experience scores.

We caution that it's particularly challenging to assess clinician quality because Medicare does not collect beneficiary-level clinical information or patient-reported outcomes.

Quality of care is also difficult to assess in 2020 due to the effects of the coronavirus pandemic. While we report 2020 results for our quality measures, we have not used those results to inform payment adequacy conclusions. Although the risk-adjusted rates of ambulatory care-sensitive hospital use went down in 2020, we still see geographic variation in these rates, which signals opportunities to improve.

Rates of ambulatory care-sensitive hospitalizations and ED visits are about twice as high in some hospital service areas than others. Patient experience scores remain relatively high, with top scores of 84 for rating of health plan and 86 for rating of health care quality.

We assess clinicians' revenues and costs using the following indicators: Medicare payments per beneficiary, the change in clinicians' input costs, the ratio of commercial payment rates to Medicare's payment rates, and physician compensation from all payers.

Based on analysis of Medicare fee-for-service claims, we found that total allowed charges for clinician services grew by an annual rate of 2 percent per beneficiary between 2015 and 2019.

However, in 2020, allowed charges per beneficiary fell by 10.6 percent when the pandemic caused many beneficiaries to delay or forgo care. In total, allowed charges were $8.7 billion less in 2020 than in 2019.

Congress has provided clinicians with billions of dollars to at least partially offset their pandemic-related revenue losses from Medicare and other payers. We estimate that since the pandemic started, clinicians have received at least $17 billion through the Provider Relief Fund and up to $18 billion through forgiven loans from the Paycheck Protection Program.

There continues to be an increase in the Medicare Economic Index, or MEI, which measures clinicians' input costs adjusted for economy-wide productivity. The MEI increased by 1.9 percent in 2020, and CMS projects that it will increase by 1.8 percent in 2023.

It is important to know that the changes in allowed charges during 2020 was not uniform throughout the year. As shown in this figure, total allowed charges per beneficiary for fee schedule services were slightly higher in the first two months of 2020 compared to those months in 2019.

Starting in March 2020, however, spending began to decline sharply and by April was $125 less than the same month in 2019, a difference of about 50 percent.

Starting in May, spending began to rebound and by June had almost reached pre-pandemic levels. Allowed charges continued to remain just below 2019 levels for the rest of 2020. Monthly changes in the volume of clinician services follows the same pattern.

I will now hand things off to Ariel.

MR. WINTER: Next, we looked at the ratio of commercial PPO rates to fee-for-service Medicare rates for clinician services. The ratio was 138 percent in 2020, up from 136 percent in 2019.

The ratio varied by type of service. For example, commercial rates were closer to Medicare rates for E&M office visits, but farther apart for coronary artery bypass graft surgery.

The growth in commercial prices could be a result of increased consolidation of physician practices, which gives providers more leverage to negotiate higher prices with commercial payers.

Finally, we look at physician compensation from all payers. From 2016 to 2019, median physician compensation from all payers across all specialties increased at an average annual rate of 2.5 percent.

Despite reduced Medicare spending on clinician services due to the pandemic, median compensation continued to grow in 2020, rising 1 percent to $304,000. But median compensation in 2020 continues to be much lower for primary care physicians than for many specialists.

Compensation from all payers reflects Medicare's physician fee schedule, because many private insurers base their payment rates on Medicare's fee schedule.

Therefore, the differences in compensation among specialties probably reflect Medicare's historic underpricing of E&M office and outpatient visits relative to other services.

CMS substantially increased the RVUs for these visits in 2021. But there are still opportunities to improve the overall accuracy of the fee schedule.

To summarize our analysis, payments appear to be adequate. Most beneficiaries report access to care that is comparable to the privately insured and to prior years.

The number of clinicians billing Medicare is stable, while the number of clinician encounters per beneficiary declined in 2020 due to the pandemic.

Regarding quality of care, there is wide geographic variation in the rates of ambulatory care-sensitive hospital use, and CAHPS patient experience scores remain high. However, it is difficult to interpret quality measures in 2020 due to the effects of the pandemic.

In terms of clinicians' revenue and costs, Medicare payments to clinicians declined by $9 billion from 2019 to 2020, but clinicians received tens of billions of dollars in relief funds to offset financial losses due to the pandemic.

Medicare payments per beneficiary decreased in the spring of 2020, but then rebounded and almost reached pre-pandemic levels by June. The MEI is projected to continue growing.

Commercial payment rates for clinician services continue to exceed Medicare rates, and physician compensation from all payers increased modestly between 2019 and 2020, despite the pandemic.

This leads us to the Chair's first draft recommendation, which reads: For calendar year 2023, the Congress should update the 2022 Medicare base payment rate for physician and other health professional services by the amount determined under current law.

Current law calls for no update in 2023, but clinicians can receive positive or negative adjustments under MIPS or get 5 percent bonuses for being in an A-APM.

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

Now I'm going to switch gears to talk about another issue. Before the public health emergency, CMS only paid for telehealth services if they were provided using two-way audio and video technology. But during the PHE, Medicare waived this requirement and now pays for many telehealth services when they're provided through an audio-only interaction.

In our March 2021 report, we presented a policy option in which CMS would temporarily cover some telehealth services -- including audio-only services -- after the PHE, if there is potential for clinical benefit.

During this limited period of time, policymakers should collect more evidence about the impact of telehealth services, including audio-only, on access, quality, and cost.

But, with certain exceptions, there is no information on Medicare claims indicating whether a telehealth service was provided by an audio-only or an audio-video interaction.

Therefore, apart from some exceptions, CMS and others are unable to use Medicare claims data to assess the effects of audio-only telehealth services on access, quality, and cost.

To address this issue, the Chair's second draft recommendation is: The Secretary should require that clinicians use a claims modifier to identify audio-only telehealth services.

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

CMS has already decided to adopt a claims modifier for audio-only services for mental health and substance use disorders, so this recommendation would extend this policy to all audio-only services.

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

DR. CHERNEW: Ariel, thanks.

There's a lot here. I think, Dana, we will jump right into the queue. This is for Round 1 questions. When we get to Round 2, I'm going to ask all of you to just make a statement about how you feel, if you can accept the first and the second recommendation, and then make any other comments that you want. In Round 2, I'm going to go around and make sure everyone gets a chance to at least say if they can support where we are. But for now, let's go with Round 1 questions.

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

DR. DeBUSK: Thank you, Dana. Two questions, and then I'll save everything else for actually the next chapter. But do we have a reliable way to measure -- and I know we tried to do this a few years ago, but do we have a reliable way to measure the distribution of independent versus hospital-employed physicians? And I guess my follow-up to that -- and this isn't a super-rhetorical question; it's a genuine question -- should we consider the balance of independent versus employed physicians as one of our indicators of payment adequacy?

That's it. Again, I'll save the rest for Round 2.

MR. WINTER: I'll take a crack at that, Brian.

So there are various studies out there that have estimated the share of physicians who are independent versus employed by hospital or health systems, and we did our own work on this in 2017, and there have been some studies since then. So we can provide you some of that information. We can investigate whether there is a recurring source of data that we could use to keep track of that information.

In terms of your second question, we could think about that, but off the top of my head I can't think of how that would affect our assessment of payment adequacy. So maybe you could say a bit more about that or we can talk more offline if you'd like.

DR. DeBUSK: Well, I guess a follow-up question to my question would be, I mean, would we, for example, see a mass exodus of independent physicians moving to hospitals? Would that have an implication that maybe the hospital rates are increasing at a differential rate, say, to physicians? And again, this isn't some simple, rhetorical question. It's just that would we look at flow of human capital in and out of other payment areas as an indicator of payment adequacy, albeit one of many indicators of payment adequacy?

MR. WINTER: So we have certainly seen a substantial increase in the share of physicians who are employed by hospitals and health systems. I think that the reasons for that are quite complex, and we have discussed them in previous work, and go beyond Medicare's payment rates for physician services.

One of the factors that we've emphasized is the growing differences in how much Medicare pays for a service when it's provided in an independent practice versus a hospital-affiliated practice that is billing as a hospital outpatient department. We have made recommendations on that. We have a new body of work that Dan has begun working on and presented to you, I think, last month.

So I think it does certainly -- that disparity, those differences between sites and service can influence whether physicians are employed independently or a hospital and billing their services under the OPPS. But I'm not sure that would be a direct indicator of payment adequacy. But that's something we can think about further.

DR. CHERNEW: Can I jump in quickly on that point? Again, thank you for your question, and I'm sure it will come up in a number of things, and because we are so concerned with these sort of cross-fee schedule issue we do have a whole body of work on site-neutral payments. It is challenging, although you could argue otherwise, Brian, certainly in Round 2, that we should make a change. The question would be if we were to raise physician payments, how much of the consolidation do you actually think we would forestall and how much will we be paying in order to forestall that?

So I think the first order of thinking in my mind is less about how to harmonize in a site-neutral way in this work -- of course we have the separate site-neutral work -- and in this particular exercise asking with the criteria we have are these payment rates adequate for physicians to provide access to high-quality care?

Again, that's a subject for discussion, but it is a little bit narrower than what you're raising, at least in my thinking. And others can disagree. I'm just explaining my view. We should probably keep going on.

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

DR. DUSETZINA: Thanks for the excellent report. I just have two questions about some of the data on access to primary care, and one of them goes back to, in the materials, Figure 4.3, where what you show is 8 percent of people report that they try to get a new primary care provider, and almost 20 percent of them said they had a big problem getting a primary care provider when they were trying to.

And I guess one thing I'm just curious about, is there any way to find out more about that 18 percent of people? Like is there something specific about those individuals where we may have a gap in access to care that we could dig into a bit more?

And if you want me to go ahead and ask the second question, or I can pause and see if you want to respond to the first one.

MS. BURTON: We can certainly do research to see if we can get information on that very niche, tiny percent of beneficiaries. It's really a very tiny percent, though.

DR. DUSETZINA: Yeah, I definitely see that overall, that it's only a small percent because of 8 percent times the 18 percent. But, you know, if these are kind of the people endorsing that they're trying to get a new PCP, it's like, well, that's the group that this question is really relevant for, and if almost 20 percent of them are having a hard time it would just beg the question of why.

The other question I had was about some of the great work that you presented around health disparities in the report, and one of the issues was a question about did you wait longer than you wanted for your care. And I just wondered, is there a measure of like wait times specifically so we know kind of how long you wanted to wait is measured similarly across groups or people with similar health care needs? Is there a more objective like number of days you had to wait type of measure?

MS. BURTON: Not really. It's hard to kind of tease that apart, but I can make a note to see what more we can do for the future.

DR. DUSETZINA: Okay. Great. Well thank you again for this fantastic report.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you very much, and again, my applause for taking on this topic, a complex, nuanced issue.

I have two questions. The first I'm just curious about, and it's a question, not a critique. I can't find the number in the document right now, but the low threshold was 15 beneficiaries. Is that correct? Providers seeing 15 beneficiaries or less would be excluded from the analysis? I was just wondering the rationale for that threshold. That seems still very low to me.

MR. GERHARDT: I'll take that. So our analysis of like encounters, we exclude providers that have seen very few beneficiaries just to kind of take the noise out of the analysis. It represents very, very little, relatively speaking, a small part of the overall encounters. So it is to kind of put a floor or a minimum threshold so there's not as much churning of the clinician base, and we can sort of look at the trend over time in a reliable way.

DR. RAMBUR: So my question is more the opposite. I was just curious if that's too low. I mean, it seems like a higher threshold could be a floor. So I just didn't know if that was the standard floor or whatever. It's really not a huge issue, but, you know, 30 a year seems low to me, or whatever. So I was just curious if that's sort of standard, but it's not a big point for me. I definitely agree you have to exclude the low volume because of the churn.

The other question I had related to the beneficiaries self-reporting their provider or nurse practitioner or physician assistant or MD, but later on there is analysis related to claims and billing. And I was just curious if incident-to billing by a nurse practitioner or a PA shows up as a physician encounter or as the encounter of the person providing the service and billing in that manner.

[No response.]

DR. RAMBUR: Thundering silence?

DR. MATHEWS: So for lack of answer on the part of the staff here I will make a run at it. So any services provided by an NP or PA incident to a physician service would be billed under that physician's NPI. Is that correct?

MR. WINTER: Yes.

DR. RAMBUR: Yes, that's my understanding. So the reason that I'm bringing it up is it may be that some of the disparities or discrepancies we think we are seeing is that there's less physicians in rural areas, so they are not billing under incident-to. And I know, not for this report but in the future, I think it would be really terrific if we could kind of have a sense of what the magnitude of that incident-to billing is. I know MedPAC made a recommendation before to get rid of incident-to billing. This is just another example of where it gets in the way of understanding what's really happening.

So hopefully that didn't go into Round 2, but thank you.

DR. MATHEWS: And as part of that recommendation we did do some analysis to try and get at the share of incident-to physician billing that was actually being done by NPs and PAs, and we can put that back in front of you, just as a reference.

DR. RAMBUR: That would be great.

MS. KELLEY: Jonathan Jaffery.

DR. JAFFERY: Yeah, thanks, Dana, and thanks, everybody, for the great report and presentation. Just one quick question. You talked a bit about the variation that you saw in ambulatory care-sensitive conditions and fee-for-service Medicare in different parts of the country. Did you look at all beneficiaries who were in ACOs versus non-ACO beneficiaries?

MS. TABOR: We have not looked at that, but it's something on my to-do list.

DR. JAFFERY: Okay. Sounds good. Thanks.

MS. KELLEY: Bruce.

MR. PYENSON: Thank you. One of the slides you reported that physician compensation, meaning physician salaries, went up by approximately 1 percent. I think there's information that the Medicare spending and the allocation of special funds increased spending to physicians by about 15 percent. Do you have any visibility on what happened to commercial spending on physician services? What I'm trying to get at is the 1 percent, of course, is a lot lower than the increase in spending attributed to Medicare, but, of course, that's not the whole picture.

MR. WINTER: So let me try and understand. So we say that the provider relief funds were about $17 billion in funding for physicians and the Paycheck Protection Program provided loans that were forgiven up to $18 billion. That is for all clinicians. We are not allocating that specifically to Medicare. Okay, so I wouldn't add $35 billion to whatever Medicare paid clinicians in 2020.

But in terms of your question on how commercial payments to clinicians changed in 2020, I can't think of anything off the top of my head, but I wonder -- I'm looking at Rachel here on the screen -- if TheraHealth had data on that, that we could bring back to Bruce.

MS. BURTON: Yes, we do, and we can.

MR. PYENSON: Perfect. Thank you.

MS. KELLEY: Marge.

MS. MARJORIE GINSBURG: I have a question about the section on telehealth, and perhaps I'm mis-remembering our previous discussion. So on page 53, it says that we are gathering evidence that relates to audio. And I thought that we were gathering evidence that applied to all new telehealth services that started during the pandemic, not just audio. So am I mis-remembering or has something changed that I'm not aware of? Thank you.

MR. WINTER: You're correct, Marge. Our policy option does say that CMS and us and others should be examining the impact of all telehealth services on access, quality, and cost. That's part of the reason we suggested extending the flexibilities for a period of time after the

PHE.

Here in this chapter we are focused specifically on the audio-only telehealth services, because we don't have claims data that allows us to identify, in many cases, whether a telehealth service was provided over the telephone or audio and video together. And to assess that particular segment of telehealth we need better information on the claims to do that. For telehealth services in general, yeah, we can tell on the claim whether somebody was provided telehealth or not. What we can't tell is was it provided by telephone only or audio-video, in many circumstances.

MS. MARJORIE GINSBURG: Is that a problem with our data gathering or the expectations about how this is being billed? I mean, it seems to me of all the really complicated things that everybody has to do, differentiating between audio-only and audio-visual doesn't seem like it should be a deal-breaker.

MR. WINTER: Right. It's an issue with billing, billing of Medicare. So when a clinician provides a telehealth service, and let's assume it's one that can be done both on audio-video and over the telephone, and that's about 86 of them right now, the clinician, when they bill Medicare, they include a modifier, essentially a code, on the claim, that tells Medicare, that tells CMS, okay, this was done by telehealth. But it doesn't say whether it was done by audio-video or over the telephone.

And so what this recommendation would do is CMS would be changing its billing structure and telling clinicians that from now on if you do this audio-only you have to provide Modifier A, and if you do it audio-video then you bill it under Modifier B. So essentially it's telling clinicians to bill a little bit differently.

And there is a precedent for this, because CMS, beginning in 2022, they have decided to require clinicians to bill for audio-only services for mental health and substance use disorders, to include a special modifier to indicate that it was done over the telephone. So CMS has already begun doing this for certain kinds of telehealth services. What we're saying is do it for all telehealth services that can be provided over the telephone.

MS. MARJORIE GINSBURG: Okay. Thank you.

MS. KELLEY: Pat.

MS. WANG: Thank you. I had some questions about the metrics that are used to assess quality of care. I guess the thing that is so striking is that they don't seem particularly on point and they seem extremely nonspecific. And I guess the question is whether there are other metrics of physician quality that could be considered, because, for example, ambulatory care-sensitive hospital use, ED admissions can be indications of adequacy of physician supply in the community as opposed to the quality of the physician service that's rendered.

The patient experience scores that are cited are an extremely general rating of health plan, rating of health care quality. It could be I love the benefits that Medicare fee-for-service affords me and I'm rating it high, and very nonspecific to the individual physician, who is actually giving care to me.

I just wondered, this is a challenge, I think, in all of the sectors, but in many of the sectors, for example, in hospitals, what is the readmission rate? It's something that you can kind of sort of say a hospital, is there any information or have you considered any other quality indicators around physician services, because of all of the indicators that we have here -- I mean, this is such a vitally important component of our health care and Medicare program -- they just seem so atmospheric and nonspecific to physician services, the quality of specific physician services.

I'm curious whether there are others that are complicated. Is it data collection?

MS. TABOR: Yeah, this is where I would be really open to Commissioners' ideas. I've spent a lot of time kind of thinking about this, especially over the past year. And what I found was we are really stuck by the fact that we don't have clinical data. So if you think about the measures that the Commission has supported in the past, for like MA plans, so like diabetic A1C control, MedPAC does not have access to electronic health record data to be able to understand how a diabetic's blood sugar is controlled. So we're kind of stumped there.

And then thinking about like HOS measures, health outcome survey measures, about how people have improved or maintained physical health -- which again was another measure that the Commission really supported in MA -- CMS does not currently conduct that survey on fee-for-service beneficiaries, and haven't for several years. And actually

I think we have a past recommendation that CMS should go back to collecting health outcome survey results from fee-for-service beneficiaries.

And there are some process level measures that we could do in the claims data, but the Commission, again, has not really been supportive of process measures, and even for those that we could do, they're pretty narrow. They only look at perhaps some physicians, not all physicians. That's another one of the challenges we kind of face, is that, you know, a measure that's good for a primary care physician may not be applicable to a nephrologist, and vice versa.

So I guess I also struggle with this and kind of your concern and would be welcoming to any ideas on specific measures that we could develop.

MS. KELLEY: Amol. Oh, sorry, Pat. Did you have more?

MS. WANG: No, just thank you.

MS. KELLEY: Amol, you're next with a Round 1 question.

DR. NAVATHE: Thanks, Dana. So I have a couple of Round 1 questions that are probably in generally the same vein on access. So in the paper, on page 19, you have Figure 4.03, which is -- the title here is "Majorities of beneficiaries report no problems finding a new primary care provider or specialist." And I was curious about our framing here, because while there's certainly a small minority of patients or beneficiaries who are seeking, say, a new primary care provider, you know, a different interpretation could be almost 50 percent, almost half of those who sought a new primary care provider reported that they had a problem or something like that. And so I was curious if there's -- if we're relying upon stability over years or how we're as reassured as we seem to be around this access issue in the context of this analysis.

MS. BURTON: So we've interpreted these findings along the lines of what you just said in the past, but I think this year we looked at the fact that at the end of the day it's a very similar percent of beneficiaries who are experiencing problems finding a PCP or a specialist. It's like 3 or 4 percent for each of them. So that's why we thought to go with this presentation this year. But your feedback is very useful to us, so thank you.

DR. NAVATHE: Okay, thank you. So I think the other questions I have are somewhat in the same vein. On page 23 and on page 25 there's other statements I think that are important. On page 23, I think there's a note about some, I guess, data points that we could have some disparities in access, at least hints at it. So a higher share of Black beneficiaries reported having to wait longer than they wanted to for these appointments, 30 percent compared to 19 percent for white beneficiaries. And then on page 25, there was a question of higher wait times or an observation of higher wait times for low-income and middle-income beneficiaries. I was curious if we made any effort to try to bring these elements together, stratifying by race and by income, for example, to see if we can hone in on differences that may perhaps even be larger than what we're observing here, if we think about a multivariable analysis, a stratification, something to push this a little bit deeper.

MS. BURTON: So we don't have a huge sample that we're working with, so the minute we start combining variables, our cell size gets really tiny and suddenly very few things will be statistically significant. So that would be the reason we haven't done that type of analysis.

DR. NAVATHE: Okay. Got it. And then the last question I have is I realize we're using multiple sources here, but part of it is, of course, our own MedPAC survey. Have we looked at any concerns around response bias? I think oftentimes we're referencing to the private insurance market as well and saying, well, these metrics look pretty similar to what we see there, and that feels reassuring, I think, to some extent, could very well be reassuring, but it would be good to have a sense that the respondents that we're getting are, in fact, similar to -- or a representative sample of beneficiaries essentially.

MS. BURTON: Our survey produces nationally representative results. They're weighted to produce national representative results, and they produce findings that are very comparable to multiple other surveys. We've benchmarked against the health and retirement study last year and this year, and most years we do MCBS as well, and so we see findings that are very similar and comparable across our small survey versus much larger surveys. So we feel pretty confident in the representativeness of our results.

DR. NAVATHE: Okay. Those are all my questions.

Thank you.

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

MS. BARR: Just a curiosity because I'm not as familiar with it, MEI versus market basket update. Is the MEI -- you know, because we're really relying on those updates to sort of take care of all the wage costs and things like that. Is MEI -- do you have the same confidence in MEI to be able to reflect those costs as we do with the market basket updates for the hospitals?

MR. WINTER: The one thing -- the first thing I'll say about the MEI is that it's not used in the physician world to determine the update, as it used to be under the old SGR system. So it's something we track, you know, as one of our indicators because we're obviously interested in projections of cost growth in the recommendation in the year 2023 as well as what the trends have been more recently. So that's the first thing I'll say, is that it's not used by CMS to set the updates. Those are set --

MS. BARR: Because there are no updates, right? I mean, the fee schedule is frozen. Regardless of the cost

--

MR. WINTER: Right.

MS. BARR: -- the fee schedule is frozen. And so I guess I'm just struggling to understand, knowing that costs are going to go up dramatically, how can we continue to freeze the fee schedule. Is that a Round 2 question?

[Laughter.]

MS. BARR: I apologize.

MR. WINTER: I would say kick that back to Commissioners. But I can answer the second part of your first question, which was about how confident are we in the MEI. We talk about this in this year's draft chapter, as well as in prior years, that the MEI is kind of outdated and uses cost categories and cost weights that are from 2006 data from a big survey of physicians that was done then, and they really have not been updated -- they've been updated in a few minor ways, but not in a major way since then. And this goes back to a bigger problem we have, the lack of recurring accurate sources of data on physician practice costs. And CMS has acknowledged that, you know, the data is kind of out of date, but they're not aware of a better source of information. And we're also not aware of a better source of information. So there are definitely issues, and we acknowledge them.

The proxies -- the information that they use to update the change in prices, those are based on recent and pretty, you know, credible sources of information like wages and so on for professionals and other occupations. And so that part of the index I think is -- I'm more confident in. It's the cost weights, like what percent of -- is it a cost related to rent versus supplies versus compensation? That has almost certainly changed in the last 15 years.

MS. BARR: Thank you.

MS. KELLEY: Mike, that's the end of Round 1.

DR. CHERNEW: Okay. Going once, going twice, gone.

We're going to start Round 2, and we're going to go through the queue. When you make your comments, please say something about your -- I don't know -- willingness to support the recommendations so we can get sort of an explicit record, and then make any comments you have. I want to make sure we reserve time for those that are not in the queue because I will go around to make sure everybody gets a chance to at least say where they stand on the recommendations. So I think we have about 30, 40 minutes left, until 3:15 I think is when we're going. So let's start going through the queue.

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

MS. BARR: Thank you. Well, you know, I'm very concerned about the increasing costs. I think the idea of freezing the fee schedule and moving people into MIPS was great in a very low-inflation environment, and I'm very concerned about this recommendation, seriously underpaying our physicians for the work they do.

Thank you.

MS. KELLEY: Jaewon?

DR. RYU: Yeah, I think I would err on the side of agreeing with Lynn. I think in the end I could wrap my mind around it. It somewhat, you know, seems fairly reasonable, but I just can't help but feel like -- and maybe this is partly just hunch. I keep thinking about leading versus lagging indicators, and it feels like if I had to guess, given all of the things that we're seeing, my hunch is that we might be looking at lagging indicators of access rather than leading ones.

I'd point to a couple things that I found particularly concerning. One was on Slide 12 with the ambulatory-sensitive conditions and the geographic variation that we're seeing on those. I think that is to me a very troubling sign, that there's probably a lot more opportunity around access than first might meet the eye.

I think the other that I find concerning about that is that we may be inadvertently reprogramming the access expectations of beneficiaries where any urgent need, they're conditioned to go to the emergency room and don't even expect that those things can be addressed in primary care. And, of course, you know, our desired outcome I think would be very different than that. So that is one area that gives me some pause.

I think the other is just anecdotally we all know and we've talked in these sessions before about the difficulty of finding primary care, especially if you're new to a market or so forth. There's just enough there that seems to counter some of the findings in these surveys. I think one element that maybe we have not looked at are the emergence of primary care models that have some sort of subscription fee attached to them, whether it's concierge models or emerging primary care businesses that are indeed set up that way. I think those all suggest to me that the traditional kind of revenue model and the payment levels aren't keeping pace with what is needed to bolster the primary care infrastructure.

And so for all of those reasons, something doesn't sit well. It's a little bit unsettling. But I can't seem to put a concrete finger on it such that I would say that, you know, the recommendation is not acceptable. I do think it's within reason, but it feels like we've got to pay really close attention on this one.

MS. KELLEY: Betty.

DR. RAMBUR: Well, thank you. I'm going to take these one after the other. The first one in having the claims -- or a modifier for telephone-only I really strongly support. And just to refresh what I've said before, I recall living in the state of Vermont where blocks from the academic medical center you did not have broadband.

At the same time, I am concerned about things that are actually routine actually now being an additional charge, and as a nurse practitioner, I must have made hundreds if not thousands of calls. And so I think this is a good and important next step kind of balancing those two poles.

In terms of the other recommendation, I just wanted to, you know, remind myself and perhaps you that the compensation, raw compensation is 304, for primary care providers it's about 250,000 a year. And then not in the report is the average for nurse practitioners and PAs, which is both around 150,000 a year, last time I looked. And I wonder if we also at some point need to think about adequacy there. We know that with incident-to billing, a lot of work is being done by those providers with an extra 15 percent bump. So as we talk about -- a 15 percent bump and having this appear as physician work. So as we talk about site-neutral payments, I'd love to see us in the future think about provider-neutral reimbursement in which more complexity of care is reimbursed so that we're actually recognizing the value of individual service.

So looking at all of this and this enormous amount of flux, I probably land a little bit -- I'm more on the yes side. You know, I hear some of the dis-ease that Jaewon mentioned, but I think given right now I feel comfortable with this recommendation, although I'm very concerned about some of the disparities that we're seeing that were in the report.

Thank you.

MS. KELLEY: Amol.

DR. NAVATHE: Thank you. So I guess first I'll start off and say that I generally register my support for both of the Chairman's draft recommendations here. I do echo a lot of Jaewon's comments in terms of I think there's some complexity here. I think we should be very careful not to be too reassured. I think there are indicators of concern around racial lines -- or, sorry, metrics in terms of performance and experience by race as well as by income status. I think the stability is reassuring year to year, and the reference by insurers, for example, the members of private insurance companies, but I still think we should worry a little bit about that.

I would like us to find a way to go a little bit deeper, and I think if there's a way to register some support from other Commissioners on this to get deeper into the access piece, perhaps see if there are any mechanisms or capacity for the Commission, to try to either expand survey, a follow-up survey, interviews, to get at some of the mechanisms. I had brought up in my questions this question on page 25, why are low-income or middle-income beneficiaries having higher wait times. Do we have any sense of what those mechanisms are? Why is that happening?

I think my understanding to date is that we don't have a great understanding for that, and I think it feels premature to me to say, well, it seems like it's not a huge amount, so let's take a step back and not worry about it. I think, in fact, part of the Commission's obligation is to pursue such a finding and see how we can be as effective as we can in trying to uncover some of those pieces.

On the compensation side, I will say that I think it's important that we be careful about conflating two different concepts. One, is our physician reimbursement, physician fee schedule adequate from a magnitude and generosity perspective to support access to care versus the accuracy of the fee schedule in terms of supporting the right mix of services and equity across the specialties? I think it's easy sometimes to mix those two together and think that raising the fee schedule will then improve access or improve primary care participation even or specialty choice. And I'm not sure that that's actually true.

So that's one of the main factors, I think, that leads me to be supportive of the Chairman's recommendation is I think unless we actually think about some of the more underlying concepts of the fee schedule, I'm not sure that changing an update by a percent here or there is actually going to address some of the core issues that I'm hearing the Commissioners are very worried about. So I wanted to make sure to make that point as well.

Thank you.

MS. KELLEY: Larry.

DR. CASALINO: Thanks, Dana. So three points. First, I support the recommendation very strongly that the Secretary should require that physicians use a claims modifier to identify audio-only telehealth visits. I think that would be very helpful.

Second, quite a few Commissioners are expressing concerns that the report may be a bit overoptimistic about access, especially to primary care, and I agree with that as well. In some places, the framing seems to be a little off. I think I said this last year, actually. On page 19, there's a statement that only 20 percent waited longer than they wanted for an appointment for an illness or injury. To me, one out of five waiting for an appointment when they're injured doesn't seem like a low percentage and does raise to me access questions.

But the main thing I want to say, third and last, is I do have to say that I have reservations about the payment update recommendation. I'm a physician, but I don't mean to speak here as an advocate for physicians. I strongly support efforts to develop APMs, but just based on simple logic, I do wonder about current law and just stating that, you know, we support going along with current law. And I think it's a matter of -- I'm just going to argue based on what seems to me just logic, although I realize that arguments could be made both ways, and I don't -- I probably don't have as strong a belief in what I'm saying as I'm going to sound. But I'd like to raise four points for people to think about.

One is a question. Is there any other sector which Medicare uses differential payments to induce participation in alternative payment models? In other words, is there any other sector in which you get extra pay just for being in a particular type of organization or a particular type of model and not based on performance at all? And if there isn't any other sector in which that's done, what's the rationale for doing this only with physicians? So that's the first point.

Second, you know, the current law does clearly involve government in picking winners and losers, and that happens in the U.S. more than probably people like to think, but in general, I think the prevailing ideology in the U.S. is government shouldn't be very involved in picking winners and losers. You know, physicians can get a 5 percent bonus just for participating in an APM even if the APM performs poorly. In my opinion, rewards should be for performance, not simply for being part of a certain model. If an APM can perform well, it should be very well rewarded, better than APMs are rewarded now, in my opinion. But I don't think a physician should get extra revenue just for being part of an APM.

Third and next to the last point about this is this payment system goes on for so many years. Just year after year there's this 5 percent bonus and differential updates. Lynn's point about inflation, I think, in a payment program that goes on for so long is a good one. Physicians not in APMs are getting no update at a time when they're going to have to hire staff as well. For example, they're going to have a very hard time finding them and retaining them I think is problematic.

And then, you know, MIPS is supposedly a way to reward physicians who aren't in APMs for good platform, but I think the Commission in the past has very strongly pointed out that MIPS is pretty flawed to the point of -- the Commission's thinking basically should be physicians, even if they perform, extremely well in MIPS, they're very unlikely to receive a bonus that's even half of the 5 percent they can receive just for participating in A-APMs. So these are the reasons that I at least would like to hear more thoughts about the recommendation to just go with current law.

DR. CHERNEW: Can I just jump in and say one thing quickly, and then I want to keep moving on? All of the connections between the APM bonuses and stuff are things that I think are going to become important as we go through how we think about the APMs. The update recommendation we have is not directly -- we don't have a recommendation on some of those other things, particularly the things that happen after the 2023 time window. So that's Point 1. And Point 2, very much in the spirit of what Jaewon said, we do need to give a lot of thought versus leading, versus lagging indicators, and that is a core, core, fundamental question we are going to need to think through.

My general view is we aren't yet at the point where 2023 is raising alarms to me, but I do spend a lot of time thinking about the leading version based on lag data. I'm not sure I always get it right. That's why we have these conversations. But I think conceptually what Jaewon said is right.

But the APM part I'd like to deal with when we begin to think through our APM chapter. There's other complexities, it fits into benchmarks, for example, and a bunch of other things.

Anyway, that was my thinking, Larry. I didn't mean to derail the conversation, so maybe we should move on.

MS. KELLEY: Okay. I have Bruce next.

MR. PYENSON: Thank you. I support both

recommendations. I would like to point out that the landscape for commercial insurance world is likely to change in the coming years of the cost of the balance billing rules and the focus on that as well as transparency rules that have been promulgated, required fees to be identified to individual providers.

So I think some of the competitive pressures that have been of concern for the Medicare program for years -- that is, Medicare pays less than commercial, what if physicians don't want to see Medicare patients -- I think those concerns are going to be less in the future than they've been in the past.

I would say the issue of the fee schedule seems to me to be unrelated, in many ways, to the dissatisfaction and the burnout of physicians, which are, as in many organizations, more related to management and infrastructure and schedules. So I think those are really serious issues. Physicians have been the target of blame for the problems of the system, and that certainly doesn't help either.

So I think we're at the point with the employment of physicians that organizations that employ above a certain number of physicians ought to be required to file some form of Medicare cost report, just like we're saying for ambulatory surgery centers, because I don't think it makes sense, in 2021, to think of physicians as independent practitioners working out of their home, but it seems like a lot of the Medicare systems are built on that model.

So, in summary, I do support the Chair's recommendations, but I think there are other issues with the physician workforce issue, the availability of primary care, access to certain populations, that really deserve our attention and fixing. Thank you.

MS. KELLEY: Brian.

DR. DeBUSK: First of all, I do support the claims modifier to identify audio-only claims. I think it is really good policy. I am concerned, and I'm trying to remember who, in their opening comments -- I think maybe it was Lynn -- who was talking about the update itself. The zero update for 2023 does concern me. I mean, we have the 3.75 one-time increase that corresponds to the rebalancing of the RBRVS that CMS and the RUC did a couple of years ago. That expires this year. The 1 percent just does concern me. I don't know that a zero update is practical.

I think we are probably going to drop physicians into employment.

I think if nothing else, you know, we talked a little bit about primary care, if nothing else perhaps we revisit reinstating the primary care incentive payment, for example, because I believe in previous Commission work I believe we included reinstating the PCIP and some of their boldfaced update recommendations for the March report. I would have to go back and fact-check myself but I think we have done it before.

Anyway, I have some concern about the zero-percent update, and I just don't know how practical and feasible it is. Thank you.

MS. KELLEY: Paul.

DR. PAUL GINSBURG: Thanks, Dana. Like Brian, I support the modifier for audio-only visits. And on the issue of the updates, I have been uneasy about this for a long time because I keep thinking of the hypothetical. Let's say that current low is not zero. The current low is the MEI. You know, what's the chance of this Commission would decide for physicians, now their update should not be the MDI; it should be zero. You know, we reserve the zero updates for areas where we think we're really paying a lot too much.

I really like Bruce's idea about considering cost reports for organizations of physicians above a certain size thresholds. I think that would be very important.

I also think that to the degree that there are problems of access, they are probably much more pronounced in primary care than in at least procedurally oriented specialties. The area in California that I live now has long had a primary care shortage, and this is just what people tell me. But something that's much more concrete is the fact that the largest non-Kaiser group in the area that I live refuses to take new Medicare patients for primary care. It will take them willingly for specialty care but not for primary care.

So, I mean, I think there are indicators. I think it is worthwhile for the Commission to try, in the future, to dig somewhat deeper, think about the ways to tap into this. And, you know, primary care access problems for Medicare is more difficult to recognize because so many fewer patients are looking for a new primary care physicians than are looking for specialists, because, you know, for the most part people stay with their primary care physicians, unless they move or unless their physician retires. So there are a lot fewer people are, in a sense, vulnerable to an access problem.

So, you know, I think for this year I'm probably okay with supporting the Chairman's recommendation, but not forever. Now this is my last year, but perhaps the Commission shouldn't be doing this forever. I think it should be maybe working on further fixes for underpayments for primary care, separate from the update process, but also as part of the update process looking somewhat harder at that access.

MS. KELLEY: Dana.

DR. SAFRAN: Thank you. So just starting with the easy part, I definitely support Recommendation 2 around the claims modifier for audio-only visits. On Recommendation 1, I share the concern of many of my fellow Commissioners. So I would say I reluctantly support Recommendation 1.

But, you know, the issue here for me, and it sounds like for many others, is that we have, for a long time, felt that MIPS was very poorly constructed, and it hasn't improved significantly. And so to see MIPS as the basis for rate increases for physicians who are not in advanced payment models just really almost adds insult to injury in terms of how we're looking to deal with physician payment.

And so me, as I reflect on this, the chapter and this conversation, it really feels like it is time for this Commission to take a step back and look holistically at the way that we measure and reward quality in the Medicare program. We have long wanted to move in that direction, that we could harmonize across the programs or where we decide to create differences to do that purposefully, not because of deficiencies in the data we have available to us and so forth. So I would really encourage us to think about that as the next important policy matter that we take up.

I also want to caution us against complacency, that what we see in the survey results reflects experiences that we can feel confident in, not only because they tell a good story but because they're the same story told in other surveys. I want us to understand that the other surveys suffer from the same nonresponse by us that we have, and nonresponse by us cannot be addressed through the weighting process that I understand that we and other surveys use.

We know, at this point, we have enough data point, both survey and otherwise, to tell us that there are some quite vast disparities in care, vast disparities in access, and the fact that the surveys aren't showing us that tell us that those who are missing, systematically, from responding to the surveys are having a different experience and we're not able to pick up on that.

So there is no easy solutions to how to address that nonresponse bias, but at this time where all attention really has turned meaningfully onto health equity, I think it is a moment where we can take a new look at what methodologies we can use to begin to engage populations that have always refrained from participating in our surveys and the others.

And then finally I just want to lend my voice of support to the points made by others, most recently right before me by Paul, around finding some mechanism to incorporate fixes for payment for primary care. I think that's something -- you know, this is my fifth round here, and we talk about it every year, and we haven't really spent time to consider what that might look like, but I hope we will do that in the next cycle.

Thank you.

MS. KELLEY: Pat.

MS. WANG: Thank you so much. I support Recommendation 2. It makes a tremendous amount of sense.

The conversation has been really interesting, and, you know, the overwhelming feeling that I get from it is that we're not talking about a sector. We're talking about hundreds of thousands of individual practitioners who are in a multitude of specialties and do different things every day. Jaewon outlined many of the dynamic changes that are going on with the way that physicians practice, and that description applies to different types of specialties.

The additional one that I would throw in there are there are many physician groups that are now looking for risk in Medicare Advantage, from Medicare Advantage plans, and are organizing themselves, whether they are piggybacked, insurance-company owned, independent, what have you, which is another indicator of, I think, something going on, like maybe fee-for-service is just a really hard way to make a living so those who, regardless of the update factor, so that people are looking for different ways to practice. I think it has to do with more than money, though money is very important.

I wanted to suggest, I just wonder whether it could help, given the vastness of the so-called sector, whether in future analyses or maybe going forward it could help, the survey responses on access or just a small sample, and people have talked about the gaps in what they really tell us, is it time to look at some of the physician manpower analyses, you know, PCPs per 100,000, what's the ideal specialist per 100,000, what's the ideal cognitive specialties? I suspect that we might find, especially with the group and specialists, 75 percent of physicians now taking Medicare are specialists, and a slight decline in primary care physicians. It's possible that we might glean something about that.

I am troubled, as other people are, with the notion of a zero update, but I'm also troubled with the idea of the update just gets peanut-buttered across this vast heterogeneity of specialists, geographies. You know, I think it would be hugely appropriate in some cases and probably inappropriate in other cases.

So I feel like, you know, going forward, more understanding of sort of manpower supply that could inform our understanding of where there might be need for more targeted approaches. People have talked about primary care. I throw the cognitive specialties in there. It's really, really hard to get an appointment with a neurologist, if anybody's ever tried. And maybe there really do need to be more targeted -- there definitely need to be more targeted approaches, and I would urge that we not let that fall off the radar screen.

The peanut-buttered update factor, I think, zero is terrible, but peanut-buttering a number across the whole sector feels very unsatisfactory to me as well. So having said that, which would lend support to the Chairman's recommendation, I would hope that we -- or I would sort of make it conditional, I guess, that support, that we continue this deeper dive into looking for more targeted payment adjustments to ensure true access and quality, because that's the other thing that's really missing, to everybody's points, in the earlier conversation. We don't really know what we're paying for.

Thank you.

MS. KELLEY: Jonathan Jaffery.

DR. JAFFERY: So thanks, Dana. I will try to be brief because my comments are a lot of similarities to what my fellow Commissioners have said.

So first off, I am also fully supportive of the second recommendation. It makes perfect sense. And I too have some difficulty grasping zero-percent update, as well as thinking about how it makes sense that in the future we would set the updates in stone so far in the future. I think some of our goals around maybe incenting people to move into advanced APMs through a differential update could still be accomplished without having those numbers set so far in advance.

I think Pat's point was really interesting about groups getting more interested in taking risk. One of our other goals has been to try and think about how to get those MA payments that are population-based to plans but then get transferred to providers. You know, 85 percent of them get transferred to providers, fee-for-service trying to move that dial. And a lot of the providers, as she pointed out, are starting to have that interest so we should help support that.

So in the short run I know we're not going to solve lots of problems now, immediately, so I think for the immediate term I can be supportive of Recommendations 1 and 2, but do feel like we need to think about this really quickly. And actually, I really liked Brian's idea of folding in a recommendation around a bump to primary care physicians, and as he pointed out, we have some precedent for that in the past. If there's a way to frame it that includes cognitive specialties as well, I think that would also certainly be acceptable. Thank you.

MS. KELLEY: I think that's the end of the queue, Mike, unless I've missed someone. Please shout if I have.

Mike, I'm sorry. We can't hear you. Let me see. Try now? I think we've lost you, Mike.

DR. MATHEWS: Dana, let's try and give Mike 30 seconds or so, and if he can't rejoin, we'll try and sum up here.

MS. KELLEY: Okay. David?

DR. GRABOWSKI: Yeah, I can be really brief here while Mike's getting his mic in order. I'm generally supportive of both of the draft recommendations. I think the audio-only rec is a no-brainer. The update recommendation is a bit more challenges, as other Commissioners have been discussing. I do share the concern about the survey methodology. I think Amol mentioned starting a broader discussion on how we might gather additional information and really improve the measures that we have.

Dana started that discussion, and I loved her point about when we compare a flawed survey with other flawed surveys, it's not surprising we potentially get similar results.

But I really suggest -- and I know this idea has come up in the past -- that we might want to think outside the box. One idea we've talked about has been audit studies could be a potential approach, especially towards getting at access issues around race or gender or other factors, dual eligibility. I think there are opportunities here to try other approaches, so I would love this to be sort of a broader discussion going out about how we can sort of build a better set of measures for evaluating access and quality for physicians.

Thanks.

DR. MATHEWS: Dana, has Mike been able to rejoin?

MS. KELLEY: I don't -- Mike, I think, has logged off and will try to log back in.

DR. CHERNEW: I am back.

MS. KELLEY: All right.

DR. CHERNEW: I am back. Can you hear me?

MS. KELLEY: Yes, we can, Mike.

DR. CHERNEW: I am sorry.

What I wanted to do was to go through the rest of the Commissioners who didn't get a chance to comment on the recs. They don't need to make a broader comment. I just want to know where the people that haven't spoken stand. So I think -- I'm not sure I have the exact list. You may, but I could start, for example, Wayne, do you have comments on this topic? You may have talked while I was gone.

MS. KELLEY: Wayne, we can't hear you. I'm sorry. We seem to be having some audio issues. Try again, Wayne, with your mic.

No, I'm sorry. Maybe we could go to Stacie while Wayne tries to --

DR. DUSETZINA: Hopefully this works.

MS. KELLEY: Yes, we can hear you. Thank you.

Wayne, you might want to log out and log back in.

DR. DUSETZINA: I am fully supportive of Recommendation 2. Like the others, I think a claims modifier makes a lot of sense, and I'm looking forward to seeing how the audio-only telehealth tracks.

And then for Recommendation 1, I'm supportive, but I also have really appreciated the other Commissioners' comments especially around primary care, and I do think that there are some signals of access problems for people who are having to switch to a new PCP in particular. So I think that really trying to dig into those and figure out how to do some targeted improvements for PCPs would be great.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: I also support Recommendation 2, and like the comments of so many of you, I support Recommendation 1. My interest in delving more deeply into the issue around PCPs and access to PCPs and compensation of PCPs is very high on my agenda. So the more work we can get in that area I'd support, but for now, I'm fine with both 1 and 2.

MS. KELLEY: I think Jon Perlin may have his camera off, but is he listening and does he want to weigh in?

DR. PERLIN: Thanks, Dana. Let me join in supporting Recommendation 2. That's easy. Let me also join in the chorus of concern about the indicators of access adequacy. I think I've made this point every year, and I've referenced my father, who is a very healthy but older old individual, and, you know, this is where I think as individuals enrolled in Part B we have the opportunity to think outside the box and seek census. It's been the primary care that is the issue, and, you know, as an internist, that's what I hear from patients broadly. I realize the plural of anecdote is not data, but that's our obligation to get those data.

I also want to endorse the targeting of primary care for that reason. I think Larry also makes a couple of important points that Dana reinforced. First, the MIPS is flawed, a shared point, and Larry's point that rewarding participation as opposed to rewarding performance, you know, drives the participation but doesn't necessarily drive to the quality we want. So I, too, will reluctantly get behind the recommendation, but even between now and

January, if there's further consideration of a recommendation for really a census, not just a survey of beneficiary access, and special consideration for primary care, I would be there in support of that as well.

Finally, Brian's point, when you think about why physicians are going to concierge model or going to consolidated groups, you know, I think it's hard not to draw the line to add these concerns. Thanks.

DR. RILEY: This is Wayne. Can you hear me now?

MS. KELLEY: Yes, we can. Thank you, Wayne.

DR. RILEY: Thank you, Dana. Rich discussion, a very complicated topic. I'll have to join Jaewon in a mild dissent on the pay update. You know, as a primary care general internist, just anecdotally, there's not a week or a month that goes by where I don't get someone calling me because they can't find a primary care physician. And it's complicated, but it's an urgent need that we have to help the Congress think about. You know, no problem, no quarrel with the modifier for the telehealth visits.

DR. CHERNEW: I don't know if I'm with you. Am I with you?

MS. KELLEY: Yes, we can hear you.

DR. CHERNEW: Okay. I'm not sure exactly which one you're hearing me through, so hold on one second. Can you hear me now?

MS. KELLEY: Yes, we can.

DR. CHERNEW: Because I can't hear you. But in any case, what I wanted to say -- now I might be able to hear you. Say something.

MS. KELLEY: Can you hear me?

DR. CHERNEW: Yeah. I feel like I'm in a Verizon commercial. In any case, I am so sorry. I think I heard you all. I just wanted to make one last point because I think we've now heard from everybody. Is that right, Dana?

MS. KELLEY: I believe we have.

DR. CHERNEW: Great. So the one thing that Jim clued me in on as this was going on is the E&M rule is scheduled to give primary care physicians roughly a 4 to 6 percent fee bump from where they were. So this gets to a little bit of Amol's point and a little bit to the peanut buttering. I guess that's a code for "spread," a comment that Pat made, which I think is spot-on, which is there's a distinction between overall amount of the fee schedule, what we're doing now, and how it gets distributed across the different groups.

I very much hear and very much appreciate all of the discussions about the nuances and all of the concerns about the data analyses and the data and, in particular, Jaewon's points about the leading and the lagging indicators, which you will continue to look at. So I will ponder all of these comments. I will tell you my gut feeling now is although I share your concerns, particularly those around supporting access to primary care, I think the recommendation we're doing now is a little bit more of the peanut butter recommendation, and hopefully -- you know, we've been supporting primary care for a long time, and hopefully things through the E&M rule, et cetera, will be helpful. I don't know if any staff want to make comments on that point before we move on -- we're a little bit over -- move on to the next section.

DR. MATHEWS: Yeah, let me just very quickly mention the fact that we have -- you know, speaking of leading versus lagging indicators, we have been concerned about what's happening with respect to access to primary care for at least a decade now. We've seen this greater difficulty in finding new primary care physicians relative to finding new specialists. That differential has persisted over time. We see specialists composing a greater share of the physician population, and we have, you know, again, a number -- this year is the first year, I think, that we saw an absolute decline in the number of primary care physicians participating in Medicare.

We've made a number of recommendations over the years to try and focus on increasing the supply of primary care physicians treating Medicare patients. These have taken the form of things like the semi-cap or partial capitation for primary care. We've discussed a loan forgiveness program a ways back. We did discuss, you know, a rebalancing of the fee schedule not inconsistent with what CMS ended up doing with respect to E&M, but we've got a long track record here, and so at, you know, our earliest possible convenience, we can repackage some of that stuff for the benefit of the Commissioners who haven't been along for that ride, and we can see what other new ideas we can generate.

But we do hear you loud and clear that, you know, this is a targeted problem that might benefit from a targeted solution rather than giving an across-the-board update to all physicians and hoping it lifts all boats.

DR. RILEY: Yeah, Jim, this is Wayne. As one of the newer Commissioners who's very interested in primary care access issues, that would be very helpful for my learning. Thank you.

DR. CHERNEW: Okay. I apologize for my audio issues. I am hoping you can all hear me now.

MS. KELLEY: Yes.

DR. CHERNEW: Okay. I very much appreciate this. This has been a really, really, really fruitful discussion. I think there has been a whole wide range of really productive comments about both measurement and substance, and I think I and, as Jim just mentioned, the staff share all of the concerns. I hope it's clear that it's been evident in a number of things that have been going on for a long time.

That said, it does need to be clear in the chapter. We need to think about our indicators and all the other things that you said. So we will take that all under advisement, and now I think we should move on to the next session, which is now going to be Dan talking about ambulatory surgery centers. So hopefully my Internet and everything will hold out, but for now -- I will be here. I'm going to go off camera for a minute, but I will be here, and we're going to turn it over to Dan.

DR. ZABINSKI: Can you hear me?

MS. KELLEY: Yes, we can, Dan.

DR. ZABINSKI: All right. Thank you.

Good afternoon. In this presentation, we will be discussing payment adequacy for ambulatory surgical centers, or ASCs. For the broader audience, PDF versions of the slides are available on the webinar control panel on the right side of your screen. And I would also like to thank Lauren Stubbs for her assistance on this analysis.

In our assessment of payment adequacy for ASCs, we use the following measures: access to care, measured by the capacity and supply of ASCs as well as the volume of services; quality data, using measures from the ASC Quality Reporting Program or ASCQR; access to capital measured by the change in the number of ASCs and acquisitions by corporate entities; and aggregate Medicare payments. And finally, we are not able to use margins or other cost-dependent measures because ASCs do not submit cost data to CMS.

A key difference from most prior years is that the coronavirus public health emergency has had a tragic and disproportionate effect on Medicare beneficiaries and on the health care workforce. From the perspective of assessing the payment adequacy, the PHE has affected the applicable indicators. Therefore, while it is important to analyze 2020 data to understand the state of beneficiaries' access to care, quality of care, provider's access to capital, Medicare payments, and provider's costs, it is more difficult to interpret these data than usual. For example, changes in quality metrics may reflect the effects of the pandemic on the elderly rather than a change in the quality of care provided to Medicare beneficiaries.

As the Commission stated last year, to the extent the coronavirus effects are temporary -- even if over multiple years -- or vary significantly across providers, they are best addressed through targeted temporary funding policies rather than a permanent change to all providers' payment rates in 2023 and future years.

For example, ASCs did receive some relief from the public health emergency through the Provider Relief Fund and the suspension of the sequester.

An overview of ASCs in 2020, the Medicare fee-for-service payments to ASCs were about $4.9 billion; the number of fee-for-service beneficiaries served was 3.0 million; and the number of Medicare-certified ASCs was about 5,900. Also, the ASC payment rates will receive an update of 2.0 percent in 2022.

Turning our discussion to payment adequacy we use the measures we presented on the second slide. On this table, the values for measures of payment adequacy in the first column indicate there was strong growth in the ASC setting from 2015 through 2019, but the public health emergency had an adverse effect on the number of beneficiaries served and the volume of services per fee-for-service beneficiary, as both those measures decreased in 2020. Nevertheless, the number of ASCs continued to increase in 2020.

A little more detail about the decrease in volume. Even though the volume of ASC services decreased sharply in 2020, nearly all the reduction occurred in spring of that year. We evaluated monthly volume in 2019 and 2020 for the 30 most frequently provided ASC services, which constitute 75 percent of all ASC services. This diagram shows that ASC volume in April 2020 was only 11 percent of the April 2019 volume, but the volume strongly rebounded and the volume in December 2020 was 97 percent of December 2019 volume.

Turning to ASC quality , in most of the other sectors that my colleagues will cover over the next two days, 2020 quality is difficult to assess because of the effects of the PHE. For ASCs, these concerns aren't as pertinent because the measures are more stable. We found that ASCs have five measures for which we can compare 2019 to 2020. We found that four of them were unchanged from 2019 to 2020, and one improved. We caution, however, that the measure that improved is voluntary and not many ASCs submitted data for it. Also, note that ASCs were not required to submit quality data from the first six months of 2020.

Finally, CMS is in the process of improving the ASC quality reporting program, but we still have two concerns about it. First, there is no plan to implement a value-based purchasing program, and second, the claim-based outcomes that CMS has implemented or plans to implement into the ASC QR do not apply to all ASCs.

Turning to access to capital, the best measure for evaluating ASCs' access to capital is the growth in the number of ASCs, because capital is needed for new facilities. This graph shows that the number of ASCs has steadily increased over time. Growth of 2.0 percent in the number of ASCs in 2020 indicates that access to capital has been at least adequate. In addition, hospital systems and other health care companies have been acquiring ASCs, and this trend continued in 2020, and these acquisitions suggest that ASCs are profitable.

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

The final payment adequacy measure we'll cover is ASC revenue. From 2015 through 2019, ASC Medicare revenue per fee-for-service beneficiary increased at a strong rate of 6.7 percent per year. But the public health emergency caused revenue per fee-for-service beneficiary to decrease by 3.9 percent in 2020. This decrease was due to a host of factors, but the most important effects occurred among the users of ASC services.

On one hand, revenue per beneficiary that used ASC services increased by 10.2 percent. Among the factors that contributed to this increase were a 6.3 percent increase in the average relative weight of the surgical services provided, a 2.6 percent payment rate update, a 0.6 percent increase in revenue from increased drug spending, and a 1.2 percent increase in revenue from the suspension of the sequester. On the other hand, these increases were more than offset by a 15 percent reduction in the number of fee-for-service beneficiaries who used ASC services.

On a final point, we were not able to determine a margin for ASCs because ASCs do not submit cost data to CMS. However, there is a Pennsylvania state agency that collects cost and revenue data from all ASCs in that state, and this agency used these data to calculate a total margin in 2020 of 22 percent.

To summarize our ASC findings, the PHE affected the payment adequacy measures, but they remained generally positive despite the decrease in ASC volume. After a substantial decrease in Spring 2020, volume rebounded strongly and was nearly back to the 2019 level by the end of the year. In addition, the number of ASCs increased in

2020, and this increase in the number of ASCs, coupled with the continued acquisition of ASCs by corporate entities, suggests at least adequate access to capital.

Regarding quality, the available measures were largely unchanged from 2019 to 2020. In addition, the ASC sector should move to a value-based purchasing program for measuring quality.

Finally, aggregate Medicare payments decreased in 2020 after several years of strong growth, but payments per user of ASC services increased substantially.

Also, we remain concerned that ASCs do not submit cost data, even though the Commission has recommended doing so since 2009. All other facilities that participate in Medicare submit cost data, including small facilities such as hospice, home health, and rural health clinics. Therefore, we see no reason why ASCs should not be able to submit cost data without being overly burdened.

In the end, all the decreases in payment adequacy measures for ASCs reflect the effects of the public health emergency and have little to do with the adequacy of ASC payments. Moreover, the effect of the pandemic has varied over time, but we do not anticipate any long-term changes to the ASC landscape that will persist past the end of the public health emergency.

For the Commission's consideration today the Chair has the following draft recommendation:

For calendar year 2023, the Congress should eliminate the update to the 2022 conversion factor for ambulatory surgical centers.

Given our findings of payment adequacy and our stated goals, eliminating the update is warranted. This is consistent with our general approach of recommending updates only when needed. The implication of this recommendation for the Medicare program is that it would produce savings, as the update for the ASC conversion factor is 2.0 percent for 2023, and anything less than that will produce savings.

We anticipate this recommendation would not diminish beneficiary access to ASC services or providers' willingness or ability to furnish those services. We note that, to the extent the PHE continues into 2023, any needed additional financial support should be targeted to the affected ASCs that are necessary for access and done outside the annual update process.

Also the Commission has wanted ASCs to collect and submit cost data for many years, and the Secretary has the authority to require it. Therefore, the Chair has a second draft recommendation:

The Secretary should require ambulatory surgical centers to report cost data.

Collecting these data, as Medicare does for other providers, would improve the accuracy of the ASC payment system. The Secretary could limit the burden on ASCs by requiring a cost report that is limited in scope. Implementing this recommendation would not have a direct effect on program spending, and we anticipate no effect on beneficiaries' access to ASC services. However, ASCs could incur some added administrative costs.

That concludes this presentation. I would like to open the session to discussion about the analyses and the Chair's draft recommendations. Thank you.

DR. CHERNEW: Okay. Dana, I think we're ready for the queue, Round 1.

MS. KELLEY: All right. I think we have just one Round 1 question, so please let me know if you need to get into the queue. So we'll just go with Marge for right now.

MS. MARJORIE GINSBURG: Thank you. So I'm looking at a statement on page 12, where it says "The Commission is concerned about access to care with low use of ASCs." Why are we concerned? I mean, why make that statement? If equivalent care can be had at hospital outpatient departments, why would we go so far as to say that we're concerned about low access to ASCs? I'm just not sure what information we have to support that.

DR. ZABINSKI: You know, there is an advantage of ASCs that oftentimes the alternative to an ASC is an HOPD, and the cost-sharing for the beneficiary and the payment by the program is going to be typically lower if it's provided in an ASC than in an HOPD. I think that's the main reason we're concerned about it.

MS. MARJORIE GINSBURG: Huh.

MS. KELLEY: Okay. I see no more requests for Round 1 questions so I think we're ready to go to Round 2, if that's okay with you, Mike.

DR. CHERNEW: It is wonderful, yes.

MS. KELLEY: All right. Brian.

DR. CHERNEW: Let me just say, we're going to let the people in the queue go, but then we're going to go around. Everyone is going to speak in Round 2. But if you don't have a comment you just make your preferences about the recommendations known. But we will go in order of the queue. So go ahead, Dana.

MS. KELLEY: Okay. Brian, you're next.

DR. DeBUSK: First of all, thank you for an excellent report.

ASCs, and I would include the PFS in this as well, I see the ASCs and the PFS as an important tool to preserve the autonomy of physicians, of private practice physicians. And, you know, we're often concerned about policies that drive physicians into hospital employment or private equity or supergroups or something else, and the consolidation itself may be good or bad. That's outside the scope of this. But physicians not having the choice or the ability to remain private and self-employed, I think not having that choice is categorically a bad thing.

So obviously I am very supportive of ASCs but I do want to question some of our logic just regarding ASCs in general. For example, the paper cited a 2 percent growth in ASCs as an indicator of adequacy. But we are dealing with a payment setting that offers 48 percent savings. I mean, I'm not sure. If this were, for example, a Part B drug, and this Part B drug offered 48 percent savings, and it was only growing at 2 percent year over year, I don't think we would find that acceptable. I think we'd consider that a problem.

And we cite things like the potential to induce volume, because the physicians and the facilities are financially aligned, but isn't that what we're also trying to do with alternative payment models, in general? I mean, I don't see us trying to forbid physician-led ACOs, for example.

And the idea that these ASCs may induce volume, well, they probably do. They do because they reduce the cost 48 percent. I mean, I would argue that, if you go back to my Part B drug example, if we reduced the price of the drug 48 percent and more people could afford it, of course we would induce volume. So this idea that induction is categorically a bad thing, I'm not sure I agree with that.

We also pick on some very specific procedures and say, well, maybe we don't want these procedures to be done. And probably my favorite example is spinal injections. For years, in our chapter, we said, well, the rate of spinal injections in ASCs may be an indication of low-value care. But the majority of spinal injections don't occur in ASCs. They occur in physicians' offices, and I don't think we take that as a sign that we have too many doctors.

So again, the logic doesn't really hold up, and, by the way, those physician offices are already covered under a site-neutral policy so there isn't a financial incentive to move those into ASCs.

So the other thing that I want to really focus on -- again, I don't agree with the logic, but the other thing I really want to focus on are the unintended consequences. Because picture this: Medicare underutilizes ASCs relative to hospital outpatient departments, relative, for example, to the Medicare Advantage program. Medicare, due to its rates, just does not provide services to as many, proportionally, beneficiaries as MA does.

Now when that happens that drives the beneficiary back to the hospital where they pay more, they have more cost-sharing, it costs the program more. Well, that higher cost gets incorporated into the average fee-for-service spending calculation, which gets incorporated into the

Medicare Advantage benchmark. Well, the Medicare Advantage plans don't have a problem with ASCs. They are using them. They are using them with very powerful site-of-service enhancements.

So here's the roundabout issue that we're creating here. By keeping the hospital rates high and keeping the ASC rates low, we're actually subsidizing Medicare Advantage, because again, MA has no problem accessing ASCs, and they're providing some really powerful site-of-service incentives to do that.

So here's my proposal. I do think we categorically need cost reporting for ASC. I think that should be non-negotiable. I think it is going to be a little tricky as vertically integrated as all these different settings are becoming. I think it will be tricky to do much with the information, but I still think we deserve the cost reports.

The current law calls for an update to the ASC payments. I would support that update. But I would even go further and just monitor MA's use of ASCs and make sure that we're using them in the roughly proportional rates. Because again, if we're not we're just subsidizing MA.

I do think the Secretary should modify the ASC claim system so that it can accommodate comprehensive APCs. I know this is more of a technical issue, but I think allowing ASCs to handle the CAPCs really paves the way for a site-neutral payment policy. I know we've got some work in process on that, but I think there's a great opportunity here to develop a site-neutral system between physician offices, ASCs, and HOPDs, that work a lot like their PAC system, where what we're doing is we're looking at the procedure to be performed and the characteristics of the patient to set the table.

And then finally I think we should move ASCs to a new quality reporting system. I think what we should do is move them to the HVIP, like we've developed for hospitals. I think it would be great to have the smaller number of measures, to use peer grouping, to do away with tournament models. I think it would be great, again, to harmonize the quality reporting systems of a new HVIP with ASCs.

So again, I can't emphasize this enough. I think we have a payment setting here that offers a 48 percent savings, and I don't think we're taking advantage of those savings. Thank you.

DR. CHERNEW: There are several people that have comments on this point. I think Dana Safran was first and then Paul.

MS. KELLEY: Bruce as well.

DR. CHERNEW: And then Bruce.

DR. SAFRAN: Yeah, thank you. Just quickly, the comment I had deals with something that comes up every year around this time, and, you know, I'm really struck by Brian's point that, you know, gee, growth of only 2 percent doesn't sound like enough given the cost savings. But I think in the absence of a good way to assess the appropriateness of procedures and knowing that we do have an overuse challenge, I wonder aloud every year whether getting more of something you don't need is actually a bargain. So I just want to offer that as, you know, some tempering of our enthusiasm for how fast ASCs should be growing.

DR. DeBUSK: Dana, on that point, should our issue be with the specific procedure or should it be with the setting? Because, you know, maybe we do too many colonoscopies. I genuinely don't know. But I would think that that's more of a conversation about the procedure and the clinical benefit more so than, well, we don't want to do them in these small ASCs, but it's okay to do the same thing in a hospital. That's one of my underlying questions.

DR. SAFRAN: Right, but, you know, I think we know that if we build it, they will come. And so, you know, having further growth of a setting in which to do procedures, even if it's a lower-cost setting, is going to get us more procedures. And in the absence of a way to really know appropriateness of procedures, I continue to have concerns about that.

DR. DeBUSK: Dana, I'm going to be fun and hyperbolic on this one. Just for fun. It's my last run with this.

DR. CHERNEW: Go ahead, Brian

DR. DeBUSK: What if I applied that same to biosimilars? I mean, that could induce volume, too, if we made them more affordable.

DR. CHERNEW: So we will have a separate discussion of biosimilars and how to manage the use there, and we will have a continued discussion of site-neutral. I do have some responses to your comments, Brian, but I want to wait as others go and give their responses, and then we're going to have to make sure we get through everybody, and we'll continue this discussion.

I guess, Paul, you were next.

DR. PAUL GINSBURG: Sure. You know, I think -- I agree with Brian about how the ASC is a valuable part of the Medicare program. Not only is it less expensive, but, you know, patients like it better because they'd rather, if they can, do something on a day basis rather than staying overnight in the hospital. And this will lead to some overuse, of course, because, you know, the procedures become easier for them. But my perspective is that we already pay an adequate amount to, you know, attract more capital into ASCs. I don't think we need to give ASCs a lot more to get it to be an important part of the Medicare program. And, you know, I support the recommendation of zero updates because of the staff paper indications that, you know, capital is not a problem in ASCs. You know, physicians have a huge preference for practicing there because ASCs are willing to do more to accommodate their being productive. And so I just don't think -- so I'm agreeing with Brian about this is valuable, but I'm saying that, you know, we shouldn't be paying more than we have to to get adequate ASC access.

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

MR. PYENSON: I do. I likewise agree with Brian and Paul. I would say the problem, I think, is that we're paying hospital outpatient way too much for the procedures, and fixing that is something that should be part of our recommendation.

In terms of the zero update, I'm struck by the similarity in situations between hospitals and ASCs, and for hospitals, the recommendation is current law, but for ASCs it's not. So I'm concerned with that. I'd rather see both of them have no update. But I think there's other issues that we can address with ASCs because I think that's a delivery system of the future, and I was struck, as I am every year, with the data on how small and specialized ASCs are for particular kinds of services. And I think encouraging more comprehensive kinds of services through ASCs would be in the interest of beneficiaries and spending of the Medicare program.

I do wonder in this age of employed physicians if the incentives aren't just about the same for a physician owner of an ASC or their employee or the employee of a hospital in terms of generating volumes. So on this point, I think there's ways to address the concerns that Dana and others have expressed, but I see this as a delivery system -- a component of a better delivery system of the future.

DR. CHERNEW: Okay. So let me just jump in. I think there's no one else on this point, and then I want to continue on the queue.

DR. PAUL GINSBURG: Mike, I have one more thing to say.

DR. CHERNEW: Okay.

DR. PAUL GINSBURG: I just want to ask staff if they had any information about the rates that MA plans pay ASCs. The reason is because, you know, most providers are paid very close to Medicare rates in MA except for services where Medicare is overpaying, like clinical labs, durable medical equipment, various skilled nursing facilities. And those are indicators that Medicare is overpaying. So do we have any information on payment rates by MA to ASCs?

DR. MATHEWS: I do not believe that CMS is requiring MA plans to submit encounter data for ASC services. We can double-check that, but I'm setting expectations low there. But we will also look to see if there are other sources of information that bear on this question, and we'll loop back with you.

DR. CHERNEW: So let me just make a few quick comments in response to Brian's point. The first one is the prices are 48 percent less, but I'm not sure that it actually is 40 -- you know, there's a lot of differences when we do our site-neutral work to understand what's there. And then, of course, in that context, my solution would not be to raise the ASC rates as much as when there's a site-neutral thing to think about lowering HOPD rates, except the problem there is then we have to weave that into what the overall hospital viability is, and so it's not something that can be done easily. So we will continue to look at that equalization stuff through our site-neutral work.

The core question here is if we pay ASCs more than a zero percent update, would we get more ASCs and would we save Medicare money? And I am very dubious of that particular hypothesis. One, they're growing relatively quickly already, and we would have to be paying all the -- we would be paying more for all the marginal services, and we're already paying what strikes me as something that must clearly be very profitable given that you're getting a substantial amount of for-profit entry and interest. So my general feeling is it emphasizes to me the need for alternative payment models that can treat, you know, this whole setting in a less fragmented way, but that part aside, you take our standard criteria of is there access, is there capital flowing into the industry? Again, we've been recommending for a long-time margin data from the ASCs. You could argue it might not matter, but I think consistent with our notes here, I'm sort of where Paul is, that we're paying more than enough, and I don't see a need personally to pay more, although I think revisiting issues around site-neutralness is important, that's sort of where I come down on this particular recommendation.

I understand, Brian, your view strongly that we should pay more. I don't know how much more you think we would shift from HOPDs if we did that, and if we did that, how we would have to respond in our hospital updating recommendations and a whole slew of other things. So it gets quite complicated when they all get tied together.

So, Jim, do you want to add anything to that? Dan, do you want to add anything to that?

DR. ZABINSKI: I don't have anything to add, no.

DR. CHERNEW: All right.

DR. DeBUSK: By the way, I do agree. I think site neutrality is the key, because if you were, for example, to match the ASC updates or continue to match them to the HOPD updates, I think you'd continue to decant off procedures. And to your point, Michael, I think part of what you were saying is it could actually hurt hospital finances if we don't have some type of site neutrality there, because you could cherry-pick, for lack of a better word, in the absence of that.

DR. CHERNEW: Right. And, Brian, to a point that you've made in many conversations in the past, we have to think through our case mix adjustments and how we think through exactly what we're getting and how well the ASCs can work given the hospitals need their stand-by capacity and a whole bunch of other things. So I think it gets very tricky to make the simple statement that we're paying for the same service, we're just paying different amounts, and, therefore, we need to raise the ASCs. I think the sort of simplest way to view this sector is you have substantial persistent growth of for-profit entities entering a sector that has not been very amenable to providing cost data, and so it's hard for me to think why we need to pay more, that we would be better off if we paid them more. As a general rule, I think if there's -- again, and I'm in favor of for-profit things in general, but in general, my take is when you see a lot of for-profit entities entering a space, I don't worry that you've a payment problem. In the hospital sector, you see almost the exact opposite, like I view them as completely different. We have conversations in hospitals about closures and a whole slew of other things. No one is worrying about a 2 percent growth per year in hospitals in a range of -- we worry much more about the other issue there, which is why there's this asymmetry in the updates, just for people who want to at least know my thinking.

That was probably not very eloquent. I apologize, but luckily there's more people in the queue, so you guys can bail me out. Who's next, Dana?

MS. KELLEY: Lynn.

MS. BARR: Thank you. So one of the things I was curious about in the growth of the ASCs -- and this is probably more a Round 1 question -- is: Are all these ASCs the same? Are we talking about, you know, the growth in ASCs, are these like plastic surgery centers or places that really aren't doing, you know, traditional health care? Is there any data to that, you know, that goes to that? Are they really doing broad ambulatory surgery or are they more specific to certain types of things that really would not be relevant to Medicare beneficiaries?

I agree with not doing an increase. I do support the Chair's -- both recommendations of, you know, no increase, and also getting the cost report data so we can better understand, because I do agree, I don't think that any of the providers should make a disproportionate margin to others unless there's, you know, real benefit for the taxpayer. And to Brian's point, maybe there is. But I just don't really understand it well enough to know. So I do agree with the recommendations.

DR. ZABINSKI: Just one thing on that, Lynn. We know that the greatest growth has been among ASCs that provide pain management services. You know, there's been growth in all the different types and what they specialize in, but the most substantial growth has been in the pain management area.

MS. BARR: Interesting. Thank you.

MS. KELLEY: Stacie?

DR. DUSETZINA: Thanks for this great report. I will say I also support the recommendation for no payment update. I think in general there were a couple of things in the report that I really think are worth highlighting. One is -- you know, again, the issue of the cost reports, yes, they should submit cost reports. It seems like that would be one way to justify this difference in understanding the profitability and whether or not the payments are adequate. Without that information, it seems unreasonable to just keep raising payments because we just don't know.

The other issue is the CMS quality measures that were suggested in the report. I would say I very strongly agree that it would be nice to have much better information about especially the appropriateness of services provided to Medicare beneficiaries, maybe to help answer some of the questions that have come up. I think Dana pointed to this really nicely in her comments.

And then I think the other thing that just stood out to me in the report was the issue around people who were dually eligible and their lack of access to the services. And I think that's a really important thing to monitor and try to understand more.

So, overall, very supportive. I also just echo -- I know the Commission has recommended it over and over again with the cost reports, but I think we keep beating that drum until we have the information we feel we need to make smarter decisions.

MS. KELLEY: Bruce, did you want to say more here?

MR. PYENSON: I'll pass. Thank you.

MS. KELLEY: Betty?

DR. RAMBUR: Thank you very much. I'm probably far less sanguine than some of you and will put myself a bit in the Dana camp and also echoing some of the things that were just said by Stacie. To me, one of the most intriguing things in the report, very much maybe a micro piece, was that Maryland has the most ASCs and Vermont the least. And what's interesting to me about that is Maryland's goal budget is for hospitals, and so I've always wondered if that creates what I call squishing out -- a very scientific term, not as good as peanut buttering, but in other segments; whereas, in Vermont, they attempted for all-payer, all-setting. And for a long time, they really kept the clamp down on these. So this is a very interesting thing to me.

At least in my experience, owning is very, very different than other forms of two-sided risk. I don't think we can compare those. And I do worry about, to paraphrase Dana, the risk of getting more of something you don't need. So I would be far more tepid about any kind of expansion in funding until we really have good cost and quality reporting data. And so I completely support this recommendation.

Thank you.

MS. KELLEY: Pat.

MS. WANG: Thanks. I support both of the recommendations for the reasons that have been articulated by other Commissioners, and I appreciate Stacie's raising or drawing attention to the interesting statistics about low use by dual-eligibles of ASCs. It would be really good to know more about what that is or what that's about.

I did want to just make a comment because there were a few references to MA rates and the efficiencies that MA plans can get when fee-for-service is paying too much for a certain service. I think it's a very important observation. But I do want to note that MA plans often pay more than fee-for-service because it's a market-based network dynamic. They pay more for hospital services in some cases. They pay more for the physician fee schedule. In many cases, they pay more for dialysis services than fee-for-service. It doesn't -- it's not like the lesser of fee-for-service or what you can negotiate with somebody. Would that it were that way. I just want to make that point. There are a lot of puts and takes into the cost that an MA plan incurs.

Thank you.

MS. KELLEY: Mike, that is the end of the queue. Should we go around now to everyone?

DR. CHERNEW: We can absolutely go around. You can pick the order, Dana.

MS. KELLEY: All right. Let's see if I can pinpoint the people we haven't heard from yet. Amol?

DR. NAVATHE: Thank you. I support both

Chairman's recommendations. Just in terms of thinking rationale, I agree with a lot of the Commissioners' points. I think in general I think ASCs are a very positive player in the sector around efficiency. I think they should be supported.

I agree with the general framing of would a different payment update, you know, increase the sort of marginal capacity entry financial stability of the sector. It doesn't seem that that's the case to me. I support the idea that site-neutral is generally a good policy. I support the idea that we probably need alternative payment models because in many cases, even if the ASC is the best and most suitable and most cost-efficient for a beneficiary and best experience, et cetera, et cetera, oftentimes the referring physician, operating physician, whomever, doesn't necessarily have any incentive to try to make that happen. And so we need to be able to move upstream. It's a multifactorial problem, and I think that is part of the reason -- Betty alluded to this -- that we have so much geographic variation.

So in summary, I support very much the Chairman's recommendations. Thank you.

MS. KELLEY: Jonathan Jaffery.

DR. JAFFERY: Thanks, Dana. I'll be brief. I very much support both of these. This is, as people know, a conversation we've been having every year for the last few years. So I won't -- for the reasons people have stated, I'm very supportive of both.

Thanks.

MS. KELLEY: Jaewon?

DR. RYU: Yeah, me as well. I have nothing further to add, but I do support the draft recommendations.

MS. KELLEY: Larry?

DR. CASALINO: Yeah, I came into the meeting supporting both, and I still feel that way. Certainly the cost reports I feel very strongly about. If we feel it's appropriate to in some way kind of telegraph that, you know, without cost reports, it could be hard to give updates in any year. I haven't really thought through the permission to do something like that, but I think that would be good.

In terms of the update, the payment update, Brian and Bruce were very eloquent, I thought, but then Paul and Dana and Mike also had very good responses. So I do support also the zero percent recommendation this year.

I will say, though, that it wouldn't feel right to me, despite what -- Mike had some good arguments, but year after year to give hospital outpatient departments an update for doing the same procedure that ASCs are not getting enough pay for. I understand, Mike, that the fundamental principle is are beneficiaries getting good access, but that's sticks in the craw a little bit. But, in any case, at this point I support both recommendations.

MS. KELLEY: Wayne?

DR. RILEY: Yes, approve and endorse the recommendations as outlined.

MS. KELLEY: Jon Perlin?

DR. PERLIN: I can support them both as well. I would just note, remember, ASCs are not all the same. Their proximity to a hospital may be different. Their case mix may be very different. And I'd just note that there still may be some differences with HOPD and hospitals, and that if the patient goes bad, where do they go? Not another ASC.

Thanks.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: I support it as well, but I'm constantly annoyed by the lack of cost reports, and I wonder if there's a point at which we cut them off at the knees, if I may be dramatic.

Thank you.

MS. KELLEY: I think, David, you might be the last.

DR. GRABOWSKI: Thanks. It's hard to follow cut them off at the knees, but I'll try. I'll be brief. I support both of the Chair's draft recommendations. I also agree with others that ASCs are an important part of the delivery system.

In my mind, however -- and this might come out more negative than it seems, but I think the two recommendations are actually linked, and very much following what Larry said, if ASCs won't show us their cost reports, it's really hard for us to show them a positive update. Once again, Brian, I agree with what you were arguing there, but it's just really hard to know actually what sort of value, without this key data point, they're actually offering.

And to Mike's point, I really found that compelling. As long as we're seeing for-profit entry and capital, it's hard to really, you know, argue that we should show them a positive update or we're not paying enough. So without that data, it would be really hard to recommend a positive update.

Thanks.

DR. CHERNEW: So, Dana, was that the end?

MS. KELLEY: Yes.

DR. CHERNEW: Okay. So we're going to take a break until 4:10, so I am not going to summarize very long. I will simply say that my sense is that by all of our standard payment adequacy measures, ASCs are adequately paid. If we were going to go higher than the current recommendation, I would want to see actual evidence that we would get more ASCs in ways that we're substituting away from care that we're otherwise paying too much for, in a way that wouldn't make us otherwise compensate the HOPDs for the services that really there's a lot of cross-subsidies going on here. But we will take all of these comments under consideration.

Dan, as always, thank you very much for your presentation, and let's just -- I'm going to go off camera.

We're going to take about a five-minute break and come back at about -- actually maybe we'll do it until 4:15 because I spoke too long.

So let's take a break until 4:15. Then we're going to come back, and we'll have to be efficient in the other sectors. Okay.

MS. KELLEY: The session will remain open.

DR. CHERNEW: The session will remain open, and let me emphasize 4:15.

MS. KELLEY: Thank you.

[Recess.]

DR. CHERNEW: Okay. We should probably get going because we've taken some of the session time to break. So, Nancy, do you want to lead off our discussion of dialysis?

MS. RAY: Yes, I will, Thank you, Mike.

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

Today we are going to talk about the outpatient dialysis payment update for calendar year 2023. First, I'll discuss some background on this payment system. Then we'll walk through the payment adequacy analysis. And we'll end with the Chair's draft recommendation.

Outpatient dialysis services are used to treat most patients with end-stage renal disease. Since 2011, Medicare has paid dialysis facilities for each treatment they furnish using a defined "ESRD bundle" that includes drugs and labs that in prior years were separately billable.

In 2020, there were about 384,000 Medicare fee-for-service dialysis beneficiaries treated at 7,800 facilities. Total FFS spending was about $12.3 billion for dialysis services.

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

A key difference from most prior years is the coronavirus public health emergency which has had tragic and disproportionate effects on the health care workforce and on Medicare beneficiaries, particularly beneficiaries with end-stage renal disease. Dialysis patients are at increased risk of mortality from COVID-19.

From the perspective of assessing the adequacy of Medicare payments, the public health emergency also has had material effects on our payment adequacy indicators.

Therefore, though analyzing 2020 data is important to understand what happened to indicators of beneficiaries' access to care, the quality of that care, provider's access to capital, and Medicare's payments and providers' costs, it is more difficult to interpret these indicators than is typically the case.

As the Commission stated last year, to the extent the coronavirus effects are temporary -- even if over multiple years -- or vary significantly across providers, they are best addressed through targeted temporary funding policies rather than a permanent change to all providers' payment rates in 2023 and future years.

With respect to dialysis facilities, Congress and CMS have helped ease some of the public health emergency challenges for these providers through receipt of COVID relief funds and the suspension of the sequester.

We look at beneficiaries' access to care by examining industry's capacity to furnish care as measured by the growth in dialysis treatment stations, in-center stations. Between 2019 and 2020, growth in in-center treatment stations is keeping pace with the growth for all dialysis patients across all health coverage groups. In your mailing materials, we highlight the growth of dialysis patients in Medicare Advantage over time.

The last point about capacity: In 2020, more facilities opened than closed; there was a net increase of roughly 105 facilities.

Another indicator of access to care is the growth in the volume of services -- trends in the number of dialysis fee-for-service covered treatments and fee-for-service dialysis beneficiaries. Between 2019 and 2020, the total number of fee-for-service dialysis beneficiaries and dialysis treatments each declined by 3 percent. While the share of dialysis patients enrolling in MA increased between 2019 and 2020, we attribute most of the decline in fee-for-service treatments and fee-for-service beneficiaries to higher mortality and fewer patients starting dialysis in 2020 due to the public health emergency. Importantly, the number of dialysis treatments per fee-for-service dialysis beneficiary remained steady in

2020, averaging 115 treatments per beneficiary.

And, lastly, the 20 percent marginal profit suggests that providers have a financial incentive to continue to serve Medicare beneficiaries.

We also look at volume changes by measuring growth in the volume of dialysis drugs included in the PPS bundle. Since the PPS was implemented in 2011 and these drugs were included in the payment bundle, providers' incentive to furnish them, particularly the erythropoietin-stimulating agents, ESAs, has changed. Between 2010 and 2020, use of ESAs has declined by 60 percent, with some positive changes to beneficiaries' health status. In more recent years, we see some substitution among ESAs for the lower-cost product, which is consistent with the goals of the PPS. Expanding the payment bundle in 2011 is an example of how Medicare can use payment policy to decrease spending and improve health outcomes.

It is difficult to assess quality in 2020. Let's first talk about some differences in quality compared to prior years.

First, we see an increase in the rates of mortality and decrease in the number of transplants in

2020. These changes are likely due to the public health emergency. By contrast, between 2018 and 2019, mortality rates were steady, and the number of transplants increased from year to year.

Next, monthly all-cause hospital admissions and ED visits declined in 2020. By contrast, in 2018 and 2019, rates of admission and ED use held steady.

However, other key quality metrics are either improving or holding steady.

One indicator that measures how well the dialysis treatment removes waste from the blood -- dialysis adequacy -- remains high in 2020. And use of home dialysis, which is associated with improved quality of life and patient satisfaction, continued to increase by 1 percentage point per year since 2017. In 2020, 16 percent on average of all patients dialyzed at home.

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

There are new entrants to the dialysis sector, including CVS Health that is currently running a clinical trial for a home hemodialysis machine and operating dialysis facilities. The 2020 all-payer margin was 16 percent, increasing to 16.5 percent with relief funds.

So now let's talk about providers' financial performance. This slide shows the Medicare margin under the ESRD PPS since 2011.

In the early years, the increase in the margin is chiefly a result of the decline in drug use. The decrease in the margin between 2013 and 2017 was due to the rebasing of the base payment rate in 2014 to account for the decline in ESRD drug use, as I showed you on slide 7. The TDAPA for calcimimetics, a transition drug add-on payment adjustment, that began in 2018 accounts for the increase in the margin in 2018 and 2019. The availability of generic versions of the oral calcimimetic in 2019 contributed to the margin increase. The decline in the aggregate Medicare margin between 2019 and 2020 is linked to increasing cost per treatment, particularly labor and overhead, and the TDAPA payment declining from ASP + 6 percent to ASP + 0.

In 2020, the Medicare margin is 2.7 percent. As you can see, the Medicare margin varies by treatment volume. Smaller facilities have substantially higher cost per treatment than larger ones, particularly overhead and capital costs. The lower Medicare margin for rural facilities is related to their capacity and treatment volume. Rural facilities are on average smaller than urban facilities, have fewer in-center stations, and provide fewer treatments.

The 2022 projected margin is 1.2 percent. We expect the 2022 margin to be lower than the 2020 margin because: the increase in payments based on net updates in 2021 and 2022 will be lower than cost growth; there is also an offset by the reduction in payments when CMS included calcimimetics into the bundle in 2021; and there is a small estimated reduction in total payments due to the ESRD Quality Incentive Program in 2022.

So here is a quick summary of the findings. Access to care indicators are generally favorable. Quality is difficult to assess. In 2020, dialysis adequacy continues to remain high and home dialysis increased. Good trends. Tragically, mortality increased in 2020. The 2022 Medicare margin is projected at 1.2 percent.

This leads us to the Chair's draft recommendation. For calendar year 2023, the Congress should update the calendar year 2022 Medicare end-stage renal disease prospective payment system base rate by the amount determined under current law.

Next slide, please.

In terms of spending implications, this draft recommendation will have no impact relative to the statutory update. We expect beneficiaries to continue to have good access to outpatient dialysis care. We also expect continued provider willingness and ability to care for Medicare beneficiaries.

And so that concludes this presentation, and we look forward to your discussion.

DR. CHERNEW: Nancy, Thank you.

Let's jump directly to Round 1.

MS. KELLEY: All right. I have Jonathan Jaffery first.

DR. JAFFERY: Thanks, Dana. Thanks, Nancy. That was a great presentation, and thanks to you and Andy both for a great chapter.

You know, you mentioned how difficult the outcomes have been for the dialysis population and the added mortality during COVID on top of pretty high baseline mortality and morbidity. Absolutely true. Even just thinking about beyond mortality, there's such a high hospitalization rate and how challenging that was during the pandemic as people feared getting COVID and not being able to be visited by family members. So really a huge burden, so I'm glad we're talking about this a little bit.

I have just one question. Just thinking about incident patients and this will probably lead into my Round 2 comment later, but in the chapter you talked about looking at kind of later starts first versus -- or incident starts with higher levels of residual renal function and cut-offs at eGFR 10. I wonder if you have other data looking at different cut-off levels, specifically around 15. And then in addition to that, as some folks here may know, eGFR is the calculation of kidney function calculated off serum creatinine lab value that takes into account some other factors like age and gender. The formula that has been used for a number of years now has always included race as another factor, particularly if people are Black. And over the last year or two, it has really, you know, been recognized that that was not a good idea and erroneous, and so people have been using that less. But that has ended up -- one of the things is it has created some disparities in terms of people starting dialysis or getting referred for transplant or things like that.

So I don't know if there's any data you have about if or where and when race has been included as a factor in some of those calculations and incident starts. Thanks.

MS. RAY: Okay. Very good question. A couple of points.

I was not able to update that analysis, unfortunately, this year. We did not get the data. The equation that I use is the standard equation that does include race. That being said, I could -- I mean, I could talk with you offline to discuss other potential cut-offs to use.

DR. JAFFERY: That would be great. An offline conversation sounds perfect.

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

MS. BARR: I do. Nancy, great job, as always. So obviously the flag went up when you said 90 rural facilities closed in the last year. Is that correct? And so do you have more information about -- I mean, how is that related to trends? You know, we're saying we have access, but if that many rural facilities closed, you know, what is the trend on rural here? And is there -- you know, obviously they're low volume. Do we have a serious access problem?

MS. RAY: So the number [inaudible] that closed -- I'm sorry, let me be clear. A total of 90 facilities closed. That's both urban and rural. That was not just rural, to be clear.

MS. BARR: Got it.

MS. RAY: That being said, we have seen a trend over the past several years where we do see rural facilities disproportionately closing. We made a recommendation in our June 2020 report to improve the low payment -- a low payment adjustment and rural adjustment factor to specifically target isolated, low-volume facilities. And that would actually improve, we think, the financial status of smaller facilities that are essential to beneficiaries' access to care.

MS. BARR: Thank you. Is that part of this recommendation then? I mean, do we like kind of bolt that onto this and remind people that like a negative 20 percent margin probably isn't going to cut it? How many of those 90 were rural was the question.

MS. RAY: So, number one, I will make sure that that recommendation is prominent in the chapter. How many, number? Of the 91, roughly 30 were located in rural areas this year.

MS. BARR: Thank you. Appreciate it.

MS. KELLEY: Brian?

DR. DeBUSK: Thank you. Really great chapter. I have three questions.

The first one was around the vertical integration of the LDOs, and we've discussed this in the past, but I think the LDOs make a lot of their own drugs or some of their own drugs and equipment. Do we have any independent measures of how that vertical integration affects their overall profitability? And what portion of that can and can't be seen in the Medicare cost reports? I'm just wondering, is their margin below the water line?

And then the other two questions are pretty easy, so I'll ask them all at once. Of the calcimimetics, under the TDAPA policy, when that was incorporated into the bundle, could you speak a little bit to how that was incorporated? Were all those costs just simply absorbed into the bundle? Or was it a percentage of the cost? I'd like to learn a little bit about the mechanics of that.

And then my third question would be: Are there any upcoming TDAPA -- or I think there's a payment for innovative equipment and supplies, too. Are there any of those payments on the horizon, any large anticipated payments, for example, in the upcoming years?

Those would be my questions. Thank you.

MS. RAY: Okay. Regarding the vertical integration, yes, at least one of the large dialysis organizations manufactures dialyzer and also has -- and does manufacture some ESRD drugs, including injectable iron. That is true. I think it is very difficult to tease that out. What you're looking for from the cost reports is very difficult to tease out.

Regarding the TDAPA, so what CMS looked at utilization for part of -- I'm trying to remember now. 2019 -- and I can get back to you with the specific years, but they took the utilization at least from 2019 and built -- and increased the payment rate by roughly $10 a treatment to account for the calcimimetics.

Regarding any upcoming add-on payments, in your paper there will be a TPNIE -- that's a transitional payment for new and innovative equipment -- for home dialyzer equipment. And I think it remains to be seen about whether or not there will be any future -- you know, near-future TDAPA for any new ESRD drugs.

DR. DeBUSK: Okay. Thank you.

MS. KELLEY: Jaewon.

DR. RYU: Yeah, thank you for the chapter, Nancy. I think this is always an interesting topic to tackle. I just had a couple things to ask around the 21st Century CARES Act and the entry and migration towards Medicare Advantage and its impact on projecting all-payer margins going forward. So I think in Slide 9, you reference the all-payer margin in 2020 was 16 percent. Do we have any early indicators of 2021 -- I know it would be very early -

- in terms of how much migration there has been into the Medicare Advantage space? And the second question is: I recall from the past that Medicare Advantage, the margins for the LDOs and dialysis, it's higher.

And so the reason why I ask is just that migration seems to be something we may want to factor in because that mix shift, the payer mix, if you will, would suggest potentially a higher profitability, which may inform, you know, how we think about payment updates. So just curious what we have, if anything, on that front.

MS. RAY: So I'm hoping Andy can help address your questions.

DR. JOHNSON: I couldn't wait you out, Nancy.

So we have some indication from the dialysis providers that say that their payer mix has shifted a little bit more towards Medicare Advantage. We're working to get some data that would give us a comprehensive view of how much of a shift starting in 2021. We usually get that data after the calendar year has ended, so we're working to get it a little ahead of time, and we can include that in the report.

DR. CHERNEW: Okay. We're in Round 2. I think there's one Round 2 person in the queue, and then we're going to have to go quickly through the rest to just comments and reactions. I think that one person is you, Jonathan. Dana, have I got that wrong?

MS. KELLEY: No. That's correct.

DR. CHERNEW: Okay. Jonathan, Round 2, and then we're going to go through everybody.

DR. JAFFERY: Great. Thanks, Mike.

So, first of all, I'm fully supportive of the draft recommendation. I just wanted to talk for a second about, you know, some of the uniqueness. It's very challenging to think about how to best incent the right care. Really the thinking is, as I intimated with my Round 1 question, around incident patients and how we incent really optimal care as people are transitioning from late-stage chronic kidney disease to starting dialysis or getting a transplant to renal replacement therapy. It's such a unique situation we have. Obviously, this population is very expensive and has been for the Medicare population for a long time. It's one of the few carve-outs where people get on Medicare for it regardless of other qualifying factors. And so you've got a lot of people who are shifting from late Stage 4 or even Stage 5 chronic kidney disease from some other insurance provider now to Medicare as they start dialysis.

I just wonder if there's something that we should be thinking about. Again, it goes a little bit outside the realm of the dialysis payment or certainly dialysis payment update. But if there's some ways to think about, through payment policy, greater incentives for providers to care for people with late-stage chronic kidney disease. You mentioned, Nancy, some of the places where people are working in that space, not only the LDOs but, you know, the CVSs and Somatus and stuff like that, some of these other startups. But there really is, I think, a big opportunity for us to think about how we could incent people to better take care and increase coordination in those later stages pre-dialysis.

I know there have been some kidney dialysis education payments. Those haven't really worked. Nobody has really done them for a variety of reasons. But the fact of the matter is once a patient has very late-stage chronic kidney disease, either late Stage 4 or early Stage 5, without symptoms or with some symptoms, or without symptoms and some mild complications of chronic kidney disease, the effort it takes to manage that and the coordination in the ambulatory setting is really quite significant. And from the provider's standpoint, in some ways it's much simpler to shift somebody into dialysis where you're not having to try and coordinate that care. It's more automatically coordinated, the system is set up better, and the reimbursement is much higher.

So really it's kind of this perfect storm for saying, well, let's just get people, the minute they show signs of symptoms or indications, to shift them over to dialysis, even if it's not necessarily in everybody's best interests. There's really no differentiation between the payment for that coordination of care in the later stages of chronic kidney diseases. There is in somebody who's got an earlier stage and it's not that difficult to manage.

So, anyway, something for us to think about going forward, and it's, again, not part of the update question, but it's hard to separate these out, and I think it really does impact our payments for the ESRD program overall and absolutely impacts the overall quality of care for the patients with late-stage chronic kidney disease.

Thank you.

MS. KELLEY: Bruce?

MR. PYENSON: Thank you. This might be a Round 1 question, but I'll try to make it a comment as well. On page 44 of the text, Nancy, you identify administrative -- different components of costs and administrative and capital account for something like 43 percent of the costs of the dialysis stage, and supplies and labor account for 45 percent. And those struck me as the labor component seemed to be a relatively small amount of the cost compared to when we think of hospitals at 80 percent labor, that sort of thing.

So I was wondering if you had information on the cost of dialysis in other countries, notably the two large players are international companies and perhaps contribute to their own, you know, supplies and certainly administrative and general expenses. So, you know, of course, we know that costs of health care are higher in the U.S., and that's often attributed to, you know, labor or other factors. But given the vertical integration, I think I would be interested in seeing if the equivalent of a dialysis daily rate is very different in other advanced

countries given the vertical integration here across
borders.

MS. RAY: So I will have to get back to you on that, Bruce. I don't have information at the tip of my fingers on the cost of dialysis in other countries. Let me see what I can dig up for you, and we'll let you know next month.

MR. PYENSON: Thank you. I appreciate that.

Do you have thoughts, or if others do, on the high portion -- what I thought was a high portion in administrative in general and capital for dialysis?

MS. RAY: So, you know, we do see some variation across the different organizations in the amount of overhead A&G costs, costs per treatment.

Regarding the capital cost, I guess all I can say to that is, you know, unlike some other sectors -- hopefully I'm not like putting my foot in my mouth here -- like home health, for example, I mean, dialysis facility, particularly for in-center dialysis, you know, is bricks and mortar. They have water filtration systems and so forth. Regarding the --

DR. CHERNEW: Nancy, I'm sorry. I don't mean to interrupt you. We have about 13 minutes, and I want to get everybody through to make a comment on the recommendation. So is it possible, Bruce, you could take some of this offline?

MR. PYENSON: Thank you. Happy to do that.

DR. CHERNEW: Do you want to say something about the recommendation, Bruce?

MR. PYENSON: I'm not convinced that dialysis organizations need an increase or that it would be required to maintain care for beneficiaries.

DR. CHERNEW: Okay. I think Pat was going to make a Round 2 comment.

MS. WANG: Okay. I support the Chairman's recommendation. I hear what Bruce is saying, but certainly I think it's worth considering. But I support the Chairman's recommendation.

I just wanted to add a comment because I thought Jonathan Jaffery's comments were so important. I just wanted to add one other comment, and I realize this is not exactly a MedPAC thing. But when you look at the profile of these beneficiaries, they're disproportionately younger, male, and Black. If there is anything that we should take away from this -- and low-income, dual, poor. If there's anything we should take away from this, it's the importance of supporting Medicaid programs in states because this is when it starts. It starts a lot earlier. Medicare gets folks when they've developed the disease and they qualify as ESRD, but their conditions are starting way, way, way before. And there's a lot that can be done with continuous coverage and, you know, good care to try to sort of alter the course of that disease progression. So we do the best that we can in Medicare when somebody is already sick, but I just want to emphasize the importance that it starts a lot earlier. And whether it's ACA coverage, commercial coverage, Medicaid coverage, because I do think a lot of folks start in Medicaid, it's just really important.

Thank you.

DR. CHERNEW: Thanks, Pat.

Dana, I think that was the last person in the Round 2 queue, so maybe we can just go around and, again, it's okay if we go a little long, but I don't want to go too long because we're getting toward the end, and we have hospice next. So, Dana, can you take us around to get the people who haven't spoken in Round 2?

MS. KELLEY: Yes.

DR. CHERNEW: Okay.

MS. KELLEY: Brian, do you want to go ahead?

DR. DeBUSK: Yes. First of all, I support the recommendation as written. I share Bruce's view that the LDOs are very profitable, probably surprising profitable due to vertical integration. But I also support an increase due to the points that Jonathan and Pat made. A lot of these beneficiaries are high-need, and we need to make sure that they're attractive to providers.

Thank you.

MS. KELLEY: Marge.

MS. MARJORIE GINSBURG: I support the recommendations as written. Thank you.

MS. KELLEY: Dana?

DR. SAFRAN: I also support the recommendations as written. I find the quality data that was reported really concerning and so would like us to better understand that going forward. But this doesn't seem the moment to do anything other than what's indicated in the current statute.

Thanks.

MS. KELLEY: Wayne?

DR. RILEY: I am supportive of the recommendation.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: I support the recommendation.

MS. KELLEY: Jon Perlin?

DR. PERLIN: I support and also endorse the comments that Jonathan Jaffery and Pat made and Dana's comments on quality. Thanks.

MS. KELLEY: Lynn?

MS. BARR: I support the recommendation with the caveat that something needs to be done for the low-volume and rural communities.

MS. KELLEY: David?

DR. GRABOWSKI: I support the Chair's draft recommendation. Thanks.

MS. KELLEY: Jaewon.

DR. RYU: I support as well.

MS. KELLEY: Stacie?

DR. DUSETZINA: I also support the recommendation.

MS. KELLEY: Larry?

DR. CASALINO: I also support the recommendation. I just want to add, Andy and Nancy, the staff reports are always good, but I found this one exceptionally lovely. It was so well written, and if you wanted to give someone just a 30-, 40-page document that would really help them understand dialysis, integrate everything about it, this was really good. Congratulations. Very nice job.

MS. KELLEY: Amol?

DR. NAVATHE: I also support the Chairman's draft recommendation as written.

MS. KELLEY: And, Betty, I think you are last but not least.

DR. RAMBUR: Thank you. So I support the recommendation, and I just want to comment on Jonathan's earlier comment about the challenge of care coordination, and I'm now realizing that my own family had this outcome of somebody being recommended for dialysis when they really probably didn't need it yet. So if that could happen to a nurse who's kind of in the middle of this, how often does that happen? So I think that's really important.

I also want to underscore or agree with Dana's comments about quality and how important it is for us to follow through on that and also Larry's comment on the excellent report.

Thank you.

MS. KELLEY: Okay, Mike.

DR. CHERNEW: Yes, you all are just wonderful, so let me just go on record. That's a comment to the staff and the Commissioners. So thank you for the comments and particularly your conciseness with them. It was a useful set of reactions.

So thank you to Nancy and I appreciate it, Andy. This has been helpful, and I think we're going to move to our last session of the day, which is going to be Kim talking about hospice services. So, Kim.

MS. NEUMAN: Thanks, Mike.

Good afternoon. I would like to remind the audience that the slides for this presentation are available on the control panel on the right side of the screen.

Today we are going to talk about the hospice payment update for fiscal year 2023. First, we'll discuss some background, then we'll walk through the payment adequacy analysis. Then we'll talk about two additional issues, the hospice aggregate cap and telehealth visit reporting, and we'll end with the Chair's draft recommendations.

Before we begin, I also want to note there is a textbox in your paper with an update on non-hospice spending for beneficiaries are enrolled in hospice that I would be happy to discuss on question.

So first we'll begin with two background slides on hospice. You've seen these slides before so I'm going to highlight just a couple points. Hospice provides palliative and supportive services for beneficiaries with terminal illnesses who choose to enroll. To qualify, a beneficiary must have a life expectancy of six months of less if the disease runs its normal course. But there is no limit on how long a beneficiary can be in hospice as long as a physician certifies that the patient continues to meet this criteria.

Next, we have background on hospice payment system. A couple things to highlight. Medicare makes a daily payment for each day a beneficiary is enrolled hospice, regardless of whether services are furnished. Medicare's payments to hospice providers are wage adjusted, and there is also an aggregate cap that limits the total payments a provider can receive in a year, and we will discuss that cap more later. This daily rate structure, as we've discussed before, has made long stays in hospice profitable.

In 2020, over 1.7 million Medicare beneficiaries, including nearly half of decedents, received hospice care from over 5,000 hospice providers, and Medicare paid those providers $22.4 billion.

As discussed across the sectors today, the pandemic has had tragic and disproportionate effects on Medicare beneficiaries and on the health care workforce. The pandemic also has had effects on payment adequacy indicators, which means it is more difficult to interpret these indicators than is typically the case.

As the Commission stated last year, to the extent that the coronavirus pandemic's effects are temporary or vary significantly across providers, they are best addressed through targeted temporary funding policies rather than a permanent change to all providers' payment rates in 2023 and future years.

With respect to hospice providers, some of the

COVID-related polices that have been enacted by Congress or CMS include COVID relief funds received by some providers, and suspension of the 2 percent sequester. CMS has also permitted hospices to offer services via telehealth in certain circumstances, and granted agencies waivers on certain regulatory requirements

As we consider hospice payment adequacy, we'll use the same framework as you've seen in the other sectors. One difference, though, is that we'll present margin estimates for 2019 instead of 2020, and that is because the data needed to calculate the hospice aggregate cap calculations lags.

So now, moving to our payment adequacy indicators. First, we have data on provider supply. The total number of hospice providers represented by the orange line has been increasing for many years. In 2020, the total number of providers grew 4.5 percent. The green line in the chart is the number of for-profit providers. We can see from the chart that all of the net growth in provider supply in 2020 was accounted for by growth in for-profit providers.

In 2020, tragically, with onset of the pandemic, deaths among Medicare beneficiaries and hospice use among Medicare decedents increased. Overall, deaths among Medicare beneficiaries increased nearly 18 percent in 2020. The number of Medicare decedents who used hospice during the year also increased about 9 percent. Because deaths rose more rapidly than hospice enrollments, the share of decedents using hospice declined between 2019 and 2020, from 51.6 percent to 47.8 percent. It is not unexpected the share of decedents receiving hospice would decline in a pandemic, so this trend is not a reflection of Medicare payment adequacy.

Indicators of access to care are mostly favorable. In 2020, number of hospice users and number of days of hospice care increased. The site of hospice care shifted, likely due to the pandemic, with an increase in beneficiaries receiving care at home, in assisted living facilities, and hospitals, and a decrease in beneficiaries receiving hospice care in nursing facilities and hospice facilities.

Among decedents, average length of stay increased in 2020, while median length of stay was stable.

The amount of visits furnished to hospice enrollees declined between 2019 and 2020, from an average of 4.3 visits per week to an average of 3.5 visits per week. Some of this change in in-person visits may have been offset by telehealth visits, which we are unable to quantify.

Marginal profit, a measure of whether providers have an incentive to treat Medicare beneficiaries, was strong at 17 percent in 2019.

It is difficult to assess quality in 2020. CMS quality data are unavailable for 2020 because CMS suspended data reporting due to the public health emergency. The most recent available CMS quality data indicate hospice CAHPS scores were stable through 2019, and there was a slight improvement in share of patients receiving at least one visit from a nurse or other clinician in last three days of life in 2019. Claims data for 2020 indicate in-person visits declined in 2020. However, this is likely due to public health emergency and not necessarily a reflection of quality

So next we have access to capital. Hospice is less capital intensive than some other Medicare sectors. Overall access to capital appears adequate. We continue to see growth in the number of for-profit providers, which increased about 7 percent in 2020, suggesting that capital is accessible to these providers.

Reports from publicly traded companies and private equity analysts indicate that the hospice sector is viewed favorably by the investment community in 2021, and anticipated in 2022. We have less information on access to capital for nonprofit freestanding providers, which may be more limited. Provider-based hospices have adequate access to capital through their parent providers.

Next, we have margins. As I mentioned, different from other sectors, we have historical margin data through 2019, because of the standard data lag in calculating aggregate cap overpayments.

First, looking at the chart on the left, the aggregate Medicare margin in 2019 was 13.4 percent. That's an increase from 12.4 percent the prior year. Freestanding hospices had strong margins at 16.2 percent. Provider-based hospices had lower margins than freestanding hospices.

Margins also vary by ownership. For-profit hospices had substantial margins at 19.2 percent. The overall margin for nonprofits was 6 percent, but looking just at freestanding providers, the nonprofit margin was higher at 10.5 percent. Urban and rural hospices both had favorable margins at 13.6 percent and 11.5 percent, respectively.

Now looking at the figure on the right, we have margins by provider length of stay quintiles. This figure shows that margins increase as length of stay increases. The dip in margins in the highest length of stay quintile is because of the effect of the hospice aggregate cap.

Next, we have our margin projection. For 2022 we project a margin of 12 percent. We arrive at this projection by starting with the 2019 margin and making several assumptions. First, we assume revenues increase based on net updates of 2.6 percent in 2020, and 2.4 percent in 2021, and 2.0 percent in 2022. We also assume current law regarding the sequester, which means we assume the sequester is suspended thru first quarter fiscal year 2022 and reinstated thereafter.

With respect to cost growth, it is possible that increasing wages could result in higher cost growth than we have historically seen in this sector. In light of that, for our 2022 margin projection, we assume a rate of cost growth similar to the market basket. This means we are assuming higher cost growth than what we've historically seen in the hospice sector as costs have typically grown more slowly than market basket. For example, in 2020, routine home care costs per day grew about 1.2 percent.

Putting all these assumptions together, we project a margin of 12 percent in 2022.

To summarize, indicators of access to care are generally favorable. The supply of providers continues to grow, due to entry of for-profit hospices. Number of hospice users and average length of stay among decedents increased. In-person visits declined in 2020, likely due to the pandemic. Marginal profit in 2019 was 17 percent. Quality is difficult to assess in 2020. Access to capital appears adequate. The 2019 aggregate margin is 13.4 percent, and the 2022 projected margin is 12 percent.

Now let's switch gears and talk about the hospice aggregate cap. The cap limits total payments a hospice provider can receive in a year. The cap is an aggregate limit, not a patient-level limit. If a provider's total payments exceed the number of patients, served multiplied by the cap amount, the provider must repay the excess to Medicare. Currently, the cap is just over $31,000, and the cap is not wage adjusted.

In 2019, we estimate that about 19 percent of hospices exceeded the cap. These providers had margins of 22.5 percent before the cap and 10 percent after. For the last two years, in March 2020 and 2021, instead of an across the-board reduction in payments, the Commission recommended the hospice cap be wage-adjusted and reduced by 20 percent. Changing the cap in this way would make it more equitable across providers and would reduce aggregate Medicare expenditures by focusing payment reductions on providers with long stays and high margins.

Our simulation model, using historic 2019 data and assuming no utilization changes, estimates that the cap policy would reduce aggregate Medicare payments by about 3.7 percent.

Now turning the Chair's draft recommendation. Given the margin in the industry and our other positive payment adequacy indicators, the analysis suggests that hospice aggregate payments exceed the level needed to furnish high-quality care. So the Chair has put forward the following two-part draft recommendation, which is the same as last year's.

It reads:

For fiscal year 2023, the Congress should eliminate the update to the fiscal year 2022 Medicare base payment rates for hospice and wage-adjust and reduce the hospice aggregate cap by 20 percent.

The draft recommendation would keep payment rates unchanged in 2023, at their same 2022 levels. It would also modify the aggregate cap to focus payment reductions on providers with long stays and high margins, while the majority of providers' payments would be unaffected by the cap policy change.

In terms of implications, the recommendation would decrease spending relative to the statutory update. In terms of beneficiaries and providers, we expect that beneficiaries would continue to have good access to hospice care, and that providers would continue to be willing and able to provide appropriate care to Medicare beneficiaries.

Now turning to telehealth. CMS has temporarily permitted hospice telehealth visits during the public health emergency under certain circumstances. Different from in-person visits, hospices are not required to report telehealth visits on Medicare claim.

A lack of data impairs our ability to understand the extent to which telehealth visits have been furnished during public health emergency. Requiring hospices to report telehealth visits would increase the program's ability to monitor beneficiary access to care.

So, the Chair has a second draft recommendation. It reads:

The Secretary should require that hospices report telehealth services on Medicare claims.

With this draft recommendation, the Secretary would collect data on telehealth visits going forward for as long as the agency permits telehealth visits in hospice.

In terms of implications, there would be no impact on Medicare program spending. In terms of beneficiaries and providers, there would be no direct impact on beneficiary access to care, but the draft recommendation would improve the agency's ability to monitor access.

Hospice providers may incur some additional administrative costs associated with claims data reporting.

So, that brings us to the end of the presentation. I look forward to your discussion, and I turn it back to Mike.

DR. CHERNEW: Great. Thanks so much. This is really an important area.

So, Dana, can we start the Round 1 queue?

MS. KELLEY: Yes, we can. I think it's Jonathan Jaffery.

DR. JAFFERY: Yeah. Thanks, Dana, and Kim, thanks for a great report and a great presentation.

There is something I don't understand as well as I guess I should. In the reading there is a text box that talks about non-hospice spending for hospice enrollees. And so I guess if you could clarify, are those erroneous payments that we should be looking at? So when somebody is enrolled in hospice, all of their spending, really, hospice is responsible for, and any extra fee-for-service benefits or payments are erroneous, or just some subset of those are happening, or they are all appropriate and there's just a fair amount of it?

And maybe a corollary to that, are there any circumstances where MA payments continue when someone is enrolled in hospice, either erroneously or not, or is it that they are switched to fee-for-service under at least current situation and any non-hospice spending is then part of fee-for-service payments?

MS. NEUMAN: So the way it works is that hospice is responsible for all services for palliation of the terminal condition and related condition, and the beneficiary waives coverage of those kinds of services from anyone but the hospice.

So if there are services that are unrelated to the terminal condition and related conditions then that would fall outside of hospice, to be paid, if it's a Part A or Part B service, to be paid by fee-for-service Medicare, and if it were a drug, and the beneficiary had Part D or an MA-PD, to be paid by Part D.

Now the sort of tricky thing here is that CMS has said that they expect that virtually all services for a beneficiary who is nearing the end of life is related to the terminal condition or related conditions, so CMS would expect there to be a small amount of spending that's sort of outside of the benefit. So there is a bit of a disconnect between that principle and sort of the level of spending that we see, that the text box discusses. In 2018, I think it was about $1.3 billion of spending outside of the hospice benefit, for hospice enrollees.

And so there has been discussions by CMS. We've also looked at this previously, trying to understand, you know, how much of the spending is truly unrelated versus how much of it is, I guess, erroneous or improper payments. And so that is sort of what is underlying the text box and sort of the rationale for looking at the topic.

And then I think you asked about the MA plans as well. So when someone gets a service outside of hospice, as I said, Part A and B would cover it, if it was like a doctor's service and if it was unrelated. But if the MA plan had reduced cost-sharing as a part of its benefit, then it theoretically might still pay for that piece of it.

Additionally, to the extent that the MA plan is an MA-PD plan, and if it were a drug that were considered unrelated, outside of the hospice benefit, then the MA-PD plan would be liable.

DR. JAFFERY: Thank you.

MS. KELLEY: David.

DR. GRABOWSKI: Great. First, Kim, great work here. I always enjoy this chapter. And Jonathan's great question is actually a perfect lead-in to mine. I was going to ask, the next generation here is obviously trying to carve hospice into MA, and you mentioned this, just kind of discussing in the chapter how currently under the CMS Innovation Center's VBID models there is a small number of Mas that are starting to do this.

Do we know anything yet of how that is going? And some of the issues Jonathan was worried about I think could potentially be corrected by this kind of model. Is that the future, and do we know anything yet about how that's going? Thanks.

MS. NEUMAN: So this is the first year, 2021, of the VBID, so it's early to know how it's going. I do think that as the Commission has thought about this issue of service outside of hospice, you know, sort of this unrelated services, that the idea of MA model and the carve-in, one of its benefits would be potentially greater accountability across the services that hospice enrollees receive. And so it might address some of these concerns.

One lingering issue, however, is that for those beneficiaries who are not in Medicare Advantage and remain in fee-for-service, it will still remain fragmented as it is today.

DR. GRABOWSKI: Thanks.

MS. KELLEY: Lynn.

MS. BARR: Thank you, Kim, for an excellent report. It is really well done.

So we go to, in your report, Table 11 -- so not in your slides but in the report, Table 11.3, and we look at access for rural patients. Is this really adequate? I guess, you know, so forget the urban adjacent because they're being served by urban hospices, but there is much lower utilization in non-adjacent rural and non-micropolitan areas that would have the kind of population. So is there any thinking about how you can address the disparities for the rural population in this recommendation?

MS. NEUMAN: So with respect to the different usage rates across rural and urban areas, we have seen, over time, this pattern of the urbans having the highest rate of hospice use, and then sort of stepped down a little bit as areas get more rural.

What we have seen, though, is that over time hospice use is increasing across all of these areas. This last year, with the pandemic, numbers of beneficiaries in these areas still did increase, even though the percentage of decedents using hospice in areas declined. But we're generally seeing an upward trend across all categories.

And so we haven't contemplated an update, any kind of differential update by type of provider or that sort of things. We've sort of addressed the sector as a whole.

MS. BARR: I don't really see the gap narrowing. You're right. They're both increasing. I haven't plotted it out but it does appear like there's a very significant disparity. And we don't see access, you know, so many of our rural hospitals don't have access to hospice care. So I'm just wondering, like what do we have to do to fix that, if this is a desire.

DR. CHERNEW: Let me give a general comment, and, Jim, I'd like for you to jump in. This is a persistent problem in all of these update issue, which is because we're picking a single update factor, we often end up in a situation where there's pockets of concern, if you will, in terms of access. It's not clear to me, and I will defer to

Kim, if we think that there is significant under-access to hospice care in rural areas. But I think is like some of our other activities to try and sort out that problem. So we have to worry in a sector where the, say, average payment seems more than generous to think, well, we need to up it even more because there's places that we don't want to pay more. Our general view has been targeted, and we've tried to look across the board.

And that's more of a philosophical point than a specific hospice point, but I take your concern. It is a valid concern.

MS. BARR: Yeah. So, Mike, only a third of the frontier patients are using hospice versus half of urban, so it's pretty big.

DR. CHERNEW: That's right, although it's not clear we would want to pay -- I don't know how much you would have to pay.

MS. BARR: No, and I don't want to pay everybody else more, but we should somehow address it, I think.

DR. CHERNEW: Yeah. So there's a separate question I'll defer to Kim on hospice use in some of those areas, and I don't want to in any way dismiss it as an important issue. I just want to say we try to avoid holding all of the problems with the single update recommendation. We must make a single update recommendation, which is what we're doing here.

So Kim, if you want to make a comment specifically about hospice access adequacy in those areas, that would be great. And Jim, if you want to comment on the philosophy that just outlines, that would also be useful. But first we'll go to Kim.

MS. NEUMAN: So I don't think I can speak directly to hospice access in frontier areas and the drivers of distance versus preference versus a variety of factors. It is something that we could spend some time thinking about, going forward. But I don't think I can address that right now.

MS. BARR: Thank you for considering it.

DR. MATHEWS: And just to add to that, hospice is unique in that it is an elected service at the end of life and it does reflect a number of different cultural and personal and religious attitudes, you know, with respect to what happens at that juncture in one's life. And it is maybe more nuanced than to say, you know, differences in utilization among different populations reflect automatic disparities that need to be addressed.

You know, we've seen historic underutilization or lower utilization of hospice among certain minority populations who might have a preference for more intensive life-preserving measures, such as long-term care hospitals and the end of life. And similarly we have seen people who live in frontier areas -- we're talking about population densities of less than 6 people per square mile -- you know, people like that have a propensity to be independent and not rely a lot on this kind of benefit, necessarily.

So there's a lot more to it than simply the raw utilization numbers for this benefit.

DR. CHERNEW: Yes, and this is going to come up, though, Lynn. The principle behind this is going to come up when we do home health. I imagine you're just waiting for that one. It may come up -- I can't recall now, honestly, how this comes up in SNF. But it comes up across the board. This is an important issue, and the issue of heterogeneity -- I think I said this earlier today -- the issue of heterogeneity in providers and their systems and their setups is important, and we are doing an exercise which is really about a single update.

And so we are trying to find a balance between making sure that access is generally adequate and not overpaying, on average, and when we find particular areas where we think we need something -- and several people have mentioned them throughout the themes today, groups we need to worry about, and I agree with those comments completely -- we are trying to find other mechanisms by which we can solve those problems, instead of having the entire fee schedule be pushed by the group that may be the one that you might care about the most.

I don't know if that was clear. Again, if we were in person I might be able to get a sense of all your faces. But I hope you understand, that's sort of the broad philosophy, at least, of how I think of these updates is try and make them right, on average, and find policies to protect groups who you think might need protection when they're not. And how that works is always tricky. Two-part recommendations are challenging. What if they don't do the second part? And having them separate is challenging because what if any one of the standalone ones seems somehow incomplete? And how do we make them work between the sectors and the site-neutral stuff that Brian was talking about earlier in ASCs, leads us into a whole body of like site-neutral work. And it's just hard to get everything right in this general exercise.

So I guess I'm begging your forgiveness, if you will, but I think it's reasonable.

MS. BARR: I totally understand, but, you know, I just would think that the for-profit people are not going to go to these rural areas, and so there's a supply issue as well, right? I mean, and so, anyway, I appreciate it, and I hope we can address it at some point. I don't think it's all cultural. Thank you.

DR. CHERNEW: Right. And I guess I'll say one other example. When we look at Medicare Advantage, there was an explicit policy decision made to pay 115 percent fee-for-service in some areas, right. Whether you may think good or bad about it, we're not having a Medicare Advantage discussion now, but that's the time of what -- they tried to target certain things in certain types of places. And again, that's an average update discussion. That is more of a distributional discussion. These discussions, today and tomorrow, are not that well-suited for distributional things, although we do try and finesse it when, you know, when it's possible.

Anyway, I think we have Bruce next. Am I right, Dana?

MS. KELLEY: Yes, that's correct.

MR. PYENSON: Thank you very much, Mike. Just a question here, your view overall about the impact of nursing and staff shortages on hospice. There has been a lot talked about that for health care overall and SNFs, and home health, and hospitals. What's your view of how that might pan out for hospice?

DR. CHERNEW: Kim, do you want to answer? Do you want me to -- I can tell -- why don't you go, Kim.

MS. NEUMAN: No, you go.

DR. CHERNEW: Okay. So that's my biggest concern. That's my stay-awake-at-night issue, right? In some cases like when we went to current law, we had a discussion about, well, we just have to hope that the people that are building the various wage indices are doing it well, because we're not going to be able to guess how to do it from where we sit now.

In this case it's a little bit different. I will tell you what gives me a little bit of solace is Lynn's comment, notwithstanding. We are starting with an average margin that's double digits. So I remain very concerned about the workforce issues. I am not going to commit to this, but since it's laid and I've lost all discretion, I am hoping that next year we have workforce even more prominently featured in a cycle of what we deal with.

There's a lot of aspects of workforce we have to deal with. This is a somewhat narrower discussion now, in the hospice case. But the same is going to be true for home health. It's obviously a problem for hospitals. We have had that discussion. I am very, very worried about the workforce, and I'm not actually talking -- honestly, just to be clear, I'm not talking as much about the physician workforce. I will just speak anecdotally. The demand I see for med school is not fading dramatically. I'm much more worried about the non-physician workforce, and we need to pay more attention to that.

But for the purposes of these updates I think the question would be, well, what if we were off by 4 percent on the inflation that people have to pay? In the hospice case, at least on average, there is still a large margin there, and I would hope that we would find a way to absorb it. I would obviously rather that not be the case. But I don't think we should pay more, assuming that that is what is going to happen, and pay across the board. Every time we pay we place a bigger burden on a whole bunch of other folks.

So maybe you can tell by the rambling I'm nervous about it. Thanks for asking.

Do you want to add anything Kim?

MS. NEUMAN: I would just say that we've assumed higher cost growth that we've seen historically in this sector. You will notice that the margins have been stepping up almost every year, and that's because costs grow more slowly than payment rates. And so we are, in our projection, assuming that they are growing faster. So we don't have a crystal ball to know exactly how much faster, but we're using the best source we have, which is market basket, to try to account for it, and that's why you see the projection go down a little bit when historically we haven't been seeing margins going down.

MR. PYENSON: Thank you.

MS. KELLEY: Marge.

MS. MARJORIE GINSBURG: Thank you. No matter how many times we read the hospice material I'm intrigued every time.

I have a question. It says somewhere -- it says on this report that only 16 percent of Medicare beneficiaries are duals, but it said that the percent of duals in hospice are 42 percent. I've said this in the past and I missed it. Why is that, and is anybody as surprised as I am that the duals are so much higher in hospice than in other areas? I wonder if you have any insights on that. Thank you.

MS. NEUMAN: So that chart, I think you're looking at -- is it 11.3, the 42 percent for dual eligibles? So what that represents is the share of dual eligibles who died in 2019, who used hospice. So of that pool of dual eligibles, if they are 16 percent, as you said, then 42 percent of that group who died used hospice, and the other 58 percent passed without hospice. That's how that chart is structured.

MS. MARJORIE GINSBURG: Oh. So I completely misread it, basically.

MS. NEUMAN: Well, I think we need to clarify the title a little bit.

MS. MARJORIE GINSBURG: Okay. Thank you.

DR. CHERNEW: And if I have it right, that's the end of the Round 1 queue. Dana?

MS. KELLEY: Yes, and David Grabowski is the only person in Round 2.

DR. GRABOWSKI: Great.

DR. CHERNEW: After you talk, David, we're going to go around the horn again. Dana is going to go around the horn to get people's reactions to the recommendations. But you're first, David.

DR. GRABOWSKI: Great. Thanks, and I'll be brief as well, Mike. I want to say first that I support both of these recommendations. I did want to make one point, however.

As my Round 1 question suggests, I'm particularly interested in the Medicare Advantage carve-in and other efforts to improve coordination and appropriate access to services at the end of life. I have no idea whether the MA carve-in is the answer here. That's why we do these evaluations. But I'm really excited about these kind of ongoing efforts to look at value of hospice and how we can encourage more use and better use of this model.

As Kim noted, we have very few or almost no developments in traditional Medicare. We're sort of stuck with the current system. Usually on MedPAC we point to alternative payment models as the potential answer. I'm not certain in this case they move the needle much.

Mike and I were involved in an evaluation that we published in Health Affairs several years ago, that looked at end-of-life care under the Medicare Shared Savings Program. We didn't find much going on there in terms of changing end-of-life services and trajectories.

There were some ideas in the text that Kim put forward that I liked, and I'm wondering how to better integrate those into kind of our work flow. I am, as I said, very supportive of the recommendations we're looking at, but they feel like -- oftentimes I feel like MedPAC is ahead of the field and here I feel somewhat like talking about caps and payment updates isn't quite getting where I think beneficiaries -- we could add the most value.

Final point, and maybe this is putting my Dana Safran hat on, but I'm always frustrated by the section, quality is challenging to assess. We read that every year.

This isn't a MedPAC problem. It's a data and measurement problem for the field. But it would be great -- and once again, I don't think this is our problem, but sort of how do we grow the measure set here and improve the quality measures? Because it's really hard to assess whether beneficiaries are getting the care they want and need.

I'll stop there. Once again, Kim, great work on this, and I'm supportive of both recommendations. Thanks.

DR. CHERNEW: Thanks.

MS. NEUMAN: Mike, would it be okay if I followed up on a point on quality? So I just wanted to mention that CMS is working quite hard on a new hospice assessment instrument, and they have a contractor that is working to develop new measures. And it is very challenging, but I just wanted to highlight that there is work going on. It may be a bit before we see it, but they are working.

DR. GRABOWSKI: I may no longer be on the Commission, but maybe in five, seven years or something somebody will -- they will get to look at better quality measures, so we can all look forward to that. Thanks.

DR. CHERNEW: Okay.

MS. KELLEY: Shall we go around the room then?

DR. CHERNEW: Absolutely.

MS. KELLEY: All right. Let's start with Betty.

DR. RAMBUR: Thank you. I support the recommendations. Sorry. My dog has decided to get excited right now. But I just wanted to comment. Although it was many years ago I did my dissertation, Barriers to Delivery of Home Health Services By Population Density, and the heart of my question really was how do people die at home, although I didn't have the language at the time.

I am particularly interested in frontier counties, and I would just like to say, although I absolutely hear what Lynn is saying, I also very much hear what Jim is saying in that was a whole different set of challenges and opportunities at that time. Something as simple as not being able to get the mail, which seems pretty easy now, could actually be a whole cascade of a problem.

So I support these recommendations and I do think, you know, really special different challenges, like frontier counties, need a different kind of approach entirely. So I support this and thank everybody for their hard work.

DR. PAUL GINSBURG: I presume the dog endorses that.

DR. RAMBUR: What's that?

DR. PAUL GINSBURG: I presume the dog endorses that.

DR. RAMBUR: He does. He does. He's saying, "Where's my dinner?" is what he's actually saying.

MS. KELLEY: Jaewon.

DR. RYU: I support both recommendations as well.

MS. KELLEY: Amol?

DR. NAVATHE: I support both recommendations.

MS. KELLEY: Jonathan Jaffery.

DR. JAFFERY: I support both recommendations, and in particular I just want to comment that, you know, we've talked a lot about how to target different things a little bit more elegantly and the cap approach, policy approach I think does just that. So I endorse that.

MS. KELLEY: Stacie?

DR. DUSETZINA: I also support both of these recommendations, and just a note. Kim, great report, and I also am glad to hear about the work on quality measures here. I feel like I have had just kind of a recollection vaguely of one of our prior conversations about things like overuse of prescription drugs that are for chronic conditions and reducing that and improving pain management as some part of a conversation with the Commission, maybe a couple of meetings back. But I think these are some great steps forward.

MS. KELLEY: Brian.

DR. DeBUSK: I support both recommendations. You know, I particularly like the idea of the cap, which is a standing recommendation that we have. I also hope in future work we can look at hospice with a very high live discharge rates as well, because there seems like there's some questionable actors in that category also. Thanks.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: I support both recommendations.

MS. KELLEY: Bruce?

MR. PYENSON: I support both recommendations.

MS. KELLEY: Larry?

DR. CASALINO: I also support both recommendations and I like what Jonathan Jaffery said about, it's really quite elegant the cap solution, and I also like what Brian said about live discharges.

MS. KELLEY: Lynn?

MS. BARR: I support both recommendations with a caveat that the aggregate cap should exclude rural patients. They are much more difficult and expensive to serve, and that might provide a larger incentive for these for-profit organizations to serve those patients.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: I also support the recommendations, and I definitely support Brian's comment about we need to do more work to get rid of the bad actors. And if we do that then, Lynn, we can then focus the resources to the rural communities. But we have far too many bad actors in this one category, more so, I think, than almost any other category that I'm familiar with. Thank you.

MS. KELLEY: Jon Perlin?

DR. PERLIN: I support both recommendations. I do want to recap something I pointed out a couple of years ago, which is that while I understand the rationale for the way that we've arrived at a policy to support the original intent of hospice, the fact of the matter is that -- and this is really where my clinician hat comes out -- is that the population we're serving is changing. There is an increased need for care of individuals with degenerative diseases, cognitive orders, dementia, Alzheimer's in particular, et cetera.

And, you know, I think one of the things that we have to think about is how those individuals are being served. And so while it's not under the aegis of the original intent of this program, and I think our approach helps to support the original intent of the program, are we missing part of the picture, which is the changing Medicare beneficiary population? Thanks.

MS. KELLEY: Wayne?

DR. RILEY: Yes, I support and approve.

MS. KELLEY: Dana?

DR. SAFRAN: Yes. Full support for both recommendations. Thank you for the really great work and the excellent, robust conversation this afternoon.

MS. KELLEY: Mike, that's everyone except Pat. Pat had to drop off the call.

MS. WANG: I'm on the phone, Dana. Okay. So I support both of the Chairman's recommendations. Thanks.

DR. CASALINO: And if I may, just on Jonathan Perlin's point about Alzheimer's and other dementias, for example, Karen DeSalvo made the point a year or two ago, pretty forcefully, I think, that hospice is being used increasingly to care for Alzheimer's patients, for example. That may not be the best solution, and at some point that might be a contribution by, first of all, evaluating that, and secondly, if it seems to indicate it, thinking about whether there's a better way than hospice to approach patients with severe Alzheimer's.

So I think that Jonathan was suggesting, I just wanted to underline that as something to think about for the future.

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

DR. GRABOWSKI: Very quickly. And the other side, Larry, it actually runs in the other direction as well, that we have a misuse of post-acute care, for example, at the end of life, where we have high rates of hospitalizations, SNF use. Those are when individuals should be in hospice. So I totally agree with you that hospice is probably substituting for long-term care but oftentimes other services are actually substituting for hospice.

DR. CASALINO: I agree, David, and better that hospice does it than all that other stuff. But there may be a better solution.

DR. GRABOWSKI: Yeah, no, and it would be great to get hospice to individuals that need it rather than, you know, SNF and rehab. There was a provocative title of a piece called "Rehab to Death," and that's, I think, the model we're thinking about here, that poor fit between patients and setting.

DR. CHERNEW: And I will say that while we didn't find much in end-of-life care and alternative payment models, one of the areas where it looks like alternative payment models is doing a good job -- and again, I think the jury is still out, to some extent -- is in the broad post-acute allocation setting.

So I think it is a really challenging area, clinically, because there's so much that's hard for one to observe from the outside. I also don't know if the MA demonstration will be a solution, but it is certainly, I think, a reasonable thing to try. This is an area where some coordination, some engagement with patients and the families beyond what might have traditionally existed as valuable, and it is going to take some more work overall. But I think through MA, some of the payment models, hopefully we will move things in the right direction. But for now we're just doing updates.

I'm going to stick with thank you to everybody. It has been a very productive, albeit somewhat lengthy day. As always, I appreciate all of your inputs. I will say -- actually, I will pause for a second to see if anyone wants to make any closing comments before I ask the public for any of theirs.

[No response.]

DR. CHERNEW: Okay. So for those of you that are joining us, please feel free. We encourage you to reach out and send us your thoughts. They are all reviewed. You can send an email to meetingcomments@medpac.gov, or you can go to the newly designed MedPAC website, MedPAC.gov, and go to Public Meetings, and go to Past Meetings, and you see a link to submit comments, or you can just email meetingcomments@medpac.gov.

To all of the Commissioners, thank you for your time today. For all of the staff, double thank you for all of your work today. It is always humbling to see all the analysis that goes into these updates, and I very much appreciate the rigor with which you do your work.

So I think we will close now until tomorrow morning. I believe we start at 10 in the morning. Do I have that right. I don't want to be late and I don't want be early, but I believe we're starting at 10.

Jim, anything you want to add besides that?

DR. MATHEWS: Nope. All good.

DR. CHERNEW: All right. Then we're going to close on that. All good. Hopefully we'll see all of you and some of the public tomorrow morning. Thanks, everybody.

[Whereupon, at 5:43 p.m., the meeting was recessed, to reconvene at 10:00 a.m. on Friday, December 10, 2021.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Via GoToMeeting

Friday, December 10, 2021
10:01 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
PAUL B. GINSBURG, PhD, Vice Chair
LYNN BARR, MPH
LAWRENCE P. CASALINO, MD, PhD
BRIAN DeBUSK, PhD
STACIE B. DUSETZINA, PhD
MARJORIE E. GINSBURG, BSN, MPH
DAVID GRABOWSKI, PhD
JONATHAN B. JAFFERY, MD, MS, MMM
AMOL S. NAVATHE, MD, PhD
JONATHAN PERLIN, MD, PhD, MSHA
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AGENDA PAGE

P R O C E E D I N G S

[10:01 a.m.]

DR. CHERNEW: Okay. So we should jump in.

DR. CARTER: Okay. Good morning, everyone. The audience can download a PDF version of these slides in the handout section of the control panel on the right hand of the screen. And before I start I wanted to thank Lauren Stubbs for her help with this chapter.

This session presents information about the adequacy of Medicare's fee-for-service payments to skilled nursing facilities, or SNFs. We do this by looking at four categories we have seen throughout these presentations: access to care, quality of care, provider access to capital, and Medicare costs and payments. The specific indicators are on this slide. Based on these indicators, we will present the Chair's draft update recommendation for Medicare's base payment rates to SNFs.

A key difference from prior years is the coronavirus public health emergency that has had tragic and disproportionate effects on Medicare beneficiaries and on health care workers. Nursing homes were particularly hard hit. COVID-19 cases and deaths were high among nursing home residents, and staff have experienced fatigue and burnout as they struggle to manage care under exceptionally difficult circumstances.

From the perspective of assessing the adequacy of Medicare payments, the public health emergency has had material effects on our indicators that make it more difficult to interpret changes.

As you have heard before, to the extent the coronavirus effects are temporary, even if over multiple years, or vary significantly across providers, they are best addressed through targeted temporary funding policies rather than a permanent change to all providers' payment rates in 2023 and future years.

Turning specifically to SNFs, the Congress provided relief funds to help offset the lost revenue and additional costs to treat patients, including Medicare beneficiaries. The relief funds provided general distribution of 2 percent of total revenues and additional targeted funds to nursing homes of about $10 billion.

In addition, three key changes in payments and policies were made, including the suspension of the sequester that normally would lower payment rates by 2 percent, the waiving of the three-day prior hospital stay to qualify for coverage, and the extension of benefits for some beneficiaries. Finally, many states temporarily raised their Medicaid nursing home payment rates during at least some of the public health emergency, which will affect the total margins of the facilities.

Unrelated to the public health emergency, a new case-mix system was implemented on October 1, 2019. It considers many dimensions of patient complexity and de-emphasizes rehabilitation therapy. Later, when the public health emergency hit, the case-mix system may have been better able to recognize the higher costs associated with treating COVID-19 cases.

Though intended to be budget neutral, CMS estimated that the new case-mix system increased payments in 2020 by 5.3 percent compared to what would have been paid under the old case-mix system.

In this year's final rule, CMS noted the large increase in payments and sought stakeholder input on a proposed approach that would lower payments by 5 percent and whether to phase in the reduction. Its final decision will be included in the final rule for fiscal year 2023.

Before we discuss the indicators, here's a snapshot of the industry in 2020, with more detail in the paper. There were about 15,000 providers, most of which also provide long-term care services, which the program does not cover. Program spending totaled $28.1 billion. About 1.2 million beneficiaries used SNF services. Medicare makes up a small share of most facilities' volume and but a larger share of revenue.

The indicators of access were mixed but unlikely to reflect the adequacy of Medicare's payments. Instead, they reflect the effects of the pandemic.

Supply was stable at about 15,000. Eighty-eight percent of beneficiaries lived in counties with at least 3 SNFs.

Between 2019 and 2020, covered admissions per fee-for-service beneficiary decreased 7.9 percent. SNF stays were longer so total days declined only 1.5 percent. These changes are the product of three trends. First, hospital referrals slowed, especially early in the pandemic. Second, during the pandemic, beneficiaries have been reluctant to use SNFs for their post-acute care needs. And third, the secular trends of lower fee-for-service use as MA enrollment expands and the alternative payment models have shortened or avoided stays in the setting altogether.

Reflecting these trends, there was a large decline in occupancy rates, and rates remain much lower than they were in 2019. The marginal profit, a measure of whether providers have an incentive to treat Medicare beneficiaries, was very high, 25 percent.

Shifting gears to quality, our indicators of quality care, maintaining high quality of care was hard during the pandemic and challenged many facilities. Residents accounted for almost 20 percent of the COVID-19 deaths in the U.S.

While the risk adjusted rates of successful discharge to the community decreased and the risk-adjusted rates of hospitalizations increased, we cannot draw conclusions about the relationship of these findings to the adequacy of Medicare's payments because our indicators reflect circumstances unique to the public health emergency. Further, our quality metrics rely on risk-adjustment models that do not include COVID-19 diagnosis information.

Because the vast majority of SNFs are also nursing homes, we assess the adequacy of capital for nursing homes. Merger and acquisition activity slowed in 2020 during the public health emergency but appears to have at least partly rebounded in 2021.

HUD is a key lender, and its financing decreased about 10 percent in 2020, though about as many projects were financed. The total margins in this setting improved considerably in 2020, to 3 percent. The improvement reflects the provider relief funds, changes in Medicare policies, and the temporary increases in many states' Medicaid nursing home payment rates.

Capital is expected to remain adequate in 2022. The continued aging of the population and the fact that SNFs are lower cost compared with other institutional PAC providers favor the setting, and government financing is considered stable.

The coronavirus pandemic has had significant impacts on providers costs and payments. On the cost side, a key factor in the relatively low cost growth was the decline in number of employees during the pandemic. Between February and December 2020, BLS data show a 9.6 percent decline in the number of employees. The cost increase would have been smaller but weekly wages increased during the same period, capturing the higher use of more costly contract labor, overtime, and pandemic premium pay. Another factor was lower therapy costs as a result of new case-mix system.

On the payment side, providers saw their payments increase with the suspension of the sequester and the implementation of the new case-mix system. In addition, there was some shift in payments from other payers to Medicare that accompanied the waivers of coverage requirements.

In 2020, the average margin for freestanding facilities was 16.5 percent. This is the 20th year in a row that the average was above 10 percent. When we allocate a share of the provider relief funds to Medicare, we estimate the margin was just over 19 percent. These margins illustrate why Medicare is considered a preferred payer.

Across facilities, margins varied substantially, and there is more detail in the paper.

Variations in Medicare margins reflected several factors including differences in economies of scale. For example, nonprofit facilities are typically smaller and have higher costs per day. Also, for the past several years, nonprofits have had higher cost growth compared with for-profit SNFs.

As required by law, we consider the costs associated with efficient providers. Efficient providers are those that perform relatively well on both cost and quality measures. The measures we use are standardized cost per day and risk adjusted rates of successful discharge to the community and rates of hospitalization.

In 2020, 9 percent of the SNFs included in the analysis were relatively efficient, and that is about the same as last year.

Compared to other SNFs, relatively efficient providers had higher community discharge rates and lower hospitalization rates. They also had lower standardized costs per day and higher payments per day. These results are very similar to what we reported last year.

The combination of lower costs and higher revenues resulted in a median Medicare margin of almost 23 percent, an indication that Medicare's payments are too high relative to the costs to treat beneficiaries.

We also look at the average payments per day that some MA plans pay for SNF care. In two publicly traded companies and in a survey of almost 1,300 SNFs conducted by the National Investment Center for Senior Housing and Care, fee-for-service payments averaged 27 percent higher than MA payments.

Our analysis of the age and average risk scores for MA and fee-for-service users indicate that the differences between the two groups would not explain the differences in payments. The publicly traded companies with SNF holdings report seeking managed care business, suggesting that the lower MA payments are attractive.

We project that the SNF margin will decrease in 2022 to 14 percent. This is because costs are expected to increase more than the payment rate increases.

To estimate costs, we used CMS's estimates of the market baskets for 2021 and 2022. The market baskets consider how labor and other costs will change in both years.

On the payment side, we assumed that payments will increase by the updates included in the final rules for 2021 and 2022, and that the temporary suspension of the sequester will be reinstated on January 1, 2022. If the suspension remains in effect for longer, margins would be higher, all else equal. Margins could also be higher or lower if changes in costs or payments differ from the projections

In summary, our indicators are generally positive. Supply is stable and the large declines in volume reflect the pandemic and not the adequacy of Medicare's payments. The high marginal profit indicates providers had a strong incentive to treat Medicare beneficiaries.

The unique circumstances of the public health emergency confound our measurement and assessment of the quality of care.

SNFs have adequate access to capital, and this is expected to continue. The total margin increased.

Medicare margins in 2020 was high, and for relatively efficient providers they were even higher.

The projected margin for 2022 is 14 percent.

This brings us to the Chair's draft recommendation. It reads:

For fiscal year 2023, the Congress should reduce the 2022 Medicare base payment rates for skilled nursing facilities by 5 percent.

While the effects of the pandemic on beneficiaries and nursing home staff have been devastating, the combination of federal policies and the implementation of the new case-mix system resulted in improved financial performance.

The high level of Medicare's payments indicates a reduction to payments is needed to more closely align aggregate payments to aggregate costs.

In terms of implications, spending would be lower relative to current law. Given the high level of Medicare's payments, providers should continue to be willing and able to treat beneficiaries, and beneficiaries will have adequate access to care.

And with that, I'll turn things back to Mike and look forward to your discussion.

DR. CHERNEW: Carol, thank you, and I want to welcome everybody and, of course, this session highlights again the incredible personal challenges that the public health emergency has raised and the work that an enormous number of people have done to deal with that. So I won't belabor that point.

We are going to jump through the queues, so Dana, I'm going to let you manage them, and I think Amol is the first Round 1 question, if I followed this correctly. If I'm wrong, Dana, please correct me.

MS. KELLEY: I had Lynn first.

DR. CHERNEW: Oh. Got it. Lynn, you're first.

[No response.]

DR. CHERNEW: Lynn?

MS. KELLEY: I think we've lost Lynn so Amol, why don't you go ahead. I'm sorry about that.

DR. NAVATHE: No problem. So first off, thanks, Mike, for your remarks and for the great work here. Clearly a very challenging sector in the context of COVID, and I appreciate the efforts to highlight that as well.

I have hopefully what is a relatively simple question, which I think is COVID-related. But in the context of the shift to the PDPM risk adjustment system and the changes that were noted particularly in the paper about the therapy minutes and the like, I was curious if there's any information whatsoever about patient experience type measures. I know we don't have that much in terms of quality measures here. Are those measures that CMS basically suspended in the context of COVID, and we don't have any information? Is there any information from the earlier part of the year that might be helpful? I was just curious about that.

DR. CARTER: Yeah, I don't have any information about that. I'm sorry, and I don't think that is information that is regularly collected and reported out.

DR. NAVATHE: Thank you.

MS. KELLEY: Larry.

DR. CASALINO: Carol, nice, as always. Could we take a look at Slide 7? I just want to clear something up about margins, which should be obvious. So here we have marginal profit 25 percent. Carol, that means the profit on taking one more patient, right?

DR. CARTER: That's right.

DR. CASALINO: And the revenue for that patient is expected to be 25 percent higher than your variable costs of taking care of that patient. So that one, I think, is pretty clear.

Could we go to 9? Actually, let's go to 11.

Okay, so here we're talking about, say, 20 consecutive year, margin was above 10 percent. That margin is the profit for -- there's different ways to say it, but let's just say if you took all of your Medicare revenue and divided by all of your Medicare costs for your SNF patients you would have a margin of about 10 percent. Correct? So that one's pretty obvious.

But then let's look at Slide 9, the middle thing there with the green top.

DR. CARTER: Yep.

DR. CASALINO: What is this 0.6 percent and 3 percent?

DR. CARTER: So that's in the total margins. So that's across all payers and all lines of business. And so this margin is heavily influenced by Medicaid payment rates.

DR. CASALINO: Okay. So unlike most all payer margins in other settings where we're seeing them go up from the Medicare margin, this one is heavily influenced by Medicaid and that's why it's so low.

DR. CARTER: Right. Right. Medicare is the high payer in this sector.

DR. CASALINO: Yeah. And what percent of the revenue comes from Medicare versus Medicaid, about?

DR. CARTER: So we don't have that information on the cost report, but in terms of days Medicaid is about 16 percent, something like that, and private and other is about 20, and Medicare is about 10.

DR. CASALINO: So what would happen to these total margins if we reduced the Medicare rates 5 percent?

DR. CARTER: I haven't modeled that but they will go down a tic, but Medicare revenues are only 17 percent of a provider's revenue, so they will go down a little bit but not a lot.

DR. CASALINO: Right. So it would take it down just somewhere between 2 and 3 percent probably, as a guess. Does that sound right?

DR. CARTER: Right, and these also reflect the influx of the provider relief fund, so are temporary. And so in the future those will go away.

DR. CASALINO: Those total margins will be worse.

DR. CARTER: Yeah, and they've hovered between -0.3 and 4 percent for 15, 20 years. So they've bounced around being fairly low for a long time.

DR. CHERNEW: Larry?

DR. CASALINO: Yeah.

DR. CHERNEW: No, you keep going. When you're done with your questions I'll say something, but I want to let you finish your questions first.

DR. CASALINO: Yeah, well, I'll finish my questions and then you can explain where I'm going down the wrong path. But let's look at Slide 11 one more time. I'm just about done. Slide 11, please. Okay.

So the aggregate margin we're looking at here is for Medicare only. Is that right?

DR. CARTER: That's right.

DR. CASALINO: Okay. And Carol, I'm sorry. I'm still trying to get straight on this. So if that was reduced by -- you know, if the payment rate was reduced by 5 percent, that is going to reduce the all-payer margin, but you haven't modeled it but probably to somewhere between 2 and 3 percent?

DR. CARTER: Well, I haven't modeled it but it is going to be a small reduction because Medicare is not that large a share of facilities' revenue.

DR. CASALINO: Okay. Got it. Thank you.

DR. CARTER: You're welcome.

DR. CASALINO: Take it away, Michael.

DR. CHERNEW: Well, I'm going to make a broad comment because it comes up across many of these fee schedules, although this is the one that honestly is the one that causes me to lose the most sleep.

There's a text box, as you saw, Larry, in the chapter, and this big question that we try to go out of our way to emphasize, which I will now emphasize again, which is how Medicare payment rates should respond to Medicaid payment rates. And our charge is to set payment rates adequately to ensure access to high-quality care for Medicare beneficiaries. And so in this particular case there's always this pressure because Medicaid is paying so much less.

I'll let others comment on this as we go around. It's important, but it's been a longstanding MedPAC principle not to raise our payment rates to compensate for underpayment of others. I might add in the hospital sector we don't lower our payment rates because commercial is paying more, in the same way.

That is maybe not as pristine a statement as I would like it to be. I do worry a lot about the access of

Medicare beneficiaries to high-quality SNF care, and I acknowledge that that is sensitive to Medicaid payments, so we can't completely wash our hands of what's going on in the Medicaid program. But as a general principle we're trying to avoid compensating for low Medicaid rates, for reasons that I think are outlined in the text box.

There may be discussion around that point. It has been a longstanding MedPAC position. Glenn Hackbarth made that point repeatedly. Jim may want to weigh in. But the tension is always around the point that you're raising because, as is noted, everything about what you see in Medicare -- the comparison to Medicare Advantage, the Medicare aggregate margins, and stuff like that -- suggests we're paying quite a lot and have been for a long time. That does not mean that the nursing homes themselves, the SNFs, or more broadly the nursing homes, are being paid what they might need to be paid to do all that they do. And that is a -- did I mention that was a stay up at night kind of concern? But that's sort of where I am.

Jim, do you want to add anything to that?

DR. MATHEWS: You've correctly articulated the longstanding position here. The one thing that I would add is that, as a corollary to that position, we also note that, you know, overpaying for skilled nursing facilities on the Medicare side doesn't really help those nursing homes with very, very small shares of Medicare patients and very large shares of Medicaid. It is creating a disproportionate benefit for those nursing homes who treat on the SNF line of business a relatively large share of Medicare patients. So even if there were an interest in subsidizing, this would be an incredibly inefficient and ineffective way of doing it.

DR. CASALINO: And just to be clear, I think, Mike and Jim, what you've said is very helpful. But, in fact, the questions I was asking weren't really directed at this or at trying to make a policy point. We had some discussion of it in the executive session yesterday, about the difficulty in the slides and chapters sometimes of distinguishing between the marginal patient and overall Medicare margins and between all-payer margins and Medicare margins. So this I think is a good example. I feel like 7, 9, 11, ponderous as it may be, more specific labeling would have avoided questions such as the one I asked, although I think it's helpful to hear what you guys have to say about the policy.

DR. CHERNEW: Yeah, I just wanted to make sure, because it is glaring, the margins on Medicare patients are glaringly different from the aggregate margin, which can only happen if we reported the Medicaid margins; they would be glaring in the other direction. That's how this is playing out.

Carol, I think -- again, you're small on my screen. I think you wanted to jump in, so I should let --

DR. CARTER: I only wanted to make the targeting point that Jim already made, that it's exactly -- it would target exactly the wrong facilities if we were to do that. Very inefficient.

DR. CHERNEW: But, again, we digress. So I think, Lynn, you were lost. Now you're found.

MS. KELLEY: Mike, I think Bruce wanted to get in on this point.

DR. CHERNEW: I'm sorry. Okay. You manage it, Dana.

MS. KELLEY: Okay. Bruce?

MR. PYENSON: So on this point, I noticed that it seems like almost all SNFs also handle nursing home. There are very few SNFs that are pure SNFs. And I wonder if you could comment on the reason for that, because if you were a pure SNF, then you wouldn't have much in the way of Medicaid. So what --

DR. CARTER: Yes, so it tends to be the hospital-based providers, which are really not set up to be nursing homes. They're set up to provide really post-acute care for the patients who were admitted there as inpatients. So it's mostly the hospital-based facilities that are not also nursing homes.

MR. PYENSON: Could you comment on why, since it seems that the SNF portion is so much more profitable, why we don't see freestanding, pure place SNFs?

DR. CARTER: I don't know. I think some of the new entrants into the market are moving in that direction or at least going after what they would term the subacute care market, which is more the Medicare and MA payer mix, which is, you know, not the long-term residential care. So I think the new entrants tend to want to be in a different mix than, say, the average facility. I don't think there are very many freestanding SNF-only providers.

MR. PYENSON: So it seems as though the market may be suggesting that the nursing home component, the non-SNF component, is an important part of their business model.

DR. CARTER: Right.

MR. PYENSON: And do you think that might have something to do with the admissions to hospitals and subsequent discharges to the SNF beds?

DR. CARTER: I'm sorry. I kind of missed the question. What was it?

MR. PYENSON: Do you think the value of the Medicaid portion of the nursing home portion is that hospitals will tend to return patients after a three-day stay to the SNF from which they came?

DR. CARTER: I think in general facilities do get the patients that were hospitalized to their SNF, and then those patients stay as nursing home residents. You see some shifting, but very little.

MR. PYENSON: Thank you.

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

DR. DeBUSK: Yes. I'd like to go back for just a moment. We have this issue of Medicare cross-subsidizing

Medicaid. It strikes me as a little bit difficult because if we wanted to protest too much over, say, again, the Medicare subsidy, you could argue that MA plans could really have the same issue when it comes to dialysis. What would we say if perhaps an MA plan said, well, we don't want to subsidize Medicare's dialysis or really even commercial payers subsidizing hospitals based on Medicare rates? So I mean, I do agree -- excuse me?

DR. CHERNEW: I'm sorry, Brian. Go on. I have a tendency to get excited. Finish.

DR. DeBUSK: Well, the other comment, the other thing I wanted to mention, Bruce, I think to your question about these stand-alone SNFs, I don't think that you've seen the stand-alone SNFs, but I do think you see some really advanced care models where it's the hoteling or hospitality industry. I can give you some names, but there are some places in Minnesota and Florida that have really peeled off all of the traditional -- or not all, a lot of the SNF use, but are going with what amount to very specialized SNFs. But they're doing it for cost and quality purposes.

Thank you.

DR. CHERNEW: Okay. Let me just jump in, Brian. I'm sorry. I'm working on controlling my enthusiasm. I think it's important to note that in those cases where there's higher payment, hospitals, because of commercial, MA, and the dialysis case, we do not lower our recommended updates in those sectors because we see that they're getting money from other places. If we were going to set hospital rates to hit some total margin, for example, we would have a much lower recommended hospital update. The same would be true in dialysis. So there are complexities here -- I imagine Jeff Stensland's on -- about the relationship between overpayments in other sectors and costs and how that distorts our measures of margin, for example, which we worry about. But we do not, when we think of the updates, try to lower our updates because providers are getting more money from some other sector, and we try not to raise our updates because they're not getting enough from some other sector. We try and come up with a rate that conceptually is a rate that will ensure Medicare beneficiaries get access to high-quality care, because, as we all know, the system is not as -- we live in a fragmented system. It's not as fragmented as my comment would imply that it was. What other payers do certainly affects a whole bunch of things. They affect the access of Medicare beneficiaries. They affect the number of providers. They affect the costs that those providers incur. So we try and do our best.

But, conceptually, we are trying to be consistent between what happens when there is an underpayment from another sector or an overpayment from another sector, and that's what we would say to the MA plans, and that's what we would say in the case of dialysis.

Now, I saw there's now a whole list of "on this point" people in the now "on this point" queue, Dana, I believe.

MS. KELLEY: Yes.

DR. CHERNEW: So I'm going to let you run through the "on this point" queue discussion, and I do appreciate that Larry's question was actually a Round 1 question, which I think was well appreciated, about how we're using the same terms, although I do think in this particular case it has surfaced what the core issue is in the SNF recommendations. So I think it's worth spending a little time on this. So, Dana.

MS. KELLEY: Paul, did you have something you wanted to add here?

DR. PAUL GINSBURG: Yes. Actually, until Carol had answers one of Larry's questions, I hadn't realized what a small percentage of nursing home patients are Medicare SNF patients, 10 percent. And I was thinking that the reason -- obviously, there's a huge incentive for someone to come up with a Medicare-only SNF, and I presume the reason it doesn't happen that often is a scale economy, that, you know, this multi-product firm between the custodial care for Medicaid and some others and the SNF care for Medicare, you know, just spreads fixed costs more widely.

I don't know, Carol, if you've thought about that or have any insights into it.

DR. CARTER: Yeah, I actually meant to say something about that. It must may be a capacity thing. You may not be able to fill a reasonably sized facility with SNF-only Medicare patients.

I guess the other thing I'd point out is these are really different products, so we can talk about the underpayment by Medicaid, but you're actually buying a different product. It's not Medicaid's paying lower rates for the same thing. They're buying something different. And so that's just maybe a little different than comparisons in other settings where, you know, a dialysis session may be fairly uniform.

MS. KELLEY: David.

DR. GRABOWSKI: Yeah, I was going to give a short lecture on scale economies, but Paul stole my thunder here, so I'll hold off and wait for Round 2. Thanks.

MS. KELLEY: Okay. Lynn, go right ahead.

MS. BARR: Thank you so much. So as part of the work that we've done with CMS on the quality improvement organizations and looking at the data from the QIOs on rural SNFs versus urban SNFs, there is a significant disparity, and the large majority of two-star SNFs in many states are rural. And so when we're talking about, you know, we're talking about -- obviously, we have to talk about the whole thing, but I think that somebody mentioned yesterday, you know, is the quality we have in these SNFs good enough? Obviously, we had just a horrendous situation with the PHE, and I think many of us feel that the quality needs to be improved and our beneficiaries need to be better protected. But then if you look at the quality in rural, it's horrendous.

And so I would ask the staff, could you look at the two-star SNFs in rural versus urban to better understand the disparities between the two as you think about rates? Because, again, a 5 percent reduction in the two-star rural SNF, that might close it. I don't know. Maybe that's a good thing. I don't know. There may be access issues, but I'm not sure that we're looking at this with a lens that would protect the underserved.

I kind of snuck a Round 2 in there. I apologize, Michael.

DR. CARTER: Yeah, and I would only say that in our quality measures we don't use the star ratings, so we can consider that maybe for our future work. But at least in general we have steered away from star ratings.

MS. BARR: With good reason, and I understand that, but we also have the -- I mean, CMS thinks it's nearly a crisis, and in their last request for the QIOs, it was very heavily focused -- and this was a couple of years ago, before the pandemic. It was super heavily focused on two-star SNFs in rural. And we also have the quality scores, and there's also big disparities there as well.

DR. CHERNEW: So let me again jump in and make a broad point, which is the -- and, again, Carol, please correct me if I'm wrong. I'm going off of Table 4 from the mailing materials, and if I'm incorrect, I probably should have asked a Round 1 question, but in any case, my sense is that the margin issues on average in the rural areas are not substantially worse than what we're reporting overall in general.

So this gets into another very complicated principle, which I will probably articulate over the years, which is we cannot set our payment updates such that the most vulnerable places are okay. That will involve overpaying a vast swath of providers. So we are trying -- and I very much want both -- everyone who can hear, and maybe some who don't, to understand. This is also a really agonizing issue, for all the reasons you've said, the equity issues, the access issues, which is why we have started some of the safety-net work and the other things. Our general policy at MedPAC has been when there's situations where there are really important providers that we have to try and support, but we don't want to, for lack of a better word, create 25 percent margins in everybody else, we try and find targeted ways to do that.

And so the challenge, which is always the case in these update recommendations, is we're trying to come up with a single update, and what we would like to do is protect the places -- again, our mission is access to high-quality for Medicare beneficiaries. We want to protect the providers that do that. We want to do that in a targeted way, which is often not by increasing the payment overall. And that remains the challenge. I again want to emphasize it is in no way indicative of a lack of concern of the Commission or the Commissioners to access to care in rural areas or for vulnerable populations. In fact, I would say quite the contrary, that's where we spend a lot of our time pondering what to do.

Again, Jim, do you want to say something about this broad point?

DR. MATHEWS: No. You covered it well.

DR. CHERNEW: And so, Carol, you may have a response. If I said anything wrong, you should let me know.

DR. CARTER: No. It's all good.

DR. CHERNEW: Okay. Then we're back to you, Dana.

MS. KELLEY: Okay. Just a reminder for people to mute their mics when you're not speaking.

Bruce, I still have you in the Round 1 queue. Did you have an additional point or additional question?

MR. PYENSON: I do, which is I noted in the reading material, Carol, that you talked about interest of investors in the nursing home industry and that -- but that the nursing home industry and SNFs are perhaps the last unconsolidated type of service unit left in health care. But I wonder if you could comment, if you have thoughts on how our reimbursement policy might affect the consolidation or not of nursing homes.

DR. CARTER: You're right in noting that this could be an industry that's ripe for consolidation because it's pretty unconsolidated right now, and I have some figures in the chapter that talk about how large the largest companies are, and they're pretty small. I think if we see consolidation, it's going to be at the regional level, and I think it's because this is a sector where knowing potential partners and referring hospitals and developing those relationships is the key to SNF volume. And knowing the intricacies of state licensing and Medicaid policies is really important. And so I think even -- we've seen some large national chains scale back their footprints in markets to really focus on select markets because of the need to have a pretty good understanding of the markets that they're in.

Does that help?

MR. PYENSON: Thank you very much.

DR. CHERNEW: I want to jump in again. Dana, is that the end of Round 1?

MS. KELLEY: No, it's not. I have three more people.

DR. CHERNEW: Okay. So I'm not sure I'm getting all of the Round 1 queues when people are sending them, but, remember, we don't have that much more time this session. We have several people in Round 2, and we are going to go around and make sure that everybody says how they feel about the recommendation. So I will try and be quieter, and I just wanted to give everybody a time check. So go ahead, Dana.

MS. KELLEY: Pat.

MS. WANG: Carol, I think it's a very good observation that you noted that MA plans, some MA plans anyway, pay less for SNFs. Do you have more -- actually, you don't need to answer, and maybe this is Round 2. It would be good to understand a little bit more about the ways that MA plans may be using SNF, because we're using it as sort of a payment relativity indicator that they're paying less. But without the three-day prior inpatient stay requirement I think MA plans may be using SNFs a little bit differently, have just been paying differently. So it might be an area for further exploration to see whether or not that's really a fair comparator.

Going back to the projected Medicare margin in 2022 on Slide 14, I wanted to ask, this is a 2022 projection so does this assume that the 5 percent case-mix overage is still in the revenue?

DR. CARTER: Yes, because it's current law.

MS. WANG: It's current law. Okay. So if CMS were to do something about that effective 2023, would that affect our recommendation, because the projected margin would be kind of -- current law would have changed such this projection would not have a lot of continuity in 2023.

Do we care about that or do we just need to go by the best that we know today?

DR. CARTER: I think we typically -- I mean, in our projections we always assume current law. We can't anticipate what CMS will do as it takes a reduction, how big it will be, over how many years. So it's hard for us to factor that into our projections.

DR. CHERNEW: I think, very briefly -- that's an excellent point, Pat -- again, as a general point, we make our recommendations assuming current law remains current law. Should there be a change in current law our interactions with the Hill or other people would acknowledge that in how we would get the spirit of the recommendation. Our recommendation is based on current law, and our interpretation and communication of them would change if there was a substantial change in current law.

MS. WANG: That makes sense, Mike. Thank you.

Carol, the other question I have is, I mean for this sector in particular, given the effects of the pandemic, and you touched on it before about people's reluctance, perhaps, to go to SNF or to some sort of, you know, nursing home setting, et cetera, et cetera. Are there reliable business projections about the stiff capacity requirements going forward? And I guess it goes to this margin projection, again. I guess that in addition to current law we assume current utilization and demand, because if volume were to drastically change, for example, as a result of the impact of the pandemic, which in this sector you could see there could be very impacts, in addition to everything that's going on with the sector, does that factor into our recommendation at all, or is that also something that we would expect the Hill to kind of be agile and recognize that and do necessary adjustments in 2022?

DR. CARTER: Right. So I think our 2020 numbers, the costs have already reflected the large drops in volume. I don't think we're going to continue to see large drops in volume. So whatever changes there have been in the cost structure of facilities I think, by and large, we're capturing in the data that we're seeing.

The market basket that OAC, the Office of the Actuary, puts together projects, you know, what they think is going to happen with labor, what they think is going to happen with all the supply categories, and we're not in best position to sort of second-judge, nor do I think we want to second-judge those market basket projections. But I do think in terms of volume change we've seen the worst of it, and volume is slowly returning, although I will say that I think as volume returns we're going to be sticky, and I don't think they're going to return to pre-COVID levels.

MS. WANG: Okay. You touched on market basket. Final question. Is the market basket update sensitive to the skill mix in SNF and long-term care facility settings in particular? It's a different workforce than, for example, in a hospital.

DR. CARTER: It is a setting-specific market basket.

MS. WANG: Okay. Thank you.

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

MS. MARJORIE GINSBURG: I did but we can skip it because it's pretty much been answered. Thank you.

MS. KELLEY: All right. Dana, did you have a Round 1 question?

DR. SAFRAN: Thanks. Just a quick one. I think

I heard earlier in the discussion that Carol said that there wasn't patient experience measure for skilled nursing facilities, and I was confused by that because I'm pretty sure there is a nursing home CAHPS survey, though I'll admit I don't know whether that actually is required to be administered or even whether it's part of what gets displayed on Medicare compare sites, so it's just something for a clarification there.

DR. CARTER: I can look into that. I'm not quite sure. I can get back to you offline on that.

DR. SAFRAN: Okay. Thanks, Carol.

MS. KELLEY: All right. That's the end of Round 1, Mike. Shall we move to Round 2?

DR. CHERNEW: Yes. We're getting to really the end of this session so I'm going to ask for sort of brief comments. We are going to go around. Lynn, is it possible to hold off your Round 1 question? We've got 10 minutes left. We've got everyone to do a Round 2.

MS. BARR: Okay.

DR. CHERNEW: So let's start with Round 2. Please be aware of the time, and please say your reaction to the recommendation. Once we get through Round 2 I'm going to go around to everybody and get their sense of the recommendation.

So go ahead, Dana.

MS. KELLEY: David, you are up.

DR. GRABOWSKI: Great. Thanks, Mike, and I will be brief. Thanks, Carol. This is great work, as always. I am supportive of the Chair's draft recommendation. I think is really a time where we have to follow Mike and Jim's guidance about focusing on the update and not trying to fix broader issues with the sector.

Mike mentioned this sector in particular keeping him up at night. It keeps me up too, Mike. There's a lot of thorny issues going forward, especially vis-à-vis Medicaid underpayment.

That said, the data presented in the chapter I think strongly suggests we are overpaying in Medicare and that the 5 percent cut is warranted for fiscal year 2023.

I did want to quickly make three points, however. The first is a longer-standing point. The latter two are really pandemic specific.

So the first point -- and, Larry, your question really highlighted this perfectly so I won't belabor it --

SNF payment is broken. It's been broken pre-pandemic. This has been true for a long time. Medicare pays double-digit margins. Medicaid pays a negative margin in most states. As was suggested by Carol, we then have Medicare cross-subsidizing Medicaid.

I love that text box. I guess I'm a nerd -- I don't guess; I know I'm a nerd -- but that's my favorite text box every year in any MedPAC report, Carol, because it really highlights what's wrong with this sector.

When I talk to federal policymakers and they ask me how to fix nursing homes broadly I always point to underfunding, and then they look at Medicare and say, "Wait a second. We're paying double-digit margins." And this really suggests the answer isn't kind of increasing Medicare rates, for all the reasons that are mentioned in that text box. It's about integration. It's about fixing the kind of disconnect between Medicare and Medicaid. We've had chapters in the past about these integrated or blended models like the special needs plans, like the Financial Alignment Initiative. I think that's the future, not trying to kind of balance Medicare and Medicaid here.

So two pandemic-specific points. The first is that -- I mean, Carol noted this nicely -- volume is still way down in this sector. We saw chapter after chapter where utilization largely bounced back after that kind of March/April time period in 2020. That didn't happen in this sector. Volume is still down. I think, Carol, you're right, it's creeping back, but I don't know what this sector is going to look like going forward.

And I completely agree with you, Carol, that it's not purely linear, that this is just going to come back. There's going to be some stickiness, as you suggested.

So I do think we need to monitor utilization in the coming years, and I don't know the steady state will ultimately look post-pandemic like it did pre-pandemic.

Final point, labor came up yesterday. This is a sector where they are really suffering from staffing shortages. The Bureau of Labor Statistics is suggesting 400,000 fewer workers today than pre-pandemic. Now I know census is way down, so that's not quite an apples-to-apples kind of comparison, but I do think a lot of nursing homes around the country are really struggling to recruit staff.

Jaewon made a really important point yesterday. It's not just the RNs and LPNs. It's also the certified nurse aides. Many of them have gone to other parts of the economy outside of health care. So I do think labor is going to be a huge issue here that we're going to want to pay close attention to in the coming years.

Once again, I'm very supportive of the recommendation, and thanks again, Carol, for a great chapter. Thanks.

MS. KELLEY: Jon Perlin.

DR. PERLIN: David Grabowski so eloquently captured many of the things that I was going to say so let me just put a ditto on that.

I would just offer this sort of thought with respect to our posture, is that we're focused, at this time of year, on costs and the update, and really, our responsibility when we think of quality simultaneously is value, or the relationship of the outcomes to the resources that are invested. I think we need to be clearer in terms of what those outcomes are supposed to be, in terms of what we desire in conjunction with Medicaid. I think there does have to be more coordination in terms of surge capacity, in terms of infection prevention, in terms of workforce stability.

David, correct me if I'm wrong, but we were talking about the turnover in those wage-grade roles, something on the order of 300 percent. And, you know, even if you got the most competent individual day one, day one a 300 percent turnover is new, and that lack of stability is disruptive to care, disruptive to process, et cetera. And so I think we need to really home in on that, in particular.

And even though volume hasn't bounced, I tell you from an acute care perspective that it's maldistributed. It's available in some places where it may not be desirable to patients, it's backed up still. And this is especially in those markets where we're having continuing COVID surges.

So notwithstanding those points I support the Chair's recommendation. Thanks.

MS. KELLEY: Amol?

DR. NAVATHE: Well, two very well-spoken sets of comments from David and Jon so I'm going to try to be brief, because I would also put a ditto on their remarks.

Briefly, I support the Chair's recommendation. I think this is obviously a very challenging sector that has through a very tough time. I think I also want to just recognize out there that SNFs services and the role that SNFs play is clinically a very challenging one, given the types of patients that they care for and the complexity oftentimes of the patients they are caring for, certainly in an aggregate sense.

I support the recommendation because also in the context of the recommendations that we've made previously, the Commission has made year after year after year, which I think is an important context to understand why the financial picture looks the way it looks, and even despite the challenges around labor side, the challenges that the sector has faced over the past 18 to 24 months, that this still, in fact, makes sense.

And the last point I think to make is just to echo the point around, I think hopefully we can start to bring up as part of our work, maybe even connecting with MACPAC, around how we can better think about financing the SNF piece, both the kind of short term as well as the nursing home part, because the idea that we are living in this subsidization world certainly doesn't seem like the right way to do it. And I think Mike and Jim and others have outlined the view of MedPAC, which is also very important.

So thank you. In summary, I just wanted to voice support for the recommendation.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you very much. I just want to comment on how much I appreciate this dissecting out of the different operational definitions of the term "margin," because when I was initially reading this I was thinking given these margins why aren't we able to recruit and retain staff? And clearly that is a crisis at the working surface, which many of us, including me, are very concerned with.

So saying that I absolutely agree that we must stay in our own lane, and I don't think Medicare has the largesse to get out of its lane, and it's actually the wrong tool, for all the reasons many of you have talked about.

I would suggest that we need to -- it would be welcome to think about access in frontier counties separately in the future, because I think it's a whole different story. And using a term from yesterday, no matter how much we peanut-butter it, it probably would still be too thin there because it's a whole different set of circumstances.

And then just to pile on on the issue of labor and workforce needing fresh approaches and fresh strategies. So I very much support this recommendation and really thank all of you, the staff and Commissioners, for helping solidify the issues for me. Thank you.

MS. KELLEY: Lynn?

[No response.]

DR. MATHEWS: I think we've lost Lynn.

DR. CHERNEW: No. She's here. I think she's muted.

MS. KELLEY: Lynn, are you there?

DR. CHERNEW: Is she muted by us?

MS. KELLEY: I don't think so. Can you try unmuting again?

MS. BARR: Okay. I got it now. Thanks. Sorry. I was getting the "you're muted." All right. I apologize. I'm having all kinds of technical difficulties, not to mention, you know, spiritual difficulties by having this conversation today.

So I do support the 5 percent cut for urban SNFs. That makes perfect sense. But I don't understand what it's going to do to rural, and I don't understand why we can't make different payment recommendations for underserved -- you know, we have different payments for rural physicians and hospitals, but we don't have different payments for rural post-acute care.

The quality in rural post-acute care is terrible. Ask CMS. They know better than anyone. And I don't know what their margins are. I think they're very low. They're low volume and obviously low quality.

So I'm not sure that that 5 percent won't be catastrophic, but I support the Commission in terms of this is what we need to do for the rest of the country. Could somebody please look at its effect on rural?

DR. CASALINO: Michael, would you or somebody respond to Lynn's question about, well, why not do the 5 percent cut for everywhere except rural?

DR. CHERNEW: So I will give my recommendation, my answer, and then I'm going to turn to Jim, unless you want to go first, Jim.

DR. MATHEWS: No. I'm interested to hear what you have to say.

DR. CHERNEW: I knew you were going to say that. I realize my strategic error. There's not enough time for me to wax on on that.

Our charge here, Larry, is very specific. There is a SNF fee schedule. It has a single update factor, and we need to make a recommendation about what that update factor is. That's what we are being asked.

There is a separate question about how to deal with particular providers of interest, which, as we are embarking on our safety net we can ponder the scope of that work and how to do that. We would end up tying ourselves in knots if every sector we tried to tailor our recommendations to not just change the recommendation but to change which subset of providers it did or didn't apply to. So that, I view, as a fundamental frustration with the task that we have at hand.

It is the case that if we thought there was evidence of something catastrophic, our recommendation would cause something catastrophic going on somewhere, we would put more weight on that. I will defer to Carol, but I don't think that's the case here. I think the evidence is simply that the margins from Table 5 that I looked at in rural areas in general were quite healthy. So I won't say that we shouldn't look more, but given the work and the evidence you had I don't think we see broad-based concern that there's going to be a problem. That doesn't mean there might not be or we shouldn't look more.

Carol, do you want to say anything about that before I turn to Jim?

DR. CARTER: I would just point out that the margins for frontier SNFs were high. They're 19 percent.

DR. CHERNEW: Yeah. So there may be a problem. We haven't seen where it is in the analysis we've done. We will continue to look at this, as we always do, but the broader point is we will not make a recommendation, a conditional -- we are making a recommendation for the actual fee schedule we have to do. And I'm hoping Jim says that's right. Otherwise I might go off-camera.

DR. MATHEWS: And in the interest of time I'll leave it at that.

DR. CHERNEW: Okay.

MS. KELLEY: Okay. We have one more Round 2, Mike, and then I'll just start going through people we haven't heard from to ask if they support the recommendation.

Bruce, why don't you go ahead.

MR. PYENSON: The Chairman's recommendation strikes me as being very close to the case-mix error that CMS made, so I'm surprised we're not looking a bigger reduction.

I do want to recognize the substantial work that the Commission has made in site-neutral payment policy for PAC, and I think that work, if it were implemented, would have a beneficial effect on the sector, and perhaps begin to address some of the issues and concerns that have been raised this afternoon.

So I'm hesitant to suggest a lot of other avenues of work going forward because of the potentially big impact of site-neutral payment, and I don't want to lose sight that that really is an important element of the future for this area of Medicare payment. Thank you.

MS. KELLEY: All right. Now I'll circle around to get everyone's view on the recommendation. Marge?

MS. MARJORIE GINSBURG: Yes, I support them.

MS. KELLEY: All right. Wayne?

DR. RILEY: Yes, I'm supportive.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Supportive also.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: I support the Chair's draft recommendation.

MS. KELLEY: Pat?

MS. WANG: I support the recommendation.

MS. KELLEY: Stacie?

DR. DUSETZINA: I also support the recommendation.

MS. KELLEY: Dana?

DR. SAFRAN: I support the recommendation. I'll just chime in in support of the several comments made about exploring more robust ways to consider quality in this sector. I think it's really critical, and I think some of the comments that were made about potential synergies of Medicaid, and I know very little but understood from this conversation that we're talking about different products, so to speak, for Medicaid. So it may not be possible, but the small sample issue for SNFs' measurement has always plagued us and left us with very few measures. And so this idea of potentially being able to have alignment in the measurement across Medicare and Medicaid programs is one I think we should pursue. So thank you.

MS. KELLEY: Paul.

DR. PAUL GINSBURG: I support the recommendation. I would have been willing to support an even larger cut, given the fact that Medicare SNF revenue is a fairly small part of nursing home revenue. And I also support Mike's explanation about why we should not consider separate rates for different subsectors.

MS. KELLEY: And Brian.

DR. DeBUSK: I support the recommendation as written. Building on Bruce's earlier comment, though, I would ask that we consider a second bold-faced recommendation that the 5.3 overpayment introduced through the implementation of the PDPM also be addressed, because I would hate to see that go unaddressed for several years. Thank you.

DR. CHERNEW: Thanks, Brian. Jim, do you have any comment on Brian's last point?

DR. MATHEWS: Why don't we talk after the meeting.

DR. CHERNEW: Okay. And that is the end of this discussion, I believe, Dana.

MS. KELLEY: That is correct.

DR. CHERNEW: So to move us along, because we're a little bit behind schedule, we're going to jump right into the home health presentation, and that's going to be Evan. So Evan, take it away.

MR. CHRISTMAN: Good morning. Today's presentation will have three components. We will review the payment adequacy framework as it applies to home health; we will review the analysis pertaining to a mandated report required by BBA 2018; and we will also provide the Chair's draft recommendation for 2023.

As a reminder, a PDF version of these slides is available on the control panel.

As an overview, Medicare spent $17.1 billion on home health services in 2020. There were over 11,400 agencies, and the program served about 3.1 million beneficiaries.

Home health experienced two major events in 2020.

First, like other sectors, they experienced the disruption of the COVID-19 public health emergency.

As noted in prior presentations, the disruption of the PHE complicates interpreting our payment adequacy indicators. For example, many of the utilization changes in home health care were likely due to PHE-related factors and less influenced by Medicare payment policies.

Also, the suspension of the sequester and COVID relief funds provided compensation for lost Medicare revenue.

In addition, due to the PHE, CMS broadened telehealth services that HHAs could provide, permitting the delivery of virtual home health visits for the first time. All of these factors had an effect on home health utilization in 2020.

The second major event in 2020 was the implementation of payment changes to the home health PPS required by the Bipartisan Budget Act of 2018. These changes, even without the effects of the PHE, could have affected the mix and amount of home health care services delivered to beneficiaries.

Coming to the BBA changes we are required to study, the law mandated that two changes to the PPS be implemented on January 1, 2020. The first was a new 30-day unit of payment, and the second was the elimination of the number of therapy visits provided during home health as a payment factor in the case-mix system.

The mandated changes were implemented through a new case-mix system called the "Patient Driven Groupings Model." The BBA 2018 requires MedPAC to provide an initial assessment of these changes by March 15, 2022. When considering -- I'm sorry. Could you go back a slide?

When considering the impact of PDGM, it is important to remember that home health agencies were implementing the new policies at the same time that they were experiencing significant disruption due to the PHE. As a result, the effects of the PHE need to be considered when we assess the impact of these policies.

On this slide you will see our payment adequacy update framework on the left, and on the right is a summary of the statutory language for the mandated report. I will not review them in depth here, but the main point is that they both require that we assess cost, quality, and utilization in 2020, so our chapter and this presentation will include our standard review of payment adequacy with a particular focus on the impact of the 2020 payment changes to satisfy the BBA mandate.

We begin with supply and access. As in previous years, the access to home health appears to be very good. Eighty-eight percent of beneficiaries live in a county served by five or more home health agencies; 99 percent of beneficiaries live in a county served by at least one home health agency.

Turning to supply, the number of agencies was over 11,400 by the end of 2019. The decline in agency supply of 1 percent was actually lower than the average decline for recent years, and this suggests that neither the PHE nor PDGM had a significant negative affect on the supply of agencies. And in 2020, home health agencies had a marginal Medicare profit of 22.9 percent.

Turning to volume, the share of beneficiaries using home health declined by 4.7 percent in 2020.

The figure on this slide shows monthly utilization of 30-day periods in the two years. As you can see, utilization in 2020 is lower through the year compared to the prior year, but most of the lower volume occurs in

April and May. It recovers in June and July, and volume remained at about 95 percent of 2019 utilization later in 2020. The timing of the decline in volume and the later recovery suggests it was not due to PDGM and reflects the impact of the PHE.

Turning to patient mix, despite the interruptions of the PHE, the types of patients typically served in home health did not change significantly.

For example, in both years, the shares of 30-day periods from the hospital and the community were similar. Similarly, the share of periods that were initial or subsequent periods of home health did not change, and the share of periods classified as a low-visit periods, or LUPA periods, did not change.

Most notably, the clinical mix of patients in 2020 in the 12 clinical categories used by PDGM was about the same as the mix in 2019. This indicates that the PHE did not change the primary clinical reason for which beneficiaries received home health care.

We did see more 30-day periods reporting the highest levels of functional debility and the highest-paying co-morbidities, but these may reflect changes in agency coding practices.

We also examined the CMS-HCC scores of home health beneficiaries in 2019 and 2020, and the scores for 2020 were slightly lower than 2019, indicating that during the PHE and the implementation of PDGM, the severity of patients receiving home health did not change significantly.

Turning to the number of home health visits in 2020, the total number of visits declined by about 19 percent, a steeper decline than the decrease in beneficiaries served.

On a 30-day period basis, the average number of in-person visits declined from 10.2 in 2019 to 9.2 in 2020. Almost all of the decline was attributable to a drop in therapy visits, which may, in part, reflect the impact of the PHE, but it may also reflect that the BBA removed the number of visits provided in a period as a payment factor. And there is more on this in your paper.

However, the decline in visits should be interpreted carefully. CMS expanded coverage of telehealth during the PHE, allowing home health agencies to provide virtual visits.

Home health agencies are not required to submit any detailed information on the type of telehealth services they provide or the amount they provide to beneficiaries.

This makes it challenging to assess the impact of the PHE and PDGM in 2020, as we cannot observe when home health agencies use telehealth as a substitute or complement for in-person services.

Our next indicator is quality. While performance on quality measures in 2020 was mixed, these results should be interpreted cautiously.

The data for 2020 reflect temporary changes in the delivery of care and data limitations unique to the PHE and may not reflect the quality of care provided to beneficiaries. For example, the hospitalization rate in 2020 may have been lower because beneficiaries were less willing to seek inpatient care.

The increase in mortality due to the PHE may have lowered performance for the successful discharge to the community measure because death shortly after discharge is an adverse outcome under this metric.

In addition, the Commission's quality metrics rely on data from pre-pandemic years to predict beneficiary risk. COVID-19 is a new diagnosis and is not included in the current risk-adjustment models, though many associated conditions are. As a result, our models may not precisely represent the acuity and mix of patients receiving care in 2020.

Next we look at capital. It is worth noting that home health agencies are less capital-intensive than other health care providers and relatively few are part of publicly traded companies.

Nonetheless, financial analysts have concluded that the publicly traded agencies have adequate access to capital, and the all-payer margins equal 8.1 percent in 2020.

In aggregate, home health spending declined 4.7 percent in 2020. Home health spending was declining prior to 2020, but the decrease this year is larger than prior years.

2020 is the first year of the 30-day unit of payment, so computing an annual payment increase is not possible.

As an alternative, we computed payment per in-person visit. This was computed by dividing the total fee-for-service payments for each year by the in-person visits for the year. While this measure may not reflect telehealth, it provides a rough metric for payment relative to the services provided by HHAs.

Payment per in-person visit in 2020 increased by about 16 percent to $209. This increase is a product of changes in visit utilization and payment factors.

For the payment side, the increase reflects several policies, including the payment update and the sequester suspension. In addition, it appears the nominal case-mix in 2020 increased by about 4 percent.

On the visit side, as noted earlier, the number of in-person visits declined by about one per 30-day period.

Taken together, the increase in payments and decrease in in-person visits result in payment per in-person visit being 16 percent higher in 2020.

Turning to Medicare margins for 2020, we can see that the margin for this year were 20.2 percent. The trends by type of provider show that follow-ups have better margins than nonprofits, and rural agencies had slightly higher margins than urban. And with the provider relief funds, Medicare margins equaled to 21.9 percent.

This year we again examined the performance of relatively efficient home health agencies. We use a similar definition to what you have seen in the other sectors today. Based on these criteria, about 15 percent of agencies met this standard.

Compared to other agencies, efficient providers had lower hospitalization rates, fewer visits per 30-day period, and slightly lower costs. Their patients generally had a case-mix similar to the patients of other providers. And the relatively efficient providers had a median Medicare margin of over 24 percent.

We project that margins for 2022 will equal 17 percent, a slight decline from the 2020 level. Though the margins will remain high, this decline is due to several payment and cost factors.

On the payment side, home health agencies received the full update in 2021 and 2022, and we assume that the sequester was in effect.

Our cost assumptions for 2022 are informed by the experience of 2020, which saw abnormally high-cost growth of 3.1 percent. This is higher than the average of 1.4

percent for recent years but may reflect the PHE. If cost growth returns to the lower rates observed in the past, the margin for 2022 could be higher.

The experience of 2020 and our projections for 2022 reflect the high margins of home health agencies under PPS. Home health margins have averaged in excess of 16 percent a year since 2001 for freestanding agencies.

Finally, I turn to the summary. Overall our indicators are positive. Ninety-nine percent of beneficiaries live in a county with at least one home health agency. Volume decreased, though this appeared to be mostly related to the COVID-19 emergency. And agencies had positive marginal profits of 22.9 percent.

In quality of care, we saw mixed indicators, but the unique circumstances of the public health emergency confounded our efforts to measure quality this year.

In terms of access to capital, agencies had positive all-payer profit margins of 8.1 percent, and the large for-profit companies continue to have access to capital.

For payments and costs, home health agencies had Medicare margins of 20.2 percent in 2020 and the efficient provider had median margins over 24 percent. And as noted earlier, we project margins for 2022 of 17 percent.

I would also note that in terms of our mandated report, the BBA 2018 changes to home health care payments did not appear to have a negative effect on access or quality of home health care in 2020, though the PHE and lack of telehealth information confounds measuring the impact of these changes.

Next we turn to the Chair's draft recommendation for 2023. It reads: For calendar year 2023, the Congress should reduce the 2022 Medicare base payment rate for home health agencies by 5 percent.

The spending implication of this would lower payments relative to current law, and the beneficiary and provider implications are that access to care should remain adequate, and it should not affect the willingness of providers to serve beneficiaries; but it may increase cost pressure for some providers.

Next I turn to a draft recommendation for telehealth.

The lack of information about the frequency, duration, or mode of telehealth services received during home health care makes it challenging to characterize service use under the benefit.

Given the recent expansion of telehealth coverage under the home health benefit, it would be appropriate to require agencies to report the delivery of telehealth services on Medicare claims.

Collecting this information would ensure that these services are accounted for when analyzing the home health care benefits received by patients and for setting payments under the home health PPS.

Medicare already requires agencies to report detailed information for in-person visits, so a requirement for telehealth should be feasible for agencies and Medicare.

The recommendation reads: The Secretary should require that home health agencies report the telehealth services provided during a 30-day period.

This should have no impact on spending, and in terms of beneficiary and provider implications, beneficiaries' access to care should not be affected. Agencies may incur some costs to provide the additional administrative data.

This completes my presentation. I look forward to your questions.

DR. CHERNEW: Terrific. Thank you, Evan.

And so, Dana, we're ready for Round 1.

MS. KELLEY: All right. Dana, do you want to go ahead?

DR. SAFRAN: Thanks. Just very briefly, my questions, again, have to do with the quality assessment. In the report and in your summary here, there's a very limited set of measures that we say that we're looking at, and I just am curious how we picked those relative to, for example, the measures that are used in home health Stars program. There is, I know, a home health CAHPS survey, though I don't think a CAHPS survey is part of Stars. But Stars, interestingly, does include functional outcome measures as well as some process measures. So I just wanted to get an understanding of how we're picking and choosing the couple of measures we're looking at for our assessment on payment adequacy.

Thanks.

MR. CHRISTMAN: Yeah, I can say a few things about that, and then I think this has come up in the quality work that Ledia and Carol have worked on, and they might want to come in. But I guess the -- you know, I think the measures we have focused on have been that, you know, the successful discharge to community and the hospitalization rate during the home health stay. And those measures are both claims-based measures, which, you know, gives them a kind of reliability that's difficult to establish with other measures.

I think the biggest -- you know, we have in the past reported the functional measures, and I think we had concerns that those were prone to differences in provider coding practices or, you know, I guess I would just comment that, in general, those rates, when we did report them, they always went up regardless, for example, of what was going on with Medicare payment and volume. So I think we thought for that reason they might be less reliable.

Ledia and Carol, do you guys have anything you would want to add?

MS. TABOR: I think you've covered it.

DR. SAFRAN: Okay. Well, thanks. I'm unfortunately going to be offline when we get to Round 2, but I'd be interested to work with the staff, happy to do that offline, to really consider -- you know, it seems -- if these measures are being used -- and I believe they are -- for Medicare payment and reward of performance, then, you know, we may have our opinions about their inadequacy, and we may be right. But we should still be factoring them into our considerations here around payment adequacy would be my point of view. Sorry for injecting that during Round 1, Mike, but I'm going to have to drop in a moment for a conflict.

DR. CHERNEW: All good, Dana.

MS. KELLEY: Okay. Bruce?

MR. PYENSON: Thank you. Evan, you mentioned and described including telehealth details in the claims. I'm wondering if you would see value in having telehealth details in the cost report as well so that the aggregate volume of services provided to Medicare beneficiaries and an allocation of the cost for those services in the cost report?

MR. CHRISTMAN: The existing Medicare cost report does require that agencies submit cost report -- excuse me, telehealth costs, you know, and maybe we can put something in the draft to make that clearer, and maybe we can -- you know, right now it's just kind of a blob. It's a line. It could be any form of telehealth at any level of volume. And, you know, maybe we can put some language in the text that, you know, any helpful information about the cost which should be included in the cost reports.

MR. PYENSON: Thank you.

MS. KELLEY: Larry.

DR. CASALINO: Yeah, two quick questions, Evan. One, like SNFs, which we just talked about, is the fact that the all-payer margins are much lower than the Medicare margins due to the relatively high volume of Medicaid payments for home health agency care.

MR. CHRISTMAN: So there's -- it's similar and it's different. The main point to carry in your head is that Medicare is a higher -- on average, it's a higher share of home health agency volume than what you see in SNFs, so it's like 50, 55 percent, somewhere in there, of agency volume. But, you know, my understanding is that Medicaid -- pretty much any other payer pays less to home health agencies, so, yes, their overall margins are lower than their Medicare margins.

DR. CASALINO: So do we think that commercial payers also pay less to home health agencies than Medicare?

MR. CHRISTMAN: My understanding is that Medicare Advantage pays less, yes.

DR. CASALINO: And is that because of a lack of consolidation in home health so they don't have negotiating leverage?

MR. CHRISTMAN: I guess -- yes. I mean, I would say that's probably a big part of it, yes.

DR. CASALINO: Okay. And there's no Medicare regulation requiring them to pay at least the Medicare minimum? No, of course not. Okay.

My second question kind of goes back to what you were just talking about a few minutes ago. I think the recommendation about reporting telehealth probably maybe should be a little more specific. It might be a good place to say something perhaps separating out audio and audio-visual, as we're doing in other areas. But, also, as I read the recommendation, it is pretty -- a blob, as you say, so they just have to say yeah, there was telehealth during this 30-day period; they have to say there were three episodes, but not separate them out? Or do they, in effect, need to provide some information each episode? I think maybe give a little bit of thought to that before getting to the final recommendation, certainly about specifying audio versus audio-visual, but maybe also making it so that people can see there was a telehealth episode on January 5th and on February 2nd and on February 6th and not just that there were three during that time period.

MR. CHRISTMAN: We can add some of that to the discussion, I think, of the recommendation.

DR. CASALINO: Good. Thank you.

MS. KELLEY: Lynn?

MS. BARR: Thanks, Dana. So the access data that you show, Evan, seems incredible. Everyone has home health. And yet the payment is about $200 regardless of how far you have to drive, and their fixed cost is the cost of labor, right? I mean, that's the majority of the cost. And so we have an incredible problem getting access to home health. We have a super high SNF cost. I have no alternatives in post-acute care in most of my rural communities, which is a real disconnect with what you're seeing. And I was wondering if you would be able to do some sort of GIS study on the distance between the home health agency and the patients to understand it isn't really about Zip codes, it's about distance. And we have no way of accommodating for that, and so I'd love if we could take a different look at access, because the numbers you have are amazing, and if it was true, I would be all over it. But we really don't see that, and it's a huge problem for us.

MR. CHRISTMAN: Yeah, I mean, I think we explored doing some GIS work a few years ago, and the upshot was that building that data is really expensive to do a lot of beneficiaries and get -- you know, assuming you've got a good address on them, which is hard, then getting someone --

MS. BARR: Right, it could be post office boxes. That's right. It looks like they live in town.

MR. CHRISTMAN: Right

MS. BARR: I've got a post office box.

MR. CHRISTMAN: Right, and so it's difficult. I think in the past when we have looked at agencies in the sort of expanded rural scale, like the rural non-adjacent frontier and things like that, it has been true that like the frontier agencies have lower margins, but they were still well over 10 percent. I guess what I'm saying is, you know, there may -- I certainly don't mean to dispute that what you see is happening, but we have a hard time seeing it happen in the data and seeing a relationship to payment.

MS. BARR: If I can make a suggestion, Evan, why don't you survey case management departments in rural hospitals and ask them if they can get home health? Because they tell us, "We can't." If you tell you they can, then they're going to have to talk to me, because I don't have access.

MR. CHRISTMAN: Fair enough.

MS. BARR: Maybe that would be a cheap way to figure this out pretty quickly.

MR. CHRISTMAN: Yeah, I mean, I guess the other point I would make is -- again, it's more anecdotal, but I would say over the years I've had agencies from both urban and rural locales come in and tell me about their unique costs. I once had an agency that served what you would probably consider one of the best-connected areas in the country, urbanized, and they said that because of traffic they had very high commute times, the same things that you'll say about rural areas. And they had security costs because some of the neighborhoods they served required security.

I don't mean to discount the things you are observing. I guess it's just sort of -- it's a little hard to say -- sometimes it's hard to see in the data that, you know, rural have it worse, if you can see what I'm saying.

MS. BARR: Oh, yeah, and I don't doubt that -- I mean, travel costs are not accounted in the home health rates, and that seems ridiculous because it can be very high in both urban and rural areas, and it is an important factor. But I believe most urban patients can get home health, and, again, you know, from what I've been told, we can't. So if you can get some different data, I'd love to see it, if you could maybe, like I say, survey the hospitals and ask about access.

Thank you.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks, Evan, for great report. I was just curious if you could comment on any potential trends over the past 18-plus months, 18 to 24 months, on integration or consolidation, particularly -- so curious in general, curious in the context of overlap of potential types of services with hospice. I think part of what's motivating this is obviously we've seen a large change in facility use over the past 24 months, and there has been, at least we've heard about anecdotally a lot of shift towards home-based care. And so it seems like this could be a potential shift that could also drive the consolidation and integration piece. I didn't see anything particularly in our report about that. I was curious if you have any sense on those things.

MR. CHRISTMAN: I mean, I think that the consolidation -- you know, there's a few large for-profit companies that have been looking at growing their provider networks, and when the -- 2020 was sort of set as the year that the new payment system was to go into effect. I think a lot of things slowed down because people wanted to see what agencies would prosper under the new arrangement. And then, of course, the emergency happened. I've gotten the sense that some of the for-profits have started in the last couple of months going out and sort of resumed a lot of their mergers activity. But I guess, you know, in the 15-year scope that I've been following home health, you know, that has kind of always been their plan. I don't know that it's accelerated per se, other than they kind of had to take a pause.

DR. NAVATHE: So a quick follow-up question. Are there any particular ownership type metrics that we're able to track from kind of an empirical data perspective?

MR. CHRISTMAN: So there's the PECOS data, which evidently can let you track some of this stuff. We haven't looked at it for this particular application. You know, we also just track what the companies themselves report in terms of what they're doing in MA. I mean, I guess, you know, in terms of the larger for-profit chains that are publicly traded, they're still a relatively small share of the action.

DR. NAVATHE: Great. Thank you.

MS. KELLEY: Mike, so I'm scrolling through here. I think I've hit all the Round 1 questions, but please speak up if I've missed you. Otherwise, I think we're ready to go to Round 2.

Mike, we can't hear you.

DR. CHERNEW: I was asking if anyone was going to say something, and my inadvertently being on mute gave them time. So, yes, let's go to Round 2.

Again, let me remind you in Round 2 that your comments about your views on the recommendation are important.

MS. KELLEY: All right. We'll start with Jonathan Jaffery.

DR. JAFFERY: Thanks, Dana, and thanks, Evan. Great report and excellent presentation. Very clear as always. I'll start off by saying I support both recommendations.

My comment really, it actually builds a little bit on what Lynn had started to talk about, and it goes beyond the home health. It's something that has occurred to me, sort of really has gnawed at me since I've gone through the reading last week, and I think it's a theme that has come up in a number of these discussions across sectors. It's a little bit different in different sectors, but it really gets down to our methods for assessing access. And I feel personally torn a little bit now, and I'm sensing this from other people, some concern that maybe our measures of access aren't fully adequate. It could be for different reasons in different sectors. I think the thing that jumped out at me, the reading in the home health agency sector is talking about, you know, what was said, 99 percent of beneficiaries live in a county with at least one and 87.9 with five or more. And it's just not clear to me that that translates to access. And I agree with you, but I don't think is necessarily specific to rural versus urban or anything like that. You know, we see that -- we own a home health agency, and there's a lot of challenges with access here for those services, even for our own patients. And traffic is getting worse, but it's not a big factor here.

And so I don't know if some of these are labor issues. I'm sure that is a big part of it. I know all the sectors are seeing that more and more. We see it in hospice here as well. But I'm just not sure that these measures really capture -- at least not as defined by having the presence of a business there that's equating access.

Larry mentioned something yesterday, I think it was about, you know, one in five people miss something. Does that mean access is adequate? It's just -- I think we're all really struggling with this. I know I am.

One other piece to mention about the access is what I think we need to get to. We really started to talk about this more and more over the last few cycles, but these don't address disparity and health equity issues. And so I know that's complicated, and a lot of that data is not readily available, and maybe that's one of the things we need to start working towards, is getting, you know, race and ethnicity and language data embedded in things so that we can actually start to assess this. But we could have lots of home health agencies and, you know, on average good access, and yet actually exacerbating disparities and worsening our health equity issues.

So I just wanted to point that out, and, again, that's not all on you, Evan, because I think this does -- this comment does bridge all the different sectors in different ways.

MS. KELLEY: Okay. David.

DR. GRABOWSKI: Great. Thanks, Evan, for this excellent work. I am supportive of the draft recommendation. Jonathan sort of focused and I very much agree with his comments -- those were well said, Jonathan -- on access. I want to push a little bit on quality. I don't know if Dana rejoined us, but she started this kind of line of questioning in the first round.

You know, just looking at the data, we just talked about SNFs. SNFs are still down in terms of volume. Home health use has actually largely rebounded, and I would suggest, given some of the issues we observed with SNFs during the pandemic, home health may actually be a growth area going forward. And so I think the key issue here is how do we encourage high-value home health care use and minimize the lower-value use, which I think has been present in this sector for a long time.

I'll just give a short history, and I promise this is short. Back in the 1990s, we paid based on visits. Not surprisingly, we got lots of visits. Many of them were low-value. Starting in the year 2000, we started paying based on therapy. Not surprisingly, we got lots of therapy and home health, once again, lots of it low-value therapy.

As Evan noted, now we pay based on patient characteristics and acuity. Not surprisingly, I think we're going to get lots of patient characteristics and lots of acuity. That's my prediction.

The question still remains: Are we getting good value? And I think the quality measures here don't allow us to really sort of tease out whether we're actually getting a good return for what we're paying for home health. So I think a place that we want to think about going forward is how do we actually improve the measure set here and how do we then use that measure set to really direct patients to those high-value services, because I really believe we're going to have a lot more beneficiaries seeking these services. Individuals want to be out of SNFs. They've always wanted to be out of SNFs, but I think in particular, following the pandemic, that's going to be a real area of importance and ensuring that we're actually getting those home health services that improve quality I think is going to be really important.

Once again, I'm supportive of the recommendation, and, Evan, thanks for this great work.

MS. KELLEY: Brian.

DR. DeBUSK: Thanks. I'd like to echo the comments regarding the great work. I really enjoyed the chapter. Thank you, Evan.

I do support the recommendation in the chapter. I would also hope that we go back and address the extra 6 percent of payment that was introduced through the PDGM. I saw, Jim, where we provided a comment on August 24th about the adjustment, and I think we were agreeing with CMS to make the adjustment to the base rates based on what I gleaned from the letter.

One thing I was going to ask, is this an opportunity, though, that 6 percent adjustment that has to be made, is there perhaps a better way to make that adjustment? Does it have to be applied to the base rate? Or to echo some of my fellow Commissioners' comments, is this an opportunity to address either access, equity, or even quality concerns through that 6 percent adjustment? And, again, I'm sure that's something we could take offline, but I'd be interested to see if there are other ways that that 6 percent could be applied in a more focused on targeted way.

Thank you.

MS. KELLEY: Lynn.

MS. BARR: Thank you. I support the recommendation of the Commission on reducing these rates in general, but, again, I feel like we need to do a lot more work on understanding the implications in rural. Since we're not getting the services today, maybe it won't matter.

MS. KELLEY: Larry.

DR. CASALINO: So this is a sector where profits are high and employee turnover is high. So one has to actually ask, well, where is all that margin going? Pay is not the only reasons that employees turn over, but it's a big one. So, again, we have a sector where there are high profits, low pay, high turnover. I think we all agree that home health agencies and SNFs, anywhere really, but certainly in those two, high turnover is probably highly correlated with poor quality. If you've had any practical contact with those kind of settings, you can see that, I think.

So I'm agreeing with what several people have said that -- I agree with the recommendation. I'm fine with that. But I think we in our work on looking across sectors for post-acute care and how to measure value there and how to reward value, I hope we really look at turnover rates. This has come up a few times in the discussion today. That's probably a much better measure of quality than many of the measures we have.

But there's another reason why turnover rates would be important, I think. If turnover rates are an important measure of quality and there's strong financial incentives attached to not having turnover rates, then some of those profits, those very large profits that are being taken in in these sectors are going to have to be given to employees to increase their wages, or else there's going to be financial penalties in the quality incentive programs. I just think that's vital. It's just -- you know, I'm kind of taking off my Commission hat here, taking off my Commissioner hat, and putting on my old community organizer hat. It's just -- we've grown so used to it, you know, that we hardly even pay attention, but it is outrageous that you have places with 20 percent margin and 300 percent turnover, because the money is only sucked up to the top and it's not going to the people who work there, not for their salaries, not for their working conditions.

I don't want to just keep repeating myself, but I do hope that in our other work now on incentive programs and quality measurement for this sector and others we will consider turnover as a very strong measure that should have financial incentives tied to it.

MS. KELLEY: Stacie?

DR. DUSETZINA: Thank you. I will just say ditto to everything that Larry just said. I think if there's a way that we could better incentivize potentially better pay, if that's the main reason for turnover, or try to address some of the workforce issues in both the home health and the SNFs, that would be really excellent. If we could do that through better payment policy, that would be great.

I also want to say I support the recommendation as it's drafted.

DR. CHERNEW: And if I got that right, you were the last person in the queue, Stacie. Dana, how did I do?

MS. KELLEY: Very good, Mike.

DR. CHERNEW: Thank you, Dana.

So now we're going to go through the rest of folks just so we can get a reaction to the recommendation. And then for those we see at home, we will then take a break and come back again at 1 o'clock. But why don't you, Dana, go through the folks that have not yet given their opinions on the record.

DR. MATHEWS: Before we do that, just a reminder to everyone. We do have two recommendations on the table here.

DR. CHERNEW: Thank you, Jim.

MS. KELLEY: All right. We'll start with Paul.

DR. PAUL GINSBURG: I support both recommendations, enthusiastically. I'm very intrigued by our discussion about employee turnover and would like to look in the future in terms of making that a quality indicator, both information for Medicare beneficiaries and for the public. And also even consider is there a way to actually put it into the payment system, where those with lower turnover might get higher rates.

MS. KELLEY: Bruce.

MR. PYENSON: Thank you. I support the two recommendations, though would want clarification for Chair's draft recommendation 1 that the reduction is separate from the fix to PGDM.

I would also echo Paul's comments that some form of quality metric or reimbursement tied to staff turnover and putting that into the context of quality would be valuable. So I think that's based on sound hypotheses, of course I think the evidence would support it also. Thank you.

MS. KELLEY: Betty?

DR. RAMBUR: Thank you. I support the recommendation, and I can't tell you how pleased I am to hear this enthusiasm for thinking about turnover. It's always struck me as so paradoxical that we talk about providers as home health agencies and SNFs and yet it's actually the people delivering the care that are providing the care.

So I would be strongly supportive of a quality measure looking at turnover by category, and from work I've done years ago and also in other settings it really did vary by nursing assistant, LPN, registered nurse, et cetera, and perceptions of safety in the workplace were part of turnover, which is certainly relevant now with COVID. So I'm very enthusiastic to hear that, and I think it's a key quality measure in areas that are so direct, particularly areas that are so direct care-intensive.

The other thing I wanted to mention is something that hasn't come up verbally, I don't think, unless I missed it, is the hospital-at-home movement, which is certainly going to explode, I believe, and then how do we have this nexus between acute care delivered in the home and other kinds of what we would normally have considered post-acute or long-term custodial care.

So thank you so much, and this is actually very encouraging. Not what's happening is encouraging, but a potential solution measuring quality, including turnover. Thank you.

MS. KELLEY: Thank you, Betty. Pat?

MS. WANG: I support both of the Chairman's recommendations and have really appreciate the quality of the discussion. I think that the interest in understanding more about access is a good area to try to flesh out with more information. I really don't think that the update factor is the way to address that because that might be a multi-factorial situation, and the fact that margins are so high suggests that throwing more money at operators is not necessarily the best way to solve that access problem. But it's worth looking into and trying to understand and develop targeted solutions. But I'm happy that we're staying away from that when we talk about update.

I'm very interested, as well, in the discussion on turnover, and I think it is a great idea to start understanding more about how to interpret the turnover rates and what a measure of quality around that would be, because I'm sure that there's some nuance to that.

In the interim, I wonder whether it would make sense to recommend that CMS include overall turnover rates in its star ratings, just in terms of what's on Nursing Home Compare, whatever the equivalent of home health compare, but in public information. Because it strikes me that if you are looking for care for a loved one or what have you that that might be something relevant to consider.

But I support the recommendations. Thanks.

MS. KELLEY: Amol.

DR. NAVATHE: Thank you. I also support both Chairman's draft recommendations, and like Pat support the idea of exploring a turnover measure further, and I agree that the payment update is not the right way to get there, given the context that we have here. And like Betty, I look forward to work also exploring how alternative payment models, hospital-at-home, et cetera, are going to impact the home health space as well. Thank you.

MS. KELLEY: Jaewon?

DR. RYU: Yeah. I support both recommendations as well, and also would put a ditto on the conversation, specifically that the item around turnover and labor, I think borrowing from Jonathan's pointing out of some of the themes from yesterday's discussion and today, that I think the other theme has been an awful lot about labor and its movement into different industries and different segments. And I think it's probably a good thing for us to keep in the forefront.

MS. KELLEY: Wayne.

DR. RILEY: Yes, I too am supportive of both recommendations, and again underscore the labor issue and the high turnover rate. You know, many of the colleagues who work in these settings are black and brown and of lower income and struggling to make a living and/or to make a life. So I fully agree with both these recommendations.

MS. KELLEY: Jon Perlin.

DR. PERLIN: I can support both as well. I would just want to add my plus-one to Dave Grabowski's earlier comments, with the only amendment that if you recall last year's discussion, I think it was Karen DeSalvo, so I was thinking as a primary care provider, thinking about what the current uses of home health are. And while they are framed historically and they bring a standard created across the different channels of post-acute care, to be rationalized in that regard, as we think about Medicare beneficiaries' needs I think the issue that dovetails with the hospital-at-home movement but also dovetails really with trying to keep patients out of hospitals and out of higher-acuity environments is using resources like home health as a preventive service, not just a recovery service. Thanks.

MS. KELLEY: Marge.

MS. MARJORIE GINSBURG: I enthusiastically support the recommendations, and like others really appreciate Paul's comments about turnover rates. And I think it was Pat's comment about asking CMS to start tracking that and measuring it and showing it, and I think that will go a long way towards hopefully beginning to give particular emphasis and support for those whose turnover rates are lower than others. So my strong endorsement. Thank you.

MS. KELLEY: Mike, I think that is everyone.

DR. CHERNEW: Yes. So again, thank you for what was really a terrific discussion, and I particularly appreciate the ability to hold separate the update recommendation, things we're doing now, from our other concerns about quality measures and pockets of access issues, all of which, both of which are particularly important. So I am appreciative of that.

I think for now in a moment we're going to take a break until 1:00, and then we'll come back and we'll talk about rehab facilities. But I will say to those that are listening we really do look forward to your comments as well, so please reach out to us. You can send an email to meetingcomments@medpac.gov, or you can go to the medpac.gov website, the public meetings and past meetings, and there will be a link where you can send comments. It will send you also to meetingcomments@medpac.gov. There you go. That's perfect.

So again, thank you all, and we will be back at 1:00 to talk about rehab facilities and then long-term care hospitals. So again, thank you, everybody, and we'll see you in a minute.

[Whereupon, at 12:00 p.m., the meeting was recessed, to reconvene at 1:00 p.m. this same day.]

AFTERNOON SESSION

[1:00 p.m.]

DR. CHERNEW: Let me start, Jamila. I am just going to introduce you.

Welcome back, everybody, to our afternoon session on updates. We're going to start with rehab facilities, and so we will turn it right over to Jamila. Jamila?

DR. TORAIN: Thanks, Mike.

Good afternoon. Before we start I will outline today’s presentation for Inpatient Rehabilitation Facilities, also known as IRFs. Special thanks to Bhavya Sukhavasi for her help with this presentation. The audience can download a PDF version of these slides in the handout section of the control panel on the right-hand side of the screen.

As you’ve seen in earlier presentations today, we continue to use our established framework. To assess the adequacy of IRF Medicare payments, we assess beneficiaries’ access to care, quality of care, IRFs’ access to capital, and Medicare payments and IRFs costs. More information on these indicators can be found in your meeting materials.

As previously mentioned in earlier presentations, a key difference from most prior years is the coronavirus public health emergency which has had tragic and disproportionate effects on Medicare beneficiaries and on the health care workforce as well as payment adequacy indicators for IRFs.

Throughout the presentation, I will describe our payment adequacy indicators keeping this perspective in mind and I will distinguish any difficulties that the public health emergency has presented for our interpretation of the IRF payment adequacy indicators of 2020.

As mentioned in previous presentations, coronavirus effects are best addressed through targeted, temporary funding policies, rather than a permanent change to all providers' payments in 2023 and future years.

To help cover losses and expand access to care during the public health emergency, the Congress provided relief funds to help cover lost revenue and additional costs to treat patients, including Medicare beneficiaries. IRFs benefitted from provider relief funds that provided general distribution of 2 percent of total revenues and the Paycheck Protection Program.

In addition, temporary changes in payments and policies were made, including the suspension of the Medicare sequester that normally would lower payment rates by 2 percent, waiving the IRF-specific three-hour rule and 60-percent rule which broadened criteria for admission into

IRFs. Collectively, federal support to date has generally maintained IRF providers' financial performance in 2020, and more funds remain to be distributed.

Before we discuss the indicators of IRF payment adequacy, here's a quick overview of the IRF industry in 2020. In 2020, there were 1,113 IRFs, and about 335,000 beneficiaries had 379,000 stays. Medicare spent about $8.0 billion on IRF care provided to fee-for-service beneficiaries. Medicare accounted for about 54 percent of IRF discharges.

Now I'll review our assessment of payment adequacy for IRFs. We'll start by considering access to care.

In 2020, the indicators of access were mixed but unlikely to reflect the adequacy of Medicare's payments. Instead, they reflect the effects of the pandemic.

While almost 20 percent of the IRF closures were the result of voluntary mergers, a combination of low occupancy rates, history of unsteady financial performance, such as consecutive negative margins, and the coronavirus pandemic may have pushed many other IRFs to close.

Despite the decline in supply, if we look at marginal profit, we see a robust 38 percent for freestanding IRFs, and 19 percent for hospital-based IRFs, meaning that both sets of providers have an incentive to serve additional Medicare beneficiaries assuming that they qualify for IRF-level care. Additionally, from 2019 to 2020, occupancy rates were stable at 67 percent.

However, there was a 7.4 percent decrease in the volume of Medicare IRF cases, but this likely reflects the decrease in elective acute-care hospital services requiring subsequent IRF care, not the adequacy of Medicare payments.

Specifically, as seen in other sectors, there was a sharp decline in volume in the spring of 2020 followed by a rebound in the summer of 2020. The drop in volume that we observed in the spring is consistent with a temporary suspension of elective surgeries in ACHs from March through May of 2020. The rebound in volume, later in the summer of 2020, may have been the result of the pent-up demand for surgical services after many fee-for-service beneficiaries' surgeries had been cancelled or delayed.

In an effort to ease some of the burden on health care providers during the public health emergency, CMS also enacted numerous waivers to increase beneficiaries' access to IRF services.

Shifting gears to the second category of IRF payment adequacy indicators, the quality of IRF care, the coronavirus pandemic makes it difficult to assess the quality of care provided to fee-for-service Medicare beneficiaries in 2020.

Our 2020 indicators reflect temporary changes and data limitations unique to the public health emergency rather than trends in the quality of care. Further, some of the Commission’s quality metrics rely on standard risk-adjustment models that use performance from previous years to predict beneficiary risk, and COVID-19 is a new diagnosis that is not included in the current risk-adjustment models.

With those caveats in mind, the changes in 2020 cannot be used to draw conclusions about trends in the quality of care provided to Medicare beneficiaries and its relationship to Medicare payment adequacy.

All-condition hospitalizations remained steady, and the share of patients successfully discharged to the community increased slightly.

Turning now to access to capital. As I noted in your paper, over three-quarters of IRFs are hospital-based units, which access needed capital through their parent institutions. As you heard yesterday, hospitals maintained good access to capital. Furthermore, the aggregate all-payer total margin of hospitals with IRF units was slightly higher than hospitals without such units.

As for freestanding IRFs, over 50 percent are owned or operated by one large company. Their investor reports indicate that this chain has good access to capital. While mergers and acquisition activity was minimal for this company in 2020, it picked back up in 2021, acquiring or opening 9 home health care agencies and 12 hospice locations. Although this company received $237 million in relief funds, they returned all funds before the end of summer of 2020, further emphasizing that their access to capital is good.

Overall, the all-payer total margin for freestanding IRFs is a robust 10.2 percent.

The coronavirus pandemic has had significant impacts on providers payments and costs. On the payment side, providers saw their payments increase due to a combination of the annual update, suspension of the

Medicare 2 percent sequester, temporary flexibilities in IRF criteria such as the three-hour rule, and faster growth in case mix.

On the cost side, the average cost per case increased 8.5 percent reflecting fewer IRF cases over which to spread their fixed costs, higher unit costs for labor and public health emergency-related expenses, such as cleaning and personal protective equipment, an increase in IRF average length of stay, and again faster growth in case mix.

On the previous slide I pointed to faster growth in case-mix index as one common reason IRFs experienced relatively higher payment and cost growth in 2020. While some of the growth in case mix increased coding intensity as opposed to real change in IRF patients' average condition, there are a few other reasons growth in case-mix was 11 percent between 2019 and 2020.

First, more IRF cases were coded with comorbidities in 2020. For example, the share of claims for neurological conditions other than stroke that were coded with comorbidities rose from 67.2 percent in 2019 to 72.4 percent in 2020.

Second, the waiver of the three-hour rule during the public health emergency, which allowed IRFs to admit patients even if they were not able to tolerate three hours of intense therapy a day, allowed IRFs to admit patients with greater functional impairment, as well as patients with more comorbidities.

Third, the deferral of elective procedures and patient anxiety resulted in only the most acute patients seeking care.

Moving on, the aggregate Medicare margin has been over 13 percent since 2015. In 2020, IRF Medicare margin remained high at 13.5 percent and increased to 14.9 percent when including an estimated Medicare share of federal relief funds.

Financial performance continued to vary widely across IRFs. For example, in 2020, the aggregate Medicare margin for freestanding IRFs was 23.5 percent. In contrast, hospital-based IRFs had an aggregate Medicare margin of 1.6 percent. We also see wide differences in margins of for-profit and nonprofit IRFs as most free-standing IRFs tend to be for-profit and most hospital-based IRFs are non-profit. The primary driver in these differences in margins is costs, which tend to be lower in free standing and for-profit providers.

Next, we will move on to our analysis that examines relatively efficient IRFs.

In 2020, 33 percent of the IRFs included in the analysis were relatively efficient. Compared to other IRFs, relatively efficient providers had hospitalizations rates that were slightly lower than other IRFs. In contrast, this year, relatively efficient providers had slightly lower rates of successful discharge to the community. Nonetheless, their standardized costs per discharge were 16 percent lower, leading to a large difference in the median Medicare margin, which was 17.9 percent for the relatively efficient group compared with 3.6 percent for other IRFs.

With that we will move on to discuss our projected Medicare margin for IRFs in 2022. Similar to 2020, we expect that cost growth is likely to exceed payment growth in 2021 and 2022. In addition, the Medicare 2 percent sequestration suspension is scheduled to expire. Therefore, we've projected that the aggregate margin will decrease slightly to 13.0 percent in 2022.

In summary, despite the coronavirus pandemic, our four categories of payment adequacy indicators for IRFs are generally positive.

First, in terms of fee-for-service Medicare beneficiaries’ access to care, while IRF supply declined in 2020 and volume declined sharply in the spring of 2020, steady occupancy rates and high marginal profit for freestanding and hospital-based IRF providers suggests that IRFs continue to have capacity that appears to be adequate to meet demand.

Second, we cannot draw conclusions about quality in 2020, as measure changes reflect the public health emergency rather than changes in quality or payment adequacy.

Third, IRFs maintain good access to capital markets. The all-payer total margin for freestanding IRFs is a robust 10.2 percent.

Fourth, Medicare payments and IRFs costs indicators were positive. In 2020, the aggregate Medicare margin was 13.5 percent. We project a margin of 13.0 percent in 2022.

And so that brings us to the update for 2022.

The Chair's draft recommendation reads:

For 2023, the Congress should reduce the 2022 Medicare base payment rate for inpatient rehabilitation facilities by 5 percent.

To review the implications, on spending relative to current law, Medicare spending would decrease. Current law would give an update of 2.1 percent. On beneficiaries and providers we anticipate no adverse effect on Medicare beneficiaries' access to care. The recommendation may increase financial pressure on some providers.

With that I will close. I am happy to take any questions. Thank you.

MS. TABOR: Jamila, that was outstanding, and we will jump right in, so Dana, will you start the queue?

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

MR. PYENSON: I would like to question whether we have any insight into whether these facilities were being used for surge capacity in the epidemic. Do we have any way of knowing that?

DR. TORAIN: So there was a waiver that allowed IRFs to house acute-care hospital patients in their setting, and vice versa. Hospital-based IRFs were allowed to house patients in the acute-care hospital setting. And that waiver worked really well with the 60 percent rule waiver, which gave IRFs the ability to -- they didn't have to count any patients coming from the overflow of acute-care hospitals in their 60 percent in patient criteria.

And so there is modifier on the claims that we are able to count that basically signals whether IRF used any of the waivers, but it wasn't separated by waiver type. And so I could look further into whether there's a way to see how many IRFs used that specific waiver, if you would like.

MR. PYENSON: I'm just curious. It's perhaps the case that the drop in use would have been even greater without those waivers. Is that --

DR. TORAIN: Drop in relocation?

MR. PYENSON: Yes.

DR. TORAIN: I think so. I think they were put in place to help with some of the barriers to access for IRF services in 2020, for sure.

MR. PYENSON: Okay. Thanks, Jamila.

MS. KELLEY: David.

DR. GRABOWSKI: Great. Thanks, Jamila. This is excellent work.

I wanted to ask about Medicare Advantage in this sector. You had a paragraph at the bottom of page 27 in the report that discussed a relative growth in revenue attributable to Medicare Advantage. I really don't know -- how does Medicare Advantage pay IRFs? It seems still like a relatively low share of overall volume. You noted at one of the big companies it was up to 14 percent in 2020 of their total revenue was attributable to Medicare Advantage. I'm just curious if you could say a little bit more about, does MA pay comparable rates? Do we know anything about Medicare Advantage in this sector? Thanks.

DR. TORAIN: Yeah. So I can actually look in to see if the rates are comparable. That's not something that I've actually looked into. But we do, here at MedPAC, have access to IRF-PAI data, which in 2010 IRFs were required to report that information. And so I do have numbers where we can actually look at the utilization level and say that in 2020 it was higher in comparison to previous years.

But like you mentioned, I did mention in the paper that in the industry our providers reported that in comparison to same quarter in 2019 they also saw an increase in the share of revenues from MA. So the numbers were like 10.6 in 2019 fourth quarter, to around 14.2 percent for the same quarter in 2020. So it's still a low share but it's there, and it is increasing, and they attribute that to things like increased clinical collaboration and the waiver of the prior authorization for that short period in 2020.

DR. GRABOWSKI: Yeah, I was going to ask a follow-up but you answered it there at the end. I wonder how much of this is kind of waiver-specific and how much of this is a real permanent change. It will be interesting to follow in the coming years.

DR. TORAIN: Yeah.

MS. KELLEY: I just want add one thing here. several years back Carol Carter and I looked at the use of IRF services by MA plans, and one of the things we found was that a higher share of the users were stroke patients. And so it did seem to be focused much more on a particular clinical type, but that, as I said, was some time ago, and that's certainly something that Jamila might be able to look into more going forward.

DR. GRABOWSKI: Good point, Dana. I wonder if they use it very differently, given some of the prior auth rules that MA can apply versus traditional Medicare. Thanks.

MS. KELLEY: Pat.

MS. WANG: Thanks. My questions were in the general realm of what Bruce and David have already raised, but just to sort of put a finer point on it, you know, I'm aware of at least one hospital-based IRF that, during the height of the pandemic basically converted its IRF into a coded hospital, probably using the waivers, and, you know, it was great that they had the ability to do that.

You know, I guess I just am curious about, and encouraging following up on your response to Bruce's question about how people may have used the waivers, and also whether there is a way to understand how much of the waiver flexibility was used to treat overflow of actual acute COVID cases. It's simply that, you know, to the extent it's meaningful, it may have some impacted on understanding the 2020 performance indicators. It would be good to try to understand that a little bit.

And so whether, you know, you may have seen more of that differ between hospital-based and freestanding, because I think the hospital-based IRFs were logical places for hospitals under stress to turn to, to gain extra COVID impatient capacity.

The other thing I was just curious about, between this paper and also the LTCH paper, where I would ask the same question about to what extent did it convert to acute COVID treatment or related treatment. The two papers described the demographics of the patient population, and they were kind of different. I just wondered if you had any insight. I realize that these are geographically concentrated. They're not uniformly distributed, these two types of intensive, post-hospitalization settings. But in IRF it seemed like the more typical profile was white male over the age of 80 and in LTCH it was black male under the age of whatever, slightly skewing on the younger side.

I just found that kind of startling, because in some of the PAC work the idea is paying according to patient characteristics and acuity of illness and what the patient needs rather than the setting. But I was just struck by that and wondered if you had any insight into what that's about.

DR. TORAIN: Yes. So that is something that we've noticed. I mean, I think offline I would want to talk to Katherine more about that, the differences that you brought up. But I do think that a lot of it is around the criteria that sets the IRFs apart from the SNF setting and the LTCH setting, that intense therapy that's required. I do think that it narrows the patient population down, why they're specifically over 85, why blacks, dually eligible. That I have to look into further. But I think it would be interesting to talk to her and see if we can figure out that out.

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

MS. KELLEY: Okay. I believe that is the end of Round 1, unless I've missed someone. Please do speak up.

Should we start Round 2, Mike, or did you want to jump in here?

DR. CHERNEW: No, I think that was useful, and let's just give everyone a second. I think David Grabowski, if I have this right, is going to start again on Round 2.

MS. KELLEY: Yes.

DR. CHERNEW: Okay, David, you're up.

DR. GRABOWSKI: Thanks, Mike, and I'll be brief here. I very much support the Chair's draft recommendation, and my comment really fits well with kind of both my first-round question and Pat and Bruce's as well.

You know, IRFs played a very different role during the pandemic than I think they have historically, and it makes it really challenging to kind of put the information in the report and in Jamila's presentation today into context.

I'm a big believer that --

MS. WANG: We lost your sound.

MS. KELLEY: Dave, we lost your sound.

DR. GRABOWSKI: -- post-pandemic we want to end these waivers and go back. We do not want the -- did I lock up there? Can you hear me now?

MS. KELLEY: We can. Can you just --

DR. CHERNEW: We may have lost the crucial --

MS. KELLEY: We can't --

DR. GRABOWSKI: All right. Am I back here? Sorry.

MS. KELLEY: Yes. You're back now. David --

DR. GRABOWSKI: I'm just going to say that --

MS. KELLEY: How about if I go to Jon Perlin, and David, maybe you could log out and log back in?

DR. CHERNEW: Or go off video. We might be able to hear you better.

Let's go to Jon Perlin, and then we'll come back.

MS. KELLEY: Yes. Thank you. Go ahead, Jon.

DR. PERLIN: Well, thanks. David is so expert I was really hoping to listen to his comments.

That said, I do have some angst about the effect of peanut-buttering this approach on hospital-based versus freestanding IRFs. Obviously, you know, the chapter and the presentation allude to likely differences in cost of staff and infrastructure as well as the potential for differences in patient acuity.

In practical terms, you know, the ability to care proximally for patients has certain advantages, but I was just looking at a couple of references. There's a paper by Hong et al. from 2019, looking at nearly 100,000 stroke patients and those that had exposure to IRF is significantly better than those that went to SNF, adjusted for other variables of severity.

So I'd just hate to throw the baby out with the bathwater, but, you know, I want to support, but it strikes me that there are two very different sets of circumstances, as demonstrated by our own data, in terms of the operating margin of these centers. It seems that me that while it may be a recommendation I could stand by, you know, in one context I have angst about it in the hospital context. Thanks.

DR. CHERNEW: So let me just say, this is going to be a theme maybe for this meeting, of course. We have one fee schedule for IRF and we have one update that we recommend. So we could think about targeted things if we thought that was a particular problem. I think in the chapter there's a little bit of concern about how the cost accounting is spread, broadly speaking, about systems.

My personal view is for a lot of these non-freestanding organizations another reason why the payment system is being so fragmented is challenging. This is a Peter Butler, back in the day when I was on the MedPAC, this was a common Peter Butler refrain, about how complicated it is to set the fee schedules for organizations that in service delivery and across different fee schedules.

So that's where we are, Jon. I understand your point. Jamila, do you want to add anything?

DR. TORAIN: So I can say that we've noted the disparity the between the two is something that is at the top of mind for us, and it's actually something that outside of payment adequacy we are pursuing in a project with a contractor now, because it's something that stick out.

But the three things that really separate the two, freestanding and hospital-based providers, in terms of their performance, in the past we've studied their case mix, that contributes to differences in payments and costs; their coding and their strategies around coding and the intensity of it; and then really it nails down to like their costs. They're just really different.

Just like in 2019 and 2020, hospital-based IRFs, their routine costs were 45 percent higher than freestanding IRFs. And when you try to think about why these things are happening, some of the things that we thought about are just the incentives for freestanding and for-profit IRFs to have incentives to be lower cost for their investors. And then you think about hospital-based IRFs that had a parent institution that they are essentially a part of.

And so we're thinking about that, and it's something we're pursuing. So we definitely will update you and have more answers, but I think it is around coding, case mix, and costs.

DR. PERLIN: Thanks.

MS. KELLEY: Okay. We're going to try David now.

DR. GRABOWSKI: Okay, great. Dana, can you hear me okay?

MS. KELLEY: Yes, we can. Thank you, David.

DR. GRABOWSKI: Super. As I was speaking I saw Jim shaking his head, and I thought what I was saying was pretty innocuous. I hope it wasn't anything I was saying. It was just that he couldn't hear me.

I don't know where I cut off, but I think you heard the beginning. I was making the point that it's hard to draw a lot from this past year going forward. IRFs played a very different role during the pandemic. They were very much a relief valve for hospitals in terms of discharge around the country, and the idea they'll play this role going forward, I don't think that's very realistic. I think they'll go back to the role they played historically.

And so I think, first, once the pandemic is over, once the public health emergency is over, I really believe we want to end these waivers. I think these waivers have been important historically. I don't know that these waivers have worked as well as the dual-payment structure has worked in long-term care hospitals, and we'll talk about that sector next. But I actually think there's an opportunity to kind of think a little bit more about appropriate use of inpatient rehab facilities, especially in the context of the huge margins that we've observed in this sector.

To sum up, they played a really important role during the pandemic, but that role will not be the role they play, I think, going forward. And so I very much support the Chair's recommendation. Thanks.

MS. KELLEY: Mike, should I go around the room now?

DR. CHERNEW: I think Pat had a Round 2 comment, if I followed correctly. Is that right, Pat?

MS. WANG: Yes. Thank you so much. Just real quickly, I support the Chairman's recommendation, simply because I don't think that the update is the place to sort of try to develop different policies. We don't have enough information.

That said, I share Jon Perlin's concern, and Jamila, I'm really happy that you're looking a little bit more closely into this, you know, understanding that hospital-based versus freestanding have different cost structures and, you know, the cost reporting may be completely different.

I'm still curious about, to the extent that we can get more information about this phenomenon of who used waivers, what kind of COVID relief or COVID direct care was provided by the sector in 2020 and 2021, and whether there are any differences between hospital-based and freestanding, that again might inform our view of their performance and their indicators in 2020.

I also, if it's not too much trouble, wanted to know whether it would be possible to sort of tease apart the demographic profile of freestanding versus hospital-based, just to see whether the overall observation holds when you separate it by sector.

I support the recommendation because I think that this is what we have to work with, and I don't have an alternative, but I very much encourage further digging to try to understand the difference and the tremendous disparity in profit margin between these freestanding versus hospital-based. Thanks.

DR. TORAIN: And, Pat, I do know that I have overall information, as I said, or I know I have information about data on the overall number of modifiers that were used, COVID-related modifiers that were used on claims this year, and they are broken down by freestanding and hospital-based. But what I need to look into is whether I can see which waiver, like three-hour rule versus 60 percent rule, like that breakdown. So I will follow up with you.

MS. WANG: Actually, can I just ask, out of curiosity, if a hospital-based IRF or even a freestanding IRF was being used for overflow capacity for an inpatient hospital and the patient was a COVID patient, would the IRF get the 20 percent COVID bump?

DR. TORAIN: No. so IRFs didn't receive -- there was no 20 percent bump for IRFs, but for hospital-based, if a hospital-based received an acute care patient they would be paid as an acute care patient, and if an IRF patient went to an acute care setting they were paid as IRF patients. But there was an exception made for freestanding IRFs, where, at some point in one of the states they were able to be paid -- acute care hospital patients were paid as freestanding IRF rates.

MS. WANG: Okay. So if an IRF was treating an acute inpatient, who had COVID, would they get the 20 percent bump that was attributable to the inpatient payment?

DR. TORAIN: That's a good question. I will have to look into that. But I just know that overall, again, in this segment, they did not have a 20 percent bump. But I will have to look and see if an acute care patient was [inaudible].

MS. WANG: Yeah.

DR. TORAIN: Yeah, but I think, I mean, I think the way it's written is that if it's an acute care patient it's just there, and the IRF is paid the IPPS rate. So I think that would include the bump. But I will double-check.

MS. WANG: Interesting. Okay. Thank you.

DR. CHERNEW: Sorry. I think Pat was last. But I do want to ask a question, and there's been a few others that have come across in the chat. So actually, Jon Perlin, you asked a question. Do you want to ask it in public?

DR. PERLIN: Sure, Mike. The question really was are the IRF data included in the hospital's overall Medicare margin or, in fact, is it separate? Group wisdom seems to be that it's separate based on a different claims certification number, but it would be great to know if that's correct.

DR. TORAIN: So hospital-based IRFs, they are the hospital cost report form, there's a subsection on the cost report for the IRF providers where they report their payments and their revenue, and so that's what's used, so it's separate that way. So the margin that we're referring to is hospital-based IRFs margins.

DR. MATHEWS: Jamila --

DR. CHERNEW: I'm sorry. I'll let you jump in in a minute, Jim. That said, some of the joint costs between the hospital and the IRF may be allocated across the cost reports, if I understand correctly. In other words, if there's a parking lot at the hospital that's used for both the short-term acute care hospital and the IRF, that parking lot cost could be allocated. Again, I'm not sure that's -- I say that like I know. It's really a question.

DR. PERLIN: Yeah. I'd just go back to Slide 12 for a minute. It's obviously an extraordinary spread there. And just think about what we're apt to incentivize in terms of, you know, if one wants the hospital-based IRFs to perpetuate, you know, that's one signal. If you don't, that's another signal. But that's a pretty broad spread there.

DR. CHERNEW: Jim, you were going to say --

DR. MATHEWS: Actually, I see Jeff jumped in. Jeff, do you want to take over do you want me to?

DR. STENSLAND: I was just going to clarify that there is this separate part of the hospital cost report which is the hospital-based IRF. So Jamila will report that as a hospital-based IRF margin. But that margin will also be incorporated in what we call the overall Medicare margin, so that overall Medicare margin for the hospital will include the inpatient, the outpatient, the home health, the graduate medical education, and the SNF, if the hospital owns a SNF.

MS. KELLEY: And it's also true that in the IRF margin that's reported here for hospital-based IRFs, hospital costs are allocated. You know, some overhead costs from the hospital are allocated here as well.

DR. PERLIN: That's pretty helpful. It would be interesting as we go forward next year to understand whether relatively efficient hospitals actually have a conspicuous absence, understanding that hospital-based IRFs are rarer based.

DR. CHERNEW: I think this is also an area where the concept of marginal profitability. Larry, I realize I'm using the word "margin" again in a different way. Taking out the fixed costs and just looking at the variable part actually is important in this case.

But I hear what you're saying, Jon, that there is a wide spread on this slide and we should think through that, which is what's going to motivate my next question before we go around. Let me pause to make sure we're okay on this before I ask my question.

DR. NAVATHE: So just to make sure I understand here, so based on what Jeff said, what we're observing here for IRF margins are based off of the IRF revenue or IRF allocation of costs, and specific effectively, to some extent, to IRF services. But when we're looking at it in the hospital chapter, the hospital chapter is actually an umbrella across a number of different services if they're hospital-based. They're not referencing the short-term acute hospital portion of the services. And in that way there is actually some quote/unquote "double counting," if you will, across these different sectors.

DR. MATHEWS: The hospital chapter does both. We do report a margin under the hospital prospective payment systems that reflects the payments and costs relative to those services. Then we present the overall Medicare margin that Jeff just described.

MS. KELLEY: I think there's one last piece of information that might be helpful here. Jamila, can you remind us what share of the freestanding IRFs are owned by one particular company?

DR. TORAIN: Over 50 percent.

MS. KELLEY: That's what I thought. Thank you.

DR. CHERNEW: I want to ask one -- you know what? Actually, I'm going to pass on my question because we're getting to the end and I do want to go around. So I will be able to take my question offline.

So Dana, why don't we go around. This session was scheduled, if I got this right, Dana, until 1:45?

MS. KELLEY: Yes.

DR. CHERNEW: Yeah. So we should go around, for those who haven't talked, just to get their sense of the recommendation, and then we're going to move on to long-term care hospitals.

MS. KELLEY: All right. I'll start with Marge.

MS. MARJORIE GINSBURG: The recommendation has my approval.

MS. KELLEY: Wayne?

DR. RILEY: Yes, I approve.

MS. KELLEY: Larry?

DR. CASALINO: I approve. I'll note we made the exact same recommendation last year.

MS. KELLEY: Jaewon?

DR. RYU: I support as well.

MS. KELLEY: Jonathan?

DR. JAFFERY: I support the Chair's recommendation.

MS. KELLEY: Amol?

DR. NAVATHE: I support the recommendation.

MS. KELLEY: Betty?

DR. RAMBUR: Thank you. Very briefly, I also wanted to voice my support for the question that Pat asked about differentiating use by demographics. That was very puzzling. And the information about freestanding versus hospital-based and now this new information, at least new to me, that greater than 50 percent are freestanding. This has been one of the most difficult areas for me to wrap my head around, but given everything that I have heard so far I am in support of the recommendation.

MS. KELLEY: Bruce.

MR. PYENSON: I support the recommendation.

MS. KELLEY: Stacie?

DR. DUSETZINA: I also support the recommendation.

MS. KELLEY: Lynn?

MS. BARR: I support the recommendation.

MS. KELLEY: Dana? Dana, your mic?

We're having trouble hearing you, but I'm reading your lips, and she supports the recommendation. Paul?

DR. PAUL GINSBURG: I support the recommendation.

MS. KELLEY: And Brian.

DR. DeBUSK: I support the Chairman's recommendation and hope reports like this drive us toward a unified PAC payment model.

MS. KELLEY: Okay, Mike. That's it.

DR. CHERNEW: Wonderful. Thank you, everybody, and Jamila, thank you very much. That was really excellent.

Did you want to say something, Jon? Okay. Jon, just nod.

Okay. So we're going to jump ahead onto our next session, which is long-term care hospitals. So Katherine, you are up.

MS. LINEHAN: Thanks. First a reminder to our audience that you can download the slides from the control panel.

We're here to discuss how payments to long-term care hospitals should be updated for fiscal year 2023. In this final presentation, I will provide background on LTCHs and the dual-payment rate system; summarize PHE-related policies that affected LTCH; proceed through our payment adequacy framework; and conclude with the Chair's draft recommendation for the 2023 update.

To qualify as an LTCH under Medicare, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average length of stay for certain Medicare cases of greater than 25 days.

Medicare has paid LTCHs according to a dual payment-rate system since 2016. Under that system, the program pays the LTCH PPS standard payment rate for cases that qualify because they immediately follow an acute care hospital discharge and had either three or more days in an intensive care unit or received prolonged mechanical ventilation in the LTCH. Other cases receive a site-neutral rate based on the IPPS rate.

Between 2016 and 2019, non-qualifying cases received a transitional blended payment of 50 percent of the higher standard LTCH PPS rate and 50 percent of the lower site-neutral rate. In 2020, blended rates were to be phased out and the full site-neutral rate phased in, but full phase-in was interrupted by the PHE, as I'll discuss on the next slide.

Congress responded to the coronavirus pandemic by providing support to health care providers, including LTCHs. You have already heard my colleagues discuss the federal grant and loan programs and the suspension of the two-percent sequestration payment adjustment, so here I want to note the LTCH-specific temporary policy changes related to the PHE.

CMS waived the 25-day average length of stay requirement when an LTCH admits or discharges patients to meet the demands of the PHE.

The CARES Act temporarily waived Medicare policies to allow for expansion of inpatient capacity. Specifically, all Medicare cases are paid the LTCH PPS standard rate and LTCHs are not required to maintain at least 50 percent of qualifying cases to be eligible to be paid as an LTCH.

Now some summary data on LTCHs in 2020. Care provided in LTCHs is expensive. The average Medicare payment per case was about $45,000 for all cases, and about $50,000 for cases meeting the LTCH PPS criteria. LTCHs are also infrequently used. Fee-for-service Medicare beneficiaries had about 78,000 stays. Total Medicare spending on care furnished in 348 LTCHs was approximately $3.4 billion dollars in 2020.

To determine the update recommendation for LTCHs for fiscal year 2023, we review payment adequacy using the framework that you've seen in other sectors. I will discuss these indicators next.

First, I'll focus on access to care where we examine use of LTCH services and provider capacity. When considering access to care in LTCHs, it's important to note that they are not available in every part of the country, and many beneficiaries receive similar services in short-term acute care hospitals or some skilled nursing facilities.

In 2020, the number of all LTCH cases, the green and blue segments of the bar combined, fell nearly 15 percent and the number of LTCH-qualifying cases, the blue segment, fell 13.4 percent. This reduction, particularly in qualifying cases, is due, in part, to the overall reduction in upstream acute care volume during the pandemic. But as we see in the chart, the volume of LTCH cases, particularly non-qualifying cases, has been steadily falling prior to the PHE, as intended under the dual payment rate system.

Now we will look at monthly declines in use to understand the volume reduction in fiscal year 2020. The pattern for LTCHs is somewhat different than what we saw in other sectors. In this figure we see that the biggest monthly LTCH case volume differences between 2019 and 2020 were in December, January and February, prior to the first major wave of COVID-19 cases in March 2020. Recall that in fiscal year 2020, providers had incentives to reduce the number of site-neutral cases for which they began receiving site-neutral rates, rather than blended transitional rates. The temporary waivers of the site-neutral payments, the length of stay requirements, and discharge payment percentage requirements changed these incentives to allow LTCHs to provide expanded inpatient capacity. Starting in March 2020, LTCH volume was closer to 2019 levels than it was earlier in the fiscal year.

Between 2019 and 2020, the number of LTCHs decreased 3.6 percent. This is less than the average annual reduction in facilities between 2016 through 2019. Since the dual payment rate system began through 2021, 83

LTCHs have closed. These closures were primarily in markets with multiple LTCHs, as discussed in your paper.

Occupancy in 2020 averaged 65 percent. This suggests that LTCHs had ample capacity in the markets they served.

Finally, LTCHs' marginal profits suggest that LTCHs with available beds continue to have a financial incentive to increase their occupancy with Medicare beneficiaries who meet the criteria. The average LTCH marginal profit on fee-for-service Medicare cases was about 18 percent in 2020. For LTCHs with a high share of Medicare cases meeting the criteria, marginal profit was 20 percent.

Our second category of LTCH payment adequacy indicators is the quality of care. The coronavirus pandemic makes it difficult to assess the quality of care provided to FFS Medicare beneficiaries in 2020.

As in other PAC settings, we look at two measures. While risk-adjusted rates of hospitalizations increased, and rates of successful discharge to the community increased in 2020, we cannot draw conclusions about the relationship of these findings to Medicare payment adequacy because our indicators reflect circumstances unique to the PHE. Increased mortality related to COVID-19 and COVID-related capacity constraints at acute care hospitals could affect both measures. Further, our post-acute care quality metrics rely on risk-adjustment models that do not explicitly account for the effects COVID.

Moving on to access to capital. LTCHs' access to capital depends on their all-payer profitability, which increased between 2019 and 2020. For all LTCHs in 2020, all-payer margins were 4 percent. For LTCHs with a high share of Medicare cases meeting the LTCH PPS criteria all-payer margins were 6 percent in 2020.

Given a decade of policies that have constrained LTCH growth and the implementation of the dual payment rate system, the availability of capital has been limited across the sector. We expect this to continue until after the dual payment rate system is fully implemented. That said, evidence from the two largest companies providing LTCH services suggests they have access to capital during the PHE period. The largest company providing LTCH services acquired multiple LTCHs and announced new joint LTCH ventures in 2021.

The final element of our payment adequacy framework is payments and costs for Medicare cases. For all LTCHs and those with high shares of qualifying cases, the increase in payments per case more than offset the cost growth in 2020.

Payments per case in all LTCHs increased more than 9 percent in aggregate. For LTCHs with more than 85 percent of qualifying cases, payments per case increased 8.7 percent. The 2020 increase in payments per case reflects temporary payment increases related to the PHE, including increased payments for site-neutral cases and suspension of the 2 percent sequestration adjustment.

Changes in costs per case, which reflected reduced volume, increases in length of stay, and coronavirus pandemic-related costs contributed to aggregate growth in costs per case of 4.2 percent between 2019 and 2020. For LTCHs with more than 85 percent of qualifying cases in 2020, cost per case increased 4.9 percent.

Because Medicare's payments grew more than providers' costs in 2020, the aggregate Medicare margin for all LTCHs, in blue, increased to 3.6 percent. To understand performance of providers under the LTCH PPS, we focus the subset of LTCHs with a high share of qualifying cases, in green. Among these providers in 2020, aggregate Medicare margins were 6.9 percent, compared to 2.9 percent in 2019. When allocating relief funds reported on cost reports to Medicare payments, as we did in other sectors, Medicare margins increase by 1 to 1.5 points.

As in previous years, our projection of the LTCH margin focuses on LTCHs with a high share of cases paid under the LTCH PPS, and even the qualifying cases, even though all cases were paid under the LTCH PPS. We project that the Medicare margin for these LTCHs will decrease in 2022 to 2 percent. This projection is based on market-basket-level cost growth for these LTCHs, as discussed in your paper.

To make this 2022 projection on the payment side, we assume that the suspension of the 2 percent sequester expires on December 31, 2021. We also assume that the temporary waiver of site-neutral payments for non-qualifying cases will end in January 2022, when the PHE is currently set to expire. If those policies remains in effect for longer, the 2022 margins would be higher, all else equal. Margins could also be higher or lower if LTCHs increase or decrease the number of qualifying cases relative to what they were in 2020.

In summary, our indicators of LTCHs' payment adequacy showed effects of the pandemic and the temporary waiver of policies that allow LTCHs to provide expanded hospital capacity. With respect to access, volume declined, but the largest monthly reductions in early fiscal year 2020 appear to be related to the implementation of the dual payment rate system.

Occupancy rates were steady, supply decreases were lower than in the pre-PHE period, and marginal profits increased. Quality of care is difficult to assess in 2020 due to the PHE. LTCHs had access to capital in 2020. Their aggregate all-payer margins increased. And finally, Medicare margins increased in 2020, due to temporary PHE-related payment policies. Assuming the resumption of the dual payment rate system policies, we project that margins in 2022 will be 2 percent.

This brings us to the Chair's draft recommendation. Medicare payments to LTCHs are not updated in law, so our recommendation is made to the Secretary.

The Chair's draft recommendation reads:

For fiscal year 2023, the Secretary should increase the 2022 Medicare base payment rate for long-term care hospitals by the market basket minus the applicable productivity adjustment.

CMS typically makes the update based on market basket and productivity forecast which is currently forecast to be 2 percent. This recommended update is expected to have no effect on federal program spending relative to the expected regulatory update.

We anticipate that LTCHs can continue to provide Medicare beneficiaries who meet the LTCH PPS criteria with access to safe and effective care.

And with that, I will turn it back to Mike.

DR. CHERNEW: Katherine, thank you.

I just want to point out that there's no current law recommendation but the recommendation we have is parallel what essentially is happening in current law in other fee schedules, so I think that's right, Katherine. So it's sort of equivalent to a current law recommendation.

All right. We should go through Round 1, and if I have this correct Brian is first, but if not, Dana will correct me.

MS. KELLEY: No, that's right. Go ahead, Brian.

DR. DeBUSK: I have one question. You know, the case criteria that we set forth, what Congress actually used was really close to the criteria that we had originally recommended. I think 96 days on the ventilator or 3 days in an ICU. Could you speak to the appropriateness of that? I mean, we've had a couple of years now to look at it. What's your sense on the fairness and accuracy and appropriateness of that criteria?

MS. LINEHAN: Well, I think the MedPAC recommended actually eight days in the ICU, not three days, so the MedPAC recommendation was more stringent, and I believe that that was based on some analysis that MedPAC and others had done. So I think that that was what MedPAC thought was sort of empirically justified. But the three-day requirement was, you know, less stringent, obviously.

I'm not quite sure what you're asking me about the appropriateness.

DR. DeBUSK: You know, appropriateness, that's fair. That's a poor word choice. I guess with the benefit of a couple of years of hindsight now, is your general sense that we got the case criteria right for this site-neutral policy? Is your general sense that we got the criteria right?

MS. KELLEY: Katherine, do you want me to make a run at this?

MS. LINEHAN: Sure. I mean, I guess I'll just say if you're asking whether we're -- I think the eight days was based on sort of I think what we thought were cost differences between these types of case, but, you know, I wasn't here for that. So yeah, Jim, why don't you take a crack at it.

DR. MATHEWS: Yeah, I'm going to try and do this as diplomatically as possible without weighing in on the question of whether it's appropriate or not. I think the policy changes that were put in place, you know, whether they were ours as recommended or the ones that were legislated by the Congress, which happened pretty close together in time, actually. It was quite awkward, as I recall.

Regardless, they had the effect of getting the sector to focus on the subset of patients who we and others had determined most warranted the LTCH level of care. And, you know, when you look at the changes in utilization that have occurred since then, particularly that stacked bar chart that Katherine showed, where most of the decline in case over time, which was anticipated and a desired policy, occurred from the non-qualifying cases. And I know my eyesight isn't as good as it was a few years ago, but when I squint I look at that chart and see a fair amount of stability in the qualifying cases over time, which is, again, a desired outcomes.

And then the last thing I will say is when we look at the differential financial performance of LTCHs under the new payment system, those that have responded to the criteria and focused on those most LTCH-level type patients, performed financially better than LTCHs that don't.

So, you know, whether the criteria are appropriate, I'm not a clinician, but whether the criteria achieved a desired effect, I think they did.

Does that help?

DR. DeBUSK: Yes. Thank you.

MS. KELLEY: Okay. I think that is all we had for Round 1 questions. I'll just pause a minute in case someone wanted to speak up with another Round 1 question. Oh, Pat, go ahead.

MS. WANG: I'm sorry. Katherine, I don't know if you heard the question that I asked Jamila, but it was an observation, which you pointed out in the chapter, which was great, about the demographic profile of LTCH patients under 65, black male, dual, ESRD. It's so different from the IRF profile, and people talk about these two facilities as not exactly the same, you know, they're different criteria. But they're not different enough to explain that dramatically different a demographic portrait. And I just wondered if you could offer any insight for us.

MS. LINEHAN: The answer is no, but that's something we could look at. I mean, I don't know whether the profile of patients has changed since the implementation of the site-neutral payment policy, but I don't think so.

I do think, and I think I cite this work that was sort of speculating about some of these differences, and some of it I think may have to do with the location of some of these facilities, they are concentrated in certain geographies. There are a lot of LTCHs in a handful of states. So that could be a factor.

It could also reflect preferences for end-of-life care or patterns -- I shouldn't use preference -- that could reflect patterns in end-of-life care service provision. So those are a couple of possible factors, but this is certainly something we could look at more.

MS. WANG: Thank you.

MS. KELLEY: Can I just add one last thing? I'm just harkening back again to the work that Carol Carter and I did on looking at use of IRFs several years back. I'm not so sure the patient profiles between IRF and LTCH overlap as much as they do, say, between IRF and SNF. So I think that also may play some of a role here in terms of differences in the patient populations, you know, patients needing to be able to tolerate three hours of therapy a day. That's a very different patient than someone who's ventilator-dependent, perhaps. So that, I think, also could play a role here.

Should I move to Round 2, Mike?

DR. CHERNEW: I'm hoping you will, and I think that's going to bring us back to Brian.

MS. KELLEY: Yes.

DR. DeBUSK: Thank you. Yes, I do support the recommendation, the Chairman's draft recommendation as written. You know, my earlier question about the case criteria, my general sense here is they implemented largely what we recommended. I realize there's a difference between three and eight ICU days, but it is nice to see that our site-neutral policy was implemented and appears, based on this presentation, appears to be working. So it is nice to see us resume ordinary, market basket updates for them.

So again, I support the recommendation.

MS. KELLEY: David.

DR. GRABOWSKI: Thanks, Dana. I also support the Chair's recommendation. There is some strong academic research questioning the value of long-term care hospitals historically. However, similar to Jim and Brian, I do believe site-neutral payment has been a success in achieving its desired effect, and I really think we can look at this as a success story here.

So I very much believe, similar to what I said about inpatient rehab facilities, we want to go back to site-neutral payment at the end of the public health emergency, because it's worked really well. And once again, I'll repeat my comment earlier. I wonder if there's lessons we can learn from this. I appreciate what Dana Kelley just said about the difference in the LTCH and IRF populations, but this policy has worked well, and it's not clear to me that the IRF policy --

MS. KELLEY: We've lost David again.

DR. GRABOWSKI: -- and so that have tried to limit inappropriate utilization quite worked as well. Maybe that going forward and some potential lessons. Thanks.

MS. KELLEY: David, we lost you a little bit at the end there, but I think we got the gist of your comment.

DR. CHERNEW: We heard the bit about you supporting the recommendations.

DR. GRABOWSKI: That's all you needed, Mike, right?

DR. CHERNEW: No, we needed everything. Some needed more than others. Thank you, David.

How are we doing now?

MS. KELLEY: That's the end of the queue for Round 2, so I can go around the room if you'd like.

DR. CHERNEW: I would like. Thank you.

MS. KELLEY: All right.

DR. CHERNEW: And one more thing before you do that. If you have a comment and you think of a comment beyond just saying, you know, you can do that when Dana comes around to you. So, in any case, Dana, go ahead.

MS. KELLEY: Okay. Paul?

DR. PAUL GINSBURG: I support the recommendation.

MS. KELLEY: Jaewon.

DR. RYU: I do as well.

MS. KELLEY: Larry.

DR. CASALINO: I support the recommendation but I would move that we delete Paul's support because it looks like he's talking from behind a veil of ignorance there.

DR. PAUL GINSBURG: That's what you see in the picture is the sun hitting the laptop screen.

DR. CHERNEW: He's just rubbing in that he's now in California.

DR. CASALINO: I retract my suggestion.

MS. KELLEY: Wayne?

DR. RILEY: Yes, I'm supportive.

MS. KELLEY: Jon Perlin?

[No response.]

MS. KELLEY: We'll come back to Jon. Marge?

MS. MARJORIE GINSBURG: I support it.

MS. KELLEY: Lynn?

MS. BARR: I support. Thank you.

MS. KELLEY: Stacie?

DR. DUSETZINA: I also support the recommendation.

MS. KELLEY: Bruce?

MR. PYENSON: I support the recommendation.

MS. KELLEY: Betty?

DR. RAMBUR: I support. Thank you.

MS. KELLEY: Pat?

MS. WANG: I support.

MS. KELLEY: Amol?

DR. NAVATHE: I also support the recommendation. I do have one other comment, which is in general I agree with David's point that the site-neutral here has worked well and we can see a nice policy response, and hopefully that serves as maybe not a template but at least a case in point to refer to in future cases.

I think it is worth exploring this question of appropriate fit, if you will, for LTCH versus not, going forward, and I would caution us from being a little too overenthusiastic about interpreting the data and seeing exactly what we want to see from it, because what we're really seeing is a response to the policy design, not solely a response to the appropriateness measure itself. So I think we should just be a little bit careful about that.

But I am supportive. I think we definitely made a concrete advance through this policy design, so I don't want to take away from that. I just think we should continue to work on what is probably the most important remaining piece of this policy going forward. But I support the Chairman's recommendation. Thanks.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: I support the Chair's recommendation as well, and I just want to echo, I had some of the same thinking around the point Amol had just made, and I think when we come back to this topic it is worth looking again at some of the things we talked about before, which is some of the outcome data, where despite meeting the criteria, a very high percentage of patients don't survive, you know, a 30-day post discharge stay or their inpatient stay at the LTCH.

And so there may be better ways to further refine what the criteria are, and I think we should be comforted by the fact that we know if we do that there's a high likelihood that it will actually drive the behavior in the direction that we want. Thanks.

MS. KELLEY: I'll try and see if Jon Perlin is able to ring in here. I think maybe he stepped away. And Dana Safran has also stepped away, so I think that's everyone, Mike.

DR. CHERNEW: Okay. Then let me pause for a second and see if anyone wants to make any other comments.

Hearing none I will say again to the public that is listening, we really would like to hear your feedback on what we've done. We hope you've found this afternoon useful, and if you stayed for the other sessions this month we hope you found them useful as well. But if you have comments please send an email to meetingcomments@medpac.gov, or go onto the MedPAC website that you see there and reach out to us.

I want to give particular thanks to the

Commissioners for all of their insights and work. You may not, at home, realize how much materials was sent to all of these Commissioners, and that, of course, reflects an enormous amount of staff work that I could not be more appreciative of. So again, thank you very much to the staff and all that they've done for their analysis and presentations. And understand they're doing things besides just this.

So with those thanks I think we will reconvene in January when we will have votes on this material. So I very much look forward to that. And without further ado, thanks, everybody. Have a safe and joyous holiday season, and I will be in touch. Anything you want to add, Jim?

DR. MATHEWS: No. Take care.

DR. CHERNEW: Thanks, everybody.

[Whereupon, at 2:14 p.m., the meeting was adjourned.]