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Northern Virginia Health Policy Forum: What's Next in Healthcare: The Defining Trends to Follow

TRANSCRIPT

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Introduction: Jim Scott

Good afternoon, and welcome to this month's Northern Virginia Health Policy Forum. My name is Jim Scott, and I am the president of Applied Policy, a consulting firm based in Alexandria, Virginia. My colleagues and I host these monthly gatherings to share information and exchange ideas with you on the issues shaping twenty-first century American healthcare.

With Congress back in session and election year issues coming into focus, health policy is dominating much of the conversation in Washington. At the end of August, the Centers for Medicare & Medicaid Services – CMS – released the highly anticipated list of 10 medications that will be subject to price negotiations with the government. Now that those drugs have been selected, the focus turns to how those negotiations will play out and what the impact will be on patients and drug development.

At the same time, Congress and the administration are trying to make headway addressing a host of other critical issues that impact the health of virtually every American, including issues with nursing workforce shortages, the need for hospital pricing transparency, the rise of Medicare Advantage enrollment, and maternal health.

Joining us today are three influential reporters who work for significant and well-known publication. Each of our panelists are keen observers of health policy and how it is shaped here in Washington. They are Michelle Stein, Health Care Editor, Reporter, and Assistant Publisher at Inside Health Policy; Rachana Pradhan, Correspondent at KFF Health News; and Shannon Firth, Washington Correspondent at MedPage Today. Good afternoon and thank you for joining us.

I'd like to start by asking you individually to share the professional experiences that have brought you to your positions as influential reporters working for significant publications. Michelle, what professional experiences led you to your role at Inside Health Policy?

00:00 (18:48) (Michelle Stein) *(not transcribed yet)*

(Rachana) Hello, everyone. I came here to care about health news, because I wanted to write about, you know, the decisions or lack of decisions that really happen in inside the beltway, if you will, and explain it to people who really don't necessarily have a grasp of how decisions get made and what it means for them. And so that's why you know, we have the benefit of being able to publish to a really wide audience and hopefully help people you know, better understand a little bit about how our healthcare system works or doesn't work for them.

00:41
Shannon same question, what led you to your role at MIT ha.

00:48 (21:08)
Um, you so I came to reporting on healthcare through a sort of secure, circuitous route. I started my career in book publishing. I also worked at an education startup. And from there I decided I wanted to be a journalist. And I chose healthcare, in part because of my family background and there's a lot of physicians and nurses in my family and I have a real interest in reporting on those issues and reporting on mental health in particular, and I think that is where I do hear a lot of stories are from friends and family and become more interested in writing about those those topics.

01:35
Thanks, Shannon. It's currently mid September and along with back to school as we've seen over the past few years. We're also in threat of government shutdowns. Congress is considering a number of health care issues, including pharmacy benefit manager reforms and drug shortages. Shannon What are you watching from Congress for the end of 2023 and looking into 2024?

02:00
Thank you, Jim.

02:02
So first of all, I didn't say thank you to apply policy and the Northern Virginia Health Policy Forum for hosting me here. And the bills in Congress that I'm watching, assuming that we are the Congress is able to avert a shutdown are

focused and focused a lot on looking at drug price bills, there's bills in four different committees. Or four different committees have held hearings to discuss the challenges around drug prices. Most of those bills are focused on and target PBM. So pharmacy benefit managers, a lot of the issues there and a lot of the provisions are specific to transparency and competition. So they're looking to increase transparency around how pharmacy benefit managers which are the middlemen between the insurers, and the between the drug companies and the insurers or the patients.

02:58
How they choose which drugs are put on formularies which drugs are covered essentially, and which drugs are preferred. So there's going to be transparency around that hopefully.

03:11
And there's also moves to increase competition right now. With three largest PBMs control 80% of the market. And one of the things that Congress would like to look into is whether the consolidation of PBMs in terms of being owned or merged with health plans and pharmacies is is a problem. Essentially, a PBM can pay its own pharmacies, what it wants and pay independent pharmacies a different amount. So that's something that we'll also be looking into, apart from PBMs also looking at physician payments and laws or sorry bills that would help to address the the cuts in Medicare payment that physicians have been quite upset about last year. They averted.

03:59
The.

04:09
Physicians managed to avert a deeper cut than had been expected. But there's still still a there's still expecting at least a two or 3% cut as of CMS is proposed update this past July. So CMS sorry, rather, Congress is via Raul Ruiz is looking to pass a bill that would link physician payment to inflation, specifically the Medicare economic index. So that is another thing that we'll be looking at. And then apart from that, there's the healthcare workforce challenges.

04:51
There's a bill that was introduced just last week by Bernie Sanders and Roger Marshall, Senator Roger Marshall and Senator Bernie Sanders. Roger Marshall is a physician OBGYN and they are looking to help expand the workforce, both in primary care and with nurses, doctors, nurses, doctors, mental health professional dentists, they're really looking to help address bring bills out that would address these shortages in a comprehensive way through through

repayments of loans, through investing in graduate, graduate medical education spots, increasing the number of primary care GME spots and through investments in community colleges and state run programs for two year nursing degree programs. So that's a mouthful, but those are a couple of things few of the things that I'm looking at.

Thanks, Shannon. Rach. Um, what are you watching for the rest of this year and into next year?

Well, I think Shannon ended on a bunch of stuff that was super important. I think, for me, I think the few things that certainly in the near term kind of going into the end of the month and funding the government one thing that we're interested in following here, you know, funding of community health centers, obviously they're looking to get their that extended. So that's something that we definitely have an eye on, I think, sort of a professional slash personal interest of mine, which we've written about here a bit is, you know, coverage of of these new generations of weight loss medications, the GLP one and similar drugs, obviously, there's a lot of interest from certain manufacturers to get Medicare to cover these new kind of generation of very effective drugs for weight loss, which of course they cannot have Medicare recover right now. So, um, you know, but I guess the CBO score is the is the tricky one on that one, but it seems like there's some bipartisan appetite to sort of revise the statute that created Medicare Part B.

07:09
The other thing I would say is, of course, going into 2024 out is just not necessarily just legislation, but I'm interested in seeing sort of how Republicans in the House especially sort of wrap up their oversight activities of the Biden administration going into an election year and seeing additional, they've done of course, like some of their focus has been on the inflation Reduction Act and Medicare drug negotiation, but also drug shortages and sort of how those issues play out in the next in the months to come.

07:45
Thank you, Michelle. What stories are you following for the rest of this year and into 2024?

07:52
I think Shannon and Rachina hit on quite a few of them the physician payments and the Community Health Center funding.

08:01
But one of the following on that rash and one of the things that I will be watching is to see what happens with the lower costs more Transparency Act that was

pulled from a House vote yesterday, the house had planned to vote under on that bill under the suspension of the rules. And that bill included PBM reform, hospital price transparency since like neutral provisions and funding for community health centers, a delay of the Medicaid dish cuts which is set to go back in October 1, and a few of the other what we typically call the you know health care extenders. So especially leading up to the end of the month, I'm going to be watching very carefully to see what happens with the funding for some of these health extenders, the special Diabetes Program, the National National Health Service Corps, and then you know, some of the graduate medical education programs. These programs are set to sunset at the fiscal year. So it'll be interesting to watch how that plays out. And also how that might tie in to the overall government funding debate and the talk over a possible CR or government shutdown, as well as you know what happens with the lower lower cost more transparency bill overall. So it'd be I'll be following all of that leading up to the end of the fiscal year and then beyond that, there is basically the possibility of what could come up in a year and package and what that could look like, which I am you know, there's so much that could go into that the physicians are facing more cuts and are there's various different kinds of cuts and it'll be curious to see how Congress tackles that. Just earlier this morning before this webinar, I believe was Anna Eshoo, who said an Energy and Commerce hearing that Congress wants to take a look at Medicare device, breakthrough device coverage pathways and that a bill on that a bipartisan bill from that committee could be moving.

10:18
But there were some concerns at that same hearing, which covered about 25 pieces of legislation. There were some concerns about how you pay for some of these bills that have been brought up. So it'll be interesting to see if Energy and Commerce looks at another package and see if there was more work that they're doing there. And then and there is, you know, there's also more hearings on pharmacy benefit managers today. There is a whole lot of work going on on that front with drug pricing and pharmacy benefit managers in particular, on both sides of Congress. This the Senate is obviously Senate Finance Committee has been focused on that quite a bit so it'll be interesting to see what happens there as well.

11:03
Thanks, Michelle. Now let's turn to the Medicare drug pricing negotiation program.

11:09
As we know, CMS recently announced a list of 10 drugs subject to negotiation under the Medicare drug price negotiation program. Rachana, will consumers actually see a cost savings when they check out at the pharmacy counter?

11:25. Rachana
Well, so I think that's a great question, Jim. I think the thrust of course of the Medicare drug negotiation program is really to save the Medicare program and therefore taxpayers money with what we spend right now on prescription drugs under the program. So I think that it's possible that patients who whose Medicare plans, you know, require them to pay significant co pays for their medication. It's possible of course after starting in 2026, that they might see some relief, but I think that probably in the closer or nearer term, really the thing that is going to provide patients, more direct and probably noticeable financial relief is the $2,000 cap that goes into effect in 2025. So that's what we've sort of been reporting on here. I think that it may not, the drug negotiation program itself may not necessarily noticeably lead to significant sort of out of pocket savings that a consumer would notice. But other parts of the IRA, I think would be more meaningful in that regard.

12:35
Thank you. Michelle, are there any issues raised by drug price negotiation or other parts of the inflation Reduction Act that you think aren't getting enough attention? And if so, what are those issues and why should they be highlighted?

12:51
Issues that needs to be kind of paid attention to it. This is of course, everyone is looking at and paying attention to the numerous lawsuits I believe it's up to eight lawsuits over the drug price negotiation at this point, and there's discussion about how it looks like maybe those are heading towards the Supreme Court. That's what they might be geared towards. So that obviously is one thing everybody needs to keep an eye on. Another one is there's been concerns that there are patent reforms needed. To curb attempts to evade price negotiation. There are concerns from some consumer advocates that some of the drug makers are looking to essentially rework some of their drugs to avoid the price negotiation by making that making them into new injectable versions. And that's going to be one thing to keep an eye on as well.

13:48
Thanks for Shell ranch. Are there any issues in your view that aren't getting enough attention and should be highlighted?

13:56
Um, I think when the list of time drugs came out, of course, there was a lot of examination and you know, briefings about the list. That was chosen and how, you know, sort of surprises potentially are things that were not included, even accounting for some of the first like the exceptions that exist in the IRA for that

would exempt some drugs naturally from negotiation. I still have some questions though. That I think haven't really been thoroughly answered as to.

14:27
There were forecasts and estimates by researchers about certain drugs that were probably likely going to be included in 2026 and were not. I think even those estimates led to one drugmaker preemptively filing a lawsuit against the Biden administration and then their drug did not end up on the list. So I still have questions kind of going into - even though CMS has said they looked at gross Part-D costs for determining which drugs would be selected but I still think that there's some lingering sort of uncertainties in my mind about how that list of 10 was really settled.

15:07
Thank you, Shannon. What are your thoughts on the Medicare drug price negotiation program?

15:13
I think that I think that Rachana and Michelle covered this pretty well here, but I do think it's important to pay attention to the lawsuits that are happening right now. There's, you know, we won't see a change in price until 2026. So there's a lot of that's a lot of time for, for things to happen in the courts.

15:36
At the same time, I think, you know, there has been a whole lot of pushback on this. I mean, as you can see in these lawsuits, there has been a whole lot of pushback on CMS for bringing up these provisions. And they are suggesting that this isn't really price negotiation that this is more of price fixing price setting. So we will definitely be seeing that argument in the courts along with concerns about stifling innovation.

16:11
Thanks for Shannon. Rachana, You touched on this earlier, CMS has indicated that its goal is to lower costs for Medicare as a whole and then pass those savings on to individual taxpayers, even those who don't take one of the drugs. How might that look from a Medicare prospective? Are they talking about lower premiums or what are they talking about there? And are those realistic goals?

All right, I mean, I do think that you could see, I mean, lower premiums is certainly one possibility for how this would manifest but again, like currently, service, as Michelle and Shannon hit upon, you know, we're only talking 10 drugs in 2026. Obviously, that list is going to grow over time. But really, you know, this is just the start of this and we're starting with a pretty limited you know, array of

products. The second thing I would say is yeah, you know, there's a lot of litigation out there. 2026 is very far away, it is an eternity as far as what could happen between now and then, and whether this program even survives. And so I think that certainly it's a it's a goal that could be met in theory, but how meaningful it will be is that, you know, really guys it's hard to predict right, just based on those factors.

17:34
JS: Some observers have said that CMS has no ability to negotiate drug prices will stifle innovations, Shannon, what is your reporting telling you about that? And do you see that as a legitimate concern?

17:47
SHANNON: I think drug companies have been saying this for a very long time and I think it is a very logical concern to say that with less revenue there'll be less interest in from investors and unless perhaps less money for R&D. The counter to that is that as the CMS director Meena Seeshamani pointed out that when these 10 drugs, when the drug price list came out, there wasn't a big hit to the stock market. And as Larry Levitt and others have pointed out, there's just that argument about stifling innovation, the ECB, the ECB O has estimated that there would be perhaps 13 fewer drugs in the next three decades.

18:39
And it's out of 1300 potential drugs being produced. So the question which no one really can answer is, will those 13 drugs be? Well some of those be life saving drugs? Will they be me to drugs? That we, we really don't know. So I think it's hard for me or anyone else to really predict how, how meaningful that argument is, but those are kind of the two sides there.

19:06
Michelle, do you have any thoughts on how the drug price negotiation program might affect innovation?

19:15
I think Shannon covered it pretty well. But I'm just going to add here that Congress is also looking at and there's also been a push for quicker coverage of innovative drugs like the Alzheimer's ,like Alzheimer's drugs and the coverage, the push for quicker coverage on some of this for both Congress and CMS looking at some of these reforms. I think that kind of shows that there is still a focus on innovation and that some of this innovation is still expected.

19:49

Um, Michelle, we have a question from the audience. They're asking, “Isn't the physician hospital reimbursement regime also price setting? So why, while the process is different, isn't it this the same thing for drugs?”

20:07
Well, I think the easiest way to the easiest thing to point out with that is that these are literally different parts of Medicare with the with, particularly if you look at Part D versus Part A Part B, but yes, Medicare is saying, we put out our rules and this is what we are going to be paying you for these services for physicians and hospitals. So I I don't know how else you get around that.

20:36
Thanks, Michelle.

20:38
And now let's turn to the Medicare program itself. Shannon, as you've covered in a recent article, physicians saw a 22% drop and Medicare reimbursement rates over the last 20 years. Do you think this contributes to the trend of hospitals and health systems acquiring physician practices?

20:59
Thank you, Jim. Yeah, um, I reported that after adjusting for inflation, over between 2021 and 2023, there was this roughly 20, 26% Dip in terms of physician payment.

21:18
And as I mentioned at the beginning of the talk here, there has been concern around continued cuts to physician payment and reimbursement. As for the trend, of healthcare systems, acquiring physician practices, I expect that will continue and I do think that it would make sense that an independent physician practice would think that perhaps with all the pressures on them between staffing regulation the need to deal with prior authorization requests, it might be easier to be part of a larger health system and have those things perhaps taken care of for them.

22:03
But in the same respect, a physician could just opt to leave the Medicare program and perhaps stand up a concierge practice instead. So there's different routes for physicians to go here if they feel that they're not getting their money's worth but from Medicare and that is that is the serious concern though.

22:29

Michelle, at the time that CMS proposed its Physician Fee Schedule, the consumer price index was 8% or more than 8%. And as Shannon pointed out, the physicians ended up with a with a with a cut this year. And then there's bills in Congress to increase physician payments, but if we increased physician payments, are there any concerns that increased spending could hurt the Medicare trust fund?

23:02 (Michelle)

So I think one of the one of the things that we have to look at is the trust fund it's the Medicare trustees report itself has looked at some of these payment amounts and pointed out that there could be access issues and that you have to waive payment and access that is literally in some of the trustee reports that have been coming out since the Affordable Care Act. They've noted this within those reports themselves.

23:32
And I think that it's one of those things that everybody looks at but the other thing to look at is that the Trust Fund has actually gained a few years left the Trust Fund has increased over the last few years. And and we're gone from I believe 2026 to Shannon, you might be able to back me up here. I think it's 2031 at the moment for the for the Medicare trust fund. (I'm sorry, you can't back you up there but just your numbers.)

24:05

But it is it has increased nevertheless, it has increased over the last few years. And so this is as some of these physician pay cuts have been averted over the past few years. And I will also point out that averting physician pay cuts really isn't for lack of a better way of phrasing this. Anything new between SGR and these last few years, this is kind of a repeated cycle that has been going on for quite a few years that these cuts come up. They get averted. There's concern about for the cuts. They get averted at a year on package and it it happens over and over again.

24:51 (SHANNON)

I will just interject and say that. I think the difference this time is that the doctors and nurses and all of health care has been infected now by the pandemic so they feel you know, the physicians I've heard them feel like this is kind of a slap in the face, given how hard they worked and how much they you know, did put their

lives on the line during the pandemic to help and see patients so it is very much like Groundhog Day very much the same thing as the doc fix. I'm completely agree with you.

25:27
But I think that that's the argument that they've made. This is why we're more upset and more frustrated than usual perhaps is the other.

(MICHELLE)

The other thing I will add to this too, that makes us slightly differences. There's a lot of focus on the budget neutrality aspect of the physician fee schedule this time around were okay if some of these cuts are tied to the increase in pay for evaluation and management services, then that means some physicians would do better than others under the physician fee schedule and the way this is working. And it's been described to me multiple times as the robbing Peter to pay Paul scenario. And I think a lot of the frustration is being turned to towards the budget neutrality aspect of the Physician Fee Schedule itself, as opposed to just everybody's being treated the same and that's just across the board cuts.

26:25 (JIM)
Thank you. Let's turn to Medicare Advantage.

Somewhere around 50% of Medicare beneficiaries are now choosing the Medicare Advantage program instead of fee for service and with 10s of billions of dollars of government spending and calls and for CMS and Congress to revamp the program to better serve beneficiaries and improve payment accuracy. Can you tell us what you're seeing and how this will affect patients?

27:04 (MICHELLE)
Starting with me, I'm sorry. I had a bit of a technology issue. Could you repeat that, Jim?

(JIM) . . . with Medicare Advantage. But you know, I think it's close to the majority of Medicare beneficiaries are getting their health care through Medicare Advantage now.

27:22
CMS, there have been calls for CMS and Congress to revamp the program to better serve beneficiaries and improve payment accuracy. Can you tell us what you're following on Medicare Advantage and how it might affect patients?

27:39 (MICHELLE)

Well, there's been a huge push on Medicare Advantage to look at risk adjustment, to look at potential upcoding or overcoating depending on who you talk to about this, to look at the home risk assessments.

That has been a huge focus and has drawn a lot of controversy. And there is I think, also just given the time of year one thing that's going to be important to look at is tied more to what is open enrollment going to look like this year, considering CMS if we remember last year had started to crack down on advertisements around MA plans and what those can look like and raising concerns about television advertisements in particular, and Congress had stepped in as well with Ron Wyden in the Senate Finance Committee raising a bunch of concerns around this as well. So I think it'll be really important to see what open enrollment looks like and to see what the advertising around that looks like is as well as these long standing concerns about upcoding and risk adjustment. And then we also have a lawsuit over the red V roll as well. And we need to see how all that plays out within with the new revenue rule. So there's quite a few things going on and Medicare Advantage to watch as well.

28:55 (JIM)

Thanks Michelle. Rachana, any thoughts on Medicare Advantage and things you're following there?

Now the one thing I was gonna piggyback on, but Michelle mentioned was was red V. I think that's the thing that we're focusing on paying attention to hear the most.

So what is for our audience? What is red V and why do people care about it?

Oh, gosh, how do I explain this? I'm I'm gonna maybe pass it off to someone else to better explain the nuances about Medicare Advantage audits and sort of the backstory with what the rule did this year.

29:28
Anyone else want to take a stab?

29:32
I have to take a pass on that. I'm sorry. But I had my shot. I think I can I can at least help a little bit. With this.

29:41 (MICHELLE)

So I will say not to plug our coverage or anything but my colleague Bridget has done a great job of covering all of this on rad v. So the red v is the risk adjustment, data validation audits and basically it is going it's going back and looking at how all of this risk adjustment has basically been handled. Now Humana sued September 1, over the risk adjustment rule and the process CMS follow for finalizing the regulation and they were alleging that the fact that CMS didn't include a fee for service adjustment to draft the final rule violates the Administrative Procedures Act. Basically, earlier this year, CMS had finalized this rule that there's an argument that it's essentially the argument that the insurers were making is that it eliminates parity between MA and fee for service by not including this fee for service adjustment. It and basically CMS with this rule was looking to extrapolate Medicare Advantage audit data beginning with year 2018. So so they're basically can go look back they had considered looking further back from 2018. But they ended up starting there and retro actively essentially recouping what the agency calls overpayments CMS is anticipates retro actively recouping about 479 million in overpayments from Payment Year 2018. And they forecast recovering around 4.7 billion between 2023 and 2032 based on the new audit structure, so there's a lot of money at stake with this

(JIM). . . right and then just clarify a little bit more risk adjustment is so important to a Medicare Advantage because they submit bids every year and they bid on sort of an average beneficiary and then then CMS adjusts the payment based on their health care conditioned to pay more for sicker and more expensive beneficiaries and less for healthy beneficiaries. So the risk adjusters really determine how much the Medicare Advantage plans get get actually paid for their enrollees. And then the audits are designed to true up any any inconsistencies. So thanks for clarifying that. Michelle, and for bringing it up.

32:16 (JIM)
Let's turn to nursing in nursing homes.

32:21
Almost by any measure the country's nursing workforce shortages persist. Recent estimates expect about 800,000 nurses to leave the workforce in the next four years, which is in the top one, which is on top of the 100,000 who left during the pandemic. Shannon, can you tell us about the status and source of the workforce shortages as well as the Biden administration's effort to counter this trend?

Yes, thank you.

32:50 (SHANNON)

Very quickly. I'm also going to plug my colleague's coverage on Medicare Advantage. I am not the person on that beat but Gerald Clark has done some phenomenal reporting on the quote unquote dirty little secrets in Medicare advantage in terms of limited networks and other things. But moving on to nursing

The nursing workforce right now.

Sometime I think around last April or May there were predictions that one and five nurses could leave nursing in the next before I think 2027 And so we have about 4.55 point 2 million nurses, registered nurses in the country so to see that many nurses leave could be a significant problem. I am hearing from experts who are doing these analyses right now that there is they are seeing actually a rebound in terms of the total nurse supply and I don't have numbers right now but they are seeing nurses coming back to nursing, whether they're coming back or whether they're graduating and moving into nursing. I'm not quite sure. But they're seeing that rebound.

34:04
But the experts that I spoke with said that they're not seeing the trend as not seeing the same trend as much in hospitals, which means that you're still going to see that stress and that stretching of the workforce in hospitals.

34:22
The reasons for nurses leaving the workforce are many but burnout and moral distress during the pandemic are among them. But I would definitely point anyone to Linda Aikens research. She's at the University of Pennsylvania, who really tries to emphasize as a lot of nurse leaders try to emphasize that these problems were there prior to the pandemic and the hospitals that weren't dealing with them prior to the pandemic that weren't ensuring that they had good staffing that their hospitals were safe, that people were treated well. The hospitals that were underperforming, then had bigger problems during the pandemic. So when the Aiken would argue that the workforce issues were not the root cause of the workforce issues wasn't the pandemic it was more of a contributing factor that made things a lot lot worse.

35:19
In terms of the Biden administration, the Biden administration is injecting about $100 million into the nursing workforce, trying to build up faculty trying to ensure that there's a smooth career ladder for nurses who are LPN, for example who want to become RNs.

35:39
They are investing.

35:42
They're also trying to fill gaps in in areas they know it's needed, such as primary care and maternal health and mental health. And I'll stop there.

35:54
Thanks, Shannon. In an effort to guarantee the delivery of safe, reliable and high quality care, CMS recently proposed a rule that would set minimum staffing requirements for long term care facilities and nursing homes.

Rachana, can you tell us about the proposals and what stakeholders have said about them so far?

Sure. So um, so CMS proposed, you know, certain minimum staffing standards across a wide variety of roles, you know, for clinicians that are in that are provide care and long term care facilities. So roughly what they propose at least on nurse staffing levels. They require nursing homes have daily average nurse staffing levels that would amount to roughly about one registered nurse for every 40 for long term care facility residents. But they said the rule I think was point 55 hours per resident and then similarly on certified CNAs are certified nurse's aides and nurses assistants, they said they called for a 2.45 Nurse Aide hours per resident per day that's about you know, one nurse's aide for every 10 residents of course, you know, CMS did not provide any funding, you know, for these new requirements, which of course, is something that the industry has raised as being of a significant concern, because they are saying it's an unfunded mandate. And if we can't find the workers, you know, this is not essentially not going to be tenable.

37:31
I think that but the things that we are, you know, that I'm definitely interested in, there is, you know, an exemption process for you know, CMS is saying that, if long term care facility can prove that there's a worker shortage in the area, and that they've really tried to make efforts to recruit employees and they still can't meet the staffing standards if they're finalized, and they'll be exempt from penalties under the regulation.

37:58
And I think the industry of course, has expressed some displeasure with CMS proposal. But on the other side, there have been advocates for long term care residents who have said, they really should have gone much farther even though it's a step in the right direction.

38:14
And so I think it'll, that's definitely something that we're very interested in following along as this rule moves to be finalized.

38:24
Thank you. We have a question from the audience. They're asking if the panel thinks there should be or will be flexibility in implementing the minimum staffing requirements, such as allowing licensed practical nurses and or three year registered nurses as opposed to nurses with Bachelors of Science Nursing degrees, to fulfill the staffing requirements.

38:50
Rachana, any thoughts on that?

38:53
Well, I think I think that that's one of the things that is bound to kind of be raised you know, as CMS accepts comments on this regulation, whether the agency would would do it, you know, of course, I can't predict but I do think it's worth noting, you know, there is obviously like I said, like an exemption already built into the proposed regulations. You know, there are my colleagues have done some reporting on this topic, which is that, you know, nursing homes, especially in rural areas are very worried that this rule you know, is just, it's like insult to injury almost. They already have to deal with such thin staffing levels and say they don't have money to hire and find, you know, even find professionals who can do this work and this is just going to be a really added and potentially unsustainable burden for them to fulfill. So I do think, you know, CMS clearly is is trying to thread the needle between you know, doing something that they can claim as robust even though there's disagreement about that, and also not sort of imposing standards that are really not sustainable and then in the end, what if you have so many numerous exemptions and in essence it the regulation does not really amount to very much so.

40:17
Thank you. It's shocking to me that in the face of a workforce shortage, CMS would propose increased staffing requirements without any additional funding to meet those requirements. So it'll be interesting to see how that that plays out. Let's turn to hospital chart price transparency. This past summer, CMS proposed changes to the existing hospital price transparency regulations. Michelle, what can you tell us about that proposal where it stands now and the industry's response?

40:49

Sure, I I actually, if you don't mind, Jim would like to back up a little bit to kind of do a how we got here with the with that rule from the summer. Because if you remember back in and I believe it was February of this year, CMS had put out a turns out to be relatively controversial. update on where hospital price transparency was standing where CMS was touting, essentially progress and saying that the hospitals were doing better on the price transparency front and there was more information available than there had been.

41:31
So that was in February, and, and to CMS, and CMS.

41:39
Forgive me, I apologize for the noise of my dog in the background.

41:44
And then Chiquita Brooks was sure CMS administrator Brooks was sure was basically called before Congress and Congress had a whole bunch of questions for her and basically was pushing saying they didn't think it was going quite as well as CMS had kind of put forward in this Health Affairs article.

42:05
And at the same time that she went before Congress, CMS released, basically an enforcement update saying that they were going to increase some of their enforcement of these price transparency aspects that we're currently in regulation.

42:22
All of that happened before we even got to the price transparency rule that was put out as part of the part of the 2024 Hospital Outpatient Prospective Payment System. Now within that, CMS then put forward a whole bunch of new provisions, basically, basically trying to beef some of this up, and basically, you know, making things a little bit a little bit more strict with what what needed to be included on some of this. You had provisions.

43:05
CMS proposing require requiring hospitals to display required standard charges using a CMS templates and hospital required to encode some of the standard charge information. You had a whole bunch of these proposals and improving CMS said it was going to be proposing to improve and streamline enforcement capabilities. So there was a whole bunch of different proposals that were part of this rule. And now we're basically disappoint you know, we have the rule comments, and now we're waiting to see how CMS moves on finalizing some of these proposals that are put forward back in July.

43:53
Thank you, Michelle.

Oh, you know, when when patients go to the hospital, they're, they're going in often for a specific surgery and when they come out of that hospital, they get bills from the hospital bills from an anesthesiologist bills from the surgeon and a variety of other practitioners when in their mind they were just going in for a surgery. And then it's often a surprise to them, how much insurance paid or what they didn't pay, whether it was in network out of network, what did they do if they have secondary insurance was that build and you know, they ended up sorting through a pile of explanation of benefits, even when it's a elective elective surgery. If we had to shop for groceries, the way we shop for hospital care in terms of when we find out how much it's going to cost us there would likely be a public outcry. How close are we to true transparency and hospital pricing and what effect would true transparency have on the health care system?

45:03
I think that part of that is going to depend on who you ask.

45:08
There are consumer advocates who will who will say that there's not nearly as much transparency and clearly some in Congress are coming down on that side as well because as I mentioned, that lower cost more Transparency Act in has quite a few hospital pricing, transparent transparency for divisions in it as well. And then there there there are others who are saying that you know this is working and CMS is making changes so we're gonna have to see but the fact is that it is still difficult for an individual person to let's say, go and look up a specific to try and get specific price information about a specific service ahead of time based on their individual insurance information. That is still very difficult. And I think that is what a lot of people would think of as price transparency would be the ability to find out ahead of time and say hey, what am I going to have to pay for this? And that is still relatively difficult. So I think most people would argue that if that is your goal, we're not to that point.

46:25
Thanks, Michelle. Now let's turn to maternal health. The CDC recently reported that one in five American women feel mistreated during maternity care. The rate of reported mistreatment was even higher among black women at 30%. Hispanic women at 29% and multiracial. Women at 28%. Shannon, you cover maternal health issues, what's causing this and are there specific steps that can be taken to improve maternity care?

46:58
Thank you, Jim. Yeah, I think there's a lot that can be done to improve maternity care, the study that you mentioned is definitely proof of that. Just recognizing that, you know, in that study, the study author noted that these women are being not only listened to but berated or yelled at and the the worse

47:23
and they have worse outcomes with the cause of it. The study was looking at maternal morbidity which is considered a near miss for mortality. So these are not just you know, slight hiccups in a in a pregnancy or delivery.

47:38
In terms of the drivers of maternal mortality that were so first off, black women have three and four times the rates of maternal mortality compared to white women, American Indian Pacific Islanders, Native American, I'm sorry, I won't get the terms right but they also have higher rates of maternal mortality and babies of these women have higher rates of death and premature birth.

48:06
The drivers of these issues are implicit bias, higher rates of chronic disease, in part because of social determinants of health. Another issue that I wrote about recently and came up in the study was climate change. So extreme health, sorry, extreme heat, impacts maternal morbidity and mortality in terms of women.

48:35
In their third trimester, it's it's most pronounced in elements third trimester so if you're a person who has to say walk to work or works outside or doesn't have air conditioning, that is a threat to your health, especially if you are giving birth in the heat of summer.

48:55
In addition to these drivers, there are definite solutions and Congress.

49:01
Congress woman, Lauren Underwood, along with a lot of other members of the maternal, black maternal health caucus, I'm going to get that name wrong but there's a lot of buy in for this. But so far, a lot of the bills in the mom the bus as they're calling it have not passed those bills are focused on expanding Medicaid to 12 months after pregnancy after delivery, sorry, expanding maternal maternal maternal mortality review committees, which gather data on the root causes of deaths, investing in doulas and the perinatal workforce and focusing on just diversifying the perinatal workforce as well. As there's also a bounce that focus

on substance use and mental health which can obviously lead to these maternal deaths.

50:01
Thanks, Shannon. It looks like we're running out of time so I just have a final question for each of you. Michel, from your perspective, what's the one most important thing for the audience to remember from your remarks today?

50:18
I think the most important thing to kind of take away and remember from some of this is that it's going to be a very busy last few months of the year and what the landscape looks like.

50:29
Right at this point in mid September could be very different from what it looks like on December 31.

50:38
And, Shannon, from your perspective, what is the one most important thing for the audience to remember from your remarks today?

50:48
So I didn't really touch on this, but in terms of the nursing nursing workforce, I just want to add in that one of the key problems in terms of building the nursing workforce is the lack of faculty. There are 85,000 qualified applications that are rejected every year for nursing. So if we want to build the nurse workforce, we need quality education. We need faculty there and there should be some movement towards that. Even though we may be seeing a rebound. Now, Nurse workforce issues are chronic and can continue.

51:23
Thank you and Russia, you get the final final thought. What is the one thing that the audience should remember today? All right, if there's one thing but one thing that I want to mention that we didn't talk about is in a recently the census just came out with their updated income poverty and health insurance coverage estimates for 2022. And, you know, the the pandemic level, I guess, pandemic era levels of health coverage in this country are likely going to decline in the coming years because of pandemic era projections that are ending or have ended. And so, Medicaid, just enrollments in particular is something that we're really just starting to see. And they are happening on a very widespread scale. And I think that we might start to see, you know, that potentially strain, you know, certain, I guess, certain providers who have to start seeing an uptick in the number of uninsured patients that they're now having to treat. And so that's

something that yeah, that I'm definitely focused on in the I think that's going to be a 2024 story as well as right now.

52:36
Thank you. This brings us to the end of this month Northern Virginia Health Policy Forum. I want to thank our panelists, and the members and the members of our audience for joining us today and our applied policy team for their hard work putting this form together.

52:54
Applied policy we'll hold the next Northern Virginia Health Policy Forum in mid October, where we will host a panel to discuss health policy issues and diagnostic testing. Again, thank you for being with us and enjoy the rest of your day.

53:13
Thank you.

53:15
Thank you.