
Sent: 2/18/2025 3:24:08 PM -0500
To:
CC:
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Subject: FW: FW: Nonprofit Hospice Community Policy Priorities
Attachments: image001.png; image002.png; image003.png; image004.png; NPHI Policy Priorities .docx; NPHI_POP_Blueprint.pdf

Confidential, iterative, and pre-decisional

From: Quinten Lyons <quin@nphihealth.org>
Sent: Tuesday, February 18, 2025 12:38 PM
To: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Cc: Ethan McChesney <ethan@nphihealth.org>; Tom Koutsoumpas <tom@nphihealth.org>
Subject: Nonprofit Hospice Community Policy Priorities

Hi Stephanie,

I hope you are having a productive week. I am reaching out on behalf of the National Partnership for Healthcare and Hospice Innovation (NPHI), the leading national organization representing the nonprofit hospice and palliative care provider community. With over 120 member programs across 38 states, NPHI members collectively care for hundreds of thousands of Medicare beneficiaries each year as they approach the end of life.

In light of your new role at CMS, I would like to initiate a conversation about the critical issues affecting the nonprofit hospice community. Please find attached our *People Over Profits* blueprint, which outlines the unique value our members bring to hospice care, along with a brief letter detailing our organization's policy priorities.

NPHI is committed to working collaboratively with you and CMS to address fraud and abuse within the hospice benefit while ensuring the long-term solvency of Medicare.

Please do not hesitate to reach out if you have any questions or if we can be of any assistance. We stand ready to serve as a resource for any hospices issues that might come across your desk.

Regards,

Quinten Lyons
Policy Associate
717.817.3896 | Quin@nphihealth.org



The national voice for not-for-profit advanced illness, hospice, and palliative care.



Dear Stephanie,

I am reaching out to you on behalf of the [National Partnership for Healthcare and Hospice Innovation](#) (NPHI) – the leading national organization representing the nonprofit end-of-life and serious illness care provider community. I write to emphasize the *critical* importance of the hospice care benefit, which now serves over half of all annual Medicare decedents. In recent years profiteering behavior and outright fraud have infiltrated this benefit, leading NPHI to work [hand-in-hand](#) with Congress, urging CMS to take stronger action to address program integrity concerns. We remain committed to stronger enforcement and oversight; we also acknowledge that this benefit is in dire need of modernization to fix many of the misaligned incentives driving bad actors into the space.

I encourage you to take a few minutes to review our [People Over Profits](#) blueprint – our vision for a better healthcare system. We look forward to working with you to ensure Americans have access to the serious illness and end-of-life care they deserve.

Established more than four decades ago, the Medicare hospice benefit was designed to deliver high-quality, compassionate care to individuals with terminal conditions, regardless of where they reside. This benefit not only enables Medicare beneficiaries to receive care in the comfort of their own homes but also significantly reduces Medicare expenditures by minimizing hospitalizations and ER visits at the end-of-life. When delivered in accordance with the spirit and intent of the benefit, hospice is a holistic and all-encompassing care delivery model that produces cost savings for the Medicare program and better outcomes for the patient and family compared to hospital-based end-of-life care alternatives.

In recognizing the potential to capture Medicare savings via increased hospice utilization and simultaneously reduce fraud, waste, and abuse, NPHI is developing a proposal to redesign the hospice benefit in a way that promotes upstream palliative care and aligns payment with both quality outcomes and the provision of services. The goal of this alternative benefit framework is to provide Congress, CMS, and other stakeholders with options to redesign the benefit while protecting Medicare beneficiaries, their families, well-meaning providers and the solvency of the Medicare program. We look forward to working with you on this effort in the coming months.

Concurrently, we remain committed to advancing interim improvements to the current Medicare hospice benefit, including addressing ongoing workforce challenges, supporting telehealth flexibilities, and promoting access to high-quality care across the post-acute continuum.

NPHI and our over 120 community-based palliative and hospice care providers stand ready to enhance end-of-life care for all Americans. Should you have any questions, concerns, or comments regarding the above information, please do not hesitate to contact NPHI Policy Director, Ethan McChesney, at ethan@nphihealth.org.

Sincerely,

Tom Koutsoumpas

NPHI Founder & CEO





June 2023

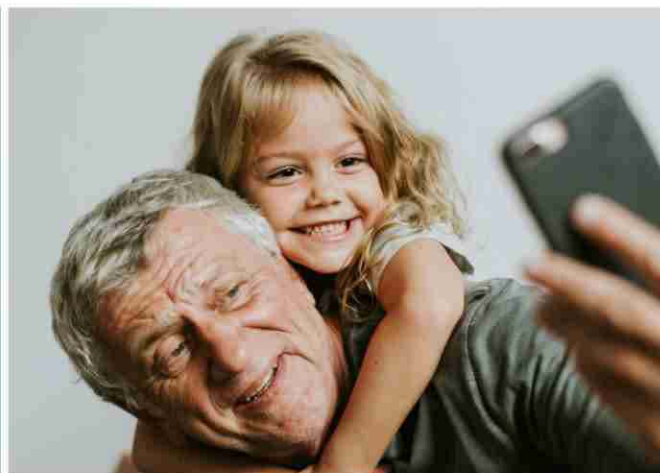


People Over Profits

*A Values-Based Movement
for Declining Health*



National Partnership
for Healthcare and
Hospice Innovation



Partners and Acknowledgements

This blueprint was developed by the National Partnership for Healthcare and Hospice Innovation, in collaboration with Emergence Creative. This project was funded by NPHI's 100+ nonprofit, community-based members across the United States.

Original data presented throughout this document comes from *Views and Experiences of Aging & End-of-Life Care in the US*, an NPHI-led survey conducted by Southeastern Institute of Research in partnership with Emergence Creative.

The caregiver perspectives included in the blueprint come from qualitative research conducted by Innate Motion, in partnership with Emergence Creative. This research, as well as the blueprint release and related materials, were supported by generous funding from our partners at Elea Institute.

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Table of Contents

Methodology

04

Letter from the CEO & President

05



Executive Summary

06



Sections

01 Healthcare for the (Mostly) Healthy 14

02 Navigating Chronic, Serious, & Advanced Illness 20

03 Aging 32

04 Death, Dying, and Grief 40

05 Home 50



Recommendations

54

References

60

Methodology

Qualitative Study¹:

Caregiver Experiences and
Perceptions of Declining Health
(N=31)

Quantitative Study²:

Views and Experiences of Aging &
End-of-Life Care in the US
(N=2,009)

This study is referenced in text
throughout as "NPHI survey."

Literature Review of 100+ Published Sources

Group Working Sessions

Involving 100+
CEOs, Policy Experts,
Healthcare Providers,
and Communications
Professionals

Subject-Matter Expert Interviews

(N=32)

Letter from the CEO & President

For more than 50 years, nonprofit providers who serve patients and families in declining health have built a reputation for delivering elite care in often chaotic circumstances. Across the continuum from illness to aging to end of life, the individuals who do this work every day are nothing short of heroic. Together, they represent the vanguard of a movement to transform healthcare in the United States.

This transformation has never been more urgent and necessary. As this blueprint details, healthcare costs—and profits—keep rising, while outcomes for patients and families grappling with declining health keep getting worse. This is particularly true in the most vulnerable communities, who face greater risks and have less access to treatment. By reimagining care to better address the needs of the most vulnerable, we can improve care for everyone. Community-based, values-driven organizations, like the 100+ members of NPHI, have known this all along.

What unites these organizations is something much deeper than nonprofit tax status—it's about values, vision, and expertise. Only by raising our collective voice and asserting ourselves as the trusted authority on quality care for those in declining health can we fight back against the cynical profit-seeking that threatens our industry. As you will see in the data we have

collected, widespread public distrust of the healthcare system is linked to the financial motives that dictate how that system works.

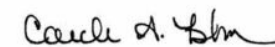
This is only the first step. In the coming months and years, we will advance a shared story that speaks to the concerns of patients, families, healthcare providers, payers, and policymakers. This is our moment, and we will rise to the occasion—together.

Sincerely,



Tom Koutsoumpas

Chief Executive Officer, National Partnership for
Healthcare and Hospice Innovation



Carole Fisher

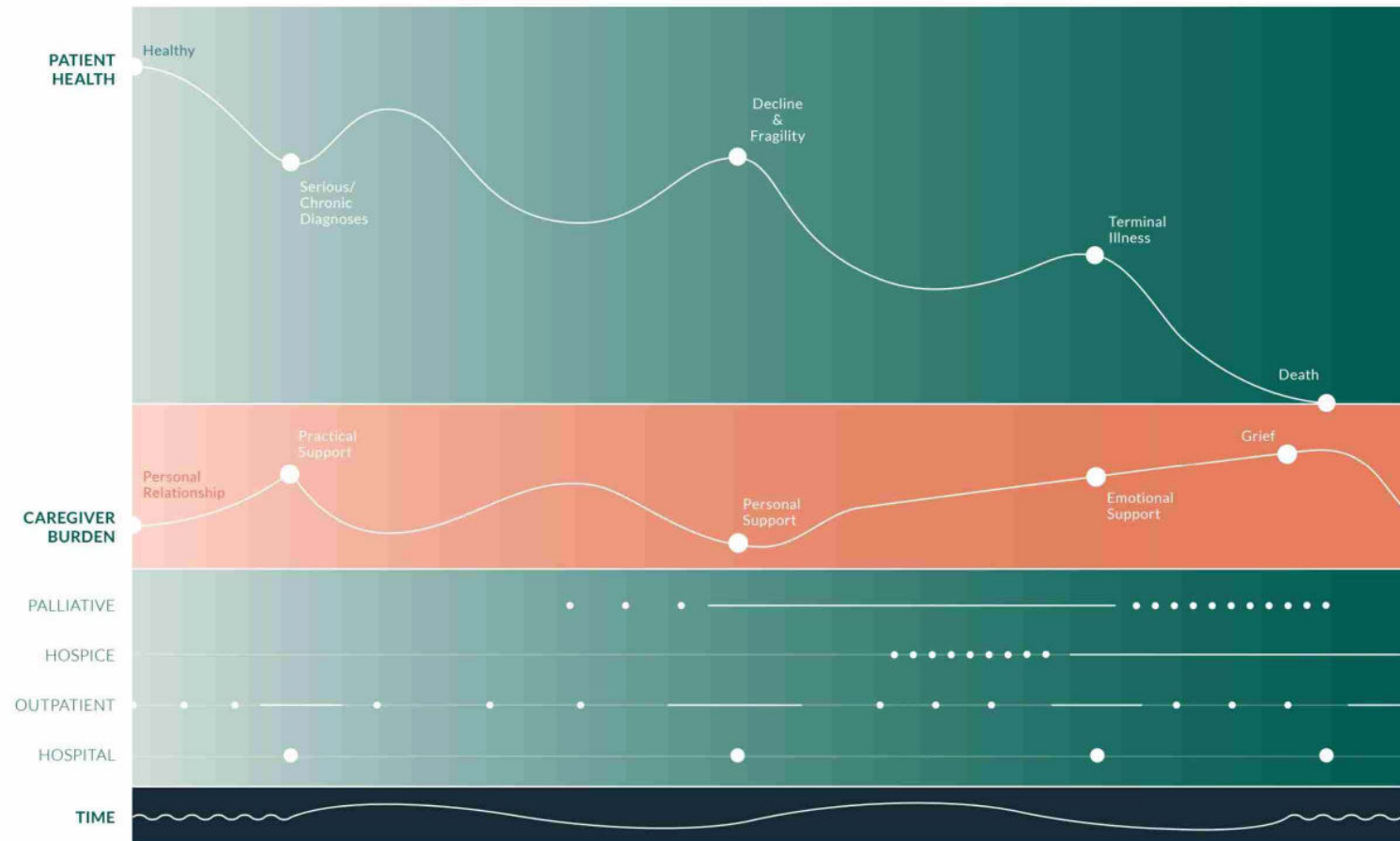
President, National Partnership for Healthcare and
Hospice Innovation

Executive Summary

Good times, bad times

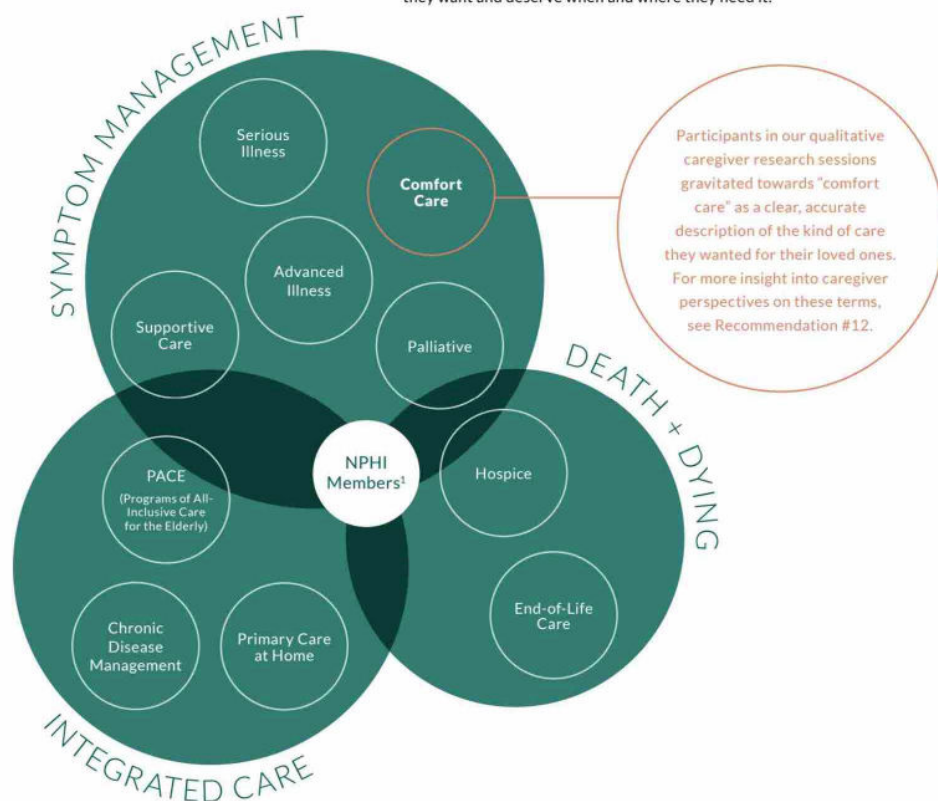
The United States healthcare system is facing a reckoning. A set of interconnected social, demographic, medical, and economic forces are radically reshaping how healthcare works—and doesn't work—in our society. Despite America's reputation as a world-leader in research, innovation, and treatment, health outcomes at the population level are getting worse even as costs soar. The reason for this is not necessarily that people are getting "sicker" or that they are getting "sick" in new ways. Many of the factors that drive high costs and poor outcomes could be managed effectively and efficiently. Instead, our fractured healthcare system often stands in the way of coordinated, comprehensive, human-centered care. Resolving these tensions will require grappling with the experiences and attitudes of the American public—as well as the systemic factors that shape their perceptions. Based on that understanding, community-based, mission-driven organizations can offer a new narrative of what healthcare can and should be.

The Patient Journey



Slipping through the cracks

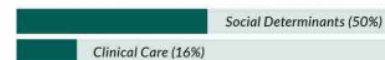
Unsurprisingly, the impact of this flawed system is felt most acutely by those in declining health. Declining health can be understood as an umbrella term that encompasses serious, advanced, terminal, and chronic illnesses, as well as the natural effects of aging. After centuries of progress in medicine, nutrition, and physical safety, it is now the combination of illness and aging that leads to the vast majority of deaths in the US. Accordingly, a variety of models have emerged to address different facets of the aging process and the continuum of illness. This complex landscape produces myriad logistical and bureaucratic challenges and prevents many individuals from getting the kind of care they want and deserve when and where they need it.



The gaps in care become even more stark when we consider the experiences of the most vulnerable communities. From higher infant mortality rates to decreased life expectancy, health disparities between white and non-white communities have persisted for decades, but only recently have these issues begun receiving the public attention they deserve. A wealth of evidence demonstrates that non-white patients experience significantly worse outcomes than white Americans with the same health conditions. For example, African Americans are 30% more likely³ than whites to die prematurely from heart disease, and African American men are twice as likely as white men to die prematurely from stroke.

On top of a long legacy of institutional racism and bias in healthcare, a significant factor in these disparate outcomes is the role of social determinants of health. Issues like access to housing, nutritional foods, and clean air and drinking water are increasingly understood to be drivers of morbidity and mortality that disproportionately affect vulnerable communities. Studies show that social determinants may account for more than 50% of health outcomes,⁴ while clinical care accounts for as little as 16%.⁵

Effects on Health Outcomes



There is growing consensus that social supports have a positive effect on health and well-being and must be integrated with the healthcare system to not only eliminate health disparities, but improve care for the entire population. While there are models and organizations practicing this type of integrated care across the country, our public policy and medical institutions have not fully embraced this evolution in thinking. The US currently spends⁶ only 90 cents on social support for every dollar spent on healthcare, while other industrialized nations spend twice as much on social support as they do on healthcare.

Follow the money

Despite these sobering realities, for companies in the healthcare sector, business is booming. Profits for the healthcare industry are expected to approach \$700 billion by 2025,⁷ with no signs of slowing down.^{7a} What should we make of the immense profitability of the industry and its shortcomings in achieving quality outcomes for those in declining health? A recent survey of the American public found that only 18%² of Americans trust the US healthcare system to put their well-being ahead of profits.



The growth and profitability of the healthcare industry didn't happen overnight. Spending and profits exploded in the post-World War II era,⁸ due to factors like the introduction of Medicare and Medicaid; the growth of the hospital industry; and advances in medical technology, procedures, and pharmaceuticals. Alongside these shifts—and perhaps because of them—the physician workforce has become increasingly specialized, prompting dire warnings about the coming shortage of primary care physicians, especially in rural areas. Without access to a consistent primary care physician, it will become ever more challenging for individuals in declining health—particularly those from vulnerable populations—to find the kind of coordinated, multidisciplinary care they need. Despite a pandemic that had an outsized impact on these populations and a mountain of research detailing the problem, there has been little progress on the kind of systemwide transformation the moment demands.

Past is prologue

Meanwhile, a very different story has unfolded in parallel. Starting in the 1960s, the pioneering work of figures like Dame Cicely Saunders, Elisabeth Kubler-Ross, and Florence Wald gave birth to a new model of healthcare, focused on relieving pain and improving quality of life for the seriously ill and dying. As hospice organizations began to emerge across the US throughout the 1970s and 1980s, almost all were community-based nonprofits. Many of those organizations continue their work today, often with a significantly expanded set of services to meet the needs of a more diverse population and changing clinical realities.

One critical facet of the hospice model with significant implications for the current healthcare environment is an emphasis on providing care in the patient's home. Home-based care aligns with hospice's prioritization of comfort and quality of life, but it also offers care teams crucial insight into social and environmental health risks. Patient preference for home-based care has increased in recent years, accelerated by the COVID-19 pandemic. A recent survey⁹ found that some 70% of Americans over 50 would prefer to receive care in the home, and by some estimates¹⁰ up to 25% of all Medicare fee-for-service and Medicare Advantage spending could shift to home-based care by 2025. With decades of experience delivering quality, home-based care for patients and families with complex needs, nonprofit hospice organizations should be viewed as leaders in this transformation. Yet for all their expertise, compassion, and courage, nonprofits are now facing an existential threat.

Since the passage of the Medicare hospice benefit in 1982, a growing number of new, for-profit companies have entered the space. Some 40 years later, hospice has become the single most profitable sector¹¹ of healthcare in the US. Private equity firms have taken an interest in the space, and the number of for-profit hospices has exploded from 30% of all providers in 2000 to 73% in 2020. While more patients are using hospice services than ever before, the quality and variety of care delivered by for-profits, as well as the

types of patients they serve, differs sharply from nonprofit providers.

The NPHI-sponsored 2019 study,¹² *Hospice Medicare Margins: Analysis of Patient and Hospice Characteristics, Utilization, and Cost* outlined these differences:

Nonprofit vs. For-Profit



These findings were validated by a 2023 review¹³ of more than 650,000 patient and family surveys about experiences with hospice care, conducted by the RAND Corporation. On average, families reported having worse care experiences with for-profit hospices and were less likely to recommend for-profits to their peers. Significantly more for-profits were rated in the low-performing category across all eight measures the researchers studied.

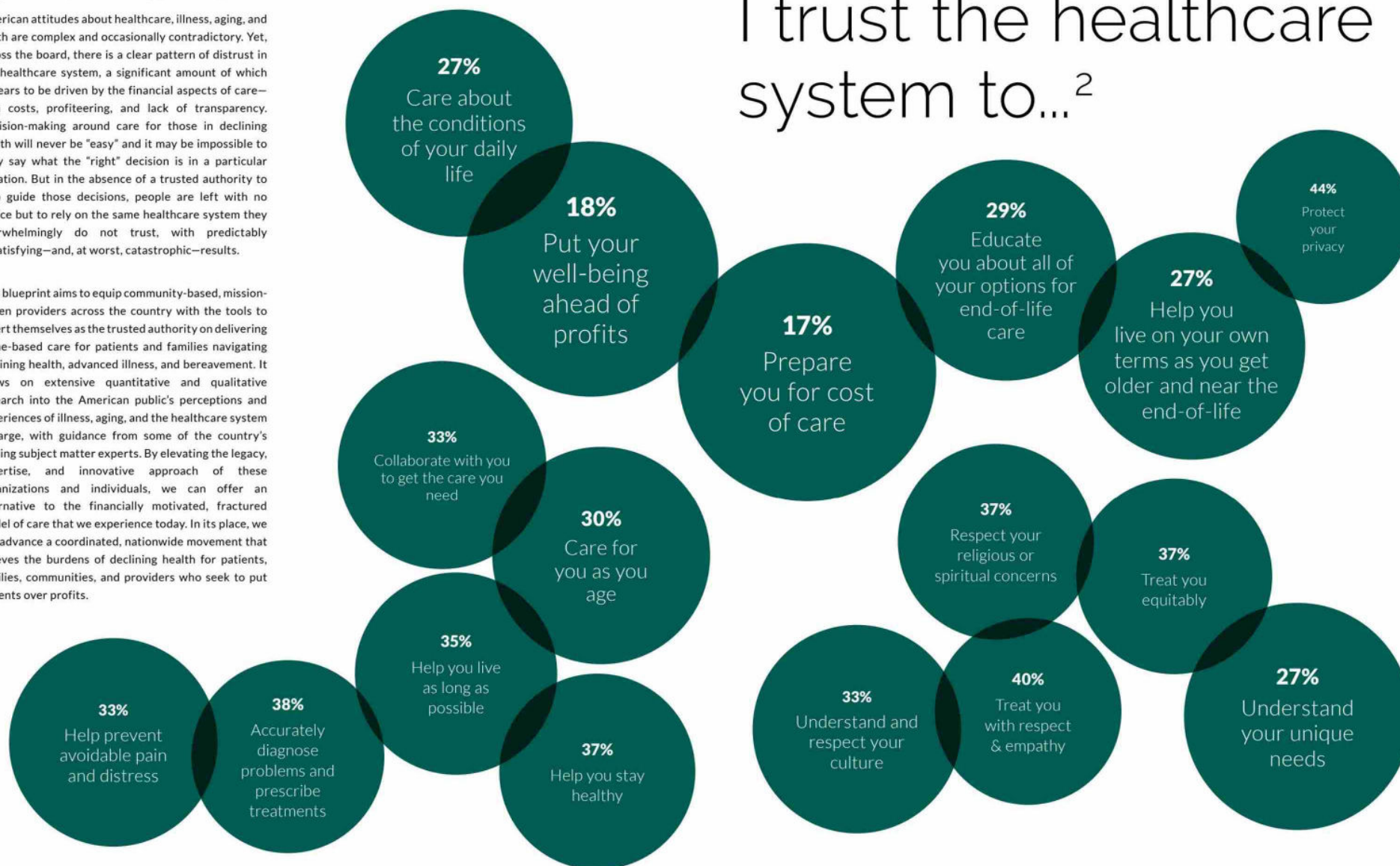
In addition to these important distinctions, the rapid growth of the for-profit industry has coincided with even more alarming trends like outright fraud and abuse targeting both the Medicare hospice benefit and patients. A 2022 *ProPublica* investigation,¹⁴ published in the *New Yorker*, revealed a widespread pattern of potential criminal misconduct that lined the pockets of shareholders and executives at the expense of patients, families, and taxpayers. While these bad actors represent a minority of providers, they reflect a broader trend in healthcare of prioritizing profit over patient well-being.

Urgent need, immense opportunity

American attitudes about healthcare, illness, aging, and death are complex and occasionally contradictory. Yet, across the board, there is a clear pattern of distrust in the healthcare system, a significant amount of which appears to be driven by the financial aspects of care—high costs, profiteering, and lack of transparency. Decision-making around care for those in declining health will never be “easy” and it may be impossible to truly say what the “right” decision is in a particular situation. But in the absence of a trusted authority to help guide those decisions, people are left with no choice but to rely on the same healthcare system they overwhelmingly do not trust, with predictably unsatisfying—and, at worst, catastrophic—results.

This blueprint aims to equip community-based, mission-driven providers across the country with the tools to assert themselves as the trusted authority on delivering home-based care for patients and families navigating declining health, advanced illness, and bereavement. It draws on extensive quantitative and qualitative research into the American public's perceptions and experiences of illness, aging, and the healthcare system at large, with guidance from some of the country's leading subject matter experts. By elevating the legacy, expertise, and innovative approach of these organizations and individuals, we can offer an alternative to the financially motivated, fractured model of care that we experience today. In its place, we will advance a coordinated, nationwide movement that relieves the burdens of declining health for patients, families, communities, and providers who seek to put patients over profits.

I trust the healthcare system to...²



01

Healthcare for
the (Mostly)
Healthy

Peer pressure

Individual attitudes about healthcare in the context of declining health are not formed at the precise moment of diagnosis. They are shaped by a lifetime of experiences—from routine check-ups to treatment for acute needs. On top of those direct lived experiences are external factors, like a friend's anecdote or a news story. In recent years, there has been a great deal of bad press about various aspects of healthcare. Price gouging "pharma bro" Martin Shkreli became one of the most hated people in America overnight, drawing new attention to profiteering in the pharmaceutical industry. In parallel, more than two-thirds¹⁵ of all bankruptcies in the US are now the result of medical debt. COVID-19 did not create the deep structural flaws of American healthcare, but it did exacerbate them and drive a surge in media attention.

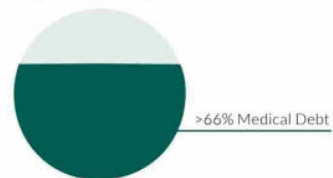
NPHI survey data offers a deeper perspective on the general attitudes of the American public regarding the healthcare system. The word "system" is critical here—opinions about care providers, like doctors and nurses, remain generally favorable, in sharp contrast to the way the public views institutions.

How much do you trust the following?²²



These jarring statistics present a significant opportunity for community-based "safety net" providers to assert themselves as trustworthy institutions that stand in sharp contrast to the perceived shortcomings of both the public and private sectors. Every time a new story is published about price hikes in the pharmaceutical industry or an insurance provider denying coverage for a lifesaving treatment, the public's faith is further eroded. By contrast, providers who care for all patients, regardless of their ability to pay, have a compelling story to tell about their role as "safety net" providers, delivering the best care to those who need it most.

All Bankruptcies in the US

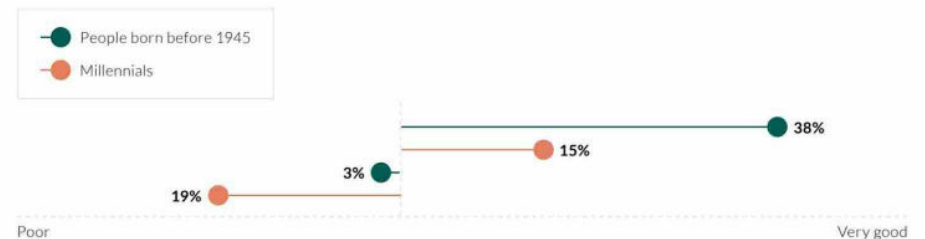


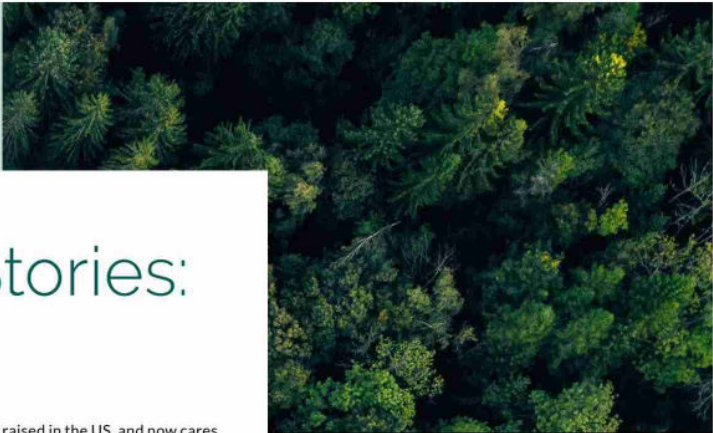
Out of the mouths of babes

Given that younger, healthier individuals have less firsthand experience interacting with healthcare, external influences like media coverage may play an outsized role in shaping how they view the healthcare system at large. Politically, younger people tend to be more critical of institutions than older generations on issues ranging from climate change to criminal justice reform to universal healthcare. It is no surprise, then, that even in the context of generally negative opinions about healthcare, younger generations stand out. NPHI survey data found stark differences in opinion between the oldest and youngest respondents.

This may be explained by a general resistance to the idea of "American exceptionalism" among younger respondents, as well as a greater awareness of injustice and inequality across American society.

While community-based providers in the declining health space tend to have older patient populations, the philosophy and mission that drives these organizations may be appealing to younger members of the community.

How do you rate the US healthcare system overall?²²



Real Stories: Shanu

Shanu was born in India and raised in the US, and now cares for both her parents and her husband's parents, along with her own children. All three generations of the family live together and share responsibility for care of the elderly family members.

For Shanu, the biggest burden comes not from providing care but from the paperwork and bureaucracy associated with insurance and healthcare. Even after living in the US for many years, she is still disturbed by how complex the healthcare system is and how transactional her interactions with it can feel. She sees many of these issues as symptomatic of a broader self-centeredness in American culture, and is quick to contrast this mentality with the more communal, tight-knit culture of families in India. When she's unable to pick up a prescription or drive one of her parents to the doctor, someone else in the family is always ready to pitch in, exemplifying this spirit of shared responsibility.

Balancing her work, family, and caregiving duties is taxing, but Shanu sees it as a privilege to care for her parents just as they cared for her when she was young. Similarly, she knows that her own children are internalizing this philosophy and will care for her in old age, continuing the circle of life.

Just like it takes a village to raise a child, it takes a village to make the elderly comfortable...but this culture is not a village. Our village in America sucks, it's been burned down.

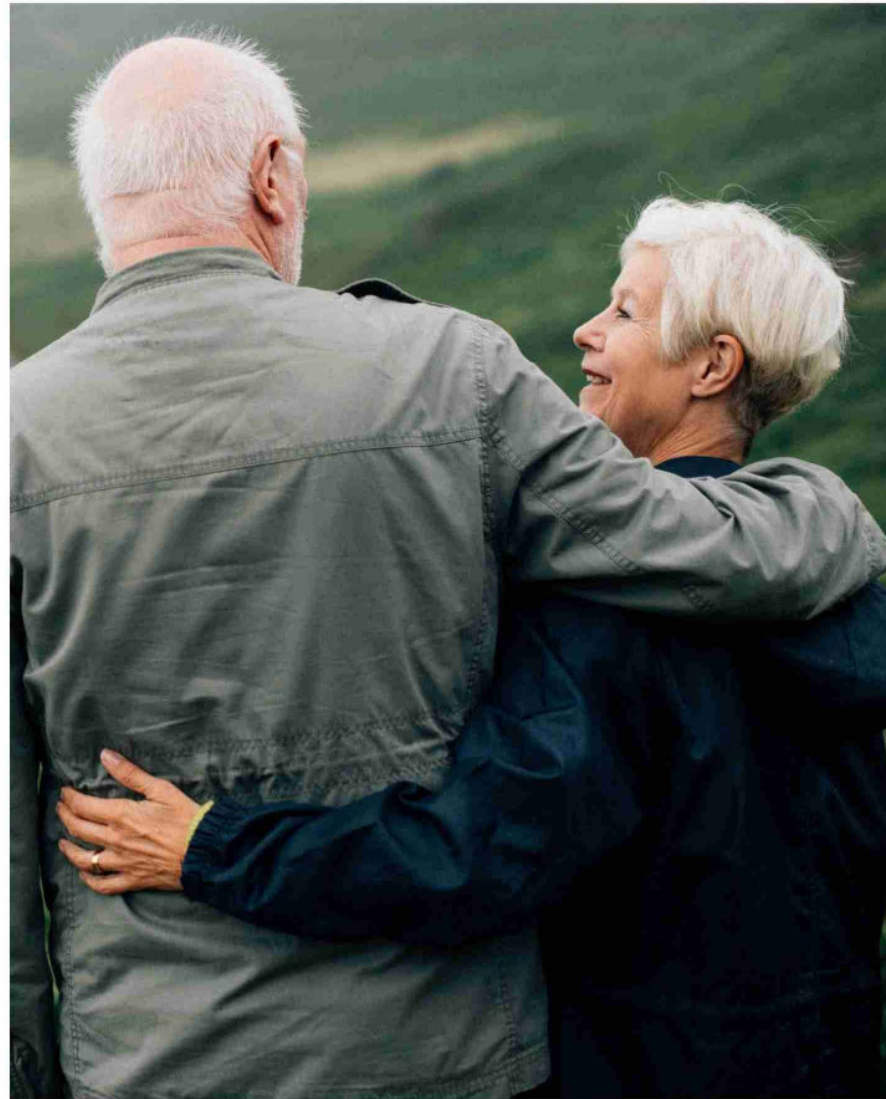
United we stand, divided we fall

Pinpointing the primary source of the public's skepticism of the healthcare system is not challenging—it's about money. A 2022 NPHI survey probed on trust of the healthcare system in general, but also looked at how much the public trusts that system across a variety of more specific areas, from privacy to quality of care to respecting an individual's culture. The two lowest-rated categories both relate to financial aspects of care.

How much do you trust the US Healthcare System to...²

18% Put your well-being ahead of profits

17% Prepare you for cost of care



These dismal numbers only tell part of the story. When examining the views of uninsured populations, the results are even more striking. Nearly 80% say they don't trust the healthcare system to accurately diagnose and treat conditions or prevent avoidable pain and distress. One could argue that accurately diagnosing and treating conditions, as well as preventing avoidable pain and distress, are among the most fundamental tasks of healthcare. If the system can't be trusted to perform these functions, something is deeply broken.

As noted in the Executive Summary, many of the factors driving poor health outcomes stem not from healthcare itself, but from social determinants of health. Data has shown that housing instability¹⁶ and food insecurity¹⁷ affect 10-15% of the population, and those factors are independently associated¹⁸ with health outcomes like postponing medications or medical care, emergency department visits, and hospitalizations. To truly address issues of trust in healthcare, it will be essential to account for related social and economic factors.

Support for resources like housing, food, and transportation is often accessible only through a patchwork of means-tested programs, which often involve onerous, bureaucratic processes. As in the case of healthcare, there are thousands of local service providers in communities around the country working to fill the gaps against immense odds. Similarly, mission-driven organizations that care for those in declining health, following the original hospice model, place great emphasis on social, behavioral, and emotional considerations. This is a significant point of differentiation from the narrower medical model pursued elsewhere in the healthcare system, and lays the groundwork for natural alliances among values-aligned health and social service providers in communities around the country.

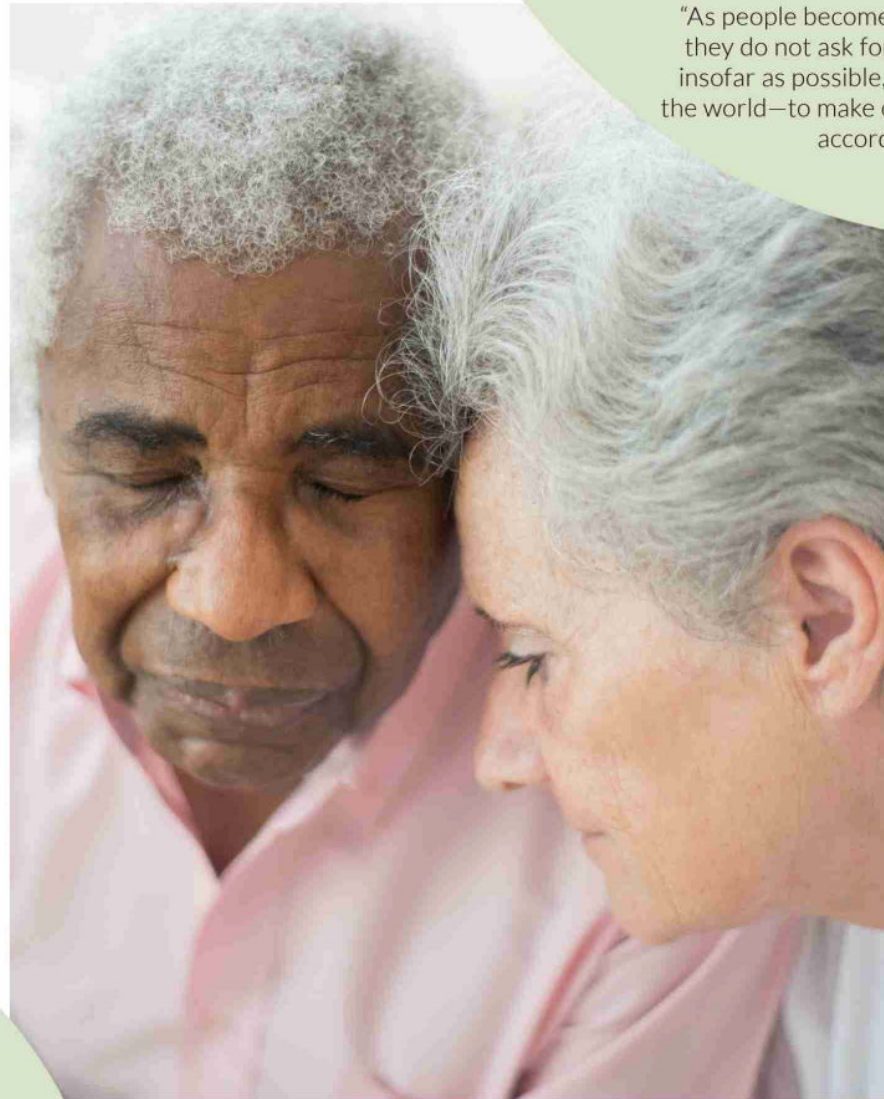
02

Navigating Chronic, Serious, and Advanced Illness

An 85 year-old living with dementia. A 65 year-old managing cardiovascular disease. A 45 year-old diagnosed with advanced cancer. A child born with a congenital heart defect. Being diagnosed with a serious or chronic illness is a profoundly disorienting experience at any age. Despite the distinct pathology of different conditions, reckoning with a drastic shift in health status causes a break in one's sense of self. We all have an internal narrative, a story we are constantly writing about who we are as human beings, and with a change in physical or mental circumstances, that narrative can collapse—this is not what was “supposed” to happen. For both the patient and their loved ones, real support is about something bigger than treatment. It's about conceptualizing what a new story can look like, and having the courage to write it.

“I cannot make you understand.
I cannot make anyone understand
what is happening inside me.
I cannot even explain it to myself.”

Kafka, *The Metamorphosis*



“As people become more aware of the finitude of their life, they do not ask for much... They ask only to be permitted, insofar as possible, to keep shaping the story of their life in the world—to make choices and sustain connections to others according to their own priorities.”

Gawande, *Being Mortal*

In the context of serious illness, the idea of “care” is often synonymous with “treatment.” Disease is a problem to be solved, not a state of being to be understood, processed, and managed. As physician specialization has accelerated over the past 50 years, the healthcare system has gotten better at treating the illness, perhaps to the detriment of caring for the patient. The exception to this is the field of palliative medicine, which offers a more holistic view that focuses on the human being with an illness, rather than just the illness. There is broad recognition in the medical community of the value that palliative medicine can have. In 2008, the American Board of Medical Specialties (ABMS) began offering board certifications¹⁹ in hospice and palliative medicine across 10 different subspecialties—“the first time 10 ABMS member boards have collaborated to offer certification in one area.”

Such broad recognition of the value of palliative medicine has had mixed results. One analysis²⁰ found that acceptance of palliative medicine has increased to the point where 85% of medium to large hospitals now have palliative medicine teams present. Yet, the same paper used survey data of current palliative medicine practitioners to warn of a looming shortage of palliative specialists, with “19% [of providers] expressing a 50% or higher chance of leaving the field in 5 years, 47% intending to leave in 10 years, and 66% leaving in 15 years.” Low reimbursement rates for palliative medicine result in less competitive salaries, which drives more new medical school graduates towards other specialties. Against the backdrop of an aging population with ever more patients managing multiple chronic, complex, serious health conditions, this projected shortfall should be cause for alarm.

Real Stories: Corrina

Corrina is a young Black woman who cares for her aging mother, now in the final stages of lung cancer. On top of being a caregiver, she's balancing school, work, and motherhood, leaving her with very little time for herself.

When Corrina's mother was initially diagnosed with cancer, she refused treatment and didn't tell anyone in her family about it. Only when her condition worsened and she became visibly frail did Corrina and her brother learn of their mother's illness. As a Black woman, Corrina's mother deeply distrusts the healthcare system, which influenced her decision to forego aggressive treatment for her cancer. She was adamant about not wanting to be in a hospital, but her home was not wheelchair accessible and as her condition worsened, Corrina had no choice but to admit her anyway.

The guilt over this decision haunts Corrina, and she's highly vigilant about the quality of care her mother gets and the compassion of the hospital staff. She's able to find inspiration in her young son and talks about the importance of celebrating life and accepting death, but also knows from past experience that the grief may stay with her long into the future.

“

I learned from my mom that being African American and female, automatically we don't feel like we're getting the top treatment.

”

Hope for the best, plan for the worst

As disorienting as a diagnosis of serious illness can be, it's something the majority of Americans have given at least some thought to.

The challenge, of course, is that it is impossible to truly think through what it will be like to have a serious illness until it happens. Further complicating matters is the well-documented difficulty of providing an accurate prognosis. The groundbreaking research of Nicholas Christakis has highlighted the tendency of physicians to be overly optimistic in their predictions of life expectancy, in particular among oncologists. Aside from the clinical difficulty of accurately determining prognosis, there is a deeply human factor at play here. No one wants to be the bearer of bad news, yet looking at actual patient preference is instructive.

While it is unsurprising that, given the choice, the majority of Americans would prefer both honesty and hope, it's striking just how few seem to prioritize hope over honesty. Concluding that physicians need to be more forthright with patients navigating declining health is easier said than done.

How much have you thought of the following...²

● A great deal
 ● Some
 ● Not very much
 ● Not at all

How you would pay the costs of medical care and other services you or another family member might need as they age

32	43	18	7
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Your own wishes for medical treatment if you were to become seriously ill

31	47	18	6
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Who would help care for you or another family member if someone became seriously ill or needed special support

32	46	17	7
----	----	----	---

56%

Both

36%

For their doctors to be completely honest when there is little chance of recovery

When a patient is seriously ill, which of the following do you think is more important?

3%

Not sure

3%

For their doctors to emphasize hope

1%

Neither

Worse outcomes, less trust

Vulnerable populations face both greater risk of developing certain serious and chronic illnesses, as well as worse outcomes from those conditions. The factors driving these disparities are complex—from a lack of preventative care to the influence of social determinants—and earlier, more sustained engagement of palliative medicine would have distinct benefits in these populations. It is impossible to talk about the future of healthcare in the US without centering the experiences of vulnerable populations. “By the year 2044, [minorities] will account for more than half of the total U.S. population, and by 2060, nearly one in five of the nation’s total population will be foreign born.”²³ Alarmingly, insofar as certain disparities have decreased in recent years, the cause is often a decline in the health of majority groups, rather than improvements in minority health. By reimagining healthcare to be responsive to communities with the greatest health needs, we can elevate the quality and accessibility of care for all.

“Racial and ethnic disparities are arguably the most obstinate inequities in health over time.”

*Communities in Action*³

Along racial and ethnic lines, the interplay between trust in the healthcare system, proactive health management, and development of chronic disease is a major driver of disparate outcomes. NPHI’s survey data² showed that about 1 in 5 Americans actively avoid healthcare unless it is absolutely necessary. Among Black respondents who avoid healthcare, some 76% say it is because the healthcare system does not treat their racial or ethnic group well (compared with only 23% of white respondents). This finding aligns with studies showing that Black and hispanic patients receive fewer primary care visits and preventive health measures, like cancer screenings and flu vaccines.

Lower rates of primary care utilization in these communities, along with environmental factors like access to nutritious food, contribute to higher incidence of chronic diseases. This is particularly noteworthy with respect to conditions related to obesity, such as diabetes and heart disease.

- 47%²¹ of Black adults have been diagnosed with cardiovascular disease, compared with 36% of white adults.
- Black adults are 30% more likely³ than whites to die prematurely from heart disease.
- Black men are twice as likely as white men to die prematurely from stroke.
- Hispanic women are more than twice as likely as white women to have diabetes.
- American Indians are three times more likely than whites to have diabetes.

Black Americans also face higher risk and mortality for certain types of cancer. The death of actor Chadwick Boseman at age 43 highlighted the elevated risk for colon cancer in the Black community, prompting discussion about the importance of earlier screenings for at-risk groups. It is noteworthy that overall incidence of colon cancer among younger people is also on the rise. Focusing on improving screening practices and treatment for the highest-risk communities is about more than justice—it’s about improving outcomes for the entire population.

As it pertains to palliative medicine, one well-documented form of health inequity is treatment for pain. A 2016 study²² found that black patients were half as likely to receive pain medication as white patients reporting the same symptoms. There are similar disparities in pain treatment related to gender. Women may be perceived as less tolerant of pain and more likely to exaggerate it, resulting in undertreatment. For example, pelvic pain, a common cause of pain among women, goes untreated in one-third of all cases.

Compounding these trends is a lack of awareness of palliative medicine among non-white communities. One study of adults in California found that three-quarters of black and hispanic patients had never heard of palliative care, compared with only half of white patients. Access to and utilization of palliative consultations varies widely by institution, but lack of awareness, unequal treatment of pain, and higher incidence of serious illness all suggest that non-white communities would benefit from better integration of palliative approaches. A recent mixed-methods study²³ found that “[Minority] patient and family caregivers revealed positive experiences with palliative care but demonstrated experiences of discrimination in health care before referral to palliative care.”





In addition to racial and ethnic disparities, rural populations are also vulnerable to unequal access to care. One study³ highlighted a disconcerting trend: "...after a period of steady decline over decades, rural counties are experiencing an increase in the number of premature deaths." The same study found that, compared with urban residents, "...rural communities have higher rates of preventable conditions (such as obesity, diabetes, cancer, and injury), and higher rates of related high-risk health behaviors (such as smoking, physical inactivity, poor diet, and limited use of seatbelts)."

As in the context of racial disparities, awareness and comprehension of what palliative medicine is and can offer are significant factors in underutilization of these services in rural communities. Conflation of palliative and hospice—among physicians and patients—fuels the perception that introducing palliative medicine means that the physician has "given up" and death is near. That association has also contributed to the proliferation of terms used to describe palliative programs: serious/advanced illness care, symptom management, supportive care, etc. Improved education of the general public and healthcare providers are essential to bringing the benefits of palliative medicine to more patients across the continuum of care.

The barriers to wider access to palliative medicine extend far beyond individual attitudes and perceptions, however, particularly in the rural context. In one qualitative study²⁴ of rural palliative practitioners in Indiana, participants cited poor compensation, lack of outpatient resources, and logistical challenges of following up with patients who live in remote areas. Thus communities with some of the highest need for palliative services may be least able to access those services.

Pediatrics: a unique challenge

In the pediatric context, many of the same barriers to wider utilization of palliative care hold true, but there are also a number of factors that make this population distinct.

In response to these diverse needs, significant strides have been made in recent years to increase the availability of specialized pediatric palliative care programs in both inpatient and outpatient settings. A review²⁵ focusing on implementation of palliative care in the pediatric oncology setting found that children who received specialized palliative care "...had improved symptom burden, pain control, and quality of life with decreased intensive procedures, increased completion of advance care planning and resuscitation status documentation, and fewer end-of-life intensive care stays with higher likelihood of dying at home. Family impact included satisfaction with SPPC and perception of improved communication."

Of particular importance for policymakers and payers are the potential financial savings associated with more proactive use of palliative care. A pilot²⁶ program in California reported the following results:

PER ENROLEE PER MONTH HEALTH CARE COSTS DECREASED BY

\$3331

INPATIENT COSTS WERE REDUCED BY

\$4897

Despite these massive individual and systemic benefits, palliative medicine remains a comparatively poorly-compensated specialization, limiting the number of trained providers. Current reimbursement mechanisms have also hindered the uptake of such programs, particularly in the outpatient or home-based setting. Community-based organizations that serve the needs of declining health are well-positioned to advocate and provide more consistent, comprehensive, and high quality care for pediatric patients with serious illness. Part of that mission requires educating payers and policymakers about the medical, personal, and financial benefits of palliative medicine.

Pediatric palliative care pilot program found...



"Pediatric patients...live with and die from a wide array of often-rare diseases that require specialized care; the trajectory of their illness experiences is often either much shorter or far longer than that of adult patients; the child is always cared for in the context of a family, which also needs support and often care; the mechanism of financing health care in general and palliative care specifically is different for the young versus older adults."

NIH Report²⁷



Why her? What did she do?
...You can't plan these things.
There's no rhythm, no rhyme,
no method... Sometimes our
responsibilities choose us.

Real Stories: **Delilah**

Delilah is a writer and event planner from Mississippi, who lost her daughter after a difficult series of health issues that began when her daughter was a child. Just as her daughter was nearing the end of her life, Delilah's husband was diagnosed with Parkinson's, so her caregiver journey continues.

When her daughter was only 8 years old, she developed brain tumors, which were treated but then reappeared every few years until she died. While struggling with the intensive treatment the tumors required, she also developed severe obesity and diabetes, which further complicated her prognosis. A self-described "hardass," Delilah was outraged when nursing homes refused to admit her daughter because of her age and size. Finally, after both her daughter and her husband had a series of falls at home, she knew she couldn't care for them both on her own. She was able to get her daughter into a nursing home, and then reluctantly contacted a local hospice agency when it was clear that she was declining. Immediately, she was blown away by the understanding and comfort provided by the hospice team, and she regrets not contacting them sooner.

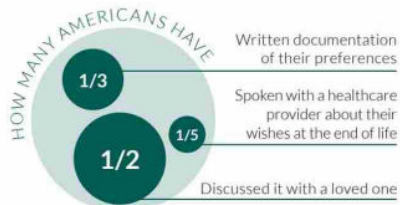
Now, as she contemplates her husband's declining health, she says she's learned to be more patient and accepting of what she can't control. As painful as the loss of her young daughter was, it taught her to be more present and to focus on the time she and her husband have together.

03

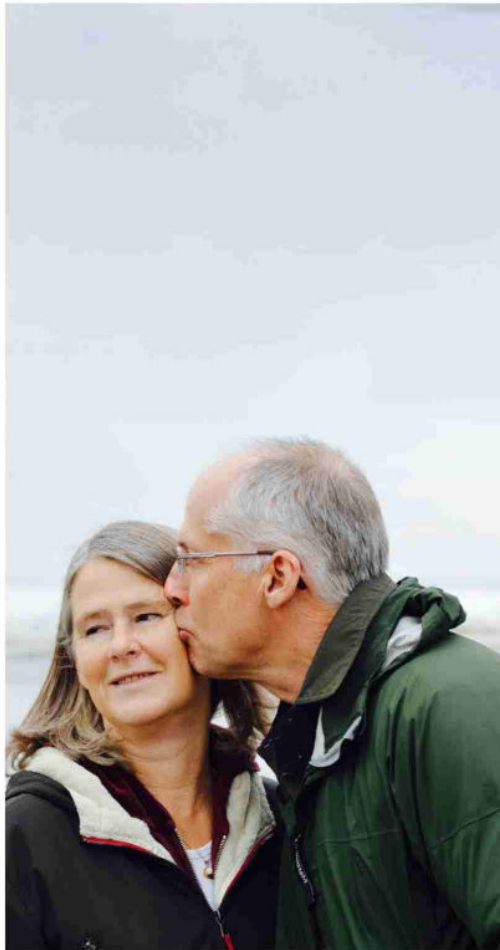
Aging

You're only as old as you feel

Like illness, the experience of aging can be profoundly disorienting, and is unique to every individual. Aphorisms like "40 is the new 30" or "70 is the new 50" illustrate the subjectivity of what it means to age or "become old." In fact, research²⁸ has demonstrated that as we get older, our perception of our age tends to lag behind our actual age. It's no surprise, then, that decisions about the changing conditions of a person's life—such as moving into a retirement community or assisted living facility—are inherently fraught. In American society, the absence of robust community-based social and personal support for people who are aging, coupled with the increasing precarity of housing for much of the population, have left healthcare institutions "holding the bag" for care of the elderly. It's hard enough to admit we need help with activities that were once second-nature. When the only option for support involves the healthcare system, with all of its baggage and public distrust, it's no wonder so many Americans resist making plans and taking action to prepare for aging and declining health. According to NPHI survey data²:



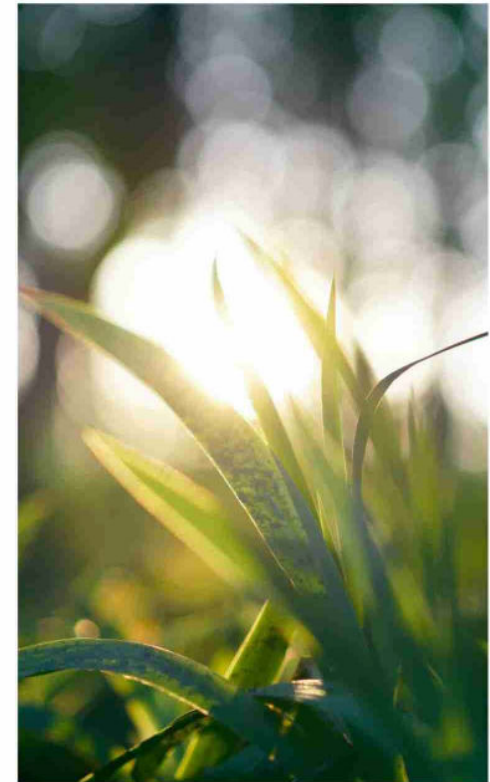
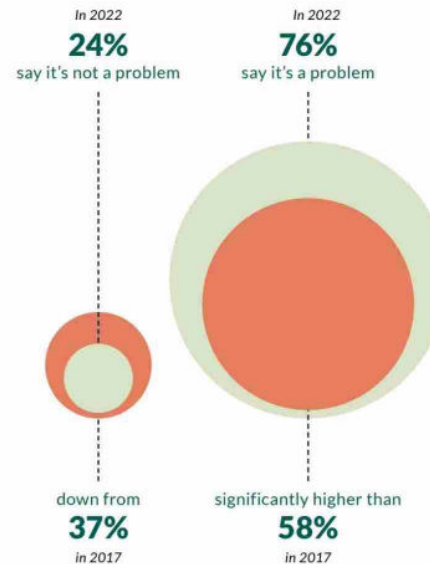
Yet, perhaps paradoxically, the same survey showed that a majority have given at least "some thought" to key questions about care they might need as they age.



Similarly, the survey findings demonstrate that beyond an individual awareness of their own aging, most respondents are broadly aware that the US population at large is aging—and they're concerned. What's more, data suggest that the population is becoming ever more concerned about the age wave. Comparing the recent NPHI survey with the 2017 Kaiser Family Foundation study that was used as a model, we see a noteworthy trend.

In summary, we can see that Americans are aware of the realities and challenges of aging, both as individuals and as a society. But translating that awareness to consideration and action remains one of the signature challenges facing healthcare providers who serve aging populations. A key factor, yet again, is trust. Only 30% of NPHI survey respondents trust the healthcare system to care for them as they age, and the number drops to 10% for uninsured respondents.

How much of a problem, if at all, is the growing number of older people in the US?



Health is only part of the picture

To build a healthcare system that is more responsive to the needs of an aging population, it is critical to look at the specific facets of aging that cause the most concern. Breaking down the NPHI survey data below, we can identify a number of key insights.

Top Concerns About Aging



Individual fears, concerns, and experiences vary widely, but from these insights we can identify a few key strategies that are cross-cutting. Significantly, these strategies are already being practiced by mission-driven hospice and declining health providers around the country: home-based care, consideration of social determinants of health, and emotional, interpersonal, and spiritual support.



Aging in place

As has been noted previously, the vast majority of older Americans exhibit a clear preference for remaining at home as they age. This is unsurprising—home is where we feel most comfortable and safe. Yet, for increasing numbers of Americans, including those in older age ranges, having a stable, safe, place to live is becoming more challenging. Jennifer Molinsky, a researcher focused on housing for the aging population, noted²⁹ that, "Over 10 million households headed by someone 65 and over are cost burdened (paying more than a third of their income on housing); half of these pay more than 50 percent." Housing shortages and high prices represent a nationwide crisis across all age demographics, and for older adults, these financial burdens have a significant impact on health and well being.

On top of rising housing costs, financially-strapped older Americans may struggle to afford needed healthcare, foregoing medications or preventive visits to save money. A recent federal report³⁰ found that some 5 million Medicare beneficiaries struggle to afford their prescriptions, with Black and Latino adults over 65 being 1.5 to 2 times more likely to report difficulty

affording prescriptions. The cumulative impact of such experiences, alongside the multifaceted influence of social determinants of health, contribute to the close correlation of life expectancy with wealth or poverty. By some estimates³¹, the gap in life expectancy between the richest 1% and the poorest 1% of Americans is 14 years for men and 10 years for women.

Even for better-off Americans who can afford stable housing, aging at home is not necessarily safe or practical. One analysis²⁹ found that "less than 4% of homes offer a no-step entry, single-floor living, and wide enough doors and hallways to accommodate a wheelchair." The limited stock of such homes, and the high cost of renovating one's home to be more accessible, represent significant barriers to enabling more of the population to safely age at home. These challenges also point to the urgent need for greater access to quality, home-based care, which can help mitigate risks so that residents can remain in place for as long as possible.

Real Stories: Suzy

Suzy is a devoted caregiver for her 96-year-old mother, who has been in and out of the hospital repeatedly as her health has declined in recent years. As challenging as the experience has been, she is unequivocal in her view that being a caregiver is a privilege, not a burden.

The practical and emotional difficulties that come with her role as a caregiver pale in comparison to her frustrations with the healthcare system and the staff members she interacts with. She speaks forcefully about the clear influence of money on healthcare, perceiving that the demands of seeing more patients with fewer staff members inevitably leads to a lack of empathy and compassion. Notably, she emphasizes that these issues have gotten significantly worse in recent years, and patients and their families have little power to change it.

An outspoken advocate for "elder respect," she is meticulous about putting up pictures of her mother in the hospital room to remind staff that she is a human being. Still, her overall experience has felt transactional and dismissive, at a time when dignity and compassion should be top priorities.

We're treated as transactions and disposable, and I think your Mom or your grandfather or whoever, they deserve better. We all deserve better because we're going to be in that position, too. That coldness, that dismissal is just really prevalent.



It takes a village

In addition to basic architectural considerations related to aging in place, a lack of cohesive, community-based support puts older Americans at even greater risk. Given the massive role that social determinants of health play in influencing health outcomes, it is critical that individuals who are aging at home have access to support for nutrition, transportation, and physical activity. Institutions like assisted living facilities account for many of these needs in their basic operational models, but given that the vast majority of Americans would prefer to remain at home, it is critical to bolster the availability of such services in the community. Currently, older Americans are forced to choose between the risks of living on their own terms at home and the safety that institutions can offer. Community-based support services offer a way out of this binary.



On top of the more straightforward benefits of services like meal delivery, community-based services for adults who are aging in place can also help combat isolation and loneliness. The National Academy of Sciences³² detailed the striking associations between isolation and loneliness and adverse health risks.

- About a quarter of adults over 65 are socially isolated, and nearly 50% report feeling lonely.
- Loneliness was associated with a 59% increased risk of functional decline and a 45% increased risk of death.
- Social isolation was associated with a 50% increased risk of developing dementia.

The paradox is that the individuals who are most isolated and at highest risk are, by definition, most likely to go unnoticed in the community. Without strong social and community ties, many older adults, particularly those with chronic health conditions that limit their mobility, may languish in their homes, disconnected from the kinds of support that might be most valuable. The National Academy of Sciences report notes, "nearly all persons who are 50 years of age or older interact with the health care system in some way...so this interaction may serve as a touchpoint to identify those who are isolated or lonely." This observation aligns with other research that has linked isolation with increased hospital readmissions and Medicare expenditures (though data on these points is mixed). Given the clear impact of isolation on health outcomes, and the healthcare system's unique position to intervene, it is critical that social connection be prioritized in support services for aging populations.

Researchers⁵ have indicated that so-called "social prescribing" can be a valuable tool for intervening in cases of social isolation: "[social prescribing] is believed to result in better social and clinical outcomes for people with chronic conditions and their caretakers, [and] a more cost-efficient way to use health and social care." Yet, translating this recommendation into action has remained challenging. First, although social isolation may be associated with greater Medicare

expenditures and increased hospitalizations, other research suggests that high-risk, isolated populations may be less likely to use preventive healthcare, such as primary care visits or routine screenings. As a result, the patients who would benefit most from social prescribing in the primary care context may be hardest to reach.

Perhaps more importantly, the National Academy report notes that "...despite the promising nature of many community-based programs, this type of support often remains underused due to the weak or nonexistent link between health care practitioners and community-based services." A significant exception to this trend are "safety net" healthcare organizations that serve the needs of declining health and aging populations. Mission-driven hospices, specifically, tend to have deeper community ties, and may therefore be better equipped to connect high risk patients with community-based social support. One study³³ of 203 US hospice organizations (80% of which were nonprofit) found that more than 80% reported using internal funds to pay for non-clinical services not covered by Medicare. The most commonly reported expenses were for food, utilities, shelter, and funeral costs. Beyond paying for such support directly, the vast majority of these organizations "reported collaborating with community agencies to help patients and families to access available resources to obtain a similar range of basic necessities and services."

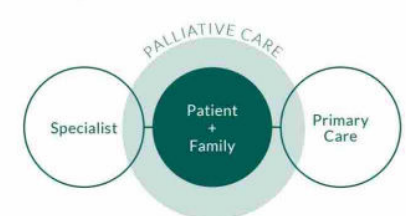
Another key facet of the nonprofit hospice model is the significant role that volunteers play. Given the largely charitable, volunteer-based roots of the hospice movement, the Medicare hospice benefit stipulates that volunteers should deliver 5% of total care hours. While many nonprofit providers that began as hospices have broadened their service lines to provide care for non-hospice patients, the presence of volunteers remains integral. These volunteers offer a wide range of non-medical services, from transportation to music and pet therapy to death doula programs. Such services have direct value for patients, caregivers, and families, but they also illustrate the deep ties nonprofits tend to have to the communities they serve. Because almost



all of the original hospices in the US were nonprofit, such organizations have often been operational for significantly longer than more recent for-profit competitors. The longevity of nonprofits has enabled them to develop deep roots in the community, and strong volunteer programs are a testament to that presence.

Hospice and end-of-life care will be discussed in more detail in the following chapter. However, it is critical to note that many hospice organizations have vastly expanded their service offerings across the care continuum, indicating that aging populations could benefit from engagement with community-based providers as a complement to their primary care and specialist teams. The multidisciplinary approach such organizations offer, alongside their deep connections to community support services, have significant potential to reduce isolation, address social determinants, and improve health outcomes.

Integrated Care



04

Dying, Death,
and Grief

As challenging as aging and illness can be, nothing about human existence is more fundamentally incomprehensible than death. No matter one's religious or spiritual beliefs—or lack thereof—few of us can ever truly conceive of what it means to die until we're directly confronted with the possibility. This is a uniquely modern problem—the proportion of people who die suddenly or accidentally continues to shrink. And while that's a credit to modern safety regulations, hygiene, and medical advances, it's had the unintended consequence of forcing us to contemplate something we're by and large either unwilling or unable to truly process. Significantly, what people fear most about death is not death itself, or the afterlife, but how their death will affect others—financially, emotionally, practically. The grief of loved ones left behind, in other words, may be more painful to think about than our own needs.

“Life is pleasant.
Death is peaceful.
It's the transition
that's troublesome.”

Isaac Asimov

As life expectancy has increased and treatments for a variety of ailments, and even aging itself, have become more sophisticated, the experiences of declining health and death have become increasingly medicalized. While medicine has much to offer, it has not solved the fundamental reality of mortality. There will always come a point at which the potential for cure or recovery goes from slim, to remote, to non-existent. Physicians, particularly in certain specialties like oncology, may be reluctant to accept this diminished chance at a cure. As human beings, physicians feel invested in each patient's case, and as physicians, they are trained to use their knowledge to “solve” discrete problems. As a result, they are comfortable describing additional therapeutic options, or clinical trials a patient could join, but they are less comfortable accepting the reality of decline and death.

The role of physicians, and the healthcare system more broadly, in counseling patients about their options at the end of life is massive. In NPHI's survey,² about two-thirds of respondents said they would be comfortable talking about their end-of-life care wishes with a doctor or healthcare provider—more than spouses, priests and spiritual advisors, or other family members. About 75% of respondents believed Medicare should cover such conversations, yet only 14% reported having had a conversation with a healthcare provider about their end-of-life wishes and only 29% have documentation of their wishes.

These data points indicate a willingness to talk about death, and a desire to have such conversations in a healthcare context. Yet, simultaneously, we see very little follow-through to action, with the most commonly cited rationale being “I haven't gotten around to it” (56%). Part of the explanation appears rooted in the central theme of distrust. Even as most respondents report relatively high trust in doctors and nurses as individuals, they remain overwhelmingly distrustful of the healthcare system, particularly in the context of end-of-life care.

Deciding what matters

In order to improve the frequency and value of end-of-life planning conversations, it is essential to understand the specific concerns patients have. Asked what concerns them most about their own death, NPHI survey respondents rated “how my loved ones will be affected” (59%) and “missing the lives and events of others” (51%) highest, well above other options like “whether there is an afterlife” (28%) or “what will happen to my body after I die” (20%). Similarly, asked what is most important to them at the end of life, we see an emphasis on loved ones.

Significantly, the single lowest-rated factor surrounding end of life was “living as long as possible.” A related question takes this insight a step further—only 13% of respondents said that “preventing death and extending life” should be the most important task for healthcare at the end of life. Of course, in a perfect world, we'd all

Thinking about the circumstances that might surround the end of your own life, how important is each of the following to you?

84%

Making sure family is not burdened by tough decisions about your care

83%

Making sure family is not burdened financially by your care

64% (Lowest-Rated)

Living as long as possible



want to live "as long as possible," but when considering the end of life, individual priorities appear to shift towards the impact on others, as well as comfort (85%) and peace (85%).

Another area that respondents place great emphasis on is where they will die.

The widespread preference for receiving care in the home and remaining at home throughout the aging process has been discussed throughout this document, and will be explored further in the next section. This preference for the "comforts of home" applies equally to the end-of-life context.

Where would you prefer to die? Where do you think you are most likely to die?

Only 6% would prefer hospital...

...but 14% think they will

35% are not sure where they think they'll die

58% would prefer to die at home

but only 31% think they will



The original architects

As utilization of hospice care has risen in recent decades, public awareness of hospice has accordingly risen as well. According to NPHI's survey data,² 96% of respondents have at least heard of the term. Among respondents who have at least some familiarity, hospice is regarded favorably by three-quarters and, interestingly, there is a strong correlation between degree of familiarity and favorability ratings.

Percent selecting "5 – very positive" opinion on hospice care



Such positive responses may conflict with the experience of some hospice professionals; anecdotes from interviews with those working in hospice often portray the word itself as triggering, and many go to great lengths to avoid mentioning "the h-word" in front of patients and families. A possible interpretation of this disconnect is that the moment hospice is introduced to a family is inevitably a moment of crisis, fear, confusion, or despair—particularly when, as is often the case, hospice referral happens in the final days of life. No matter how enlightened or open minded a patient and their loved ones might be about the prospect of death, the event itself remains tragic. Reflecting on the experience after the fact, families may be more likely to view the experience positively, which would explain the connection between firsthand experience, familiarity with hospice, and high favorability. Indeed, another common experience reported by hospice workers is families telling them, "I just wish we had called sooner."

Even as hospice utilization has increased nationwide, notable disparities exist between white and non-white communities. A 2020 Johns Hopkins study³⁴ found that:

"34.9% of Black study participants who died used hospice services over the study period, compared with 46.2% of white participants. Black Americans were significantly less likely than white Americans to use three or more days of hospice. Also, Black Americans were more likely to have multiple emergency room visits and hospitalizations, or to undergo intensive treatments in the last six months of life—regardless of the cause of death."

Given the historical injustices that Black communities have faced—particularly in the context of healthcare—it is unsurprising that there is hesitancy to opt for a service that will, by definition, involve the cessation of curative treatment. Yet, it is also well-established³⁵ that in many cases, patients on hospice actually live longer than similar patients who undergo intensive treatment.

The benefits of addressing these disparities extend beyond social justice. One study³⁶ found that "Medicare spends about 20% more on the last year of life for Black and Hispanic people than White people," suggesting that greater hospice utilization would have a significant impact on overall healthcare spending. Of course, all Medicare beneficiaries should be entitled to choose the care that aligns with their goals. Yet, in practice, more intensive treatment is often the default approach in end-of-life situations—less a choice patients make than something that happens to them.

"You'll go in there and they'll eat you alive...I hate to say [something] bad about hospitals, but it's true."

Black-owned hospice executive³⁷

“

When hospice came, I would still go over there every day, but now I'm going over with my kids. I'm cooking, giving my grandmother a hug, saying a prayer. My caregiver role became totally different, it became more of a love giver.

”



Real Stories: **Sally**

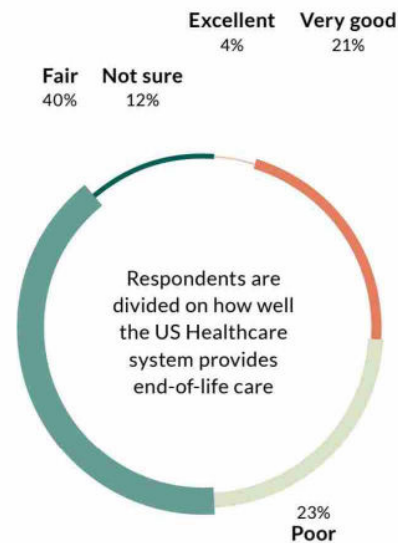
Sally is a middle-aged Black woman who spent several months as the primary caregiver for her grandmother, who died after a long battle with cancer. She and her large, tight-knit family benefited greatly from the support of hospice during the final months of their grandmother's life.

Sally's family has always been close, but when their grandmother's health began to decline, they rallied around her and relied on each other for emotional support. As the matriarch of a large family, Sally's grandmother was known for her cooking, and never missed hosting holiday meals and family reunions. When her cancer became too advanced, doctors recommended hospice, and Sally was pleasantly surprised at how gentle and supportive the hospice team was. She cherished having the time to listen to her grandmother's stories and sensed that her grandmother was at peace with dying. The hospice team knew when death was approaching, and helped get the full family together to share stories and pray during the final days.

Sally recounts the story of this final chapter with a smile, emphasizing that it was joyful and peaceful for both her grandmother and her family members.

Communities over systems

Reviewing NPHI's survey data,² there is a clear tension between the overwhelmingly negative view respondents had of the healthcare system at large and the generally favorable view those same respondents had of hospice. Respondents were also divided over how well the healthcare system provides end of life care.



The even distribution of "very good"/"excellent" and "poor," coupled with the very high number of "fair" or "not sure" ratings, suggest a wide variance in personal experiences with end-of-life healthcare. A 2023 *New York Times* article³⁸ highlighted the persistent reality of aggressive, invasive medical treatment at the end of life. The "comments" section of the article—while obviously anecdotal—includes hundreds of accounts of horrifying end-of-life experiences, an alarming number of which center on the role of financial incentives.

"...my 94 y/o father decided [my mother] should have the pacemaker so she did. She is a shut in, is in pain and there is not much joy in her life these days... Implanting the pacemaker was recommended by the hospital because they make [a] lot of money doing this procedure; this was not done to improve her quality of life."

"Make a living will, folks...[otherwise] you will become a living, breathing, suffering piggy bank for the medical community. And call hospice. They are experts and will remove your loved one from the grips of an out-of-control and profit based system that is regularly torturing people to death."

"For my aunt, the cancer treatment was the "end" of a life she enjoyed and the beginning of a life no one would want."

Hospice care has always occupied a unique place within the healthcare system. Its religious and charitable origins set it apart from other types of healthcare, yet many aspects of the hospice model are now being touted as the future of healthcare in general. Multidisciplinary teams, patient-centered care, shared decision-making, social determinants of health, home-based care—these principles are now mainstream among healthcare thought leaders, and may represent the future trajectory of healthcare. Hospice leaders have been advocating these same concepts for more than 50 years, suggesting that experts in end-of-life care may be well-suited to guide the rest of the field.

More specifically, given the problematic influence of financial incentives and profiteering, it is community-based hospice organizations that have the opportunity to be the leaders of this movement. This is not a moral argument about the virtue of nonprofit tax status as such. A wealth of evidence highlights the clear differences between nonprofits and for-profits, from frequency of visits to breadth of services to the types of patients cared for. The RAND Corporation conducted a study³⁹ to examine family experiences with both types of organizations and found that "caregivers whose family member received care in a not-for-profit hospice reported the best care experiences, generally followed by those who received care in a for-profit independent hospice. Those who received care in a for-profit state/regional chain or a for-profit national chain reported the worst care experiences."

Setting aside more general considerations about the role of profit in healthcare, the issue is particularly problematic in the hospice context. In an editorial response to the RAND study, one researcher summarized⁴⁰ the issue:

"Even if patients or their families experience poor quality care and wish to change hospice agencies (as one could with a physician or home health agency), the short time frame of hospice enrollment (one-quarter of patients are enrolled for a week or less) and the potential of disruption during an extremely stressful time make such switching of hospices essentially impossible. Because hospice is generally a once-in-a-lifetime experience for families, comparative experience does not exist and reporting deficiencies or quality concerns after a patient has died may seem futile."

These factors, in addition to the flat rate that Medicare pays for all hospice patients, present clear incentives for hospice companies to seek out lower-need patients and offer fewer services. By contrast, nonprofits are the experts at delivering quality care to the highest need patients, no matter what the financial consequences.

"It's not just about nonprofit versus for profit. It's about how much more we offer. We've been here for 25 years. We're going to be here for the next 25 years."

NPHI Member CEO¹

Family and caregiver grief

An often overlooked aspect of hospice care is robust grief and bereavement support for families both before and after the patient has died. A number of studies have outlined the detrimental impact of grief on caregiver mental health. By some estimates,⁴¹ about 20% of caregivers will experience psychiatric symptoms like depression or "complicated grief" after the loss of a loved one. As in many other aspects of healthcare, there are also noteworthy disparities in impact for the most vulnerable communities; one study noted that "Individuals with lower income, lower education, and those who are African Americans are also more likely to exhibit greater depression and complicated grief after the death."

Additional research⁴² has noted that targeted interventions to address caregiver grief both before and after the death of the care recipient have led to reduced depression among caregivers. In particular, caregivers and families of Alzheimer's patients who received tailored grief support reported significantly greater resilience and lower rates of chronic depression than those in the control group. The study also found that these results were sustained for over a year, suggesting that early, sustained grief support is key to improving long-term mental health outcomes for caregivers.



Grief Support Intervention vs. Control Group



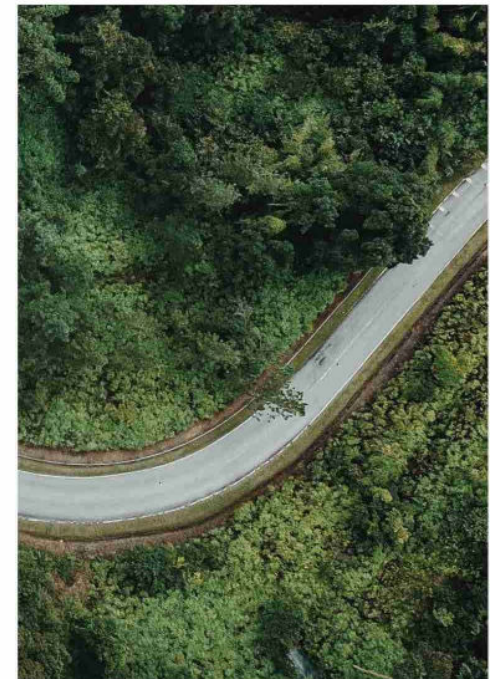
These positive outcomes demonstrate the potential benefits of greater hospice utilization, since the hospice model prioritizes grief support for caregivers and families. The inverse may also be true. In one study,⁴³ over 18 months of follow up, surviving spouses whose loved one underwent a life-sustaining treatment in the final month reported greater increases in depressive symptoms than those who did not.

There is also a significant body of research indicating that the impact of grief extends beyond mental health. By some estimates,⁴⁴ becoming a widow increases one's mortality risk by 48%, with a diverse, interconnected set of potential factors influencing that increase. On top of the emotional and mental strain associated with loss, surviving spouses must adapt to practical changes in their living circumstances and disruptions in their degree of social connection. Men, in particular, are less likely to have a close confidant than women, which may make them more vulnerable to adverse outcomes after losing a spouse.

Hospice providers have expertise providing end-of-life care not just for patients but for their caregivers and families as well, and studies suggest that such support has a positive influence on health outcomes for the bereaved. Nicholas Christakis⁴⁵ explored the relationship between spouse survival and hospice utilization, finding that both men and women whose partners had used hospice care lived longer after the partner's death than those who did not use hospice.

Given that hospice quality metrics rely heavily on family member satisfaction, often reported after the patient has died, it is unsurprising that nonprofit hospices perform significantly better than their for-profit counterparts. One study⁴⁶ examining the association between amount of volunteer support and family satisfaction found, "Bereaved family members in hospice programs that use a higher rate of direct volunteer patient care hours reported higher ratings of the quality of care for that hospice program." Similarly, lower rates of volunteer involvement were directly associated with lower "excellent" ratings from patients.

The complex experience of grief has clear implications for caregiver and family health and wellbeing. With half a century of experience delivering expert care at the end of life, nonprofit hospice organizations are uniquely equipped to address this challenge. Significantly, many nonprofit hospices extend their grief support offerings to the entire community, not just family members of patients they have served. Such comprehensive support is deeply interconnected to the role that philanthropy and volunteerism play in the nonprofit hospice model. As a result, increasing competition from for-profit providers poses a dire threat to long-term community grief support.



05

Home

Bringing it all back home

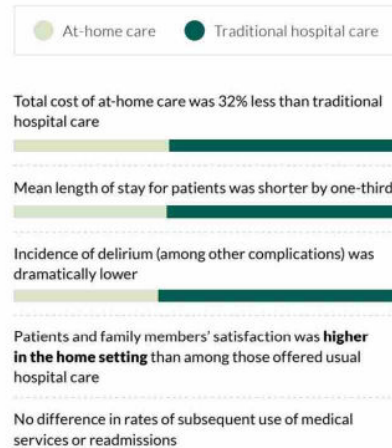
We are currently in the midst of a large-scale reorientation of healthcare that will increasingly focus on the home as a site of care. This is not new, of course. For hundreds of years, doctors routinely—and sometimes exclusively—made house calls to treat patients in their homes. As hospitals proliferated and expanded their outpatient service offerings, this trend reversed for much of the 20th century. A turning point came in the spring of 2020, when COVID-19 forced millions of people into quarantine, and healthcare providers scrambled to care for the huge influx of patients into hospitals around the country. As has been widely reported, routine, preventive care suffered greatly during the pandemic, with consequences we still cannot yet fully comprehend.

In the midst of this crisis, many states and insurance providers adjusted their regulations for telemedicine, to grant greater flexibility to patients and providers who were suddenly unable to access in-person care. These changes accelerated the already-growing boom in investment in virtual health solutions, and while utilization of telehealth has stabilized from its peak during the height of the pandemic, the impact appears to be lasting. A McKinsey report⁴⁷ found that:

- Telehealth utilization is now 38X greater than it was before the pandemic.
- Consumer and provider attitudes towards telehealth have improved.
- Venture capital investment in digital health has tripled compared to pre-pandemic numbers.

Beyond the explosion of interest in digital tools, in-person, home-based care is also experiencing growth and investment. One market forecast⁴⁸ reported that, “The U.S. home healthcare services market is projected to grow from \$94.17 billion in 2022 to \$153.19 billion by 2029...” Beyond the obvious patient benefits of convenience and comfort, providing care in the home has great potential for reducing costs to the system overall.

Advantages to home-based acute care⁴⁹



For populations in declining health, particularly among the elderly, providing care in the home also offers unique insight into the non-medical factors influencing a patient's health. More than⁵⁰ 300,000 older Americans are hospitalized for a hip fracture each year, about 95% of which are caused by falls. In a population that is more likely to have issues with balance and be on multiple medications which may cause dizziness, it is essential that living quarters are designed with safety in mind.

Home visits from healthcare providers with expertise in this population present a critical opportunity to identify risks and implement safety adjustments. Further, home visits offer clinicians the opportunity to see where medications are stored, what food is available in the kitchen, and assess the cleanliness of the home, which can offer insight into the patient's mobility and self-efficacy. In short, home visits represent a crucial opportunity to address social determinants of health for high risk populations.

Despite the optimism and potential around digital solutions and home-based care, there are reasons to be wary of the rapid influx of investment in for-profit providers. As previously discussed, widespread distrust of the healthcare system appears to be linked to suspicions about profit-seeking. Further, the changes in regulation of telehealth during COVID-19, while a necessity, created a “black box” effect, where practices changed abruptly with little oversight.

As with the growth of the for-profit hospice industry, allowing the trajectory of the field of home health to be dictated by investment companies, national and

regional chains, and start-ups could have the effect of eroding care quality. Meanwhile, nonprofit, community based organizations specializing in declining health have decades of expertise providing quality, home-based care to patients with complex needs. Payers and policymakers should look to such organizations as the vanguard of this transformation in healthcare.

Summarizing the essential meaning of home for those in declining health, Atul Gawande writes in *Being Mortal*: “Home is the one place where your own priorities hold sway. At home, you decide how you spend your time, how you share your space, and how you manage your possessions. Away from home, you don’t.” Across the entire continuum of care, a focus on home will shape the future of healthcare. Ensuring that this transformation serves patient wellbeing rather than shareholder value will require a coordinated nationwide movement led by the nonprofit, community-based organizations that have provided this type of care all along. Amplifying their values, vision, and expertise to key audiences—from providers to payers to policymakers to patients—is the first step.



“Home is the one place where your own priorities hold sway. At home, you decide how you spend your time, how you share your space, and how you manage your possessions. Away from home, you don’t.”

Gawande, *Being Mortal*

Real Stories: Rosie

Rosie is a successful business owner and the sole caregiver for her mother, who is in the final stages of cancer. Her mother's declining health coincided with the outbreak of COVID, so Rosie invited her to move into her home, where she has lived ever since.

The biggest challenge for Rosie has been an intense feeling of isolation. She's always had a strained relationship with her mother, who can be critical and demanding, and the emotional impact of that dynamic feels even more acute now that she has totally reoriented her life and home to be a caregiver. An outgoing, social person who loves to entertain at her home, Rosie now feels completely cut off from her friends, hobbies, and children. Yet, for all her sacrifice and dedication, her mother is often hostile and judgemental. Rosie resents her brother, who refuses to help out but remains "the favorite child" in the eyes of her mother.

While Rosie has the financial means to bring in outside help, her mother's stubbornness makes this a non-starter, resulting in a "lose-lose" situation where both she and her mother are unhappy and overwhelmed.

I would have a whole team here 24-7, but my mom would never...it's not that she wants only me, she's just a very private person...she never liked having people in her home.

Recommendations

Recommendation #1

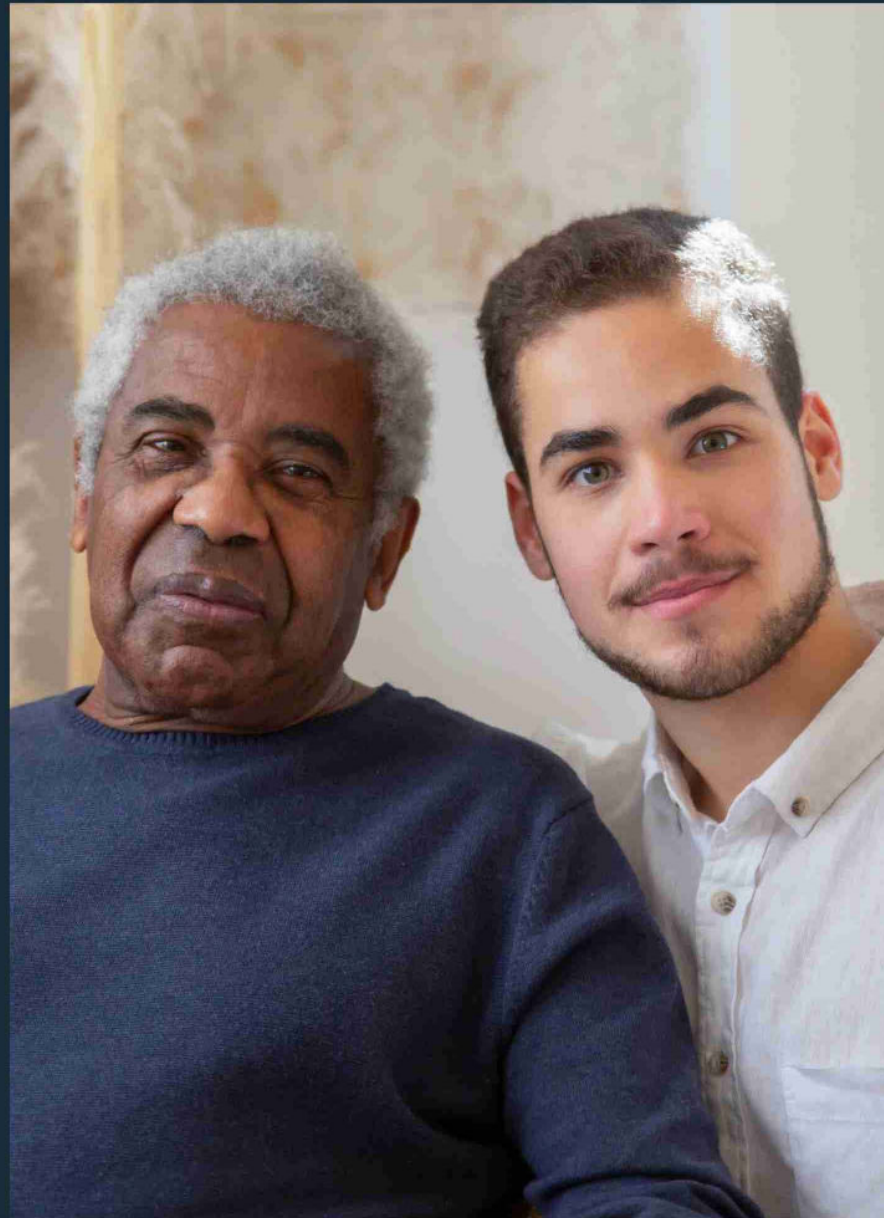
If you see something, say something

Expand public relations and thought leadership efforts to speak out on issues beyond declining health and end-of-life care. When there is public outcry about pharma profiteering or corruption anywhere in the healthcare industry, use it as an opportunity for education about the advantages of choosing a community-based, mission driven provider. Such commentary doesn't need to be political—Americans across the ideological spectrum are looking for someone to trust.

Recommendation #2

Play the “long game”

Target schools and younger audiences for volunteer opportunities, death doula programs, staff recruitment, community engagement events, and educational programming. Taking a more outspoken stance on issues like healthcare and health equity could earn the trust of the next generation of caregivers and care seekers. The return on investment for this might be decades out, but as a field it is a critical component of changing the culture.



Recommendation #3

Connections across the continuum

Use the deep connections your organization has to other safety net healthcare and social services organizations to tell a new story about what community-based support looks like. Connections between values-aligned providers not only help patients find the support they need, they also establish the organization's role as a deeply entrenched part of the community that is here for the long haul. Knowing how to “speak the language” of organizations that share your values can help form new connections as well.

Recommendation #4

Honesty is the best policy

Patients say that they want honest guidance, and want that guidance from physicians. But most physicians, particularly specialists, aren't comfortable having those conversations. Organizations that specialize in declining health and end-of-life care have the firsthand experience and expertise to lead a culture shift within the broader healthcare community. Target medical schools, residents, and early-career physicians with data, messaging, and educational opportunities to highlight this disconnect and gain skills in handling Advanced Care Planning discussions.

Recommendation #5*Double down on social determinants*

One way to sidestep public distrust of healthcare might be to lead with social determinants instead. By framing risks as environmental or situational, we can protect the pride of aging communities, who might not be ready to admit they need help. Hospices have a long tradition of connecting vulnerable patients to community-based support for non-medical needs, and even providing those services themselves. Emphasizing this aspect of what you provide reorients the topic in the public's mind, and potentially avoids two major triggers of distrust: profit-seeking and the healthcare industry.

Recommendation #6*Trusted messengers*

The significant role of volunteers and donors in community-based, nonprofit organizations is a major point of differentiation from for-profits. These groups provide a valuable, diverse array of programs and services, and also serve as vital ambassadors for their organizations in the community. Often inspired to become donors and volunteers by their own experiences with loved ones, these community members have compelling stories to tell that can reframe the discussion for those who are less familiar with the subject. Further, volunteer and donor involvement is a clear manifestation of the deep, long-term community roots that nonprofits have. Formally training these individuals to be effective communicators and arming them with the data and messaging to become real-world advocates is a major—and potentially cost-effective—opportunity.

**Recommendation #7***The “Good Housekeeping” effect*

Awareness and consideration of the differences in quality and approach among providers is generally low. Simplifying the story through a public-facing “seal of approval”—with associated messaging and campaigns to define the meaning and value of NPHI membership in a more consumer-friendly format—could help mission-driven organizations stand out from the competition. Since there is a robust body of evidence demonstrating that NPHI members, and nonprofits more generally, outperform the field, there is a clear opportunity to translate complex quality metrics into a quick, identifiable symbol of excellence.

Recommendation #8*Defining grief support*

While there is a wealth of research on the adverse impact of grief on the health and wellbeing of surviving caregivers and families, there is relatively little insight into the type and quality of grief support offered by hospice organizations. Encouraging Centers for Medicare and Medicaid Services and policymakers to more rigorously evaluate this aspect of hospice care can inform program design and service delivery, and would likely benefit community-based organizations that offer more robust grief and bereavement support. It is critical, however, that reimbursement for these services be linked to the depth and quality of the program, rather than a “bare minimum” standard that can be easy to implement to boost revenue.

Recommendation #9*More than six months*

As hospice organizations expand their services upstream to provide palliative care to an ever-broader range of patients in declining health, Centers for Medicare and Medicaid Services should reimagine the hospice benefit to offer greater support across the continuum of advanced illness care, rather than tying it to a specific (and often hard to predict) life expectancy. In doing so, policymakers should be attentive to the unique benefits of community-based nonprofit providers, and structure benefits to be supportive of the long-term sustainability of those organizations.

Recommendation #11*Demystify the day-to-day*

Doing an audit of everything you offer—beyond what is mandated by Medicare—will reveal just how much of an impact you have. Meal delivery, transportation, pet therapy, grief support in the community—many organizations do this heroic work because they believe in it, but that doesn't always translate to compelling communications. Placing more emphasis on the full spectrum of what you offer to the community can reframe the conversation.

**Recommendation #10***Promoting accountability*

Reforms to hospice payment methodology should focus on giving more accountability to providers for patient outcomes while eliminating opportunities to "game the system." Shifts in payment structure are critical to reducing the incentives that currently facilitate profiteering at the expense of patient wellbeing. Providers that serve as a "safety net" in their communities should be rewarded for the quality of care they provide to the patients with greatest need.

Recommendation #12*Make yourself comfortable*

In many of the caregiver research conversations, participants gravitated towards the phrase "comfort care" as a clear, welcoming way to describe the kind of care their loved ones deserved. The moderators also offered alternative terms like palliative medicine, symptom management, and serious or advanced illness care, but participants either did not understand those terms or found them cold and clinical. Hospice was generally viewed favorably, but as other research has noted, it is often perceived as an option only in the final days or weeks of life. Additional large-scale, quantitative research could shed light on the most effective terminology for patients and caregivers across the continuum of declining health.

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Contact Us

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From: "Carlton, Stephanie (CMS/OA)" (b)(6)
ADMINISTRATIVE GROUP
(b)(6)

Sent: 2/18/2025 3:24:25 PM -0500

To: "Aramanda, Alexander (CMS/CM)" <alexander.aramanda@cms.hhs.gov>;
"Albanese, Joseph (CMS/CM)" <joseph.albanese@cms.hhs.gov>; "Brooks, John
(CMS/OA)" <john.brooks1@cms.hhs.gov>

CC:

BCC:

Subject: FW: FW: Nonprofit Hospice Community Policy Priorities

Attachments
:
image001.png; image002.png; image003.png; image004.png; NPHI Policy
Priorities .docx; NPHI_POP_Blueprint.pdf

Could one of you meet with them?

Confidential, iterative, and pre-decisional

From: Quinten Lyons <quin@nphihealth.org>
Sent: Tuesday, February 18, 2025 12:38 PM
To: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Cc: Ethan McChesney <ethan@nphihealth.org>; Tom Koutsoumpas <tom@nphihealth.org>
Subject: Nonprofit Hospice Community Policy Priorities

Hi Stephanie,

I hope you are having a productive week. I am reaching out on behalf of the National Partnership for Healthcare and Hospice Innovation (NPHI), the leading national organization representing the nonprofit hospice and palliative care provider community. With over 120 member programs across 38 states, NPHI members collectively care for hundreds of thousands of Medicare beneficiaries each year as they approach the end of life.

In light of your new role at CMS, I would like to initiate a conversation about the critical issues affecting the nonprofit hospice community. Please find attached our *People Over Profits* blueprint, which outlines the unique value our members bring to hospice care, along with a brief letter detailing our organization's policy priorities.

NPHI is committed to working collaboratively with you and CMS to address fraud and abuse within the hospice benefit while ensuring the long-term solvency of Medicare.

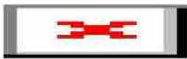
Please do not hesitate to reach out if you have any questions or if we can be of any assistance.
We stand ready to serve as a resource for any hospices issues that might come across your desk.

Regards,

Quinten Lyons

Policy Associate

717.817.3896 | Quin@nphihealth.org



The national voice for not-for-profit advanced illness, hospice, and palliative care.



Sent: 4/8/2025 2:45:51 PM -0400
To:
CC:
BCC:
Subject:

Summary:

-  (b)(5)
- This occurs through cleverly-designed taxes on Medicaid managed care organizations (MCOs) designed to subvert certain federal program integrity requirements.
- On their way out the door, the Biden administration doubled the amount of approved waivers that utilize this loophole – all in blue states (CA, MI, MA, NY).
- The Trump administration tried to address this loophole, among other things, through a much broader rule in the first term, but was unable to do so prior to the term ending.

Brief History

- Medicaid requires states to contribute, on average, about 40 percent of Medicaid spending.
- States have historically looked for ways to lessen their contribution, including by using provider “donations” or “taxes” as a means of raising the state’s share of spending.
- Congress and others have recognized that this leads to abuses – raising the federal government’s share of spending without commensurate state participation – violating the spirit of the federal-state partnership.
- This has been [criticized](#) by [some](#) as “Medicaid money laundering.” Even [President Obama](#) proposed reducing states’ ability to use provider taxes and former [President Biden](#) characterized them as a “scam.”

Confidential, Iterative, and Predecisional

From: "Carlton, Stephanie (CMS/OA)" (b)(6)
ADMINISTRATIVE GROUP
(b)(6)
(b)(6)

Sent: 3/26/2025 6:29:37 PM -0400

To: Shannon Campagna <SCampagna@PortfolioStrategiesLLC.com>

CC: "Morgan, Katarina (CMS/CCIIO)" <katarina.morgan@cms.hhs.gov>

BCC:

Subject: RE: RE: Meeting request from former Safeway CEO Steve Burd

Attachments: image001.jpg

:

Hi Shannon – Good to hear from you. Would love to connect with you and Steve, but that timing is tough for us with the expected arrival Dr. Oz around then. Could we look to another trip?

Confidential, iterative, and pre-decisional

From: Shannon Campagna <SCampagna@PortfolioStrategiesLLC.com>

Sent: Wednesday, March 26, 2025 6:26 PM

To: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>

Subject: Fw: Meeting request from former Safeway CEO Steve Burd

Stephanie, hi! I am hopeful that my email found it's way to you last week. Please let me know if it's possible to get on your schedule or if there's someone within CMS who would be an appropriate proxy.

Shannon

202-400-1810

From: Shannon Campagna
Sent: Friday, March 21, 2025 8:42 PM
To: stephanie.carlton@cms.hhs.gov
Subject: Meeting request from former Safeway CEO Steve Burd

Stephanie, congratulations on your new role at CMS. It is always heartening to see former Hill staff rise to the top of agencies!

I hope you will remember working with Safeway CEO Steve Burd during the ACA when you were on the Hill. I am happy to share that Steve has continued his work in the healthcare space and he continues to think about ways to streamline U.S. healthcare, enhance efficiency and realize cost-savings. He penned an op-ed that appeared in [Real Clear Markets](#) this week.

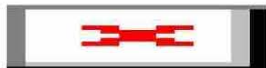
Having spent the better part of the last two decades reinventing how healthcare services are provided, Steve identifies five major areas of focus in the [article](#) he calls "low hanging fruit," that include: (1) Drug Costs for both Medicare and Medicaid, (2) Royalty Payments to the National Institute of Health (NIH), (3) Cancer Services, (4) Wellness Services and (5) Fraud and Abuse.

These are practical, data-driven solutions that align with fiscal responsibility, smart government, and better patient care.

Steve is considering a trip to DC the week of April 7 and I respectfully request a meeting with you and your team on that Monday or Tuesday. Steve would welcome the opportunity to discuss these solutions and is anxious to share his learnings with the Administration.

I am hopeful that we can make this work - are you able to meet with us that week?

Shannon



Shannon Campagna | 202.400.1810



U.S Office of
Management and Budget

U.S Office of
Personnel Management



MEMORANDUM

TO: Heads of Executive Departments and Agencies

FROM: Matthew J. Vaeth, Acting Director, Office of Management and Budget;
Charles Ezell, Acting Director, Office of Personnel Management

DATE: January 20, 2025

RE: Federal Civilian Hiring Freeze Guidance

1. Purpose. This memorandum provides additional guidance regarding the freeze on the hiring of federal civilian employees as directed by the President on January 20, 2025, via Presidential Memorandum (PM) entitled "Hiring Freeze." This guidance clarifies immediate actions to be taken by Heads of executive departments and agencies to implement the PM and provides information on the types of exemptions authorized under this hiring freeze as well as instructions on how departments and agencies can request exemptions from the Office of Personnel Management (OPM) for critical situations where additional exemptions may be warranted.

2. Coverage. This memorandum applies to all Executive departments and agencies regardless of the sources of their operational and programmatic funding and to all types of Federal civilian appointments, regardless of the length of the appointment, except as provided for below or otherwise provided in law. No vacant positions existing at 11:59 A.M. on January 20, 2025, may be filled and no new positions may be created, except in limited circumstances. For the purposes of this memorandum, a position is not considered vacant if an individual has been given an offer of employment prior to noon on January 20, 2025, has signed an offer letter in acceptance of the position, and has a designated start date on or before February 8, 2025. All positions that are not exempt from the hiring freeze must be unlisted from USAJOBS.gov and any other applicable websites no later than January 21. Any recruiters seeking to fill positions on behalf of the government must cease correspondence with candidates no later than January 21.

Contracting outside the Government to circumvent the intent of the PM shall not be permitted. For example, agencies shall not acquire by contract with a commercial vendor services that are substantially similar to those that would have been provided by a Federal civilian in a vacancy covered by the PM.

3. Mandatory Exemptions. For the following exemptions, hiring of veterans shall be prioritized in accordance with veterans' preference statutes. The following exemptions to the Federal civilian hiring freeze are required:

- a. Military personnel in the armed forces and all Federal uniformed personnel, including the U.S. Coast Guard, the Commissioned Corps of the U.S. Public Health Service, and the Commissioned Officer Corps of the National Oceanic and Atmospheric Administration.
- b. Positions related to immigration enforcement, national security, or public safety.
- c. The nomination and appointment of officials to positions requiring Presidential appointment or Senate confirmation, the appointment of officials to non-career positions in the Senior Executive Service or to Schedule A or C positions in the Excepted Service, the appointment of officials through temporary organization hiring authority pursuant to 5 U.S.C. 3161, or the appointment of any other non-career employees or officials, if approved by agency leadership appointed by the President.

Agency heads shall consult with the OPM in determining the scope and extent of positions covered by these mandatory exemptions.

4. Other exemptions. For the following exemptions, hiring of veterans may be prioritized. In addition, the following exemptions to the Federal civilian hiring freeze are permitted:

- a. Filling of positions under programs where limiting the hiring of personnel would conflict with applicable law.
- b. Nomination and appointment of officials to positions requiring Presidential appointment, with or without Senate confirmation.
- c. Appointment of seasonal employees and short-term temporary employees necessary to meet traditionally recurring seasonal workloads, provided that the agency informs its OMB Resource Management Office in writing in advance of its hiring plans.
- d. Hiring by the U.S. Postal Service.
- e. Appointments made prior to January 20, 2025, under the Pathways Internship and Presidential Management Fellows programs (this does not include the Recent Graduates program): Agencies shall review such appointments on a case by case basis. Agencies should ensure that such hires understand the provisional nature of these appointments and that retention is not guaranteed.
- f. Conversions in the ordinary course to the competitive service of current agency employees serving in positions with conversion authority, such as the Veterans' Recruitment Act (VRA).
- g. Appointments made under 5 C.F.R. § 213.3102(r) (time limited positions in support of fellowship or professional/industry exchange programs) provided that the total number of individuals employed under this authority does not exceed the number of employees onboard (hired under this authority) on January 20, 2025.

- h. Placement of persons with restoration rights accorded by law, such as restoration after absence with injury compensation and restoration after military duty.
- i. Job offers made prior to noon on January 20, 2025, for which the individual has accepted the position and has a designated start date on or before February 8, 2025. Those individuals should report to work according to their respective designated start date.
- j. Job offers made and accepted prior to January 20, 2025, but for which the individual has a confirmed start date that is later than February 8, 2025 (or does not have a confirmed start date), are revoked. If an agency head would like to renew an offer, the agency head should consider essential mission priorities, current agency resources, and funding levels when making determinations about whether to reinstate job offers. If the agency head decides to reinstate the offer, the agency head must seek written approval from OPM before proceeding to hire the employee.
- k. Internal career ladder promotions.
- l. Reallocations (i.e., noncompetitive reassignments and details) of current Federal civilian employees within an agency to meet the highest priority needs (including preservation of national security and other essential services) are not affected. Details (reimbursable and non-reimbursable) between agencies are also not affected; however, agency leadership should ensure that any reimbursable details between agencies are not being used to circumvent the intent of the hiring freeze.
- m. Term and temporary appointments of existing Federal employees may be extended up to the maximum allowable time limit, consistent with the conditions/requirements of the legal authority originally used to appoint the employee.
- n. A limited number of voluntary transfers of current SES between agencies, as necessary to secure the leadership capacity of agencies, and where needs cannot be met by reallocation of resources within an agency's current workforce; however, filling of such vacancies is subject to OPM approval in accordance with section 5 below.
- o. The head of any agency may exempt any positions that it deems necessary to:
 - i. Meet national security (including foreign relations) responsibilities, that are not covered by Section 3, or
 - ii. Meet public safety responsibilities that are not covered by Section 3 (including essential activities to the extent that they protect life and property). Agencies may refer to longstanding guidance, which provides examples of such activities in OMB Memorandum. Agency Operations in the Absence of Appropriations dated 11/17/1981 [see examples 3(a) to 3(k)].

Agency heads should consult with appropriate personnel, including the agency Chief Human Capital Officer (CHCO) or equivalent and agency counsel when determining what positions to exempt from the hiring freeze. Agency heads are also required to obtain the approval of the OMB Resource Management Office before seeking the approval of OPM to exempt positions using their agency head authority before implementing these exemptions. This approval must be requested and received in writing before any exemption to the hiring freeze is permitted. Note that in the case of an Inspector General's (IG) office, the Inspector General is considered the agency head for the purposes of determining which positions in the IG office are exempt based on the definitions above, as well as for the purposes of the agency-head review of job offers in the IG office that either do not have a start date or have a designated start date beyond February 1, 2025.

5. Exemptions Granted by OPM. OPM may grant additional exemptions from the hiring freeze for critically important situations, such as ensuring the highest-quality possible provision of Social Security, Medicare, and veterans' benefits. Accordingly, if an agency head assesses that circumstances warrant additional exemptions to the hiring freeze other than those specified above, a request must be made in writing to OPM and signed by the agency head. OPM must approve the request in writing prior to moving forward. The request must:

- Explain the critical need and how it relates to essential services or critical mission requirements.
- Explain why reallocation (reassignment/detail) of existing staff within the agency is not possible to meet the needs outlined in the request.
- Explain the urgency of the need and the consequences of not filling the position within a 3 to 6 month timeline.

Agencies must also notify their respective OMB Resource Management Office of exemption requests to OPM under this provision. Agencies should submit exemption requests to OPM at employ@opm.gov for non-SES positions, with a copy to Amanda Scales at amanda.scales@opm.gov. For approval to transfer executives under Section 4(n), agencies should submit their request to SERS@opm.gov, with a copy to Amanda Scales at amanda.scales@opm.gov.

6. Effective Dates. The guidance in this memorandum is effective immediately. Within 90 days of the publication of the PM issued on January 20, 2025, the Director of the Office of Management and Budget (OMB), in consultation with the Director of OPM and the Administrator of the United States DOGE Service (USDS), shall submit a plan to reduce the size of the Federal Government's workforce through efficiency improvements and attrition. The hiring freeze will expire upon implementation of the OMB plan, with the exception of the Internal Revenue Service (IRS). The freeze shall remain in effect for the IRS until the Secretary of the Treasury, in consultation with the Director of OMB and the Administrator of USDS, determines that it is in the national interest to lift the freeze.

7. Reports. On the last day of each month, the head of any agency subject to the hiring freeze shall send a report to OPM at employ@opm.gov with the following:

- Name, Job Title, Pay Plan, Series, Grade, Manager Name, Offered Date (date offer was extended), Intended Start Date, and Date of OPM Approval for all job candidates who were extended offers in that month
- Name, Job Title, Pay Plan, Series, Grade, Manager Name, Offered Date (date offer was extended), Intended Start Date, and Date of OPM Approval for all job candidates who accepted offers in that month
- Name, Job Title, Pay Plan, Series, Grade for all new employees who started that month
- Name, Job Title, Pay Plan, Series, and Grade for all employees who departed in that month
- Total employee headcount
- List of positions listed on USAJOBS and/or any other websites discoverable online

8. Inquiries. Questions from departments and agencies regarding the instructions and guidance in this memorandum should be addressed to agency OMB Resource Management Officers and the OPM Office of Workforce Policy and Innovation at employ@opm.gov, with a copy to Amanda Scales at amanda.scales@opm.gov.

Appendix: Summary of Required Actions by Agency Heads

Important: Please be advised that OPM will remove all postings on USAJOBS.gov that do not clearly meet exemption criteria as described in this memo. Agency head may request approval to reinstate any postings with Amanda Scales, Chief of Staff, OPM at amanda.scales@opm.gov.

ACTION: Agency head must send a summary email to the Chief of Staff, OPM confirming once all of the actions outlined below have been completed and no later than January 22, 2025. OMB shall be cc'd for awareness on this email.

- Offers signed prior to 12pm on January 20, 2025 with a start date ON OR BEFORE February 8, 2025
 - ACTION: Continue/proceed with hiring/onboarding process.
- Offers signed prior to 12pm on January 20, 2025 with (a) a start date AFTER February 8, 2025 OR (b) an unconfirmed start date
 - ACTION:
 - Agency head ensures all of these offers are revoked no later than 5:00 pm EST on January 21, 2025, unless the agency head specifically determines in writing that the offer should be reinstated.
 - If agency head determines that any of these offers should be reinstated, agency head must request and receive approval in writing (via email) from the Chief of Staff, OPM before moving forward with the offer(s). The request should cite the relevant exemption criteria and justifications as outlined in the memo before moving forward. OMB shall be cc'd for awareness on this request. The agency head shall perform this review in bulk and send one email request, with all offers and their justifications listed, for OPM review and approval.
- Vacant positions as of 12pm on January 20, 2025
 - ACTION:
 - Agency head ensures hiring managers, recruiters, and any other employees involved in the hiring process at any stage, instruct candidates that we are no longer hiring for the role and cease correspondence no later than 5:00 pm EST on Tuesday, January 21, 2025.
 - If agency head determines that any of these jobs are exempt from the hiring freeze per the criteria outlined in this memo, and therefore should continue to be posted, agency head must request and receive approval in writing (via email) from the Chief of Staff, OPM before implementing these exemptions. The request should cite the relevant exemption criteria and justifications outlined in the memo before moving forward. OMB shall be cc'd for awareness on this request.

- Jobs posted to USAJOBS.gov and/or any other external website used to market jobs with the federal government
 - ACTION:
 - Agency head ensures that all jobs currently posted to USAJOBS, and any other external website concurrently in use to market jobs (for example, Monster or LinkedIn) with the federal government, are removed no later than 5:00 pm EST on Tuesday, January 21, 2025.
 - If agency head determines that any of these jobs are exempt from the hiring freeze per the criteria outlined in this memo, and therefore should continue to be posted and actively recruited for, agency head must request and receive approval in writing (via email) from the Chief of Staff, OPM before implementing these exemptions. The request should cite the relevant exemption criteria and justifications outlined in the memo. OMB shall be cc'd for awareness on this request.

Notification of Updates to Systems & Processes:

To ensure the hiring freeze is observed, (1) OPM may communicate updates to job posting and offer approval procedures, and (2) agency heads are required to provide OPM with a monthly report (details outlined in the Reports section below).

Required Reports:

On the last day of each month, the head of any agency subject to the hiring freeze shall send a report to the Chief of Staff, OPM and to employ@opm.gov, with OMB cc'd for awareness, with the below:

- Job candidates who were extended offers in that month:
 - (1) Name, (2) Job Title, (3) Manager Name, (4) Offered Date (date offer was extended), (5) Intended Start Date, and (6) Date of OPM Approval
- Job candidates who signed offers in that month:
 - (1) Name, (2) Job Title, (3) Manager Name, (4) Offered Date (date offer was extended), (5) Intended Start Date, and (6) Date of OPM Approval
- Employees who departed in that month:
 - (1) Name, (2) Job Title
- Total employee headcount
- List of positions on USAJOBS and/or any other websites discoverable online

From: Quinten Lyons <quin@nphihealth.org>
Sent: 2/18/2025 12:38:13 PM -0500
To: "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>
CC: Ethan McChesney <ethan@nphihealth.org>; Tom Koutsoumpas <tom@nphihealth.org>
BCC:
Subject: Nonprofit Hospice Community Policy Priorities
Attachments: image001.png; image002.png; image003.png; image004.png; NPHI Policy Priorities .docx; NPHI_POP_Blueprint.pdf

Hi Stephanie,

I hope you are having a productive week. I am reaching out on behalf of the National Partnership for Healthcare and Hospice Innovation (NPHI), the leading national organization representing the nonprofit hospice and palliative care provider community. With over 120 member programs across 38 states, NPHI members collectively care for hundreds of thousands of Medicare beneficiaries each year as they approach the end of life.

In light of your new role at CMS, I would like to initiate a conversation about the critical issues affecting the nonprofit hospice community. Please find attached our *People Over Profits* blueprint, which outlines the unique value our members bring to hospice care, along with a brief letter detailing our organization's policy priorities.

NPHI is committed to working collaboratively with you and CMS to address fraud and abuse within the hospice benefit while ensuring the long-term solvency of Medicare.

Please do not hesitate to reach out if you have any questions or if we can be of any assistance.

We stand ready to serve as a resource for any hospices issues that might come across your desk.

Regards,

Quinten Lyons

Policy Associate

717.817.3896 | Quin@nphihealth.org



The national voice for not-for-profit advanced illness, hospice, and palliative care.



From: "Aramanda, Alexander (CMS/CM)" <alexander.aramanda@cms.hhs.gov>
Sent: 2/18/2025 4:12:27 PM -0500
To: "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>;
"Albanese, Joseph (CMS/CM)" <joseph.albanese@cms.hhs.gov>;
"Brooks, John (CMS/OA)" <john.brooks1@cms.hhs.gov>
CC:
BCC:
Subject: RE: RE: Nonprofit Hospice Community Policy Priorities
Attachments: image001.png; image002.png; image003.png; image004.png

Yes, I am happy to do so. Would you prefer to copy me on your reply or for me to separately reach out?

From: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Sent: Tuesday, February 18, 2025 3:24 PM
To: Aramanda, Alexander (CMS/CM) <alexander.aramanda@cms.hhs.gov>; Albanese, Joseph (CMS/CM) <joseph.albanese@cms.hhs.gov>; Brooks, John (CMS/OA) <john.brooks1@cms.hhs.gov>
Subject: FW: Nonprofit Hospice Community Policy Priorities

Could one of you meet with them?

Confidential, iterative, and pre-decisional

From: Quinten Lyons <quin@nphihealth.org>
Sent: Tuesday, February 18, 2025 12:38 PM
To: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Cc: Ethan McChesney <ethan@nphihealth.org>; Tom Koutsoumpas <tom@nphihealth.org>
Subject: Nonprofit Hospice Community Policy Priorities

Hi Stephanie,

I hope you are having a productive week. I am reaching out on behalf of the National Partnership for Healthcare and Hospice Innovation (NPHI), the leading national organization representing the nonprofit hospice and palliative care provider community. With over 120 member programs across 38 states, NPHI members collectively care for hundreds of thousands of Medicare beneficiaries each year as they approach the end of life.

In light of your new role at CMS, I would like to initiate a conversation about the critical issues affecting the nonprofit hospice community. Please find attached our *People Over*

Profits blueprint, which outlines the unique value our members bring to hospice care, along with a brief letter detailing our organization's policy priorities.

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Please do not hesitate to reach out if you have any questions or if we can be of any assistance.

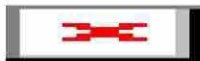
We stand ready to serve as a resource for any hospices issues that might come across your desk.

Regards,

Quinten Lyons

Policy Associate

717.817.3896 | Quin@nphihealth.org



The national voice for not-for-profit advanced illness, hospice, and palliative care.



From: "Brooks, John (CMS/OA)" <john.brooks1@cms.hhs.gov>
Sent: 4/4/2025 10:30:41 AM -0400
To: Brian Blase <bblase@paragoninstitute.org>
CC: "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>; "Sofio, Noah (CMS/)" <noah.sofio@cms.hhs.gov>; "Neal, Phaedra (CMS/OA)" <Phaedra.Neal@cms.hhs.gov>
BCC:
Subject: RE: RE: Meeting request

Brian -

Good to hear from you. Copying Steph and Noah for awareness and Phaedra who will be able to work through the scheduling.

Cheers,

John

From: Brian Blase <bblase@paragoninstitute.org>
Sent: Friday, April 4, 2025 10:28 AM
To: Brooks, John (CMS/OA) <john.brooks1@cms.hhs.gov>
Subject: Meeting request

Hi John:

I hope you are doing well! I spoke with Dr. Oz last night about meeting next week, and he asked for the following week since his schedule will be tough next week since he's in California. He asked that I reach out to someone in his leadership team to arrange this meeting, so I'm emailing you. If there is any chance he would have some time next week, that would be ideal for me as I'll be in town Tuesday through Thursday. If that doesn't work for him, I'm happy to make a trip the following week. We'd like to meet with him, in part, to discuss Paragon's two major Medicaid reform papers: [Addressing Medicaid Money Laundering: The Lack of Integrity with Medicaid Financing and the Need for Reform](#) & [Medicaid Financing Reform: Stopping Discrimination Against the Most Vulnerable and Reducing Bias Favoring Wealthy States](#).

If there is a better person for me to make this request to (which I'm certain there is), please pass along their contact information.

Thanks very much and I look forward to seeing you next week.

Best,

Brian

--



Brian Blase
President

Paragon Health Institute

O: 703.527.2734 | C: (b)(6)

paragoninstitute.org

Reforming government. Empowering patients.

From: "Oz, Mehmet (CMS/OA)" <(b)(6)@cms.hhs.gov>
Sent: 5/23/2025 4:02:51 PM -0400
To: "Brandt, Kimberly (CMS/OA)" <kimberly.brandt@cms.hhs.gov>; "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>; "Klomp, Chris (CMS/CM)" <chris.klomp@cms.hhs.gov>; "Brooks, John (CMS/OA)" <john.brooks1@cms.hhs.gov>

CC:

BCC:

Subject: Re: Re: New HC fraud scheme of note

Fabulous article. We need to highlight CMS role in identifying hospice laundering as a clue to multinational criminals. I want to visit the brave officers involved in DOJ operation and celebrate our CMS war room. (b)(5)

Get [Outlook for iOS](#)

From: Brandt, Kimberly (CMS/OA) <kimberly.brandt@cms.hhs.gov>

Sent: Thursday, May 22, 2025 9:16:37 PM

To: Oz, Mehmet (CMS/OA) <(b)(6)@cms.hhs.gov>; Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>; Klomp, Chris (CMS/CM) <chris.klomp@cms.hhs.gov>; Brooks, John (CMS/OA) <john.brooks1@cms.hhs.gov>

Subject: New HC fraud scheme of note

I got briefed today on this case which was announced earlier this week and will have a wave two involving money which was allegedly laundered thru some sham CA and FL hospices...more to come in the next two weeks, but this is what we are now up against in HC fraud in some of these areas. (b)(5)

(b)(5) No action now but wanted to start to help you all know the types of things that are occurring and some of the really bad actors involved.

<https://www.justice.gov/usao-cdca/pr/13-members-and-associates-rival-armenian-syndicates-arrested-federal-complaints>

Get [Outlook for iOS](#)

From: Craig Moore <cmoore@premiersolutionpartners.com>
Sent: 5/9/2025 11:42:21 AM -0400
To: "Oz, Mehmet (CMS/OA)" <mehmet.oz@cms.hhs.gov>; "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>; "Brooks, John (CMS/OA)" <john.brooks1@cms.hhs.gov>; Kim.Brandt@cms.hhs.gov; "Czajkowski, John (CMS/OA)" <John.Czajkowski@cms.hhs.gov>
CC: Abe.Sutton@cms.hhs.gov; "Cantwell, Kathleen (CMS/OSORA)" <Kathleen.Cantwell@cms.hhs.gov>
BCC:
Subject: Re: Re: Urgent - Cost Containment Opportunity for Medicare/Medicaid
Attachments: Outlook-2cdlzd15.png; Outlook-z35sdmj2.png

Good Morning,

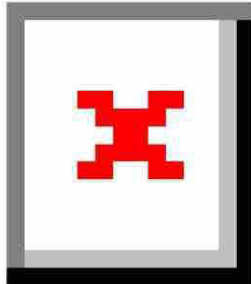
I hope you have had a chance to review the deck I attached.

Would love to find 30 minutes in the next few weeks to explore the potential here. We can provide significant savings fairly quickly if we can establish an implementation strategy on a state-by-state basis.

Looking forward to sharing more and assisting in significant waste reduction.

Respectfully,

Craig Moore
Sales/Business Development
CMoore@PremierSolutionPartners.com
Mobile (b)(6)



From: Craig Moore
Sent: Tuesday, May 6, 2025 4:16 PM
To: Mehmet.Oz@cms.hhs.gov <Mehmet.Oz@cms.hhs.gov>; Stephanie.Carlton@cms.hhs.gov <Stephanie.Carlton@cms.hhs.gov>; Steph.Carlton@cms.hhs.gov <John.Brooks@cms.hhs.gov>; Kim.Brandt@cms.hhs.gov <Kim.Brandt@cms.hhs.gov>; John.Czajkowski@cms.hhs.gov

<John.Czajkowski@cms.hhs.gov>

Cc: Abe.Sutton@cms.hhs.go <Abe.Sutton@cms.hhs.go>; Kathleen.Cantwell@cms.hhs.gov

<Kathleen.Cantwell@cms.hhs.gov>

Subject: Urgent - Cost Containment Opportunity for Medicare/Medicaid

CMS Team,

My firm has presented solutions to CMS staff in the past with positive reception.

An almost immediate savings opportunity deals with high-cost claims(\$100k+). Quantify Health, our forensic claims auditing platform, utilizes experienced teams of professionals in various medical specialties to quickly audit claims for errors and overbilling by comparing the itemized billing against the patient's record of care. This process, which has a turnaround time of 10 business days or less, is conducted on pended claims and delivers an historic average of 16% net savings on claims in this category.

****For perspective, we deliver \$100-\$150 per plan member annually.**

Conservatively, 160mm plan members x \$100 equates to \$16 Billion in annual savings.

In the spirit of reducing waste fraud and abuse, It is my belief that working in conjunction with State and Federal teams, we can deliver a tremendous savings to the American people.

I look forward to hearing back from you. I'm happy to have my office coordinate an introductory Zoom meeting to share more.

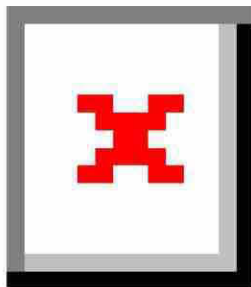
Thank you for your consideration

Craig Moore

Sales/Business Development

CMoore@PremierSolutionPartners.com

Mobile: (b)(6)



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From: Shannon Campagna <SCampagna@PortfolioStrategiesLLC.com>
Sent: 3/26/2025 6:26:05 PM -0400
To: "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>
CC:
BCC:
Subject: Fw: Fw: Meeting request from former Safeway CEO Steve Burd
Attachments: Outlook-obxe0cah

Stephanie, hi! I am hopeful that my email found it's way to you last week. Please let me know if it's possible to get on your schedule or if there's someone within CMS who would be an appropriate proxy.

Shannon

202-400-1810

From: Shannon Campagna
Sent: Friday, March 21, 2025 8:42 PM
To: stephanie.carlton@cms.hhs.gov
Subject: Meeting request from former Safeway CEO Steve Burd

Stephanie, congratulations on your new role at CMS. It is always heartening to see former Hill staff rise to the top of agencies!

I hope you will remember working with Safeway CEO Steve Burd during the ACA when you were on the Hill. I am happy to share that Steve has continued his work in the healthcare space and he continues to think about ways to streamline U.S. healthcare, enhance efficiency and realize cost-savings. He penned an op-ed that appeared in [Real Clear Markets](#) this week.

Having spent the better part of the last two decades reinventing how healthcare services are provided, Steve identifies five major areas of focus in the [article](#) he calls "low hanging fruit," that include: (1) Drug Costs for both Medicare and Medicaid, (2) Royalty Payments to the National Institute of Health (NIH), (3) Cancer Services, (4) Wellness Services and (5) Fraud and Abuse.

These are practical, data-driven solutions that align with fiscal responsibility, smart government, and better patient care.

Steve is considering a trip to DC the week of April 7 and I respectfully request a meeting with you and your team on that Monday or Tuesday. Steve would welcome the opportunity to discuss these solutions and is anxious to share his learnings with the Administration.

I am hopeful that we can make this work - are you able to meet with us that week?

Shannon



Shannon Campagna | 202.400.1810

From: Shannon Campagna <SCampagna@PortfolioStrategiesLLC.com>
Sent: 3/21/2025 8:42:22 PM -0400
To: "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>
CC:
BCC:
Subject: Meeting request from former Safeway CEO Steve Burd
Attachments: Outlook-obxe0cah

Stephanie, congratulations on your new role at CMS. It is always heartening to see former Hill staff rise to the top of agencies!

I hope you will remember working with Safeway EO Steve Burd during the ACA when you were on the Hill. I am happy to share that Steve has continued his work in the healthcare space and he continues to think about ways to streamline U.S. healthcare, enhance efficiency and realize cost-savings. He penned an op-ed that appeared in [Real Clear Markets](#) this week.

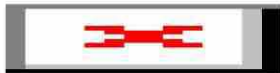
Having spent the better part of the last two decades reinventing how healthcare services are provided, Steve identifies five major areas of focus in the [article](#) he calls "low hanging fruit," that include: (1) Drug Costs for both Medicare and Medicaid, (2) Royalty Payments to the National Institute of Health (NIH), (3) Cancer Services, (4) Wellness Services and (5) Fraud and Abuse.

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I am hopeful that we can make this work - are you able to meet with us that week?

Shannon



Shannon Campagna | 202.400.1810

Sent: 6/17/2025 11:45:30 AM -0400

To:

CC:

BCC:

Subject:

Both Medicaid and marketplace

(b)(5)

Marketplace

91% of Medicaid benes have a smart phone

More than \$10B double enrolled

(b)(5)

Chief of Staff and Deputy Administrator
Centers for Medicare and Medicaid Services

Confidential, iterative, and pre-decisional

From: "Ohlendorf, Thomas (CMS/OIT)" <Thomas.Ohlendorf@cms.hhs.gov>
Sent: 3/14/2025 11:05:51 AM -0400
To: "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>
CC:
BCC:
Subject: Farewell
Attachments: image001.jpg; image002.jpg; image003.jpg; image004.jpg

Steph:

We have not met and that is unfortunate because I did want to meet you.

Today is my last day at CMS; I am retiring.

Speaking as a beneficiary, keep doing what you are doing; you are doing a great job protecting my Medicare.

For the future, lean on OIT and ramp up the use of AI; particularly in the area of seeking out fraud and abuse. There are many people in OIT that are AI gurus and all of the contractors have a handle on it.

You can reach me at tohlendorf61@gmail in the future if you desire.

Thank you,

Tom Ohlendorf

Centers for Medicare & Medicaid Services (CMS)

Office of Information Technology (OIT)

Enterprise Systems Solutions Group (ESSG)

Division of Medicare Systems Support (DMSS)

☎ 410.786.0220 ☎ thomas.ohlendorf@cms.hhs.gov

ADS: ☎ 443.417.0187 ☎ 410.569.9883

7500 Security Blvd., N3-18-06
Baltimore, MD 21244-1850

Need more information? Please visit [the OIT website.](#)

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From: "Aramanda, Alexander (CMS/CM)" <alexander.aramanda@cms.hhs.gov>
Sent: 6/4/2025 3:28:34 PM -0400
To: "Brooks, John (CMS/OA)" <john.brooks1@cms.hhs.gov>; "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>
CC: "Klomp, Chris (CMS/CM)" <chris.klomp@cms.hhs.gov>; "Albanese, Joseph (CMS/CM)" <joseph.albanese@cms.hhs.gov>; "Armstrong, Rebekah (CMS/OL)" <rebekah.armstrong@cms.hhs.gov>
BCC:
Subject: FW: FW: Stark/Mail Order Issue
Attachments: 0-FFS Sr Staff-05-12-25.pptx

John & Steph,

Flagging this note below on the mail order pharmacy issue raised by COA (and other stakeholders), particularly the heads-up that Dr. Vacirca may raise this issue at a meeting next Thursday with Dr. Oz.

I've attached a recent CM slide deck (slides 13-15) that covers the high level background as well as a draft, preliminary response to OMB's request for views on related legislation that we collaborated with OL on (note: to my knowledge this Rfv has not been made public or shared with stakeholders).

Let us know if you have any questions or need anything specific for Dr. Oz in advance of this meeting.

Best,

Alec

(b)(5)

(b)(5)

(b)(5)

(b)(5)

DRAFT, PRELIMINARY, CONFIDENTIAL

From: Dylan Moore <dmoore@farragutpartners.com>

Sent: Tuesday, June 3, 2025 3:40 PM

To: Aramanda, Alexander (CMS/CM) <alexander.aramanda@cms.hhs.gov>; Albanese, Joseph (CMS/CM) <joseph.albanese@cms.hhs.gov>

Subject: Stark/Mail Order Issue

Hey Alec and Joe—hope you both are doing well. Just wanted to follow up on the Stark/Mail Order issue Ted and I met with you guys on back in April to see if there was any update or anything you needed from us? I also wanted to give you both a heads up that an oncologist we work with, Dr. Jeff Vacirca, is meeting with Dr. Oz next Thursday and this will be on his list of items to raise with him.

Thanks gents!

Alec—made my first trip to Citi Field over MDW to watch Mets/Dodgers. Was really awesome to see the ballpark and loved the vibes in game. Of course we picked the game with a 1.5hr rain delay—that was fun! Was the most Mets, Mets game of all time. Ha

Dylan

Dylan Moore

Partner

Farragut Partners LLP

1225 New York Ave. NW, Suite 600

Washington, DC 20005

(b)(6)

From: "Krepich, Christopher (CMS/OC)" <christopher.krepich@cms.hhs.gov>
Sent: 6/8/2025 11:00:46 PM -0400
To: "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>
CC:
BCC:
Subject: RE: RE: Krepich - can you take a look at this draft op-ed?
Attachments: 20250608 Medicaid draft op-ed ck.docx

Left a few comments for consideration tonight. Would like a little more time to add substantive edits in the AM after we connect for a few to talk overall strategy.

(b)(5)

From: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Sent: Sunday, June 8, 2025 10:20 PM
To: Krepich, Christopher (CMS/OC) <christopher.krepich@cms.hhs.gov>
Subject: Krepich - can you take a look at this draft op-ed?

Had discussed with Dr. Oz and trying for the WSJ. It's based on our Senate presentation. The red text is where I'll ask the team to verify numbers, but would love your review and then we can share with Dr. Oz.

Steph

As the Senate finalizes One Big Beautiful Bill, the Medicaid provisions continue to generate a frenzy of lobbying activity, media hysteria, and general confusion. Lobbyists are being paid millions to preserve commercial payment rates for safety net providers. The liberal media is screaming that 11 million people will have to start working or show proof that they're actually eligible to keep government benefits. If you're not *really* into healthcare policy, it's hard to know what to believe.

The truth: OBBB doesn't cut Medicaid spending or benefits. Instead, it addresses four years of unchecked waste, fraud and abuse. The Biden Administration allowed Medicaid to pay hospitals at commercial rates, send grants to labor union, fund diversity programs and issue student loan forgiveness—egregious misuses of taxpayer dollars. Congress is finally mustering the courage to fix those abuses and focus Medicaid on its core mission.

Let us explain the facts. Federal taxpayers will invest \$660B in Medicaid this year – and without changes, federal spending would skyrocket to a trillion dollars a year by 2034. Under OBBB, Medicaid will never see a cut below today's \$660B baseline, and the reforms will manage the rate of growth to an average of 2.9% a year – more in line with economic growth. Three major reforms accomplish this goal.

First, OBBB applies established welfare work requirements to Medicaid. To continue to qualify for Medicaid benefits, individuals will need to show 20 hours of work each week – and if they're not able to work, volunteering in their communities or training for a new job counts. As President Obama observed, work serves as "a centerpiece of any social policy" providing not just income but "intrinsic dignity" and "sense of purpose." This concept has bipartisan roots grounded in President Clinton's 1996 reforms adding work requirements to cash assistance programs (resulting in a 10-21% improvement in work participation rates). Critics claiming this creates administrative burdens ignore our commitment to develop user-friendly, technology-enabled solutions within 18 months.

Second, OBBB restores basic eligibility verification suspended during COVID-19. Pandemic policies halted Medicaid and CHIP eligibility checks for three years, driving enrollment growth to 8.5% annually and peak enrollment of 96.3 million. (b)(5)

(b)(5)
(b)(5) after adjusting for population growth. OBBB implements straightforward eligibility verification measures: regular address confirmation, cross-referencing Social Security death files, requiring income documentation beyond self-attestation, and periodic eligibility reviews.

Third, OBBB goes after money laundering through provider taxes and hospital overpayments. Under bizarre Medicaid rules, healthcare providers welcome state taxation because states leverage those revenues for 2:1 federal matching funds, then redistribute payments exceeding original taxes. Such schemes have distorted the federal-state financing agreement. Federal contributions rose from 57% five years ago to 68% today. While states cite balanced-budget requirements to justify these schemes, this logic has driven the federal debt towards \$36 trillion and recent credit downgrades.

The Biden Administration allowed Medicaid to pay certain providers 2-3 times Medicare rates through "state directed payments"—reaching commercial insurance payment levels. These payments exploded from \$24 billion in 2021 to \$124 billion this year – and not surprisingly, CMS has 179 pending state requests for more. Worse, only half the states distributing these overpayments comply with agreed-upon quality improvements. OBBB simply lowers the Biden era cap from commercial rates to the Medicare cap that the Obama Administration put in place.

As clinicians who have cared for Medicaid patients, we understand the program's vital role supporting society's most vulnerable—such as low-income cancer patients and disabled

individuals requiring 24/7 care or lifelong support. We're committed to serving them – and insisting that the Medicaid program deliver better health outcomes for them.

The choice is clear: defend the status quo for a system riddled with waste and abuse or restore Medicaid to its core. We choose reform.

Mehmet Oz, a physician, is the Administrator of the Centers for Medicare and Medicaid Services (CMS). Stephanie Carlton, a nurse, is the Deputy Administrator of CMS.

From: Shannon Campagna <SCampagna@PortfolioStrategiesLLC.com>
Sent: 3/26/2025 6:41:09 PM -0400
To: "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>
CC: "Morgan, Katarina (CMS/CCIIO)" <katarina.morgan@cms.hhs.gov>
BCC:
Subject: Re: Re: Meeting request from former Safeway CEO Steve Burd
Attachments: image001.jpg

Certainly - he will be here again, and there is the option of a virtual meeting too - an innovation since our first go round! I'll revert back.

Thanks for your positive response.

Shannon
202-400-1810

From: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Sent: Wednesday, March 26, 2025 6:29 PM
To: Shannon Campagna <SCampagna@PortfolioStrategiesLLC.com>
Cc: Morgan, Katarina (CMS/CCIIO) <katarina.morgan@cms.hhs.gov>
Subject: RE: Meeting request from former Safeway CEO Steve Burd

Hi Shannon – Good to hear from you. Would love to connect with you and Steve, but that timing is tough for us with the expected arrival Dr. Oz around then. Could we look to another trip?

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From: Shannon Campagna <SCampagna@PortfolioStrategiesLLC.com>
Sent: Wednesday, March 26, 2025 6:26 PM
To: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Subject: Fw: Meeting request from former Safeway CEO Steve Burd

Stephanie, hi! I am hopeful that my email found it's way to you last week. Please let me know if it's possible to get on your schedule or if there's someone within CMS who would be an appropriate proxy.

Shannon

202-400-1810

From: Shannon Campagna

Sent: Friday, March 21, 2025 8:42 PM

To: stephanie.carlton@cms.hhs.gov

Subject: Meeting request from former Safeway CEO Steve Burd

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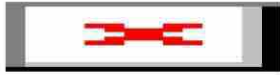
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Shannon



Shannon Campagna | 202.400.1810

From: "Thomas, Grant (CMS/CMCS)" <grant.thomas@cms.hhs.gov>
Sent: 6/27/2025 4:13:27 PM -0400
To: "Chen, Emily (CMS/OA)" <emily.chen@cms.hhs.gov>; "Krepich, Christopher (CMS/OC)" <christopher.krepich@cms.hhs.gov>; "Deo, Gita (CMS/CMMI)" <gita.deo@cms.hhs.gov>; "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>
CC:
BCC:
Subject: RE: RE: Can y'all take pen on this?
Attachments: CMS Comment on State Directed Payments (for Board Book).pdf; image001.png

See attached for the letter from the North Carolina State Treasurer that he wrote to CMS in 2023 urging CMS not to approve SDPs at average commercial rate due to the adverse impact it would have on the state's health insurance plan and North Carolina citizens on private health insurance plans.

The below is from Brian Blase to back up and support the below statements.

"Tying Medicaid payments to commercial rates encourages providers and insurers alike to further increase the costs of private health insurance, leading to reduced wages for hard-working American families. North Carolina State Treasurer, Dale Fowell, highlighted how these provider tax and SDP schemes would increase health care costs, including commercial rates, in a letter he penned to CMS."

Because this payment structure makes Medicaid rates 2x-3x greater than Medicare rates, this payment structure also threatens access to care for our seniors on Medicare by creating incentives for providers to prioritize Medicaid patients over seniors and individuals with disabilities enrolled in Medicare."

-
-

From Brian Blase:

To your question on commercial rates, Medicare rates, and Medicaid rates. Every year, RAND does a hospital pricing study assessing hospital prices as a percentage of Medicare across the country. Here is a link to their studies: [Hospital Price Transparency Study | RAND](#). On average, commercial rates are 2.5 times Medicare rates.

In our money laundering paper, we assessed SDP preprints. We found that 25 of them have hospital prices as a function of ACR. And that the average percent of ACR was 84%. Thus, taking that percentage and multiplying it by average commercial rates being 2.5x Medicare means that on average Medicaid rates through SDP are more than 2x Medicare.

If you are looking for some examples of the problem, you can find them in this WSJ article from April: [Hospital Chains' Medicaid Profits Are a Juicy Target for GOP Budget Hawks - WSJ](#).

And we just posted a blog on this: [Championing Senate Reforms and Countering Rural Hospital Hysteria in the Fight Against Medicaid Money Laundering - Paragon Health Institute](#)

Dear Brian,

Thank you so much for writing this amazing article about Medicaid provider tax: [Championing Senate Reforms and Countering Rural Hospital Hysteria in the Fight Against Medicaid Money Laundering](#). I completely agree with you and would like to share some related articles I contributed to:

Health Affairs Forefront: [North Carolina Medicaid Expansion Puts Employers And Workers At Risk For Higher Hospital Prices](#)

Health Affairs Forefront: [Medicaid Financing Requires Reform: The North Carolina Case Study](#)

Forbes: [CMS Invites Hospitals to Raise Prices and Buy Physician Practices](#)

The Hill: [North Carolina's Medicaid Expansion Comes with Inconvenient Truths](#)

In my view, Democrats designed the Medicaid provider tax scheme in the name of "helping patients" to transfer cash from federal taxpayers to large hospitals in certain states in exchange for their support of the states' Medicaid expansion and for political gain.

These windfall dollars fuel hospital consolidation, undermine independent physicians and small hospitals, raise commercial prices and insurance premiums, and harm Medicaid patients by misallocating limited public resources. Ultimately, hardworking American families, vulnerable Medicaid patients, employers of all sizes, independent physicians, and small hospitals all end up as victims of this fiscal scheme.

Thank you again for your incredible work!

Thanks,

Grant Thomas

Grant Thomas

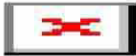
Senior Advisor

Center for Medicaid and CHIP Services

Centers for Medicare and Medicaid Services

grant.thomas@cms.hhs.gov

(b)(6)



From: Thomas, Grant (CMS/CMCS)

Sent: Friday, June 27, 2025 3:27 PM

To: Chen, Emily (CMS/OA) <emily.chen@cms.hhs.gov>; Krepich, Christopher (CMS/OC) <christopher.krepich@cms.hhs.gov>; Deo, Gita (CMS/CMML) <gita.deo@cms.hhs.gov>; Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>

Subject: RE: Can y'all take pen on this?

Please see attached for additional edits that I added after receiving information from Brian. I have included the relevant additions below. Also, I do not know if it is helpful or not from a comms perspective, but former President Obama, former Vice President Biden, Senator Durbin, etc. have all made critical comments of provider taxes in the past.

Tying Medicaid payments to commercial rates encourages providers and insurers alike to further increase the costs of private health insurance, leading to reduced wages for hard-working American families. North Carolina State Treasurer, Dale

Fowell, highlighted how these provider tax and SDP schemes would increase health care costs, including commercial rates, in a letter he penned to CMS.

<https://www.shpnc.org/media/3232/download?attachment>

Because this payment structure makes Medicaid rates 2x-3x greater than Medicare rates, this payment structure also threatens access to care for our seniors on Medicare by creating incentives for providers to prioritize Medicaid patients over seniors and individuals with disabilities enrolled in Medicare.

Thanks,

Grant Thomas

Grant Thomas

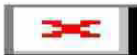
Senior Advisor

Center for Medicaid and CHIP Services

Centers for Medicare and Medicaid Services

grant.thomas@cms.hhs.gov

(b)(5)



From: Chen, Emily (CMS/OA) <emily.chen@cms.hhs.gov>

Sent: Friday, June 27, 2025 2:53 PM

To: Krepich, Christopher (CMS/OC) <christopher.krepich@cms.hhs.gov>; Thomas, Grant (CMS/CMCS) <grant.thomas@cms.hhs.gov>; Deo, Gita (CMS/CMMI) <gita.deo@cms.hhs.gov>; Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>

Subject: Re: Can y'all take pen on this?

Hi - saw that we changed the text for rural hospital spend to be as a % of SDPs

This is not less than (b)(5) It is closer to (b)(5) Please let me know what figure we're trying to be calculate.

2024: 19.5B (Medicaid inpatient + outpatient rural hospital spend) / 103B (SDP spend) = 18.9%

2025: 20.5B (Medicaid inpatient + outpatient rural hospital spend) / 124B (SDP spend) = 16.5%

Emily Chen
Senior Advisor | Office of the Administrator
(301) 708-1030

Confidential, iterative, and pre-decisional

From: Krepich, Christopher (CMS/OC) <christopher.krepich@cms.hhs.gov>
Sent: Friday, June 27, 2025 2:40 PM
To: Thomas, Grant (CMS/CMCS) <grant.thomas@cms.hhs.gov>; Chen, Emily (CMS/OA) <emily.chen@cms.hhs.gov>; Deo, Gita (CMS/CMMI) <gita.deo@cms.hhs.gov>; Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Subject: RE: Can y'all take pen on this?

Style edits attached and a comment about one of the pre-prints namechecked.

From: Thomas, Grant (CMS/CMCS) <grant.thomas@cms.hhs.gov>
Sent: Friday, June 27, 2025 2:27 PM
To: Chen, Emily (CMS/OA) <emily.chen@cms.hhs.gov>; Deo, Gita (CMS/CMMI) <gita.deo@cms.hhs.gov>; Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>; Krepich, Christopher (CMS/OC) <christopher.krepich@cms.hhs.gov>
Subject: RE: Can y'all take pen on this?

See below for my additions in **black bold**. I reached out to Brian Blase to see if he had any data to back up the claims below regarding incentives, and he said he is going to send me some data that they have from North Carolina. He said that this is all new policy so they are writing about the incentives that face states from such high Medicaid rates. But they do have some data out of North Carolina that he will send.

Thanks,

Grant Thomas

Grant Thomas

Senior Advisor

Center for Medicaid and CHIP Services

Centers for Medicare and Medicaid Services

grant.thomas@cms.hhs.gov

(b)(6)



From: Chen, Emily (CMS/OA) <emily.chen@cms.hhs.gov>

Sent: Friday, June 27, 2025 2:23 PM

To: Deo, Gita (CMS/CMMI) <gita.deo@cms.hhs.gov>; Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>; Thomas, Grant (CMS/CMCS) <grant.thomas@cms.hhs.gov>; Krepich, Christopher (CMS/OC) <christopher.krepich@cms.hhs.gov>

Subject: RE: Can y'all take pen on this?

Small **edit** to the rural stat, with full calculation context below.

- 2024 total Medicaid expenditures (NHE): \$926B
- 2024 Medicaid inpatient + outpatient hospital spending for rural hospitals (OACT): \$19.5B
- $19.5/926 = \sim 2.1\%$

The Biden Administration approved excessive payment rates to hospitals – at commercial rates for a safety net program. This is unprecedented after tradition of Medicare caps that even the Obama Administration codified.

Spending on SDPs has increased (b)(5) over the last (b)(5) years.

Since just this Wednesday (June 25), one state submitted 15 new preprints for specific facilities, focused on payments for professional services. The preprint values range between \$8 million and \$250 million (per preprint) in brand new SDP spending, totaling more than \$1 billion. They are targeted for specific facilities, including academic medical centers and non profits [Cleveland Clinic, Nationwide Children’s Hospital, Southern Ohio Medical Center, Kettering, and Bon Secours Mercy]. This is highly unusual for the State of Ohio, which has not used preprints much to date.

This is going to cost taxpayers (b)(5) on what this would be if ALL states were up to ACR] over the next ten years if we don’t take action.

This isn’t about rural hospitals – that’s less than (b)(5) of the impact.

This isn’t about making sure hospitals can take care of patients – their corporate profits are growing (for publicly traded hospitals: 6% in 2022 to 8% in 2024).

(b)(5)

This is about corporate profiteering off a welfare program. We all have a moral obligation to take care of our most vulnerable, not to view them as a profit pool. Who is willing to defend excessive payments to hospitals?

Tying Medicaid payments to commercial rates encourages providers and insurers alike to further increase the costs of private health insurance, leading to reduced wages for hard-working American families.

This payment structure also threatens access to care for our seniors on Medicare by creating incentives for providers to prioritize Medicaid patients over seniors and individuals with disabilities enrolled in Medicare.

The impacts of this will vary by state, and the more we've dug into state specific estimates, the more embarrassed states should be about these schemes and money laundering.

(b)(5)

(b)(5)

Emily Chen

Senior Advisor | Office of the Administrator

(301) 708-1030

Confidential, iterative, and pre-decisional

From: Deo, Gita (CMS/CMMI) <gita.deo@cms.hhs.gov>

Sent: Friday, June 27, 2025 2:21 PM

To: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>; Chen, Emily (CMS/OA) <emily.chen@cms.hhs.gov>; Thomas, Grant (CMS/CMCS) <grant.thomas@cms.hhs.gov>; Krepich, Christopher (CMS/OC) <christopher.krepich@cms.hhs.gov>

Subject: RE: Can y'all take pen on this?

(b)(5)

(b)(5)

Let me know if any questions!

Best,

Gita Deo

Confidential, iterative, and pre-decisional

From: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>

Sent: Friday, June 27, 2025 2:05 PM

To: Chen, Emily (CMS/OA) <emily.chen@cms.hhs.gov>; Deo, Gita (CMS/CMMI)

<gita.deo@cms.hhs.gov>; Thomas, Grant (CMS/CMCS) <grant.thomas@cms.hhs.gov>; Krepich, Christopher (CMS/OC) <christopher.krepich@cms.hhs.gov>

Subject: Can y'all take pen on this?

Can y'all take pen on filling out the highlighted parts? Grant is monitoring input from OACT on the model and may add a line on incentives created from SDPs. Gita has SDP spending. Emily – you ok with the rural #s? Krepich – style points?

The Biden Administration approved excessive payment rates to hospitals – at commercial rates for a safety net program. This is unprecedented after tradition of Medicare caps that even the Obama Administration codified.

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This is going to cost taxpayers (b)(5) on what this would be if ALL states were up to ACR] over the next ten years if we don't take action.

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This is about corporate profiteering off a welfare program. We all have a moral obligation to take care of our most vulnerable, not to view them as a profit pool. Who is willing to defend excessive payments to hospitals?

The impacts of this will vary by state, and the more we've dug into state specific estimates, the more embarrassed states should be about these schemes and money laundering.

(b)(5)

(b)(5)

Confidential, iterative, and pre-decisional

From: "Neal, Phaedra (CMS/OA)" <Phaedra.Neal@cms.hhs.gov>
Sent: 5/20/2025 10:56:15 AM -0400
To: Ashley Gunn <ashley@millerstrategies.com>; "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>
CC: "Perez-Rivera, Diana (CMS/OA)" <Diana.Perez-Rivera@cms.hhs.gov>
BCC:
Subject: RE: RE: CMS and California state plan amendment on IGT for public ambulance providers
Attachments: image001.png

Looping in Steph's EA, Diana. Thanks.

Phaedra Neal

Executive Assistant to Dr. Mehmet Oz, CMS Administrator

Office of the Administrator

phaedra.neal@cms.hhs.gov

(b)(6)



From: Ashley Gunn <ashley@millerstrategies.com>
Sent: Tuesday, May 20, 2025 10:51 AM
To: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>; Neal, Phaedra (CMS/OA) <Phaedra.Neal@cms.hhs.gov>
Subject: Fwd: CMS and California state plan amendment on IGT for public ambulance providers

Hi Steph,

Who would handle the CA state plan amendment on IGT for public ambulance providers?

Appreciate you!

Thank you,
Ashley Gunn
Miller Strategies, LLC
[801 Pennsylvania Avenue N.W.](https://www.millerstrategies.com)
[Suite 350](https://www.millerstrategies.com)
[Washington, D.C. 20004](https://www.millerstrategies.com)
[\(916\)996-0488](https://www.millerstrategies.com)
[www.MillerStrategies.com](https://www.millerstrategies.com)

Begin forwarded message:

From: "Northrup, Stephen" <stephen.northrup@gmr.net>
Date: May 16, 2025 at 4:39:55 PM EDT
To: Ashley Gunn <ashley@millerstrategies.com>
Cc: "Dhokai, Andy" <Andres.Dhokai@gmr.net>, Luke Wallwork <luke@millerstrategies.com>
Subject: CMS and California state plan amendment on IGT for public ambulance providers

Ashley, happy Friday!

Do you have the ability to bring this issue to Steph Carlton's attention, or whomever else at CMS is in the know, even if we can't get a meeting right away?

We need to know what CMS's intention is in relation to the IGT that California filed on March 25. CMS has 90 days to review it and we are about halfway thru that period.

We obviously want to set up a discussion as well with CMS, as Luke knows from our call on Wednesday.

We want to make sure the right people at CMS are looking at this, because approving it would run counter to the President's desire to root out fraud and abuse in Medicaid.

Talking points on the way shortly....

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This email has been scanned for viruses and malware, and may have been automatically archived by Mimecast, a leader in email security and cyber resilience. Mimecast integrates email defenses with brand protection, security awareness training, web security, compliance and other essential capabilities. Mimecast helps protect large and small organizations from malicious activity, human error and technology failure; and to lead the movement toward building a more resilient world. To find out more, visit our website.

From: Shannon Campagna <SCampagna@PortfolioStrategiesLLC.com>
Sent: 4/28/2025 12:19:14 PM -0400
To: "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>
CC: "Morgan, Katarina (CMS/OA)" <katarina.morgan@cms.hhs.gov>
BCC:
Subject: Re: Re: Meeting request from former Safeway CEO Steve Burd
Attachments: Outlook-2rors4fh.jpg

Stephanie, hi! And hi Katrina - I am hopeful we can get something scheduled within next 30 days. Any feedback on your availability?

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From: Shannon Campagna <SCampagna@PortfolioStrategiesLLC.com>
Sent: Wednesday, April 23, 2025 9:29:08 PM
To: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Cc: Morgan, Katarina (CMS/CCIIO) <katarina.morgan@cms.hhs.gov>
Subject: Re: Meeting request from former Safeway CEO Steve Burd

Stephanie, hi!

Steve had a great reception on the Hill when he was in town earlier this month - we had six Member level meetings and the feedback was very positive for Steve's ideas for healthcare savings.

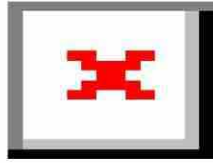
Last week Steve was happy to see the EO from the President on drug pricing. He penned a letter applauding the President's EO and outlined some additional thoughts on going even further. I am attaching it for your consideration.

Steve will be back in DC for further conversations in May - he is available to travel DC on the following dates.

May 5 - 8
May 12 -16
May 19 -22

Is there a time within that range that works for a meeting with you and the Administrator? We would build his trip around this meeting.

I have attached his bio as a refresher, and here is a link to the OpEd he wrote for [Real Clear Markets](#).



The \$300 Billion Annual Healthcare Fix Washington Can't Afford to Ignore

After spending 50 years in the private sector where cost reduction opportunities are near infinite in number, I believe the \$2 trillion in savings currently being considered by the Administration and

urldefense.proofpoint.com

Thanks for your consideration Stephanie. I look forward to hearing from you, and to reconnecting.

Shannon
202-400-1810

From: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Sent: Wednesday, March 26, 2025 6:29 PM
To: Shannon Campagna <SCampagna@PortfolioStrategiesLLC.com>
Cc: Morgan, Katarina (CMS/CCIIO) <katarina.morgan@cms.hhs.gov>
Subject: RE: Meeting request from former Safeway CEO Steve Burd

Hi Shannon – Good to hear from you. Would love to connect with you and Steve, but that timing is tough for us with the expected arrival Dr. Oz around then. Could we look to another trip?

Confidential, iterative, and pre-decisional

From: Shannon Campagna <SCampagna@PortfolioStrategiesLLC.com>
Sent: Wednesday, March 26, 2025 6:26 PM
To: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Subject: Fw: Meeting request from former Safeway CEO Steve Burd

Stephanie, hi! I am hopeful that my email found it's way to you last week. Please let me know if it's possible to get on your schedule or if there's someone within CMS who would be an appropriate proxy.

Shannon
202-400-1810

From: Shannon Campagna

Sent: Friday, March 21, 2025 8:42 PM

To: stephanie.carlton@cms.hhs.gov

Subject: Meeting request from former Safeway CEO Steve Burd

Stephanie, congratulations on your new role at CMS. It is always heartening to see former Hill staff rise to the top of agencies!

I hope you will remember working with Safeway CEO Steve Burd during the ACA when you were on the Hill. I am happy to share that Steve has continued his work in the healthcare space and he continues to think about ways to streamline U.S. healthcare, enhance efficiency and realize cost-savings. He penned an op-ed that appeared in [Real Clear Markets](#) this week.

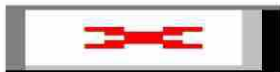
Having spent the better part of the last two decades reinventing how healthcare services are provided, Steve identifies five major areas of focus in the [article](#) he calls "low hanging fruit," that include: (1) Drug Costs for both Medicare and Medicaid, (2) Royalty Payments to the National Institute of Health (NIH), (3) Cancer Services, (4) Wellness Services and (5) Fraud and Abuse.

These are practical, data-driven solutions that align with fiscal responsibility, smart government, and better patient care.

Steve is considering a trip to DC the week of April 7 and I respectfully request a meeting with you and your team on that Monday or Tuesday. Steve would welcome the opportunity to discuss these solutions and is anxious to share his learnings with the Administration.

I am hopeful that we can make this work - are you able to meet with us that week?

Shannon



Shannon Campagna | 202.400.1810

From: "Krepich, Christopher (CMS/OC)" <christopher.krepich@cms.hhs.gov>
Sent: 6/27/2025 2:39:43 PM -0400
To: "Thomas, Grant (CMS/CMCS)" <grant.thomas@cms.hhs.gov>; "Chen, Emily (CMS/OA)" <emily.chen@cms.hhs.gov>; "Deo, Gita (CMS/CMMI)" <gita.deo@cms.hhs.gov>; "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>
CC:
BCC:
Subject: RE: RE: Can y'all take pen on this?
Attachments: SDP TPs 2025.06.27 239pm.docx; image001.png

Style edits attached and a comment about one of the pre-prints namechecked.

From: Thomas, Grant (CMS/CMCS) <grant.thomas@cms.hhs.gov>
Sent: Friday, June 27, 2025 2:27 PM
To: Chen, Emily (CMS/OA) <emily.chen@cms.hhs.gov>; Deo, Gita (CMS/CMMI) <gita.deo@cms.hhs.gov>; Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>; Krepich, Christopher (CMS/OC) <christopher.krepich@cms.hhs.gov>
Subject: RE: Can y'all take pen on this?

See below for my additions in **black bold**. I reached out to Brian Blase to see if he had any data to back up the claims below regarding incentives, and he said he is going to send me some data that they have from North Carolina. He said that this is all new policy so they are writing about the incentives that face states from such high Medicaid rates. But they do have some data out of North Carolina that he will send.

Thanks,

Grant Thomas

Grant Thomas

Senior Advisor

Center for Medicaid and CHIP Services

Centers for Medicare and Medicaid Services

grant.thomas@cms.hhs.gov

227-225-6998



From: Chen, Emily (CMS/OA) <emily.chen@cms.hhs.gov>
Sent: Friday, June 27, 2025 2:23 PM
To: Deo, Gita (CMS/CMMI) <gita.deo@cms.hhs.gov>; Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>; Thomas, Grant (CMS/CMCS) <grant.thomas@cms.hhs.gov>; Krepich, Christopher (CMS/OC) <christopher.krepich@cms.hhs.gov>
Subject: RE: Can y'all take pen on this?

Small **edit** to the rural stat, with full calculation context below.

- 2024 total Medicaid expenditures (NHE): \$926B
- 2024 Medicaid inpatient + outpatient hospital spending for rural hospitals (OACT): \$19.5B
- $19.5/926 = \sim 2.1\%$

The Biden Administration approved excessive payment rates to hospitals – at commercial rates for a safety net program. This is unprecedented after tradition of Medicare caps that even the Obama Administration codified.

Spending on SDPs has increased (b)(5) over the last (b)(5) years.

Since just this Wednesday (June 25), one state submitted 15 new preprints for specific facilities, focused on payments for professional services. The preprint values range between \$8 million and \$250 million (per preprint) in brand new SDP spending, totaling more than \$1 billion. They are targeted for specific facilities, including academic medical centers and non profits [Cleveland Clinic, Nationwide Children's Hospital, Southern Ohio Medical Center, Kettering, and Bon Secours Mercy]. This is highly unusual for the State of Ohio, which has not used preprints much to date.

This is going to cost taxpayers (b)(5) on what this would be if ALL states were up to ACR] over the next ten years if we don't take action.

This isn't about rural **hospitals** – that's less than (b)(5) of the impact.

This isn't about making sure hospitals can take care of patients – their corporate profits are growing (for publicly traded hospitals: 6% in 2022 to 8% in 2024).

(b)(5)

This is about corporate profiteering off a welfare program. We all have a moral obligation to take care of our most vulnerable, not to view them as a profit pool. Who is willing to defend excessive payments to hospitals?

Tying Medicaid payments to commercial rates encourages providers and insurers alike to further increase the costs of private health insurance, leading to reduced wages for hard-working American families.

This payment structure also threatens access to care for our seniors on Medicare by creating incentives for providers to prioritize Medicaid patients over seniors and individuals with disabilities enrolled in Medicare.

The impacts of this will vary by state, and the more we've dug into state specific estimates, the more embarrassed states should be about these schemes and money laundering.

(b)(5)

(b)(5)

Emily Chen

Senior Advisor | Office of the Administrator

(301) 708-1030

Confidential, iterative, and pre-decisional

From: Deo, Gita (CMS/CMMI) <gita.deo@cms.hhs.gov>
Sent: Friday, June 27, 2025 2:21 PM
To: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>; Chen, Emily (CMS/OA) <emily.chen@cms.hhs.gov>; Thomas, Grant (CMS/CMCS) <grant.thomas@cms.hhs.gov>; Krepich, Christopher (CMS/OC) <christopher.krepich@cms.hhs.gov>
Subject: RE: Can y'all take pen on this?

(b)(5)

(b)(5). Let me know if any questions!

Best,
Gita Deo

Confidential, iterative, and pre-decisional

From: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Sent: Friday, June 27, 2025 2:05 PM
To: Chen, Emily (CMS/OA) <emily.chen@cms.hhs.gov>; Deo, Gita (CMS/CMMI) <gita.deo@cms.hhs.gov>; Thomas, Grant (CMS/CMCS) <grant.thomas@cms.hhs.gov>; Krepich, Christopher (CMS/OC) <christopher.krepich@cms.hhs.gov>
Subject: Can y'all take pen on this?

Can y'all take pen on filling out the highlighted parts? Grant is monitoring input from OACT on the model and may add a line on incentives created from SDPs. Gita has SDP spending. Emily – you ok with the rural #s? Krepich – style points?

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(b)(5)

(b)(5)

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From: Quinten Lyons <quin@nphihealth.org>
Sent: 2/18/2025 4:22:17 PM -0500
To: "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>
CC: Ethan McChesney <ethan@nphihealth.org>; Tom Koutsoumpas <tom@nphihealth.org>; "Aramanda, Alexander (CMS/CM)" <alexander.aramanda@cms.hhs.gov>
BCC:
Subject: RE: RE: Nonprofit Hospice Community Policy Priorities
Attachments: image001.png; image002.png; image003.png; image004.png

Stephanie – thank you for the timely response. We would be delighted to join.

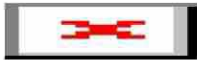
It's great to meet you, Alexander. Let me know if you need anything from our end, and please forward along any relevant meeting/scheduling information.

Regards,

Quinten Lyons

Policy Associate

717.817.3896 | Quin@nphihealth.org



The national voice for not-for-profit advanced illness, hospice, and palliative care.



From: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Sent: Tuesday, February 18, 2025 4:16 PM
To: Quinten Lyons <quin@nphihealth.org>
Cc: Ethan McChesney <ethan@nphihealth.org>; Tom Koutsoumpas <tom@nphihealth.org>; Aramanda, Alexander (CMS/CM) <alexander.aramanda@cms.hhs.gov>
Subject: RE: Nonprofit Hospice Community Policy Priorities

This message is from an EXTERNAL SENDER

Hi Quinten – I'm looping in one of my colleagues, a leader for CM, to meet on this topic. We're asking CEOs to join for these intro meetings, if at all possible.

Steph

Confidential, iterative, and pre-decisional

From: Quinten Lyons <quin@nphihealth.org>
Sent: Tuesday, February 18, 2025 12:38 PM
To: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Cc: Ethan McChesney <ethan@nphihealth.org>; Tom Koutsoumpas <tom@nphihealth.org>
Subject: Nonprofit Hospice Community Policy Priorities

Hi Stephanie,

I hope you are having a productive week. I am reaching out on behalf of the National Partnership for Healthcare and Hospice Innovation (NPHI), the leading national organization representing the nonprofit hospice and palliative care provider community. With over 120 member programs across 38 states, NPHI members collectively care for hundreds of thousands of Medicare beneficiaries each year as they approach the end of life.

In light of your new role at CMS, I would like to initiate a conversation about the critical issues affecting the nonprofit hospice community. Please find attached our *People Over Profits* blueprint, which outlines the unique value our members bring to hospice care, along with a brief letter detailing our organization's policy priorities.

NPHI is committed to working collaboratively with you and CMS to address fraud and abuse within the hospice benefit while ensuring the long-term solvency of Medicare.

Please do not hesitate to reach out if you have any questions or if we can be of any assistance.

We stand ready to serve as a resource for any hospices issues that might come across your desk.

Regards,

Quinten Lyons

Policy Associate

717.817.3896 | Quin@nphihealth.org



The national voice for not-for-profit advanced illness, hospice, and palliative care.



From: "Pothen, Meril (CMS/CCIIO)" <Meril.Pothen@cms.hhs.gov>
Sent: 2/6/2025 1:33:35 PM -0500
To: "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>
CC: "Cantwell, Kathleen (CMS/OSORA)" <Kathleen.Cantwell@cms.hhs.gov>;
"Hutchinson, Claire (CMS/CM)" <claire.hutchinson@cms.hhs.gov>;
"Harper, Scott (CMS/OPOLE)" <scott.harper@cms.hhs.gov>
BCC:
Subject: FW: FW: SIGNATURE AUTHORITY NEEDED: Retail Pharmacy
Standard: Extension of Effective Date
Attachments: Sec Sig Memo-Retail Pharmacy Delay Final Rule (CMS-0056-F2) (02-06-25).docx

Hello Steph! We need your permission ASAP to use your signature (OSORA has it on file) on the attached memo. More info is below, and John has signed off!

From: Cantwell, Kathleen (CMS/OSORA) <Kathleen.Cantwell@cms.hhs.gov>
Sent: Thursday, February 6, 2025 1:15 PM
To: Wu, Jeff (CMS/CCIIO) <Jeff.Wu@cms.hhs.gov>; Rice, Cheri (CMS/CM) <Cheri.Rice@cms.hhs.gov>; Pothen, Meril (CMS/CCIIO) <Meril.Pothen@cms.hhs.gov>; Hutchinson, Claire (CMS/CM) <claire.hutchinson@cms.hhs.gov>
Subject: SIGNATURE AUTHORITY NEEDED: Retail Pharmacy Standard: Extension of Effective Date

Attached for authority to pen is the Secretary memo for the rule to delay the effective date of the Retail Pharmacy Standard Rule, consistent with the Presidential Memorandum on Regulatory Freeze. John Brooks approved the rule to move forward – its very short, simply delays the effective date – but we need to go to the Register ASAP because the effective date that we are delaying is February 11. The memo is part of the Administrative record, so we need to secure signature prior to release. Thanks.

Kathleen



DATE:

TO: Dorothy A. Fink, M.D., Acting Secretary

Through: Cortney L. McCormick, M.A., Executive Secretary

FROM: Stephanie Carlton, Acting Administrator

SUBJECT: DECISION – Administrative Simplification: Modifications of Health Insurance Portability and Accountability Act of 1996 (HIPAA) National Council for Prescription Drug Programs (NCPDP) Retail Pharmacy Standards; and Modification of the Medicaid Pharmacy Subrogation Standard; Delay of Effective Date—Final Rule (CMS-0056-F2)

ACTION REQUESTED

The purpose of this memo is to request your approval and signature on this rule to delay the effective date of the subject final rule based on the Presidential memorandum regarding regulatory freeze.

RECOMMENDATION

It is my recommendation that you sign the final rule.

EXECUTIVE SUMMARY

In accordance with the Presidential memorandum of January 20, 2025, titled “Regulatory Freeze Pending Review,” the effective date of the final rule titled “Administrative Simplification: Modifications of Health Insurance Portability and Accountability Act of 1996 (HIPAA) National Council for Prescription Drug Programs (NCPDP) Retail Pharmacy Standards; and Modification of the Medicaid Pharmacy Subrogation Standard” is delayed until April 14, 2025. (We note that the Presidential memorandum specified that the effective date of the delay would be 60 days from the date of the memorandum. However, EOP/OMB requested and OGC agreed that the delay would be 60 days from the effective date of the final rule.)

That final rule made modifications to the adopted standards for the following retail pharmacy transactions: health care claims or equivalent encounter information; eligibility for a health plan; referral certification and authorization; and coordination of benefits. It also adopted a modification to the standard for the Medicaid pharmacy subrogation transaction.

Notable Timing Factors and Administration Priorities:

This final rule is targeted for publication by February 10, 2025 to ensure that the recommended delay is

effective before the effective date of the final rule, February 11, 2025.

OPTIONS AND DISCUSSION

The final rule titled “Administrative Simplification: Modifications of Health Insurance Portability and Accountability Act of 1996 (HIPAA) National Council for Prescription Drug Programs (NCPDP) Retail Pharmacy Standards; and Modification of the Medicaid Pharmacy Subrogation Standard,” published in the December 13, 2024 **Federal Register** (89 FR 100763).

The final rule was subsequent to the proposed rule of the same title that published in the November 9, 2022 **Federal Register** (87 FR 67634). In that rule, we proposed to adopt modifications to the retail pharmacy and Medicaid subrogation standards. The final rule adopted modifications to standards for electronic retail pharmacy transactions and the Medicaid pharmacy subrogation transaction adopted under the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

/S/ Stephanie Carlton

DECISION

Approval of CMS’s final rule to delay the effective date of the retail pharmacy and Medicaid subrogation standards regulations.

Approved []
Disapproved []
Briefing Needed []
Additional Comments:

/S/ Dorothy A. Fink, M.D.

Date

Attachments

TAB A: Document for Signature

From: "Deo, Gita (CMS/CMMI)" <gita.deo@cms.hhs.gov>
Sent: 5/2/2025 3:39:19 PM -0400
To: "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>
CC:
BCC:
Subject: RE: RE: Here's the idea
Attachments: 5.2.25 Dr. Oz Deck Data File v1.csv; Medicaid Opportunities 5.2.25 v2.pptx

Hi Steph,

Please see attached for the draft deck. Have a few options for you on some of the slides and some thoughts on which one makes most sense. Also attached is the data excel in case helpful!

BTW – all the images are pulled from opensource images and have credited the photographer.

Let me know if you need anything else.

Best,

Gita

Confidential, iterative, and pre-decisional

From: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Sent: Friday, May 2, 2025 10:15 AM
To: Deo, Gita (CMS/CMMI) <gita.deo@cms.hhs.gov>
Subject: Here's the idea

Need 4-5 slides for Dr. Oz for a speech this weekend at Milken. Here's a start, but it's definitely rough! Storyline is this – with ideas for slides called out below:

Medicaid spending today isn't sustainable (see ideas for a slide in attached)

House Republican are working to invest MORE in Medicaid tomorrow than we spend today – let's be clear on the facts (slide you already made)

The only thing we're going to cut is (b)(5)

We want to protect Medicaid for who it's designed for: our kids, pregnant women, the poor, and disabled Americans

We want to strengthen local communities – by helping people get back on their feet in a job they love or volunteering for their fellow Americans

We want to work with the states to Make America Healthy Again

We need real commitment from our state partners – no more money laundering that cheats federal taxpayers (see attached for a first cut on slides)

We have to crush fraud, waste, and abuse (one slide showing opportunity to reform)

We have to negotiate a better deal for taxpayers on Medicaid

Chief of Staff and Deputy Administrator

Centers for Medicare and Medicaid Services

Confidential, iterative, and pre-decisional

From: Craig Moore <cmoore@premiersolutionpartners.com>
Sent: 5/6/2025 4:16:41 PM -0400
To: "Oz, Mehmet (CMS/OA)" <mehmet.oz@cms.hhs.gov>; "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>; "Brooks, John (CMS/OA)" <john.brooks1@cms.hhs.gov>; Kim.Brandt@cms.hhs.gov; "Czajkowski, John (CMS/OA)" <John.Czajkowski@cms.hhs.gov>
CC: Abe.Sutton@cms.hhs.gov; "Cantwell, Kathleen (CMS/OSORA)" <Kathleen.Cantwell@cms.hhs.gov>
BCC:
Subject: Urgent - Cost Containment Opportunity for Medicare/Medicaid
Attachments: Outlook-2cdlzd5.png; Quantify Health 10-28 Deck.pdf

CMS Team,

My firm has presented solutions to CMS staff in the past with positive reception. An almost immediate savings opportunity deals with high-cost claims(\$100k+). Quantify Health, our forensic claims auditing platform, utilizes experienced teams of professionals in various medical specialties to quickly audit claims for errors and overbilling by comparing the itemized billing against the patient's record of care. This process, which has a turnaround time of 10 business days or less, is conducted on pended claims and delivers an historic average of 16% net savings on claims in this category.

**For perspective, we deliver \$100-\$150 per plan member annually.

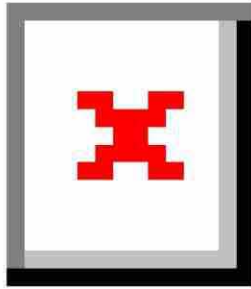
Conservatively, 160mm plan members x \$100 equates to \$16 Billion in annual savings.

In the spirit of reducing waste fraud and abuse, It is my belief that working in conjunction with State and Federal teams, we can deliver a tremendous savings to the American people.

I look forward to hearing back from you. I'm happy to have my office coordinate an introductory Zoom meeting to share more.

Thank you for your consideration

Craig Moore
Sales/Business Development
CMoore@PremierSolutionPartners.com
Mobile: (b)(6)



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From: "Rowell, Scott (HHS/IOS)" <Scott.Rowell@hhs.gov>
Sent: 2/25/2025 4:56:30 PM -0500
To: "Albanese, Joseph (CMS/CM)" <joseph.albanese@cms.hhs.gov>;
"Anderson, Hannah (HHS/IOS)" <Hannah.Anderson@hhs.gov>;
"Armstrong, Rebekah (CMS/OL)" <rebekah.armstrong@cms.hhs.gov>;
"Bellomo, Vincent (OS/IOS)" <Vincent.Bellomo@hhs.gov>; "Boothby,
William (OS/IOS)" <William.Boothby@hhs.gov>; "Bradway, Courtney
(HHS/ASL)" <Courtney.Bradway@hhs.gov>; "Brandt, Kimberly
(CMS/OA)" <kimberly.brandt@cms.hhs.gov>; "Brooks, John (CMS/OA)"
<john.brooks.cms@ees.hhs.gov>; "Bruno, Michael (ACF)"
<Michael.Bruno@acf.hhs.gov>; "Buckham, Matthew (HHS/IOS)"
<Matthew.Buckham@hhs.gov>; "Callahan, Kenneth (HHS/IOS)"
<Kenneth.Callahan@hhs.gov>; "Carlton, Stephanie (CMS/OA)"
<stephanie.carlton@cms.hhs.gov>; "Chertman, Willy (HHS/IOS)"
<Willy.Chertman@hhs.gov>; "Chiarello, Gustav (HHS/ASL)"
<Gustav.Chiarello@hhs.gov>; "Clem, Chris (OS/IOS)"
<Chris.Clem@hhs.gov>; "Corry, Thomas (HHS/ASPA)"
<Thomas.Corry@hhs.gov>; "Cutler, Diane (HHS/IOS)"
<Diane.Cutler@hhs.gov>; "Del Rosso, Cristina (HHS/OGC)"
<Cristina.Delrosso@hhs.gov>; "Diamantas, Kyle (FDA/OC)"
<Kyle.Diamantas@fda.hhs.gov>; "Engels, Thomas (HRSA)"
<TEngels@hrsa.gov>; "Fink, Dorothy (OS/OASH)"
<Dorothy.Fink@hhs.gov>; "Forte, Gabriella (HHS/OASH)"
<Gabriella.Forte@hhs.gov>; "Foster, Robert (HHS/IOS)"
<Robert.Foster@hhs.gov>; "Gardner, Scott (HHS/IOS)"
<Scott.Gardner@hhs.gov>; "Gillson, Zoe (OS/IOS)"
<Zoe.Gillson@hhs.gov>; "Gradison, Andrew (ACF)"
<Andrew.Gradison@acf.hhs.gov>; "Granito, Catherine (HHS/IOS)"
<Catherine.Granito@hhs.gov>; "Guernsey, Andrew (HHS/IOS)"
<Andrew.Guernsey@hhs.gov>; "Haridopolos, Stephanie
(HHS/OASH/OSG)" <Stephanie.Haridopolos@hhs.gov>; "Harper,
Melissa (ACF)" <Melissa.Harper@acf.hhs.gov>; "Johnston, Darcie
(OS/IEA)" <Darcie.Johnston@hhs.gov>; "Knox, John (ASPR/IO)"
<John.Knox@hhs.gov>; "Long, John (OS/IEA)" <John.Long@hhs.gov>;
"Matthews, Earl (HHS/OGC)" <Earl.Matthews@hhs.gov>; "McCormick,
Cortney (HHS/IOS)" <Cortney.McCormick@hhs.gov>; "Melanson,
Heather F. (HHS/IOS)" <Heather.Melanson@hhs.gov>; "Miller, Noah
(OS/IOS)" <Noah.Miller@hhs.gov>; "Minor, Clark (OS/IOS)"
<Clark.Minor@hhs.gov>; "Moreno, Mia (HHS/IOS)"
<Mia.Moreno@hhs.gov>; "Nahill, Liam (HHS/ASPA)"
<Liam.Nahill@hhs.gov>; "Nelson, Peter (CMS/CCIIO)"
<peter.nelson1@cms.hhs.gov>; "Nixon, Andrew (HHS/ASPA)"
<Andrew.Nixon@hhs.gov>; "O'Brien, Conner (HHS/OCR)"
<Conner.O'Brien@hhs.gov>; "O'Neill, Mark (HHS/ASL)"
<Mark.O'Neill@hhs.gov>; "Rihbany, Kelsey (HHS/IOS)"
<Kelsey.Rihbany@hhs.gov>; "Riley, Rachel (OS/ASA)"
<Rachel.Riley@hhs.gov>; "Rowe, Jarrett (OS/IEA)"
<Jarrett.Rowe@hhs.gov>; "Rowell, Scott (HHS/IOS)"
<Scott.Rowell@hhs.gov>; "Savas, Steve (HHS/ASL)"
<Steve.Savas@hhs.gov>; "Shuy, Caitrin (HHS/ASFR)"
<Caitrin.Shuy@hhs.gov>; "Spear, Stefanie (HHS/IOS)"
<Stefanie.Spear@hhs.gov>; "Sutton, Abraham (CMS/CMMI)"
<abraham.sutton@cms.hhs.gov>; "Sweny, Anna (HHS/IOS)"
<Anna.Sweny@hhs.gov>; "Thompson, Dorian (OS/IOS)"
<Dorian.Thompson@hhs.gov>; "Tignor, Beth (HHS/IOS)"

<Beth.Tignor@hhs.gov>; "Villa, Tatiana (OS/IEA)"
<Tatiana.Villa@hhs.gov>; "Weir, Shana (OS/ASA)"
<Shana.Weir@hhs.gov>; "Womack, Kimberley (AASPR/IO)"
<Kimberley.Womack@hhs.gov>
CC: OS - OPDIV Executive Officers
<OS.OPDIVExecutiveOfficers@ees.hhs.gov>; OS - STAFFDIV Executive
Officers <OS-STAFFDIVExecutiveOfficers@ees.hhs.gov>; "McCormick,
Cortney (HHS/IOS)" <Cortney.McCormick@hhs.gov>; "Weir, Shana
(OS/ASA)" <Shana.Weir@hhs.gov>; "Fusaro, Vincent
(OS/ASA/PSC/RLO)" <Vincent.Fusaro@psc.hhs.gov>; "Bruce, Melissa
(OS/ASA/PSC/OD)" <Melissa.Bruce@psc.hhs.gov>; "Rice, Garey
(HHS/ASFR)" <Garey.Rice1@hhs.gov>
BCC:
Subject: Return To Office - ACTION by March 7th
Attachments: RTO Remote Staff Report 2025-02-15.xlsx

Colleagues

Iâ€™m writing to you to provide information on the current Return to the Office (RTO) efforts. As you all know, HHS submitted a plan that provided milestones and action items to meet the RTO requirements set forth by OPM and the Presidential Memorandum on the subject. Current activities related to telework agreements, returning managers and senior leaders are well underway and we are executing as planned.

As we look forward, we have more complex activities that must be coordinated, not only within your organizations, but across HHS. Many HHS subcomponents have recruited employees from across the country to work remotely. Given our nationwide hiring efforts, we have a significant percentage of workers on remote agreements who may not be able to report to an HHS facility, consistent with the RTO plan milestones. As such, we may need to provide exceptions to implementation milestones.

As Op/StaffDiv leaders, we must own this responsibility. As you know there will be many requests for exemptions or other reasons why select employees may attempt to circumvent the RTO plan. While you must work with your staff to track and manage this process, I insist that you do not delegate decision making responsibilities to your subordinates.

With that said I want to make sure that you are actively engaged in this process. We cannot allow exceptions to become excessive or to serve as a basis for undermining the intent of the Presidential memorandum. As such, I would like to request that you submit a monthly report of your employees who will not be able to report to a Federal facility by the April 28th implementation date.

To ensure proper accountability, I am directing that you as political appointees personally approve the aforementioned reports. Where you have policy concerns about RTO actions, you may contact me to discuss those items on a case-by-case basis. I will coordinate these activities with the land holding OPDivs as well as the Program Support Center (PSC) and the General Services Administration (GSA).

*The attached template provides the key data points we wish to capture. **The first report is due Friday, March 7th and will be due on the 7th of each month until further notice.** Email these reports directly to me, with a copy to Ms. Shana Weir and Mr. Garey Rice. Please keep in mind, these reports will be used to monitor your progress in meeting full implementation of the RTO plan. Exceptions are temporary and coordination at the Op/StaffDiv level is expected.*

We are looking to automate this process in the very near future and will be reaching out to your Op/StaffDiv to support this effort. As this will be an iterative process I will provide additional guidance as we help identify solutions across HHS.

Regards,

Rowell

DCS-OPS

[illegible]

From: Shannon Campagna <SCampagna@PortfolioStrategiesLLC.com>
Sent: 5/18/2025 7:37:38 PM -0400
To: "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>
CC: CMS OA Incoming 47 <OAIincoming47@cms.hhs.gov>
BCC:
Subject: Re: Re: Meeting request from former Safeway CEO Steve Burd

Stephanie, thanks so much for getting back to me. Steve is a strong supporter of the MAHA movement and his views align closely with the priorities Dr. Oz has outlined at CMS. As you may recall from his time at Safeway, Steve has long been a champion of health and wellness, and in recent years, he has been particularly active in advancing cancer prevention and care initiatives.

Weâ€™re hoping to schedule a meeting so Steve can share some of his ideas on cancer/chronic disease prevention and wellness, and explore how elements of his work might be implemented or supported through CMS. I believe Dr. Oz would find the conversation both timely and aligned with his vision for the agency.

Steve is based in northern California so it may be hard to get him here this week (although he has a plane, so it's not out of the question). He will be here on May 31 on his way to Europe in the event you all are up for an early Saturday breakfast downtown. If you are on the road, he would consider traveling to wherever you are. What might work for you both?

Shannon
202-400-1810

From: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Sent: Saturday, May 17, 2025 6:50 PM
To: Shannon Campagna <SCampagna@PortfolioStrategiesLLC.com>
Cc: CMS OA Incoming 47 <OAIincoming47@cms.hhs.gov>
Subject: Re: Meeting request from former Safeway CEO Steve Burd

Hi Shannon - Could you give us a better sense of the specific topics? Also looping in our email for incoming requests so that I donâ€™t lose track of responses. :-)

Confidential, iterative, pre-decisional

From: Shannon Campagna <SCampagna@PortfolioStrategiesLLC.com>
Sent: Thursday, May 15, 2025 3:59 PM
To: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Cc: Morgan, Katarina (CMS/OA) <katarina.morgan@cms.hhs.gov>
Subject: Re: Meeting request from former Safeway CEO Steve Burd

Stephanie, hi! And hi Katrina - Steve is asking if this meeting is doable -any feedback on your availability and the possibility of a meeting before the end of the month?

Get [Outlook for iOS](#)

From: Shannon Campagna <SCampagna@PortfolioStrategiesLLC.com>

Sent: Wednesday, April 23, 2025 9:29:08 PM

To: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>

Cc: Morgan, Katarina (CMS/CCIIO) <katarina.morgan@cms.hhs.gov>

Subject: Re: Meeting request from former Safeway CEO Steve Burd

Stephanie, hi!

Steve had a great reception on the Hill when he was in town earlier this month - we had six Member level meetings and the feedback was very positive for Steve's ideas for healthcare savings.

Last week Steve was happy to see the EO from the President on drug pricing. He penned a letter applauding the President's EO and outlined some additional thoughts on going even further. I am attaching it for your consideration.

Steve will be back in DC for further conversations in May - he is available to travel DC on the following dates.

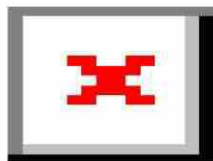
May 5 - 8

May 12 -16

May 19 -22

Is there a time within that range that works for a meeting with you and the Administrator? We would build his trip around this meeting.

I have attached his bio as a refresher, and here is a link to the OpEd he wrote for [Real Clear Markets](#).



The \$300 Billion Annual Healthcare Fix Washington Can't Afford to Ignore

After spending 50 years in the private sector where cost reduction opportunities are near infinite in number, I believe the \$2 trillion in savings currently being considered by the Administration and

urldefense.proofpoint.com

Thanks for your consideration Stephanie. I look forward to hearing from you, and to reconnecting.

Shannon
202-400-1810

From: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Sent: Wednesday, March 26, 2025 6:29 PM
To: Shannon Campagna <SCampagna@PortfolioStrategiesLLC.com>
Cc: Morgan, Katarina (CMS/CCIO) <katarina.morgan@cms.hhs.gov>
Subject: RE: Meeting request from former Safeway CEO Steve Burd

Hi Shannon – Good to hear from you. Would love to connect with you and Steve, but that timing is tough for us with the expected arrival Dr. Oz around then. Could we look to another trip?

Confidential, iterative, and pre-decisional

From: Shannon Campagna <SCampagna@PortfolioStrategiesLLC.com>
Sent: Wednesday, March 26, 2025 6:26 PM
To: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Subject: Fw: Meeting request from former Safeway CEO Steve Burd

Stephanie, hi! I am hopeful that my email found it's way to you last week. Please let me know if it's possible to get on your schedule or if there's someone within CMS who would be an appropriate proxy.

Shannon
202-400-1810

From: Shannon Campagna
Sent: Friday, March 21, 2025 8:42 PM
To: stephanie.carlton@cms.hhs.gov
Subject: Meeting request from former Safeway CEO Steve Burd

Stephanie, congratulations on your new role at CMS. It is always heartening to see former Hill staff rise to the top of agencies!

I hope you will remember working with Safeway CEO Steve Burd during the ACA when you were on the Hill. I am happy to share that Steve has continued his work in the healthcare space and he continues to think about ways to streamline U.S. healthcare, enhance efficiency and realize cost-savings. He penned an op-ed that appeared in [Real Clear Markets](#) this week.

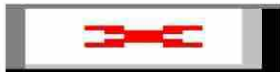
Having spent the better part of the last two decades reinventing how healthcare services are provided, Steve identifies five major areas of focus in the [article](#) he calls “low hanging fruit,” that include: (1) Drug Costs for both Medicare and Medicaid, (2) Royalty Payments to the National Institute of Health (NIH), (3) Cancer Services, (4) Wellness Services and (5) Fraud and Abuse.

These are practical, data-driven solutions that align with fiscal responsibility, smart government, and better patient care.

Steve is considering a trip to DC the week of April 7 and I respectfully request a meeting with you and your team on that Monday or Tuesday. Steve would welcome the opportunity to discuss these solutions and is anxious to share his learnings with the Administration.

I am hopeful that we can make this work - are you able to meet with us that week?

Shannon



Shannon Campagna | 202.400.1810

From: CMS EPRO <EPRO@cms.hhs.gov>
Sent: 2/27/2025 9:39:48 AM -0500
To: "Brandt, Kimberly (CMS/OA)" <kimberly.brandt@cms.hhs.gov>; "Brooks, John (CMS/OA)" <john.brooks1@cms.hhs.gov>; "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>; CMS Administrator 47 <CMSAdministrator47@cms.hhs.gov>; "Czajkowski, John (CMS/OA)" <John.Czajkowski@cms.hhs.gov>; "Payne, CAPT Skip (CMS/EPRO)" <Skip.Payne@cms.hhs.gov>; "Rice, Cheri (CMS/CM)" <Cheri.Rice@cms.hhs.gov>; "Waltersdorff - CMS/EPRO, Rodney (CMS/EPRO)" <rodney.waltersdorff@cms.hhs.gov>; "Wu, Jeff (CMS/CCIO)" <Jeff.Wu@cms.hhs.gov>
CC:
BCC:
Subject: EPRO Hazards & Threats Awareness Summary Report (27Feb25)

All,

The following are specific hazards/threats monitored by EPRO, which are categorized by the level of actual or possible impact and/or the status of CMS Employees, Facilities, Operations, and beneficiaries.

CMS Emergency Coordination Center – Not Activated

- Nothing significant to report.

High

- Nothing significant to report.

Medium

- Nothing significant to report.

Low

- **National Weather** (for more information, please visit the [Weather Prediction Center](#)) – A clipper type system will track across the Northeast today, with a stronger system expected for this first weekend of March. Snow accumulations are expected for portions of the Great Lakes region and New England. Winds will also become gusty across most of the eastern two-thirds of the country this weekend. These winds and low humidity may increase fire weather concerns for portions of the Plains.
 - **Snow** – MN, WI, and ME
 - **Mixed Precipitation** – WA, MT, ND, MN, WI, MI, IN, OH, TN, NC, VA, WV, DC, PA, NY, CT, MA, NH, VT, and ME
 - **Rain** – TX, LA, AR, MS, FL, WA, DC, MD, DE, NJ, and RI
 - **Rain/Thunderstorms** – GA, SC, NC, VA, TN, KY, IN, and OH
 - **Freezing Rain Possible** – PA, NY, CT, MA, NH, VT, and ME
- **D.C. Weather** (for more information, please visit the [Weather Prediction Center](#))

- **Today** – Cloudy. Numerous showers, mainly this morning. Highs in the upper 60s. Southwest winds 10 to 15 mph with gusts up to 25 mph, becoming west 15 to 20 mph with gusts up to 35 mph this afternoon. Chance of rain 60 percent.
- **Tonight** – Partly cloudy. Lows in the upper 30s. West winds 10 to 15 mph. Gusts up to 30 mph in the evening.
- **Friday** – Mostly sunny. Highs in the mid-50s. West winds 10 to 15 mph with gusts up to 25 mph.

No Impact/Monitoring

- **Child in West Texas is First U.S. Measles Death in a Decade** – The first measles death in the growing outbreak in West Texas was a school-aged child. This is the first U.S. measles death since 2015, when a woman in Washington state died. The number of confirmed measles cases reported in an outbreak in West Texas is now at 124, the [Texas Department of Health Services](#) said in an update Tuesday, an increase of 34 since late last week. Most of the cases are in children ages 5 to 17 ([CNN](#), 26Feb25).
- **Lackawanna Man Pleads Guilty to Defrauding Medicaid** – Acting U.S. Attorney Joel L. Violanti announced today that MuneF Fadhel, 37, of Lackawanna, NY, pleaded guilty before U.S. District Judge John L. Sinatra, Jr. to health care fraud, which carries a maximum penalty of 10 years, and a \$250,000 fine. While working at Great Lake Transportation, he knowingly submitted multiple false and fraudulent records seeking transportation reimbursement for trips. Fadhel submitted claims for shared rides which he certified as individual rides in order to claim a higher reimbursement amount. This resulted in a loss to Medicaid in excess of \$95,000 ([DOJ](#), 20Feb25).
- **USDA Details New Plan to Tackle Bird Flu** – Brooke Rollins, Agriculture Secretary, outlined the new five-pronged approach, which will focus on increasing biosecurity on egg-laying farms and helping farmers who [have lost flocks](#) recover more quickly. She said USDA may temporarily allow imports of eggs to expand supply. Rollins said USDA was also exploring the use of vaccines and therapeutics in chickens to cut down on culling of birds, but the agency has not yet authorized any for use ([CNN](#), 26Feb25).
- **Miami Couple Charged with Health Care Fraud and Money Laundering Conspiracies** – According to the allegations, Magaly Travieso was an advanced practitioner registered nurse and the owner of ProMed Healthcare, L.L.C., a medical clinic that purportedly provided services to beneficiaries with commercial insurance, Medicare, and Medicare Advantage Plans, and to Medicaid recipients. From approximately March 2019 through at least January 2023, Travieso allegedly conspired with others to submit over \$20 million in fraudulent claims for reimbursement, of which ProMed received over \$10 million ([DOJ](#), 20Feb25).

Active Public Health Emergency ([PHE](#)) Declarations and Expiration Dates:

- Opioid Crisis, Nationwide: 22Mar25
- Hurricane Helene, GA: 22Mar25*
- Hurricane Helene, NC: 23Mar25*
- Hurricane Helene, TN: 24Mar25*
- Southern California Wildfires, CA: 06April25*

* Denotes Accompanying Presidential Declaration

NOTE: EPRO will continue to monitor the development of any significant event, and further updates will be provided should the condition worsen or significantly change.

EPRO CONTACTS/ADDITIONAL INFORMATION

Questions, comments, concerns, additions, or subtractions to this EPRO update should be directed to EPRO@cms.hhs.gov.

Label	Description
ECC Status	Activation status (Activated/Not Activated) and Activation Level (1-5) with corresponding designation (Low-Emergency)
High	Significant/Major Impact to CMS Employees, Facilities, Operations, and/or Beneficiaries
Medium	Probable/Moderate Impact to CMS Employees, Facilities, Operations, and/or Beneficiaries
Low	Possible/Minor Impact to CMS Employees, Facilities, Operations, and/or Beneficiaries
No Impact/Monitoring	No Impact to CMS Employees, Facilities, Operations, and/or Beneficiaries. Potential Hazards & Threats being monitored by EPRO
Post-Event Recovery/Impacted Facility Update	Updated information on post-event recovery and the status of the reported impacted facilities
Active PHE	Active Public Health Emergency (PHE) Declarations and Expiration Dates:
Recurring Reports	Reports scheduled on a regular basis

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Confidential and deliberative, pre-decisional communication

-TAB

From: "Pothen, Meril (CMS/CCIIO)" <Meril.Pothen@cms.hhs.gov>
Sent: 2/6/2025 1:54:10 PM -0500
To: "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>
CC: "Cantwell, Kathleen (CMS/OSORA)" <Kathleen.Cantwell@cms.hhs.gov>;
"Hutchinson, Claire (CMS/CM)" <claire.hutchinson@cms.hhs.gov>; "Harper,
Scott (CMS/OPOLE)" <scott.harper@cms.hhs.gov>; "Brooks, John (CMS/OA)"
<john.brooks1@cms.hhs.gov>
BCC:
Subject: RE: RE: SIGNATURE AUTHORITY NEEDED: Retail Pharmacy Standard:
Extension of Effective Date

Thanks, Steph. Kathleen, let us know if you need anything else.

From: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Sent: Thursday, February 6, 2025 1:44 PM
To: Pothen, Meril (CMS/CCIIO) <Meril.Pothen@cms.hhs.gov>
Cc: Cantwell, Kathleen (CMS/OSORA) <Kathleen.Cantwell@cms.hhs.gov>; Hutchinson, Claire (CMS/CM)
<claire.hutchinson@cms.hhs.gov>; Harper, Scott (CMS/OPOLE) <scott.harper@cms.hhs.gov>; Brooks, John
(CMS/OA) <john.brooks1@cms.hhs.gov>
Subject: RE: SIGNATURE AUTHORITY NEEDED: Retail Pharmacy Standard: Extension of Effective Date

Approved. Thanks, Meril.

Confidential, iterative, and pre-decisional

From: Pothen, Meril (CMS/CCIIO) <Meril.Pothen@cms.hhs.gov>
Sent: Thursday, February 6, 2025 12:34 PM
To: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Cc: Cantwell, Kathleen (CMS/OSORA) <Kathleen.Cantwell@cms.hhs.gov>; Hutchinson, Claire (CMS/CM)
<claire.hutchinson@cms.hhs.gov>; Harper, Scott (CMS/OPOLE) <scott.harper@cms.hhs.gov>
Subject: FW: SIGNATURE AUTHORITY NEEDED: Retail Pharmacy Standard: Extension of Effective Date
Importance: High

Hello Steph! We need your permission ASAP to use your signature (OSORA has it on file) on the attached memo. More info is below, and John has signed off!

From: Cantwell, Kathleen (CMS/OSORA) <Kathleen.Cantwell@cms.hhs.gov>
Sent: Thursday, February 6, 2025 1:15 PM
To: Wu, Jeff (CMS/CCIIO) <Jeff.Wu@cms.hhs.gov>; Rice, Cheri (CMS/CM) <Cheri.Rice@cms.hhs.gov>; Pothen,

Meril (CMS/CCIIO) <Meril.Pothen@cms.hhs.gov>; Hutchinson, Claire (CMS/CM) <claire.hutchinson@cms.hhs.gov>
Subject: SIGNATURE AUTHORITY NEEDED: Retail Pharmacy Standard: Extension of Effective Date

Attached for authority to pen is the Secretary memo for the rule to delay the effective date of the Retail Pharmacy Standard Rule, consistent with the Presidential Memorandum on Regulatory Freeze. John Brooks approved the rule to move forward – its very short, simply delays the effective date – but we need to go to the Register ASAP because the effective date that we are delaying is February 11. The memo is part of the Administrative record, so we need to secure signature prior to release. Thanks.

Kathleen

From: "Brooks, John (CMS/OA)" <john.brooks1@cms.hhs.gov>
Sent: 6/5/2025 3:19:18 PM -0400
To: "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>
CC:
BCC:
Subject: FW: FW: Medicare is a target as Senate GOP faces megabill math issues

FYI – on Medicare

John Brooks

Chief Policy & Regulatory Officer
Centers for Medicare & Medicaid Services

Draft, Pre-decisional, Deliberative

From: Brooks, John (CMS/OA)
Sent: Thursday, June 5, 2025 1:10 PM
To: Armstrong, Rebekah (CMS/OL) <rebekah.armstrong@cms.hhs.gov>
Cc: Klomp, Chris (CMS/CM) <chris.klomp@cms.hhs.gov>; Brandt, Kimberly (CMS/OA) <kimberly.brandt@cms.hhs.gov>
Subject: RE: Medicare is a target as Senate GOP faces megabill math issues

Yeah, it's definitely not limited to waste, fraud, and abuse. But would definitely create savings. From a TA perspective, depending on how steep the coding reductions are, may need to modify the minimum coding intensity adjustment...

John Brooks

Chief Policy & Regulatory Officer
Centers for Medicare & Medicaid Services

Draft, Pre-decisional, Deliberative

From: Armstrong, Rebekah (CMS/OL) <rebekah.armstrong@cms.hhs.gov>
Sent: Thursday, June 5, 2025 1:01 PM
To: Brooks, John (CMS/OA) <john.brooks1@cms.hhs.gov>
Cc: Klomp, Chris (CMS/CM) <chris.klomp@cms.hhs.gov>; Brandt, Kimberly (CMS/OA) <kimberly.brandt@cms.hhs.gov>
Subject: RE: Medicare is a target as Senate GOP faces megabill math issues

Yes – Long story short, Sen. Cassidy pitched his MA bill (the No UPCODE Act) to the President yesterday and framed it as a bill targeting WFA. He believes he got the sign off to move forward on it. The Senate is very concerned as they believe the bill goes further than WFA. The bill is attached.

From: Brooks, John (CMS/OA) <john.brooks1@cms.hhs.gov>
Sent: Thursday, June 5, 2025 12:48 PM
To: Armstrong, Rebekah (CMS/OL) <rebekah.armstrong@cms.hhs.gov>
Cc: Klomp, Chris (CMS/CM) <chris.klomp@cms.hhs.gov>; Brandt, Kimberly (CMS/OA) <kimberly.brandt@cms.hhs.gov>
Subject: FW: Medicare is a target as Senate GOP faces megabill math issues

Rebekah –

Any color on what they are looking at?

John Brooks

Chief Policy & Regulatory Officer
Centers for Medicare & Medicaid Services

Draft, Pre-decisional, Deliberative

From: POLITICO Pro <alert@email.politicopro.com>
Sent: Thursday, June 5, 2025 12:46 PM

To: Brooks, John (CMS/OA) <john.brooks1@cms.hhs.gov>

Subject: Medicare is a target as Senate GOP faces megabill math issues



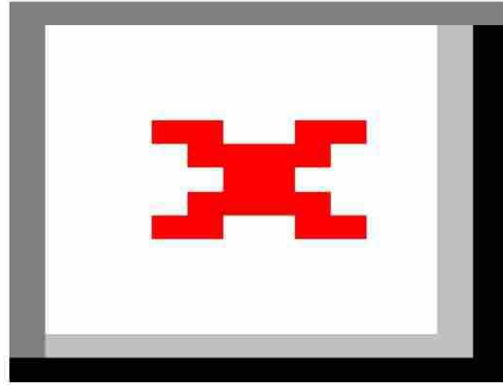
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Medicare is a target as Senate GOP faces megabill math issues

Republicans have so far kept hands off the politically sensitive program. But senators are now desperate to find additional spending cuts.

BY JORDAIN CARNEY, MEREDITH LEE HILL, ROBERT KING | 06/05/2025
12:45 PM EDT



Sen. Roger Marshall of Kansas said fellow Senate Republicans are interested in potentially wringing savings out of Medicare despite its third-rail reputation. | Francis Chung/POLITICO

Senate Republicans are eyeing possible Medicare provisions to help offset the cost of their megabill as they try to appease budget hawks who want more spending cuts embedded in the legislation.

Making changes to Medicare, the federal health insurance program primarily serving seniors, would be a political longshot: It would face fierce backlash from some corners of the Senate GOP, not to mention across the Capitol, where Medicare proposals were floated but didn't gain traction.

But Senate Republicans are now seriously considering it as they race to pass their party-line tax and spending package before a self-imposed July 4 deadline. The idea came up in closed-door meetings this week and, crucially, some Republicans believe President Donald Trump is on board with touching the program as long as it's limited to "waste, fraud and abuse."

"I think anything that is waste, fraud and abuse are obviously open to discussions," Senate Majority Leader John Thune (R-S.D.) said Thursday when asked about Medicare.

Cracking down on some smaller areas of the vast program could net significant savings for Senate Republicans. The other main area they're planning to tap is ratcheting down the House-negotiated state-and-local-tax-deduction cap – [as Thune first acknowledged to POLITICO Tuesday](#). Both are politically explosive areas that will trigger serious blowback in the House.

"I think the focus, as you know, has been on addressing waste, fraud and abuse in Medicaid," Thune added when pressed on Medicare. "But right now we're open to suggestions if people have them about other areas where there is clearly waste, fraud and abuse that can be rooted out in any government program."

Sen. Ron Johnson (R-Wis.), who was among the Republicans on the Senate Finance Committee who went to the White House Wednesday to meet with Trump about the tax portion of their megabill, told reporters he believed the president was more amenable to making Medicare changes than he might have previously let on.

"I think the president is actually open to any elimination of any waste, fraud and abuse ... wherever," he said, though added that Trump "doesn't want to cut benefits."

Finance Committee Republicans wanted to use their audience with Trump to press their case for making certain business tax incentives permanent, but a significant chunk of the conversation instead focused on senators pitching their individual ideas for how to inject more savings into their version of the House-passed bill.

A band of House moderates is deeply uncomfortable with the idea of touching Medicare in the megabill, even if it is in the name of "waste, fraud and abuse." Speaker Mike Johnson said in a brief interview Thursday that he wouldn't "address hypotheticals."

But he reiterated he doesn't want to inject any more major political fights into the already fractious talks. Johnson said the House GOP's "work reflects more than a year of very careful and deliberate discussion and ideas and so, you know, we're very satisfied with the product we've sent over there, and I hope they'll change it as little as possible."

Some House lawmakers briefly floated the idea of overhauling Medicare Advantage — which enables older Americans to buy private plans offering health coverage — to garner savings. Critics have accused Medicare Advantage plans of using financial gamesmanship to increase federal payments, but targeting the program would likely draw the ire of the insurance industry.

The search for more cuts comes as GOP senators look for areas where they can go beyond the House's \$1.6 trillion in cuts. But the push is being complicated because some Senate committees, including the Agriculture panel, are likely to scale back the savings found by their House counterparts.

Leadership is pushing the Agriculture Committee to net \$150 billion in cuts as they work to scale down a controversial House plan to shift billions in food aid costs to states, according to four Republicans with direct knowledge of the matter. That's half of the \$300 billion in agriculture cuts from the House bill, and GOP senators are still trying to fit in a \$70 billion farm bill package.

As part of an effort to generate more savings, Republicans have floated several ideas related to Medicaid, including tightening the House's work requirements and trying to roll back — not just freeze — the use of state provider taxes. Both of those ideas would face their own block of opposition within the Senate GOP.

But they also raised Medicare as part of a lengthy debate Senate Republicans had among themselves Wednesday, when they met first with CMS Administrator Mehmet Oz and subsequently got briefed by the chairs of the Armed Services, Banking and Commerce Committees on their pieces of the megabill.

"There was legitimate debate about: Can we do more with Medicaid? Are we doing too much with Medicaid? How much waste, fraud, abuse is there in Medicare — why don't we go after that? I think we should," Sen. Kevin Cramer (R-N.D.) said about the discussion Wednesday.

Asked if there was any consideration of including Medicare as part of the megabill, Sen. Roger Marshall (R-Kansas) said, "There is on the Senate Republican side."

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From: "Deo, Gita (CMS/CMMI)" <gita.deo@cms.hhs.gov>
Sent: 5/22/2025 10:02:29 AM -0400
To: "Jones, Christopher (CMS/OA)" <christopher.jones@cms.hhs.gov>; "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>
CC:
BCC:
Subject: RE: RE: Medicaid slides for senate dinner

Thank you so much!

Best,

Gita Deo

Confidential, iterative, and pre-decisional

From: Jones, Christopher (CMS/OA) <christopher.jones@cms.hhs.gov>
Sent: Thursday, May 22, 2025 9:50 AM
To: Deo, Gita (CMS/CMMI) <gita.deo@cms.hhs.gov>; Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Subject: RE: Medicaid slides for senate dinner

Will start working on now. I'll send the data for each request line item as I pull or get from CMCS staff.

Chris

(b)(6)

Confidential, iterative, and pre-decisional

From: Deo, Gita (CMS/CMMI) <gita.deo@cms.hhs.gov>
Sent: Thursday, May 22, 2025 9:42 AM
To: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>

Cc: Jones, Christopher (CMS/OA) <christopher.jones@cms.hhs.gov>
Subject: RE: Medicaid slides for senate dinner

Perfect, thanks Chris – if you could also let me know what data you are planning to share I can get started on the rest, that would be great!

Best,
Gita Deo

Confidential, iterative, and pre-decisional

From: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Sent: Thursday, May 22, 2025 9:35 AM
To: Deo, Gita (CMS/CMMI) <gita.deo@cms.hhs.gov>
Cc: Jones, Christopher (CMS/OA) <christopher.jones@cms.hhs.gov>
Subject: Re: Medicaid slides for senate dinner

Amazing. Chris can share data from CMCS.

Confidential, iterative, pre-decisional

From: Deo, Gita (CMS/CMMI) <gita.deo@cms.hhs.gov>
Sent: Thursday, May 22, 2025 7:49 AM
To: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Subject: Re: Medicaid slides for senate dinner

happy to - I'll pull a draft together for you to look at

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From: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Sent: Thursday, May 22, 2025 6:45:08 AM
To: Deo, Gita (CMS/CMMI) <gita.deo@cms.hhs.gov>
Subject: Fw: Medicaid slides for senate dinner

Want to help on this one?

Confidential, iterative, pre-decisional

From: Oz, Mehmet (CMS/OA) (b)(6) <[\(b\)\(6\)@cms.hhs.gov](mailto:(b)(6)@cms.hhs.gov)>
Sent: Wednesday, May 21, 2025 10:26 PM
To: Snyder, Drew (CMS/CMCS) <drew.snyder@cms.hhs.gov>; Armstrong, Rebekah (CMS/OL) <rebekah.armstrong@cms.hhs.gov>
Cc: Sofio, Noah (CMS/OA) <noah.sofio@cms.hhs.gov>; Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>
Subject: Medicaid slides for senate dinner

In preparation for my Senate Luncheon with Senator Scott and Johnson, we need slides that show the crises faced by Medicaid, but we should NOT give recommendations on solutions.

Medicaid per capita spend per patient across all 50 states
Medicaid portion of state budgets and impending crises
Growth in spending 50% in last 5 years
What costs the most in Medicaid (where does the money go?) hospitals, pharma, etc
Medicaid 10M (1965) to 80M today
Dual enrollment fraud (\$14B)
DME, Skin substitutes & Hospice fraud
Provider Tax Legal money laundering
Able bodied person with kids pays better than a Sick Kid on Medicaid
Work requirement history and comparison to TANF and SNAP
Work requirement impact on budget and unemployment

Thanks for helping with these images. We can discuss later this week so a draft can be generated for the Senators to review by early next week. Oz

Confidential, iterative, pre-decisional

From: Mehmet Oz <mehmetoz@me.com>
Sent: 5/2/2025 2:04:09 PM -0400
To: "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>
CC:
BCC:
Subject: Additional Slides

Attachments available until Jun 1, 2025

FYI

From: Brian Blase <bblase@paragoninstitute.org>
Subject: Re: Slide deck
Date: May 2, 2025 at 11:31:16â€AM EDT
To: Mehmet Oz <mehmetoz@me.com>

Great to see you as well.

Two attachments - one is the full Medicaid deck that we have put together and one is the survey results that I gave you yesterday.

Please call or message me anytime.

Best,
Brian

On Fri, May 2, 2025 at 10:58â€AM Mehmet Oz <mehmetoz@me.com> wrote:
Great seeing you yesterday. Please send your deck when convenient. Best Oz

[Click to Download](#)

43BB_Paragon_Medicaid_briefing_slides_clean.pptx
18.7 MB

[Click to Download](#)

250054 Paragon Health Institute National Online Survey - Executive Summary (1) (1) (1).pdf
1.2 MB

From: "Brandt, Kimberly (CMS/OA)" <kimberly.brandt@cms.hhs.gov>
Sent: 3/31/2025 7:58:35 PM -0400
To: HR@opm.gov; "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>
CC:
BCC:
Subject: What i did last week

- *Coordinated final plans for RIF at our agency
- *Developed final strategy for kickoff of our fraud data operations center which launched on 3/31 to find fraud, waste and abuse across CMS programs
- *Finalized staffing and other needs in anticipation of the arrival of the new CMS Administrator
- *Reviewed contracts and developed a plan for descoping or terminating over 100 different contracts across CMS
- *Finalized language for inclusion in CMS payment rules intended to curb waste, fraud and abuse in the programs

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From: "Thomas, Grant (CMS/CMCS)" <grant.thomas@cms.hhs.gov>
Sent: 6/27/2025 2:26:51 PM -0400
To: "Chen, Emily (CMS/OA)" <emily.chen@cms.hhs.gov>; "Deo, Gita (CMS/CMMI)" <gita.deo@cms.hhs.gov>; "Carlton, Stephanie (CMS/OA)" <stephanie.carlton@cms.hhs.gov>; "Krepich, Christopher (CMS/OC)" <christopher.krepich@cms.hhs.gov>
CC:
BCC:
Subject: RE: RE: Can y'all take pen on this?
Attachments: image001.png

See below for my additions in **black bold**. I reached out to Brian Blase to see if he had any data to back up the claims below regarding incentives, and he said he is going to send me some data that they have from North Carolina. He said that this is all new policy so they are writing about the incentives that face states from such high Medicaid rates. But they do have some data out of North Carolina that he will send.

Thanks,

Grant Thomas

Grant Thomas

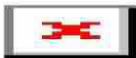
Senior Advisor

Center for Medicaid and CHIP Services

Centers for Medicare and Medicaid Services

grant.thomas@cms.hhs.gov

(b)(6)



From: Chen, Emily (CMS/OA) <emily.chen@cms.hhs.gov>
Sent: Friday, June 27, 2025 2:23 PM
To: Deo, Gita (CMS/CMMI) <gita.deo@cms.hhs.gov>; Carlton, Stephanie (CMS/OA)

<stephanie.carlton@cms.hhs.gov>; Thomas, Grant (CMS/CMCS) <grant.thomas@cms.hhs.gov>; Krepich, Christopher (CMS/OC) <christopher.krepich@cms.hhs.gov>

Subject: RE: Can y'all take pen on this?

Small **edit** to the rural stat, with full calculation context below.

- 2024 total Medicaid expenditures (NHE): \$926B
 - 2024 Medicaid inpatient + outpatient hospital spending for rural hospitals (OACT): \$19.5B
 - $19.5/926 = \sim 2.1\%$
-

The Biden Administration approved excessive payment rates to hospitals – at commercial rates for a safety net program. This is unprecedented after tradition of Medicare caps that even the Obama Administration codified.

Spending on SDPs has increased (b)(5) over the last (b)(5) years.

Since just this Wednesday (June 25), one state submitted 15 new preprints for specific facilities, focused on payments for professional services. The preprint values range between \$8 million and \$250 million (per preprint) in brand new SDP spending, totaling more than \$1 billion. They are targeted for specific facilities, including academic medical centers and non profits [Cleveland Clinic, Nationwide Children's Hospital, Southern Ohio Medical Center, Kettering, and Bon Secours Mercy]. This is highly unusual for the State of Ohio, which has not used preprints much to date.

This is going to cost taxpayers (b)(5) on what this would be if ALL states were up to ACR] over the next ten years if we don't take action.

This isn't about rural **hospitals** – that's less than 5% of the impact.

This isn't about making sure hospitals can take care of patients – their corporate profits are growing (for publicly traded hospitals: 6% in 2022 to 8% in 2024).

(b)(5)

This is about corporate profiteering off a welfare program. We all have a moral obligation to take care of our most vulnerable, not to view them as a profit pool. Who is willing to defend excessive payments to hospitals?

Tying Medicaid payments to commercial rates encourages providers and insurers alike to further increase the costs of private health insurance, leading to reduced wages for hard-working American families.

This payment structure also threatens access to care for our seniors on Medicare by creating incentives for providers to prioritize Medicaid patients over seniors and individuals with disabilities enrolled in Medicare.

The impacts of this will vary by state, and the more we've dug into state specific estimates, the more embarrassed states should be about these schemes and money laundering.

(b)(5)

(b)(5)

Emily Chen

Senior Advisor | Office of the Administrator

(301) 708-1030

Confidential, iterative, and pre-decisional

From: Deo, Gita (CMS/CMMI) <gita.deo@cms.hhs.gov>

Sent: Friday, June 27, 2025 2:21 PM

To: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>; Chen, Emily (CMS/OA) <emily.chen@cms.hhs.gov>; Thomas, Grant (CMS/CMCS) <grant.thomas@cms.hhs.gov>; Krepich, Christopher (CMS/OC) <christopher.krepich@cms.hhs.gov>

Subject: RE: Can y'all take pen on this?

Added in the SDP numbers below – also removed the sentence of X of defense as it will show a lower number given defense budget, can figure out another comparison if that's helpful. Let me know if any questions!

Best,

Gita Deo

Confidential, iterative, and pre-decisional

From: Carlton, Stephanie (CMS/OA) <stephanie.carlton@cms.hhs.gov>

Sent: Friday, June 27, 2025 2:05 PM

To: Chen, Emily (CMS/OA) <emily.chen@cms.hhs.gov>; Deo, Gita (CMS/CMMI)

<gita.deo@cms.hhs.gov>; Thomas, Grant (CMS/CMCS) <grant.thomas@cms.hhs.gov>; Krepich, Christopher (CMS/OC) <christopher.krepich@cms.hhs.gov>

Subject: Can y'all take pen on this?

Can y'all take pen on filling out the highlighted parts? Grant is monitoring input from OACT on the model and may add a line on incentives created from SDPs. Gita has SDP spending. Emily – you ok with the rural #s? Krepich – style points?

The Biden Administration approved excessive payment rates to hospitals – at commercial rates for a safety net program. This is unprecedented after tradition of Medicare caps that even the Obama Administration codified.

Spending on SDPs has increased (b)(5) over the last (b)(5) years.

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This is going to cost taxpayers (b)(5) on what this would be if ALL states were up to ACR] over the next ten years if we don't take action.

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This isn't about making sure hospitals can take care of patients – their corporate profits are growing (for publicly traded hospitals: 6% in 2022 to 8% in 2024).

This is about corporate profiteering off a welfare program. We all have a moral obligation to take care of our most vulnerable, not to view them as a profit pool. Who is willing to defend excessive payments to hospitals?

The impacts of this will vary by state, and the more we've dug into state specific estimates, the more embarrassed states should be about these schemes and money laundering.

(b)(5)

(b)(5)

Confidential, iterative, and pre-decisional