



Justification of appropriation request for the Committees on Appropriations

Fiscal Year 2026



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Justification of appropriation request

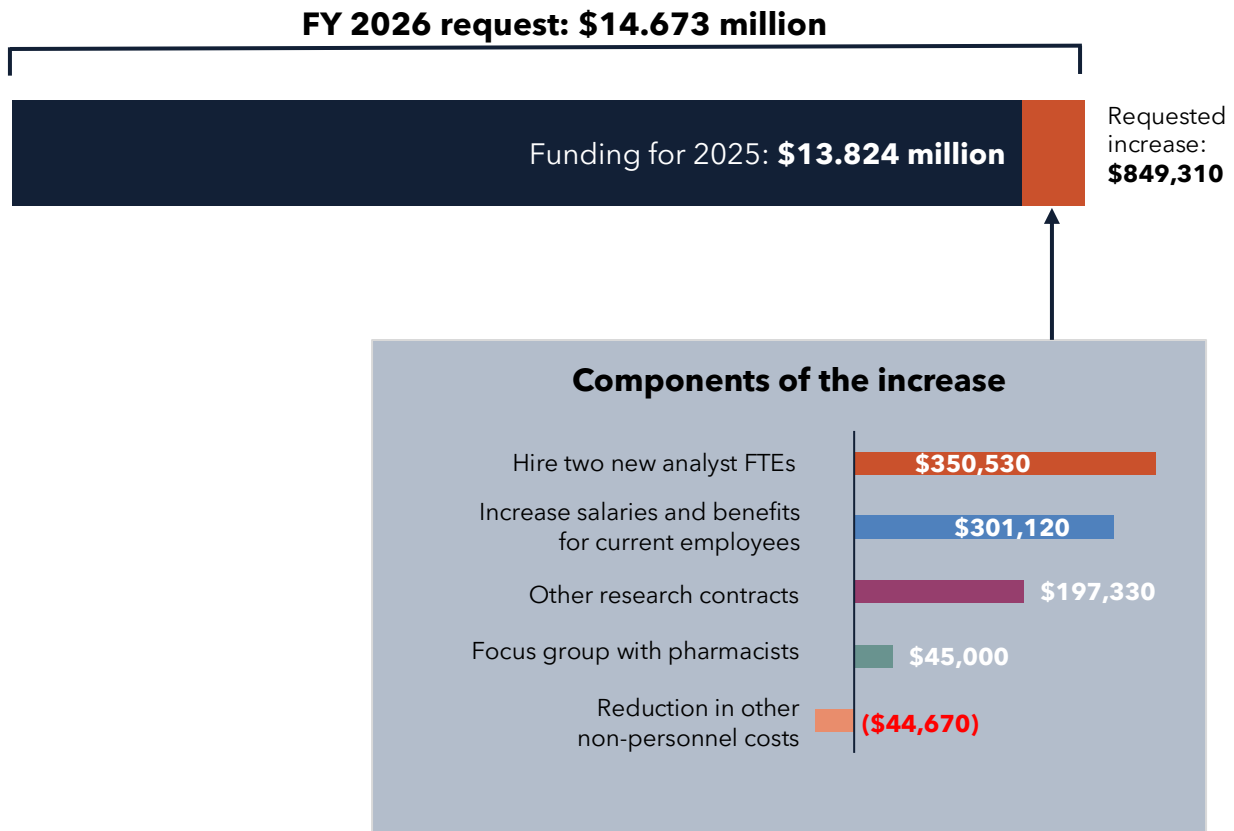
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Overview of MedPAC's request for appropriations for FY 2026

The Medicare Payment Advisory Commission (MedPAC) requests appropriations of \$14.673 million for fiscal year (FY) 2026. The request amounts to an increase of \$849 thousand, or 6.1 percent, from the \$13.824 million that MedPAC received for FY 2025. The FY 2025 continuing resolution amount reflects the third consecutive year that MedPAC received \$13.824 million in its annual appropriation. MedPAC's FY 2026 request amounts to a 2 percent average annual increase since FY 2023, lower than the annual increase in inflation over that period.

The request is based on considerable interest from the Congress in the expert analysis and advice the Commission provides to support the twin goals of ensuring Medicare beneficiaries' access to high-quality care and addressing the program's urgent fiscal challenges. MedPAC consistently provides timely and accurate assistance to the Congress in a budget-conscious manner. The requested budget would provide MedPAC the resources to support the Congress in its mission to oversee a growing and increasingly complex Medicare program and to help ensure its long-term sustainability. The Commission routinely provides assistance to the Congress with Congressional testimony, technical assistance on draft legislation, data analysis, and briefings on a range of Medicare payment issues—particularly for staff members of the committees with jurisdiction over Medicare. In 2024, the Commission fulfilled over 250 requests for technical assistance from Congressional staff.

The requested increase for FY 2026 stems largely from increased costs from personnel to maintain MedPAC's responsiveness to congressional requests and research contracts to support the 119th Congress's interests. MedPAC's request also includes reductions in other costs, including professional and consultant services.



About 40 percent (\$350,530) of the increase in our FY 2026 request would pay for two new analyst full-time equivalents (FTEs). These analysts will help further develop the Commission’s policy work and expand our ability to respond to Congressional requests across a range of Medicare payment issues, including software technologies in Medicare, the effects of Medicare Advantage on health care providers, and Medicare beneficiaries’ access to care. The Commission has been operating at a reduced staffing level for much of the past decade, and returning to a full staffing level would aid the Commission’s service to Congress. Another 35 percent (\$301,120) of the increase would go to salaries and benefits for current staff, which would allow MedPAC to retain our experts to continue providing timely and accurate responses to congressional requests. Our FY 2026 request also includes an expected increase in spending on research contracts, including \$45,000 to conduct focus groups with pharmacists and analyze findings to better understand the issues they face in delivering care to Medicare beneficiaries, with a particular focus on changes from policies included in the Inflation Reduction Act of 2022 (IRA). The request would also fund MedPAC’s beneficiary and physician focus groups at the 2024 level of effort so that the Commission’s advice to Congress incorporates timely and personalized perspectives of how beneficiaries and physicians experience the Medicare program. That increase would also go toward new analyses to support the completion of two

reports mandated by the Congress (one on reforms to the home health payment system and one on the costs of furnishing ground ambulance services).

Operating under a continuing resolution in 2025 presented a challenge for the agency. MedPAC took several steps to be able to operate at the funding level received in 2025. First, the agency changed its hiring plans to add fewer and more junior positions relative to our FY 2025 request. Additionally, the agency lowered spending on research projects by conducting fewer focus groups with Medicare beneficiaries and clinicians who serve Medicare beneficiaries relative to prior years and by forgoing a contract for work analyzing software technologies in Medicare. MedPAC will respond to a high volume of requests for assistance to the 119th Congress as lawmakers confront Medicare's urgent fiscal challenges. Additional resources would enable us to be even more responsive to these requests.

In addition to the FY 2026 appropriation request, in coordination with the Medicaid and CHIP Payment and Access Commission (MACPAC), we request two legislative changes to our contracting authority that would allow both agencies to operate more efficiently and grant us the same flexibilities afforded to other legislative branch agencies. The first includes the authority to execute contracts that span multiple fiscal years, and the second provides certain liability protections.

Basis for MedPAC's FY 2026 budget request

Our FY 2026 request is based on considerable interest from Congress in the expert analysis and advice the Commission provides to support the dual goals of ensuring Medicare beneficiaries' access to high-quality care and addressing the program's urgent fiscal challenges. As the Medicare program grows in size and complexity, so too do the challenges it faces, as reflected in the breadth of the Commission's recent work, which included new work to address cost-sharing differences faced by beneficiaries in rural areas, tracking the effects of software technologies and machine learning in the Medicare program, monitoring and reporting on the effects of changes to Medicare made under the IRA, the quality of care for Medicare patients residing in nursing homes, and continued analysis of "site-neutral" payments in Medicare. In addition, the Commission continues to identify opportunities for federal budget savings, and our standing recommendations would reduce federal spending by hundreds of billions of dollars, thereby improving program solvency and reducing burdens on the taxpayers and beneficiaries who finance the program.

The requested level of funding reflects the costs of the human capital, policy research, and data management and security needed to ensure MedPAC's efficient operation in support of the Congress's ongoing work to oversee and improve the Medicare program. Demand for MedPAC's analyses and the Commission's workload has grown along with the Medicare program. MedPAC last achieved a full staffing level of 37 full-time staff

(which reflects 2 FTEs for Commissioner’s time) in 2011 and 2012. Since that time, MedPAC has operated at a reduced FTE level with the assistance of part-time consultants. The proposed budget would allow MedPAC to return to a full staffing level, while maintaining resources to access specialized labor from part-time consultants to provide targeted support, as needed. This two-pronged approach allows the Commission to respond nimbly to a growing number of highly specialized and complex congressional requests.

MedPAC takes several important steps to promote transparency in our work. Transparency is achieved by conducting Commission meetings in public, webcasting those meetings for public viewing, and publishing meeting transcripts and presentations on our website. We also publish all of our reports, comment letters, and congressional testimony on our website. We have included a list of stakeholders we met with in 2024 in Appendix E of this document. Starting in the fall of 2023, we began publishing our expected analytic agenda for the upcoming year, allowing the Congress and Medicare’s stakeholders advance notice and opportunity to provide timely information and feedback.

MedPAC’s FY 2024 accomplishments

In addition to the two standing reports that the Commission produces annually pursuant to our authorizing legislation and several other informational products that we provide each year to support the Congress, the Commission submitted three special mandated reports in 2024, including one on the performance of Medicare Advantage (MA) special-needs plans (SNPs), one on Medicaid use and spending in nursing homes, and another on rural emergency hospitals as part of our March report to the Congress. Also, in 2024, the Commission began work to complete two mandated reports due in 2025 and three mandated reports due in 2026. The Commission also conducted work to respond to two additional requests that the House Committee on Appropriations, Subcommittee on Labor, Health, and Human Services, Education and Related Agencies included in its FY 2025 appropriations bill committee report. One request asked the Commission to provide more information about Medicare beneficiaries’ access to care, with a particular focus on the participation of primary care clinicians in Medicare. The other request asked for more information about differing incentives for documenting diagnostic codes in MA and fee-for-service (FFS) Medicare. The Commission conducted this work in 2024 and discussed analyses and findings related to these requests at our December 2024 and January 2025 public meetings; we included our formal written responses in our March 2025 report to the Congress.

MedPAC routinely provides technical assistance and policy advice to the Congress in the form of testimony, feedback on draft legislation, and briefings, particularly to professional staff of the committees with jurisdiction over Medicare. During FY 2024, we briefed committee staff both formally and informally on the Medicare program

and its funding sources, the physician fee schedule, outpatient dialysis, durable medical equipment, inpatient rehabilitation facilities, software as a medical service, graduate medical education, and the MA program. The Commission also testified twice before the U.S. House of Representatives Committee on Energy and Commerce, once before the Subcommittee on Health, and once before the Subcommittee on Oversight and Investigations. One testimony focused on ensuring Medicare beneficiaries' access to care and reducing burden for providers, and the other testimony focused on improving payment accuracy in the Medicare program.

MedPAC received a heavy volume of requests from the Congress in 2024, fielding over 250 requests for technical assistance. That technical assistance ranged from providing data analysis to help congressional staff understand potential effects of different policy options, to explaining interactions of draft legislation with other aspects of the Medicare program, to reviewing legislative text.

Throughout the year, the Commission continued our regular order of business and submitted 11 comment letters to the Centers for Medicare & Medicaid Services (CMS) in response to proposed regulations. In addition to providing independent, nonpartisan feedback to CMS, these comment letters help to inform congressional staff of the potential effects of proposed regulations affecting Medicare.

The Commission submitted two letters in response to requests for information: a bipartisan congressional request on primary care provider payment reform and a request from CMS on MA data. The Commission also submitted a letter to the U.S. Senate Committee on Finance in response to a request for feedback regarding a white paper on bolstering chronic care through physician payment. We anticipate a greater level of effort in 2026 regarding the provision of technical assistance, staff briefings, comment letters, and other formal requests for information.

The requested budget will provide MedPAC with the resources necessary to support the Congress in its mission to oversee the Medicare program and ensure its long-term sustainability. In our analyses, recommendations, and technical assistance, MedPAC provides significant value to the Congress. Our current set of recommendations provides the Congress with policy advice and analyses to shore up Medicare beneficiaries' access to high-quality care, achieve program savings of hundreds of billions of dollars, and improve incentives in Medicare's payment systems to promote value. Our objective in the coming year is to continue providing timely, accurate, and relevant assistance to the Congress in a budget-conscious manner.

Role of MedPAC

MedPAC is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare

program. In addition to advising the Congress on payments to providers in Medicare's traditional FFS program and to private health plans participating in Medicare, MedPAC provides information on beneficiaries' access to care, quality of care, and other issues affecting Medicare beneficiaries and providers. The Commission's work in all instances is guided by three principles:

1. Beneficiaries should have access to high-quality care in an appropriate clinical setting;
2. Medicare's payments should support efficient care delivery, thereby ensuring that the program's fiscal burden on beneficiaries and taxpayers is not greater than necessary; and
3. Providers should have incentives to supply appropriate care in an efficient manner.

In our role as an advisor to the Congress, MedPAC provides independent, analytically driven policy advice and day-to-day technical support. This support comprises, in part, a range of deliverables, including two standing mandated annual reports, comments on CMS's proposed regulations, compilations of data and statistics on the Medicare program, and summaries of Medicare payment systems. We also produce additional reports as required by legislation and other congressional direction.

In addition to these products, the Commission plays a vital role supporting the Congress in its policy deliberations related to the Medicare program. MedPAC strives to inform policymakers' discussions with reports on emerging issues or trends in Medicare. Commission staff regularly provide briefings and analysis for Members of Congress and congressional staff, as well as technical assistance on draft legislation.

Commission deliberations and formal recommendations help inform legislative frameworks and help congressional staff explain and present policy options to Members of the Congress, other congressional staff, and stakeholders. When legislation is enacted, MedPAC monitors the implementation and impact of Medicare policies and programs and reports back to the Congress with findings.

Value of MedPAC

The greatest challenges for the Medicare program are ensuring that beneficiaries have access to high-quality care; ensuring good value for the taxpayers and beneficiaries who fund the program; and safeguarding the long-term sustainability of the program. Medicare spending has grown substantially over the last decade, placing an increasing

financial burden on the taxpayers and beneficiaries who finance it. In 2024, Medicare spent over \$1 trillion to provide care for over 65 million beneficiaries.

Identifying policies to constrain growth in Medicare spending and opportunities for savings has been a trademark of MedPAC's work. The Commission's unimplemented recommendations would produce hundreds of billions in budget savings.

The Commission's recommendations and analyses have informed much of the major Medicare legislation over the last decade, including the Inflation Reduction Act of 2022 (IRA); the Consolidated Appropriations Act, 2021; the Bipartisan Budget Act (BBA) of 2018; the 21st Century Cures Act; and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). In 2024, MedPAC continued to work on issues of high interest to the Congress, including considering updates to Medicare payment for clinician services, evaluating beneficiary access to care in the MA program, examining staffing ratios and turnover rates in nursing facilities, analyzing Medicare Part B drug payment rates and 340B ceiling prices, assessing prices of generic drugs under Medicare Part D, reviewing rural hospitals and clinician payment policy, examining telehealth in Medicare, assessing Medicare coverage of and payment for software as a medical service, evaluating methods to establish Medicare payments for select conditions treated in inpatient rehabilitation facilities (IRFs), and reviewing ambulatory surgical centers.

MedPAC provides timely assistance and value by virtue of being a highly efficient organization. Commission staff carry out the core functions of the organization while responding in a timely manner to congressional requests and additional mandates. Returning to our full FTE level will ensure that Commission staff can continue to fully support the Congress's growing demands for independent and expert advice on Medicare policies.

MedPAC's dual responsibilities

To fulfill our charge of informing and advising the Congress on the Medicare program, MedPAC engages in two distinct but intertwined operations that provide an invaluable source of independent, expert advice to the Congress about the Medicare program.

First, the Commission conducts public meetings most months from September through April. In these public meetings, Commission staff present analyses that touch on nearly all aspects of Medicare payment policy, and MedPAC Commissioners provide valuable insight and direction on policies affecting beneficiary access to care and Medicare spending. Commission staff brief the authorizing committees about these analyses before every meeting so that congressional staff are informed of the Commission's work and have an opportunity to ask questions and provide feedback.

Organizing and executing this rigorous meeting schedule requires substantial effort from everyone in the organization.

Second, the Commission is responsible for producing MedPAC's two annual reports to the Congress, which are required by statute and submitted every March and June. Developing and producing these reports involves an extensive, multi-step process. Throughout the course of the year, staff members generate and refine original analyses; present these analyses to Commissioners at public meetings; incorporate Commissioner feedback; solicit and incorporate feedback from stakeholders, other researchers, and congressional staff; submit work for external review; and draft final papers to be included in the reports. In the March report, the Commission assesses the adequacy of Medicare's FFS payments to providers and makes recommendations on appropriate payment rate updates. We also provide status updates on the MA program, the Medicare prescription drug program (Part D), and ambulatory surgical centers, including recommendations as indicated to improve program performance. In the June report, the Commission reports both on additional refinements to Medicare's various payment systems and on broader issues affecting the Medicare program, including changes to health care delivery and the market for health care services. These standing reports also provide a vehicle by which we respond to other mandates from the Congress.

Since 2018, the Congress has tasked the Commission with 14 additional mandated reports and seven formal congressional requests due through 2026, including reports mandated by the Bipartisan Budget Act (BBA) of 2018; the Further Consolidated Appropriations Act, 2020; the Consolidated Appropriations Act, 2021; the Consolidated Appropriations Act, 2022; and the House report language accompanying the Consolidated Appropriations Act, 2023. The Commission submitted three special mandated reports in 2024, including one on the performance of MA special needs plans, one on Medicaid use and spending in nursing homes, and another on rural emergency hospitals as part of our March report to the Congress. The Commission also responded to a formal congressional request for information on primary care provider payment reform, provided a formal letter response to a U.S. Senate Committee on Finance white paper on bolstering chronic care through physician payment, and responded to a CMS request for information on MA data.

While conducting public meetings and producing MedPAC's mandated reports, Commission staff also provide advice and technical support to congressional staff, working with the committees that have jurisdiction over Medicare and others to support the policymaking process. This technical support takes many forms, including reviewing drafts of legislation and providing technical feedback, representing and explaining the views of the Commission on particular topics, briefing congressional staff on Medicare payment systems, and generating original analytic work upon request. Congressional staff frequently submit requests with short

turn-around times on a wide variety of Medicare topics that require, at different points, the expertise of all Commission staff members. Maintaining a staff of experts is essential to the Commission's ability to provide congressional staff with the timely, technical advice they need as they pursue policies that affect Medicare beneficiaries, providers, and program spending.

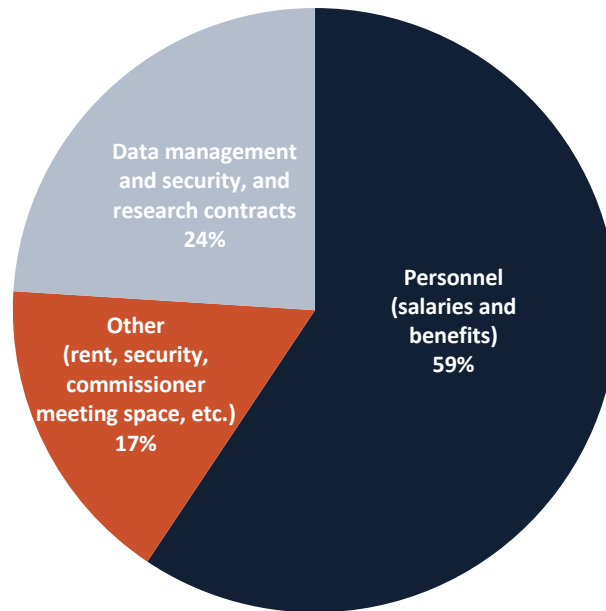
Demand for this latter type of Commission work has increased substantially over the past several years, in terms of the breadth, depth, and complexity of issues we are asked to explore, the data we are asked to produce and analyze, and the number of staff and stakeholders with whom we consult. In 2024, MedPAC fulfilled over 250 requests from congressional staff for briefings, technical assistance, data analysis, and consultations on a wide variety of topics, including the Medicare program and its funding sources, telehealth policy, hospital payment policy, the physician fee schedule, drug payment policy, outpatient dialysis, ambulance services, durable medical equipment, IRFs, geographic practice cost indices, skilled nursing facilities, laboratory services, imaging services, software as a medical service, graduate medical education, indirect medical education, site-neutral payment policy, and the MA program.

The Commission twice testified before the U.S. House of Representatives Committee on Energy and Commerce in FY 2024. In October 2023, MedPAC testified before the Subcommittee on Health on ensuring Medicare beneficiaries' access to care and reducing burden for providers. In April of 2024, MedPAC testified before the Subcommittee on Oversight and Investigations on improving payment accuracy in the Medicare program. Following each of these hearings, MedPAC submitted responses to questions for the record, which are posted on our website, along with the agency's testimony.

Cost centers

MedPAC's budget has relatively few major cost centers: personnel; data management and security and research contracts; and other costs, such as rent and security. Our FY 2026 request is distributed across those three centers with 59 percent in personnel costs including salaries and benefits; 24 percent in data security and management, and research contracts; and 17 percent in other costs including rent, security, space at the Ronald Reagan Building and International Trade Center for commissioner meetings, professional and consultant services, commercial contracts, as well as equipment and furnishings. The concentration of costs in these areas makes it difficult to continuously find additional efficiencies; however, we continue to constrain spending within our control.

**FY 2026 request: Allocation of MedPAC's costs
by major cost center**



Personnel

Our FY 2026 budget request includes an increase in personnel costs of \$651,650. That increase reflects a human capital strategy that will enable us to support the Congress as effectively as possible.

The Commission's greatest strength, as well as our largest cost center, is human capital. The Commission staff consists of a small management staff, an analytic staff, and a few administrative and operational staff. The management and analytic staff are highly trained health policy analysts and economists who are experts in their respective fields, with extensive experience working in research, the private sector, and government. Staff conduct a broad range of analytic work on topics identified as priorities by the Congress and the Commission. The requested increase in personnel costs stems from the following pressures:

Increased wage pressure. The agency anticipates higher costs from increases in salaries and benefits from current staff of \$301,120. As a labor-intensive organization that relies on expert analysts, MedPAC must offer salaries within the salary cap that are competitive with the executive branch, private research organizations, and private-sector companies that all recruit economists and analysts with expertise in health care policy and financing research. Recognizing the importance of offering competitive salaries to attract and retain staff with this expertise, the Congress (in the

Consolidated Appropriations Act, 2022) increased MedPAC's salary cap. That flexibility has helped us to retain and recruit expert staff but also has increased our personnel costs.

Return to full staffing level. Returning to a full staffing level, adding two analyst FTEs, accounts for \$350,530 of the requested increase. As the Medicare program has grown, so too has demand for MedPAC's analyses and the Commission's workload. The need for analysis and advice has been particularly important as policymakers grapple with the long-term fiscal status of the Medicare program, beneficiary access to care, and technological changes that create opportunities and challenges for the health care system and its workforce.

Since 2013, MedPAC has operated at a reduced FTE level and has relied on some labor from part-time consultants. The proposed budget for FY 2026 would allow MedPAC to return to a full staffing level while efficiently maintaining resources to access specialized labor from consultants as needed. This two-pronged approach better enables us to respond nimbly to a growing number of highly specialized and complex congressional requests. Maintaining our staff capacity continues to be important as we have incurred the retirements of several key analysts over the last few years and expect several more in the coming years. The two additional analysts will help further develop the Commission's policy work and expand our ability to respond to Congressional requests across a range of Medicare payment issues, including software technologies in Medicare, the effects of Medicare Advantage on health care providers, and Medicare beneficiaries' access to care.

As an example of how the Commission has worked to ensure our analysis keeps pace with the growing complexity of the Medicare program, in 2024 MedPAC hired a full-time research director to provide methodological and analytic expertise and direction across our work, with particular focus on MA and Part D. In support of the Commission's goal of providing expert advice to the Congress, we also began to contract with a physiatrist who has provided invaluable physician expertise regarding a broad range of clinical issues that intersect with Medicare payment policy.

Data management and security

Maintaining the security of the Medicare data the Commission analyzes for Congress is a mission-critical cost. The Commission contracts with a data management firm to ensure the security of those sensitive data and to supplement our data programming capacity. The Congress relies on the Commission as a source of data-driven and empirically rigorous information and expertise. That requires MedPAC staff to analyze very large data sets, including large Medicare FFS claims files; provider cost reports; Part D claims files; MA plan bid, quality, and encounter data; and commercial insurer claims data. The data sets contain information about beneficiary health

conditions, business intelligence, and other sensitive information. Contracting with a data management firm enhances our ability to process large data sets in a timely, secure manner. Working with this firm has also helped ensure that we fully comply with increased government regulations regarding the security of personally identifiable health information on tens of millions of current and past Medicare beneficiaries. Ensuring the security of these data is essential, and the related costs under this contract represent a mission-critical expenditure for the Commission. Given the large amount of data the Commission analyzes for Congress, and the central importance of that analysis to our mission, we will closely monitor developments in data security policy, and will keep the Committee informed of any important changes that affect our operations.

Research contracts

MedPAC also devotes a portion of our budget to contract support for select research projects. The Commission achieves efficiencies by contracting for additional expertise to supplement the work of Commission staff. Because of MedPAC's workload and the complexity of our analyses, access to external research consultants has been critical to providing timely and accurate advice to the Congress on key Medicare policy issues. With the requested budget increase of \$242,330, the Commission intends to conduct focus groups with pharmacists and analyze findings to better understand the issues they face in delivering care to Medicare beneficiaries, with a particular focus on changes stemming from the IRA. The increase would also allow for MedPAC to conduct its beneficiary and physician focus groups at their 2024 level (a key indicator of access to beneficiary care and the adequacy of Medicare's payments to clinicians). The request will also fund new analyses needed to help staff complete two of our upcoming reports mandated by the Congress, including a final report on how reforms of the home health payment system have affected beneficiary access to care and financial performance in the sector, and a report on the costs of furnishing ground ambulance services.

Other costs

The Commission also incurs other costs in the course of fulfilling our mission. The largest of those costs include rent (including security payments to the Department of Homeland Security), spending on specialized labor from professional and consultant services and commercial contracts, and spending on equipment the Commission purchases to safeguard our data assets. MedPAC's FY 2026 request includes a \$44,670

reduction in other costs, primarily driven by a modest reduction in professional and consultant services.

Requested legislative changes

In coordination with MACPAC, we request two legislative changes to our contracting authority that would allow both agencies to operate more efficiently and grant us the same flexibilities afforded to other legislative branch agencies. The first includes the authority to execute contracts that span multiple fiscal years; the second provides certain liability protections.

Multi-year contracting authority

Both MedPAC and MACPAC use contracts to support analytic and security functions. Currently, our agencies must structure the terms of contracts to align with the federal fiscal year on a 12-month period. Thus, our agencies must renegotiate or renew all of our contracts at the same time each year, an inefficient and administratively burdensome process. Multi-year contracting authority would allow our Commissions to obtain more competitive pricing for services we currently purchase on a fiscal year basis by securing best value to the government for longer periods of time. In addition, multi-year contracting authority increases agency efficiency by reducing the administrative burden of negotiating contracts on an annual basis. As specified in 41 USC 3904, this authority is currently provided for the Government Accountability Office, the Library of Congress, the Chief Administrative Officer of the House of Representatives, the Congressional Budget Office, the Secretary and Sergeant at Arms and Doorkeeper of the Senate, the Capitol Police, the Architect of the Capitol, and the Secretary of the Smithsonian Institution.

To allow for multi-year contracting authority, we respectfully ask for consistent authority with other legislative branch agencies as detailed in the Appropriations language on page 37.

Contracting parity

Software licenses and data agreements upon which MedPAC and MACPAC rely often include license agreements or terms of use. Often these agreements contain

boilerplate terms that conflict with existing federal law. Two of the terms presenting concern are the indemnification and governing law clauses:

- *Indemnification.* Federal law prohibits federal agencies from obligating themselves for unlimited future liability. Open-ended indemnifications create potential for violations of the Anti-Deficiency Act.
- *Governing law.* MedPAC and MACPAC are not subject to state and local laws because of the sovereign immunity granted to the Federal Government under the U.S. Constitution.

When license agreements contain such terms, MedPAC and MACPAC staff must devote resources to negotiating changes with consultants, which delays procurement processes. In some cases, the Commissions are unable to negotiate terms with a company and thus cannot use a product or service, which inhibits operations and can hinder the agencies from fulfilling our missions.

Executive branch agencies solved these issues by requesting, and being granted, the following Federal Acquisition Regulation (FAR) clauses: FAR 52.232-39 and FAR 52.233-4. These clauses provide efficiencies by eliminating the need for executive branch agencies to negotiate those provisions that are embedded as boilerplate terms and conditions in license agreements. The language provided on page 37 would make such terms automatically inapplicable to MedPAC and MACPAC contracts, thereby protecting us from inadvertent future liability while increasing our efficiency and freeing up resources for other important activities. Other legislative branch agencies, including the Congressional Budget Office, have obtained the same protections (e.g., see Section 130 of Title I of Division I of the Consolidated Appropriations Act, 2018 (P.L. 115-141)).



Activities and accomplishments

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The Commission is involved in the Medicare policymaking process in several capacities, including fulfilling reports mandated by the Congress on a wide range of topics, identifying and calling attention to emerging issues and trends, supporting the legislative process through recommendations and technical assistance to the Congress, and monitoring the implementation and impact of new policies.

The Commission's impact can be gauged qualitatively, examining the degree to which the Commission's deliberations have shaped the policy conversation about Medicare in the Congress—and in the health policy environment more broadly. For example, recent Medicare legislation—both introduced and enacted—has been informed by MedPAC's recommendations (see *Adoption of MedPAC Recommendations* below for specifics).

The Commission's accomplishments can also be expressed in terms of outputs. These outputs include both congressionally mandated work products and additional requests made to the Commission. For example, in FY 2024, MedPAC:

- Submitted our two annually mandated reports to the Congress;
- Produced a data book on health care spending and the Medicare program;
- Produced a data book in collaboration with MACPAC on beneficiaries who are dually eligible for Medicare and Medicaid;
- Submitted two additional mandated reports: one reviewing payment to rural emergency hospitals and another on the performance of MA-SNPs;
- Responded to a congressional request for information on primary care provider payment reform;
- Responded to a congressional request for feedback on a U.S. Senate Committee on Finance white paper on bolstering chronic care through physician payment;
- Responded to a request for information from CMS on MA data;
- Testified before the U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Health on ensuring Medicare beneficiaries' access to care and reducing burden for providers and responded to questions for the record following the hearing;
- Testified before the U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Oversight and Investigations on improving payment accuracy in the Medicare program and responded to questions for the record following the hearing;
- Published 20 Payment Basics briefs, an annually updated series widely used by congressional staff;

- Responded to over 250 requests for technical assistance from the Congress;
- Submitted written comments on 11 proposed rules and other policy solicitations from CMS;
- Held seven public meetings;
- Made presentations at seven stakeholder meetings and conferences;
- Conducted 21 in-person focus groups with nearly 115 beneficiaries and about 75 physicians in three states, as well as three virtual focus groups with beneficiaries residing in rural areas across the U.S., to better understand the experience of Medicare beneficiaries and their health care providers;
- Fielded an annual survey through mail and online for approximately 5,000 Medicare beneficiaries ages 65 and over and approximately 5,000 privately insured people ages 50 to 64 in order to better understand beneficiaries' access to care;
- Held more than 90 meetings with over 120 stakeholder groups and policy analysts in order to gather input for policy consideration; and
- Conducted site visits to six states (California, Delaware, Maine, Mississippi, Pennsylvania, and Washington) to better understand the experiences of rural hospitals, providers of dialysis and hospice, and hospital-at-home services.

The following subsections, as well as Appendixes C, D, and E, are lengthier summaries of the Commission's recent activities and accomplishments.

Adoption of MedPAC recommendations

MedPAC recommendations have informed Medicare policy set by the Congress and CMS on a range of issues. It is difficult to quantify the degree to which our recommendations are adopted because many are adopted with modifications. However, recent legislation has included key provisions that reflect the Commission's recommendations and advice. Selected policies adopted into law since 2018 are listed below.

- The Inflation Reduction Act of 2022 (IRA) included two provisions consistent with policy ideas that the Commission discussed and recommended, including:
 - *Restructuring the Medicare Part D benefit above the out-of-pocket threshold.* In our June 2020 report, the Commission made recommendations on restructuring the Part D benefit to cap enrollees' out-of-pocket spending so that plans appropriately take on greater insurance risk to bring the benefit back to its original approach of using

more risk-based payments with stronger incentives for plans to manage benefit spending. The IRA lowered enrollee cost sharing to 0 percent, raised plan liability for both brands and generics to 60 percent, and lowered Medicare reinsurance for brands to 20 percent and to 40 percent for generics. These provisions are directionally consistent with the Commission's June 2020 recommendations.

- *Modifying the average sales price (ASP) system.* In our June 2017 report, the Commission made recommendations on modifying the Part B drug ASP system. The IRA requires manufacturers to pay Medicare a rebate when the ASP for their product exceeds an inflation benchmark and ties beneficiary cost sharing to the inflation-adjusted ASP, starting in 2023. This policy is consistent with the Commission's June 2017 recommendation.
- The Consolidated Appropriations Act, 2022, extended Medicare telehealth flexibilities for five months following the end of the public health emergency (PHE), directionally consistent with the Commission's March 2021 policy option to extend Medicare's telehealth flexibilities for a limited duration following the end of the PHE.
- The Consolidated Appropriations Act, 2021, created a new hospital designation, the rural emergency hospital, consistent with the Commission's June 2018 recommendation.
- The Bipartisan Budget Act (BBA) of 2018 contained several provisions consistent with policy ideas that the Commission has discussed and recommended, including:
 - Sunsetting the exclusion of biosimilars from the Medicare Part D coverage-gap discount program. In our March 2018 report, the Commission made recommendations to remove the financial incentives that favor originator products and promote price competition between originator products and biosimilars, which could reduce Part D prices over time. The BBA provision is consistent with the Commission's March 2018 recommendations.
 - Establishing an enrollment-weighted method of determining star ratings when MA contract consolidations occur. In our March 2018 report, the Commission made recommendations to prevent certain MA contract consolidations from affecting plan quality ratings and bonus payments. The BBA provision is consistent with the Commission's March 2018 recommendations.
 - Eliminating the number of therapy visits as a payment factor in the home health prospective payment system (PPS) beginning in 2020. The Commission had long recommended that the number of therapy visits

be eliminated as a factor in payment determinations (most recently in our March 2018 report).

- Basing a modified Medicare low-volume hospital payment adjustment on total discharges, rather than Medicare discharges only. In our June 2012 report to the Congress on serving rural Medicare beneficiaries (mandated by the Patient Protection and Affordable Care Act of 2010), the Commission discussed the importance of targeting payments to providers in order to improve access while using Medicare spending efficiently. The BBA provision mandating the use of total discharges to measure patient volume is consistent with these goals.
- Permanently reauthorizing institutional SNPs (I-SNPs), narrowing the conditions eligible for chronic condition SNPs (C-SNPs), expanding the existing Center for Medicare & Medicaid Innovation (CMMI) Value-Based Insurance Design Model (allowing for MA benefit design flexibility), requiring the Secretary to develop a unified grievances and appeals process for dually eligible beneficiaries, and imposing more stringent standards to demonstrate dual-eligible SNP integration. These provisions are consistent with a set of recommendations the Commission made in our March 2013 report.
- Reforming the home health rural add-on payment to better target extra Medicare payments. In our March 2017 report, the Commission concluded that the home health rural add-on payment was poorly targeted. The BBA of 2018 provision aims to better target the add-on payments, which helps to address the Commission's concerns.
- Establishing an Accountable Care Organization (ACO) Beneficiary Incentive Program to allow certain two-sided-risk ACOs to make incentive payments to assigned beneficiaries. The Commission has supported giving ACOs more options for incentivizing beneficiaries to use providers within their ACO.
- Expanding access to telehealth services in MA and ACOs for end-stage renal disease (ESRD) beneficiaries and for stroke patients. In our March 2018 report on telehealth (mandated by the 21st Century Cures Act), the Commission articulated a set of principles (cost, access, and quality) to evaluate individual telehealth services before adoption into Medicare coverage, and discussed telestroke, MA plans, and ACOs as examples where greater flexibility may be desirable.
- Requiring ground ambulance providers to submit cost reports. In our June 2013 report on the ambulance fee schedule (mandated by the Middle Class Tax Relief and Job Creation Act of 2012), the Commission supported requiring ground ambulance providers to submit cost reports.

In addition, CMS has adopted several of the Commission’s recommendations through its rulemaking process. Selected policies adopted through rulemaking since 2018 include:

- The MA/Part D final rule for calendar year (CY) 2024 further limited insurers’ ability to offer dual-eligible SNP (D-SNP) “look-alike” plans (traditional MA plans targeted at dually eligible beneficiaries), consistent with the Commission’s June 2019 chapter on promoting integration in D-SNPs.
- The hospital inpatient prospective payment systems (IPPS) final rule for FY 2023 changed the calculation of the IPPS outlier fixed loss amount, consistent with the Commission’s comment to modify the approach to account for the number of costly COVID-19 cases in FY 2021.
- The physician fee schedule (PFS) final rule for CY 2023 required clinicians to use a claims modifier to identify all audio-only telehealth services, consistent with the Commission’s March 2022 recommendation.
- The PFS proposed rule for CY 2023 requested comment on incorporating an administrative benchmark approach to the Medicare Shared Savings Program (MSSP), consistent with discussions in MedPAC’s June 2022 report to the Congress.
- Beginning on January 1, 2021, CMS expanded the durable medical equipment, prosthetic/orthotics, and supplies (DMEPOS) competitive bidding program (CBP) to include off-the-shelf knee and back braces. The Commission supported shifting such DMEPOS products from the DME fee schedule to the CBP in our June 2018 report to the Congress.
- The MA and Part D final rule for CY 2021 implemented restrictions for D-SNP “look-alike” plans. In our June 2019 report to the Congress, the Commission raised concerns over the growing use of look-alike plans to circumvent D-SNP requirements.
- In the final rule updating the Medicare payment rates and the value-based purchasing program for skilled nursing facilities (SNFs) for FY 2020, CMS implemented a new case-mix system. The Commission began discussing needed reforms to the SNF PPS in our June 2007 report, and the following year we recommended a design to base payments on patient characteristics and to better target payments for nontherapy ancillary services.
- The hospital outpatient prospective payment system (OPPS) final rule for CY 2019 implemented site-neutral payment for evaluation and management clinic visits provided in off-campus hospital outpatient departments and freestanding physician offices. In 2012 and 2014, the Commission recommended that the Congress reduce or eliminate differences in payment rates between hospital outpatient departments and physician offices.

- In the 2019 MA and Part D rate announcement and call letter, CMS adjusted the payment rate for MA employer group waiver plans so that the payments are more consistent with how comparable non-employer plans are paid. The Commission recommended this adjustment in our March 2014 report to the Congress.
- The physician fee schedule final rule for CY 2019 reduced the add-on percentage for certain Part B drugs paid based on wholesale acquisition cost (WAC) from 6 percent to 3 percent. The Commission recommended this policy in our June 2017 report to the Congress.
- The hospital IPPS final rule for FY 2018 included a policy change to begin using the S-10 worksheet in Medicare's cost reports to distribute uncompensated care payments. The Commission recommended this policy in our March 2016 report on hospital inpatient and outpatient services. That rule also included a revision of the methodology used for paying long-term care hospitals for short stays, and it improved incentives for providers to base discharge decisions on clinical needs rather than payment. The Commission discussed this policy approach in multiple reports to the Congress and in comment letters to CMS on the FY 2015 and FY 2016 proposed IPPS rules.

Commission meetings

From October through September of each fiscal year, the Commission holds seven public meetings to develop and approve reports and make recommendations to the Congress. The Commission staff briefs the committees that have jurisdiction over Medicare, CMS, and MACPAC before each meeting to ensure that the staff are informed of the items that compose each meeting's agenda.

The Commission contracts with the Ronald Reagan Building and International Trade Center in Washington, DC, as the venue for our live-streamed public meetings, given our statutory mandate to hold deliberations in public. Throughout FY 2024, each live-streamed session was viewed by approximately 150 to 360 attendees. There is broad interest from staff on the committees with jurisdiction over Medicare, stakeholders across the country, other government personnel, and members of the public to continue to view the Commission's deliberations virtually. The agenda for each meeting over the past year is described in Appendix C.

Research reports

In 2024, the Commission completed all requested/mandated reports and presented them to the Congress in accordance with statutory deadlines. In the process of

preparing these reports, Commission staff made about 40 public presentations to Commissioners, requiring staff to conduct relevant analyses and develop draft decision memoranda, background documents, and other materials. Further, staff gathered additional information for these reports through meetings with a wide range of external groups, described below.

March 2024 report to the Congress

On March 15, 2024, the Commission submitted our annual mandated report to the Congress on Medicare payment policy, complying with a statutory requirement each year to provide the Congress with recommendations on whether and how to update Medicare's payments to different providers and the rationale for our recommendations. The report addressed the following areas:

- Assessing payment adequacy and updating payments for hospital inpatient and outpatient services, physician and other health professional services, outpatient dialysis services, SNF services, home health services, IRF services, and hospice services;
- The status of ambulatory surgical center services;
- The status of Medicare's Part D prescription drug benefit;
- The status of the MA program;
- Estimating MA coding intensity and favorable selection;
- Dual-eligible special needs plans (mandated report, as described below); and
- Rural emergency hospitals (mandated report, as described below).

To fulfill a statutory requirement, this report also included our annual chapter on the budgetary context for Medicare payment policy.

June 2024 report to the Congress

On June 13, 2024, the Commission submitted our annual mandated report to the Congress on Medicare and the health care delivery system. This report focused on broad questions confronting the Medicare program, as well as more sector-specific issues, and fulfilled a statutory requirement to each year provide the Congress with a report examining the issues facing the Medicare program. Topics included:

- Approaches for updating clinician payments and incentivizing participation in alternative payment models;
- Provider networks and prior authorization in MA;

- Assessing data sources for measuring health care utilization by MA enrollees;
- Encounter data and other sources;
- Paying for software technologies in Medicare;
- Considering ways to lower Medicare payments for select conditions in IRFs; and
- Medicare’s Acute Hospital Care at Home.

Other mandated reports completed in FY 2024

In addition to our standing annual reports to the Congress, the Commission publishes specific reports that directly respond to congressional mandates in legislation or formal requests. In 2024, the Commission published two reports in compliance with mandates in the Bipartisan Budget Act of 2018, the Affordable Care Act of 2010, and the Consolidated Appropriations Act, 2021.

- *The Consolidated Appropriations Act, 2021. To review data on payments to rural emergency hospitals as part of the March report, beginning in 2024.* The Congress created the rural emergency hospital (REH) designation in the Consolidated Appropriations Act, 2021. The Act also mandated that the Commission annually review data on payments made to REHs as part of our March report. Because the program began in 2023, complete REH claims data were not yet available for our March 2024 report; in its initial year, the report provided context on the evolution of Medicare’s support for rural hospitals, gave background on the REH designation and the hospitals that have converted to REHs, and described the Commission’s 2023 site visits to (prospective) REHs to understand their experiences and decision-making processes.
- *The Affordable Care Act of 2010. To review Medicaid use and spending and non-FFS Medicare margins in nursing homes.* Section 2801 of the Affordable Care Act of 2010 requires the Commission to examine spending, use, and financial performance trends in the Medicaid program for providers that have a significant portion of revenues or services associated with Medicaid. In our March 2024 report to the Congress, we report on nursing facility (the term we use for Medicaid-certified facilities that provide long-term care, also commonly called “nursing homes”) spending trends for Medicaid and financial performance for non-Medicare payers.
- *The Bipartisan Budget Act, 2018. To submit to Congress a study on the performance of MA-SNPs.* The Bipartisan Budget Act of 2018 permanently authorized D-SNPs and required them in 2021 to meet new standards for integrating the delivery of Medicare and Medicaid services. The plan must meet one of three additional criteria for integration such as care coordination, qualifying as a highly

integrated dual-eligible SNP (HIDE-SNP), or assuming “clinical and financial responsibility” for both Medicare and Medicaid benefits provided to enrollees. The Commission was mandated to periodically compare the performance of different types of D-SNPs and other plans that serve dual-eligible beneficiaries. As required by the mandate, in our March 2024 report to the Congress, we compared plans’ performance using quality measures that plans report as part of the Healthcare Effectiveness Data and Information Set® (HEDIS®) and patient experience data that plans collect using the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) beneficiary survey.

Other publications

In addition to the congressionally mandated reports, the Commission also released the following publications frequently used by congressional staff:

- *MedPAC and MACPAC Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid* (January 2024). In collaboration with MACPAC, this data book provides tables and graphs that present information on the demographic and other personal characteristics, expenditures, and health care utilization of individuals who were dually eligible for Medicare and Medicaid coverage.
- *A Data Book: Health Care Spending and the Medicare Program* (July 2024). The Medicare data book provides tables and graphs describing the Medicare program, Medicare beneficiaries and their utilization of health care services, and Medicare’s payment systems. The Medicare data book is the result of discussions with congressional staff members regarding ways that MedPAC can better support them.
- *Payment Basics* (October 2024). Payment Basics is a series of brief overviews of how 20 of Medicare’s payment systems function.

FY 2025 reports to the Congress

We submitted our March report to the Congress on March 12, 2025, which focused on Medicare payment policy. We also submitted two mandated reports and two congressional requests in our March 2025 report to the Congress:

- A report mandated by the Consolidated Appropriations Act, 2021, to review data on payments to rural emergency hospitals.
- A report mandated by the Affordable Care Act of 2010 to review Medicaid use and spending and non-FFS Medicare margins in nursing homes.
- A report requested by the House Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education and Related

Agencies' FY 2025 committee report on the extent to which MA and FFS incentives result in different relative rates of diagnostic coding and may result in payment differentials between MA and FFS.

- A report requested by the House Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education and Related Agencies' FY 2025 committee report on Medicare beneficiaries' access to care, including the share of primary care providers that refuse to accept or limit the acceptance of new Medicare patients and data on Medicare patients' wait times for visits with new primary care providers.

Our June report will focus on specific issues in payment and delivery system reform and will be submitted to the Congress by our June 15th statutory deadline. We plan to submit our Medicare data book in July 2025 and *Payment Basics* on each of the Medicare payment sectors in October 2025, as we have in past years.

Primary source data collection

Gathering primary source data and information is an essential activity for the Commission to fulfill our statutory mission. To that end, the Commission engages in a wide range of primary source data collection efforts, including meeting with key stakeholders, such as individual health care providers, associations of health care providers, beneficiaries, and experts in health care policy and medicine; purchasing non-Medicare proprietary data; conducting a national survey of Medicare beneficiaries; convening focus groups with beneficiaries and providers; and conducting site visits to various health care providers to better understand their experience with the Medicare program.

These interactions both inform the Commission's recommendations and help Commission staff better anticipate and respond to congressional requests, since many of the stakeholder groups with whom MedPAC meets are the same groups that lobby the Congress for their policy priorities.

National survey of beneficiaries

Every year, MedPAC fields a survey to assess beneficiaries' reported access to clinician care. We survey about 5,000 Medicare beneficiaries ages 65 and over and over 5,000 privately insured people ages 50 to 64. Survey data are weighted to produce nationally representative results, which are available to us within two months of fielding. The survey provides insight into beneficiary access to care and use of health care services relative to privately insured patients. Findings from this survey are key to our annual assessment of the adequacy of Medicare payments to clinicians.

Dialogue with stakeholder groups

In FY 2024, the Commission met with over 120 stakeholder groups, a 60 percent increase compared with 2023. A partial list of the groups the Commission met with in 2024 is included in Appendix E. In 2025, members of the Commission staff will continue to meet with outside groups in order to gather insights to inform MedPAC's findings and recommendations. These interactions are supplemented by written statements submitted by stakeholders to the Commission members and staff following our public meetings. Written comments are distributed to MedPAC Commissioners and staff and posted on our website for the public.

Focus groups

Each year, MedPAC staff hear directly from Medicare beneficiaries and health care providers in a variety of urban and rural geographies through focus groups we conduct. Commission staff use those focus groups to gain additional understanding of their respective experiences with the Medicare program. In 2024, we held 21 in-person focus groups with Medicare beneficiaries and physicians residing in Philadelphia, PA; Phoenix, AZ; and Dallas, TX. Additionally, we held three virtual focus groups with beneficiaries residing in rural areas across the country. We asked those groups about beneficiaries' access to care, beneficiaries' coverage choices, the delivery of care, clinician telehealth adoption and beneficiary use, and quality measurement.

Site visits

To increase our understanding of the health care market and the impact of Medicare payment policy on providers, Commission staff make annual site visits to a range of providers across the country, visiting different locations and types of facilities each year. In 2024, staff conducted site visits in Maine, Mississippi, and California to interview administrators and staff at rural hospitals. Staff also conducted site visits in Pennsylvania and Washington to interview physicians and providers of hospice and dialysis services. Finally, staff visited a hospital-at-home provider to better understand the model of care provided, the screening of beneficiaries, and trends in enrollment.

MedPAC comments on CMS regulations

In addition to our mandated reports, during the past year, the Commission has submitted written comments on 11 proposed rules and one request for information by the Secretary of the Department of Health and Human Services. Our comment letters serve as a resource for committee staff, providing a stronger understanding of the proposed regulations and their larger potential policy implications, and are all posted

on our website. The proposed rules on which the Commission submitted comments are listed below:

- Proposed rule on policy and technical changes to the MA program and Medicare Prescription Drug Benefit Program (Part D) for 2025 (01/05/2024)
- Advance notice of methodological changes for CY 2025 for MA capitation rates and Part C and D payment policies (03/01/2024)
- Proposed rule on the payment system for IRFs for FY 2025 and updates to the IRF Quality Reporting Program (05/23/2024)
- Proposed rule on the payment system for inpatient psychiatric facilities for FY 2025 (05/23/2024)
- Proposed rule on the payment system for hospice for FY 2025 (05/28/2024)
- Proposed rule on the SNF payment system for FY 2025 (05/28/2024)
- Request for information on MA data (05/29/2024)
- Proposed rule on the IPPS for FY 2025 (06/06/2024)
- Proposed rule on the home health payment system for CY 2025 (08/22/2024)
- Proposed rule on the payment system ESRD for CY 2025 (08/22/2024)
- Proposed rule on the payment systems for hospital outpatient departments and ambulatory surgical centers for CY 2025 (09/06/2024)
- Proposed rule on CY 2025 revisions to payment policies under the physician fee schedule and other changes to Part B payment policies (09/06/2024)

We also responded to a CMS request for information on MA data. In 2025, we expect to comment on between 10 to 15 proposed rules, regulations, and other requests for information from CMS; we expect to comment on a similar number for 2026.

MedPAC comments on congressional requests for information and feedback

The Commission has submitted written responses to two public congressional requests for information and feedback. Our response letters serve as a resource for committee staff, leadership, and Member staff on targeted questions. All of our response letters are posted on our website. The congressional requests for which the Commission submitted written comments are listed below:

- Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B (06/13/2024)
- Primary Care Provider Payment Reform (07/12/2024)

MedPAC briefings, assistance to congressional staff, and testimony

Over the last year, MedPAC was called upon regularly to provide technical support and advice to the Congress—both Members and staff, majority and minority party, formally and informally. This support took several forms.

MedPAC briefed congressional staff on a wide range of Medicare issues as well as ongoing analytic work by the Commission, including formal staff briefings addressing the MA program broadly, the physician fee schedule, and Medicare payment for software as a service. Commission staff also conducted a series of less formal briefings with staff of the committees of jurisdiction over the Medicare program on a variety of topics in addition to those mentioned previously, including IRF payment rates, outpatient dialysis services, and graduate medical education.

Commission staff responded to numerous requests from congressional staff on a wide variety of topics. These interactions included conference calls and briefings prior to each public meeting to discuss research, gather feedback, and provide information about Commission deliberations and upcoming recommendations. Commission staff provided data, background materials, and other substantive analyses. In 2024, Commission staff fulfilled over 250 requests for technical assistance from the Congress.

The Commission testified twice before the U.S. House of Representatives Committee on Energy and Commerce, once before the Subcommittee on Health, and once before the Subcommittee on Oversight and Investigations. The Commission also responded to questions for the record following both hearings. The congressional testimonies are listed below:

- Ensuring Medicare beneficiaries' access to care and reducing burden for providers (10/18/2023)
- Improving payment accuracy in the Medicare program (04/15/2024)

Collaboration with other government entities

In 2024, as in previous years, MedPAC worked collaboratively with other government entities involved in assessing and implementing the Medicare program. These interactions include exchanging information about health service delivery, quality measurement, and other topics. These collaborations are mutually valuable and contribute to greater coordination and minimized redundancy among government initiatives. Collaborations with the following other government entities included:

Congressional support agencies: Coordination and consultation with MACPAC, the Congressional Budget Office, the Congressional Research Service, and the Government Accountability Office.

Centers for Medicare & Medicaid Services (CMS): Monthly briefings on a range of issues, as well as ad hoc meetings to discuss specific topics such as Medicare demonstration programs, actuarial estimates, and other Medicare policy issues; consultations with the Center for Medicare and Medicaid Innovation and the Office of the Actuary.

Agencies within the Department of Health and Human Services: Discussions with the Office of Inspector General, the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, the Federal Office of Rural Health Policy, and state health departments.

Presentations and professional conference participation

In 2024, Commission staff extended public outreach through speaking at eight meetings hosted by key stakeholder organizations and presented MedPAC's work at a professional conference.

MedPAC staff presented to the Allied Hospital Associations, Kidney Care Partners, the Medical Device Manufacturers Association, the American Hospital Association's Post-Acute Care Steering Committee, the National Association of Rehabilitation Providers and Agencies, the Federation of American Hospitals, Health Management Associates, and the Missouri Economic Association.

MedPAC staff also presented work at AcademyHealth's Annual Research Meeting in Baltimore, MD. Staff participated in a policy roundtable on telehealth entitled "Medicare and Telehealth: Assessing the Current State of Evidence and Shaping Future Policies," presented analysis on hospital use by beneficiaries enrolled in MA and FFS Medicare entitled "Differences in Hospital Use between Medicare Advantage and Fee-for-Service Patients: Implications for Hospitals' Costs," and presented analysis on inpatient psychiatric care entitled "Who is Affected by Medicare's Coverage Limit on Psychiatric Hospitalizations?"

Members of the staff will continue to reach out to external groups through professional and academic meetings. Such efforts increase staff knowledge of Medicare policy and research and promote transparency of the Commission's work.



Supporting material

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Appropriations language

For expenses necessary to carry out section 4022 of the Balanced Budget Act of 1997, Public Law 105-33 (42 U.S.C. §1395b-6), \$14,673,000 to be transferred to this appropriation from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds.

MULTI-YEAR CONTRACTING AUTHORITY FOR MEDPAC AND MACPAC.

Section 3904 of title 41, United States Code, is amended by adding at the end the following new subsection:

“(i) THE MEDICARE PAYMENT ADVISORY COMMISSION.—The Medicare Payment Advisory Commission may use available funds to enter into contracts for the procurement of severable services for a period that begins in one fiscal year and ends in the next fiscal year and may enter into multi-year contracts for the acquisition of property and services to the same extent as executive agencies under the authority of sections 3902 and 3903 of this title.”

“(j) THE MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION.—The Medicaid and CHIP Payment and Access Commission may use available funds to enter into contracts for the procurement of severable services for a period that begins in one fiscal year and ends in the next fiscal year and may enter into multi-year contracts for the acquisition of property and services to the same extent as executive agencies under the authority of sections 3902 and 3903 of this title.”

CONTRACTING PARITY FOR MEDPAC AND MACPAC.

In fiscal year 2026 and thereafter, for all contracts for goods and services to which the Medicare Payment Advisory Commission or the Medicaid and CHIP Payment and Access Commission is a party, the following Federal Acquisition Regulation (FAR) clauses will apply: FAR 52.232-39 and FAR 52.233-4 (or a successor clause).

Authorizing legislation

The Commission’s authorization is contained in Section 4022 of the Balanced Budget Act of 1997, Public Law 105-33 (42 U.S.C. §1395b-6). This legislation authorizes “such sums as may be necessary.”

(in thousands of dollars)			
FY 2025 authorized	FY 2025 appropriation	FY 2026 authorized	FY 2026 request
\$13,824	\$13,824	N/A	\$14,673

Note: FY (fiscal year), N/A (not applicable).

Summary of changes

	FY 2025 Appropriation		FY 2026 Request	
	Base		Change from Base	
	FTE	Budget Authority	FTE	Budget Authority
Increases:				
Personnel compensation	35	\$5,761,500	37	+478,500
Research contracts		1,141,560		+242,330
Personnel benefits		2,297,350		+173,150
Misc. other services: Commercial contracts		458,150		+45,750
Software/equipment/furnishings		431,250		+23,540
LOC support services		56,550		+23,450
Travel		216,220		+13,430
Security payments to DHS		120,000		+12,000
Office supplies/services		10,800		+2,000
Rent (lease)		795,000		+1,000
Trainings and conferences		48,400		+700
Leased Equipment		710		+90
Decreases:				
Professional and consultant services		624,750		-154,840
Cell/telephone/courier/internet		36,560		-5,940
Other government services (GSA, NFC, OPM)		32,760		-2,840
Computer programming		1,670,000		-2,520
Publications		109,450		-490
No change:				
Printing and reproduction		12,000		0
Postage		1,000		0
Net change:				+849,310

Note: FY (fiscal year), FTE (full-time equivalent), LOC (Library of Congress), DHS (Department of Homeland Security), GSA (Government Services Administration), NFC (National Finance Center), OPM (Office of Personnel Management). Components may not sum to totals because of rounding.

Budget authority by object class

Object classification	(In thousands of dollars)			
	FY 2024 Actual	FY 2025 Enacted	Change	FY 2026 Request
Personnel compensation				
Full-time staff	\$5,059	\$5,425	+465	\$5,890
Commissioners	266	337	+14	350
	<u>5,325</u>	<u>5,762</u>	<u>+479</u>	<u>6,240</u>
Personnel benefits	2,067	2,297	+173	2,471
Travel				
Staff	21	50	+5	54
Commissioners	87	167	+9	176
Consultant	<u>1</u>	<u>-</u>	<u>-</u>	<u>-</u>
	<u>109</u>	<u>216</u>	<u>13</u>	<u>230</u>
Rent (lease)	771	795	1	796
Cell/telephone/courier/internet	38	37	-6	31
Leased equipment	1	1	-	1
Postage	<u>1</u>	<u>1</u>	<u>-</u>	<u>1</u>
	<u>810</u>	<u>833</u>	<u>-5</u>	<u>828</u>
Printing and reproduction	9	12	-	12
Misc. other services: Commercial contracts	430	458	+46	504
Computer programing	1,585	1,670	-3	1,667
Research contracts	2,058	1,142	+242	1,384
Other government services (GSA, NFC, OPM)	25	33	-3	30
LOC support services	88	57	23	80
Training and conferences	16	48	+1	49
Security payments to DHS	119	120	+12	132
Professional and consultant services	<u>603</u>	<u>625</u>	<u>-155</u>	<u>470</u>
	<u>4,923</u>	<u>4,152</u>	<u>+164</u>	<u>4,316</u>
Office supplies/services	6	11	+2	13
Publications	<u>104</u>	<u>109</u>	<u>-</u>	<u>109</u>
	<u>109</u>	<u>120</u>	<u>+2</u>	<u>122</u>
Software	175	179	+1	180
Equipment	162	252	+23	275
Furnishings	<u>1</u>	<u>-</u>	<u>-</u>	<u>-</u>
	<u>338</u>	<u>431</u>	<u>+24</u>	<u>455</u>
Subtotal	\$13,691	\$13,824	+849	\$14,673
Lapsing	133	-	-	-
Total	\$13,824	\$13,824	+849	\$14,673

Note: FY (fiscal year), GSA (General Services Administration), NFC (National Finance Center), OPM (Office of Personnel Management), LOC (Library of Congress), DHS (Department of Homeland Security). Components may not sum to totals because of rounding.

Actual and requested funding, FY 2024-2026

	(In thousands of dollars)			
	FY 2024 Actual	FY 2025 Enacted	Change	FY 2026 Request
Administration and management (primarily staff and Commissioner salaries and benefits)	\$9,446	\$10,388	+\$764	\$11,152
Data development, analysis, and research (primarily data management and security and outside consultant costs)	\$4,245	\$3,436	+\$85	\$3,521
Lapsing	\$133	-	-	-
Total	\$13,824	\$13,824	\$849	\$14,673

Note: FY (fiscal year). Components may not sum to totals because of rounding.

Personnel summary

	FY 2024 Actual	FY 2025 Enacted	Change	FY 2026 Request
Executive level ^a	2	3	0	3
GS/GM-13 to GS/GM-15	25	26	+1	27
GS-6 to GS-12	6	6	+1	7
Staffing level (FTEs)	33	35	+2	37

Note: FY (fiscal year), GS/GM (General Schedule), FTE (full-time equivalent). Components may not sum to totals due to rounding. This schedule is for comparison purposes only. MedPAC does not use the formal government system of grading and salaries. Each salary is determined individually following U.S. Senate personnel rules and MedPAC's personnel policies and procedures. Reflects full-year FTE averages.

^a *The number of executive level staff includes 2 FTEs allocated among MedPAC's 17 part-time Commissioners. MedPAC's authorizing legislation requires that Commissioners be paid the per diem equivalent of the rate provided for Level IV of the Executive Schedule for the time they devote to Commission business. The other position is the Executive Director.*

Staffing level

Fiscal year	Number of full-time equivalent positions ^a
2006	35
2007	34
2008	32
2009	34
2010	35
2011	37
2012	37
2013	36
2014	35
2015	34
2016	36
2017	35
2018	33
2019	35
2020	33
2021	32
2022	33
2023	34
2024	33
2025	35
2026	37 ^b

Note: Reflects full-year full-time equivalent (FTE) average number of positions.

^a The total FTE level includes 2 FTEs representing the part-time work of the 17 Commissioners.

^b Reflects fiscal year 2026 request.

Appropriations history

Fiscal Year	Budget Estimate to the Congress	Appropriation
2008 ^a	\$10,748,000	\$10,560,000
2009	\$11,403,000	\$11,403,000
2010	\$11,800,000	\$11,800,000
2011 ^b	\$12,749,000	\$12,425,000
2012 ^c	\$13,100,000	\$11,778,000
2013 ^d	\$12,210,000	\$11,162,000
2014	\$12,087,000	\$11,519,000
2015	\$12,300,000	\$11,749,000
2016	\$12,100,000	\$11,925,000
2017	\$12,234,000	\$11,925,000
2018	\$12,295,000	\$12,545,000
2019	\$12,471,000	\$12,545,000
2020	\$12,645,000	\$12,545,000
2021	\$13,142,000	\$12,905,000
2022	\$13,310,000	\$13,292,000
2023	\$13,440,000	\$13,824,000
2024	\$13,824,000	\$13,824,000
2025	\$14,477,000	\$13,824,000
2026	\$14,673,000	

^a For fiscal year (FY) 2008, the Commission received an appropriation of \$10,748,000 that was reduced to \$10,560,000 by an across-the-board rescission.

^b For FY 2011, the Commission received an appropriation of \$12,450,000 that was reduced to \$12,425,000 by an across-the-board rescission.

^c For FY 2012, the Commission received an appropriation of \$11,800,000 that was reduced to \$11,778,000 by a rescission.

^d FY 2013 reflects the appropriated amount after the sequester.



Appendixes

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APPENDIX A

2024-2025 Commission members^a

Member and Affiliation	Appointed	Term Expiration
Michael Chernew, ^b Ph.D., Chair Harvard Medical School Boston, MA	5/21/2020	4/30/2026
Amol Navathe, ^b M.D., Ph.D., Vice Chair University of Pennsylvania School of Medicine Philadelphia, PA	5/23/2019	4/30/2025
Betty Rambur, ^b Ph.D., R.N., F.A.A.N. University of Rhode Island Kingston, RI	5/21/2020	4/30/2026
Brian Miller, M.D., M.B.A., M.P.H. Johns Hopkins University Baltimore, MD	5/31/2023	4/30/2026
Cheryl Damberg, ^b Ph.D. RAND Corporation Santa Monica, CA	5/26/2022	4/30/2027
Gina Upchurch, ^b R.Ph., M.P.H. Senior PharmAssist Durham, NC	5/31/2023	4/30/2027
Gregory Poulsen, M.B.A. Intermountain Healthcare Salt Lake City, UT	5/26/2022	4/30/2025
Joshua Liao, M.D., M.Sc. University of Texas Southwestern Medical Center Dallas, TX	5/29/2024	4/30/2027
Kenny Kan, F.S.A., C.P.A., C.F.A., M.A.A.A. Horizon Blue Cross Blue Shield Newark, NJ	5/26/2022	4/30/2025

Lawrence Casalino, ^b M.D., Ph.D. Weill Cornell Medical College New York, NY	5/23/2019	4/30/2025
Lynn Barr, ^b M.P.H. Barr-Campbell Family Foundation Lahaina, HI	6/2/2021	4/30/2027
Paul Casale, M.D., M.P.H. Weill Cornell Medical College New York, NY	5/30/2024	4/30/2027
Robert Cherry, M.D., M.S. UCLA Health Los Angeles, CA	5/26/2022	4/30/2025
Scott Sarran, M.D., M.B.A. Harmonic Health; Triple Aim Geriatrics Cook County, IL	5/26/2022	4/30/2025
Stacie B. Dusetzina, ^b Ph.D. Vanderbilt University School of Medicine Nashville, TN	6/2/2021	4/30/2027
R. Tamara Konetzka, Ph.D. University of Chicago Chicago, IL	5/31/2023	4/30/2026
Wayne J. Riley, ^b M.D., M.P.H., M.B.A. State University of New York Downstate Brooklyn, NY	5/21/2020	4/30/2026

^a On May 29, 2025, two new commissioners, Thomas Diller, M.D., M.M.M., and Gohkan Metan, M.Sc., Ph.D., N.A.C.D.D.C., were appointed and will begin serving during the 2025-2026 cycle. Betty Rambur, Ph.D., R.N., F.A.A.N., was appointed as the Vice Chair. Robert Cherry, M.D., M.S.; Kenny Kan, F.S.A., C.P.A., C.F.A., M.A.A.A.; Gregory Poulsen, M.B.A.; and Scott Sarran, M.D., were reappointed to serve a second three-year term.

^b Member was reappointed to a second term.

APPENDIX B

Recently published and outstanding congressionally mandated reports and formal requests, 2025-2026

Mandate: **Consolidated Appropriations Act, 2021. Review payments to rural emergency hospitals (recurring annually)**

Due date: March 15, 2025

Description: Beginning in 2024, as part of our March report, MedPAC shall include a review of payments to a new designation of hospitals known as “rural emergency hospitals.”

Mandate: **Affordable Care Act of 2010. Review Medicaid use and spending and non-Medicare margins in nursing homes (recurring annually)**

Due date: March 15, 2025

Description: Beginning in 2012, as part of our March report, MedPAC shall include a review of aggregate trends in spending, utilization, and financial performance under the Medicaid program under title XIX and the private market for health care services.

Congressional request: Differential coding in Medicare fee-for-service (FFS)

Due date: March 15, 2025

Description: A report estimating the extent to which different incentives result in different relative rates of diagnostic coding for MA and FFS beneficiaries and the extent to which such coding differences may result in payment differentials between MA and FFS.

Congressional request: Medicare beneficiaries’ access to care

Due date: March 15, 2025

Description: A report on Medicare beneficiaries’ access to care, including the share of primary care providers that refuse to accept or limit the acceptance of new Medicare patients and data on Medicare patients’ wait times for visits with new primary care providers.

Mandate: **Consolidated Appropriations Act, 2021. Review payments to rural emergency hospitals (recurring annually)**

Due date: March 15, 2026

Description: Beginning in 2024, as part of our March report, MedPAC shall include a review of payments to a new designation of hospitals known as “rural emergency hospitals.”

Mandate: **Affordable Care Act of 2010. Review Medicaid use and spending and non-FFS Medicare margins in nursing homes (recurring annually)**

Due date: March 15, 2026

Description: Beginning in 2012, as part of our March report, MedPAC shall include a review of aggregate trends in spending, utilization, and financial performance under the Medicaid program under title XIX and the private market for health care services.

Mandate: **BBA of 2018. Effects of home health payment reform**

Due date: March 15, 2026 (Final report)

Description: Final report on the application of a 30-day unit of service for home health payment.

Mandate: **BBA of 2018. Performance of special needs plans (SNPs)**

Due date: March 15, 2026

Description: A study on the performance of MA SNPs. Initial report due March 15, 2022, and mandated biennially thereafter through 2032 and every five years beginning in 2033.

Mandate: **BBA of 2018, as updated by the Consolidated Appropriations Act, 2022. Costs of providing ambulance services**

Due date: June 15, 2026

Description: A report on information submitted by providers and suppliers of ground ambulance services through the data collection system, the adequacy of payments for ground ambulance services, and geographic variations in the cost of furnishing such services.

APPENDIX C

Commission meetings and major agenda items

Fiscal year 2024

October 5, 2023

- Considering current-law updates to Medicare's payment rates for clinician services
- Examining staffing ratios and turnover rates in nursing facilities
- An alternative method to establish Medicare payments for select conditions treated in inpatient rehabilitation facilities
- Workplan: Prices of generic drugs under Part D

November 2-3, 2023

- Mandated report: Rural emergency hospitals
- Mandated report: Dual-eligible special needs plans
- Hospice: MedPAC work plan
- Medicare coverage of and payment for software as a medical device: An overview
- Favorable selection in Medicare Advantage
- Evaluating access in Medicare Advantage: Network adequacy and prior authorization

December 7-8, 2023

- Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services
- Assessing payment adequacy and updating payments: Hospice services
- Assessing payment adequacy and updating payments: Physicians and other health professional services
- Assessing payment adequacy and updating payments: Outpatient dialysis services
- Assessing payment adequacy and updating payments: Skilled nursing facility services
- Assessing payment adequacy and updating payments: Home health care services
- Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services

January 11-12, 2024

- Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services
- Assessing payment adequacy and updating payments: Physician and other health professional services
- Assessing payment adequacy and updating payments: Hospice services
- Assessing payment adequacy and updating payments: Outpatient dialysis services
- Assessing payment adequacy and updating payments: Skilled nursing facility services
- Assessing payment adequacy and updating payments: Home health agency services
- Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services; and improving the accuracy of payment in the IRF prospective payment system
- The Medicare Advantage program: Status report
- Medicare Part D: Status report
- Ambulatory surgical centers: Status report
- Standardized benefits in Medicare Advantage plans

March 7-8, 2024

- Rural hospital and clinician payment policy: A work plan for 2024-2025
- Medicare's Acute Hospital Care at Home program
- Update on trends and issues in Medicare inpatient psychiatric services
- Preliminary analysis of Medicare Advantage quality
- Assessing data sources for measuring health care utilization by Medicare Advantage enrollees: Encounter data and other sources

April 11-12, 2024

- Telehealth in Medicare: Status report
- Alternative approaches to lowering Medicare payments for select conditions in inpatient rehabilitation facilities
- Considering approaches for updating the Medicare physician fee schedule
- Assessing consistency between plan-submitted data sources for Medicare Advantage enrollees
- Generic drug pricing under Part D
- Initial findings from analysis of Medicare Part B payment rates and 340B ceiling prices

September 5, 2024

- Context for Medicare payment policy
- Cost sharing for outpatient services as critical access hospitals
- Medicare's measurement of rural provider quality

Fiscal year 2025 (October through April)

October 10-11, 2024

- Medicare beneficiaries in nursing homes
- Findings from MedPAC's annual beneficiary and provider focus groups
- Supplemental benefits in Medicare Advantage
- Work plan for a mandated final report on the impact of recent changes to the home health prospective payment system
- Initial estimates of home health care use among Medicare Advantage enrollees

November 7-8, 2024

- Reforming physician fee schedule updates and improving the accuracy of payments
- Considering the participation bonus for clinicians in advanced alternative payment models
- Structural differences between the PDP and MA-PD markets
- Workplan: Assessing Medicare Advantage provider networks
- Medicare's coverage limits on stays in freestanding inpatient psychiatric facilities

December 12-13, 2024

- Assessing payment adequacy and updating payments: Physician and other health professional services
- Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services; and mandated report on rural emergency hospitals
- Assessing payment adequacy and updating payments: Skilled nursing facility services
- Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services
- Assessing payment adequacy and updating payments: Home health care services
- Assessing payment adequacy and updating payments: Hospice services
- Assessing payment adequacy and updating payments: Outpatient dialysis services

January 16-17, 2025

- Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services
- Assessing payment adequacy and updating payments: Physician and other health professional services

- Assessing payment adequacy and updating payments: Hospice services
- Assessing payment adequacy and updating payments: Outpatient dialysis services
- Assessing payment adequacy and updating payments: Skilled nursing facility services
- Assessing payment adequacy and updating payments: Home health agency services
- Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services
- The Medicare Advantage program: Status report
- Medicare prescription drug program (Part D): Status report
- Reducing beneficiary cost-sharing for outpatient services at critical access hospitals
- Ambulatory surgical center services: Status report
- Eliminating Medicare's coverage limits on stays in freestanding inpatient psychiatric facilities

March 6-7, 2025

- Reforming physician fee schedule updates and improving the accuracy of relative payment rates
- Reducing beneficiary cost sharing for outpatient services at critical access hospitals
- Background: Medicare insurance agents
- Preliminary work on Medigap
- Mandated report: Payment for ground ambulance services
- Examining home health care use among Medicare Advantage enrollees
- Institutional special needs plans

April 10-11, 2025

- Reforming physician fee schedule updates and improving the accuracy of relative payment rates
- Structural differences between the PDP and MA-PD markets
- Assessing the utilization and delivery of Medicare Advantage supplemental benefits
- Exploring the effect of Medicare Advantage on rural hospitals
- Paying for software technologies in Medicare
- Access to hospice and certain services under the hospice benefit for beneficiaries with end-stage renal disease and beneficiaries with cancer
- Regulations, star ratings, and FFS Medicare policies aimed at improving nursing home quality

For the 2025-2026 meeting cycle, the Commission plans to meet in September, October, November, and December of 2025 and January, March, and April of 2026.

APPENDIX D

Research projects funded through contracts

Research projects funded through contracts cover a variety of issues, including updating quality indicators, cost predictors in several settings, access to care, and more. Specific contracts in fiscal year 2024 include:

Post-acute care

- Interviews with hospital-at-home providers
- Estimating the nursing case-mix indexes used to adjust Medicare costs in calculating fee-for-service margins
- Analyzing skilled nursing facilities' drivers of costs

Physician and other health professionals

- Focus groups on beneficiary and clinician perspectives on Medicare and other issues
- Examining the effects of multiple policy changes on the physician fee schedule relative value units and spending

Drugs and devices

- Updating Part D price indexes and exploring a new index to measure the effects of launch prices
- Analysis of coverage and generosity of Part D plan formularies
- Part B drug spending and price index contract; Part B spending growth decomposition

Hospice

- Examining hospice use among beneficiaries with end-stage renal disease on dialysis who died in 2019
- Study of hospices' effect on Medicare spending

Quality

- Use of population-based outcome measures to assess the impact of telehealth expansion on Medicare beneficiaries' access to care and quality of care

Other

- Creation of a linked Medicare–Medicaid dataset and tables for the data book on dually eligible beneficiaries

APPENDIX E

MedPAC meetings with stakeholder organizations

MedPAC spends a substantial amount of staff time meeting with stakeholder organizations to gather data and information and to be accessible to these groups. These meetings may be initiated by MedPAC, interested stakeholder organizations, or through referrals to MedPAC by congressional staff. Below is a list of some of the stakeholders with whom we met in 2024:

3M Health Information Systems	American Society for Radiation
The Academy Advisors	Oncology
Actuarial Research Corporation	Anthem
AdvaMed Imaging	Association of American Medical
Advanced Medical Technology	Colleges
Association	Blue Cross Blue Shield Association
Alliance for Health Policy	The Brookings Institution
Alliance for Home Dialysis	Brown University
Alliance of Community Health Plans	California Hospital Association
Alliance of Specialty Medicine	Center for Health System and Policy
Alliance for Physical Therapy Quality	Modeling
and Innovation	Chapter
AllyAlign Health	Clear Spring Health Plan
Alston & Bird	Coalition for Rural Health Quality
Ambulatory Surgery Center Association	Coalition of State Rheumatology
American Academy of Actuaries	Organizations
American Academy of Audiology	Commission for Nurse Reimbursement
American Academy of Ophthalmology	Compassus
The American Academy of Physical	Connected Health
Medicine and Rehabilitation	Council for Quality Respiratory Care
American Ambulance Association	DaVita
American Association of Actuaries	Dialysis Clinic, Inc.
American Association of Colleges of	Dialysis Patient Citizens
Osteopathic Medicine	Dignity Health
American Association of Medical	Dollar For
Colleges	Duke-Margolis Institute of Health Policy
American Association of Retired Persons	Edwards Lifesciences
American College of Physicians	Elevance Health
American College of Radiology	Excellus
American College of Rheumatology	Eyenuk
American College of Surgeons	Federal Health Policy Strategies
American Health Care Association	Florida Society of Rheumatology
American Hospital Association	GE Healthcare
American Medical Association	George Washington University School of
American Medical Group Association	Public Health
American Medical Rehabilitation	Georgetown University
Providers Association	Greater New York Hospital Association
American Psychological Association	Hawaii Health and Planning Agency
	Healthfirst

Health Policy Insights
 Healthsperien
 Home Dialyzors United
 Humana
 Interwell
 Kaiser Family Foundation
 Kaiser Permanente
 Kidney Care Partners
 Kodiak Solutions
 Leading Age
 Leukemia and Lymphoma Society
 LHC Group
 Longevity Health
 Marquis Companies
 McDermott Plus
 MedStar National Rehabilitation
 Hospital
 Milliman
 The National Academy for State Health
 Policy
 National Association of Freestanding
 Emergency Centers
 National Association of Rural Health
 Clinics
 National Association of Long-Term
 Hospitals
 National Committee of Quality
 Assurance
 National Hospice and Palliative Care
 Organization
 National Kidney Care Alliance
 National Partnership for Healthcare and
 Hospice Innovation

NORC at the University of Chicago
 Ohio State University
 Omada Health
 Paragon Institute
 Pruitt Health
 Quest Analytics
 RAND
 Renal Healthcare Association
 Sacramento Metropolitan Chamber of
 Commerce
 Sanford Health
 Sanofi
 Security Health Plan
 Senior Care Pharmacy Coalition
 Sierra Sacramento Valley Medical
 Society
 Singapore's Ministry of Health
 Sirona Strategies
 Strive Health
 Sutter Health
 Texas A&M
 University of Michigan
 University of Minnesota
 University of Southern Maine
 Urban Institute
 US Renal Care
 Vanderbilt University
 The Vascular Care Group
 Vertuity
 Virdx
 VITAS Healthcare
 VNS Health
 WellSpace