

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Hemisphere Room
Ronald Reagan Building
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10:48 a.m.

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P R O C E E D I N G S

[10:48 a.m.]

1
2
3 DR. CHERNEW: Hello, everybody, and welcome to
4 the April MedPAC meeting, the last one of this cycle. We
5 have a very full meeting. There are going to be seven
6 sessions, and I am thrilled that we are going to jump right
7 in.

8 The first session is on improving payment
9 incentives, which I think is a bit more conceptual than
10 some of the other work that we do. But I think it's
11 actually quite important if we are going to think through,
12 we are the Medicare Payment Advisory Commission and
13 thinking through conceptually what the role different
14 payment models play I think is important.

15 So we're going to let Luis and Rachel dive right
16 in, and Rachel, it looks like you're starting.

17 MS. BURTON: Thank you. This presentation will
18 summarize a draft chapter for inclusion in our upcoming
19 June report. These slides will look similar to the ones we
20 presented in December, but they reflect some refinements
21 based on your feedback. The audience can download a copy
22 of these slides from the webinar's control panel.

1 The planned chapter would cover the following
2 content.

3 After a brief introduction, we'd mention some key
4 drivers of Medicare spending growth, describe incentives in
5 Medicare's three main payment approaches, and recap some
6 MedPAC recommendations for improving Medicare's incentives.

7 MR. SERNA: Medicare uses three approaches to pay
8 for care: standalone fee-for-service Medicare, alternative
9 payment models that are layered on top of fee-for-service
10 Medicare, and Medicare Advantage plans operated by private
11 insurers. Each creates different sets of incentives, some
12 that are inherent to a given payment approach, and others
13 that reflect current design decisions, and could be
14 modified in the future.

15 Medicare's annual survey finds that fee-for-
16 service and MA beneficiaries experience broadly similar
17 levels of access to care and satisfaction, and evaluators
18 generally do not find major differences in quality in APMs
19 and fee-for-service.

20 MedPAC regularly assesses Medicare's payment
21 approaches and recommends improvements.

22 Three principles guide our work. Number one,

1 payments should be sufficient to support beneficiary access
2 to high-quality health care in an appropriate clinical
3 setting. Number two, providers should have incentives to
4 supply appropriate and equitable care in an efficient
5 manner. Number three, Medicare payments should incentivize
6 and reflect efficient care delivery, thereby ensuring that
7 the program's fiscal burden on beneficiaries and taxpayers
8 is not greater than necessary.

9 The chapter we'll talk about today would orient
10 readers to the payment incentives for health care providers
11 in Medicare's three main payment approaches and recap our
12 recommendations for improving these incentives.

13 MS. BURTON: In the decades since Medicare was
14 created, spending on the program has made up a growing
15 share of GDP and a growing share of national health care
16 spending. In 2024, the country spent \$5.3 trillion on
17 health care, and Medicare spending made up \$1.1 trillion of
18 those dollars.

19 Several different factors contribute to expected
20 increases in Medicare spending over the next decade. First
21 is general inflation, which we have stripped out of this
22 table, since it is not a factor that health policymakers

1 can easily influence. A second driver of Medicare's
2 projected spending growth is increasing enrollment in the
3 program, as the baby boom generation continues to reach
4 Medicare's eligibility age. As shown here, the number of
5 Medicare beneficiaries is expected to increase by about 2
6 percent per year over the next 10 years.

7 Medicare's payment rates for health care services
8 are not expected to grow faster than inflation, shown by
9 the fact that these numbers are negative, so they are not
10 projected to be a driver of Medicare's spending growth.

11 Changes in beneficiary demographics are also not
12 expected to be a meaningful driver of Medicare spending
13 growth in the next 10 years.

14 According to Medicare's Trustees, the big driver
15 of spending growth, especially for Part B, is a residual
16 "other" category, circled here, which includes things like
17 growth in the volume and intensity of services and items
18 furnished per beneficiary, and growth in the average price
19 Medicare pays for physician-administered drugs and
20 biologics covered under Part B.

21 In this graph, we remove both the effects of
22 inflation, by showing all dollars in 2024 dollars, and we

1 remove the effects of baby boomer enrollment growth, by
2 showing Medicare spending on a per beneficiary basis over
3 time. We find that inflation-adjusted spending per
4 beneficiary has increased 19 percent for Part B over the
5 past 10 years, while spending declined 2.2 percent for Part
6 A.

7 Part B includes clinician services in all
8 settings, hospital outpatient encounters, and physician-
9 administered drugs, like treatments for cancer, macular
10 degeneration of the eye, and arthritis. Part A includes
11 things like inpatient hospital stays, skilled nursing
12 facility stays, and hospice.

13 When we decompose Medicare spending further, we
14 find that the fastest growing component is physician-
15 administered drugs covered by Part B. Some spending on
16 physician-administered drugs is also captured in the
17 "outpatient hospital" line.

18 In general, Medicare has paid for drugs in a very
19 different way than it has paid for other medical items and
20 services, acting as a price-taker rather than a price-
21 setter, although this is starting to change with the new
22 Medicare Drug Price Negotiation Program, which will include

1 drugs covered by both Part D and Part B.

2 MR. SERNA: Fee-for-service Medicare,
3 alternative payment models, and Medicare Advantage all
4 include incentives that can influence volume and intensity.
5 The basic design of a payment approach can create these
6 incentives, as can the overall or relative payment rates
7 used under the approach.

8 The basic design of each payment approach can
9 incentivize higher or lower volume and intensity growth.
10 For example, paying for each item or service, as in stand-
11 alone fee-for-service Medicare, incentivizes providing more
12 items and services. Capitated payments, on the other hand,
13 can encourage efficiency, but can also incentivize spending
14 time and resources coding patient diagnoses to maximize
15 payments, and can favor providers or plans in some
16 geographic areas.

17 The overall level of payment rates can also
18 incentivize volume and intensity growth. If payments are
19 too high, it can lead to overprovision of care or
20 unintended subsidies. If payments are too low, there is a
21 risk of some providers or plans not participating in
22 Medicare.

1 Finally, the relative payment rates used within a
2 payment approach can also incentivize volume and intensity
3 growth. If payments are too high for some services or
4 plans relative to others, it can lead to unintended shifts
5 in which services are delivered and in what clinical
6 setting they are provided.

7 In the next few slides, we'll walk through the
8 incentives of the three payment approaches in more detail.

9 MS. BURTON: In stand-alone fee-for-service
10 Medicare, Medicare makes a separate payment for each item,
11 service, or stay a beneficiary has. This creates an
12 incentive to increase the volume of services provided. In
13 some fee-for-service payment systems, bundling of services
14 helps to mitigate this incentive.

15 Beneficiaries in fee-for-service currently have
16 wide access to providers, but cost sharing can be a barrier
17 for beneficiaries who don't have supplemental insurance.
18 Fee-for-service Medicare also has very low administrative
19 costs.

20 In terms of overall payment levels, it is hard to
21 know if fee-for-service Medicare's prices are "right." If
22 payment rates are too high, it can encourage overuse of

1 services. If payment rates are not high enough, providers
2 might not participate in Medicare and beneficiary access
3 could suffer. It can also be difficult to set payment
4 rates for new technologies, as we discuss in your paper.

5 In terms of relative payments, payment rates for
6 some services are too high while others are too low, which
7 incentivizes the provision of some services over others.
8 For many services, the payment rate varies depending on
9 what setting it is provided in—which incentivizes
10 delivering care in higher-paid settings.

11 Setting prices can be challenging, because
12 accurate cost and time data are not always available to CMS
13 when it sets payment rates for particular services.
14 Additionally, payment rates for clinicians tend to be
15 "sticky upward," meaning they don't decline even when
16 efficiencies develop, so some services can become
17 overvalued over time.

18 MR. SERNA: Alternative payment models, or APMs,
19 include models that require providers to bear more-than-
20 nominal financial risk if their patients' spending exceeds
21 a spending target, providing an incentive to deliver
22 services more efficiently. APMs can use tools such as

1 referrals and care management services to control costs.
2 Providers who meet the applicable spending targets can earn
3 bonus payments from Medicare, and have flexibility in how
4 they spend the payments.

5 In terms of overall payment levels, it's hard to
6 get APM payment levels right. If new payments and bonuses
7 available in these models are set too high, no net savings
8 will be generated for Medicare because providers who are
9 likely to earn bonuses without much change in behavior will
10 self-select into the program. If payments are set too low,
11 and participation is voluntary, less efficient providers
12 won't voluntarily participate because they don't want to
13 risk owing penalties.

14 A further challenge is the fact that provider
15 organizations' clinician-level compensation arrangements
16 tend to reward maximizing volume and intensity, which dulls
17 APMs' clinician-level incentives.

18 Relative payment rates within APMs can also
19 affect incentives. For example, since providers in APMs
20 have easier spending targets if they code patients'
21 diagnoses more intensively or strategically curate their
22 participating provider list, there can be an incentive to

1 focus on coding and provider selection rather than just on
2 delivering care more efficiently.

3 Finally, providers in certain geographic areas
4 may have easier spending targets.

5 MS. BURTON: In Medicare Advantage, Medicare
6 makes per-beneficiary payments to MA plans, which then pay
7 providers for delivering care to their enrolled
8 beneficiaries. This payment approach creates a powerful
9 incentive to manage enrollees' spending. When MA plans use
10 fee-for-service payment rates to pay providers, it creates
11 some of the same incentive issues we discussed in a
12 previous slide. To try to limit spending, MA plans can use
13 utilization management tools like prior authorization.

14 Plans have an incentive to keep their spending on
15 Part A and Part B benefits low, in order to earn rebates
16 that enable them to offer extra benefits or lower cost
17 sharing to attract enrollees. However, challenges related
18 to setting benchmark levels and risk-adjusting payments
19 have distorted the promising incentive structure of the MA
20 program.

21 It has proven challenging to set overall payment
22 levels in a way that appropriately balances program goals.

1 Issues with MA payment policies have made it difficult for
2 Medicare to realize savings from MA. As a result,
3 Medicare's payments to plans tend to exceed what the
4 program would have spent if the same beneficiaries had been
5 enrolled in fee-for-service.

6 High payments to MA plans have prompted many
7 insurers to offer MA plans. High payments have also
8 enabled plans to offer low cost-sharing and extra benefits,
9 which have attracted many beneficiaries to MA.

10 Medicare's mechanisms for setting MA benchmarks
11 and risk-adjusting payments lead to variation in MA
12 payments across enrollees, geographic areas, and insurers.
13 Under current policies, MA plans have an incentive to code
14 patient diagnoses more intensively, to offer plans in areas
15 where benchmarks are increased the most, to curate provider
16 networks to maximize their quality score, and to attract
17 beneficiaries who are likely to use less care than expected
18 under the risk model.

19 Some plans have responded to these incentives
20 more strongly than others, resulting in large variations in
21 risk scores and payments across plans. Because CMS applies
22 a uniform across-the-board adjustment to risk scores to

1 account for the coding differences between MA and fee-for-
2 service, current policy results in unwarranted payment
3 differences across insurers and plans.

4 MR. SERNA: Opportunities to improve the
5 incentives in fee-for-service, APMs, and MA differ. As
6 we've mentioned, fee-for-service tends to promote volume
7 and intensity growth. APMs and MA plans have incentives
8 and tools to manage spending, but designing payment systems
9 by which Medicare can realize savings has been challenging.

10 The Commission has recommended improvements to
11 each payment approach and has ongoing work to identify
12 additional ways to improve incentives, guided by our
13 principles.

14 In this next section, we recap some key prior
15 MedPAC recommendations aimed at improving incentives in
16 Medicare's payment approaches.

17 MS. BURTON: To improve the core incentives in
18 fee-for-service Medicare, MedPAC has recommended
19 overhauling the fee-for-service benefit design to allow
20 cost sharing to vary based on whether a service is high or
21 low value, and to provide an out-of-pocket maximum for
22 beneficiaries.

1 In terms of overall payment levels, our March
2 report recommends increasing fee-for-service Medicare's
3 payment rates for hospitals and clinician services,
4 relative to current law, and decreasing payments for post-
5 acute care providers.

6 To improve relative payments in fee-for-service
7 Medicare, CMS should use new data sources and processes to
8 set payment rates.

9 The agency should also revise Medicare's hospital
10 payment systems to better support teaching and safety-net
11 hospitals' higher costs of care and account for geographic
12 differences in hospital staff wages. In addition, where
13 possible, payments should be site-neutral.

14 MR. SERNA: To improve alternative payment
15 models, CMS should offer a more harmonized portfolio of
16 fewer APMs, designed to work together. CMS could operate
17 one ACO model with different tracks for different sized
18 providers, and a mandatory episode-based payment model for
19 proven episodes.

20 To improve overall payment levels in APMs,
21 Medicare should stop periodically "ratcheting down" ACOs'
22 spending targets in the Medicare Shared Savings Program.

1 And to improve relative payments, Medicare should change
2 how spending targets are calculated in APMS to reduce ACOs'
3 coding incentives and reduce the favorable selection of
4 beneficiaries likely to generate lower-than-expected
5 spending.

6 MS. BURTON: To improve MA's basic design,
7 Medicare should use larger geographic markets as MA plan
8 payment areas.

9 To improve overall payment levels in MA, Medicare
10 should change how it calculates the spending benchmarks
11 that MA plans bid against.

12 To improve relative payments to different MA
13 plans, Medicare should improve how it risk-adjusts payments
14 to MA plans to reduce disparities in plan-level coding
15 intensity.

16 The MA quality bonus program should also be
17 overhauled.

18 MR. SERNA: In conclusion, stand-alone fee-for-
19 service Medicare, APMS, and MA each have a role to play,
20 but they all have room for improvement. MedPAC will
21 continue to study Medicare payment approaches and identify
22 ways to improve their incentives.

1 Future work could include analyzing Medicare
2 spending trends, to better understand sources of spending
3 growth; opportunities to harmonize fee-for-service Medicare
4 payments across settings and service types; alternative
5 methods for calculating payments to MA plans; MA plans'
6 incentives to balance access to care with efficiency
7 through networks and denials; potential improvements to the
8 design and methods used to set APM payments; and new tools
9 that could be used in fee-for-service Medicare to reduce
10 the use of low-value care.

11 The chapter we just described is planned for
12 publication in our June Report to the Congress.

13 In your discussion, we welcome your suggested
14 changes to the draft chapter. For example, please tell us
15 if any of the content was unclear and would benefit from
16 further explanatory text being added.

17 I'll now turn things back to Mike.

18 DR. CHERNEW: Great. Thank you. There is a lot
19 there because it is just so comprehensive. And we're about
20 to jump into the discussion, but I'll just say for those
21 listening at home, the goal here is fundamentally to think
22 about sort of the core nature and the potential for these

1 different things, and their pros and their cons. I think
2 you guys did a great job outlining that with the backdrop
3 of trying to find ways to create incentives to improve the
4 efficiency of the Medicare program.

5 And I think, if I have this right, Dana, you will
6 be running the queue, Greg is the first person in the queue
7 for Round 1.

8 MR. POULSEN: Yeah, thank you, and thanks, Rachel
9 and Luis. This was a great chapter. I think that this
10 paper identifies some critical issues more clearly than we
11 have in the past, and I'll comment more on some of these in
12 Round 2.

13 But we mentioned three broad factors contributing
14 to Medicare's spending growth: enrollment, general
15 inflation, and volume and intensity. And the paper calls
16 out Part B drugs specifically here. On page 12 it notes
17 Medicare pays for drugs differently than it pays for other
18 medical items and services, acting as a price-taker rather
19 than a price-setter. I am grateful for the callout, and I
20 think it's really important, and I'll say a little bit more
21 about that in Round 2.

22 But for Round 1 my question is, we're lumping the

1 pharmaceutical increases here, which the paper points out
2 are by far the biggest increases across any spending
3 category, as volume and intensity. Do we have the data to
4 specify whether this is actually volume and intensity
5 versus higher prices for the same or similar items? I ask
6 because we've seen many categories of drugs with price
7 increases 6 to 20 percent, and replacement pharmaceuticals,
8 for example, chemotherapy agents, where their replacement
9 was between 30 and 2,000 percent higher than prior years.
10 These instances are not really either volume or intensity
11 but simply higher costs to supplies.

12 So I guess the reason I'm asking that is I think
13 of volume and intensity as something where it's in the
14 purview of clinical decision-making. If it's a higher
15 price for the same or similar or replacement drugs, that
16 really isn't in the same way in the purview of the
17 clinician. So do we have data in terms of what percent of
18 that falls into the latter versus the former category?

19 MS. BURTON: I can check with Kim and Nancy on
20 the breakout. I know that there's a few different things
21 going on, including people switching to higher priced
22 drugs, and then existing drugs also, like their price is

1 just increasing over time. But I'll check with them on how
2 granular we can get.

3 MS. KELLEY: Gina, do you have a Round 1
4 question?

5 MS. UPCHURCH: Yes. Thank you. First of all,
6 thank you for laying out these issues so clearly for us.

7 Just briefly, if somebody goes to the out-of-
8 network provider, well, I understand now that they could be
9 paid in-network rates. The provider could be paid in-
10 network rates for certain things. Is that in-network rate
11 80 percent of Medicare, or is the assumption that they will
12 get the 100 percent of Medicare, they just have to get the
13 20 from somewhere else?

14 MR. SERNA: I believe the general assumption is
15 that they're getting 100 percent of Medicare.

16 MS. UPCHURCH: Okay. Just to clarify that.
17 Thank you.

18 MS. KELLEY: All right. That's all I have for
19 Round 1, unless someone wants to jump in.

20 DR. CHERNEW: I think Round 2 is going to start
21 with Brian.

22 MS. KELLEY: I had Tom first.

1 DR. MILLER: Sorry.

2 DR. CHERNEW: Oh, I didn't see that other thing.

3 MS. KELLEY: Go ahead, Tom.

4 DR. DILLER: Could we go back to Slide 8, I think
5 it was? It's the cost curve. I guess my comments are a
6 little bit extensive. I do a lot of public speaking, and
7 this is some of the stuff that I will talk about initially.
8 And I talk about the value equation, the quality divided by
9 cost, and I'll go to the cost curve.

10 And what I want to point out on this cost curve I
11 think is fairly significant. Actually, in my graph, on my
12 slides, it goes back to 1960. But from 1960 to about 1990,
13 you can see a rather rapid rise in health care inflation.
14 And in the '90s it flattens out completely. And that was
15 the heyday of the HMOs, where you had narrow networks and a
16 lot of medical management.

17 And at the end of around 2000, I was the Chief
18 Medical Officer of a not-for-profit HMO, and I remember
19 sitting in a strategy meeting saying -- this was the Bush-
20 Gore presidential election. And during that election Gore
21 vilified HMOs. So at that point in time we made the
22 decision that we were going to have to take all the

1 controls off, we were going to move from HMOs to PPOs. And
2 in that meeting it was said that 10 years from now the
3 public will be screaming about the cost of health care.
4 And that's exactly what you can see in that graph.

5 And then you get to 2010, and the ACA is put in
6 place. And it was about access to care and also about the
7 health care costs. And you can see that the curve flattens
8 again. And then you have COVID and it is taking off now,
9 at rates of 7 to 9 percent inflation, not rates.

10 What we know is, there was a report in 2012 that
11 the IOM put out. I think it was called "Best Care at Lower
12 Costs," and it basically showed that about 30 percent of
13 everything that we spend on health care creates no value
14 whatsoever for the patient. Half of that is unnecessary
15 care, and a significant part is fraud, and then there's
16 also excess administrative burdens.

17 So I think what we've done, over the last 60-some
18 years, is several experiments in how health care should be
19 financed, and I think we know what to do, and it's
20 relatively obvious from that net curve, and I'll talk a
21 little bit about it.

22 First off, fee-for-service doesn't work. So

1 every time we go back to fee-for-service the inflation rate
2 skyrockets. And we know that quality is probably about the
3 same and all that, but the cost goes way up.

4 The APMs are coming, and I really appreciated the
5 chapter. I think you guys did a fabulous job on putting
6 this together. But the APMs are, basically, at this point,
7 some incentive that's layered on top of the fee-for-service
8 system. And the problem is that the incentive isn't enough
9 to pay for the infrastructure that you need in order to put
10 things in place, in order to manage that care.

11 The MA programs have their own problems, but they
12 are probably pretty effective at controlling costs. They
13 can be overdone on prior authorization and some of the
14 heavy-handed approaches, but we also know that prior
15 authorization works in order to control costs.

16 But essentially, as I boil it down to a couple of
17 different things, what I think works are narrower networks
18 where providers are held accountable for the actual costs
19 of care and the quality of care, medical management systems
20 that are put in place, and accountability with that. And
21 what doesn't work is fee-for-service, the inflation rate
22 goes way up, large, open-access networks where there is no

1 accountability for performance, and the lack of medical
2 management with that.

3 So those are just my comments and my takes,
4 having been in this industry and run a number of networks
5 over many, many years. Thanks.

6 MS. KELLEY: Brian.

7 DR. MILLER: I have to echo many of those
8 comments and agreement, and a small thing on the slides. I
9 do actually think that the MSSP adjustment downwards
10 sometimes can actually be helpful. I do think it needs to
11 be done strategically, but I wouldn't say it should be
12 categorically increased or decreased.

13 On the philosophical comments, I completely agree
14 with Dr. Diller that centralized administrative payment has
15 not controlled costs on fee-for-service Medicare, and we
16 all know why that's the case. If you regulate price then
17 you see volume responses, and you see intensity of care
18 responses, and total cost still grows. And that's a model
19 that doesn't work to control taxpayer expenditure. In
20 fact, you can't really control expenditure, I think is what
21 that says, because we're controlling price, and then there
22 are non-price impacts which drive up total costs.

1 I think risk-adjusted capitation at the top
2 level, and we have to think carefully about whether we want
3 to risk adjust doctors, hospitals, et cetera. Risk-
4 adjusted capitation for a two-PCP practice is a great way
5 to make somebody go out of business. We tried that in the
6 '80s. It didn't work so well. Risk-adjusted capitation
7 for a large, vertically integrated health system, like a
8 Geisinger, for example, could work very well. But the
9 concept of risk-adjusted capitation of health plans, while
10 it's imperfect and there's a lot of work to do on risk
11 adjustment, et cetera, we have discussed ad nauseam, is a
12 great framework for budgeting for expenditures. And then
13 that facilitates, if we have a budget for expenditures then
14 we can facilitate revenue planning.

15 I think, as Dr. Diller pointed out, the managed
16 care tools work. We know they work. We don't need to
17 study them further. We perhaps need to think, and perhaps
18 we could be a good counselor and advisor to our friends on
19 the Hill by thinking about ways that those tools can be
20 titrated better, both in MA and fee-for-service. We could
21 look at it and say MA has lots of these managed care tools,
22 and maybe they're not deployed always in the best way or

1 maybe the process could be made better. And as we've seen
2 with fee-for-service, with WISeR, which is touching the
3 electric third rail of utilization review in fee-for-
4 service, that they're doing it in a way that is a lot
5 lighter than MA. So maybe we do need a little utilization
6 review in fee-for-service, perhaps with different
7 incentives and titrated lighter, and then make those
8 tradeoffs clearer for beneficiaries.

9 So I wanted to spend a moment then talking about
10 the benefits and risks of MA and fee-for-service, because
11 I'm a former CDER reviewer at the FDA, so I think of
12 everything in terms of benefits and risks, including
13 getting in the car, getting on a bicycle, or crossing a
14 street, with the benefit and risk.

15 Benefits and risks of MA for taxpayers and benes,
16 the benefit for the beneficiary is that MA has
17 fundamentally subsidized retirement for the working poor,
18 middle class, union, and minority retirees. I think our
19 number is 69, 70 percent of plan rebates are used to
20 subsidize integrated Medigap and integrated Part D for the
21 bene, who otherwise can't afford to buy Medigap and Part D
22 on the open market. So we might not see that as straight-

1 up savings, but that is savings in terms of if you're
2 constructing an entire benefits package as a retiree, being
3 uncovered on fee-for-service is not an option. So if
4 you're very, very poor, you end up as a dual. If you're
5 working poor or middle class you end up on MA. And if
6 you're upper middle class or wealthy, you can have a choice
7 of MA or fee-for-service.

8 So I think one of the benefits that we need to
9 think carefully about when we titrate MA is that is a
10 safety net for the lower, middle class, and middle class
11 retirees who are buying Medigap and Part D. There are
12 other supplemental benefits, but fundamentally they're
13 buying Medigap and Part D.

14 Then on the political economy question, I don't
15 know what the right price is for gas or pickles. I also
16 don't know what the right price is for an MRI or a
17 diagnostic test or the orthopedic surgeon to replace my hip
18 when I'm 70. I'm not sure what that right price is. And I
19 think there's a political economy benefit of MA, where when
20 we set a budget for fundamentally a bucket of services in a
21 population, we can think about how we want people to
22 administer that bucket. But then we do not spend our

1 limited energy thinking about what is the right price for
2 8,000 physician services, 20,000 prescription drugs.
3 Because as we're doing that, that micro-targeting of price
4 means that CMS is focused on getting the right price
5 instead of being a strong regulator.

6 So CMS, if we want to elevate the function of
7 CMS, we need to elevate them into more of a regulatory role
8 and less in micro-targeting of prices, because they can
9 only do so many things. And micro-targeting prices tends
10 not to work very well, as we have seen at managing costs.

11 The other thing is policymakers have lots of
12 other issues that they need to address, and want to
13 address, whether it's interoperability, oversight of AI,
14 and MA takes some of that price-setting for those 8,000
15 physician services, thousands of hospital services, 20,000
16 prescription drugs, et cetera, takes that slightly off the
17 table, so it's looking at a budget of a bundle of services,
18 and gives policymakers more space to do other important
19 things in health policy, which is a benefit. Risks,
20 obviously, are gaming of the risk adjustment and other
21 systems which can increase costs for taxpayers. That risk
22 is real.

1 On the fee-for-service side, I think it's not
2 that fee-for-service is unimportant. Fee-for-service is
3 equally important, and we need to think about ways to
4 improve fee-for-service operations or benefit design and
5 stop micro-targeting. So when we look at all the APMs,
6 we're talking specific interventions to a specific bucket
7 of doctors or home health or DME, and we're essentially
8 playing with 0.1 or 1 percent of expenditures, at most.
9 That's not going to bend the cost curve, and it hasn't bent
10 the cost curve. And what Dr. Diller pointed out is that 20
11 years of doing that has not bent the cost curve. And we
12 know that, so we probably should stop doing that.

13 We should think more of the benefit design. And
14 I don't necessarily agree with all these thoughts that I'm
15 going to posit, but they are thoughts. Should there be a
16 PPO network in fee-for-service? Personally, I would say
17 no, but that's an option for addressing cost. Should we do
18 utilization review in fee-for-service and but have wiser,
19 have better incentives, and be more transparent? That
20 seems like a good intervention to me. Could we improve
21 program operations and have MACs compete and manage fraud,
22 waste, and abuse, and have a Part B premium rebate to

1 reduce costs for benes and make fee-for-service more
2 affordable? Absolutely. Could we have a two-sided risk
3 program with a unified quality framework for fee-for-
4 service, ACOs, and MA, so that people are scored and graded
5 the same way across programs? Absolutely.

6 So I think we need to sort of take a step back
7 from the micro-targeting of whether it's micro-targeting MA
8 or micro-targeting fee-for-service and sort of think at
9 some of those bigger picture issues. Thank you.

10 MS. KELLEY: Tamara.

11 DR. KONETZKA: Thanks for this great work.
12 Really fascinating chapter. I really appreciate the
13 efforts you made since our last discussion to kind of
14 separate the conceptual from the design features or
15 implementation. A lot of my comments are directed at doing
16 even more of that, and especially sort of clarifying the
17 purely conceptual.

18 What I have in mind is, first of all, it might be
19 helpful to have a table. I'm thinking like a Health Econ
20 101 table, where we look at these three kinds of systems --
21 fee-for-service, alternative payment models, and
22 capitation. And the conceptual part I would actually just

1 call it capitation, because it's hard to call it MA and
2 then separate it from the design features. And then have
3 three or possibly four different sections for efficiency,
4 quality, and access. And just very clearly bullet point
5 out the incentives under each of those models. So clearly
6 under fee-for-service we don't have a lot of incentive for
7 efficiency. It encourages volume and intensity. Under
8 capitation there's much more of an incentive for
9 efficiency.

10 The part that I think got really kind of short-
11 shrifted in the text right now is quality, and I think
12 there are inherent incentives for quality or outcomes in
13 each of these models. So under fee-for-service, it's a
14 little bit unclear. Maybe quality is better because people
15 have access to whatever they want, and can go see whoever
16 they want, but there's no real incentive for coordination
17 of that care.

18 Under capitation, sort of one of the conceptual
19 positives under capitation is that insurers may have better
20 incentives to keep people healthy, to keep down costs.
21 Whatever you think of how that actually plays out in the
22 real world, certainly conceptually I think that's an

1 important piece of capitated model. On the other hand
2 there's also the inherent incentive for stinting when you
3 try to reduce costs.

4 So I think both of those are part of the
5 conceptual underpinnings of capitation.

6 And then access is the same. We could have these
7 three columns that sort of bullet point out the purely
8 conceptual aspects. And then maybe another column or
9 another line that lists out the key design features that
10 then matter in how these incentives actually get played out
11 in the real world.

12 A couple of these I want to talk about in
13 particular. One is the chapter mentions multiple times
14 that under fee-for-service beneficiary cost-sharing may
15 lead to less access to care or may present a financial
16 risk. I think that cost-sharing, first of all, it's very
17 much a design feature. It's not inherent to fee-for-
18 service. It didn't have to be that way. And when we talk
19 about it as a design feature, I think we need to mention
20 the flip side of that, which is cost-sharing is there for a
21 reason, to try to inhibit wasteful or low-value spending.
22 Again, whatever you think about how that actually plays out

1 and how that should be adjusted, I think it's an important
2 conceptual point.

3 The other conceptual point I wanted to mention,
4 that just maybe deserves a couple of lines in the text
5 here, and that is the time element. Some of these
6 incentives that we think are inherent to these payment
7 systems, especially under capitation, really depends on how
8 long a person is going to be in that plan. So a plan may
9 have an incentive to sort of invest in keeping somebody
10 healthier to decrease costs, but only if those costs are,
11 let's say, avoided hospitalizations during the time period
12 the member is in the plan. So there's always a time
13 element in these underlying incentives.

14 Okay. I think that's about it. I think these
15 suggestions are just aimed at making the chapter a little
16 clearer in separating out the conceptual and making sure
17 we've captured all the key sort of conceptual pros and cons
18 of each of these models. I think of in terms of the
19 implementation and the design features, I won't say a lot
20 of that, conceptually we have capitation, we have fee-for-
21 service. I think of APMs as somewhere in between. They
22 have kind of curbed some of the excesses of the fee-for-

1 service model, but they don't have the same power to
2 achieve these efficiency goals. In fact, in the academic
3 literature we often think about these as sort of low-
4 powered and high-powered payment systems. They're on the
5 same power to achieve and the same tools to achieve some of
6 these goals as managed care might.

7 Anyway, I just think clarifying all of that in
8 the chapter would be helpful.

9 And the last thing I'd want to say is I really
10 support continued work on sort of working on those design
11 features, and, for example, exploring policy options to
12 change Medicare Advantage payment so that we can really
13 reap more of the benefits, the conceptual benefits that are
14 in capitation. I also agree with others that fee-for-
15 service, you know, you can look at this table and see there
16 are quality and access tradeoffs to this lack of
17 efficiency. I sort of fall on the side of pure fee-for-
18 service is just going to be unsustainable financially. So
19 I also support sort of continued work on tweaking ACOs and
20 alternative payment models to perhaps give them a little
21 bit more power to reap some benefits, moving a little bit
22 more towards the capitation side, where they have a little

1 bit more power to reap some of those benefits. Thanks.

2 MS. KELLEY: Greg.

3 MR. POULSEN: Thank you very much. I very much,
4 again, really like this paper a lot. I've got three points
5 I'd like to make. I had a couple of others that have been
6 well covered by the other Commissioners that have gone
7 before.

8 In Round 1 I mentioned that I think the drug
9 inflation is sliding in under the category of volume and
10 intensity, and it may actually be better categorized as
11 unmonitored and unrecognized price increases.

12 I'm grateful for the callout on the drug impacts,
13 specifically on page 12, and also in Figure 3 in the text.
14 I would emphasize that the paper notes that rising drug
15 costs have an impact on outpatient hospital expenditures,
16 as well as on their own. With this in mind, year 3, which
17 I think is Slide 12, if we could bring that up real quick -
18 - I'm sorry, Slide 16. There we go. I think this is an
19 incredibly important graphic, in my opinion. I think it
20 shows something really, really interesting and really,
21 really important.

22 If we look at this, what we find is that in most

1 spending categories they've been pretty flat over the last
2 decade, with physician payment actually decreasing by about
3 a percent per year, and hospital spending, inpatient and
4 outpatient combined, you can see inpatient going down
5 dramatically, outpatient going up somewhat. But put those
6 two together and they have declined by 1.7 percent per
7 year.

8 And we note, though, that the dramatic increase
9 in physician-administered drugs of a growth of 8 percent a
10 year has been a meaningful but unspecified portion of
11 hospital outpatient growth. It's also pharmaceutical
12 related. And I think that's kind of a big deal that we
13 should really emphasize. I think this needs to, while I'm
14 grateful for the mention of the drugs, both directly and
15 indirectly, but I think it could be made even more
16 impactful if we brought it up into the summary in a
17 meaningful way.

18 I think that what's on this slide is deserving to
19 be a headline and not a footnote. So I think that making
20 that a big emphasis is a big deal.

21 And oh, by the way, I would point out that on two
22 of three categories that we talked about, APMs and MA,

1 there are incentives to manage all of these costs, and
2 tools to manage all the costs, except drugs, where we're
3 price-takers. It's not only Medicare that is a price-
4 taker. It's the MA plans, to a very high degree, and it's
5 certainly the APMs. So I think that deserves a real
6 callout. Because if it is the point that our previous
7 folks have said, where there are incentives, it may be that
8 those incentives are working effectively. It's just that
9 there is an area here where we have no functional
10 incentive.

11 Second point. We find that three broad factors
12 contribute to spending: general inflation, enrollment
13 growth, and service and volume intensity. We've already
14 noted that drug prices may not actually be volume and
15 intensity related but maybe actually deserving of a callout
16 on their own.

17 I would point out, though, that the number of
18 people in Medicare is obviously a big deal, but equally
19 important is the number of those folks that are moving into
20 the high-cost years of Medicare. The big bolus of baby
21 boomers, which is now in Medicare but in the low-cost end
22 of Medicare but soon to move into or rapidly moving into

1 the high-cost years, is a really big deal. I don't think
2 we give that adequate mention here.

3 I would note that Medicare beneficiaries age 75
4 to 85 cost 50 percent more than those under 75, and for
5 those folks older than 85 years, they're nearly three times
6 as costly as the young Medicare beneficiaries. That's a
7 big, big deal. And that's going to happen to us,
8 irrespective of incentives. So I think it's worth calling
9 that out very explicitly.

10 And so I wonder if there is a portion of the
11 Medicare enrollment category that we would like to call out
12 for the specifics of the demographic impact of aging within
13 Medicare, especially as that big bolus of baby boomers is
14 now moving into the 80-year-plus category.

15 Point three, particularly as Brian and Tom had
16 mentioned, I have a very high regard for accountable care
17 principles and incentives, and believe that the fundamental
18 idea behind ACOs and MAs is fundamentally correct. As the
19 chapter points out, fee-for-service payment ultimately
20 misaligns incentive, and I think all of us so far have
21 mentioned that.

22 That said, there is much fault to find in the

1 current MA implementations. The paper correctly notes that
2 MA costs Medicare more per beneficiary than fee-for-
3 service. This finding, which MedPAC has pretty
4 consistently pointed out for many years, has led some to
5 believe that MedPAC is hostile to MA. I don't think that's
6 where any of us sit. This is inaccurate, and I believe
7 that most Commissioners share my belief that if done well,
8 MA is our best opportunity to truly improve value for both
9 Medicare beneficiaries and for fiduciaries.

10 The paper correctly identifies the key problem,
11 and I like this quote from it. "The key drivers of higher
12 MA payments are favorable selection and coding intensity,
13 leading to higher payment rates that are inappropriate."
14 It is incredibly important to note here that all plans are
15 not alike in this area. Indeed, MedPAC analysis has shown,
16 for a long time, that roughly a third of MA plans cost the
17 government less than fee-for-service, even though they're
18 providing extra capabilities and extra benefits that aren't
19 available to fee-for-service beneficiaries. I would love
20 to see this point being made more directly in the paper.

21 Since the chapter is about incentives, I think it
22 makes sense to highlight that the strongest current

1 incentive for plans participating in MA is to be expert at
2 coding and risk adjustment, pushing to the edge and
3 sometimes beyond the edge of legality. This is not what we
4 would like to see as the greatest core competency of our MA
5 plans. We would like to see them be expert at assisting
6 beneficiaries in staying healthy and the lowest possible
7 cost. The sad truth today is that a dollar invested in
8 risk adjustment maximization pays a far higher return than
9 a dollar invested in beneficiary well-being.

10 As I noted, I believe that the entire risk
11 adjustment system, with its coding and selection
12 perversities, should not be tweaked but should be
13 eliminated. It does not serve a beneficial function.
14 Commercial insurance for both large and small groups for
15 decades has had success simply using historical spending as
16 the risk adjustment mechanism, setting a spending trend
17 going forward.

18 And Medicare has a huge leg up compared to any
19 commercial plan. We know the prior year spending for every
20 single Medicare beneficiary that was enrolled the previous
21 year, regardless of whether they were in fee-for-service,
22 an ACO, or an MA plan, in fact, any MA plan. So we can

1 readily calculate the prior year actual cost for any group
2 of Medicare enrollees, regardless of where they come from.

3 From an actuarial basis, this is far more
4 satisfying and evidence-based than coding and risk
5 adjusting at an individual level, and it's virtually immune
6 to game playing, and it would free up MA plans to do what
7 they should be doing in the first place, focusing on
8 enhancing beneficiary health in the most optimal way.

9 This idea, knowing the past spend and setting a
10 prospective trend, some people have called it "spend and
11 trend," has a long history of success, and we should
12 consider recommending it, in my opinion, as part of our
13 goal improvement process. And particularly in this setting
14 where we're recommending incentives. The concept is
15 equally appropriate for ACOs, and it is used, actually,
16 pretty extensively within ACO benchmarking right now.

17 Again, I love this chapter, love the topics, and
18 I think it's a really important area for us to put focus
19 on, so thanks very much.

20 MS. KELLEY: Robert.

21 DR. CHERRY: Thanks. I want to thank you for
22 this chapter. You know, it's extraordinarily complex when

1 you think of the three different payment models, yet
2 there's a simple elegance to the chapter that I really
3 liked.

4 You know, when you look at each of the payment
5 models as complementary and actually does have a role to
6 play, depending on the problem that we're trying to solve.
7 Yet, at the same time, I agree with Tom's comments and
8 Greg's comments that our attention naturally turns towards
9 MA because it represents a long-term, potentially
10 financially sustainable model for Medicare beneficiaries.
11 And I think when I look at the chapter it looks through a
12 lens of incentives, what incentivizes providers to do cost-
13 effective, value-driven care.

14 I think there's a different lens when you start
15 looking at these payment models through what
16 disincentivizes them. One of the interesting things that
17 the chapter doesn't mention, if you look at it through that
18 lens -- and this is more of a recent development so I can
19 understand why this wasn't captured -- is a spike in
20 disinvolvements among the MA population that's recently
21 occurred. From 2018 to 2024, those forced disenrollment
22 rates was running about 1 percent, and then it spiked up

1 last year to 6.9 percent, and this year to 10 percent.

2 So what that means is that 2.9 million
3 beneficiaries were forced out of their MA programs. And
4 why is that the case? It's because the health plans are
5 finding that it's no longer profitable for them,
6 particularly in rural areas. So it's decreased
7 reimbursement rates. It's rising costs. So you have
8 health plans making different decisions around their
9 business portfolio.

10 That's a real concern because it might mean that
11 these are early signals that the MA program is under some
12 sort of duress. And this is really not for the June
13 chapter, but I think we need to think a little bit longer
14 term about what these disincentives are, because I think a
15 lot of us, despite some of the controversies with the MA
16 program, do want it to be successful. So we don't want to
17 necessarily go backwards and go towards a completely fee-
18 for-service model, and there is some disadvantage to
19 overlying APMs, as well.

20 But I think we need to look at disincentives,
21 because part of the issue is we also need health plans to
22 play a role in all of this, too, and to make sure that they

1 are reasonably viable so they can offer beneficiaries the
2 type of choices that they need, depending on what problems
3 that they're trying to solve.

4 Otherwise it's a great chapter. I'm just
5 planting a seed for potentially future work. Thank you.

6 MS. KELLEY: Stacie.

7 DR. DUSETZINA: As others have said, thanks for
8 this really interesting and thought-provoking chapter. I
9 really appreciate the former comments. I'm not sure how
10 organized I am with mine, because as I think through what
11 other people have said I find it to be really compelling.

12 Robert's comments just now made me think about,
13 yes, there is a tremendous amount of benefit and potential
14 for MA and capitated payments. But I always think about
15 what happens if you lose the credible threat of fee-for-
16 service? I don't think fee-for-service is going anywhere
17 any time soon. But in some ways, there's always this
18 competition as you think about where beneficiaries are
19 choosing to enroll, and fee-for-service gives people a lot
20 of choice of doctors and kind of acts, I think, in some
21 ways, as a little bit of a guardrail, making sure that MA
22 plans have to offer a really solid benefit in order to

1 attract enrollees.

2 So I think it's important to figure out how do we
3 preserve those broad choices, fee-for-service and MA, and
4 make sure that people are really getting good value out of
5 those programs.

6 The other kind of big picture thing about when we
7 talk about fee-for-service and some of the intensity and
8 volume, and it kind of encourages, maybe, more spending
9 than we would like, we also base MA payment on fee-for-
10 service spending. So I think that it comes up in the
11 chapter. I went back, as I was thinking about it after
12 having read it, and we talk about the benchmarks. But I
13 think that's something that, you know, it's like that high
14 spending in fee-for-service, it really does kind of filter
15 down to what we end up paying MA, and it provides more
16 money for supplemental benefits, but it doesn't really
17 result in any savings to the program overall.

18 So I think figuring out if that's the direction
19 we're heading, how do some of those savings come back to
20 taxpayers, and think about lowering overall spending.

21 Another thing that I felt like when reading about
22 the alternative payment models is -- and this, again, is

1 referenced, but I kind of felt like we have seen other work
2 over the years that has really brought this out -- the lack
3 of awareness of providers and patients about being in these
4 models. And it kind of feels like if it's so subtle that
5 sometimes people don't even know they're part of it, that's
6 probably not going to get the most benefit.

7 And you allude to that. You mention about the
8 beneficiary assignment. But I think bringing that out a
9 little bit stronger would be helpful. Like it shouldn't be
10 subtle. It probably shouldn't be voluntary. It should be
11 something that has streamlined and mandatory, and you know
12 you're in it, beneficiaries are in it.

13 For future looking, this is maybe more towards
14 this end of the table for thinking about future looking on
15 fee-for-service, I really think it is important to think
16 about how would a cap on fee-for-service work to make sure
17 that it remains a really viable choice. I like that plus
18 thinking about steering patients towards high-value
19 services and thinking about cost-sharing associated with
20 higher and lower value services would be something worth
21 going down that path.

22 I think we have kind of a critical missing data

1 element when thinking about that analytic approach of
2 understanding what is the cost of improving the benefit in
3 that way, like capping it, is we don't know right now who's
4 got supplemental coverage and who doesn't in the fee-for-
5 service side of the benefits. So I think we just have to
6 consider are there strong ways to be able to do a job of
7 estimating behavioral responses to such a change and what
8 that would cost the program overall.

9 Again, really impressive work, and I'm glad to
10 see this overlay of these three broad choices, and I look
11 forward to future work here.

12 MS. KELLEY: Scott.

13 DR. SARRAN: Excellent work. I have a suggestion
14 about something to incorporate as a brief comment, and it's
15 around the disconnect between beneficiaries' clinical needs
16 and the opportunities to improve care by serving those
17 needs, on one hand, versus the delivery system
18 configuration and functioning, which we all know is
19 substantially driven by payment mechanism.

20 As Greg pointed out, there a significant number
21 of beneficiaries who are aging, and they're aging
22 increasingly with serious chronic diseases that

1 increasingly are able to be well-served by a thoughtful,
2 careful, and coordinated deployment of increasingly
3 effective and increasingly available innovations across
4 pharmacologic, device, and surgical domains. That we know
5 is a lot of what's driving Part B, essentially, the Part B
6 costs. So that's on one hand, beneficiaries' needs. At
7 least that significant part of the population.

8 On the other hand, what we have is the delivery
9 system. The delivery system that those beneficiaries need,
10 by and large, is a specialist-led, nurse practitioner-
11 quarterbacked, multidisciplinary team that is entirely
12 patient centric. What we have across all three domains of
13 payment mechanisms, for sure, for sure in fee-for-service,
14 substantially in accountable care arrangements, although
15 CMS, CMMI is starting to do some more things around
16 specialist models. And unfortunately, all too commonly in
17 MA is a single provider focus and a PCP burden around
18 responsibility for everything.

19 I'm not driving at a solution. But I'd at least
20 like to incorporate some kind of comment about how we've
21 got this problem that exists across all three of these
22 domains in terms of, again, the mismatch between

1 increasingly aging populations, wonderful set of
2 innovations that can increasingly improve quantity and
3 quality of life, and yet the way the delivery system lines
4 up today and the way those three payment mechanisms
5 unfortunately tend to reinforce that malalignment. Thanks.

6 MS. KELLEY: Josh.

7 DR. LIAO: I want to add my thanks for, I think,
8 thoughtful and timely comments on an issue that I think is
9 both technically complex but central to Medicare's future.
10 And I appreciate, in particular, that it strikes, I think,
11 a balanced framing of the kind of promises and tradeoffs
12 and different approaches. Listening to other Commissioners
13 talk I think this content really succeeds in setting the
14 table with a foundation that stakeholders, leaders, and
15 different groups can use to engage in the kind of debates
16 and discussions on topics that lie ahead.

17 Actually, I think some of the comments I've heard
18 from other Commissioners today, whether focused on MA or
19 fee-for-service or their interplay really are emblematic of
20 the kind of discussions that I think this material can set
21 up. So thank you.

22 Just a few observations. I think, first, the

1 content does a good job of articulating those strengths and
2 weaknesses, and I think underscores the fact that, in my
3 view, none of these payment approaches are immune to
4 gaming, and none of them are perfect. I think it's
5 important to do that, and I think the content does it well.

6 I think, second, I was glad to see the added
7 emphasis on the kind of maturity of different payment
8 approaches, particularly the recognition that APMs are
9 relatively young, and I think performance can and should be
10 valued in light of that, and where approaches are on the
11 maturity curve.

12 I think, third, the revisions, I think, that have
13 taken place between the prior draft and this one have
14 helped, at least for me, clarify the distinction between
15 kind of how these models work in concept and how they are
16 executed in practice. And I think the point there is just
17 distinguishing between that conceptual and implementation
18 issues can really help clarify where policy improvements
19 can be made. So I think that message comes through even
20 clearer in this version.

21 The two areas where I'd like to maybe offer
22 suggestions for consideration, I think the first is it may

1 be helpful to kind of more explicitly underscore the common
2 set of tools that I think cut across these payment
3 approaches. You know, there are some tools that I think we
4 tend to associate with one approach over the others, but
5 actually in practice is present in those others. Fee-for-
6 service serves as an underlying chassis, as some have
7 mentioned, for APMs.

8 I think there are two places in the mailings
9 where we talk about volume-based clinician compensation,
10 but they exist not just in APMs but also MA. I think
11 that's another one. Tools like prior authorization, as
12 others have mentioned, are increasingly present in
13 traditional Medicare.

14 So I think these points are made in the chapter,
15 but I wonder if it's helpful to elevate that theme more
16 explicitly. And I think the point of doing that would just
17 be to reinforce the importance of calibrating this shared
18 set of tools across these different approaches.

19 And then a second area might be that in the
20 discussion of APMs I appreciated the inclusion and mention
21 of how specialist incentives could be made stronger. And
22 there's a mention of that in the context of ACOs. I might

1 suggest building on that, and it may be worth noting that
2 there have been specialist incentives, but maybe confined
3 more to episode-based models, and that episode-based and
4 population models haven't been fully harmonized in the
5 past.

6 And then in that section where we kind of talk
7 about what groups like the Innovation Center are doing in
8 new models, it might be helpful to note examples like the
9 CARA in the lead model to help bring those two together.

10 But overall, really great content. Thank you for
11 doing it.

12 MS. KELLEY: Cheryl.

13 DR. DAMBERG: Thank you. I found this to be a
14 really interesting and excellent chapter, and I think you
15 all did a great job describing the challenges of designing
16 payment systems that incentivize the desired behavior, and
17 also the challenges of these undesired effects, including
18 gaming. And clearly that gaming is leading to increased
19 spending and other undesired behaviors like avoiding more
20 challenging patient populations to get higher payments.

21 So I think that's the real struggle ahead, which
22 is how to move from what Josh just mentioned, which is

1 conceptually the sort of newer payment approaches, such as
2 MA or APMs. Conceptually, they are, I think, moving us in
3 the right direction of trying to deliver better value, but
4 I think the execution has proven challenging.

5 And I think this sort of raises a larger
6 question. I don't think you need to address it in this
7 particular chapter, but as we continue work in this space
8 I'm trying to get a better sense of are we getting better
9 value for this greater spend, regardless of which payment
10 model. And it's clear that, say, within the context of MA
11 plans, the plans are reducing utilization, they're reducing
12 costs, so there's some savings there. Quality may be the
13 same or improving, so potentially there is positive value
14 equation. But it's not clear to me that that improved
15 value is coming back to taxpayers, in terms of real
16 savings.

17 So I think, as we try to rethink these models and
18 how we both incentivize the system to evolve to deliver the
19 kind of value we want, how do we ensure that we're still
20 putting downward pressure on spending in this country. And
21 I think, as we've seen, we just keep plowing more money
22 into the system. So I think that's a challenge that I'm

1 sort of struggling with in terms of what are the steps to
2 take.

3 I did appreciate the fact that you flagged
4 administrative costs and the differential between the
5 different types of payment models. And I think we have to
6 think hard as we're thinking about total spend about adding
7 these additional costs to the system. So again, on net are
8 we saving money? We've introduced more complexity, both
9 for patients and clinicians and health systems that deliver
10 care. So again, we need to think in the future about how
11 do we create incentives to try to bring down some of those
12 administrative costs that I think are driving spending
13 increases.

14 MS. KELLEY: Paul.

15 DR. CASALE: So I want to add my thanks. Great
16 chapter. One of the advantages, or disadvantages of going
17 towards the end is that I agree with a lot of the
18 Commissioners' comments, so that provides me with less
19 opportunity to make comments, because I don't want to
20 reiterate what's already been said.

21 But just a couple of things. First, underscoring
22 what Stacie said about one of the challenges around APMs,

1 ACOs, in particular, is that nobody knows that they're in
2 it, and the physicians don't know that they're
3 participating. You know, I saw that first-hand in the ACO
4 that I directed. It was interesting that when we asked the
5 beneficiaries, "Will you share your data?" we got a lot of
6 response. Ten percent of them said, "No, we don't want to
7 do that." But when we told them that they are in the ACO,
8 the reaction was generally, "Well, I'm in fee-for-service
9 so I'm not in MA. What is this all about?" So they really
10 have no idea. It's a real challenge, and I think it's part
11 of the maybe future work around how do think about,
12 importantly for the beneficiary, to understand what these
13 alternative payment models are and how they work and what
14 the potential advantages are for them. And I think the
15 model itself can provide additional tools for that
16 communication.

17 To Josh's point about specialty care, and I would
18 suggest maybe adding a little bit more. Certainly on pages
19 22 and 23, you make comments about episode-based models and
20 a reference team. But we know that specialists drive
21 significant costs, and they're generally not engaged around
22 alternative payment models. So maybe adding some

1 additional comments around that in the chapter,
2 particularly with other APMs that came before TEAM --
3 sorry, the episode-based models that came before TEAM --
4 not really clear that quality improved. Certain bundles
5 have a lower cost but not very many.

6 And then to Scott's point around accountability
7 and the fact that we're really in a system in which driving
8 accountability to the individual clinician really is not
9 the way medicine is practiced. And some recognition around
10 the rise in employed physicians, so they're getting mixed
11 messages between what the health systems are asking them to
12 do and then their participation in whatever, whether it's
13 fee-for-service, APM, or MA, what they're being asked to
14 do. So that tension, I think, is something I think worth
15 mentioning, and maybe potentially part of future work.

16 And then, finally, I think it was to Tamara's
17 point about maybe a little bit more around the quality
18 programs and how to lay that out within that chapter would
19 be particularly helpful.

20 So thanks again for a great chapter.

21 MS. KELLEY: Betty.

22 DR. RAMBUR: Thank you so much. You did a

1 fabulous job of really distilling and crystalizing a lot of
2 these issues. I'm very excited to see the Commissioners'
3 enthusiasm.

4 I just have a couple of comments. A number of
5 you have mentioned some maximum out-of-pocket for
6 traditional Medicare. And there was a 2012 recommendation.
7 I think that would be an important thing to relook at and
8 perhaps refresh. I think it's actually really important
9 for a number of reason. The reason it was put in place in
10 1965 doesn't really apply today. But I think it would
11 actually make the market more competitive, positively, if
12 there was an out-of-pocket maximum.

13 You also mentioned a previous recommendation of
14 2006 that CMS can be an independent committee of experts to
15 review data and methods and help set values for fee-for-
16 service scheduled services. I think that's actually really
17 important, as well. It's hard to have independent and
18 experts, but we know right the RUC has quite an outside
19 role, and maybe they'd come up with the same
20 recommendations. I think that would be a really important
21 thing for this nation to do.

22 To the extent possible that HMO versus PPO MA can

1 be separated, I do think the incentives and disincentives
2 are a little different because of the out-of-network max
3 not existing in HMO. So to the extent that you can do that
4 without it being too heavy a lift.

5 But the most important thing I wanted to
6 underscore is your last bullet, neutrals that can be used
7 in fee-for-service Medicare to reduce the use of low-value
8 care. Obviously, that would spill beyond just fee-for-
9 service. And I think this is so critical because we're
10 having an enormous discussion about price transparency in
11 this nation but not enough about value transparency. And
12 if you know the price but you don't know whether you need
13 it or not, it really doesn't help with the decision-making.

14 You mentioned, I think Josh mentioned, the
15 volume-based composition that goes across, and Scott, the
16 disincentive for teams. Those things that go across all of
17 them that really impede our beneficiaries getting what they
18 really need, I think is very important.

19 And I just want to close by saying we talk a lot
20 about low-value care as an economic issue, but it is an
21 ethical issue. We see, as clinicians, the cascade of harm
22 that happens, and it's hard enough when there's harm from

1 something a person really needed. It's tragic if they
2 didn't need it to begin with. So I really think this is a
3 big job, identifying what is low value, but thinking of it
4 is as not only economic but an ethical issue I think is
5 really important.

6 So thanks to all and the great comments from the
7 Commissioners.

8 MS. KELLEY: Mike, that's all I have in Round 2.

9 DR. CHERNEW: Wonderful. So this was a terrific
10 discussion. I'm going to try and do a little bit of
11 summarizing. We may be able to have a little bit of back-
12 and-forth. We'll see.

13 So a few broad themes. There seems to be general
14 consensus, and I'll look around the room slowly when I say
15 this, that there are real challenges with running
16 unfettered fee-for-service. Certainly that sets a stage,
17 to Tom's initial comment. So I think the fundamental
18 question, if we want the Medicare program to be able to
19 provide high-quality care in an efficient way is how to
20 provide the incentives for delivery systems to do that.
21 And I commonly say, broadly speaking, if you don't share
22 the savings there won't be any savings to share. And I

1 think that ends up being important. Then the question
2 becomes sort of how to do that in a particular way.

3 I will say, and this did come up in several of
4 the comments, that fee-for-service is, in fact,
5 foundational. It's used in the ACOs, for obvious reasons.
6 It's used to pay MA. Many MA plays actually use the fee
7 schedule in what they do. So all the work, all this notion
8 where I say things that people might think is besmirching
9 fee-for-service is not to Secretary that we don't need to
10 continue to make the payment reforms to fee-for-service,
11 that we recommended in the chapter that we have site
12 neutral, which I just say every chance I get. There's a
13 whole bunch of other ones. Betty just named a few.

14 So the fee-for-service program itself is
15 foundational, and getting it right matters. And I think
16 the core question is what are the tools that we put around?
17 I think several of you used the word, and Brian, I can
18 remember, particularly used the word "tools," we're using,
19 and I think different tools in the MA programs, in the
20 APMs, we talk about capitation in ACOs. Of course, there
21 are others that are specialty focused.

22 What I think about that is the MA tools are, in

1 many ways, stronger, and so because they're stronger we
2 give beneficiaries the choice if they want to be in MA or
3 not. And I think that choice is important for them to
4 have, to choose the MA program and the associated tools or
5 not. It used to be Medicare Plus Choice, and I think that
6 Choice part ends up being important.

7 APMs, in some ways, have fewer tools, but you
8 might think tools like utilization review or prior auth is
9 less important, if, in fact, you're the provider. Like I
10 think the original view was why do we have to prior auth
11 providers when we incent them to take the risk. I think
12 the problem is people leak outside of the APMs. They leak
13 outside of the organization that faces the incentives.

14 But the other sort of core thing, which sort of
15 went unsaid, is the tools in MA are fundamentally plan
16 based. Plans get the savings when they're more efficient,
17 at least a portion of the savings when they're more
18 efficient. The thing about APMs, I'll talk about ACOs, is
19 fundamentally if the delivery system providers are more
20 efficient, that money stays within the delivery system.
21 You can do that for better or worse, but that is sort of
22 the conceptual notion, is if ACOs work more strongly you

1 could avoid the various expenses of plans and maybe the
2 various expenses of prior auth if you could, in the
3 delivery system, figure out how to do all this without all
4 that sort of back-and-forth issues. And I defer to the
5 people who do that for a living.

6 I do want to say one thing about drugs and then
7 one broad thing about the chapter and then managing
8 expectations. As I've written recently, drugs are sort of
9 neither price nor quality in a lot of ways. They're,
10 broadly speaking, innovation, and we have to think about
11 them, I think, in that context. I do think there is a lot
12 of stuff, and we've done a lot of stuff on the pricing for
13 drugs, and there is a lot of policy going on about how to
14 price drugs and sort of a core fee-for-service setting
15 issue of how we price drugs, and I actually think that is
16 an innovation pricing straight off in fee-for-service that
17 I think is more salient than a similar tradeoff in other
18 parts of the system. But a lot of the drugs are bought in
19 a fee-for-service system, and we think about how we set the
20 prices in fee-for-service for drugs the way we do for a
21 whole bunch of other things.

22 But a lot of what I think is happening in some of

1 these new drugs is actually volume and intensity, people
2 shifting from a drug to a drug that might be less expensive
3 to a drug that might be more expensive. So there's a
4 utilization component in that. And you asked about
5 separating it out, Greg. I think that's a reasonable
6 question. We were using the CMS characterization. That's
7 why that's set up the way it is. I do think the portion of
8 that, where there are utilization opportunities to control
9 drugs that are being used when they shouldn't be, is a
10 different question than the prices. And I think the models
11 provide different incentives. And I think you'll see, in
12 some of these models, they do use drugs differently when
13 you have an incentive in a managed environment to, say,
14 control the formulary or control the first-line drugs you
15 use. So I think that is important. But I do think drugs
16 matter, but we can't forget the innovation component of
17 them.

18 So I guess I'll say one last point about this.
19 This chapter was broadly meant to lay out some of the
20 conceptual things and some of the implementation
21 challenges, and Tamara, I think, said it better than I will
22 say it, so I will try not to repeat what she said, but I

1 think she was right.

2 So much of our work is about how to get MA plan
3 payment, how to get the implementation of MA right, how to
4 get the implementation of fee-for-service. That is what we
5 do, bread and butter. So go get the March reports where we
6 talk about all those things.

7 The purpose of this chapter was sort of to lay
8 out the role that those different types of programs are
9 playing in a way that doesn't vilify any of them, and notes
10 that we have to keep working on the implementation. And I
11 think the core part of this chapter is to focus on making
12 that conceptual distinction and allowing the other bodies
13 of work that we do to talk about the various implementation
14 challenges that go across them. Because so often I hear in
15 the ether broad statements, "APMs don't work," "MA is
16 horrible," which is just simply, you know, "Fee-for-service
17 is a disaster," which I think, broadly speaking, is not the
18 case. I think there is a core role that these play, and I
19 think the central issue is what tools we put in place
20 around a foundational sort of fee-for-service world to make
21 sure that we give incentives to providers to provide high-
22 quality, efficient care, which is very hard to do in a fee-

1 for-service system. The marginal average cost distinction
2 didn't come out because you all are wiser than I. I am
3 avoiding that in public session, and I think it matters.

4 So, in general, what I heard was sort of strong
5 support for where this is going. I think we'll take all of
6 these comments and go back and review them for what we can
7 do. I do want to manage some expectations. In case you
8 haven't checked the calendar lately, this is April. It
9 turns out it's the last meeting of the cycle. Who knew?
10 The report is coming out in June, and somehow it feels like
11 the June reports need to be done in April, or at least
12 close to it. We're going to be getting chapters to review.
13 You'll hear about this tomorrow, and get your comments back
14 very shortly. So we're going to be on a very short
15 timeline.

16 But to the extent possible we will add much of
17 this commentary into what we can, and I very much
18 appreciate your engagement on this. And I encourage you,
19 as I fade off into the sunset, to continue to think about
20 the role that these programs play conceptually, and then
21 focus on implementing them as best that one can.

22 And Paul wants to add something.

1 MR. MASI: I'm so sorry. I just wanted to
2 emphasize what Mike said about, this is a great
3 conversation. Also, in managing expectations, we will take
4 back all of these comments and review the transcript and
5 work into the chapter what we can. But then also I think
6 to the extent that we're starting to think about future
7 work, a number of work, in your comments, said things like,
8 "You know, for future work," or "In the future." And I
9 just wanted to assure you, just because something doesn't
10 show up in this chapter, we've kind of noted it and we'll
11 keep it in mind as we're moving forward the project at
12 MedPAC. So thank you.

13 DR. CHERNEW: Wonderful. So we are now actually
14 exactly on time. And so we're going to take a five-minute
15 break, and then we're going to come back and we're going to
16 talk about a very tangible, very tangible implementation
17 issue related to collecting data for ground ambulance
18 services. Thank you.

19 [Recess.]

20 DR. CHERNEW: Hello, everybody, and welcome back.
21 We are now going to bring to fruition a report that we've
22 been working on for a while, that we were requested to do,

1 on data collection for ground ambulance payment and costs
2 and revenue. And for that we are going to let Dan take us
3 through this work, and then we will have a vote.

4 DR. ZABINSKI: As you'll recall, the Bipartisan
5 Budget Act of 2018 directs MedPAC to use data collected by
6 CMS to produce a report on the cost of Medicare ambulance
7 services. In March, we provided detailed results of our
8 analysis of the data and provided a draft recommendation on
9 whether collection of the cost data from ambulance
10 organizations should continue. Today, we return for a vote
11 on the final recommendation. For the audience, a copy of
12 the slides can be accessed through the control panel on the
13 right side of your screens.

14 This is our fourth presentation of this material.
15 At the March 2025 meeting, we introduced the ambulance fee
16 schedule and the Ground Ambulance Data Collection System
17 developed by CMS. At the December 2025 meeting, we built
18 on the presentation from the March 2025 meeting and
19 provided preliminary results of our analysis of the GADCS
20 data and reviewed results from interviews with
21 stakeholders. Then, at the March 2026 meeting, we refined
22 the December 2025 analysis in response to Commissioner

1 comments.

2 And for today, our plan for this presentation is
3 to discuss the report mandated by the Bipartisan Budget Act
4 of 2018; describe the ground ambulance data collection
5 system the BBA of 2018 required CMS to develop; provide an
6 assessment of the GADCS data; discuss our results from an
7 analysis of the GADCS data; and close with the draft
8 recommendation.

9 Ground ambulance services that are provided to
10 fee-for-service Medicare beneficiaries are paid under the
11 ambulance fee schedule, or the AFS. The AFS adjusts
12 payments for service intensity and for location of the
13 ambulance transport, but these adjustments are largely not
14 based on cost data and have not been updated since they
15 were implemented.

16 This lack of cost data led to a mandate in the
17 Bipartisan Budget Act of 2018 that required CMS to
18 implement a comprehensive ground ambulance data collection
19 system that includes data on ground ambulance costs and
20 revenues. CMS responded to the BBA of 2018 mandate by
21 creating the GADCS, which includes data on ambulance
22 organizations' characteristics, service area, service

1 volume, service mix, staffing, costs, and revenues.

2 The BBA of 2018 also directs MedPAC to use the
3 data collected by CMS to assess the GADCS data, the
4 adequacy of AFS payments, and geographic variations in the
5 cost of furnishing ambulance services. Also, MedPAC is
6 required to produce a report that is due June 15, 2026,
7 that includes an analysis of the GADCS data, an analysis of
8 the burden on organizations associated with the data
9 collection, and a recommendation of whether the data
10 collection should continue and whether it should be
11 revised.

12 Now we'll turn to our assessment of the GADCS
13 data.

14 The GADCS is not the first dataset to include
15 ground ambulance organizations' costs and revenues, but it
16 is the most comprehensive. Previous datasets had only a
17 few hundred records and excluded ambulance organizations
18 that shared costs with emergency responders or hospitals
19 because of concerns about the reliability of their data.

20 In contrast, the GADCS has 7,600 records and
21 includes the organizations that share costs with emergency
22 responders or hospitals. CMS worked with these

1 organizations to ensure the reliability of their cost data.
2 A key attribute of the GADCS is that it includes detailed
3 cost data that are useful for assessing the adequacy and
4 accuracy of ambulance payments.

5 We do, however, have a concern about the size of
6 the GADCS, as it has over 600 variables, many of which are
7 not needed for evaluating ambulance costs. For example, we
8 used only 150 of these cost variables in the empirical
9 results that we discuss later in this presentation. In
10 particular, the GADCS has data on some cost categories such
11 as vehicles and facilities that are more granular than
12 needed, and the GADCS also includes other variables that
13 are nice to know but not needed such as hours worked on
14 non-ambulance responsibilities and details about the
15 organization's secondary market areas.

16 To inform the recommendations that the BBA of
17 2018 requires the Commission to make, we had discussions
18 with industry stakeholders including ambulance
19 organizations, CMS, RAND, which contracted with CMS for the
20 GADCS, and ambulance trade associations. In general,
21 stakeholders noted that continued data collection would be
22 beneficial to ensure payment adequacy and accuracy.

1 However, small rural organizations reported difficulty
2 collecting and submitting data and wondered about the
3 usefulness of many questions, and that the burden of data
4 collection could be eased by streamlining the GADCS.

5 Also, the trade associations and the
6 organizations felt that start-up costs have been incurred,
7 so stopping the GADCS at one iteration would be
8 unfortunate, and the quality of the data the organizations
9 submit should improve with more experience.

10 Through our discussions with the stakeholders and
11 our work with the GADCS data, we have identified changes to
12 the GADCS that would improve it. First, some variables
13 could be dropped because many are not needed for evaluating
14 payment adequacy and accuracy. Second, other data could be
15 less granular such as vehicle costs and facility costs.
16 Finally, organizations could be required to collect and
17 submit data less frequently than annually. This could be
18 accomplished by using a nationally representative sample of
19 organizations each year rather than all organizations or
20 surveying all the organizations less frequently than
21 annually.

22 Over the next few slides, we'll present results

1 of our analysis of the GADCS data. We started by analyzing
2 the GADCS to identify which organization characteristics do
3 and do not affect ground ambulance costs.

4 The most striking finding has been the effect
5 that organization size has on their costs per transport.
6 We sorted the organizations by number of transports and
7 collected them into quartiles. In the lowest quartile of
8 transports, the costs per transport was \$2,852; in the
9 highest quartile it was one-third of that amount, at \$914.

10 We also found that government organizations have
11 much higher costs per transport than nonprofit and for-
12 profit organizations, and urban organizations and rural
13 organizations have similar costs per transport.

14 Many factors contribute to the differences in
15 costs between ground ambulance organizations, and the
16 simple tabulations like we did on the previous slide cannot
17 tell us the magnitude of the impact on costs of each
18 factor. To isolate the effect of each cost driver, we did
19 a regression analysis that estimated the effects of
20 relevant factors on ground ambulance costs. Several
21 explanatory variables in this regression were significant,
22 but two stood out.

1 First, we found that as number of transports
2 increased, costs rose at a much lower rate, indicating
3 economies of scale. The regression indicates that a 10
4 percent increase in the number of transports increased
5 costs by a smaller 7 percent, so costs per transport
6 decreases as volume increases. The implication is that
7 smaller organizations have higher costs per transport
8 relative to larger organizations.

9 Second, we found that rural organizations had
10 lower costs per transport than urban organizations when
11 controlling for other factors that affect costs, especially
12 the number of transports. However, the AFS has adjustments
13 that increase payments for rural organizations relative to
14 urban organizations.

15 The Commission recommended, in 2013, that the AFS
16 add-on payment for the first 17 miles of a rural transport
17 be replaced with an adjustment for low-volume organizations
18 located in isolated areas. Rural organizations would be
19 more likely to benefit from such a policy change than urban
20 organizations.

21 The final step in our analysis of the GADCS data
22 is a comparison of the organizations' revenues and costs,

1 which is one component in assessing payment adequacy. The
2 GADCS is the first dataset that allows for a comprehensive
3 comparison. However, it has important limitations, and on
4 the next slide we'll discuss challenges in drawing
5 conclusions about profitability from the GADCS. Then,
6 we'll present an analysis of costs and revenues under two
7 methods to help policymakers understand how payment compare
8 to costs.

9 Also, MedPAC typically includes analyses of
10 quality of care and access to capital when assessing
11 payment adequacy, but currently there is limited
12 information about these measures in the GADCS.

13 At the March meeting, we provided you with some
14 new statistics on organization revenues relative to
15 organization costs, which give a sense of the financial
16 standing of ambulance organizations. However, there are
17 challenges in evaluating measures of organizations'
18 revenues relative to their costs. Many organizations
19 receive a substantial share of their revenues from sources
20 unrelated to providing ambulance services, the largest
21 being revenue from local taxes. CMS has expressed concern
22 that organizations may have under-reported revenue from

1 these sources. Also, this is the first time most
2 organizations have submitted cost and revenue data, so
3 errors in reporting are likely.

4 We also found extremely large differences between
5 revenues and costs for some organizations. To reduce the
6 effects of these outliers, we trimmed the organizations
7 that have the 5 percent most negative and 5 percent most
8 positive differences between revenues and costs.

9 On this slide, we present median revenue-to-cost
10 ratios using both the trimmed dataset, which are the
11 numbers in the center column on the table, and our full
12 dataset, which are the numbers on the right. We have
13 revenue-to-cost ratios for for-profit, nonprofit, and
14 government-owned organizations, where revenue is revenue
15 from all sources and cost is cost from providing services
16 to all patients. Also, we weighted the results from the
17 trimmed dataset by the number of transports for each
18 organization because we were concerned that small rural
19 organizations had a disproportionate impact on the results.

20 Under both the trimmed and the full datasets, we
21 found that the government organizations have lower revenue-
22 to-cost ratios than for-profit and nonprofit organizations.

1 We emphasize that we view the government organizations in a
2 different financial context from other organizations
3 because over half their revenue is from sources unrelated
4 to billing for ground ambulance services, and they have a
5 higher service intensity than other organizations.

6 Because of this difference between government
7 organizations and other organizations, on this slide, we
8 exclude the government organizations from our analytic
9 samples. You can see that using the trimmed and weighted
10 data, the remaining urban organizations have a median
11 revenue-to-cost ratio of 1.11, meaning that revenue is 11
12 percent higher than costs. Rural and super rural
13 organizations also have median ratios greater than 1.0
14 under the trimmed and weighted data, indicating revenue is
15 higher than cost at the median.

16 When we collect the organizations into quartiles
17 by number of transports, you can see that the revenue-to-
18 cost ratio is very sensitive to the number of transports as
19 organizations in the highest quartile of transports have a
20 much higher ratio than organizations in the lowest
21 quartile.

22 To summarize today's presentation, the GADCS is a

1 comprehensive dataset that can be used to evaluate the
2 accuracy of payments across patient severity levels and
3 assess whether aggregate payments are large enough to
4 ensure patient access. Discussions and correspondence with
5 stakeholders indicated that they support continued
6 collection of the GADCS data, but the stakeholders
7 indicated that the GADCS could be streamlined to ease
8 reporting burden.

9 Also, it is difficult to use the GADCS to
10 evaluate the adequacy of payments for several reasons
11 including there is substantial revenue from sources not
12 related to billing for services; here may be under-
13 reporting of revenue from some sources; this is the first
14 year of data collection, so there are likely reporting
15 errors; there is little information about access to care
16 and quality.

17 Finally, our analysis of the GADCS data suggests
18 AFS adjustments are not well targeted. These findings are
19 consistent with findings from previous analyses by the
20 Government Accountability Office and MedPAC.

21 We now turn to the draft recommendation, which
22 says:

1 The Congress should direct the Secretary to
2 continue collecting cost and revenue data from suppliers
3 and providers of ground ambulance services. Data
4 collection should focus on information essential to
5 assessing both accuracy of Medicare payments and Medicare
6 beneficiaries' access to care; and the Secretary should
7 pursue opportunities to streamline data collection to
8 minimize burden on suppliers and providers.

9 In terms of implications, we currently estimate
10 that this draft recommendation would not affect spending
11 relative to current law, and the draft recommendation
12 should not adversely affect beneficiaries' access to
13 ambulance services or organizations' willingness or ability
14 to provide these services.

15 That concludes this presentation. We will
16 address any questions or comments you have, and now we turn
17 it back to Mike.

18 DR. CHERNEW: Dan, thank you so much. I think
19 Brian wants to say something briefly, and Tom wants to say
20 something briefly. So Brian.

21 DR. MILLER: Unsurprisingly, flawless work, Dan,
22 as always. A couple sort of philosophical comments. One

1 is the data -- and this should not surprise anyone -- the
2 data shares that we have economies of scale for large
3 ambulance providers, which is great. The problem is that
4 taxpayers and beneficiaries aren't benefitting from those
5 economies of scale with lower prices, decreased cost-
6 sharing, whatever it is, because centralized administrative
7 payment means that the payers lagging in the market is
8 surpassing them. So we have large ambulance providers, we
9 have potential savings for both taxpayers and the
10 beneficiaries. My question is can we think about
11 empowering MACs or some other sort of vehicle in the
12 payment system so that benes benefit.

13 Another thing to think about is we're actually
14 asking ambulance providers to work for free under the
15 current ambulance system because we don't pay to treat
16 people in place. Again, it feels silly to say this. I
17 think people should be paid for their work and not work for
18 free, so I think that's a conceptual area for future work.

19 And I think there is a philosophical question
20 that we should address. The government and private actors
21 purchase items and services in other markets without
22 collecting cost data. No one is going around saying that

1 landscapers should submit 600 items before they bid for
2 their service. They're submitting a bid. They're not
3 telling you the cost of the gasoline or their truck or the
4 lawn mower.

5 I think we should be thinking about competitive
6 models that dynamically drive price and non-price
7 competition over time, because price regulation means that
8 the Medicare beneficiary and the taxpayer aren't
9 benefitting from competition.

10 MS. KELLEY: Tom.

11 DR. DILLER: Great work. I think this is a
12 really well put together chapter. Mine is kind of a
13 comment and question. As I'm looking through all of this
14 information I think, but I'm not sure, that I am correct,
15 that there are really three types of ambulance
16 organizations. There's an urban, emergent care-only system
17 that's usually government provided, like fire department,
18 and it's subsidized. The second one is usually private.
19 It's a non-emergent transport. It's very efficient, and
20 they can schedule their trips. Hospital systems own them
21 or for-profit ambulance companies own them. And then
22 there's the third, rural, which is the catch-all, and they

1 have to do both the emergent and non-emergent transports,
2 and they're low volume, difficult to schedule, things along
3 that line.

4 And am I on track with that thinking, I guess is
5 the question? And the other comment is should there be
6 different reimbursements systems eventually for those three
7 types of systems, because they're very different. And I
8 don't expect an answer today with that.

9 So that was my comment. But very well done, and
10 I'm very supportive of the recommendation.

11 MS. KELLEY: All right. That's all I have, Mike.
12 Shall we move to the vote?

13 DR. CHERNEW: Yes, we should move to the vote. I
14 just want to say the recommendation of the vote is on
15 collecting the data. A lot of the other things hinge on
16 knowing some of those types of things. So okay, yes.

17 MS. KELLEY: All right. Voting on the
18 recommendation, which reads:

19 The Congress should direct the Secretary to
20 continue collecting cost and revenue data from suppliers
21 and providers of ground ambulance services. Data
22 collection should focus on information essential to

1 assessing both accuracy of Medicare payments and Medicare
2 beneficiaries' access to care; and the Secretary should
3 pursue opportunities to streamline data collection to
4 minimize burden on suppliers and providers.

5 Voting yes or no, Betty?

6 DR. RAMBUR: Yes.

7 MS. KELLEY: Paul?

8 DR. CASALE: Yes.

9 MS. KELLEY: Robert?

10 DR. CHERRY: Yes.

11 MS. KELLEY: Cheryl?

12 DR. DAMBERG: Yes.

13 MS. KELLEY: Tom?

14 DR. DILLER: Yes.

15 MS. KELLEY: Stacie?

16 DR. DUSETZINA: Yes.

17 MS. KELLEY: Tamara?

18 DR. KONETZKA: Yes.

19 MS. KELLEY: Gokhan?

20 DR. METAN: Yes.

21 MS. KELLEY: Josh?

22 DR. LIAO: Yes.

1 MS. KELLEY: Brian?

2 DR. MILLER: Abstain.

3 MS. KELLEY: Greg?

4 MR. POULSEN: Yes.

5 MS. KELLEY: Wayne?

6 DR. RILEY: Yes.

7 MS. KELLEY: Scott?

8 DR. SARRAN: Yes.

9 MS. KELLEY: Gina?

10 MS. UPCHURCH: Yes.

11 MS. KELLEY: Mike?

12 DR. CHERNEW: Yes.

13 MS. KELLEY: And Lynn Barr and Kenny Kan are
14 absent.

15 DR. CHERNEW: Greg got into the queue, but it's
16 after we kind of moved along.

17 MR. POULSEN: Yeah, it was simply to Tom's point.
18 I was going to say there really is a category where, at
19 least in the mountain states, there are lots of urban
20 transports that are done emergently by private companies.
21 They work in conjunction with EMS to do that.

22 DR. CHERNEW: And on that note, we are going to

1 go to lunch, and then we're going to come back. We're
2 going to talk about Part D benchmarks, I think, and that is
3 going to be at 2:00. But for those of you at home, please
4 do send us your comments. You can reach out at
5 meetingcomments@medpac.gov, or in any other way. We really
6 do want to hear from you. And we will see everybody else
7 back at 2. So again, thanks, everybody.

8 [Whereupon, at 12:39 p.m., the meeting was
9 recessed, to reconvene at 2:00 p.m. this same day.]

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1 AFTERNOON SESSION

2 [2:00 p.m.]

3 DR. CHERNEW: Hello, everybody, and welcome back
4 for our afternoon session. We're going to start with two
5 topics related to the market for prescription drugs. This
6 first one is following up on a general concern we have
7 about the balance between MA and traditional Medicare and
8 how all that plays out. And there is a particular issue
9 related to benchmark plans and how that works. And Tara
10 and Shinobu are going to take us through that, and I think
11 we're starting with Tara.

12 MS. O'NEILL HAYES: Thanks, Mike. Today we will
13 present findings from our analysis of regional benchmarks
14 and benchmark plan availability in the PDP market. This is
15 an issue of particular relevance to beneficiaries eligible
16 for the low-income subsidy. This presentation is not
17 intended to be a chapter in our June report. Attendees may
18 download a PDF copy of these slides from the top-right
19 corner of your screen by the paperclip icon.

20 In this presentation, we will provide some
21 background information regarding the low-income premium
22 subsidy and benchmark plans. Then we will examine trends

1 in plan offerings and impacts on beneficiaries. We will
2 explain the key factors that determine benchmark plan
3 availability. Lastly, we will discuss how one of those
4 factors, premiums, may be impacted by other variables.

5 The Commission's June 2025 report highlighted
6 four trends in the PDP market that raise concerns about the
7 continued availability of a sufficient number of PDPs.
8 Given Commissioner interest following last year's work,
9 today's presentation will focus on the first, specifically,
10 the declining number of benchmark plans, but you will see
11 how it is connected to the others, particularly the
12 divergence of premiums between PDPs and MAPDs, which
13 largely stems from the divergence in trends between gross
14 costs and risk scores between the two markets.

15 How so? Premiums are based on plans' bids and
16 are "risk standardized," meaning that bids reflect plans'
17 expected costs for a beneficiary of average costliness. A
18 higher average risk score will result in lower risk-
19 standardized costs. For example, if two plans with similar
20 expected costs for an average beneficiary had different
21 average risk scores, the plan with the higher average risk
22 score would have a lower bid, and therefore, lower premium.

1 Because MAPDs have been found to have higher average risk
2 scores and lower gross costs, they have been able to offer
3 relatively lower premiums than PDPs, on average.

4 Before we begin, let's review some key
5 definitions.

6 The low-income subsidy is additional premium and
7 cost-sharing subsidy provided for individuals with low-
8 income, referred to as LIS enrollees.

9 Benchmark plans are stand-alone basic PDPs with
10 premiums at or below the LIPSA.

11 The LIPSA, or the low-income premium subsidy
12 amount, is the additional premium subsidy for LIS enrollees
13 equal to the greater of either the regional benchmark,
14 which is the LIS-weighted average premium for basic
15 coverage for all Part D plans in a region, or the lowest
16 premium for a basic PDP in the region, which would apply if
17 there are no basic PDPs with a premium at or below the
18 benchmark.

19 The goal of the LIPSA is to subsidize a low-
20 premium plan. Let's walk through an example to help
21 explain. Here we have two hypothetical regions, A and B.

22 We'll look at region A first. Here, there are

1 four basic Part D plans, one MAPD and three PDPs. The
2 monthly premium for each plan is listed in the second
3 column, followed by the plan's assumed LIS enrollment in
4 the third column. The LIS-weighted average premium for
5 these four plans is \$42, as noted in the last column.

6 PDPs 3 and 4 have a premium below this average
7 and thus the LIPSA will equal the benchmark, and PDPs 3 and
8 4 will qualify as benchmark plans. The actual amount of
9 the low-income premium subsidy paid for enrollees in either
10 PDP 3 or 4 would be \$40 and \$25, respectively, covering the
11 full premium amount. For an LIS enrollee choosing either
12 PDP 2 or the MAPD in this region, the low-income premium
13 subsidy paid would be capped at the \$42 LIPSA, and the
14 beneficiary would have to pay the difference of \$3 for PDP
15 2 or \$8 for the MAPD.

16 In region B, there are three plans. The weighted
17 average premium, or the benchmark, is \$35, shown in the
18 last column. Because only basic PDPs can be a benchmark
19 plan and neither of the two offered has a premium below
20 that benchmark amount, the LIPSA will be equal to the
21 lowest PDP premium, PDP 3, and only that plan will qualify
22 as a benchmark plan where its premium will be fully covered

1 by the LIPSA for LIS enrollees. However, note that the
2 MAPD has a premium of \$25, below the LIPSA of \$40. LIS
3 enrollees choosing that plan will also have their premium
4 fully covered by LIPSA, but, again, only PDPs are
5 considered benchmark plans.

6 Now we'll look at recent trends and the impact of
7 declining benchmark plans on beneficiary choice.

8 As noted, the number of benchmark plans has been
9 declining, and here you can see the share of LIS
10 beneficiaries with access to one or more benchmark plans in
11 recent years. In 2022, all LIS beneficiaries had at least
12 four benchmark plans from which to choose, but in each year
13 since beneficiaries have had fewer choices, on average.

14 In 2025 nearly three-fifths of all LIS enrollees
15 had access to just one or two benchmark plans. Assuming
16 the same number of LIS beneficiaries remain in each region
17 in 2026 as in 2025, the share of LIS beneficiaries with
18 just 1 or 2 benchmark plans is estimated to have increased
19 to 68 percent.

20 The declining number of benchmark plans is also
21 increasing enrollment concentration among just a few plan
22 sponsors. Since 2022, more than 90 percent of LIS

1 beneficiaries enrolled in PDP benchmark plans have been
2 insured by one of the top five PDP sponsors. In 2025, a
3 single insurer enrolled nearly three-fifths of all LIS
4 benchmark enrollees across the country.

5 In recent years, these top insurers have become
6 exclusively national carriers and also the dominant
7 insurers in the MAPD market. Local PDP plan sponsors have
8 largely left the market, and very few have qualified for
9 benchmark status in recent years.

10 The number of declining benchmark plans has
11 occurred alongside a broader shift in the Medicare market
12 towards MA, though LIS beneficiaries have
13 disproportionately made the switch.

14 In 2025, there were just over 13 million LIS
15 beneficiaries, roughly two-thirds of whom were enrolled in
16 an MA plan, particularly in Special Needs Plans, a type of
17 MA plan available only to certain individuals, shown in
18 navy blue at the top of each column.

19 Conventional MAPDs are shown next in light blue,
20 and PDP enrollment is shown in orange, with benchmark plans
21 in the lighter orange and non-benchmark plans in the darker
22 orange, at the very bottom. Most LIS beneficiaries

1 remaining in PDPs are enrolled in a benchmark plan.

2 Now, some may be concerned about the declining
3 number of benchmark plans and the potential effect on
4 beneficiary choice and access to medications, but there are
5 safeguards to help mitigate these concerns.

6 The program's formulary coverage requirements
7 ensure broad coverage of medicines across therapeutic
8 classes. CMS assesses plan formularies to ensure the plan
9 "does not substantially discourage enrollment by any group
10 of beneficiaries." Analyses have consistently found
11 limited variation in terms of formulary coverage by plan
12 type or benchmark status, and that most Part D plans cover
13 nearly all of the prescription drugs most commonly used by
14 LIS beneficiaries. There are also regulations regarding
15 pharmacy access, with numerous minimum requirements
16 relating to distance and types of pharmacies included in-
17 network. For more detailed information regarding pharmacy
18 access in the PDP market, stay tuned to our next
19 presentation on exactly this topic.

20 Also, as noted, the low-income subsidy helps
21 ensure LIS beneficiaries face limited costs for their
22 prescription drugs.

1 Lastly, there is a contingency plan for the
2 Secretary of HHS to establish either limited risk plans or
3 fallback plans which will bear no risk to ensure coverage
4 even if no plans are initially offered in an area.

5 Still, beneficiary choice is a fundamental aspect
6 of the Part D program, and analyzing the decline in
7 benchmark plans may help us better understand the dynamics
8 at play in the broader PDP market.

9 So what have we learned about the availability of
10 benchmark plans? Well, there are three key factors that
11 affect the number of benchmark plans in a region, based on
12 the formula to calculate the benchmark and the eligibility
13 criteria.

14 First, the number of basic PDP offerings
15 determines the maximum number of benchmark plans. Second
16 is the distribution of LIS enrollees across MAPDs and PDPs.
17 And third are the premiums for basic benefits among PDPs
18 and MAPDs. As the premiums for MAPDs fall further below
19 those of PDPs, the regional benchmark will decline.

20 Let's examine each of these three factors for
21 2025.

22 This chart shows the average number of basic PDPs

1 and benchmark plans per region over time. Each column is
2 split to show the benchmark plans, in navy, at the bottom,
3 as a subset of the basic PDPs. The number of basic PDPs
4 per region has generally declined over the past decade,
5 dropping from an average of 17 in 2014 to just 5 in 2026.
6 Since only basic PDPs can be benchmark plans, the average
7 number of benchmark plans has also declined, from 10 in
8 2014 to 3 in 2026.

9 The decline in basic plans reflects the fact that
10 the number of insurers choosing to participate in the PDP
11 market has been declining, as each insurer may only offer
12 one basic PDP per region.

13 However, the decline in the number of basic plans
14 has been relatively uniform across regions and thus there
15 is limited variation in the number of basic PDPs offered in
16 each region, particularly in more recent years.

17 This chart shows the number of basic plans in
18 each of the 34 regions in 2025. The number of benchmark
19 plans per region is again shown at the bottom of each
20 column in navy. Regions with the fewest benchmark plans
21 are on the left, and those with more to the right.

22 As you can see, there was very little variation

1 in the number of basic PDPs per region: most had six; some
2 had five, and one had seven. But the number of benchmark
3 plans ranged broadly from one to five. Thus, the number of
4 basic plans per region failed to explain regional
5 differences in benchmark availability.

6 We next examined LIS distribution across the PDP
7 and MAPD markets since the formula for calculating the
8 benchmark weights each plans' basic premium by their share
9 of LIS enrollees. As the MA market share among LIS
10 beneficiaries has grown, the premiums charged by MAPDs have
11 a greater impact on the benchmark.

12 Here, we have grouped the 34 regions into
13 categories based on the number of benchmark plans available
14 in 2025 and show the average share of LIS beneficiaries
15 enrolled in MA in those regions. Among regions with a
16 single benchmark plan in 2025, represented by the bar
17 farthest to the left, 74 percent of LIS beneficiaries are
18 enrolled in MA, on average, compared with 61 percent of LIS
19 beneficiaries in regions with 4 or more benchmark plans.

20 However, there were numerous regions with two or
21 three benchmark plans that had a higher share of LIS
22 enrollees in MA than the 74 percent average among those

1 regions with a single benchmark plan. Thus, we found this
2 variable to be mildly informative as to the number of
3 benchmark plans a region may be expected to have.

4 The third factor, the average basic premiums for
5 PDPs and MAPDs, was found to be the most influential in
6 determining the number of benchmark plans in a region. A
7 consistent pattern has emerged over the past few years that
8 shows an inverse relationship between the magnitude of the
9 difference between average MAPD and PDP premiums and the
10 number of benchmark plans. This chart illustrates this
11 relationship in 2025, where we have plotted the difference
12 between average PDP and MAPD premiums for basic coverage
13 for each region by its number of benchmark plans.

14 When MAPD premiums are far below those of PDPs,
15 as is the case for those regions toward the right side of
16 the graph, there tend to be fewer benchmark plans. As that
17 gap narrows, moving closer to the y-axis, and especially if
18 MAPD premiums are higher than PDP premiums, and thus to the
19 left of the y-axis, the number of benchmark plans rises.

20 This relationship is not by coincidence. It is
21 driven by the formula used to determine the benchmarks.

22 This table explores the relationship between

1 premium differences further. Here, again, we have grouped
2 the 34 regions by the number of benchmark plans in 2025.
3 In the third and fourth columns is the LIS-weighted average
4 premiums for basic coverage for PDPs and MAPDs in each
5 grouping, followed by the difference between premiums in
6 the two markets in the last column.

7 You can see that in all four categories, PDP
8 premiums, on average, are higher than MAPD premiums, but,
9 looking at the last column, that difference shrinks as the
10 number of benchmark plans increases.

11 Among regions with a single benchmark plan in
12 2025, the LIS-weighted average PDP basic premium is \$27
13 more than the average MAPD basic premium. By contrast,
14 among regions with four or more benchmark plans, the
15 difference between average basic premiums was just \$6. The
16 same pattern held when we examined premiums for 2024 and
17 2023, though differences were smaller in those years.

18 The more MAPD premiums fall below PDP premiums,
19 particularly when LIS enrollment in MA is relatively high,
20 the fewer benchmark plans there will likely be. When the
21 average overall premium is so low that no basic PDP plans
22 have a premium below that average, there will only be a

1 single benchmark plan, the basic PDP with the lowest
2 premium. This is what happened in three of the four
3 regions with a single benchmark plan in 2025. In the
4 fourth, only one basic PDP had a premium below the overall
5 average.

6 Lastly, let's discuss some of the factors that
7 may be affecting premiums and driving these differences.

8 The differences in premiums may be related to
9 previously noted concerning trends in the PDP and MAPD
10 markets. Premiums are based on plan bids that reflect
11 plans' expected benefit costs for an enrollee with average
12 costliness.

13 As discussed last year, we observed
14 inconsistencies in risk score and cost trends in the two
15 markets in recent years. On average, MAPDs had lower costs
16 than PDPs but higher risk scores, partially explained by
17 differences in coding intensity. A systematic difference
18 in risk-standardized costs between the two markets can
19 distort premiums, result in inaccurate payments to plans,
20 and undermine competition.

21 In 2025, CMS implemented separate normalization
22 factors for PDPs and MAPDs in the risk adjustment model to

1 try and mitigate some of this disparity, and CMS has
2 announced they are considering additional changes to the
3 model.

4 Lastly, I want to note that the PDP Premium
5 Stabilization Demonstration had a notable impact on the
6 number of benchmark plans, particularly in 2025. As you
7 may recall, in 2025, CMS implemented a voluntary
8 demonstration for PDPs to lower the premiums beneficiaries
9 would pay. Importantly, the benchmark amounts were set
10 based on premiums before any reductions from the
11 demonstration, but whether a plan qualified as a benchmark
12 plan was based on its premium after the demonstration's
13 premium reductions.

14 In 2025, 22 of 90 benchmark plans, or roughly one
15 quarter, would not have qualified if selected based on
16 premiums prior to the demonstration's reductions. In 2026,
17 the impact was less severe: 8 of 88 benchmark plans would
18 not have otherwise qualified.

19 This demonstration cost \$6 billion in 2025 alone
20 and is set to continue through 2027.

21 To summarize, there are three key factors that
22 affect the number of benchmark plans in a region, with the

1 magnitude of the difference between PDP and MAPD premiums
2 for basic benefits being most influential.

3 The difference in premiums reflects differences
4 in bids adjusted for risk, which may not appropriately
5 reflect costs. Various program safeguards in place to
6 mitigate access and coverage concerns for LIS
7 beneficiaries.

8 The Part D program is in a period of significant
9 change and continues to evolve. In fact, some regions, in
10 2026, gained benchmark plans.

11 We now turn to our discussion.

12 We will continue to monitor the status of the
13 benchmark market and any relevant changes to the Part D
14 risk-adjustment model. We look forward to your discussion
15 and any questions you may have.

16 DR. CHERNEW: So I think it is time for us to
17 jump into the queue, and I think we're going to start with
18 Gina.

19 MS. UPCHURCH: First of all, thank you both.
20 This is tremendous work, and I really hope it becomes a
21 chapter and gets published, because I think it's really
22 critical for some of the most vulnerable Medicare

1 beneficiaries in America.

2 I'm getting a little confused about what is a
3 Round 1 leading question and what's a Round 2 question, but
4 I'll do my best here. Here's Round 1.

5 MR. MASI: Don't answer this question.

6 DR. CHERNEW: You're in both queues, Gina, so
7 really, it's just...

8 MS. UPCHURCH: That's right. They blend. But
9 here's sort of Round 1. More Medicare Advantage plans are
10 enhanced. Do we know if and how this is somehow related to
11 manufacturer rebates? Are rebates more generous, for
12 example, to plans and PBMs that offer lower deductibles,
13 smaller copays, that kind of thing? Do we have any idea of
14 that?

15 MS. SUZUKI: So, in general, I don't think
16 there's a systematic difference between PDPs and MAPDs. I
17 think it varies by drug product, so it might depend on
18 which drugs the plans' enrollees are taking. I think it's
19 important to note that the insurers that are participating
20 in the two markets, the larger ones are almost identical,
21 and that they're using the same PBMs. And I think a lot of
22 the variation probably derives from the kinds of drugs that

1 are used.

2 MS. UPCHURCH: Okay, I just wondered, because
3 enhanced plans, they can be enhanced in several ways. One
4 is, obviously, having more generous formularies. So I
5 wondered if it was tied somehow to rebates for those types
6 of plans.

7 MR. MASI: Gina, can I ask a quick clarifying
8 question, to your Round 1 clarifying question. Were you
9 wondering about drug rebates or the Medicare Advantage
10 rebates as a result of --

11 MS. UPCHURCH: Sorry. I mean, drug manufacturer
12 rebates.

13 MR. MASI: Oh, okay, okay.

14 MS. SUZUKI: I don't think that is going to
15 directly relate to whether one offers enhanced, that we
16 know of. But I think a lot of the enhanced benefits are
17 funded by the MA rebates, that Paul just mentioned, and,
18 therefore, the premiums for supplemental benefits are
19 either zero or very low.

20 MS. UPCHURCH: Okay. I guess I'm just wondering
21 if drug manufacturers are choosing to have enhanced plans
22 so they have bigger rebates to do other things with. And

1 that would then decrease the number of basic plans.

2 Okay. So related to drug benefits, if more
3 Medicare Advantage moved to enhanced plans, should we
4 assume that some are trying to avoid people with low-income
5 subsidy? As we know, we believe there is favorable
6 selection, and people that are in Medicare Advantage plans
7 versus somebody that might be in traditional Medicare. Do
8 we have a sense that people are trying to avoid sicker
9 people who are eligible for the low-income subsidy in fee-
10 for-service Medicare? And that's the leading question.

11 MS. SUZUKI: So one thing I will say is I think
12 selection work in the MA sector probably drives a lot of
13 selection in the medical world. I don't think we have a
14 good sense of whether that's true in terms of drug
15 spending.

16 MS. UPCHURCH: Okay. All right. Thank you. We
17 care about benchmarks. So Senior Pharmacy, the program I'm
18 work, we work with a lot of people with low-income subsidy
19 that are looking for a benchmark plan, and the reason it
20 really matters is people take more and more brand
21 medications. It's harder sometimes to find plans that
22 cover your mix of brand-name drugs. And if you only have

1 one benchmark plan, does it cover the brand names that you
2 may need?

3 So do we know if fewer benchmark plans have led
4 to more formulary substitutions? We may not know this. Is
5 anyone tracking this, and are there ideas about clinical
6 outcomes about these substitutions that may have to happen
7 because there is only one benchmark plan? Because I think
8 some of you know, and sometimes it's better to pay a little
9 premium to make sure all your meds are covered, even if
10 you're eligible for the low-income subsidy, right, to pay a
11 little premium to make sure you're mixture, or if they're
12 not, there's a therapeutic substitution which, by the way,
13 pharmacists are very involved with, and they get paid
14 nothing for, to do therapeutic substitution to help people
15 get on plans that cover their drugs. Do we have any sense
16 of whether there's a lot of therapeutic substitution going
17 on, because as we have fewer and fewer benchmark plans, and
18 do we know anything about clinical outcomes, because all of
19 a sudden you can't get that insulin, you have to take this
20 insulin. I mean, that's a big deal to a lot of people.
21 And even dosing. You take this statin, and then you're on
22 that statin. I mean, do we know?

1 MS. O'NEILL HAYES: I do not know off the top of
2 my head, and I can certainly look to see if there are other
3 studies that have been done on those specific questions. I
4 do know there are appeals processes that beneficiaries can
5 go through, of course you're aware of. You know, if your
6 drug is not on formulary you can appeal to try and get
7 coverage, so that might be an option. But we can look
8 specifically into the question you're asking about.

9 MS. UPCHURCH: Great. Thank you. That would be
10 super helpful. And then the last question, I know this
11 used to be true, and I'm not sure if it still is, but
12 Medicare Advantage plans, once the bids come out and the
13 benchmarks come out, the Medicare Advantage plan gets a
14 second opportunity to rebid. Do standalone drug plan
15 sponsors get a chance to rebid?

16 MS. O'NEILL HAYES: They do not, and I'll try to
17 provide a little clarity, and I might ask Shinobu to step
18 in if I get this incorrect. My understanding is that
19 they're not necessarily rebidding, but they can adjust the
20 amount of the buydown that they apply to either premium or
21 like supplemental benefits. They can adjust their rebate
22 buydown amounts to try and get to where they want their --

1 MS. UPCHURCH: So they can only take the
2 difference and disburse it differently? They can't change
3 the difference?

4 MS. SUZUKI: So I don't know if this would help.
5 But when MAPD plans bid, they have a target premium amount.
6 But the target premium amount is dependent on the national
7 average bid. And, therefore, when their expectations about
8 the target premium amount doesn't actually match what they
9 got, based on the national average bid, they get to adjust
10 the amount of rebates they apply to hit that target premium
11 amount and bid amount.

12 MR. MASI: And just to be real clear. Shinobu,
13 when you said rebates, in that context we're talking about
14 the rebates that MA plans get as part of the Part C payment
15 system. And then hopefully this clarifies, but we'll see.
16 It's correct that standalone PDPs don't get to rebid in a
17 similar way, obviously because they are just no source of
18 Part C rebates. But there is a little flexibility if
19 you're within a certain de minimis range. Can you say a
20 little bit about that?

21 MS. O'NEILL HAYES: Yes. PDP plans can choose to
22 be a de minimis plan to qualify for a benchmark if they are

1 within a de minimis amount, which is \$2. So if they are
2 within \$2 of the benchmark in their region they can say,
3 "Include us as a benchmark plan, please," and then they
4 forego that portion that is over the benchmark, which would
5 be \$2 or less.

6 MS. UPCHURCH: Thank you, guys, so much.

7 MS. KELLEY: Mike, that's all I have for Round 1.

8 DR. CHERNEW: Fortunately, Gina is going to start
9 Round 2.

10 MS. KELLEY: Yes, she -- oh, I'm sorry, Cheryl.
11 Go right ahead, Cheryl.

12 DR. CHERNEW: That didn't show up on my --

13 DR. DAMBERG: That's because I've been having
14 computer problems. Okay. So I had a question. Among the
15 national carriers, like the dominant players that offer
16 both MA and PDP contracts, can they negotiate combined
17 discounts on drugs for both types of plans, simultaneous,
18 or are there discrete negotiations for each contract type?
19 I'm just trying to understand how they leverage kind of
20 their market power in ways that might benefit one or both
21 of those plan types.

22 MS. SUZUKI: So I think those are confidential

1 negotiation contract terms, but we do not have insight
2 into. When we have looked at rebates for the same drug
3 offered by plan sponsors, it did tend to vary even within
4 the plans offered by the same insurer. And I think that
5 may have to do with the structure of a contract, where the
6 rebate amount may be greater if your volume is higher, for
7 example. And I think there is another element where some
8 plans may have different terms depending on whether you
9 have a low-income beneficiary or a non-low-income. But we
10 don't actually know the negotiation terms to know exactly
11 what they do.

12 MS. KELLEY: All right. Should we go to Round 2
13 now, Mike?

14 DR. CHERNEW: And we now think it's Gina.

15 MS. UPCHURCH: Yes. Thanks. Again, I'm very
16 appreciative of this work and hope we continue it. It
17 would be very helpful, and I think I've mentioned this
18 before, but to have an idea of who and what groups
19 contribute to the Part D plan and how much they contribute,
20 both overall, and then I would love to see it broken down
21 by cost per person of the benefit.

22 Over time, this will help us understand and

1 compare how this contrasts and compares to how we pay for
2 medicines under Part A and Part B. If we can break down
3 brand versus generic, that would be even better. So number
4 one, beneficiary contributions. They pay premiums. They
5 have cost-sharing at the pharmacy or now through paying
6 insurers through the PPP, the pay model protection, the
7 Prescription Payment Plan. So they either pay the insurer
8 at the pharmacy counter and they pay premiums. So what is
9 that total cost? Drug manufacturers. They give discounts,
10 the 10 percent, the 20 percent. There are also rebates
11 that they provide. How much is that, on the back end? We
12 may or may not be able to get that.

13 States pay for full-benefit duals. They
14 contribute to the drug plan, Medicare and capitated direct
15 payments to the Part D plans, and they reinsure the
16 catastrophic phase as well as covering people with low-
17 income subsidy expenses.

18 And then, finally, the plans, which are really
19 just the receivers, the pass-through for the Medicare
20 dollars, to actualize this benefit, but do any of them end
21 up spending more than they make by administering this plan?
22 I would just be curious to know if plans are actually

1 contributing dollars or just passing through Medicare
2 dollars.

3 So just getting a sense of who is paying for it
4 and how much is it. What is the value that is going into
5 each person's drug benefit through Part D.

6 We have low-income subsidy footnotes on two pages
7 that shares 2025 data around what does it cost for generic
8 versus a brand and then the assets testing. We now have
9 2026 numbers. So if we can update that, that would be
10 terrific. And I've got those if we need them.

11 And then it would be helpful to mention the
12 under-enrollment in the low-income subsidy as well as,
13 we're not talking about it now, but the Medicare savings
14 programs, the Part B assistance programs. It's really
15 tough to reach people who are eligible for the low-income
16 subsidy. And current law is making it even more
17 cumbersome. There had been some suggestions to use
18 automation to help people, to use other systems that have
19 their income and assets to see if they're eligible for Part
20 D assistance, but that is done away with. So even as we're
21 using AI for more things, we have stopped automation in
22 helping low-income people with Part D. And that is very

1 disappointing, but is the case.

2 So do we know how many people, and should we
3 mention there are, I think, about a third of people who are
4 eligible for low-income subsidy in Medicare savings
5 programs are not enrolled.

6 And then given a person's mix of brand medicines,
7 as we talked about, again, I just wanted to make this
8 point. Sometimes it is better for them if we don't have
9 therapeutic substitution or we can't appeal to actually
10 have people and pay a little bit of premium to ensure that
11 the medicines they need are covered. So just to make that
12 point.

13 But again, I really appreciate the great work.

14 MS. KELLEY: Brian.

15 DR. MILLER: Thank you. A great chapter. I'm
16 going to admit, Part D is very challenging, so it was much
17 clearer after reading this chapter. So I appreciate the
18 succinctness and organization.

19 And I wanted to take a couple sort of steps back
20 and sort of zoom out of it for Part D for us, because I
21 thought it might be helpful. Plan prices reflect the cost
22 of constituent goods and services, and there are some

1 admin costs on that and some profit. I think we all wish
2 that those non-clinical costs would be lower.

3 One of my friends is the North Carolina
4 Treasurer, and he's not a health care person so I think his
5 thoughts sort of about health care actually help me a lot.
6 And his framing, to me, was, because I said all this health
7 care stuff, and he's like, "No, no, no. We need lower unit
8 costs without nonsense." And I thought that was a really
9 good framing.

10 So the standalone Part D market is super
11 important for benes to have access to fee-for-service,
12 because you have to shop and you buy Medigap, or you get
13 Medigap through Medicaid or something else, and then you
14 buy a standalone D. So if we want people to have actual
15 choice, not fake choice but real choice, we need a
16 standalone Part D market that actually works, which is why
17 I think we all are concerned about standalone Part D plans.

18 And then we're saying plan prices are high, and
19 then the benchmark plans are exiting, and the reason
20 benchmark plans are exiting is it's hard to construct that
21 smaller benefit without the sort of add-ons, and the tools
22 that plans have are limited, right. They have benefit

1 design. They have network design. They have other
2 insurance tools. And those are breaking with high drug
3 prices.

4 So the Part D costs have gone a little bananas.
5 They've gone bananas because we've seen some product
6 manufacturers are very well behaved, and other product
7 manufacturers are not as well behaved. And we've seen
8 things that Stacie and Gina and others are more familiar
9 with than I, to be honest, you know, manipulation of
10 patents, manipulation of exclusivity, abusive of FDA
11 regulatory mechanisms like the citizen petition process.
12 So all this drives up costs, and then, oh, by the way, we
13 have a biosimilars market that's not actually functioning
14 as a generics market, so then you have specialty outpatient
15 biologic drugs, which the Part D plans, which are a
16 commodity product, are struggling to then price into their
17 premiums. And then Part D premiums go up and plans exit,
18 and then fee-for-service isn't a viable option for the
19 bene, which is not fair. You want a viable set of choices
20 between fee-for-service, ACO, and MA.

21 So, fundamentally, drug pricing broke our nice
22 Part D model. It was a pretty good model, and it was

1 broken through drug pricing, and that's why Congress
2 responded with the IRA, and the administration has
3 responded with MFN, because I think everyone is super
4 frustrated. At least that's my sense from listening to our
5 prior discussions on Part D, and you all can correct me if
6 I'm wrong.

7 So if we're going to have a viable, standalone
8 Part D market, which is what I viewed this chapter is about
9 -- and again, steer me if I'm reading it wrong -- this
10 information is a good level set for us, but I think if the
11 Commission wants to think about sort of what our
12 assumptions in benefit design are for Part D, do we still
13 think six protected classes is the right answer? That's
14 expensive. I understand why we have protected classes.
15 Maybe that needs to be reconsidered.

16 Another this is Part B drugs are weirdly over in
17 the medical benefit. Do we need to move them to the
18 outpatient prescription drug benefit to make that benefit
19 more viable, and let the physician-administered services
20 focus more on physician services and take that drug
21 component out of there and move it into the D model?

22 Another thing we talked about at a prior meeting,

1 outside of our jurisdiction, the patent and exclusivity
2 issues. There's a need for an abbreviated biologic license
3 application pathway to make biosimilars cheap.

4 And then I think another thing to think about is
5 can we expand the practice of community pharmacy, an
6 independent community pharmacy, and can we empower
7 community pharmacists to start small, standalone Part D
8 plans? Because who better to provide insight into
9 formulary construction than the pharmacist who actually
10 deals with patients every day? And I would say there is
11 one example that I know of, of a pharmacist-owned pharmacy
12 chain that created a standalone Part D plan market, and I
13 believe it's KPH in upstate New York, Kinney Drug, and
14 someone can correct me if I'm wrong.

15 The other thing I noted, which is not in this
16 chapter but doesn't necessarily need to be in this chapter,
17 is that the MAPD enrollment is also decreasing because
18 Medigap is super expensive and Part B premiums are
19 unaffordable. So that's sort of another outside this
20 chapter, but playing into, perhaps, some of the pressures
21 in the standalone Part D market.

22 And then a final thought is I know folks are

1 concerned about too much choice in MA and then too little
2 choice in Part D. And I think that we just need to be
3 really consistent and careful. And we have pretty good
4 evidence in other markets that choice and competition
5 results in better price competition and better non-price
6 competition, both of which benefits consumers. So we
7 actually want more competition. And that we have little
8 evidence that that choice and competition actually harms
9 consumers in those markets.

10 So I think we want more competition in MA
11 markets, and I realize people might have different thoughts
12 about whether that's price or non-price competition. I
13 think both are good. And I think we want more price and
14 non-price competition in the part D market, too. Thank
15 you.

16 MS. KELLEY: Stacie.

17 DR. DUSETZINA: Great. Thanks for this fantastic
18 work. I felt myself a couple of times being challenged by
19 it, so I was kind of wondering how everybody else was
20 hanging in there, because it is a lot, a lot of dense
21 material.

22 I had a question, and this is probably a little

1 bit more of a Round 1 question, on the first one. On page
2 16 of the chapter you mentioned that the share of people
3 with LIS who are in a one or two below benchmark PDP
4 situation, is 68 percent of LIS beneficiaries, phasing one
5 or two below benchmark. And I wondered if we know if those
6 are different plan sponsors or if it's like the same plan
7 sponsor? So is it the same company or different companies
8 in that situation, when there are two?

9 MS. O'NEILL HAYES: When there's two? Each one
10 of those is going to have to be from a different sponsor,
11 because each sponsor can only have one basic PDP per
12 region. So they can't have two benchmarks in a given
13 region.

14 DR. DUSETZINA: Okay. Thank you. The other
15 things that I just was trying to work through in my mind
16 and figure out how they might work were thinking through
17 the issues around the bids and kind of the differences
18 between MAPDs and PDPs, and the way that PDPs can segment
19 the population much more clearly. So you have these
20 special needs plans that are for dual-eligible populations,
21 whereas the PDP is also going to have to try to make that
22 plan maybe potentially attractive to non-LIS beneficiaries.

1 And I was trying to parse out exactly how the
2 special needs plan enrollees count. I think what I saw is
3 that you said that the special needs plans are included in
4 the benchmarks for the weighted average premium but not in
5 the bids. But I wanted to double-check that, and if that's
6 true, I was just trying to work through in my mind, how do
7 we then account for that? It seems like the deck is always
8 going to be stacked so that PDPs are always going to just
9 be more expensive, because the benefits that they're
10 offering maybe just look a little different.

11 MS. O'NEILL HAYES: Yeah. So first to make sure
12 I'm understanding right and maybe provide a little clarity.
13 SNP premiums are included as their LIS share, and their
14 premiums are included in the weighted average. They do
15 also submit bids, but their bids are not included in the
16 NAMBA. So that was one piece I wanted to make sure we
17 clarified.

18 And then in terms of the effect of SNPs and LIS
19 benes moving into those plans, and then their premiums
20 counting for the benchmark but not in NAMBA, is something
21 we have talked a lot about, and to be honest, we don't have
22 a clear picture of what we think that effect is. And

1 Shinobu, do you want to say a little bit more?

2 MS. SUZUKI: I'll just add that when we talked to
3 actuaries about this particular issue, that SNPs are not
4 included in NAMBA, the effects of excluding SNPs from NAMBA
5 calculations likely depends a lot on their risk scores
6 relative to their costs, because bids are standardized, the
7 risk scores for their enrollees. And it was not clear to
8 us whether we had expectations about which direction that
9 effect is.

10 DR. DUSETZINA: Okay. That's really helpful.

11 MR. MASI: I'm so sorry to jump in, but I want to
12 make sure we also tease out something else you were talking
13 about, Stacie. And I think you raise a good point that
14 there are features of the special needs plan program, for
15 example, being able to tailor benefits to a specific
16 population, being able to select like a specific service
17 area within a region, that make a lot of sense for that
18 model, but create differences with how standalone PDPs are
19 able to operate that then produces some static when we try
20 to put these things together.

21 DR. DUSETZINA: Piggybacking on something that
22 Gina also had mentioned was this issue of maybe providing a

1 little bit more clarity around the cost-sharing and what
2 those look like under the LIS plans. This gets a little
3 bit back to this issue of the MAPDs, because they can
4 segment the population better, they may max out on
5 deductibles and have higher cost-sharing because they know
6 that's not borne by the beneficiary. So then your premium
7 can look really attractive versus in the PDP market.

8 It might be that everybody is coalescing around
9 the higher deductibles and higher cost-sharing anyway now,
10 but that's just one that I feel like could be helpful.

11 And I think it would be useful for people to
12 understand, for this market, who is paying those different
13 components. So when they set a maximum deductible amount
14 on those plans, that that's not actually coming from the
15 beneficiary.

16 One of the other things that I found to be really
17 interesting, and I appreciated how well you walked through
18 the safeguards from beneficiaries and how drug access might
19 still be okay even with one plan. But then in Table 2 in
20 the chapter, where you show the difference in the premiums
21 between the lowest premium and the next premium for the
22 PDPs, it made me wonder a lot about that. It was like, on

1 average, about \$55, and that is a huge amount of money. So
2 to Gina's point, if, for some reason, the one point below
3 benchmark PDP in your area does not cover your drugs, and
4 you can't appeal and get it, you don't really seem to have
5 any kind of low-cost options to move into in the PDP
6 market. So I think that's a really, really important
7 issue, and one of the reasons the one plan is kind of a
8 tricky thing, because that's a high premium. Like \$55 is a
9 lot of money for a PDP premium.

10 MS. O'NEILL HAYES: Yeah, in that table we showed
11 that 66 percent of the PDP LIS enrollees were in the
12 benchmark plan in those regions, and only three were in the
13 next highest PDP. So yeah, it's clearly making a
14 difference for them.

15 DR. DUSETZINA: Yeah, exactly. Because like
16 you're not going to move into that. So maybe your only
17 option then is an MAPD plan, if you really are premium
18 sensitive but you need to go to a different plan to get
19 your drug. And I don't know how often that happens.

20 But overall I think this is exceptional work. I
21 think it is important to continue to monitor. One of the
22 things for future in this work, I think, is also

1 considering the plan sponsors themselves, and when you're a
2 plan sponsor, who is the one below benchmark PDP. You have
3 an MAPD, and what does that MAPD look like in that region.
4 Just trying to think through incentives that plans might
5 have.

6 But again, fantastic work, as always.

7 MS. KELLEY: Mike, that's all I have in the
8 queue, unless I've missed someone.

9 DR. CHERNEW: No, that was all I had in the
10 queue, too. Let me make -- we have Kenny in the queue.

11 MR. KAN: Thank you for the insightful analysis.
12 The analysis suggests a structural mismatch issue in that
13 the system uses MAPD to set the price, but MAPD is excluded
14 from qualifying as a benchmark plan. That's the mismatch.
15 You have a blended pricing rule, and a restricted
16 eligibility rule. This strikes me as a government pricing
17 rule that distorts competition by mixing two different
18 markets but only allowing one to participate in the subsidy
19 outcome. Very unusual.

20 CMS has recognized this issue and has begun
21 addressing the concern by fixing the risk adjustment
22 between PDP and MAPD, first in '26, and now in the recently

1 released 2027 final MA rates.

2 I really like the current analysis and recommend
3 that any additional future analysis explore the feasibility
4 of the following potential solutions.

5 Number one, can we separate the benchmark systems
6 by creating PDP-only benchmark plans while allowing MAPD to
7 offer independently? This eliminates cross-market
8 distortion, but could increase federal subsidy costs, I
9 believe.

10 Number two, perhaps modify the LIS weighting in
11 the benchmark formula. This reduces the MA dominance in
12 the benchmark calculation which could help stabilize the
13 PDP benchmark but does not fully resolve this structural
14 inconsistency.

15 And three, possibly allow MAPD to qualify as
16 benchmark plans. This rewards efficiency, expands
17 beneficiary choice, and likely lowers federal costs. Thank
18 you.

19 DR. CHERNEW: Any other late queue-jumpers? Were
20 you serious? Okay.

21 MS. KELLEY: Cheryl.

22 DR. DAMBERG: I'll plus-one Kenny's comment about

1 having separate benchmarks, separate risk adjustment.

2 But one of the things that I couldn't remember
3 this, have you done any qualitative interviews with the
4 plans to try to get their sense of what's going on?

5 MS. O'NEILL HAYES: Somewhere in the last year.
6 This wasn't the specific topic, but it is something that
7 came up as we were talking to them. So we've had
8 conversations but not formally specifically on this topic.

9 DR. DAMBERG: Okay. I would encourage, you know,
10 if there's more work in the future, that we do some
11 qualitative work, just to try to get the lay of the land
12 from the people who are experiencing it on the ground.
13 Because I do have concerns, and I think this is really a
14 nice summary of what's happening in the space, and I'm
15 concerned for the long-term stability of this part of the
16 market, and given the importance for all those people are
17 who in the fee-for-service side of Medicare. So thanks.

18 DR. DUSETZINA: Cheryl reminded me. I had
19 recalled one of the comments made from those prior
20 interviews that she just asked about. And I think it was
21 something to the effect of if you're going to miss the
22 benchmark, really miss it. Like just go really high. And

1 I think that is reflected in that huge premium difference
2 between the low benchmark and the next lowest. So that's
3 what came to my mind when I was reading this chapter.

4 DR. CHERNEW: Now I think I'm going to summarize.
5 It took a bit to get there -- this was a great discussion -
6 - but my original summary before I was preempted was going
7 to be very much on the lines of what Kenny said, which is
8 there is this core question that we have essentially
9 integrated the standalone PDP. Brian started with we need
10 a functioning standalone PDP market, and, of course, we
11 have a market we call standalone PDP, but that market is
12 not standing alone, is part of TM, and particularly in the
13 PDP part we have integrated.

14 In a lot of the things, what's happening on the
15 PD side, the MDPD, with the formulas that create, for
16 example, benchmark plans. And as Kenny pointed out,
17 there's been some efforts to separate that, in part, the
18 risk adjustment stuff which you talked about in the rules,
19 that's true. But we haven't really explored that type of
20 connection. We basically treat PD plans as if they're just
21 in the same market as standalone PD plans. And as has been
22 pointed out, there are substantial differences. And Kenny

1 outlined some things that you all can decide if you want to
2 do.

3 But the only other thing I'll say about this is,
4 it's harder for me to think through separating them out
5 than you might think, because many organizations, the
6 sponsors, that are in one market or in the other market.
7 So you can try and separate them out mathematically but
8 you're not going to get organizations that are sort of
9 separate. And then there's also integration between these
10 same sponsors and the PBMs and the MA plans themselves.

11 So the challenge is having people who may not
12 want to be in MA, for whatever reason -- the networks
13 aren't right or whatever it happens to be -- have to join
14 an MA plan if they want access to some version of that.

15 So I think there are going to be a lot of
16 tradeoffs in what that basically means, given that there
17 are so many different types of integration floating around
18 in this already unbelievably complicated market.

19 But again, as Brian said, this was a really
20 useful level-setting exercise, to just see what's going on,
21 and just to work through the formulas, as sort of Stacie
22 alluded to -- leaves you thinking, these are complicated

1 formulas, where understanding sort of the rules between the
2 different groups and the implications for other parts of
3 the formulas is challenging.

4 So I hope you all continue aspects of this work,
5 but at least I think here you can tell from the discussion
6 it really was educational. I do think this is actually
7 important because you do need a well-functioning drug
8 benefit for people that don't want to be, for whatever
9 reason, in Medicare Advantage plans, and how to make that
10 work matters. So I guess that makes this a topic worth
11 continuing, and I guess that was the core. So what I hear
12 fundamentally is there is interested in broadly continuing
13 this, so we will let others ponder that.

14 But for now we're basically at 3:00, and so we're
15 at time. We're going to take a five-minute break. We're
16 going to come back at 3:05, and we will talk about pharmacy
17 and access to pharmacies. Thank you.

18 [Recess.]

19 DR. CHERNEW: Okay. We're back. You know, we
20 often talk about we don't spend a lot of time really
21 delving into what's happening in the pharmacy market. It's
22 obviously a very important aspect of care for individuals.

1 And so I think we're looking forward to hearing what we
2 have about preferred networks and pharmacy access in Part
3 D. And I guess Shinobu, you are going to start us off.

4 MS. SUZUKI: Good afternoon. We're here to
5 present our work on pharmacy networks and access in
6 Medicare Part D. This work is not intended as a June 2026
7 report chapter. We may further expand this work depending
8 on Commission interest. As a reminder, a PDF of these
9 slides is available on the right-hand side of your screen.

10 In this presentation, I will start with a brief
11 background and motivation for this work. Then Renuka will
12 walk through what's been happening in the retail pharmacy
13 market, describe Part D pharmacy networks, and how recent
14 pharmacy closures may have affected Part D pharmacy
15 networks.

16 In Part D, beneficiaries obtain prescription
17 drugs through plans' pharmacy networks. Part D plans
18 contract with pharmacies to form plan-specific pharmacy
19 networks that must meet convenient access standards which
20 vary by urbanicity. For example, in urban areas 90 percent
21 of beneficiaries must live within two miles of a pharmacy.
22 These networks determine where beneficiaries can fill

1 prescriptions at in-network rates. As a result, networks
2 can influence both the cost and convenience of obtaining
3 medications.

4 Many plans further designate a subset of in-
5 network pharmacies as preferred cost-sharing pharmacies,
6 where cost sharing amounts are lower than at other in-
7 network pharmacies.

8 Closures of retail pharmacies have accelerated
9 since 2022, affecting both chain and independent
10 pharmacies. Multiple factors have been cited as driving
11 pharmacy closures, including declining reimbursement,
12 rising costs, and market shifts toward mail-order and big-
13 box stores. Several studies have found that pharmacy
14 closures disproportionately affect rural and underserved
15 communities, raising concerns about access to pharmacy
16 services in those communities.

17 Pharmacy closures may directly affect Part D
18 pharmacy networks and beneficiary access, by reducing the
19 number of retail pharmacies available for Part D plans to
20 contract with, which may alter network composition and
21 increase the likelihood of network gaps for beneficiaries
22 in areas with few pharmacies. Pharmacy closures may also

1 contribute to increased network turnover, or "network
2 churn," even if overall network size remains stable, which
3 may affect beneficiary access.

4 Now Renuka will describe the trends in the retail
5 pharmacy market and findings from our analysis of Part D
6 pharmacy networks.

7 MS. DEWAN: Thank you, Shinobu.

8 This figure shows the trends in the number of
9 retail pharmacies from 2018 to 2025 by urbanicity category,
10 with the largest being metropolitan, in orange, and
11 micropolitan and rural shown in gray and blue,
12 respectively.

13 Between 2018 and 2025, the number of retail
14 pharmacies declined by about 1.2 percent per year, on
15 average. The decrease accelerated in recent years,
16 declining by roughly 2 percent and over 3 percent in 2024
17 and 2025. This pattern is observed across all urbanicity
18 categories, with declines of similar magnitude in
19 percentage terms.

20 We find that pharmacy ownership varies across
21 geographic areas. This figure shows the share of
22 pharmacies by ownership type across urbanicity, with

1 independents in blue and chains in orange. Metropolitan
2 ZIP codes have the highest average chain share, with chain
3 pharmacies accounting for nearly 60 percent of pharmacies.
4 This share was lower for micropolitan ZIP codes and the
5 lowest for rural ZIP codes.

6 Rural ZIP codes were predominantly served by
7 independent pharmacies, which made up more than 60 percent
8 of pharmacies. As a result, the effects of pharmacy
9 closures on access may vary by urbanicity, as closures of
10 chains versus independents may have different implications
11 across areas.

12 Pharmacy closures increased substantially from
13 2021 to 2025, driven in large part by chain pharmacies. In
14 2021, there were about 1,700, but in 2025, there were
15 nearly 4,000. By 2025, chain pharmacies accounted for the
16 majority of closures, making up about 62 percent of all
17 closures, up from 25 percent in 2021.

18 Closure rates increased across all geographic
19 areas, with higher rates in metropolitan and micropolitan
20 areas. Over this period, entries did not keep pace with
21 exits, resulting in a net decline of the total number of
22 pharmacies. These trends may have important implications

1 for pharmacy network composition and for churn in plan
2 networks.

3 One way to measure pharmacy access is to
4 determine the availability of pharmacies within a
5 geographic unit. For example, there are about 40,000 ZIP
6 codes but about 3,000 counties. Calculating the share of
7 beneficiaries with and without a pharmacy in their ZIP code
8 would capture access within a smaller region. However,
9 this may overstate lack of access if beneficiaries travel
10 to nearby ZIPs to access a pharmacy. Estimates can be
11 viewed as an upper bound on the share of beneficiaries
12 without access.

13 Using a county-level measure would capture access
14 within a broader area. However, this may understate access
15 barriers, especially in rural area. Estimates can be
16 viewed as an approximate lower bound on the share of
17 beneficiaries without access. However, even within a given
18 geography, beneficiaries near ZIP code or county borders
19 may have "convenient access" to pharmacies.

20 We examined the share of beneficiaries in ZIP
21 codes with no retail pharmacies as a proxy measure of
22 potential access constraints. Between 2018 and 2025,

1 beneficiaries residing in ZIP codes with no pharmacies
2 increased from just under 12 percent to 13 percent. In
3 2025, the share of beneficiaries in ZIP codes with no
4 pharmacies varied by urbanicity, ranging from 10 percent
5 among beneficiaries residing in metropolitan ZIP codes to
6 over 30 percent for beneficiaries residing in rural ZIP
7 codes.

8 The shares of beneficiaries residing in ZIP codes
9 with no pharmacies increased over time for all urbanicity
10 categories, with larger increases observed among
11 beneficiaries residing in micropolitan and rural ZIP codes.

12 To examine beneficiary proximity to pharmacies
13 over larger geographic areas, we conducted a similar
14 analysis using counties rather than ZIP codes. At the
15 county level, the share of beneficiaries without a pharmacy
16 nearby is much smaller. While a meaningful share of
17 beneficiaries live in ZIP codes without a pharmacy, very
18 few live in counties without one. In 2025, about 13
19 percent of beneficiaries lived in ZIP codes with no
20 pharmacy, but less than 1 percent live in counties without
21 one.

22 This pattern holds across urbanicity. In rural

1 areas, for example, about one-third of beneficiaries live
2 in ZIP codes with no pharmacy, compared to just over 1
3 percent at the county level.

4 Taken together, this suggests that most
5 beneficiaries do have access to a pharmacy within their
6 broader local area, even if there isn't one located
7 directly in their ZIP code.

8 Patients may obtain chronic and specialty drugs
9 via mail. Mail-order pharmacies could improve access for
10 individuals residing in areas with few or no retail
11 pharmacies. The decrease in the number of retail
12 pharmacies does not appear to have led to a corresponding
13 increase in the use of mail-order pharmacies.

14 Between 2018 and 2024, the share of Part D
15 prescriptions from mail-order pharmacies remained
16 relatively stable, fluctuating between 14.6 percent and
17 15.7 percent. Specialty pharmacies accounted for less
18 than 1 percent of all Part D prescriptions. Use of mail-
19 order pharmacy may differ by individual's access to retail
20 pharmacies.

21 With that context in mind, we now turn to Part D
22 pharmacy networks and the use of preferred designation.

1 As a first step, we limit our analysis of Part D
2 pharmacy network size and coverage to standalone PDPs.
3 Constructing comparable measures for MAPDs is more complex
4 because there are thousands of MAPDs and each may define
5 service area on a county-by-county basis. We could examine
6 MAPDs in future work if there is interest.

7 For each PDP plan, we construct measures of
8 pharmacy access using the Part D pharmacy network files.
9 We calculate the number of in-network pharmacies for each
10 plan within their PDP region. Using this count, we
11 construct the PDP region coverage rate for each PDP plan,
12 defined as the share of pharmacies in the region that
13 participate in the plan's network.

14 Our analysis found that PDP pharmacy networks
15 offer broad coverage. On average, in 2025, plan networks
16 included about 90 percent of the pharmacies within their
17 PDP regions. The composition of these networks closely
18 mirrors local pharmacy markets. That said, networks
19 modestly favored chain pharmacies. PDP regions are
20 roughly 60 percent chain pharmacies. The chain share in
21 PDP networks is about 4 percentage points higher, or 64
22 percent on average.

1 The extent to which chains are overrepresented in
2 networks varied across plans, typically ranging from about
3 1 to 8 percentage points, with most plans in the 3 to 5
4 point range. These patterns are consistent across plan
5 types, with basic, enhanced, benchmark, and non-benchmark
6 PDPs showing similar levels of coverage and modest chain
7 overrepresentation.

8 Plans may use preferred networks to offer lower
9 cost sharing, creating price differentials across
10 pharmacies. One study finds that some beneficiaries
11 respond to those price signals by choosing preferred
12 pharmacies. This response is observed mostly among non-LIS
13 beneficiaries. LIS beneficiaries are insulated from cost-
14 sharing differentials.

15 For non-LIS beneficiaries, preferred pharmacies
16 can lower out-of-pocket costs, with evidence showing
17 meaningful savings for those who switch to preferred
18 pharmacies. On the pharmacy side, preferred status may
19 involve a trade-off between lower reimbursement and higher
20 prescription volume.

21 Preferred pharmacy networks have been widely used
22 in Part D. In 2024, about 96 percent of PDP enrollees were

1 in plans that designated a subset of in-network pharmacies
2 as preferred. In 2025, on average, about 44 percent of in-
3 network pharmacies were designated as preferred.

4 Preferred status differs sharply by ownership
5 type. Roughly two-thirds of network chain pharmacies are
6 designated as preferred, compared to only about 3 percent
7 of network independent pharmacies. Over time, preferred
8 networks have evolved and become increasingly concentrated
9 among chain pharmacies.

10 We next examine how access to in-network and
11 preferred pharmacies differs across urbanicity. In this
12 figure, the blue bars show the share of PDP enrollees
13 living in ZIP codes with no pharmacy. The orange bars
14 display the share of PDP enrollees living in ZIP codes with
15 no in-network pharmacy. As you can see, the dark blue and
16 orange bars are nearly identical, meaning that access to
17 in-network pharmacies largely mirrors whether a pharmacy is
18 present in the ZIP at all.

19 Nationally, about 15 percent of PDP enrollees
20 live in ZIP codes with no in-network pharmacy, ranging from
21 about 10 percent in urban areas to over one-third in rural
22 areas.

1 The grey bar shows the share of PDP enrollees
2 living in ZIP codes with no preferred pharmacy. Among PDP
3 enrollees in plans with a preferred tier, about 29 percent
4 lack a preferred pharmacy in their ZIP code, rising from 23
5 percent in metropolitan areas to over 60 percent in rural
6 areas. This likely reflects network design. We have found
7 that preferred pharmacies consist primarily of chain
8 pharmacies, while independents, which make up a larger
9 share of pharmacies in rural areas, are less often
10 designated preferred. However, as discussed earlier, these
11 access measures are sensitive to the geographic unit used.

12 Building on the ZIP-level results, we examine
13 access using counties, which capture a broader geographic
14 area. At this level, access to in-network pharmacies is
15 nearly universal. The share of beneficiaries without
16 access falls from about 15 percent at the ZIP level to less
17 than 1 percent overall, and remains very small even in
18 rural areas, about 2 percent.

19 In contrast, gaps persist for preferred
20 pharmacies. Nationally, the share without access declines
21 from about 29 percent at the ZIP level to 5 percent at the
22 county level, but does not disappear.

1 These disparities are concentrated in rural
2 areas. Even at the county level, about 36 percent of rural
3 beneficiaries lack access to a preferred pharmacy, down
4 from roughly 65 percent at the ZIP level, which is still
5 substantially higher than in metropolitan areas. Again,
6 this is likely related to the network design, in which
7 preferred pharmacies primarily consist of chain pharmacies
8 and a limited availability of chain pharmacies in rural
9 areas.

10 Overall, while broader geography largely resolves
11 access to any in-network pharmacy, access to preferred
12 pharmacies remains meaningfully limited, especially in
13 rural areas.

14 Between 2021 and 2025, there was a modest
15 increase in participation rates, the share of pharmacies in
16 a PDP region participating in PDP networks. However,
17 trends in the aggregate number of pharmacies may obscure
18 underlying turnover in network participation. What we
19 refer to as "network churn" captures these dynamics,
20 reflecting both exits from and entries into plan networks.

21 Pharmacy exits from networks can occur for two
22 main reasons. First, there are market exits, where

1 pharmacies permanently close. And second, contract exits,
2 where pharmacies remain open but leave a plan's network due
3 to changes in contracting arrangements. Similarly, entries
4 into networks can reflect either new pharmacy openings or
5 existing pharmacies joining a network through new
6 contracts.

7 Pharmacy exits from networks increased notably
8 between 2022 and 2024. The total exit rate rose from about
9 3.7 percent in 2022 to 8.1 percent in 2024. Both pharmacy
10 closures and contract-related exits increased over this
11 period, though closures accounted for the majority of
12 exits.

13 Preliminary evidence shows that, similar to
14 overall retail pharmacy trends, pharmacy network entries
15 did not fully offset network exits, contributing to a
16 decline in overall network size.

17 To summarize, pharmacy closures may affect Part D
18 enrollees' access to pharmacy services, particularly in
19 areas with limited availability of pharmacies. Assessing
20 beneficiary access is difficult and requires making
21 decisions about geographic level. Results are sensitive to
22 the geographic unit used. In some areas, potential access

1 issues may be overstated when using a narrow geographic
2 boundary, for example, ZIP codes, and understated using a
3 broader boundary, such as counties. We observed lower
4 access to preferred pharmacies in rural areas compared with
5 other areas.

6 Access to pharmacy and medications is also
7 influence by other factors, including the use of mail-order
8 drugs and the availability of pharmacies in nearby ZIP
9 codes or counties.

10 We now turn to our discussion.

11 Over the last several years, pharmacies have
12 faced changes related to their Part D line of business as
13 well as broader changes affecting the entire sector. We
14 plan to continue to monitor pharmacy networks and
15 beneficiary access.

16 We plan to conduct focus groups with pharmacists
17 during the next cycle and continue our work on pharmacy
18 networks, including an additional analysis to examine the
19 effects of pharmacy closures on beneficiaries' access to
20 medications.

21 That concludes our presentation and we look
22 forward to your discussion. Thank you.

1 DR. CHERNEW: Thank you so much, both of you.
2 This is, I think, in many ways new material for us but very
3 important. So we're going to jump into Round 1, and if
4 I've got this right, Greg is first.

5 MR. POULSEN: Thank you. First off, a really
6 remedial question. I couldn't see it as I looked through.
7 What is our definition of chain pharmacies? I mean, it's
8 obviously -- I shouldn't say that -- I assume it's
9 obviously the Walgreens, CVS. But is it grocery stores and
10 others that are national in scope but also have a pharmacy?

11 MS. DEWAN: Yeah. So those would also be
12 considered big-box pharmacies. We don't include like long-
13 term care hospital pharmacies, but we do keep anything
14 that's considered a chain pharmacy.

15 MR. POULSEN: So if it's part of Kroger or
16 something like that, we consider it chain in terms of what
17 we're defining. Is this true?

18 MS. SUZUKI: We can probably get back to you on
19 this. But the key data source that we used for this
20 analysis is NCPDP's definition of chain versus independent
21 pharmacies. So we can verify exactly where the big-box
22 stores would be classified.

1 MR. POULSEN: Okay. I think that would be
2 helpful, because the vulnerability of a pharmacy that's
3 part of a large organization, even though it may not be a
4 pharmacy organization, may be quite different than a
5 family-owned, single-site kind of a place.

6 The other question that I had, which was related
7 ever so slightly to that, is as some of us may remember
8 there was a huge growth in the chain pharmacies. In this
9 case I am speaking explicitly about the pharmacy-focused
10 stores, back between 2002 and 2015, when a large number of
11 those aspired to becoming primary care sites of care, and
12 there was an enormous growth, and percentages at least as
13 big as the ones we're seeing declines in today.

14 Do we know to what extent that reversion is
15 because of the failure to succeed in primary care versus
16 the failure to be successful in delivering drugs?

17 MS. SUZUKI: So our data analysis won't give you
18 answers to those questions, but I think based on our review
19 of press releases and other news articles, and some
20 literature suggests that there are multiple reasons. They
21 do not specifically say that primary care angle was the
22 reason for closures. I think there are lots of business

1 decisions that are made for closing.

2 MR. POULSEN: I think that's really helpful. But
3 I think it's very germane, when we think about is this
4 something that is being driven because of failure in drug
5 coordination or is it because of a business strategy change
6 or business strategy failure unrelated to the drug business
7 per se. So anyway, thanks very much. Great stuff, by the
8 way.

9 MS. KELLEY: Tamara.

10 DR. KONETZKA: Thanks for this work. I learned a
11 lot by reading this chapter. I find it a little mind-
12 boggling. I think we're used to thinking about formularies
13 and drug pricing tiers that beneficiaries have to navigate,
14 and then we're kind of used to, at least on the provider
15 side, thinking about in-network and out-of-network, and
16 here we're laying on top of that preferred and not
17 preferred. It's a lot to sift through.

18 And I was wondering, as I read the chapter, how
19 to make sense of all of it in terms of the impact on
20 beneficiaries, and especially in terms of the preferred and
21 the non-preferred. I think the numbers were pretty
22 striking in the number of areas where people don't have

1 access to a preferred pharmacy. I think you said, in your
2 presentation, that this could be a meaningful difference.

3 Do we have a sense of, like, how much more, on
4 average, do beneficiaries pay if they don't have access to
5 a preferred pharmacy in their area? Like how much does all
6 this matter?

7 MS. DEWAN: The cost-sharing agreements are
8 obviously different from plan to plan and pharmacy to
9 pharmacy. That's something I definitely want to look into.
10 I think that we know that beneficiaries benefit from
11 preferred pharmacies, but we also know that they might have
12 access to preferred pharmacies through mail-order preferred
13 pharmacies. So we definitely want to look more into where
14 they're getting their cost-sharing savings.

15 DR. KONETZKA: Yeah, it would be really good to
16 get a sense of, do we need to really worry about this or
17 not, or do things just get worked out?

18 MS. SUZUKI: I would just add that as Renuka
19 mentioned in the presentation that this would affect non-
20 LIS beneficiaries but not the low-income population.

21 DR. CHERNEW: In terms of what they pay, but it
22 could affect them for a bunch of other reasons.

1 MS. KELLEY: Cheryl.

2 DR. DAMBERG: I wanted to follow on Tamara's
3 comments, because I found myself wondering how, for people
4 who live in rural areas, who have less access to preferred
5 pharmacies, how their out-of-pocket costs differ from those
6 who live in areas where there is good availability of
7 preferred pharmacies. And I don't know whether they hit
8 their out-of-pocket max earlier in the year. I don't know
9 if you know this. Maybe it's something we could look into
10 in the future, because I do think it's, to Tamara's point
11 about, does it make a material difference.

12 And then I had two other questions. In terms of
13 a pharmacy closure among the chain pharmacies, do we know
14 whether they are occurring predominantly in lower-SES
15 neighborhoods, or is it pretty uniform distribution around
16 the country?

17 MS. DEWAN: We can look into that. I know that
18 there is a lot of concentration in metropolitan areas of
19 chain closures. I think that's where they tended to
20 proliferate to begin with, as a baseline. But we can look
21 into that.

22 DR. DAMBERG: Right. And I wasn't exactly sure

1 because I think I read recently that CVS is launching these
2 new pharmacy-only and it's not going to be a big store. So
3 maybe this will sort of compensate for some of that.
4 Obviously, kind of following that storyline a bit would be
5 important.

6 And then my last question is, when I think about
7 these PDP networks favoring chain pharmacies, do we know
8 whether that's because of vertical integration between the
9 pharmacy, the PBM, and the insurer? Is there any way you
10 can sort of better unpack that story line?

11 MS. DEWAN: Yeah. That's something we suspect
12 and want to look into. But I think that we know that a lot
13 of these plans sort of tend to have agreements with these
14 chains, and that tends to be the way that the preferred
15 networks get set up. But actually linking them is
16 something we haven't done yet. We'll look into that.

17 MS. KELLEY: Paul.

18 DR. CASALE: Thanks for this work. It's really
19 terrific. Just a quick question. On the slide on the
20 geographic variation and pharmacy ownership, which was for
21 2025, you know, I live in a relatively rural area of
22 Pennsylvania, and over the years, as I drive around, I see

1 all the independent pharmacies closing. So I was curious,
2 do we have data around the trend, like over the last 10
3 years, the change in ownership for each of the geographic
4 areas? I mean, I suspect what it would show, but I didn't
5 know if we had that data.

6 MS. DEWAN: I looked at it for the last three to
7 four years, and it looks very similar to the bar graph that
8 I showed for 2025, but I don't have it for the last 10
9 years. I could look into that.

10 DR. CASALE: Well, I was curious, when the
11 independent pharmacies started to close. I have a sense
12 that it's a little bit further back beyond three or four
13 years, but some of that historic might be interesting.

14 MS. KELLEY: Gina.

15 MS. UPCHURCH: I'm thrilled that this work is
16 happening. Thank you. It's really, really important for
17 our communities. And just to build on Paul's comment, you
18 might want to see if you can link it to the introduction of
19 PBMs and the power of PBMs, and when pharmacies started
20 closing.

21 First of all, on page 17, I've got five questions
22 here, and I've got a lot to say in Round 2, but Round 1, on

1 page 17 we mentioned something. "Independent pharmacies
2 experienced--." I'm the granddaughter of an independent
3 pharmacist in Smithville, North Carolina, by the way. I
4 grew up going there as a small child, so I have a fondness
5 for independent pharmacies. Full disclosure.

6 "Independent pharmacies experienced modest net
7 gains in '21 and '23, but this pattern reversed in 2024,
8 when exits began." I think that can probably be tied to
9 the height of DIR fees, direct and indirect remuneration
10 fees. Pharmacists were losing money months after
11 dispensing a drug. They were coming back and snatching it,
12 and they called it clawback. They were raising a big
13 ruckus about it, and everybody was really paying attention.
14 If we can see if it was tied to that, that would be super
15 helpful.

16 We know now DIR fees come off the front end, and
17 I've asked lots of pharmacies and they said the
18 reimbursement is still really bad. You just know up front
19 that you're losing money, and I'll talk about that later.

20 On page 30 -- and this is going to blow people's
21 minds -- I don't believe, and you, tonight, have an
22 assignment to go home to the Medicare website and type in

1 some meds, type in some big chain pharmacies, type in some
2 independents, and see what's less expensive for the
3 consumer. It used to be the preferred pharmacies were less
4 expensive for the consumer. Now, bingo, I think it's
5 vertical integration. I think that's what you're seeing,
6 where what is happening is they're preferring their
7 vertically integrated pharmacy so that they can send volume
8 there, but the cost to the pharmacy goes down only if it's
9 a co-insurance does it go down to the individual. If it's a
10 fat copay amount or other things, the independent
11 pharmacists are often less, or the non-chain pharmacists.
12 The individual often pays less. As a pharmacist. We do
13 insurance counseling all the time, as a SHIP counselor.
14 They guessed 50/50 that it would be less at a preferred
15 pharmacy.

16 So I just think we can't use that term to assume
17 that it's less expensive for the consumer. And if
18 everybody can go try that out, that would be interesting to
19 know.

20 On page 30, you mentioned "independent
21 pharmacies' share of the retail market increased from 36
22 percent in '21 to 38 percent." Is that talking about the

1 volume of prescriptions or the number of stores.

2 MS. DEWAN: That's the number of stores.

3 MS. UPCHURCH: Okay. Maybe just make that clear,
4 that would be great. Thank you.

5 And then, just again, to build off Cheryl's
6 point, I think the impact of vertical integration on retail
7 pharmacies, and just to keep an eye on one thing, in
8 particular. Employer group waiver programs. Okay, that's
9 retiree programs. Many of these plans make you use certain
10 pharmacies, that they heavily incentivize you using mail-
11 order pharmacy or certain big-box chains, and that really
12 hurts local pharmacies. We don't really talk about that
13 much. We think about the Part D driving that.

14 But I do think employer retiree plans really hurt
15 local pharmacies. In particular large health systems that
16 are nonprofit are driving people to their pharmacies.
17 They're driving people to their mail order. And Brian
18 knows something about this because he's looked at in the
19 North Carolina State Health Plan. Many of them are taking
20 advantage of the 340(b) pricing, getting a big margin for
21 their nonprofit hospital, and they're not paying property
22 taxes or sales taxes. Meanwhile, the retail pharmacists

1 are closing, and they do pay taxes.

2 So I just hope we can look a little bit at
3 employer group waiver plans and retiree plans and its
4 impact on local retail pharmacists. And I'll have Round 2
5 questions, but I'm so thankful we're doing this work.
6 Thanks.

7 MS. DEWAN: Thank you. Just to be clear,
8 employer group waiver plans are not required to submit
9 network data, so are not included in the network analysis.

10 MS. UPCHURCH: Right. If you talk to any retail
11 pharmacist, when you do your interviews, just find out what
12 they think of the large employers and what they're doing
13 with their pharmacy benefit.

14 MS. KELLEY: That's all I have for Round 1,
15 unless I've missed someone. Shall we go to Round 2, Mike?

16 DR. CHERNEW: I think it's Stacie.

17 MS. KELLEY: You are right.

18 DR. DUSETZINA: Thank you so much. Great work
19 for both of you, as usual, and new work. So I'm really
20 happy to see this work on pharmacies.

21 Gina started out, in one of her comments, with
22 something that I was also thinking about. It's kind of a

1 plus-one on Tamara and Cheryl, around the preferred versus
2 not-preferred, and can we get more details. You know, pick
3 a preferred brand that you could walk through and give a
4 difference in the magnitude of the pricing, when it's a
5 preferred pharmacy versus non-preferred pharmacy.

6 But going back to what Gina said, in her assigned
7 homework for us. I was like, you know, when I look at the
8 Plan Finder, which is way too often -- I do a lot of
9 searching of the Plan Finder to try to understand what's
10 going on with drug prices for beneficiaries -- I often find
11 that preferred is not cheapest versus non-preferred, like
12 when I'm just searching within the plans.

13 So I do think there is something behind this kind
14 of question of do you actually save money when you go to a
15 preferred pharmacy, which sounds like nonsensical. The
16 whole thing should be it's preferred and lower cost, but
17 I'm not sure that always works out. I'm not sure how big
18 of a can of worms it is to try to figure out how often it
19 doesn't work out. Maybe I'm just looking at the wrong plan
20 and pharmacy combination. But I've often felt that it
21 didn't look like enough savings from the beneficiary side.

22 The same thing kind of applies to mail order. On

1 the section of the report where you talk about mail order
2 and thinking about when a pharmacy closes people might have
3 that substitution. I do think it would be useful to do
4 some additional analysis around the mail order
5 substitution, but also is that at a much higher price? And
6 again, this is kind of just going back, and it's somewhat
7 anecdotal, but when I'm looking at different drugs in Plan
8 Finder, across a whole range of therapies, I often find
9 mail order looks really expensive. So if I've picked a
10 plan based on a retail pharmacy in my area that closes, and
11 then I need to go to mail order, it could be that I'm
12 getting really bad pricing. So I think it would be worth
13 looking at that and how well that lines up for people.

14 You know, a couple of big-picture things, and I
15 was trying to think through how they might impact people
16 and their access to drugs. The fact that chain pharmacies
17 are preferred, that's very much kind of like, that's what's
18 being preferred, is very noteworthy. But there have been
19 some changes or movement in different states and
20 legislation. In fact, I live in Tennessee. There is a big
21 piece of legislation that they're trying to push through
22 right now to ban PBMs from owning pharmacies. So the

1 extent of which CVS is running constant advertisements
2 about this in my area is really stark.

3 But what happens if CVS goes away, so they
4 actually could say, "We're going to pull out." So I would
5 love to know more about that distribution of the chains by
6 region, so you could kind of understand when you have a big
7 policy change that maybe means a PBM and chain pharmacy
8 might leave an area, would that leave just huge swaths of
9 people kind of uncovered? So maybe a little more
10 description, like Greg's point initially, of which are
11 these pharmacies that we're talking about.

12 And then one other thing, and this is maybe like
13 an addendum for future work, but it was thinking a little
14 bit about the issues reimbursement for pharmacies. And
15 some of this, I think, is driven by losing money, even on
16 generic drugs. So there has been some interest in doing
17 like a NADAC base pricing, so acquisition cost of the
18 pharmacy plus a fee. And I was curious a little bit to
19 what extent we might think about doing some analysis to
20 understand, like if you replaced what we're currently
21 paying for these drugs with that type of model, would you
22 disproportionately benefit, like an independent pharmacy,

1 for example? But that's more like future analysis, but I
2 think it's part of the root cause of pharmacies not being
3 able to sustain their businesses and then needing to close.

4 Again, exceptionally well done and looking
5 forward to future iterations.

6 MS. KELLEY: Brian.

7 DR. MILLER: I had a few thoughts, and I have
8 more thoughts, so sorry. This is what happens when you go
9 later. A few quick thoughts, and then I wanted to
10 highlight some info and then some market structure.

11 Quick thoughts. I really don't think we should
12 be making policy about assertions of a drug here or there
13 in the Plan Finder or issues with mail order without
14 systematic data. In some cases it may be more expensive,
15 and in other cases it may be less expensive. So I don't
16 think that we should be impugning markets or market
17 participants without clear data and without looking at the
18 regulations. I suspect that the regulations have something
19 to say about the definition of what a preferred pharmacy is
20 and what the consumer or net price should be, so I would
21 direct us all to the CFR, which I had not read on this
22 issue. Otherwise I would voice what it says.

1 I also think the other thing we should realize is
2 that we want competition in the marketplace. We should be
3 agnostic of who that competition is. If it's a tax-exempt
4 pharmacy owned by UNC Health or a government-operated
5 pharmacy from Cook County, a chain store pharmacy from
6 Walgreens, or an independent community pharmacy, I think
7 all of us may have different preferences as consumers. I
8 look at my household. My wife and I have very different
9 pharmacy preferences, and that's fine, so we get to
10 experience different parts of the marketplace. I don't
11 think we should presuppose that one model is the correct
12 model. I don't think that's a good role for us.

13 I do think some of Gina's points about
14 pharmacists and independents are super important. We
15 should think about how we make a more competitive pharmacy
16 marketplace where pharmacists can and do own and operate
17 both individual pharmacies, pharmacy chains, mail orders,
18 and PBMs. I don't think we should be in the business of
19 deciding what market structure is, because in the past when
20 we've done that with things like Stark Law, for example, we
21 have destroyed independent physician practice and
22 competition and driven massive consolidation. So I think

1 statutory bans to corporate structure is generally not a
2 good idea, especially when doing so would also, at the same
3 time, ban an employee stock ownership model for
4 pharmacists, having pharmacies, and PBMs, and mail orders.

5 To the question of contracting and networks being
6 done with chains, I can say being on the board of the North
7 Carolina State Health Plan, if you look at things from an
8 operational perspective on the hospital or doctor side, a
9 plan, whether it's North Carolina or another plan, whatever
10 the market, whether it's medical pharmacy, you can do
11 contracts but you probably can't do 1,000 contracts every
12 year. So I think one of the reasons, just a practical
13 reason as to why there's probably a lot of contracts with
14 pharmacy chains is you're contracting with one chain and
15 that gets you 10,000 stores.

16 I know that the National Community Pharmacist
17 Association has set up a CIN, as an example, or a
18 clinically integrated network of independent pharmacies,
19 which is a good contracting vehicle. Obviously, we want
20 independent mom-and-pop pharmacies to be able to contract.
21 We also have to recognize that there are just logistical
22 barriers. It is not always someone being a bad actor.

1 I think one thing that we could add -- I'm sorry
2 this is taking so long -- one thing that we could add in
3 here, which would be helpful, is interviews with pharmacy
4 store managers. This is someone who manages the community
5 pharmacy, a chain pharmacy. I remember years ago when I
6 was looking at this marketplace I did that and I learned a
7 lot, and I actually learned that the vertical integration,
8 while occasionally we thought was evil, usually there was
9 more sloth than evil. So the managers, you would ask them
10 questions, expecting them to be taking advantage of the
11 vertical relationship, and they often weren't, and were
12 complaining that corporate was not doing so, and that they
13 were disadvantaged. It's a long way of saying vertical
14 integration cuts many ways. It cuts good. It cuts bad.
15 Also, you have to actually deploy it in a way that either
16 helps consumers, helps the taxpayer, or helps the business,
17 or some combination, and you can also be apathetic and do
18 none of those. And I say that not to disparage a business,
19 but just to be honest.

20 The chapter has some interesting info I want to
21 highlight. Pharmacy closures at the national level are
22 small, on average -- this is my takeaway -- but chain

1 closures at the local level are significant. Chains are
2 responsible for a lot of the closures. And then when we
3 looked at sort of the average access, for the average PDP
4 enrollee, it was pretty high nationwide, and within the
5 region I think it was 89 to 90 percent access to
6 pharmacies. The network adequacy obviously varied based
7 upon sort of distance and percentage of pharmacies. And
8 then it's when you went to the preferred that it was
9 majority chain, some independents. I think it was 44
10 percent were designated as preferred, and it was 66 percent
11 of chain and 3 percent of independents.

12 So the independents were getting pushed under the
13 bus. Probably a lot of it is due to the logistical hassle
14 that the managed care entities are facing. And, you know,
15 it's on all sides of the negotiating table to solve that
16 problem. I think independent pharmacies are super-duper
17 important, because again, people should have a choice of
18 how they get and access services and products.

19 The market share, it looked like benes who have
20 no pharmacies was pretty stable for the last decade almost,
21 which is, I think, an interesting thing.

22 And then the takeaway I saw is pharmacy closure

1 doesn't appear to correlate with the growth of mail-order
2 pharmacies, because pharmacy closure has been relatively
3 stable.

4 And then I think the other thing to think about
5 for us, as a group, it's like small plans and large plans
6 and vertically integrated plans and partially vertically
7 integrated plans probably all approach this marketplace
8 differently.

9 Final few thoughts, market structure thoughts.
10 One, the chains are actually going under and the
11 independents are sort of surviving, which is interesting.
12 And I think that's because the community pharmacists
13 approach the business differently than the chains. Again,
14 my data on this are old, but the chains look at the
15 business as selling Skittles that also has a drug store
16 attached, whereas the community pharmacists look at it as,
17 I am a pharmacy business. I also have some DME. I have
18 some consumer health products, you know, Curel lotion and
19 other things. And having a front store, a different store,
20 makes us different.

21 I think us talking with people who run community
22 pharmacies, which also tend to have more services, home

1 delivery and other things, I think that might be helpful
2 because the Medicare beneficiary needs the pharmacy. They
3 need a mail-order pharmacy. They need a local pharmacy
4 that they can drive, walk, bicycle, whatever, to, get a
5 ride, Uber, Lyft.

6 So we should get that information so we can think
7 about how we can elevate the role of the community
8 pharmacist, because when I look at the Medicare program
9 writ large, we have lots of doctor-facing stuff and we have
10 lots of hospital-facing things, but we haven't really fully
11 deployed the pharmacist. And that might be a way to help
12 both the independent community pharmacist, who are super
13 important, especially in a lot of rural areas, and then
14 also help the chains be more vibrant because the chain's
15 business model is dying. I mean, one of them, Walgreens
16 almost went under, I think, right, looking at it. They got
17 taken private and lost 90 percent of their market value.

18 UNIDENTIFIED VOICE: And Rite-Aid.

19 DR. MILLER: Yeah, and Rite-Aid did go under. So
20 that suggest that we don't want that business to
21 destabilize that whole sector because the benes need it.
22 Like mail order is not a perfect substitute. It's a

1 partial substitute, and in some senses complement.

2 So I think that conversation with the sort of
3 store managers could be really helpful. You know, I've
4 thought about just noodling, obviously doctor lens, but,
5 you know, it still matters. Co-locating diagnostic
6 testing, behind-the-counter drugs. Like lots of things
7 that we could think about and explore as a Commission. It
8 may require looking at things like Stark waivers for
9 pharmacists and other stuff. That could expand that
10 community pharmacy business so they're not stuck with the
11 front store and then endless pressure on commodity
12 products. So it's like can we think about ways that we can
13 help transform that business into a service business to
14 serve the beneficiaries.

15 So I think that's something we could do that
16 would be super constructive, because a lot of the time when
17 we look at this space we're going to be depressed. You
18 know, it'll be like Chicken Little. Are we going to feel
19 like the sky is falling, because the sky actually is
20 falling. So it's like that will give us hopefully
21 something constructive that we can suggest out of it.
22 Empower the pharmacist.

1 MS. KELLEY: Cheryl.

2 DR. DAMBERG: Thanks. I just want to say this is
3 terrific work, and I really support continuing work in this
4 space. I think this is a really helpful first step, and
5 just getting the lay of the land.

6 You know, per my earlier comments I hope that
7 there would be some continued focus on trying to understand
8 whether there are disparities in terms of which markets
9 they're exiting. The second thing about the vertical
10 integration and trying to understand those relationships
11 and how that affects the different PDP networks. And then
12 the rural area out-of-pocket costs compared to those living
13 in urban areas.

14 But in addition to that, I know the text talked
15 about looking at beneficiary travel distance to pharmacies.
16 I mean, that would definitely be kind of on the wish list,
17 but I recognize that's complicated to do.

18 So I'm wondering whether kind of a near-term
19 solution would be, I know you guys go out and do
20 beneficiary surveys and ask them about a variety of things.
21 And I couldn't remember, are there questions that ask them
22 about access to pharmacies and how far is the closest one,

1 and what their experiences are?

2 MS. SUZUKI: We have asked, in our focus groups,
3 about pharmacy access and whether that has changed. We
4 have not gotten responses that indicate people are having
5 issues accessing pharmacies, generally.

6 DR. DAMBERG: Okay. Thanks.

7 MS. KELLEY: Gina.

8 MS. UPCHURCH: Thanks so much. I have two major
9 points, and this is going to go a little different
10 direction, but it involves pharmacies and pharmacists.

11 We have ignored half of the Part D promise that
12 in addition to improving access to medicines with Medicare
13 Part D that we were going to look at the appropriate use of
14 medications as the cornerstone of Part D, and use the
15 untapped health resource of pharmacists.

16 In the retail setting we have tied their pay to
17 dispensing, and that margin is shrinking and unsustainable.
18 We have not found a way to pay them for their contributions
19 as team members. They're not considered providers.

20 PharmD's have six years -- I have my B.S. in
21 pharmacy and did a residency in geriatrics, but now they
22 all have to have a PharmD. That's six years of training on

1 specifically medication use.

2 The second point is that preferred pharmacies are
3 not always, or sometimes even often the lowest cost for
4 beneficiaries, just as mail order is sometimes not always
5 the lowest cost. Preferred-by plan means they are playing
6 that pharmacy less.

7 I look forward to the interviews, and I'm going
8 to try to predict what you're going to hear. So here's my
9 crystal ball. Branded medications, many pharmacists lose
10 money or barely break even dispensing brand medications.
11 They are slowly getting fairly reimbursed for the 10
12 negotiated drugs, and this has created some cash flow
13 issues in the slowness, but it's working out. One
14 pharmacist told me that when he dispenses Ozempic he loses
15 \$135 for a one-month supply. That's an extreme example.

16 This local access constraint, in addition to
17 some individuals ordering directly from manufacturers to
18 obtain better prices for medications, outside of the Part D
19 benefit, is very worrisome, especially for frail, older
20 adults. If clinicians don't know all the medicines someone
21 is taking, giving the varying resources or sources of the
22 medicines, it's risky business. Again, it can do more harm

1 than good to have access, especially for more frail
2 individuals. That's what I think you're going to hear,
3 brand name drugs.

4 Generic drugs, when you hear about shortages for
5 generic drugs, everybody is trying to pay the lowest price,
6 pharmacies have depended on the volume and very small
7 margins for generics, so they had to do high volume to make
8 a living. But those margins have decreased in the last few
9 years. One independent pharmacist shared with me recently
10 that his average margin for the top 10 drugs, generics,
11 that he dispensed, has decreased \$6 per generic over the
12 last four years, for about a 90-day supply. That's a lot
13 of money for a local pharmacy, or any pharmacy.

14 Pharmacists are squeezed. They are using the
15 term "handcuffed" between what they are reimbursed by the
16 plan or the PBM versus how much they use to purchase the
17 medicine from the distributor or the GPO, group purchasing
18 organization. The PBMs and the plans favor vertically
19 integrated pharmacies, and some distributors' GPOs will
20 alter their prices on the generic contracts they have with
21 pharmacies unless you lock into their purchasing program.
22 In other words, if pharmacies go elsewhere to purchase

1 less-expensive generics, they will be dinged and charged
2 more for their brand contract. It's not a free or
3 transparent market for pharmacies. I think there's a lot
4 of anger at pharmacy benefit managers.

5 We should understand all the relationships within
6 the PBM world. There needs to be more transparency. Much
7 of the federal legislation I think looks like window
8 dressing, so that the state legislation has a little bit
9 more meat on the bones.

10 I have learned some pharmacies are becoming
11 licensed insurance agents to try to make a living on the
12 side. And obviously maybe steering people inappropriately
13 in some ways.

14 Many have tried to hold onto to September, and I
15 couldn't understand why they were telling me they were
16 holding onto September. Well, that's when you get
17 vaccines, so there's a little bit of a margin for vaccines.
18 I mean, that's what they're hold on until.

19 Medication appropriateness, just a reminder that
20 medication therapy management was supposed to be the
21 cornerstone of Part D. It's never been realized. The
22 appropriate use of meds should be as important as access.

1 Or another way to say it, improving medication access
2 without an eye on the appropriate use of those medicines
3 for older adults can be a recipe for disaster. Yes,
4 financially for us all, but also in terms of the quality of
5 life of the Medicare beneficiaries we're supposed to be
6 helping.

7 Look at what other countries do and how they
8 integrate pharmacists as team members, even in retail
9 settings. Their TV ads are not about taking more and new
10 expensive brand-name drugs, but about de-prescribing PPIs
11 in older adults, proton pump inhibitors. That's Canada.

12 Also, if you're going to control Part D spending,
13 pharmacists need to help drive this work. They know how to
14 drive down drug prices. They know about therapeutic
15 substitution.

16 We look -- and I'm almost done -- at the five-
17 year enhanced MTM demonstration that you shared probably
18 last year. Very disappointing results, but not surprising,
19 because the plans were in charge of it. They mostly
20 created call centers. Beneficiaries were not in
21 relationship with a trusted pharmacist. And we know that
22 trusted messengers are key. Also, when they looked at the

1 cost savings they only looked at what you saved in A and B,
2 not in D savings, where I think pharmacists can make a real
3 difference.

4 They did a lot of phone medication therapy
5 management. A senior pharmacist was forced to do that
6 during COVID. Our pharmacists hate it. It's really hard
7 to teach somebody how to use an inhaler over the telephone.

8 Pharmacists should have access to electronic
9 health record and tips, what we call "push" often in the
10 pharmacy world, notifications of things that are going on
11 for that individual. And in North Carolina and some other
12 parts of the country we are seeing that pharmacists are
13 getting some notifications.

14 So the pharmacist shouldn't be tied just to the
15 product. If we're going to keep them tied to the product
16 we need to have fair reimbursement for the product.

17 The star ratings I think has been ineffective to
18 engage pharmacists in care. Each plan has different
19 metrics. The pharmacists don't even know about them until
20 they're halfway through the year what the metrics even are.
21 They're not the same by each plan. And heavy weighting, as
22 we talked about, goes towards adherence, and that's about

1 dispensing, and mail-order pharmacy, getting it on the
2 door. It's not about how they're actually taking the
3 medications. The pharmacist can't really impact a lot of
4 that.

5 And I do believe that some of this auto-filling
6 contributes to overuse and problems that we see.

7 I want to finish with this, an analogy. My
8 father was a dentist, and if we only paid him when he gave
9 you a false tooth, a bridge, a crown, or filled a cavity,
10 but we didn't pay for scaling, cleaning, bitewing x-rays,
11 showing you how to floss, giving you a toothbrush as you
12 walked out the door, you know, that's not how we treat most
13 people in health care. I mean, health care providers are
14 often paid for preventive. Pharmacists could do a lot
15 towards prevention, smoking cessation. So you can avoid
16 these medications. You know, good sleep hygiene, so you
17 take fewer and fewer medications for your sleep.
18 Nutrition. There's a lot of pharmacists can do. We are
19 underutilizing them.

20 So I feel like we need to leverage pharmacy
21 skills so that we're not over reliant on the product and
22 sales and more sales, especially when the sale of that

1 product can do more harm than good. And we need to
2 incentivize pharmacists and retail pharmacies to use their
3 skill sets to contribute to overall well-being of Medicare
4 beneficiaries, and they need to be reimbursed for that.

5 Earlier Brian said, you don't want to have people
6 work for free. A lot of SHIP people work for free. A lot
7 of pharmacists don't get paid for what they do. Thank you
8 so much. I really appreciate this work.

9 MS. KELLEY: Betty.

10 DR. RAMBUR: Thank you for this great work and
11 these great comments, including when there's a couple of
12 years of work here. I just have to underscore what Gina
13 said about the value of teams and pharmacists being
14 absolutely underutilized.

15 I'll be very brief. I just want to amplify one
16 point that's obvious, but there are no pharmacies without
17 pharmacists. And early in the chapter we talk about the
18 workforce shortage, but I'm really curious about when you
19 do the focus groups with pharmacists, are there positions
20 available. Enrollment in pharmacy programs has absolutely
21 plummeted in the past decade, maybe, Gina, and every
22 rationale I see is about the perceived working condition,

1 the lack of positions, the lack of career opportunity. And
2 maybe some of that pipeline thing goes in our context
3 chapter, but it's absolutely related to all of the things
4 we're talking about here. And also, obviously, it
5 intersects with payment in relationship to teams.

6 But I really hope that remembering that in the
7 end, it's the people doing the work that really make it
8 happen. It's not a building.

9 But thank you. Very interesting.

10 MS. KELLEY: Kenny.

11 MR. KAN: Thanks for the excellent analysis. I
12 worry about the impact of recent chain and independent
13 pharmacy closures on beneficiary access, especially in
14 rural and lower-income areas. For independent pharmacies,
15 the paper also suggests a clear imbalance between Part D
16 network design and economics. Independent pharmacies are
17 included in networks but rarely designated as preferred, 3
18 percent for independents versus 66 percent for chains,
19 resulting in lower patient volume and financial instability
20 due to low reimbursement, retroactive fees, and restrictive
21 PBM contracts.

22 For future analysis, and I'm very enthusiastic

1 about this body of work, I suggest we analyze the
2 feasibility of the following three approaches.

3 Number one, strongly encourage health plans to
4 offer objective criteria or preferred status with intent to
5 allow efficient, independent pharmacies to compete for
6 preferred on equal terms. How would that work? What could
7 such criteria be?

8 Number two, enforce transparent and predictable
9 contracting to ensure clear reimbursement formulas, limits
10 on retroactive fees, and fair dispute process.

11 Number three, incentivize preferred pharmacy
12 access in underserved areas. Thank you.

13 DR. CHERNEW: That was all I had, Michael.

14 MS. KELLEY: That was all I had, Michael.

15 DR. CHERNEW: So Renuka and Shinobu, thank you so
16 much for this work. I think there is a lot of interest and
17 where it can go. You heard a lot of comments. My general
18 reaction is sort of to point out to the folks at home that
19 we are the very beginning stages of looking at this. We
20 are not contemplating recommendations. We haven't
21 quantified all of the specific problems. We have a lot to
22 learn about the role that pharmacies and pharmacists play

1 overall, how we think through the role that they play and
2 certain types of things, as well as the role that other
3 professionals play and those types of things.

4 I think one of the big challenges many, many
5 types of folks want, who are involved in access of care,
6 and that's why this team-based approach is sort of a
7 different version than having a bunch of siloed, separate
8 folks trying to do somewhat similar things.

9 But I don't have much to say about what the
10 rights solutions are or what the recommendations would be
11 or even what the problems are or how to sort through the
12 fact that a lot of this is probably driven by phenomenon
13 that are outside of the purview of health care, let alone
14 out of the purview of Medicare.

15 But in any case, we really appreciate you looking
16 into this and continuing to think through these types of
17 issues. So next year I gather you'll probably see more of
18 this. But for now we're going to take about a five-minute
19 break. We're going to come back at a little bit before
20 4:15, and we're going to talk about Medicare Advantage and
21 its impact on hospitals and post-acute providers. So we'll
22 see you all in a second.

1 [Recess.]

2 DR. CHERNEW: Hello, and welcome back for our
3 last session of the day. I think it's going to come to no
4 surprise to anybody who is listening to our meeting that as
5 a group we are extremely interested in Medicare Advantage,
6 how it functions, and as it comes up every year, what does
7 the growth in Medicare Advantage mean for the health care
8 providers.

9 And we have been doing a bunch of work in this
10 area. We are continuing to that work now. And Brian is
11 going to take us through the latest iteration of our work
12 on the impact of MA on hospital and post-acute care
13 providers. Brian.

14 MR. O'DONNELL: Good afternoon. Last September
15 we presented on the association between Medicare Advantage
16 enrollment and hospitals' finances. Today, we'll recap and
17 extend that work, including new work on the association
18 between Medicare Advantage enrollment and post-acute care
19 providers' finances.

20 Before we begin, I'd like to thank Brian Klein-
21 Qiu and Evan Christman for their assistance with this work.

22 The audience can download these slides by

1 clicking on the document icon in the upper right-hand
2 corner of the screen.

3 We will start by providing a brief background on
4 MA enrollment and plan incentives. We'll then discuss the
5 association between changes in MA enrollment and hospitals'
6 finances, followed by the association between MA enrollment
7 and post-acute care providers' finances. We'll then turn
8 to the floor to Commissioners for discussion. We
9 anticipate incorporating Commissioner comments and then
10 including this work as an informational chapter in the June
11 2026 Report to the Congress.

12 Just to start off with some very broad
13 background, the share of Medicare beneficiaries enrolled in
14 MA has increased rapidly, going from 30 percent in 2013 to
15 55 percent in 2025. Furthermore, both CMS and the
16 Congressional Budget Office project continued growth in
17 MA's share of Medicare enrollment. Therefore, assessing
18 how MA growth has affected both providers and beneficiaries
19 is critical. This presentation focuses on the effects of
20 MA on providers' finances. The Commission has other
21 ongoing work assessing the effects of MA on beneficiaries.

22 As we discussed in more detail in September and

1 in your mailing materials, MA plans have an incentive to
2 find lower-cost ways to provide care, which can affect
3 providers in numerous ways. Research shows that MA plans
4 spend less on medical care than fee-for-service. At the
5 same time, beneficiaries report broadly similar levels of
6 overall access and satisfaction with care. This suggests
7 that that at least some of MA plans' lower medical spending
8 is attributable to appropriate reductions.

9 In theory, MA can affect providers finances in
10 three ways: their patient volume, their revenues per
11 patient, and their costs per patient.

12 The goal of Medicare is not to ensure provider
13 profitability. At the same time, it is important to
14 understand whether the growth in MA affects provider
15 finances, as beneficiary access to care depends on an
16 adequate supply of providers.

17 To assess the extent to which these theoretical
18 effects of MA enrollment on providers' finances actually
19 occur, we'll now shift to our examination of the
20 association between MA enrollment and hospitals' finances.

21 To analyze the relationship between MA and
22 hospitals' finances, we conducted several complementary

1 analyses. These analyses included site visits and
2 interviews with stakeholders; a comparison of MA and fee-
3 for-service beneficiaries' hospital inpatient lengths of
4 stay; an analysis of the implications of the structure of
5 Medicare's uncompensated care payments; and examining the
6 association between changes in MA penetration and
7 hospitals' all-payer operating margins, revenues, and
8 costs.

9 This presentation will briefly discuss the
10 results of each of these analyses. More details are in
11 your mailing materials.

12 Our site visits and interviews revealed
13 stakeholders had different perspectives on the effect of MA
14 on hospitals' finances. Hospitals' largely had a negative
15 view on the effect of MA on their finances, including
16 through greater difficult discharging MA beneficiaries to
17 post-acute care, which could increase hospitals' costs;
18 increased administrative costs; increased denials and
19 downgrades, which could reduce hospital revenues; and MA
20 sometimes paying less than fee-for-service.

21 From the MA plans' perspective, stakeholders
22 noted that utilization management tools can be clinically

1 appropriate and can reduce the provision of low value care;
2 hospitals may be inappropriately billing higher severity
3 services than warranted; and that MA plans often match fee-
4 for-service rates and may use other types of compensation
5 to reward providers, such as bonuses to reward meeting
6 quality benchmarks.

7 More fully investigating each of the stakeholder
8 perspectives described on the prior slide is beyond the
9 scope of this current work, but we did further explore two
10 issues, the first of which is comparing MA and fee-for-
11 service beneficiaries' hospital inpatient lengths of stay.

12 As shown in the table on the left, we found that
13 MA beneficiaries had an 11 percent longer length of stay
14 than comparable fee-for-service beneficiaries.
15 Furthermore, while MA beneficiaries had longer lengths of
16 stay across all the subgroups we examined, the differences
17 were much larger for beneficiaries seeking post-acute care,
18 including stays nearly 20 percent longer for MA
19 beneficiaries seeking care in a skilled nursing facility
20 and 32 percent longer stays for beneficiaries seeking care
21 in inpatient rehabilitation facilities.

22 These longer lengths of stay for MA beneficiaries

1 generally increase hospitals' costs per stay, since about
2 60 percent of hospitals' inpatient costs are per-diem;
3 shift costs from MA plans to MA beneficiaries, since MA
4 cost-sharing is commonly on a per-diem basis; and do not
5 change IPPS hospitals revenues per stay, since the MA rate
6 is generally per stay.

7 A second issue we explored was the structure of
8 uncompensated care payments which we found leads to
9 misalignment with hospitals' uncompensated care costs. Our
10 interviewees said that MA plans often, but not always,
11 match the fee-for-service UC dollar add-on per stay. By
12 construction, all else equal, these add-ons are higher at
13 hospitals with higher shares of MA patients.

14 As shown in the table on the right, we found, on
15 average, when a hospital's MA share of inpatient stays
16 increased by 10 percentage points, the fee-for-service UC
17 dollar add-on per stay increased by 15 percent. This then
18 results in hospitals' fee-for-service plus MA UC payments
19 becoming misaligned with each hospitals' share of UC costs,
20 and, in extreme cases, hospitals with very high UC add-ons
21 have reported being excluded from MA networks or receiving
22 well below fee-for-service rates.

1 MedPAC has recommended an approach to improve
2 targeting of Medicare safety-net payments, including UC
3 payments. We also discuss other approaches in your mailing
4 materials, and can clarify those approaches on question.

5 MS. CHERRY: Thanks, Brian. To further
6 understand the association between MA and hospital'
7 finances, we turned to published research, which was
8 limited and mixed.

9 A hospital industry analysis suggests that MA
10 patients tend to have lower payment-to-cost ratios than
11 fee-for-service patients, which would suggest worsened
12 financial conditions for hospitals. However, two recent
13 regression-based, peer-reviewed papers analyzed the
14 association between MA penetration and some hospital
15 financial outcomes. One found that MA penetration was
16 associated with improved financial conditions for rural
17 hospitals. Another found that MA penetration was
18 associated with lower all-payer inpatient revenue at rural
19 hospitals, but higher revenue at urban hospitals.

20 Due to the mixed nature of the literature, MedPAC
21 decided to conduct its own analysis on the association
22 between MA and hospital finances. We presented some of

1 this work in April and September 2025.

2 We first compared national trends in the median
3 market-level MA penetration and the median IPPS hospital
4 all-payer operating margin from 2013 to 2024, where we
5 found no clear relationship.

6 This line graph plots the median market-level MA
7 penetration rate from 2013 to 2024, where the solid, dark
8 blue MA penetration line is plotted uses the left vertical
9 axis. Consistent with the aggregate national trend, the
10 median market-level MA penetration increased from 26
11 percent to 55 percent from 2013 to 2024.

12 In addition, the graph plots the median IPPS
13 hospital all-payer operating margin, where the dashed green
14 margin line is plotted using the right vertical axis. Over
15 the same 2013 to 2024 period, hospitals' all-payer
16 operating margin did not clearly track with MA penetration,
17 suggesting little correlation between the two. However,
18 this overall view does not control for possible confounding
19 factors or examine subgroups.

20 We conducted a regression analysis examining the
21 association between market-level MA penetration and
22 hospital finance, which allows us to control for possible

1 confounding factors. Our main explanatory variable is
2 market-level MA penetration, that is, the share of eligible
3 beneficiaries in the market enrolled in MA. We defined
4 markets using National Cancer Institute-modified health
5 service areas, which are groups of counties.

6 Our main outcomes were hospital all-payer
7 operating margins, revenues, and costs from Medicare cost
8 reports. We used this data instead of MA and fee-for-
9 service revenues in part because we do not have MA-specific
10 data on revenues or costs in hospital cost reports.

11 Our study period was from 2013 to 2024, excluding
12 2020 and 2021 cost reports, which were the years where
13 hospitals were most affected by the coronavirus pandemic.
14 We examined IPPS and critical access hospitals separately
15 due to their different payment structures.

16 We used a linear regression model to estimate the
17 association between market-level MA penetration and
18 hospital finance. For those of you interested in
19 practicing Greek, the regression equation is on the right-
20 hand side of this slide.

21 Key to our method are hospital fixed effects,
22 which mean that our estimates reflect the association

1 between changes in market-level MA penetration and changes
2 in finances within hospitals over time.

3 We control for some factors that were also
4 changing over the period by including year fixed effects,
5 which control for factors that affect all providers
6 nationally. We also include a state time trend, which
7 means we controlled for state-level factors in the market
8 that changed over time, like Medicaid policies. Finally,
9 we include some time-varying market controls, such as the
10 market's population and uninsurance rate.

11 We weighted our regression by the number of beds
12 a hospital has in the first year they are in the study
13 period. Standard errors are clustered at the market level.

14 MedPAC's methods of estimating the association
15 between MA penetration and hospital finances have several
16 advantages and follow similar approaches to other peer
17 reviewed literature. Using the all-payer hospital data
18 allows us to capture the net result from all the potential
19 ways MA can be associated with provider finances.

20 Our hospital fixed effects control for hospital
21 and market level factors that are fixed over the study
22 period. Our year fixed effects, state trends, and other

1 control variables control for some factors that changed
2 over the study period.

3 However, our analysis also has limitations. In
4 general, this means our estimates should be interpreted as
5 associations, and not as causal effects of MA. One
6 particular limitation is that we cannot control for all
7 hospital and market-level factors that changed over the
8 study period. So, the associations we estimate could be due
9 to factors omitted from our models due to a lack of data on
10 these factors. Other literature that uses similar methods
11 is also affected by these concerns.

12 Because different trends between markets with
13 larger versus smaller changes in MA penetration could bias
14 our estimates, we looked at the characteristics of our
15 markets to see how different they were from one another.
16 We found that markets with smaller changes in MA
17 penetration differed in some ways from markets with larger
18 changes, even in the beginning of our study period, which
19 illustrates the limitation of possibly unobservable
20 differences that we could not control for.

21 In this table, we divided markets into four
22 groups based on how much their market-level MA penetration

1 changed from 2013 to 2024. The quartile of markets that
2 experienced the smallest change in MA penetration
3 experienced a median 13 percentage point increase, while
4 the quartile of markets that experienced the largest change
5 experienced a median 38 percentage point increase.

6 These markets differed in other ways. For
7 example, markets that experienced the largest percentage
8 point increases in MA penetration also had the highest
9 median rate of all payer inpatient stays per capita in
10 2013, before the MA penetration change.

11 These beginning-study differences raise the
12 concern that underlying differences in the markets
13 themselves, rather than changes in MA penetration, could
14 account for some of the estimated associations between
15 changes in MA penetration and in hospital finances. Our
16 analysis controls for many observable factors. However, we
17 cannot be sure that we controlled for all factors that
18 impact hospital finances and are correlated with changes in
19 MA penetration. Therefore, our estimates should be
20 interpreted as associations that may reflect a combination
21 of effects due to MA and other factors.

22 Overall, when we estimated the regression

1 coefficients, we did not find any statistically significant
2 association between MA penetration and hospital all-payer
3 operating margins, revenues, and costs, on average, for
4 IPPS hospitals.

5 In the table, the all-payer operating margin
6 coefficient suggests that a 10 percentage point increase in
7 market-level MA penetration was associated with a 0.4
8 percentage point increase in IPPS hospital all-payer
9 operating margins, although this result was not
10 statistically different from zero.

11 In addition, we found that a 10 percentage point
12 increase in market-level MA penetration was associated with
13 a 0.5 percent decrease in IPPS hospital all-payer operating
14 revenues and a 0.9 percent decrease in costs.

15 These results were also not statistically
16 different from zero association. So, we did not find an
17 association between market-level MA penetration and IPPS
18 hospital finances, on average.

19 Our estimated associations of MA penetration and
20 margins were consistently near zero under multiple
21 sensitivity analyses. One possible reason for this is
22 because both revenues and costs are components of the

1 calculation of margins, so any effect of differential
2 trends in utilization, for example, may largely balance
3 out.

4 Because changes in MA penetration could have
5 different effects on different types of hospitals, we
6 examined different subgroups. For IPPS hospitals, we
7 examined hospitals by their number of beds, or size, by
8 system membership, and the extent that hospitals were
9 vertically integrated in 2021 for a 2022 to 2024 study
10 period. Our margin results were generally consistent with
11 the overall results across these different subgroups.

12 The associations between market MA penetration
13 and hospital all-payer operating revenues and costs were
14 more prone to change compared with our analysis of margins,
15 in both the magnitude of the parameter results and the
16 extent to which they were statistically significant. For
17 critical access hospitals, we did not find statistically
18 significant associations between market MA penetration and
19 hospital all-payer operating margins, revenues, and costs,
20 on average.

21 DR. FOUT: Thanks, Krista. We now turn to our
22 work examining MA and post-acute care providers' finances.

1 Increases in MA enrollment may have different
2 effects on different types of provider, and Commissioners
3 have expressed interest in learning how effects may vary
4 across settings. We examined the relationship between MA
5 and post-acute care providers' finances. For this work,
6 PAC providers refer to skilled nursing facilities, home
7 health agencies, and inpatient rehabilitation facilities.

8 PAC providers deliver recuperative care
9 generally, but not always, after a patient leaves the acute
10 care hospital, to help patients recover, regain or maintain
11 function, and safely transition back to the community.
12 SNFs, home health agencies, and IRFs all provide
13 rehabilitation, skilled nursing, and personal care, but the
14 level of care varies, with each having distinct features,
15 as further described in your reading materials.

16 There are a few reasons why financial effects of
17 increasing MA enrollment may differ for PAC providers
18 compared to hospitals. For IRFs and home health agencies,
19 Medicare accounts for large share of all-payer revenue and
20 volume, so any changes in revenues, costs, and volume
21 related to their MA enrollees can have material
22 implications for their overall financial performance.

1 MA plans may exert more influence over PAC
2 spending than hospital spending in a few ways. First, they
3 can steer some patients to lower-cost PAC settings.
4 Second, they may be able to negotiate lower payment rates
5 relative to fee-for-service. As we have previously shown,
6 unlike for hospitals, fee-for-service payments exceed
7 costs, in aggregate, for all three PAC settings.

8 Third, plans may be effective in reducing
9 utilization relative to fee-for-service. We have
10 previously reported that aspects the fee-for-service PAC
11 payment systems financially rewards greater use and higher
12 intensity of use. For example, SNF payments are made per
13 diem so there is a financial incentives to lengthen stays
14 until beneficiary coinsurance is triggered.

15 The Commission has long recommended lower fee-
16 for-service payment rates for SNF, home health, and IRF
17 services, so lower MA payment rates for some PAC providers
18 may better align payments with costs.

19 We conducted semi-structured interviews with PAC
20 providers to understand their perspectives on how MA is
21 affecting their businesses. We also draw from interviews
22 we conducted last year with MA plans related to their home

1 health care line of business, interviews conducted with
2 hospital discharge planners related to SNF and IRF
3 placement, and other meetings with MA plans and
4 stakeholders.

5 PAC providers emphasized experiences with delayed
6 or denied care and shortened stays. IRF interviewees noted
7 longer time to admission and higher denial rates for MA
8 enrollees. Hospital discharge planners also noted greater
9 difficulty in placing patients in IRFs compared to other
10 PAC settings. SNF and home health interviewees highlighted
11 how MA plans tend to authorize a limited number of days or
12 visits at a time and how extensions were difficult to
13 obtain, even if their clinicians assessed that the patient
14 needed more care.

15 Regarding network constraints, IRF and SNF
16 interviewees noted the unwillingness of some MA plans to
17 contract with providers. Some IRFs noted that it was rare
18 for MA plans to approve their enrollees for out-of-network
19 care. SNFs and home health agencies generally reported
20 receiving lower payment rates than fee-for-service while
21 IRFs reported receiving similar payment rates for their MA
22 and fee-for-service patients.

1 From the MA plans' perspective, MA plan
2 representatives we spoke with mentioned their efforts to
3 remove prior authorization for home health care visits.
4 Some said that they match payments to fee-for-service home
5 health per-visit rates, which, as a side note, may be
6 different from the fee-for-service episode-level payment.
7 Another MA plan perspective we heard is that the limited
8 availability of PAC providers can affect MA enrollees' time
9 to placement.

10 Prior research on MA and PAC finances is fairly
11 limited. One study using data from 2012 to 2019 found
12 substantial declines in SNF all-payer revenues, costs,
13 margin, and volume associated with increases in market MA
14 penetration. Most other studies were primarily focused on
15 PAC use and outcomes in MA relative to fee-for-service. A
16 recent study found lower SNF and IRF use and substitution
17 to home health care use among MA enrollees.

18 We, in our prior work, compared home health care
19 use between fee-for-service and MA and found similar
20 overall use, but fewer home health visits in MA. A 2022
21 OIG report discussed the higher rates of denied requests
22 for prior authorizations in IRFs and SNFs under MA.

1 To examine the relationship between MA and PAC
2 providers' finances, we applied the same regression
3 framework as used to analyze hospitals' all-payer finances
4 for SNFs and home health agencies. Using regressions, we
5 estimated associations between the provider's market-level
6 MA penetration and its all-payer finances and volume,
7 controlling for market characteristics, provider fixed
8 effects, year fixed effects, and state trends using data
9 from 2013 to 2024.

10 As for the hospital results, we present our
11 findings as the percent change in the all-payer metric
12 associated with a 10 percentage point increase in MA
13 penetration. We needed to restrict our study sample to
14 freestanding providers because we are not able to separate
15 the revenue of hospital-based PAC providers from the parent
16 hospital's all-payer revenue, so all-payer margins could
17 not be calculated for hospital-based PAC providers.

18 In 2024, 97 percent of SNFs and 93 percent of
19 home health agencies were freestanding. However, most IRFs
20 are hospital-based. Only one-third of IRFs are
21 freestanding. Therefore, for IRFs we do not apply the
22 regression framework and instead provide descriptive

1 information on IRFs' volume and patient mix.

2 We now turn to our regressions results for SNFs.
3 As shown in this table, we estimated a small decrease in
4 the all-payer margin associated with a 10 percentage point
5 increase in MA penetration that was not statistically
6 significant.

7 We estimated small and statistically significant
8 decreases in both all-payer revenue and all-payer costs
9 associated with increases in MA penetration. We estimated
10 a small and statistically significant decrease in all-payer
11 facility days. This decline is consistent with the
12 estimated decreases in revenue and costs.

13 For home health agencies, as shown in this table,
14 we also estimated a small decrease in the all-payer margin
15 associated with a 10 percentage point increase in MA
16 penetration that was not statistically significant.

17 For all-payer costs we estimated a 2.7 percent
18 decline associated with a 10 percentage point increase in
19 MA market penetration. We also estimated a decrease in all-
20 payer volume measured by the number of unique patients in
21 the year, but this decrease was not statistically
22 significant. The estimates for home health agencies are

1 larger in magnitude than for SNFs, likely reflecting home
2 health agencies' larger Medicare share of all-payer volume.

3 The estimated associations between market MA
4 penetration and providers' finances varied across some of
5 the provider subgroups we examined.

6 Results varied by timing. We found that
7 associations between MA penetration and provider finances
8 were stronger in the more recent years of 2022 to 2024 than
9 in earlier years, 2013 to 2019. We also stratified by
10 provider size and found that small home health agencies
11 tended to have larger declines in finances and volume
12 associated with increases in MA penetration compared to
13 larger home health agencies. However, among SNFs, there
14 were no differences on all-payer margin by size, though our
15 findings differed for revenues, costs, and volume. Further
16 investigation is needed to better understand the underlying
17 mechanisms driving these patterns.

18 Lastly, we did not find statistically significant
19 associations between MA penetration and all-payer margins
20 for SNFs and home health agencies when stratifying by rural
21 versus urban and a measure for provider-plan vertical
22 integration.

1 We now turn to IRFs. We could not analyze this
2 sector with the same regression framework as the other
3 providers since the majority of IRFs are hospital-based,
4 for which we could not calculate all-payer margins.

5 The line in this chart shows that MA market
6 penetration among IRF patients increased from 27 percent in
7 2013 to 55 percent in 2024, tracking closely with national
8 MA enrollment trends. The bars indicate that the median
9 IRF share of Medicare days attributable to MA enrollees was
10 much lower, rising from 8 percent in 2013 to 24 percent in
11 2024. Although the median MA share of IRF days increased
12 sharply between 2019 and 2020, by about 5 percentage
13 points, it remains well below overall MA market
14 penetration.

15 The remainder of each bar represents the median
16 fee-for-service share of Medicare IRF days. For example,
17 in 2024, 24 percent of Medicare IRF days were for MA
18 enrollees, while the remaining 76 percent were for fee-for-
19 service beneficiaries.

20 We also found that the mix of patients receiving
21 IRF services differed for fee-for-service and MA enrollees.
22 This chart shows the distribution of IRF stays by clinical

1 condition at admission and payer, as reported on the IRF
2 Patient Assessment Instrument.

3 Overall, 73 percent of Medicare IRF stays were
4 for fee-for-service beneficiaries and 27 percent were for
5 MA enrollees, as shown in the middle bolded row.
6 Conditions listed above the overall total have a higher
7 share of MA enrollees, while those below the total have
8 relatively lower MA shares.

9 MA enrollees receiving IRF care were more likely
10 to be admitted for stroke, amputations, spinal cord
11 dysfunction, and traumatic brain dysfunction. These
12 conditions often require specialized rehabilitation
13 services that may be less available in other PAC settings.

14 In contrast, MA enrollees were less likely to
15 receive IRF care for conditions such as debility, 16
16 percent MA share, and orthopedic disorders, 18 percent MA
17 share.

18 To summarize our findings, for both critical
19 access hospitals and IPPS hospitals, we estimated no
20 statistically significant association between MA
21 penetration and all payer operating margins, on average.
22 We also found that MA inpatient stays tend to be longer,

1 especially for beneficiaries with an intended discharge to
2 PAC, and increases in MA enrollment can lead to a
3 misalignment in uncompensated care payments.

4 For SNF and home health agencies, we estimated no
5 statistically significant association between MA
6 penetration and all-payer margins, on average. For IRFs,
7 we could not apply the same methods, but showed that MA
8 accounts for a smaller share of IRF use than overall MA
9 penetration, and that MA and fee-for-service patients
10 differ in clinical mix.

11 As was discussed earlier, our methods, which have
12 also been used by other studies, have limitations such that
13 our results should be interpreted as associations and not
14 causal effects.

15 We'll now take your questions and feedback on
16 this material. This work is intended to be an
17 informational chapter in our June 2026 Report to the
18 Congress. As potential next steps, we plan to assess how
19 PAC use varies by beneficiary and preceding hospital-stay
20 characteristics and by payer.

21 I now turn it back to Mike.

22 DR. CHERNEW: Terrific, and you guys did a great

1 job. I think there's going to be a lot of interest. And
2 we're going to jump right in with Round 1, and I think Gina
3 is first in Round 1. I think Tamara is before Gina in
4 Round 1.

5 DR. KONETZKA: Thanks. I'm really excited about
6 this work, and you packed a lot into this chapter, so
7 really great work.

8 I have a very narrow question about the IRFs.
9 Given what we know about IRFs from our fee-for-service
10 payment chapters, the margins are pretty high. I'm
11 wondering why, in your stakeholder interviews, it seemed
12 like you reported that MA basically pays IRFs close to fee-
13 for-service rates. Why do you think that is? Is it just
14 because there's usually only one IRF around if they want to
15 send somebody to IRF? I mean, we know that MA sends people
16 to IRF at about half the rate as fee-for-service, but then
17 they pay them the full rate. So why do you think that is?

18 DR. FOUT: I often wonder that myself, and the
19 IRFs we spoke to just kind of emphasized that they kind of
20 say in passing that the IRF payment rates for MA plans kind
21 of mirror fee-for-service, but that they have longer time
22 to placement for getting an IRF patient into the IRF, or

1 getting a patient into the IRF. We are not sure why they
2 are not negotiating their rates, but they were the ones
3 that had told us that not every IRF can get into a
4 contract. But that's a good question.

5 MS. KELLEY: Gina.

6 MS. UPCHURCH: Thanks so much for this work, and
7 good job with it. So I just want to make sure I
8 understand. So Medicare Advantage plans just outright can
9 pay less to providers than 100 percent of allowable for
10 traditional Medicare?

11 MR. O'DONNELL: If they're in network, that's
12 correct.

13 MS. UPCHURCH: Okay Well, so no wonder many
14 plans are getting rid of their HMOs, because if you have a
15 PPO and you're out of network they have to give you 100
16 percent of Medicare allowable. Is that correct.

17 MR. O'DONNELL: Sorry. Can you say that again?

18 MS. UPCHURCH: So if you're in a PPO and go to
19 somebody that's out of network, that provider, who is out
20 of network, gets reimbursed 100 percent of Medicare. So if
21 they're not going to pay you well, as well as you'd like,
22 then you're just going to choose to be out of network as a

1 provider. Then you're going to be sure to get 100 -- that
2 might be another reason we're seeing fewer PPOs and more
3 HMOs. I'm just making sure I'm correct on that.

4 MR. MASI: I see several people looking at Greg.
5 Do you want to get in here?

6 MR. POULSEN: Sure. I mean, there are two
7 consequences. One, you may not see the patient at all.

8 MS. UPCHURCH: Right. Of course.

9 MR. POULSEN: And the other is that there is an
10 increased likelihood of denial.

11 MS. UPCHURCH: Because you'll need a referral for
12 that? You mean, the patient would need a referral? What
13 do mean, a denial? Oh, you mean you see them as the
14 provider and then it gets denied, even though you're just -
15 - you're out of network they can deny it for some reason?

16 MR. POULSEN: No, they can't, but you could then
17 appeal it, and say this was appropriate, but they may say
18 it wasn't medically necessary. You didn't go through the
19 appropriate steps, and so there's a process there that can
20 happen and that does happen more frequently if you're out
21 of network, for sure.

22 MS. UPCHURCH: Wow.

1 MR. POULSEN: Any providers here disagree with
2 that?

3 DR. SARRAN: For non-emergent care.

4 MS. UPCHURCH: For non-emergent, non-urgent.
5 Yeah, okay. So that was the first question.

6 And then the second one, I know that if you're a
7 provider and you're having to deal with prior authorization
8 from a Medicare Advantage plan, that you have
9 administrative costs as that provider to deal with all the
10 paperwork. From the plan's perspective, they also have
11 administrative costs to administer the prior authorization
12 program. Where does that land on the medical loss ratio?
13 Is it part of the numerator or the denominator, when you're
14 administering as the insurer the prior authorization plan?
15 Does anybody know?

16 MR. O'DONNELL: I'd want to check with our MA
17 team on that, where that number could live on the MLR data,
18 because I do know that where it lives has been kind of a
19 hot topic of debate.

20 MS. UPCHURCH: Oh, okay.

21 DR. SARRAN: There is at least some gray to that,
22 because you can categorize a lot of things as, quote,

1 "quality improvement" related.

2 DR. CHERNEW: I was going to say, in response to
3 what you were talking about earlier, the cost-sharing can
4 also differ. So if you're in a plan where it waives
5 whatever they do, but if you decide to go outside of
6 network, you could face much more out-of-pocket.

7 MS. UPCHURCH: Right. And something I heard the
8 other day, and I suppose this is true, is that what's
9 considered medically necessary is very subjective. I mean,
10 I just assumed there was like some book that I didn't have
11 that talked about what's medically necessary. But there's
12 really not that book. So it's not totally subjective.

13 DR. SARRAN: Just real quick. Typically plans
14 will use some recognized vehicle, Milliman, InterQual, if
15 they're going to deny care, because they need something
16 substantive and reasonably objective if they're to
17 withstand an appeal to their denial.

18 MR. O'DONNELL: And just to note, when we spoke
19 with a bunch of hospitals that was one of their common
20 concerns with it. They would use Milliman or InterQual,
21 and they would say still, despite a reliance on these kind
22 of relatively widely recognized metrics, they would still

1 get rejected based on medical necessity. So that's an
2 overarching concern, the potential ambiguity involved in
3 that.

4 DR. SARRAN: Those are like the Talmud. You can
5 interpret them differently.

6 DR. CHERNEW: A lot of the things in medical
7 necessity definitions are reasonably subjective. Was it
8 interfering with your life? How much pain? There's just a
9 bunch of things. And so that creates a documentation
10 thing. But even if you don't get denied, the process can
11 be challenging for everybody involved.

12 MS. KELLEY: All right. Tom, do you have a Round
13 1 question?

14 DR. DILLER: Yes, and this is kind of an
15 extension of what we're talking about at this point in
16 time. I thought this chapter was really well done.

17 The subjective complaint, if you will, is that MA
18 plans are pretty management in place through denials, or
19 approvals, prior authorizations, that is inappropriate and
20 causing harm to the finances of whether it's the hospitals
21 or the PACs. And that's because of delays or refusal to
22 admit to a PAC and/or limitations on their length of stay,

1 once you're in the PAC.

2 So this gets at the medical necessity. So you
3 can look at Milliman or InterQual, or you can do chart
4 reviews or whatnot, and that's very time consuming. But if
5 this was appropriate, then the ideal situation is the
6 people that are being admitted to those PACs would have a
7 higher risk score. And you would also, at the same time,
8 see a readmission rate that is flat or actually decreased,
9 in some way, shape, or form. So, in other words, what they
10 would be doing is admitting more appropriate patients to
11 the PAC and not seeing the negative consequences of a
12 readmission, or you could measure other things. So do we
13 know anything about those measures? And I suspect we may
14 not at this point in time, but it might be something for
15 the future to look at the appropriateness of those
16 referrals.

17 MR. O'DONNELL: Yes. I think to your main point
18 you're right. We don't have a lot of information on that.
19 But I do want to put the denials in context, is that we
20 fairly consistently heard, and I think some academic
21 research has shown, that there might be more denials, but
22 the overturn rate is really high. So you might get denied

1 and then maybe 80 to 90 percent is a common number we heard
2 of those denials are overturned. So actually receipt of
3 the care tends to typically happen. It's just the process
4 of getting there is a little more cumbersome.

5 DR. CHERNEW: And denials, there's delays,
6 there's down-coding of the claims, there's a lot of stuff
7 that goes on in this broad thing, and the admin costs back
8 and forth, it was called revenue cycle, is non-trivial.

9 MS. KELLEY: That's all I had for Round 1, unless
10 I missed anyone.

11 DR. CHERNEW: I'm too interested to follow what's
12 going on. I think Tamara is now first in Round 2.

13 DR. KONETZKA: Okay. As I said, I'm really
14 excited about this work, and I really hope that even though
15 it's going to be a June chapter that we'll be able to
16 continue this line of work that's clearly, I think, really
17 important to all of these markets that we're studying. And
18 there's so much more left to explore. So a lot of my
19 suggestions, maybe some of them you could do before June,
20 but a lot of them I know will be later.

21 I think you estimated a really reasonable
22 regression model. I think it was pretty conservative,

1 included all the right fixed effects, et cetera. And you
2 were also very explicit about the limitations of the model.
3 Maybe it was reported sort of too many times in the
4 chapter. You could probably condense that a little.

5 But I'm going to give you one more to add, and
6 that is I think the data that you presented clearly show
7 that, so, in addition to this time-varying, omitted
8 variables problems that could confound this, there is also
9 the reverse causality kind of issue. And you might just
10 want to say explicitly, as another limitation, that managed
11 care doesn't expand randomly, and maybe expanding into
12 markets where they see sort of where providers' finances
13 are such that they see that they could make money or gain
14 some efficiencies. So that would also confound it in a way
15 that's slightly different than the time-varying omitted
16 variables.

17 A couple of quick things and then I'll get to my
18 main things. The second on uncompensated care I think just
19 reinforces how some of these add-ons to fee-for-service
20 payment just have a lot of unintended consequences and sort
21 of reinforces our prior recommendations on the Safety Net
22 Index. So I think that's worth emphasizing.

1 In the hospital analysis you used health service
2 areas, which I think are a reasonable market for hospitals.
3 PAC markets, you used the same area, and PAC markets tend
4 to be a little bit more localized, right. The people want
5 to go to a SNF or, whatever, it might be in a ZIP code
6 where a home health agency serves them or doesn't. I'm not
7 sure it matters, but you might want to think about whether
8 the health service areas are also appropriate for PAC and
9 justify that in the chapter, or maybe try a different
10 market, a smaller, one of the standard ones that are a
11 little bit smaller. That might get at that difference.

12 The IRFs, you said you didn't do the analysis for
13 IRFs because only a third of them are freestanding. That's
14 really where all the patients are right now, and also where
15 the growth is. So I think it would be worth doing in
16 future iterations of this work. It would be really
17 interesting to see the effect on IRFs, especially because
18 we know that MA plans are so reluctant to send people to
19 IRFs. If they pay them the same it may not be, as fee-for-
20 service, it may not be a big difference, but I think it
21 would be an interesting analysis to add.

22 Getting onto sort of bigger things about the

1 analysis, there may be some non-linearities in MA
2 penetration. It's a little hard to add right into this
3 model, but clearly if you increase from 13 percent of MA to
4 18 percent it's going to be different than if you're
5 starting at 80. Or it may be different, right. It might
6 be good to either use some splines or just do some more
7 stratifications to see if that makes a difference.

8 Okay. So in some ways you stratified by certain
9 things, by size, et cetera. There is a part of me that
10 thinks even though you didn't find a lot of differences
11 that really the main story is still going to be in the
12 heterogeneity, maybe just heterogeneity you haven't
13 discovered yet.

14 And I'd really love to understand the size
15 effects more. And again, a lot of it wasn't significant.
16 But like the SNFs and the other providers, the SNFs and the
17 hospitals were going in different directions. So the
18 smaller SNFs seemed to be doing better with more MA, and
19 the bigger SNFs were doing worse. And for hospitals and
20 home health agencies, that direction was the opposite, like
21 more what you would think, that small facilities would be
22 more vulnerable.

1 So I'd really love to know why that is happening.
2 And this gets to, I think you did exactly the right thing
3 in looking at a market-level measure of MA penetration,
4 because that's the most exogenous and that's what we want
5 to measure in this regression. But it would be exploring
6 the heterogeneity, and that same MA penetration is going to
7 affect different facilities differently. So one way might
8 be a sort of Medicare bite variable. Like some SNFs have
9 much more Medicare, and you kind of alluded to that when
10 you were saying for SNFs this is going to have to be a big
11 effect because they are only 14 percent Medicare, on
12 average. I loved that part.

13 But just in general, for both hospitals and SNFs,
14 for example, you would expect hospitals that are more
15 dependent on Medicare to have more of an effect, or SNFs
16 that have a higher Medicare share to have more of an
17 effect. And you've taken care of that in the regression
18 with the hospital fixed effect, but I think just, again,
19 looking at it sort of stratified or looking at which
20 facilities, given their baseline levels of Medicare, might
21 be more affected might sort of reveal some differences in
22 which markets are getting affected.

1 I think that's about it. I'm very excited about
2 this line of work. I hope we can continue it. And I think
3 the big question remains of what to do about it. I think
4 the policy implications are clear, whether you find more
5 effects or not at this point. But I think at this point
6 it's well worth just discovering what the effects really
7 are in these markets and submarkets. Thanks.

8 MS. KELLEY: Greg.

9 MR. POULSEN: Thank you. I really, really love
10 this chapter, so thanks very much.

11 Before I jump into the things I really wanted to
12 mention I want to just go back to the denials, because I
13 think it's worth just pointing out that one of the reasons
14 the hospitals are so -- and it's true of other providers,
15 too -- are so unhappy about that, even though the overturn
16 rate is very high, is that it's viewed as being entirely
17 unidirectional in terms of the incentive. In the sense
18 that if a service is denied, if the revenue cycle team
19 looks at it and says, "You know, this isn't worth the
20 trouble to go through," they lose the money. If they
21 appeal it and lose, they lose the money. If they appeal it
22 and win, they still lose the time value of the money that

1 took them the three months or six months to get through
2 that appeal, and they don't get any redress for the
3 additional work they did.

4 So as Mike pointed out, it's time consuming, it's
5 a nuisance, and you have a chance, maybe a big chance, of
6 losing, even though it was a legitimate service that was
7 provided. There's a reason why the frustration exceeds the
8 apparent dollar value of the thing. So let me just start
9 with that.

10 Then I'd really like to get to what Tamara said.
11 She talked about the heterogeneity of the organizations
12 that received this. But I think equally important is the
13 heterogeneity of the MA plans, and they're very, very
14 different in how they approach some of these things. And
15 understanding that variation is hugely important. So, in a
16 sense, it's a cross-tab to the work that we have in this
17 chapter, which is looking at the impact on different
18 provider types, and I would suggest it's also important to
19 look at the different MA plan types, and MA plans
20 explicitly, in terms of how they do that.

21 Just as an example, along with all the really
22 excellent information in this, and I wouldn't say any of

1 this is contradictory at all, but as we look at the
2 hospitals' largely negative view, for instance, on the
3 discharges, if we look at plans across the board, which you
4 all gathered in a lovely way, length of stay higher, much
5 higher, when people are going to a post-acute care, that's
6 exactly the inverse if you look at certain types of plans.
7 Integrated plans, vertically integrated plans tend to have
8 lower lengths of stay because they have relationships set
9 up for post-acute care because it's in their strong
10 interest to get them moved. As opposed to they're
11 indifferent whether they get moved or not, because they're
12 happy to have them in the hospital, under a DRG.

13 Similarly, with utilization management tools,
14 with prior authorization, if it's a vertically integrated
15 plan or a plan -- and this one's interesting, and I think
16 important -- if the plan pays a capitated rate to the
17 hospital organization, or the post-acute care organization,
18 the incentive suddenly changes dramatically. And suddenly
19 you're looking at utilization management, prior
20 authorization as something, first off, that you agree
21 what's appropriate and necessary, and then you have an
22 additional tool to keep people from using the service for

1 which you've already been paid, inappropriately. So
2 there's a very, very different attitude there.

3 Another one I don't think we mentioned explicitly
4 is in-hospital caregivers from the plan, which is something
5 that we are seeing less of than we used to, but
6 nevertheless still exists in many parts of the country. If
7 they're there overseeing and deciding what you shouldn't be
8 doing, that's a very different process than they're helping
9 you to say, okay, how can we do the discharge planning to
10 get this person home effectively. The whole perspective is
11 very, very different, based on the plan type, not the
12 provider type on that.

13 Let's see. One of the things that I think we
14 have found is that sub-capitation ends up being nearly as
15 positive as ownership of integrated plans in terms of
16 achieving differences in perspective and outcome. I
17 mentioned the discharge length of stay, where we have seen,
18 in a couple of the plans that I'm directly familiar with,
19 actually considerably shorter length of stay because
20 discharges are facilitated in ways that are very difficult
21 for the hospital to do by themselves, where they don't have
22 the direct payment to the post-acute setting.

1 One of the things I wanted to just catch on that
2 really quickly is a number of integrated plans, and there
3 may be some commercial plans that do this but I'm not aware
4 of any, where they buy bed capacity in post-acute care
5 settings so that they have instant access. And that ends
6 up being good for the post-acute care site. Even though
7 they're not paying them a huge amount, it stabilizes their
8 finances to a degree to have beds that would otherwise just
9 be empty, generating some degree of revenue. But it also
10 means that when somebody is ready for discharge, they have
11 got a place to go, guaranteed, essentially. So that makes
12 a difference.

13 The other one that I wanted to mention is, and
14 this one I'll just hit really quickly. I had about 20
15 minutes of stuff here that you do not want to all hear.
16 But I think it's interesting to note that even if you look
17 at one certain organization, their reputation among
18 providers varies pretty dramatically by geography, because
19 they're managed, to some degree, locally. They have
20 different relationships, sometimes contractual, but
21 sometimes just person relationships that make big
22 differences.

1 And I'll just name a couple of names so that you
2 know what we're talking about. The way that United is
3 perceived in Denver is very different than the way it's
4 perceived in Salt Lake City, to communities that I work in
5 both. Humana, very different in Nashville than St. Louis,
6 I mean, very different in terms of how it's perceived.
7 Interestingly enough, Kaiser, which is a very different
8 type of organization, but perceived by the non-Kaiser-
9 employed providers, or not part of Kaiser providers, Nevada
10 very differently than Colorado. And even Northern
11 California than Southern California. Those are really kind
12 of just interesting how variable that is.

13 So I love this chapter, but I also want us to
14 keep in mind that all MA plans do not behave identically,
15 and nor are they either perceived or, in fact, impacting
16 providers uniformly across the country. So I just wanted
17 to put that caveat in.

18 Thanks very much for the great stuff.

19 MS. KELLEY: Brian.

20 DR. MILLER: Great chapter. I think it was
21 interesting to note the spillover effects on hospital care
22 and the comment that providers have had some time to adapt

1 to MA market penetration going up. I thought that was an
2 interesting point. Because everybody always talks about MA
3 market penetration skyrocketing, and if you look at the
4 chart it's a slow trend over time. Market penetration is
5 going up a percentage point or two a year, although that
6 might be slowing down now.

7 Policy thoughts for us. It feels sort of like, I
8 guess my parents maybe did, sort of children need to work
9 together is my takeaway from this chapter, and they're not
10 getting along, and they're fighting and throwing food at
11 each other at the dinner table. That's sort of what I'm
12 thinking when I think about hospitals and plans. They sort
13 of need to get their act together and behave like adults.
14 I get lots of emails from people complaining, plans
15 complaining about hospitals, hospitals complaining about
16 plans.

17 And it's actually getting sort of tiresome, and I
18 think that both market participants are behaving poorly, so
19 that the plans often want to turn fee-for-service into MA,
20 which is not realistic, right. It's not going to happen.
21 Shouldn't happen. That's a different plan, product,
22 marketplace for the Medicare beneficiaries. And then the

1 hospitals keep trying to turn MA into fee-for-service with
2 like 30-day prompt pay clean claims. I'm like, MA is not
3 fee-for-service, and fee-for-service is not MA. We
4 shouldn't be trying to turn one into the other. And
5 instead they should actually be solving problems rather
6 than turning a marketplace they don't like into one that
7 they do. So I think both hospitals and plans need to stop
8 that and behave.

9 I think we should start thinking about
10 operational solutions. One is IRFs don't have a network
11 adequacy rule. If we're worried about IRF access for the
12 MA bene, they don't have a network adequacy standard in MA.
13 That's something we could recommend very easily to CMS that
14 would solve that problem.

15 I think both hospitals and plans need to get
16 their acts together on the discharge process, and I'm going
17 to be pretty direct. First of all, health plans are
18 operating and making excuses like it's 1985. So us sending
19 faxed information and having some random information system
20 that's not fully digitized for utilization review, and
21 plugged into the electronic health record, like that is a
22 friction that the industry needs to address. And something

1 that we could do is actually suggest to Congress that they
2 write a law and regulations to tell the plans to fix that.
3 They've had this promise that they're going to fix
4 utilization review and prior auth and integrate it. Well,
5 I know that takes time. It can take years. But we can
6 also help them get a timeline and move the bit faster if
7 they're not doing it.

8 On the hospital side, they are, in my opinion,
9 just as guilty as the plans. Everyone says, "Oh, the
10 patient's in the bed, and that's burning the DRG time, and
11 they're not turning over." And then I see endless numbers
12 of hospitals that don't take case management and social
13 work very seriously. They underinvest. They don't have
14 the IT infrastructure. They don't have the human capital
15 infrastructure. They haven't structured the physician
16 workday or nurse practitioner workday or PA workday to
17 adequately account for this.

18 So discharge planning comes. You show up at
19 multidisciplinary rounds. The hospitalist or orthopedic
20 surgeon, whoever is there, "Oh, Mr. or Mrs. So-and-So is
21 ready. Oh, we don't have the home health," or we don't
22 have this ready, or the plan didn't do this, or we need to

1 send in this information. And then the next day comes
2 around and it's So-and-So is medically ready, awaiting
3 discharge, and it's the hospital staff have not gotten
4 their act together to get the plan the information they
5 need, or get the preferences from the beneficiary to help
6 move the system forward.

7 So my takeaway from this chapter is both sides of
8 the table need to stop complaining and start solving the
9 problem, and that if they don't solve the problem that we
10 should suggest to Congress regulations that could help them
11 solve that problem together, like adults. Because I'm
12 tired of getting emails about, you know, the two sides
13 pointing at each other like Dr. Seuss.

14 MS. KELLEY: Scott.

15 DR. SARRAN: Yeah, great work and certainly
16 important space, being the intersection between and the
17 impact of plans on providers.

18 Two very brief comments. The heterogeneity that
19 has been referred to, and that you guys did a nice job of
20 trying to tease out, I think what we're unfortunately
21 missing, and it's not easy to measure, is what plays is
22 relative market clout. So it's really the heterogeneity

1 within a market, not between markets. And if there were
2 some formulary it would be cloud of the plan minus cloud of
3 the provider, and is that number positive or negative. If
4 it's positive, the plan beats up on the provider. That's
5 not inherently evil. It could have downstream consequences
6 that are inverse but it's not inherently evil. That's just
7 what will happen.

8 And if the number is different, if the providers
9 have a lot of clout, which is increasingly the case with
10 provider consolidation, the providers extract enough money,
11 or contractual concessions from the plan, so that they're
12 not burdened. And then, on average, we gets the results
13 that you showed. So the feet are in the oven, the head is
14 in the refrigerator, and the temperature is normal. So I
15 think that's an important point. It might be just worth
16 referencing.

17 The second is this whole point about the negative
18 impact of prior authorization, financially and clinically.
19 I think it's really worth underlining and highlighting.
20 Financially, the problem we've got -- and Greg, this is all
21 now baked into the hospital cost structure because they had
22 to play these games. And they're zero-sum games, and it's

1 part of why medicine is so darned expensive, is we engage
2 in these. And as Brian points out, they're clumsy games,
3 you know, with faxes going back and forth. It's
4 ridiculous. And proprietary algorithms, and blah, blah,
5 blah.

6 So worth double-highlighting that, and I really
7 like Brian's suggestion about you've got fault on both
8 sides, and a lot of process that could be legislative or
9 regulatorily improved. I really like that.

10 The last thing I would try to include, at least a
11 brief note on, is that although this is a chapter
12 explicitly about finance, at least reference that in the
13 clinical community, in the geriatric community and the
14 rehab community there is real concern about MA plans,
15 practice patterns that, in essence, sort of move people
16 down the level of intensity. Less IRFs, more SNFs, shorter
17 length of stay in a SNF, less SNFs and more home health.
18 You know, how much rehab does a frail elderly need to
19 achieve their potential? Not easily measured and not
20 necessarily a known quantity on day one at the rehab
21 beginning. It's a moving target, and it needs to be
22 beneficiary centric and humanistic and all that. But

1 particularly a for-profit plan that's running algorithms
2 and an offsite team that's incented on financial
3 performance, there's just a lot of potential for less than
4 optimal outcomes.

5 So I think at least, again, it's a financial
6 chapter and I get that, but at least referencing that there
7 is, I think, a fairly high degree of concern in the
8 clinical community about that. Thanks.

9 MS. KELLEY: Robert.

10 DR. CHERRY: Yeah. You know, thank for the
11 presentation. I actually think this is kind of a fun
12 chapter in a lot of ways, and I'll just limit my comments
13 to the hospital portion. Because you have, on the one
14 hand, this really sound methodology, looking at MA
15 penetration and what's the impact on all-payer hospital
16 margin, and you're not seeing anything. But you're
17 suspicious, and so you go talk with hospital executives,
18 who are telling you just the opposite of what the data is
19 saying. So you have these juxtaposed physicians, and you
20 recognize that there are limitations, but don't know
21 exactly what's going on, why there's a disconnect between
22 those two narratives.

1 So I think what's going on is that there is a
2 number of tools that MAs are using to reduce their costs,
3 and there are a few that probably fairly universal between
4 hospitals. There's the prior authorizations. There's
5 movement from inpatient to observation status. And then
6 there's denials. And the common thread between all of
7 those is medical necessity documentation. And to answer
8 Gina's question more fully, in my world medical necessity
9 comes from a textbook called Schwartz for surgeons, and
10 probably for Brian it comes from a textbook called
11 Harrison's. But neither of us studied InterQual or
12 Milliman in medical school, which is the books that
13 essentially these health plans are using.

14 And I do agree that a lot of denials are
15 reversed, but the ones that aren't are costing large
16 hospitals millions of dollars. So they're seeing these
17 impacts in terms of revenue, but it's not showing up on
18 your all-payer margin. And I think the reason why is
19 because of two things that we don't like to hear about --
20 consolidation, cross-subsidization.

21 So basically, I think what's happening is that
22 hospital CEOs are looking at their commercial versus

1 governmental payer mix. And they'll lump Medicare and
2 Medicaid all in the same bucket as governmental payer, and
3 what they want to do is basically increase their commercial
4 business. And they do this through consolidation -- buying
5 physician practices, getting into ASCs, getting into
6 innovative joint ventures and affiliation agreements. And
7 then they take that extra commercial business and they
8 cross-subsidize the governmental programs.

9 The problem with all of that, as we know, with
10 consolidation it leads to increased costs, which impacts
11 the MA programs. So what do they do when they're seeing
12 these increased costs? They become more aggressive with
13 their prior authorization process, getting more patients
14 into observations, denying care, because those are the
15 tools in their toolbox.

16 So you have this loop that everyone is stuck on.
17 And I think what you're seeing, it really connects back to
18 my comments earlier this morning, is that for some MA plans
19 they want to get off the hamster wheel, and they chose to
20 exit the market. And so that's why we're seeing, in 2026,
21 so many Medicare beneficiaries, 2.9 million, actually been
22 forced to be disenrolled in these plans, because it's too

1 costly, there's reimbursement impacts, and also that's not
2 profitable for them anymore.

3 So I think we have a model that's really just not
4 sustainable, and you can't really see it in the data, but
5 that's probably what's going on is why you have these two
6 juxtaposed positions.

7 So it's an interesting Rubik's Cube, but that's
8 sort of my theory. You can take those comments however you
9 like them. But thank you for the work.

10 MS. KELLEY: Cheryl.

11 DR. DAMBERG: Really great comments from the
12 fellow Commissioners, and also there's just a lot of meat
13 to chew on here. I'm going to touch on a couple of points.
14 The first one, in the chapter it says that providers may
15 have responded to financial pressure from MA by reducing
16 staffing. And so I'm kind of curious. I suspect you
17 haven't done this, but this could be a future-looking type
18 of analysis. As MA has expanded, can you look at, in this
19 post-acute setting, and in particular skilled nursing
20 facilities, whether that's led to changes in nurse
21 staffing? Because we know nurse staffing is associated
22 with quality outcomes. And just trying to get a better

1 understanding of how that may have influenced. I know it's
2 not an easy analysis. Lots of things to control for, but
3 it could be interesting.

4 And then I guess I was also interested in what we
5 might know about the quality differences between, say, the
6 SNFs and IRFs that MA plans contract with versus the ones
7 they don't, and also how that compares to those that are
8 used by fee-for-service beneficiaries.

9 In terms of some of the other points you make in
10 the chapter, I agree there's a need to collect patient
11 experience data for patients who are in SNFs, to be able to
12 monitor the care that's delivered to ensure that things are
13 going okay from the patient's perspective and that SNFs are
14 not stinting on care.

15 Also, in terms of better targeting of
16 uncompensated care payments, I think I agree with that.
17 Obviously, the details of how to do that need to be fleshed
18 out, but I think they're poorly targeted right at the
19 moment.

20 And then also I thought it was interesting in
21 terms of raising the issue of improved cost reporting, to
22 be able to calculate MA-specific margins. I think if

1 that's something that's feasible I think we should explore
2 that some more.

3 MS. KELLEY: Kenny.

4 MR. KAN: I'm enthusiastic about this chapter.
5 The key headline is that MedPAC finds no statistically
6 significant impact of MA growth on provider margins across
7 hospitals and post-acute care.

8 Competition and choice are working, as more than
9 half of Medicare beneficiaries choose MA because it offers better
10 coordination, additional benefits, and often lower out-of-
11 pocket costs. In addition, as suggested in the chapter, MA
12 is delivering care more efficiently by managing
13 utilization, negotiating prices, and encouraging care in
14 the most appropriate setting.

15 However, let's be honest. It's not perfect.
16 Many providers are experiencing real friction, as what
17 Robert alluded to. They are dealing with prior auth
18 delays, higher administrative burden, and payment
19 uncertainty. The data even shows longer hospital stays in
20 some MA cases, often tied to delays in post-acute
21 approvals.

22 I see this as operational problems, not

1 structural failures. This means we can fix them, without
2 walking away from a model that is clearly delivering value.
3 So believe the right approach is not more government price-
4 setting or rolling back MA. I believe that the right
5 approach is to make MA work better, address provider
6 concerns via a three-pronged approach.

7 First, we should continue to push plans to
8 streamline prior authorization. For example, real-time
9 approvals, clear clinical rules, and gold carding for high
10 performing providers.

11 Second, reduce unnecessary administrative burden
12 for providers. Faster appeals, fewer retroactive denials,
13 and more predictable payment processes.

14 Third, strengthen provider alignment. Expand the
15 use of value-based contracts that reward outcomes, not
16 volume, and create real partnership between plans and
17 providers.

18 If we can do that, we can preserve what's working
19 in MA -- competition, innovation, and cost discipline --
20 while addressing legitimate provider concerns. Thank you.

21 MS. KELLEY: Josh.

22 DR. LIAO: Thanks for this chapter. I'll just be

1 brief and underscore a couple of things that I think I've
2 heard other Commissioners say. First, MA penetration is
3 not randomly assigned and lots of things are changing and
4 difficult to observe for, and I appreciate your recognition
5 of those time-bearing unobservables, I noted explicitly.

6 I do agree with other comments that maybe that
7 could be consolidated. I'd love to see a little bit of
8 mention about the broader issue of endogeneity. You know,
9 it's not clear the direction of that association, as I
10 think Tamara mentioned. MA penetration can affect hospital
11 behavior, but those dynamics can do the other way, so I'd
12 love to see that noted in some fashion.

13 Third, just underscore heterogeneity. MA plans,
14 as Greg mentioned, providers have facilities. As Tamara
15 mentioned, I think it just kind of underscores for me that
16 they're not a single MA effect, and that's been surfaced in
17 other comments. So I'd love to see that fleshed out in
18 additional analysis.

19 I think Tamara and others have echoed I think
20 helpful suggestions so I won't repeat them, but I echo
21 those.

22 I think ultimately these things obviously

1 complicate interpretation, and they point to me kind of a
2 broader challenge of all these system-level effects, many
3 of which are highlighted in these comments, are hard to
4 measure just through market-level variation.

5 So I kind of view this as really helpful analyses
6 for surfacing patterns. I would love to see this work
7 fleshed out further, and I wonder if there are non-market-
8 level things that we can feather in to get at some of these
9 other system-level effects. Thank you.

10 MS. KELLEY: Tom.

11 DR. DILLER: Yeah, I also will be really, really
12 brief with this. What my concern is is the effect on total
13 cost of care for the entire plan, the Medicare plan. And I
14 think what we all understand is that hospitals are
15 incentivized to decrease length of stay. That's very
16 clear. And one of their main tools they have is to offload
17 to PAC. Once the PAC gets the patient, they are
18 incentivized to hang onto them for as long as they can.
19 They maximize revenue in that way. And that all increases,
20 potentially, the total cost of care.

21 And then shifting just a bit away from MA, in my
22 current role, one of the things that I'm looking at is the

1 APMs, the TEAM and the bundled payments. And as we looked
2 at our own internal data, which the hospital is not at risk
3 for, is our single biggest risk is the excessive cost of
4 PAC. That's what's going to cause us to be unprofitable in
5 TEAM, relative to profitability. So we don't have the
6 tools in place. We don't have prior authorization to
7 manage that. We've got to do that not through that
8 approach but through influence and setting up the right
9 systems to be put in place in order to manage that care.
10 Thanks.

11 DR. CHERNEW: I think that was the end. Tamara,
12 do you want to say something? You put it in the chat. Do
13 you want to do it quickly?

14 DR. KONETZKA: Yeah, very briefly. One other
15 suggestion that I forgot. The chapter reminded me that
16 there has been 6 percent exist of SNFs over the time period
17 of the study, and I know even though we think fee-for-
18 service margins are healthy, we know that the SNF market is
19 a little unstable, perhaps, right now, and we do worry
20 about that in terms of access. So I'd love to see this
21 regression. And they cite MA, of course, as a reason for
22 their financial pressures. I'd love to see the same

1 analysis applied to SNF exit, to see if MA penetration is
2 associated with exit. Thanks.

3 DR. CHERNEW: So now we're almost exactly at
4 time. I'm going to sum up quickly. So a few things. The
5 first thing, I think it's important to remember that there
6 are decades worth of work, continuing work, about the
7 geographic variation in the practice of medicine. It is
8 simply not the case that we're going to live in a world
9 where there's going to be some Milliman or Schwartz
10 guideline, that physicians are all going to the same place
11 and practice the same way. They just don't. There are too
12 many unobservables. It's too hard.

13 You can say incentives drive some of it, and
14 that's possibly true, but a lot of other things are driving
15 what's going on, and that's just, I think, something we
16 have to acknowledge, which is a lot of inefficiency in the
17 system and there's a role for trying to get rid of that
18 inefficiency. And some of that reprises some of the
19 conversation we had the beginning of the day.

20 A few other things that struck me. The first one
21 is, most importantly, we focus a lot on what MA does to
22 revenue, but what seems to be clear, at least in part, to

1 me, is that the costs adjust. Whether that's good or bad I
2 think is an important topic. I had to step out, but I
3 think Cheryl was saying that point just as I was leaving.

4 Another thing related to what Tamara just said is
5 this is an analysis, I think, basically of the surviving
6 organizations, and to Robert's point, I think he's right.
7 There's exiting consolidation that goes on and plays out in
8 complicated ways. This is true not only in MA but it's
9 also what happens when Medicare fee-for-service rates
10 change in a whole bunch of ways, and I think understanding
11 that market, the influence on market structure ends up
12 mattering, and sometimes the pressure there is borne
13 outside of the Medicare system.

14 One quick comment on heterogeneity, because it
15 came out a lot. I think it's always tempting to look at
16 heterogeneity. I like looking at heterogeneity. I used to
17 tell a lot of stories about why heterogeneity matters.
18 Statistically, it's really hard to look at heterogeneity.
19 This is hard enough to do on average, but you've got
20 multiple comparison issues, you've got noise in the data,
21 you've got a whole bunch of things going on, there's
22 different dimensions of heterogeneity. So I think I'm just

1 trying to manage expectations about what folks can
2 basically do.

3 I will say, in that spirit, and to close, I
4 really like that you tied this back to the academic
5 literature. There are a lot of folks that aren't sitting
6 around the room. They're trying to look at some of these
7 issues. And I think you did a really good job of
8 acknowledging that there's that other literature and tying
9 into what's going on, and I really do appreciate it.

10 The other thing that I think is really important
11 is you showed this national trend in MA growth and then
12 trend in margins in a range of ways. So we can quibble
13 about the way you use variation and the endogeneity and the
14 confounders. But if there was really an enormous effect,
15 you would expect some how to see nationally that Medicare
16 Advantage was growing, and everyone's hostile margins now,
17 Medicare Advantage now is pretty significant, and hostile
18 margins now, on average, if you look at the March report,
19 aren't at all-time lows. I think that's the way I'm going
20 to phrase that.

21 Although there are hospital systems that are,
22 indeed, struggling, and I think it was Tamara said

1 something about the Safety Net Index, but if it wasn't, I'm
2 going to attribute it to her. I think that matters. I
3 understand that type of stuff matters.

4 But again, I agree. We don't know exactly what
5 to do. This is just information because we're asked this
6 all the time. And apart from anyone's belief about the way
7 these organizations behave to each other, and many of the
8 things, for example, Kenny said, that can be done anyway.
9 Like these organizations do that. They don't need us to do
10 that.

11 But in any case, we are asked a lot about the
12 impact of this on providers, and it really does matter,
13 because the providers, at the end of the day, are the
14 organizations that are providing the care to patients, that
15 our goal is to make sure people get access to. So I think
16 it's really valuable to continue to understand how these
17 other changes in the system are influencing the core
18 providers of value in the health care system, which is,
19 honestly, the delivery system is what people fundamentally
20 care about.

21 So anyway, thank you very, very much for this
22 work. I look forward to following it going forward. For

1 those of you at home, you can reach out to us at
2 meetingcomments@medpac.gov. You can reach us at any other
3 way. We do really want to hear your feedback, and the
4 staff takes all of it very seriously. So again, thank you
5 very much.

6 We will back tomorrow morning. We will be doing
7 some MA work. We have some work on I-SNPs. We have some
8 work on the complexity of the choice environment that
9 beneficiaries face, both of which I think are extremely
10 important. And the public meeting is going to start at
11 9:45 tomorrow morning, after our Executive Session.

12 So again, thanks all. Be safe. See you
13 tomorrow.

14 [Whereupon, at 5:36 p.m., the meeting was
15 recessed, to reconvene at 9:45 a.m., on Friday, April 10,
16 2026.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, April 10, 2026
9:46 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
BETTY RAMBUR, PhD, RN, FAAN, Vice Chair
PAUL CASALE, MD, PhD
ROBERT CHERRY, MD, MS, FACS, FACHE
CHERYL DAMBERG, PhD, MPH
THOMAS DILLER, MD, MMM
STACIE B. DUSETZINA, PhD
KENNY KAN, FSA, CPA, CFA, MAAA
R. TAMARA KONETZKA, PhD
JOSHUA LIAO, MD, MSc
GOKHAN METAN, MSc, PhD, NACD.DC
BRIAN MILLER, MD, MBA, MPH
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P R O C E E D I N G S

[9:46 a.m.]

1
2
3 DR. CHERNEW: So we're going to work on the
4 volume, but as we do, I will speak loudly to say welcome to
5 everybody for the last session of our April meeting and the
6 last session of the cycle. One of the themes that we have
7 had this cycle has been just the complexity of the Medicare
8 program, and we acknowledge that the Medicare beneficiaries
9 in navigating this complexity seek a number of different
10 information sources that themselves are complex. So we're
11 starting a body of work to think through that process of
12 how people experience the Medicare program. And to start
13 the discussion today we're going to go to Jennifer.

14 MS. DRUCKMAN: Good morning. Last month the
15 Commission discussed the complexity of Medicare enrollment
16 decisions. In MedPAC's annual focus groups with
17 beneficiaries, we hear that beneficiaries often rely on
18 various information sources to make Medicare enrollment
19 decisions. We will discuss those sources today. The
20 materials from the March and April sessions will be
21 combined into a chapter of the June Report to the Congress.

22 We would like to thank Kennedy Sams for her help

1 on this work. We'd also like to remind the audience that
2 they can download a PDF version of these slides from the
3 top right corner of the screen by the paperclip icon.

4 During today's presentation on information
5 sources for Medicare beneficiaries, I'll first touch on use
6 of information sources and marketing followed by an
7 overview of Medicare information sources from CMS. Next,
8 Pamina will describe the State Health Insurance Assistance
9 Program, or SHIP, and the findings of our interviews.
10 Finally, Ledia will review the role of insurance agents,
11 which will be followed by your discussion.

12 Beneficiaries make complex enrollment decisions
13 and understanding the enrollment requirements and time
14 frames for action can be confusing. Some enrollment
15 decisions have lifelong implications, such as Part B late
16 enrollment penalties. As discussed last month, when
17 choosing between fee-for-service Medicare and Medicare
18 Advantage, beneficiaries weigh various factors, including
19 financial protections, access to care, and extra benefits
20 offered by plans against their own needs and preferences.
21 Beneficiaries need to weigh these factors considering both
22 current and future health needs. Their future health

1 needs, of course, may not be evident at initial enrollment.
2 Also, researchers have found that individuals have
3 difficulty understanding insurance concepts and are prone
4 to various decision-making biases when selecting health
5 plans.

6 A 2022 Commonwealth Fund survey found that more
7 than half of Medicare beneficiaries used variety of sources
8 for information and advice on Medicare plan choices. About
9 one in three Medicare beneficiaries, regardless of
10 coverage, used insurance agents to choose a plan. This is
11 indicated by the bars on the left hand side of the slide.
12 Note that respondents could select more than one option, so
13 the sum of percentages will exceed 100 percent. The
14 Commonwealth Fund survey also found that about 5 percent of
15 fee-for-service beneficiaries and 9 percent of MA enrollees
16 reported using the Medicare hotline or Medicare.gov. Four
17 to five percent of beneficiaries reported using the SHIP.

18 In our focus groups, beneficiaries report
19 receiving lots of mailing materials and phone calls about
20 MA plans. Plans and TPMOs use marketing, such as TV
21 advertisements, to attract enrollees. Some stakeholders
22 have raised concerns that the growth in marketing by plans

1 and TPMOs, or third-party marketing organizations, has
2 increased confusion about Medicare coverage options for
3 some beneficiaries. A KFF review of TV ads found that TV
4 airways were flooded with ads for Medicare plans and some
5 ads suggested that Medicare beneficiaries would miss out on
6 benefits to which they are entitled if they are not
7 enrolled in an MA plan. A recent study found that the
8 number of beneficiaries who "rapidly disenroll," meaning
9 they disenroll from an MA plan during the January to March
10 open enrollment period, has notably increased, which could
11 be indicative of dissatisfaction with a chosen plan or
12 misleading marketing.

13 In conversations with some agents and others in
14 the industry, we commonly heard that the structures and
15 roles of organizations and individuals involved in
16 marketing MA plans and enrolling beneficiaries have changed
17 over time from small independent brokerages and agents to
18 large field marketing organizations, or FMOs. We heard
19 that individual agents, FMOs, call centers and lead
20 generators are considered TPMOs under the current
21 regulatory definition, but they serve different roles.

22 Stakeholders have highlighted questionable TPMO

1 lead generation activities, and the role of on-shore and
2 off-shore call centers in marketing activities. CMS has
3 recently issued a request for information on ways to modify
4 the current regulatory definition of TPMOs and to delineate
5 the roles of and requirements applicable to the different
6 kinds of TPMOs.

7 Now we will review the Medicare information
8 sources beneficiaries use to make their Medicare coverage
9 choices.

10 CMS offers several information sources that
11 beneficiaries and their families or caregivers can use to
12 get information to help navigate their enrollment and
13 coverage choices. We've listed the key sources here.
14 First, the 1-800-MEDICARE helpline responds to beneficiary
15 inquiries and is available 24 hours a day, except for
16 certain holidays. Second, the Medicare.gov website has a
17 wealth of information about Medicare enrollment and
18 benefits, including the annual Medicare & You handbook, the
19 Medicare Plan Finder, and links to other resources.
20 Beneficiaries can use the Medicare Plan Finder tool to get
21 information about the MA plans, standalone Part D plans,
22 and Medigap policies offered in their area. Plan Finder

1 provides information on such features as plan premiums,
2 cost-sharing rules, out-of-pocket limits, and supplemental
3 benefits.

4 CMS created Plan Finder in the late 1990s, and it
5 has been modified over time. Last year, CMS added
6 information from MA provider directories, which addressed a
7 key gap by letting beneficiaries see which plans have their
8 providers in their network. Prior to this change,
9 beneficiaries had to visit each plan's website to get
10 information about its provider network. However, there are
11 longstanding concerns that the information in these
12 directories can be inaccurate, which could result in some
13 beneficiaries selecting plans that don't have all of their
14 providers in the network.

15 While Plan Finder has improved, there are still
16 some limitations. For example, for MA plans, Plan Finder
17 has limited detail on supplemental benefits and
18 beneficiaries may need to review plan documents for
19 details. For Medigap plans, Plan Finder has some
20 information about premiums but it may not be accurate for
21 beneficiaries who would be subject to medical underwriting,
22 and beneficiaries need to contact the insurer to get an

1 accurate premium quote and/or buy a policy.

2 I'll turn it over to Pamina to describe the SHIP.

3 MS. MEJIA: Thanks, Jen. Now moving to another
4 source of information for beneficiaries, the State Health
5 Insurance Assistance Program, or SHIP.

6 SHIP is the main federal source of individual-
7 level counseling for Medicare beneficiaries. Created in
8 the 1990s, the SHIP is a federal program that provides
9 grants to the 50 states, the District of Columbia, Puerto
10 Rico, Guam, and the U.S. Virgin Islands to deliver Medicare
11 counseling and information assistance to beneficiaries and
12 their caregivers, as well as enroll beneficiaries in
13 Medicare plans.

14 SHIP grantees provide assistance to beneficiaries
15 through individual counseling in person, by telephone, on
16 the internet, or through email, as well as through
17 community outreach events. Just over 10,000 SHIP
18 counselors provided individual counseling to nearly 1.2
19 million beneficiaries in the second half of 2025.

20 Counselors aid beneficiaries on either a paid or
21 volunteer basis and do not receive compensation from
22 insurers. Before assisting beneficiaries, all SHIP

1 counselors must complete training and certification
2 requirements. Each grantee chooses their respective
3 training, but most draw from the training modules created
4 by the SHIP Technical Assistance Center. To promote
5 consistency in counselor certification, the Administration
6 for Community Living is developing a new national SHIP
7 counselor certification program.

8 SHIP is funded through a combination of
9 discretionary and mandatory federal funding from the
10 Medicare trust funds, as well as state and local funding.
11 Discretionary federal funding supports SHIP operations that
12 serve all Medicare beneficiaries, while mandatory federal
13 funding supports additional individual counseling and
14 outreach services targeted to hard-to-reach populations.

15 SHIP discretionary funding has not kept pace with
16 the growth in Medicare enrollment. From 2008 to 2025, the
17 annual amount of discretionary funding appropriated to the
18 SHIP, adjusted for inflation, has declined by 26 percent,
19 from about \$77 million to \$57 million. At the same time,
20 Medicare enrollment has increased by about 53 percent, from
21 about 46 million to 70 million beneficiaries.

22 As part of our work examining the complexity of

1 enrollment choices in Medicare, we conducted interviews
2 with ACL staff that direct SHIP grantees, staff at the SHIP
3 Technical Assistance Center, and counselors and staff from
4 seven different grantees. We selected grantees to
5 interview in areas with varying Medicare Advantage
6 penetration rates, shares of beneficiaries who are dually
7 eligible for Medicaid, and differing Medigap guaranteed-
8 issue policies.

9 Interviews were a semi-structured discussion on
10 topics related to the experiences of SHIP grantees working
11 with beneficiaries as they make Medicare enrollment
12 decisions, as well as the functions of the SHIP.

13 The first theme heard from interviewees is that
14 SHIP grantees assist beneficiaries that have a wide range
15 of Medicare needs and income levels, reflecting substantial
16 variation in beneficiaries' characteristics and
17 understanding of the Medicare program. Interviewees
18 explained that new beneficiaries typically contact the SHIP
19 to gain a basic understanding of Medicare's structure and
20 coverage options.

21 Throughout the year and outside of the annual
22 enrollment period, SHIP grantees we spoke with reported

1 receiving non-enrollment related questions about filing MA
2 coverage appeals, navigating the use of MA supplemental
3 benefits, and beneficiaries' inability to afford their Part
4 D prescription drugs.

5 Grantees described working with beneficiaries
6 with varying income levels as well. We heard that
7 beneficiaries with higher incomes often sought assistance
8 with selecting the appropriate Medigap policy, while
9 beneficiaries with lower incomes typically required
10 assistance with applying for Medicaid.

11 A second theme from our interviews was that SHIP
12 grantees provide in-person assistance and stay up-to-date
13 on local market conditions. Interviewees highlighted the
14 value of the local nature of SHIP grantees because they can
15 meet in-person with beneficiaries, allowing for more in-
16 depth conversations and help completing paperwork such as
17 applications for Medicaid. SHIP grantees also possess
18 local knowledge of provider and pharmacy networks,
19 available plans, and retiree coverage offered by nearby
20 employers. Interviewees also reported that grantees
21 receive referrals directly from 1-800-MEDICARE. These
22 referrals frequently involve state-specific questions

1 related to Medicaid eligibility.

2 A third theme from our interviews was that SHIP
3 grantees have ongoing limited capacity. In the interviews
4 we consistently heard of year-after-year capacity
5 challenges, with one interviewee describing their
6 counselors as "overburdened." One interviewee described
7 the 2025 Annual Enrollment Period in particular as a
8 "perfect storm" of an increased number of Medicare
9 Advantage plan terminations and provider network exits in
10 some regions, increased referrals from insurance agents,
11 and the impacts of expanded SHIP outreach and marketing
12 efforts.

13 During the AEP, SHIP grantees often reach limits
14 on the amount of counseling appointments they can take from
15 beneficiaries. When this occurs, beneficiaries are
16 referred to 1-800-MEDICARE. During the 2025 annual
17 enrollment period which ran from October 15 to December 7,
18 one SHIP grantee we spoke with reported that they had to
19 stop taking counseling appointments as early as 3 weeks
20 into the AEP.

21 I'll now turn it over to Ledia to discuss
22 insurance agents.

1 MS. TABOR: Medicare insurance agents can help
2 beneficiaries navigate their Medicare decisions. Agents
3 are licensed individuals who enroll people in insurance
4 products. As mentioned at the beginning of the
5 presentation, about a third of beneficiaries reported
6 working with an insurance agent to select their Medicare
7 coverage.

8 In our annual focus groups, beneficiaries report
9 positive experiences working with insurance agents. Many
10 beneficiaries reported that they had worked with agents to
11 determine out-of-pocket costs and premiums of individual
12 plans when selecting their Medicare coverage.
13 Beneficiaries described how their insurance agents tailored
14 suggestions based on their individual health needs,
15 especially medication lists and clinician preferences.
16 Beneficiaries in our focus groups found the agents to be
17 helpful and ultimately selected their plan after discussing
18 options with their agent.

19 We also spoke with some agents who reported that
20 they value a long-term relationship with their clients, and
21 want to get them in the best plan, regardless of financial
22 incentives.

1 Agents typically sell plans from multiple
2 insurance companies, but they are not required to sell
3 every plan in the area. In this way, the agent is
4 filtering plan options. This filtering is not always
5 apparent to the beneficiary even if the agents and agencies
6 disclose it in their communications. There is more
7 information about some of the federal requirements around
8 agent communication with beneficiaries that is in your
9 reading materials.

10 We don't know the average number of plans a
11 particular agent may sell. However, a Commonwealth Fund
12 study reviewed the plans included on three large, online
13 agent tools across five cities. They found that, on
14 average, the tools included less than half of MA plans and
15 less than two-thirds of Part D plans.

16 Agents are compensated for selling plans in
17 varying and complex ways. Agents receive initial and
18 renewal commissions from insurers for enrolling
19 beneficiaries in the MA, Medigap, or standalone Part D
20 plans they sell.

21 In addition to commissions, there are often
22 opportunities for supplemental compensation, such as a

1 bonus for meeting enrollment benchmarks, administrative
2 payments for marketing, or payments for carrying out other
3 activities for plans such as beneficiary health risk
4 assessments.

5 Now we'll discuss two general categories for
6 agent compensation for selling MA and PDPs. These are from
7 federal requirements for MA and Part D organizations
8 surrounding the compensation of agents they use to sell
9 their plans.

10 First, agents receive compensation for enrolling
11 a beneficiary in a plan. When an agent initially enrolls a
12 beneficiary in a plan, insurers can pay agents a maximum
13 amount of the Fair Market Value, or FMV, for that service,
14 which CMS sets annually. When an agent renews a
15 beneficiary's enrollment in a plan or enrolls them in a new
16 "like plan type," insurers can pay agents an amount capped
17 at 50 percent of the FMV.

18 Second, insurers can make administrative payments
19 for services other than enrollment of beneficiaries, for
20 example, training, customer service, agent recruitment, or
21 conducting health risk assessments. There is no set cap
22 for these payments.

1 For contract year 2026, the maximum amount, or
2 fair market value, that insurers can pay agents for initial
3 enrollment in an MA plan is \$694, with exceptions for
4 certain states and territories. In 2026, the maximum fair
5 market value for initial enrollment in a PDP plan is \$114.
6 The compensation for renewing enrollment is capped at half
7 those amounts.

8 As mentioned in the previous slide there is no
9 set cap for administrative payments. CMS estimates that
10 administrative payments insurers pay far exceed the
11 compensation for enrollment.

12 In general, actions of agents when marketing
13 Medigap plans are governed by state law and regulation, so
14 there are no federal compensation requirements. For
15 enrolling a beneficiary in Medigap policy, an agent
16 typically receives a percentage of the annual Medigap plan
17 premium from the insurer.

18 Multiple industry sources report that first year
19 commissions for enrollments in Medigap are about 20 percent
20 of annual premiums but can vary based on the state or plan
21 type. The commission for subsequent years is generally set
22 at 10 percent of the premium.

1 Based on this national average premium, an agent
2 selling Medigap plans could be paid about \$520 for initial
3 enrollment and \$260 for subsequent years of enrollment.

4 Note that these are general estimates because premiums and
5 rate adjustments for policies can vary. Some agents have
6 also reported receiving bonus commissions from insurers
7 when enrollment targets are met.

8 Some stakeholders have voiced concern that agents
9 have financial incentives to steer beneficiary decision-
10 making. These incentives could favor enrollment in MA
11 plans over fee-for-service Medicare with Medigap plans and
12 PDPs, in higher-premium Medigap plans over lower-premium
13 Medigap plans, and in plans that offer bonuses for reaching
14 enrollment benchmarks.

15 In focus groups held by the Commonwealth Fund in
16 2022, most agents recalled receiving higher commissions for
17 enrolling people in MA plans.

18 This slide is an illustrative example of the
19 financial incentives that agents may have to enroll
20 beneficiaries in MAPD plans over a Medigap and standalone
21 Part D plan. This is illustrative because it looks at one
22 market and we know that Medigap premiums vary by market.

1 The example also does not include data on administrative
2 and bonus payments that insurers may pay agents.

3 At initial enrollment, in 2026, an agent
4 enrolling a beneficiary in an MAPD could make up to \$694,
5 which is the CMS set fair market value. If an agent
6 instead enrolled that beneficiary into a median-priced
7 Medigap Plan G and a standalone Part D plan in that market
8 they could make a total of \$486. On that initial
9 enrollment, the agent would therefore make \$208 more for
10 enrolling the beneficiary in MA over Medigap and PDP
11 policies.

12 In the next renewal year, the difference is
13 smaller, but an agent could still make more from enrolling
14 the beneficiary in an MAPD plan. Assuming that a
15 beneficiary were to stay in the same plan in this example
16 over a 5-year period, an agent would make \$624, which is 30
17 percent more for enrolling a beneficiary into an MA plan
18 rather than a Medigap or PDP plan.

19 Insurers do not have to pay commissions to agents
20 for enrolling beneficiaries in MA plans. Insurers may stop
21 paying commissions for some plans because sales are higher
22 than desired. There are increasing reports that some

1 insurers halt commission payments for new enrollment in
2 certain MA, Medigap, and stand-alone Part D plans. These
3 increases have led to growing concerns from state
4 departments of insurance and agents about the effect of
5 zero-dollar commissions on consumer access to plans.

6 This leads us to your discussion. Today we
7 reviewed some sources of information beneficiary use to
8 make enrollment decisions including CMS information sources
9 like the Plan Finder website, SHIPs, and insurance agents.

10 This information along with the complexity of
11 Medicare choices materials discussed at last month's
12 meeting, is intended for publication in the June 2026
13 Report to the Congress

14 We are happy to answer any questions about the
15 materials we presented.

16 We look forward to the discussion and I'll turn
17 it back to Mike.

18 DR. CHERNEW: Great. Ledia, thank you. Thank
19 you all. We're about to do Round 1, but first I want to
20 acknowledge that we are now experimenting with the post-
21 COVID version of a public meeting. So thank you for
22 coming. We are happy to allow folks to want to come to see

1 how exciting this is in person. And the real part you're
2 going to see that's exciting is Gina talking about consumer
3 information.

4 So Gina, I think you're the first in Round 1.

5 MS. UPCHURCH: First of all, the staff, this is
6 what makes me so proud to be a part of MedPAC. What
7 excellent work, in talking to folks and figuring out the
8 main issues that are faced by consumers in America trying
9 to leverage Medicare benefits.

10 Just a couple of Round 1 questions and a lot of
11 Round 2 comments. First of all, we call Medicare the
12 "equal opportunity confuser," so you're exactly right. No
13 matter your age or income, Medicare is very confusing to
14 people.

15 A couple of very specific questions. And by this
16 way, this explains why in the fall I'm in a foul mood
17 oftentimes, because we're dealing with all this. On page
18 22 you mentioned the discretionary funding of the 55
19 million has not kept up with inflation or the growth in
20 population. Do we know if the mandatory spending, which is
21 a lot less, of the 16 million, has that kept up, or has it
22 changed?

1 MS. DRUCKMAN: It has not kept up but it is a
2 smaller population. It's not the full population. And we
3 can follow up with you on those number.

4 MS. UPCHURCH: It's a pittance, and I'll get to
5 that in my comments. Of the 71 million combination of
6 discretionary and mandatory -- for SHIPs is what I'm
7 talking about, sorry, payment to SHIPs -- do we know how
8 much is distributed to the local folks? Because some is
9 kept at the federal level, some goes to the state programs,
10 and then some trickles down to the community level. Do we
11 know how much of that?

12 MS. TABOR: We have the reporting on the grantee
13 at the state level. We don't have the details on how much
14 the local side is getting.

15 MS. UPCHURCH: Okay. that would be good to know,
16 because that's where the rubber meets the road oftentimes.
17 And then lastly, and you all heard me ask this before about
18 medical loss ratios, do we know where the plays paying the
19 agents for enrollment goes in the medical loss ratio?

20 MS. TABOR: It is administrative.

21 MS. UPCHURCH: And somebody's got to train the
22 agents, test the agents. Is that also administrative?

1 MS. TABOR: That is administrative, yes.

2 MS. UPCHURCH: Okay. And lastly there are some
3 third-party platform. You mentioned the FMOs. So for
4 those of you who don't know, many agents have their own
5 third-party IT system instead of the Plan Finder. They
6 have their own system. So somebody's got to be paying for
7 that. Do we know who pays for that and where those dollars
8 go?

9 MS. TABOR: That's all in the administrative, as
10 well. We are continuously learning about the complicated
11 structure of the third-party marketing organizations,
12 including the field marketing organizations that you
13 mentioned. And our understanding is a lot of the
14 administrative payments that plans are paying to the third-
15 party marketing organizations are going to developing IT
16 systems, doing the training, et cetera.

17 MS. UPCHURCH: Just so you know, the medical loss
18 ratio for Medigap is 65 percent. It is not the 85 percent.
19 Thanks.

20 DR. CHERNEW: One thing. I just want to clarify
21 the clarify. There is not direct payment for all of those
22 things. The funding for anything that an agent would do

1 all of their expenses, that is coming out of the payments
2 from the plans to the agents. That is coming out of the
3 money that you had on the slide. The money you had on the
4 slide is sort of the commission that gets paid to the
5 agent. But any expenses or other things have to come out
6 of that.

7 MS. TABOR: The administrative payments that are
8 kind of in addition to the initial and renewal
9 compensation.

10 MS. UPCHURCH: It's in addition.

11 MS. TABOR: It's in addition, yes.

12 MS. UPCHURCH: Thank you so much for this great
13 work.

14 MS. KELLEY: That's all I have for Round 1,
15 unless someone else wants to jump in. So we could go to
16 Round 2, Mike? And it is Gokhan.

17 DR. METAN: Amazing work. First of all, thank
18 you very much. I learned a lot from the chapter itself,
19 even though I knew a lot about this part of the business
20 already.

21 Before I get to some of the specific comments, I
22 would like to highlight a couple of important things that I

1 took away from the chapter. Again, this is a producer-led
2 industry, right. Agents and brokers are actually formally
3 called as producers. And as long as it remains as a
4 producer-led industry, I believe these issues in
5 distribution will persist in some shape and form. To me,
6 because the real question is how do we reduce these issues
7 and find policies that can push us towards that.

8 When I read the 40-plus pages chapter, my one
9 sentence takeaway is the core tension is that the
10 beneficiaries needs for objective, personalized guidance is
11 growing, while public sector capacity is shrinking, and
12 commercial actors with financial incentives are filling the
13 void. That's my one sentence takeaway.

14 I would also like to emphasize a few striking
15 takeaways from the paper before I move to recommendations
16 and some of the additional suggestions I have. First of
17 all, about the scale of the problem, 29 percent of the
18 beneficiaries consistently find Medicare difficult to
19 understand, and a third find it hard to compare plan
20 options. Only 27 percent sought information in the past
21 year. This suggests most beneficiaries are making high-
22 stakes decisions with little active research.

1 Marketing is adversarial. That's the second, I
2 think, important takeaway I have. MA rapid disenrollment,
3 tripling from 3.5 percent to 12.2 percent between 2017 and
4 2022, I think sends a strong signal that beneficiaries are
5 being enrolled in plans that don't fit their needs.

6 The third one I would like to call out is SHIP is
7 structurally underfunded. The inflation-adjusted
8 discretionary SHIP funding declining 26 percent from 2008
9 to 2025, while Medicare only grew 53 percent. I think that
10 is very concerning. And SHIP hitting capacity before
11 Thanksgiving, during the 2025 AEP is also striking to me.

12 And the last one I would like to call out is
13 Medicare Plan Finder. These are meaningful enhancements,
14 but to me there are significant gaps that remain. What was
15 striking to me was 2025 editions of provider director data
16 and supplemental benefit details are really good
17 improvements, but to learn that provider data is complete
18 and sourced from a private intermediary is mind-blowing to
19 me. And limited to five clinicians and excluding hospital
20 and SNFs search, that is unacceptable, in my opinion. And
21 if you compare Medicare enrollment with the Affordable Care
22 Act today, the Exchange, most of the data is available in

1 the exchanges, so why can't we do the same thing in
2 Medicare?

3 Now I will move to some of the actionable
4 recommendations I have. I will limit it to three, even
5 though I had seven. The first one is around restructuring
6 SHIP funding to match enrollment growth and formalizing a
7 triage and routing system. I think this is essential.

8 Before I start some of the kind of alternative
9 solutions we propose, I would like to again quote some of
10 the important findings in this direction. SHIP
11 discretionary funding fell 26 percent in real terms while
12 enrollment grew 53 percent. SHIP reached capacity before
13 Thanksgiving, meaning beneficiaries in the final weeks of
14 the enrollment period had nowhere to turn for objective
15 counseling. That's troublesome.

16 The 2025 AEP was described as a perfect storm
17 with call volumes four times normal levels at some sites.

18 So when I look at the total agent-broker
19 compensation payouts of \$6.9 billion reported in the paper,
20 which, by the way, I believe is an underestimate of what is
21 actually being paid, if you compare that figure with the
22 \$55.2 million spending in SHIP, the ratio is 125 to 1. Let

1 me repeat that again. The ratio is 125 to 1. Of
2 commercial marketing compensation to objective public
3 counseling. That to me is very problematic.

4 I think there are alternative solutions we can
5 propose. The first one could be Congress could index the
6 SHIP discretionary appropriations to Medicare enrollment
7 growth going forward, and provide a one-time catch-up
8 allocation to address the estimated funding gap.

9 Another alternative could be if, again, funding
10 is through our existing resources and adoption. What if,
11 for every dollar MA plans compensate agents and brokers,
12 another dollar goes into your pool of funding for SHIP?

13 The last thing I would like to talk about in this
14 area is where AI can play a role. Again, I come from a
15 technology background, so it is important for us to think
16 about where the technology can also help us. Several SHIPs
17 reported exploring rule-based chatbots for routine
18 questions. This be formalized and scaled, in my opinion.
19 An AI-powered first contact layer could handle Medicare 101
20 type of questions, eligibility screenings, and enrollment
21 period lookups. Triaging routine inquiries away from human
22 counselors so that limited SHIP capacity is preserved for

1 the complex, high-stake cases like D-SNP coordination,
2 Medicaid eligibility, MSP applications, where human
3 judgment is genuinely irreplaceable.

4 Given that average SHIP session length grew from
5 28 to 33 minutes, between 2014 and 2021, given, I think,
6 moderate deflection of routine calls would materially
7 expand effective SHIP capacity without new hiring.

8 The second area of recommendations is around
9 closing the administrative compensation loophole with per-
10 beneficiary caps and transparency requirements. CMS itself
11 acknowledged -- again, reading from the paper itself --
12 administrative fees paid per enrollee far exceed the
13 compensation paid for that. The Senator Finance Committee
14 estimates \$6.9 billion for total agent-broker and TPMO
15 payouts in 2023. But with unreported bonuses, broker
16 compensation can reportedly top \$1,300 per enrollee, based
17 on some of the research I made.

18 If we triangulate some of the information out
19 there, we are probably looking somewhere around \$20 billion
20 of spending in this space, if not more. And this is the
21 money that is not spent on care.

22 Potential recommendations in this area is

1 transparency oriented. I think CMS could require MA plans
2 and TPMOs to disclose total aggregate compensation,
3 enrollment commission plus administrative and bonus
4 payments, by agent and by plan, to CMS annually. Using
5 this data, we can establish an evidence-based total
6 compensation cap, analogous to the existing FMV framework,
7 for enrollment commissions and covering all forms of agent
8 payments.

9 The last thing I would like to call out is
10 related to the Medicare Plan Finder, and AI-powered
11 decision support within that framework. First of all, it
12 is positive news that CMS issued an RFI in February 2026,
13 specifically on AI tools for Medicare experience
14 modernization. Although it is a start, after reviewing the
15 RFI myself I'm skeptical of CMS will get much out of this
16 RFI, given the excessive restrictive requirements they put
17 into their RFI. It is my hope that they would revise going
18 forward and looking at new, innovative approaches out
19 there.

20 My recommendation on this front is I think
21 commissioning and deploying a conversational AI assistant
22 embedded directly in the Medicare Plan Finder that can

1 guide beneficiaries through plan comparison in natural
2 language, asking about their medications, preferred
3 providers, expected utilization, and financial situation,
4 then generating a ranked, personalized shop list with plain
5 language explanation.

6 The complexity of simultaneous optimization
7 includes premiums, drug formularies, provider networks,
8 supplemental benefits, and cost sharing is precisely the
9 kind of multidimensional comparison that AI handles well
10 and that overwhelms humans' cognitive bandwidth.

11 CMS's own RFI envisions this exact capability,
12 including the use of fee-for-service claims and Part D data
13 to personalize recommendations. A well-driven AI tool is
14 inherently neutral, so no commission incentive, available
15 24/7, scalable to tens of millions of beneficiaries, and
16 can be continuously updated as plan data changes annually. It
17 would directly counter the information asymmetry that
18 commercial agents can exploit. This capability also
19 strengthens, in my opinion, SHIP, as the program leverages
20 Medicare Plan Finder.

21 I would like to also emphasize important
22 governance guardrails as we invest in these technologies.

1 I think recommendations must be explainable, auditable, and
2 subject to periodic testing, analogous to the Secret
3 Shopper framework already used to evaluate SHIP counselors.

4 And last, I would like to also call out a quick
5 adjustment in verbiage in the paper. In a couple of areas
6 we are saying "best plans." We should avoid using "best
7 plan" because, per CMS guidelines, to promote the "best
8 plan" is generally prohibited unless substantiated by
9 specific data, such as five-star ratings and so forth. So
10 I think if that is the barrier holding everyone up against,
11 we should use that ourselves and change the "best plan"
12 uses from our paper, as well.

13 Thank you very much. Great work.

14 MS. KELLEY: Stacie.

15 DR. DUSETZINA: Well, I hate to follow that.
16 Those were great comments, Gokhan. So just a couple of
17 notes about the chapter. I thought it was fantastic. It
18 did a great job of outlining some of the key pressure
19 points, and picking a Medicare plan is very difficult.

20 Like Gokhan's comment around the disenrollment in
21 the chapter for the MA plans, I thought that was shockingly
22 high, the big jump. One of the things I did wonder was, is

1 part of that due to the extended time people have for
2 getting out of a Medicare Advantage plan? I think CMS
3 changed the time frame so that they had a little bit more
4 time, maybe an extra month or two, to make those
5 disenrollment decisions. And I might just check that paper
6 that you referenced to see, is it also a little bit of a
7 change there, as well.

8 I would completely buy that maybe it's because
9 they're going into the wrong plan and that they're less
10 satisfied over time, but I would want to make sure that
11 that's comparing it apples to apples for how much time you
12 have.

13 You know, your description of the barrage of
14 information that people are getting hit with and the data
15 we have varies. Really concerning, the marketing, the TV
16 ads. If you watch TV at all during that time of year
17 you've seen them all. It's crazy the amount of information
18 that's getting thrown at people, and, frankly, it doesn't
19 seem very accurate. I think John Oliver did a segment
20 showing basically some of these ads, and you're like, okay.
21 The one that stuck out to me is they were like, "You're
22 missing Part C? You have A and B and D but you're missing

1 C?" And it's like, well, okay, everybody is going to think
2 they're missing something and then try to change to get it.
3 Like, okay, that's not great.

4 You know, the statistic about the CMS audited
5 calls, and 80 percent of them had factually incorrect
6 information makes me think, you know, this is an incredibly
7 hard thing to do. So even if you're doing your best, I'd
8 imagine that brokers struggle with this. It's like you're
9 doing your best to help people to pick a plan, and then you
10 layer on financial incentives that maybe aren't that. Like
11 even if you don't have a financial incentive, it's really
12 hard to get this right. When you do, maybe you're
13 incentivized not to work as hard to get the right fit for
14 the patient.

15 I will plus-one on the improvements to the Plan
16 Finder. It's great that now you get some network
17 information about the physicians. It's limited, so it
18 needs to be improved. But you don't have to go outside of
19 the website. That's a big improvement.

20 But I was really annoyed to see that you can't
21 get Medigap information and premium information there.
22 That should be fixed. So at a basic information, you

1 shouldn't have to go somewhere else to get that information
2 too. Even if we were just patching up Plan Finder a little
3 bit more, like more network information and more on Medigap
4 premiums would be really important.

5 I do really like the idea of doing a little bit
6 more in the AI space, but I am less of an enthusiast than
7 Gokhan, to say the least. I'm like, oh, these could kind
8 of go off the rails a little bit, recommend things that
9 maybe aren't that great.

10 I kind of wonder, would SHIP be the right place
11 to pilot those tools, because then you have a very
12 knowledgeable person who is seeing how those suggestions
13 might actually work for a beneficiary. So that's what I
14 would suggest. If we went down that path of AI chatbots
15 trying to help with developing recommendations, have that
16 running through SHIP so you have a really knowledgeable
17 person who can help.

18 I think it's not great that SHIP is under-
19 resourced, that half of their workforce are unpaid
20 volunteers, although I know quite a few of those unpaid
21 volunteers, and they are enthusiastic beyond belief, so I
22 believe that they give great, great service.

1 And then the last point, you know, the broker
2 compensation piece really frustrates me. I think yesterday
3 there was a comment about people shouldn't have to work for
4 free. So I don't think that people should have to work for
5 free, and they are clearly a great source of information.
6 A lot of beneficiaries rely on them. But the differences
7 in how you get compensated across different plans, I think
8 that's not a good thing. We should level the playing field
9 so that your incentive is to get people into the right plan
10 for them and you don't get paid differently based on which
11 plan they go into.

12 And I also think that should be absolutely
13 transparent. So if you do allow for plans to pay different
14 amounts, that CMS should report, by plan, what the
15 compensation for brokers are rather than just showing this
16 upper limit that they can pay.

17 Also, the point about getting a percentage of the
18 Medigap premium, to me that is unacceptable. We know that
19 Medigap premiums vary a lot. And so the idea that you have
20 a financial incentive to get people into a very expensive
21 product is really concerning to me.

22 So I'm glad to see this work. I think it's

1 incredibly important, and look forward to making this
2 better for beneficiaries moving forward.

3 MS. KELLEY: Cheryl.

4 DR. DAMBERG: Thank you so much for all the great
5 work you did on this chapter. It's really important and
6 informative work, so we're all very grateful.

7 I kind of think about this area as choice with
8 consequences. It's my CWC acronym. And we clearly need
9 resources to help beneficiaries navigate this very complex
10 space. And I think the need for more resources is
11 important given that the space keeps getting more and more
12 complex. And I think we're all in agreement that the SHIPs
13 provide really essential services Medicare beneficiaries as
14 a source of unbiased information, and I think we
15 collectively probably agree that it's substantially
16 underfunded. And I have concerns. I'm very grateful for
17 all the volunteers who work, but my question is should this
18 be heavily an all-volunteer army of people helping people
19 make these choices.

20 And I agree with Gokhan's comments about sort of
21 need to rethink how this is funded, whether that's
22 requesting that plans sort of contribute a certain amount

1 of money per year to support the work of SHIPs in addition
2 to agents and brokers. You know, kind of this I do sort of
3 a rough calculation that looks like between the \$16 million
4 and the \$55 million we're spending about a dollar per
5 beneficiary per year, which is not a lot of money to help
6 them make a really important choice that has consequences.

7 And I think this really is so essentially,
8 particularly given that this environment keeps changing,
9 and the changes that occur each year can be overwhelming
10 for people to make sense of. And it's hard to track what
11 all these changes are. So beneficiaries rely pretty
12 heavily on agents to help them navigate that space, as well
13 as the SHIP counselors, and I think we have to provide them
14 the support they need, because again, whatever choices they
15 make have consequences.

16 I also agree that the enhancement to the Medicare
17 Plan Finder are steps in the right direction, that haven't
18 gone far enough, whether it's ensuring that all providers
19 are represented, costs are represented. We shouldn't have
20 people chasing down information from five, ten different
21 websites.

22 I also want to plus-one on something that Stacie

1 said about sort of the overwhelming number of ads. I think
2 this is really important in this space because seniors are
3 so susceptible to fraud. And as you're trying to digest
4 all of this information that's coming at you, whether it's
5 through radio, TV, other sources, I think it's hard for
6 them to sort through what's a legitimate source of
7 information. And despite the fact that CMS has guardrails
8 around what ads can say, I just think it sort of looks like
9 it's an area that's ripe for fraud, even if it's not going
10 on.

11 And then, lastly, to close, I would say overall I
12 still think, fundamentally, we need to focus on simplifying
13 the rules of engagement and the choice that the consumers
14 have.

15 MS. KELLEY: Gina.

16 MS. UPCHURCH: Thanks again for this tremendous
17 work, and I plus-one the three comments that were prior to
18 me.

19 Full disclosure. Senior Pharmacist is the SHIP
20 coordinating site in Durham, North Carolina. We have seven
21 staff, trained counselors, full-time working, 43 hours a
22 week, and we have 10 volunteers. And we work for 7 1/2

1 weeks to help people sort through this. We three months of
2 Medicare Advantage at the beginning of the year where we
3 have a lot of volunteers primarily focused there, and the
4 rest of the year the new-to-Medicare, the appeals. Okay.

5 So just a couple of things about the Plan Finder.
6 I'm going to give some very practical recommendations here.
7 Currently it only lists doctors, so you can't look up a
8 nurse practitioner or PA. You can't look up a hospital, a
9 SNF, as we've mentioned. If joining a Medicare or Medicare
10 Advantage plan you have to enter your primary care
11 provider, or they assign you one. So that's a problem if
12 you deal with a nurse practitioner or a PA. They're not
13 listed. So can free-text the providers name but it doesn't
14 always work out. It creates work for you and the
15 beneficiary to do later to correct it.

16 For example, we recent had a male who sees a
17 nurse practitioner. And we free-texted the name because we
18 couldn't put it in. The insurer assigned him to a Women's
19 Health Clinic at a local health system that was out of
20 network with his insurance. So the insurance company
21 assigned him to that. This is an example of some of the
22 headaches that create second appointments that we need for

1 people.

2 Also, if you free-text a provider it doesn't tell
3 you then that they're out of network. You only learn it
4 later. Another appointment. And as we've heard, the Plan
5 Finder sometimes says the provider is out of network when
6 we know very well they are not. Also, you cannot tell the
7 Plan Finder, when choosing a new provider on the plan, if
8 they're accepting new patients. And for many plans now it
9 says "contact the plan for provider information," which, by
10 the way, we really don't do. We actually call the
11 providers themselves and talk to the contracting people who
12 know, not the front desk, because they often do not know if
13 the Medicare Advantage plans are in or out of network.

14 And the advantage of local SHIPs or agents is
15 knowing the local networks, and it takes lots of calls on
16 our end, again, speak to the contracting folks. We have a
17 very detailed spreadsheet to try to work around what's not
18 working well with the Plan Finder. It is an improvement.
19 The Plan Finders have some physicians listed there. But it
20 needs a lot of work, a lot of work, before it can be the
21 single source of good information.

22 Another big problem with the Plan Finder is drug

1 frequency, and some of us know this well. If you put in an
2 inhaler and you say how often do you need this inhaler, you
3 say, oh, about every two months. It will often show you
4 the full cost of the inhaler because they don't allow a
5 two-month supply. So the only thing we really trust is if
6 you put in a drug every month. Well, a lot of people don't
7 need a drug every month. Or three months is usually
8 correct. But if you put in any frequency, every four
9 months, six months, or one year, you get some wild prices.
10 And we have pharmacists on the job looking at that, to see
11 if it's even relevant or correct. So the Plan Finder needs
12 to be fixed, and we've been begging CMS for this for years.

13 The Plan Finder changes should be locked in by
14 July, so we can train our staff and volunteers, not late
15 September or October, at the very last second. And it
16 feels like many times it's not been beta tested, and
17 sometimes the changes are worse than what you were dealing
18 with to begin with, through the years, not just even
19 recently but years before. You feel like somebody is
20 trying to make your life harder as a SHIP volunteer.

21 Choice architecture. Often overlooked, but we
22 find that folks that are in traditional Medicare, Medigap,

1 and a PDP, or employer group waiver plan, they're often
2 more comfortable with the predictability and less annual
3 hassle of having to look at all these things. So just when
4 we're explaining to people their choices, a lot of people
5 don't want to have to deal with this every year. So we
6 have to say to them, "It may cost you more to get a Medigap
7 supplement, but it's predictable and you know what it is."
8 So just to put that out there.

9 A reminder, folks only receive the Medicare & You
10 handbook after enrolling or drawing Social Security. So
11 those who are still working, hopefully for a large employer
12 -- if you're a small employer you should have started
13 Medicare, but if you're for a large employer you shouldn't
14 have -- you won't see the book.

15 People that are already enrolled, they get three
16 documents. They can get an Annual Notice of Change, which
17 is not tailored to the person. It's often annually about
18 24 pages that you receive in the mail. If you are new to a
19 plan, you get the Summary of Benefits. That's about 13, 14
20 pages. It's not very tailored. It comes with your welcome
21 packet. And then if you want to you can go to the Evidence
22 of Coverage, which is a tome. It's about 200 pages long.

1 And you still have to call to figure out how the dental
2 benefit works. So there are all these documents that you
3 get, and many of them still don't tailor the assistance to
4 you.

5 You already heard just a minute ago that SHIPs
6 cannot enroll folks directly in Medigap policies. Only in
7 standalone drug plans and Medicare Advantage plans. So we
8 can't use the Plan Finder to help there. The Plan Finder
9 gets a very broad range of Medigap prices. So the price
10 really depends on where you live, our age, if you smoke,
11 and that's if you have no guaranteed issue rights. If you
12 have no guaranteed issue rights, the prices can go all over
13 the place, of course.

14 Many SHIPs can get more details. We have other
15 software in North Carolina that we can actually sort of get
16 you a quote, very close to a quote, but we can't enroll you
17 in that. But not all states have that behind-the-scenes
18 software.

19 On page 44, we need to clarify. You say higher
20 premium Medigap plans tend to have more generous cost
21 sharing coverage. This is often not true. For example,
22 all G Medigap policies cover the same benefits. They only

1 vary by cost. An insurer relies on brand identity for a
2 lot of their advertising. If you are in one company, A
3 through N -- so those are your options Medigap -- the costs
4 do vary, and the higher premium does tend to translate into
5 better benefits. But if you look at a G from the different
6 companies, one that costs more does not give you any more
7 benefits. They're the exact same benefits. A through N,
8 the prices vary, but G is G, except for price.

9 And within that, by the way, there are three
10 different types of policies we have to help people
11 understand. One is called "attained age," the older you
12 get, the higher it goes, more quickly; "issue age," did you
13 buy when you were 65, you'll be grouped with other people
14 who bought when they were 65; or "community rating,"
15 meaning everybody in your community. So if you're older
16 trying to buy a Medigap you'd be better off getting in the
17 community. Now, I bet none of you all understand that.
18 That's one of the many complicated things we have to
19 explain to people. This takes a lot of time, so if folks
20 call the agent -- then folks have to call an agent to
21 complete the paperwork. A few insurers allow you to call a
22 phone number to complete that paperwork, and then they mail

1 it to you and you have to sign it, after the underwriting
2 if you don't have guaranteed issue rights.

3 So one of the things really important that could
4 help with this AI support of the Plan Finder is
5 understanding level of Medicaid eligibility. There is full
6 benefit Medicaid, there is something called MTBQ, there's
7 something MQBB, and something called MQBE, and yes, Eric, I
8 know they have different names in different states. It's
9 very complicated. It would be super helpful if on the Plan
10 Finder we could find the level of Medicaid that someone
11 has.

12 Then we'll enroll them in plans that actually
13 work well for them. We don't over-enroll them. We don't
14 put them in something they're not eligible for that gets
15 kicked back, which happens a lot. In January they're like,
16 "Oh, you enrolled them in a plan they weren't eligible
17 for." Oh, they thought they had this level but they didn't
18 have that level of Medicaid. We have to call the
19 Department of Social Services, and to get through to
20 somebody to find out the level of Medicaid somebody has.
21 So again, second appointments.

22 Stars data. I'm not talking about stars data in

1 terms of this is a 1 through 5, and based on quality. But
2 I'm talking about those of us who do SHIP, after we're done
3 counseling, we are in the CMS Plan Finder, we have to go to
4 the ACL Stars Data Entry System. There's a whole other
5 data entry system that SHIPs are required to use. I
6 believe this should end. First, we have the Plan Finder.
7 After the fact we have Stars. We have two federal
8 databases that aren't talking to each other. Speaking
9 about AI needed.

10 Stars is supposed to help SHIP demonstrate that
11 what we're doing saves a lot of money for people. And by
12 the way, we do save a lot of people money, just staying in
13 the one drug plan or certainly helping them with Medicare
14 Advantage choices. But we're losing volunteers over this
15 hassle. And it's an unnecessary burden. ACL and CMS
16 should get together and take a few of the critical elements
17 and put on them on the Plan Finder. Then ACL can extract
18 the data that it needs.

19 We need to consolidate the reporting for SHIPs,
20 because they're overwhelmed at the same time we are
21 woefully underpaid.

22 Our appointments last 30 to 60 minutes, and they

1 are often second appointments.

2 The Plan Finder now asks if you're helping
3 someone, are you a SHIP person? Are you an agent? Are you
4 a family member? This is great. That's new. However,
5 many agents/brokers use proprietary software. So we need
6 to learn more about what brokers and agents are doing, and
7 it needs to be in the system. And when brokers or agents
8 are using proprietary software, how accurate is that
9 information? I have no idea. I believe some pharmacists
10 are also using proprietary Part D software.

11 There is a system where you can find out what
12 plans people are in, and you have it in writing, and all
13 state SHIPs know this. We actually have to call the state
14 SHIP office to get that information -- is this person in
15 this plan or that plan? We cannot see it as the local SHIP
16 site. We have to get on the phone again.

17 Okay, random thoughts. Page 5, you mentioned a
18 permanent late enrollment penalty. But a reminder that
19 starting too early in most states can ruin your access to a
20 Medigap policy later. So starting B too early or too late
21 is a big deal to Medicare beneficiaries.

22 I appreciate that you make the point, the tsunami

1 of information. The good information is really crowded
2 out. It's called decision-making paralysis. People know
3 about it.

4 Page 8, I'm very concerned about some of the
5 restrictions on agents and brokers, especially since we've
6 seen some of the final rules for 2027. Very concerning.

7 Because pharmacists are losing so much money,
8 many have been encouraged to be insurance agents. To be
9 agents, it is a waste of their skill set, and clearly,
10 they're just trying to combat the steering that insurers do
11 to preferred pharmacies. And by the way, we have learned
12 some things about preferred pharmacies. They are certainly
13 not always cheapest. But I did say something wrong
14 yesterday. Preferred pharmacy doesn't mean that the plans
15 always pay those pharmacies less. That is not true, and
16 Stacie is doing some reconnaissance work on that, and
17 hopefully will share it with us.

18 Table 1, great job about this change about
19 national -- the questions that we ask people. But I would
20 just say, you'll get a very different answer for someone
21 who is new to Medicare or just rolling from year to year.
22 Having to compare employer group waiver plans or retiree

1 health plans through an employer versus Medicare Choice is
2 super complicated. So we have to triage or segment people
3 in our office. Here's a Duke retiree. Here's a North
4 Carolina State Health Plan person. Here's an IBM. Here's
5 a federal employee. And we have certain volunteers that
6 know their stuff.

7 We also really need to educate dependents. A lot
8 of dependents, spouses stay on coverage. They could do a
9 lot better leaving that employer coverage but they don't
10 know it, and they don't ask it. If you're including those
11 with employer group health plans in these surveys, many of
12 them just don't want to review the options because they're
13 overwhelmed.

14 We're very busy. We work very hard as a SHIP
15 site to cancel 3 percent. Please don't give us a lot more
16 people without a lot more money.

17 So page 20 you mentioned free SHIP counseling.
18 It's not free. We get two to three grants, tons of
19 paperwork. Oftentimes we feel like we're counter
20 detailing. Personal contact is really important.

21 Lastly, technology. Consolidate the Plan Finder
22 and the Stars. This is just pulling it together. Improve

1 the provider directories. Improve the drug searches, the
2 frequency issue, ensure access to level, so that we
3 understand Medicaid.

4 Lastly, agents/brokers. Agents can be extremely
5 helpful. Remember, it's a full-time job for them. SHIP
6 has to see a wide variety of people. The scope of
7 appointment document they have, they should be clear about
8 what they're being paid. We need to make sure that when we
9 compare the SHIP rate, we believe that we are getting about
10 \$15 per session.

11 And I've got a lot more to say, but I'm just
12 going to send my things. Overall, the Plan Finder, SHIP,
13 and the agent comments. I hope there is no malevolence
14 here. I hope the evil is in the inertia, that we haven't
15 done anything. And I hope that we can do something to help
16 consumers not be the victims of an out-of-control system.
17 But we need to fix the system, because this patchwork is
18 not helping people. Thanks.

19 MS. KELLEY: Tamara.

20 DR. KONETZKA: I think you can tell how much
21 enthusiasm there is for this chapter, and these are just
22 such great comments so far. I'll just add a few.

1 First of all, I'd say I think a commission-based
2 broker and agent system is just fundamentally flawed. You
3 know, brokers can say that they just act in the best
4 interests of the beneficiary they're helping, but just like
5 health care providers we know people respond to financial
6 incentives. It's human nature.

7 There is good evidence in the chapter, I think
8 the CMS evidence that when they listened in to broker and
9 agent calls, in over 80 percent of the time brokers weren't
10 asking the critical questions they needed to advise people
11 on the right plan for them. And that does not seem
12 surprising, right.

13 And I think, honestly, transparency, and
14 inexplicably we are taking away some of the transparency
15 requirements. But transparency I don't think is going to
16 solve the problem in this case. As a consumer, if an agent
17 comes to me and says, "I don't represent all plans," and
18 then proceeds to recommend a plan, what am I going to do
19 with that information? Do I know that there's a different
20 plan this agent does not represent that's going to be
21 better for me, or this one really is the right one? I
22 don't know. And even if I know which plans that person is

1 representing, it's not clear that I'm going to be able to
2 figure out if this is a biased decision or not.

3 I think it's just a fundamentally flawed system,
4 and I'm in favor, like I think a few other people have
5 mentioned, Gokhan and Cheryl, of really thinking outside
6 the box here, thinking about ways in which maybe we could
7 have MA plans shift some of that money they're paying to
8 agents into a fee that goes into a pool that funds all
9 kinds of unbiased brokers that have to represent all plans.
10 Because I have no doubt there's a huge amount of knowledge
11 they have, and that they really would be in a position to
12 help beneficiaries, alternatively use some of that money to
13 fund SHIPs. I think either or both would be great.

14 Second point, I'll plus-one to Stacie on this,
15 and that is I think we need to really continue to crack
16 down on the misleading market. It's just sort of
17 inexcusable that we let ads air that try to mislead people
18 into saying they're missing out on benefits or providing
19 phone numbers where people think they're calling Medicare
20 but they're actually calling Humana or UnitedHealth. And
21 clearly the evidence shows that this happens a lot. So
22 there needs to be a way to stop that from happening. I

1 think the evidence is pretty compelling and that we should
2 listen to beneficiaries who are complaining about this.

3 The third thing I'd like to say is that I do feel
4 like this all, at least indirectly, supports that we really
5 do need to simplify the choices people have. And I hope we
6 revisit the question of standardization. I think decades
7 now of behavioral economics research would tell us that
8 having a choice of 42 plans with trivial differences is not
9 going to lead to more optimal choices, or to more
10 competition, and that there are ways to change the choice
11 architecture such that you really achieve those goals.

12 And I'll end with, I think this is obvious to
13 everybody, but it's very clear to me, and to every student
14 in Health Econ 101 on the first day, health care is just
15 not like other goods. So if Tom here buys a really stupid
16 car, first of all, it's not really going to affect him that
17 much the rest of his life, and it doesn't affect me at all.
18 But if Tom here has a lot of trouble with his Medicare
19 choices and buys the wrong plan, it might have some really
20 serious consequences for him. Some of the things Gina was
21 mentioning, you know, he may not be aware that if it
22 doesn't get a Medigap plan right away or wants to switch

1 out of MA that he may not be able to get a Medigap plan,
2 for example. Or he may be faced with penalties for not
3 signing up for things at the right time, or he may not have
4 access to the services he needs if he signs up for the
5 wrong plan.

6 Those all have pretty serious financial
7 consequences, potentially, for him, and also health
8 consequences, some pretty serious health consequences. So
9 I'd say moreover, that decision doesn't just affect him.
10 It affects me. It affects all of us as taxpayers, because
11 we want people to get the right plans for them and have
12 value in what we, as taxpayers, are paying into this
13 system. And if people are making really bad decisions
14 because the information infrastructure is so bad, then we,
15 as a program, are not getting the value out of that that we
16 want. There are also some other spillovers, but I think as
17 a Medicare program we not only have an interest but an
18 obligation to try to simplify these choices and ensure that
19 beneficiaries have the information they need to make really
20 good choices.

21 Oh, I guess the final part of that is, I have no
22 suggestions about changing things in the chapter. I think

1 it was so good and so complete. But I would love us to end
2 with a sort of discussion, not any recommendations, just a
3 discussion of the policy options, some of the things that
4 have been coming up over and over I think would be a nice
5 way to tie together the chapter. Thanks.

6 MS. KELLEY: Brian.

7 DR. MILLER: I dare to be different a little bit.
8 Gokhan makes some great points. That ACA provide director
9 is a good example, I think, for the Medicare Plan Finder.
10 We should look to that.

11 I think that looking to market-driven approaches
12 like AI-driven chatbots drive customization is good. I use
13 Google Maps to avoid traffic. Technology can help us.

14 I strongly disagree on price regulation, whether
15 it's price regulation of brokers or whatever. I don't
16 think it's worked well. Folks have complained about MOR
17 and unintended consequences. I think if we regulate broker
18 compensation we're going to see similar bad impacts later.
19 And I think we should resist the wish to go to command-and-
20 control price for regulation, because those who follow us
21 will be unhappy, because we will have set up a static
22 system instead of a dynamic one.

1 Takeaways from the chapter, Medicare benes make
2 lots of choices, using a range of sources. Many advocates
3 focus on TV ads, which are misleading. I agree that they
4 are often misleading. I'd point out that CMS reviews and
5 regulates marketing materials and approves all marketing
6 materials. If we're upset about those marketing materials,
7 I think our upsetness should reside with CMS, current,
8 past, and future.

9 We could redirect Congress suggest CMS have some
10 more oversight. But I think our data actually suggests
11 that few benes use those TV ads. I saw 3 percent of fee-
12 for-service benes and 7 percent of MA benes, suggesting
13 that perhaps there's a lot of dollar spent there that don't
14 have much impacted.

15 I think instead of pushing brokers under the bus,
16 which the conversation seems to be doing, I don't think
17 that's helpful. Instead I think we should support
18 alternatives, including an improved Plan Finder, including
19 technology-driven choice, and including SHIP counselors.
20 I'm not sure that making the entire managed care industry
21 pay for SHIP counselors, though, is the right answer.

22 I also want to sort of level-set us on some

1 choices that Medicare beneficiaries make every year, if not every
2 day. They buy cars. They buy new cars, used cars, homes,
3 boats, auto insurance, renters insurance, homeowner
4 insurance, Medigap policies, MA policies. And in basically
5 every circumstance there is someone who has a financial
6 interest. When you are 80 and you buy a house, or you buy
7 a car, or you buy homeowner's insurance, or whatever it is,
8 you do not assume that the sales agent doesn't have a
9 financial interest.

10 We also are not requiring that the Ford dealers
11 sell Hyundais. So I think we need to be very careful when
12 we say we want to regulate broker compensation and broker
13 sales.

14 I also think we need to check a lot of our
15 assumptions that we're making, I heard in the conversation,
16 sort of at the door. There is this huge push for plan
17 standardization. I want to put out that it worked
18 abysmally poorly in Medigap. Everyone is in one or two
19 plans. Plan F, which is no longer for sale, because of the
20 massive induced demand, and then Plan G, and then the other
21 plans. There's a scattering of folks in there. So our
22 sort of resort to command-and-control choice and making

1 choices for people worked very poorly in the Medigap market
2 and has worked poorly for decades in that marketplace. So
3 I don't think that's a great idea.

4 I think also our assumption, we're making a very
5 big assumption, and my mentor, Gail Walensky, constantly
6 boxed my ears and reminded me that assumptions make an ass
7 out of myself. So I need to check my assumptions at the
8 door. So try and do that.

9 We're assuming that consumers need to make the
10 optimal choice. And we all want consumers to make the
11 right choice. I'm a physician and I want patients to make
12 the right choice. Eat the broccoli, take your blood
13 pressure meds, and exercise, and evidence just that people
14 don't make optimal choices.

15 We, to some degree, need to be okay with that and
16 recognize that people make choices that are consistent with
17 their values, and their values might not correspond with
18 what the optimal choice is. For example, push myself under
19 the bus. I drive a convertible, and there was a lot of
20 snow here a couple of months ago, and having a rear-wheel-
21 drive convertible was not an optimal choice. I think we
22 can all agree. That did not work well for me. My wife and

1 I then competed to drive our sport utility vehicle, and you
2 can imagine who lost. I did.

3 But the point is I made a choice that was
4 consistent with my values, and my value was I really love
5 convertibles. I love being outdoors. Others have made the
6 comment that, "Well, you know, Brian driving a convertible
7 affects him but doesn't affect other people." And, you
8 know, it affected my wife, I think, but did it affect my
9 neighborhood? Not really.

10 But then there are other choices that we make
11 which do affect others. We make choices of friends and
12 marriage, and there's a lot of great economic and social
13 and anthropological research that suggests that friends and
14 marriage affect health and wealth, a lot. So if we were
15 going to optimize for societal income and health, you know,
16 you could imagine that there would be a counselor there
17 telling us who we should marry and who we should be friends
18 with, to maximize our health and wealth output. I think we
19 all agree that that is actually sort of insane.

20 So we shouldn't be telling people what to do in
21 many parts of their life, but that we should support people
22 in making better decisions. But recognize that people make

1 the decisions that correspond with their values, and
2 sometimes those decisions, the rest of us might think are
3 suboptimal. And I make many decisions that others do tell
4 me are suboptimal, and I'm okay with that because those my
5 values and my decisions.

6 So I think that we need to recognize that
7 beneficiaries have agency, they have autonomy, and they
8 have dignity, and that we need to empower them as opposed
9 to infantilize them. So we need to support rather than
10 dictate choice, and recognize that it's okay for people to
11 make the wrong choice, that if we give them good
12 information, they're make the choice that we might think is
13 wrong but they think is right and corresponds well with
14 their values.

15 MS. KELLEY: Kenny.

16 MR. KAN: Thanks to the staff for this
17 outstanding analysis. It underscores how complex Medicare
18 enrollment is and how often beneficiaries need help with
19 high-stakes choices.

20 Beneficiaries rarely rely only on CMS tools.
21 Many use agents, family, and other supports, creating a
22 guarded choice environment. Medicare's default pathway

1 should reflect how people actually enroll. I believe one
2 reasonable default policy option is MA, as highlighted in
3 today's edition of The Wall Street Journal. For many new
4 beneficiaries, an integrated MA plan, with medical and drug
5 coverage, often with supplemental benefits, is much simpler
6 than assembling traditional Medicare, if people can compare
7 options and switch easily when MA is not the right fit.

8 The right question is whether a well-designed MA
9 default can reduce friction and improve initial beneficiary
10 decisions while preserving meaningful choice through strong
11 guardrails. Any MA default approach must address the
12 staff's concerns, which were outstanding, especially
13 marketing and third-party marketing organization, TPMO,
14 practices, and agent incentives that can steer
15 beneficiaries to narrow options.

16 Key concerns include marketing and TPMOs, look at
17 volume, targeting and framing. Agents, in terms of options
18 presented, compensation, and disclosure.

19 CMS tools, including Plan Finder, have improved,
20 but provider directory accuracy and benefit detail remain
21 uneven and SHIP counseling, though highly trusted, is
22 grossly underfunded.

1 If MA is considered as a default policy option,
2 could the following three guardrails matter as much as the
3 default?

4 One, reliable, comparable information on
5 networks, benefits, and expected total costs.

6 Two, stronger oversight of marketing and TPMOs
7 and clearer standards for communications.

8 Three, more access to unbiased counseling,
9 including SHIP, and plain language, third-party
10 disclosures.

11 Any MA default must preserve real choice and easy
12 opt-out to traditional Medicare, protections for new
13 beneficiaries, and monitoring to detect mismatches.

14 I look forward to the Commission's continued work
15 in this area. Thank you.

16 MS. KELLEY: Scott.

17 MR. SARRAN: Rather than try to make any new
18 points, because I think people made their points superbly
19 well, I'm just going to try to put my thumb on the scale in
20 two ways, in terms of my sense of what I'd like to see us
21 weight heavily in our comments.

22 First is Gokhan's points around AI-enabled tools.

1 Clearly, we cannot solve this just with human beings. This
2 is a space that is just perfectly, I think, designed for AI
3 tools to guide people in an objective fashion. I think the
4 keys to that are going to be to get the right information
5 at the front end, like the whole garbage in, garbage out
6 applies. So I think we should highlight that, that state-
7 of-the-art AI tools, with all the right information -- Gina
8 pointed out some of the serious gaps in information, you
9 know, networks have got to be accurate and all that. Plans
10 have been horribly underregulated and not at all held
11 appropriately accountable for accurate and timely network
12 information. That is just inexcusable. Yes, I get that it
13 takes work for plans to keep up-to-date on that and report
14 it, but come on. It is so central to beneficiaries'
15 decision-making. There's just no excuse for that.

16 So AI-enabled tools. That has to be incented. I
17 think there are ways, and I'm sure Gokhan can help us think
18 through ways to put guardrails around that and to ensure
19 that the tools are, in fact, objective. So that's one.

20 The second is the comp model. It is absolutely
21 in our purview, and I would say it is our responsibility to
22 ensure that the comp model is appropriate because, you

1 know, number one it is taxpayer money being spent, and
2 number two, it is not buying a car. It is much more
3 serious and potentially irreversible decision, given the
4 lack of guaranteed issue, for people that come back and
5 revert to traditional Medicare. It is absolutely in our
6 purview to comment on the comp model.

7 And the comp model, you know, in the ideal world
8 we'd figure out a way where the brokers are compensated for
9 getting the beneficiary to the product they want. And to
10 Brian's point, where I agree, is it's not the product I
11 think the beneficiary should want. It is a product
12 consistent with their circumstances, their needs, and their
13 priority, and their values. You know, you can't
14 necessarily exactly do that, but you can level the playing
15 field between different parts. I mean, there are a bunch
16 of different ways to get at it. But the point is the comp
17 model should reflect getting the beneficiary to what the
18 beneficiary wants, again, consistent with some things that
19 you can objectify.

20 So those are the two things I'd like to see as we
21 sort of shade the words and highlight that those are two
22 roads I think that will serve us well if we continue to go

1 down them.

2 Thanks for the very excellent work.

3 MS. KELLEY: Robert.

4 DR. CHERRY: Yeah. Thank you. Just a few brief
5 comments. I think this is a great chapter. There's a lot
6 of learning and sharing going on. It's interesting how
7 we've gone from how do we make good choices around Medicare
8 to how do we find choices to get help to make choices
9 around Medicare. So it's really kind of a fascinating
10 problem.

11 Without being redundant with other comments, in
12 terms of the SHIP counselors, I think can be a valuable
13 resource. It is concerning that they are constrained in
14 terms of their capacity and also concerning that only 4 to
15 5 percent of Medicare beneficiaries even utilize the
16 service. Can you imagine if 40, 50, 60 percent utilized
17 the service. I mean they wouldn't be able to take care of
18 the beneficiaries.

19 So there needs to be some sort of alternative
20 source of funding to augment the resource. And there could
21 be a number of different options. One option is you
22 maintain the free resources but you have some parameters

1 such as if you need an appointment within 30 days and you
2 can wait, then it's a free resource for you. But if you
3 need an expedited appoint within five business days then
4 maybe there's some sort of nominal fee. But there needs to
5 be some sort of funding stream, at the end of the day, to
6 augment the resources, and there are different options.

7 As far as the insurance agents, it seems that, by
8 all indications, these are capable individuals, and what
9 we're most concerned about is potential conflicts of
10 interest. And it could also be there could be a couple of
11 options for this particular group, where, yes, you're
12 knowledgeable that they have contracts with certain types
13 of health plans, but maybe there are only three plans that
14 you're really interested in and they have contracts with
15 them, you want some more information. Maybe that's not a
16 big deal.

17 But is the bigger deal that if there are other
18 offerings in your local market, that that particular broker
19 doesn't cover, perhaps there should be an option where you
20 can, for an additional fee, say "I want a full-service
21 model." So they're not subject to commissions and things
22 like that, and you're paying for the service, and they

1 basically match your needs with what's in the local market,
2 regardless of their contract.

3 So I think we have to think a little bit out of
4 the box and make sure that these resources that are
5 available, that they're funded, but also that they're free
6 of conflict, as well.

7 Otherwise, it's a great chapter, and I'm looking
8 forward to more discussion, to figure out what the policy
9 choices might be on this. Thank you.

10 DR. CHERNEW: So thank you all. In the interest
11 of time I'm going to wrap up very, very briefly, and then
12 we're going to move on to our last session. The first
13 thing is, this material is going to be integrated with
14 material from last month into an information chapter. So I
15 appreciate all the thinking about recommendations, and that
16 will have to be a battle for another day about how one
17 thinks through that.

18 If I would summarize the concerns here it's not
19 that we want people to make a particular choice or not.
20 It's, I think, that there is concern that the information
21 that's necessary to make the choice can't be found by
22 people, can't be digested by the people, and at worse,

1 might actually be biased. And I think getting the
2 information environment right to support people's choice is
3 what this has been about, and that interfaces with the
4 concern that the information people need is contingent on
5 the choice architecture, just sort of how complicated the
6 choices are. And I think you have a decision about how one
7 can improve the choice architecture and then the associated
8 information to enable people to make the choices that they
9 want to make, and that will be something that will have to
10 happen in another cycle, because this now is just going to
11 really be to raise the issue. And I think it is clear from
12 this that it's an area that a lot of people have a lot of
13 passion for, and it is, in fact, quite important to the way
14 in which people experience the Medicare program, which is
15 also what we care about.

16 So with that said, we're going to take now a
17 three-minute break, but we're going to end on time. And I
18 know you're all going to want to say things, and I'm going
19 to be sitting here, like if I want to go out telling people
20 to be quiet, and I don't, just so you know, I do not want
21 to go, right, and please shut up. Or I could be remembered
22 for that.

1 We're taking our break and coming back in a few
2 minutes.

3 [Recess.]

4 DR. CHERNEW: Okay. Now for our last session
5 we're going to talk about special needs plans, particularly
6 I-SNPs, which has been a topic of great interest. I credit
7 Scott for putting this really passionately on the radar,
8 that there are a lot of Medicare beneficiaries that reside
9 in institutions, and making sure that they get the care and
10 the services they need in an efficient way is really a high
11 priority. Eric, why don't you take us through the
12 material.

13 MR. ROLLINS: Thanks, Mike. Before I begin, I'd
14 like to remind the audience that they can download these
15 slides from the control panel on the right-hand side of the
16 screen, by the paper clip icon.

17 Last year, the Commission discussed I-SNPs as
18 part of our broader work on beneficiaries in nursing homes
19 that appeared in our June 2025 report. Commissioners were
20 generally supportive of I-SNPs and expressed interest in
21 doing more work on them. In particular, there was interest
22 in getting more information on the I-SNP model of care and

1 identifying areas where the regulatory requirements in
2 Medicare Advantage may be a poor fit for I-SNPs.

3 Today I'll briefly review last year's work on I-
4 SNPs and then provide additional information on both of
5 those topics. We do not plan to publish this material in
6 our upcoming June report, but if there is Commissioner
7 interest, we could conduct additional work on I-SNPs in the
8 next meeting cycle and include a chapter on them in our
9 June 2027 report.

10 I-SNPs are specialized MA plans for beneficiaries
11 who need the level of care provided in a nursing home.
12 We're going to focus on beneficiaries who actually live in
13 nursing homes, who account for roughly 85 percent of I-SNP
14 enrollment. The I-SNP model is based on the premise that
15 plans can improve the quality of care for long-stay
16 residents by delivering more care within the nursing home
17 and reducing the use of services such as inpatient and
18 emergency care. I-SNPs aim to do this by using nurse
19 practitioners to deliver more care within the nursing home
20 and by giving nursing homes incentives to provide more care
21 onsite. Nursing homes residents cannot enroll in an I-SNP
22 unless their facility participates in the plan's provider

1 network.

2 The I-SNP market has always been relatively
3 small, with about 129,000 enrollees, counting those who
4 live in the community. Many of the insurers that offer I-
5 SNPs are relatively small and have little or no enrollment
6 in other types of MA plans.

7 I-SNP penetration in nursing homes is low, for
8 two reasons. First, most residents do not have access to
9 an I-SNP. Residents cannot enroll in an I-SNP unless their
10 facility participates in the plan's provider network, so
11 nursing homes play a key role in determining access. As
12 shown in the left panel, we estimate that the share of
13 residents who live in nursing homes that contract with I-
14 SNPs has been growing, from 20 percent in 2018 to 34
15 percent in 2024. Second, when nursing homes residents do
16 have access to an I-SNP, fewer than half actually enroll.
17 As shown in the middle panel, the overall enrollment rate
18 in recent years has fluctuated between about 35 percent and
19 40 percent. When you put these two factors together, as
20 shown in the right panel, you can see that the overall
21 share of nursing home residents enrolled in an I-SNP has
22 grown but was still only about 12 percent in 2024.

1 Enrollment in I-SNPs is voluntary and, among
2 participating nursing homes, the residents who enroll in I-
3 SNPs differ in some respects from other residents. In
4 particular, I-SNP enrollees have longer lengths of stay and
5 lower mortality rates.

6 With respect to quality and outcomes, we found
7 that nursing homes with I-SNPs performed better than
8 nursing homes without I-SNPs on three utilization metrics:
9 hospital discharges, all-cause readmissions, and emergency
10 room visits. Lastly, the research literature on I-SNPs is
11 somewhat limited but has generally found that they reduce
12 the use of inpatient care by their enrollees and do not
13 have a clearly positive or negative impact on various other
14 quality measures.

15 Now let's take a closer look at the I-SNP model
16 of care. NPs play a key role in the I-SNP model, but there
17 is little information available about the amount of care
18 they deliver. Since nearly all of the services that NPs
19 provide for long-stay residents are classified as
20 evaluation and management or E&M, services, we examined E&M
21 service use by long-stay nursing home residents across four
22 types of coverage: one, fee-for-service Medicare; two,

1 conventional MA plans; three, dual-eligible special needs
2 plans and Medicare-Medicaid plans; and, four, I-SNPs.
3 There's more information in your meeting materials about
4 the methodology we used, but I do want to note that one
5 limitation of our analysis is that we didn't adjust for a
6 potential lack of completeness in the MA encounter data.

7 As a group, we found that long-stay nursing home
8 residents had a high level of E&M service use, an average
9 of 3.9 visits per beneficiary per month in 2022, or nearly
10 one visit per week, which is not surprising given the poor
11 health of this population. There was no difference between
12 the overall utilization rates for fee-for-service enrollees
13 versus MA enrollees. However, within MA, nursing home
14 residents in conventional plans had fewer visits than
15 enrollees in D-SNPs and MMPs or in I-SNPs. Across all
16 types of coverage, we found that long-stay residents
17 received over 90 percent of their E&M care in either the
18 nursing home or the hospital.

19 Looking specifically at E&M services provided
20 within nursing homes, we found that I-SNP enrollees had
21 more visits than long-stay residents enrolled in fee-for-
22 service or other MA plans. In the figure, each group of

1 three columns represents a different type of coverage, with
2 physician visits shown in blue, NP visits shown in orange,
3 and visits by other providers shown in gray. If you
4 combine those three categories, I-SNP enrollees had an
5 average of 3.4 visits per beneficiary per month, compared
6 to between 2.4 and 2.8 visits for the other types of
7 coverage. NPs accounted for most of the additional visits,
8 as shown by the orange column on the right.

9 Overall, our findings are directionally
10 consistent with what we heard in interviews with I-SNP
11 stakeholders during the last meeting cycle. The findings
12 indicate that I-SNPs deliver more care to long-stay
13 residents within the nursing home setting, that the
14 additional care is largely provided by NPs, and that the
15 utilization pattern for I-SNPs differs from both fee-for-
16 service and other MA plans.

17 Now we're going to shift gears and talk about
18 some MA regulatory requirements that may not be a good fit
19 for I-SNPs. We'll start with MA's network adequacy
20 requirements, which aim to ensure that enrollees have
21 adequate access to care. As part of those requirements,
22 plans must have a minimum number of providers in their

1 network and meet time and distance standards set by CMS.
2 When we interviewed I-SNP representatives last year, they
3 said these requirements were not appropriate for long-stay
4 nursing home residents. They argued that the requirements
5 are designed for plans that serve beneficiaries who live in
6 the community, while I-SNPs serve beneficiaries who live in
7 nursing homes and receive much of their medical care
8 onsite, and that the requirements have been a barrier to I-
9 SNP expansion.

10 Last year, CMS took steps to address these
11 concerns by making it easier for certain I-SNPs, namely,
12 the facility-based plans that exclusively serve nursing
13 home residents, to get an exception from these
14 requirements. However, only about 10 percent of I-SNPs are
15 potentially eligible for the exception, and there's more
16 detail in your meeting materials explaining why that figure
17 is low. We do not yet have any information about how the
18 exception is being used.

19 Commissioners could consider additional options
20 that would give I-SNPs, particularly facility-based plans,
21 greater flexibility with their provider networks. For
22 example, network adequacy could be evaluated at the plan

1 level instead of at the contract level as is currently
2 done. This would make more I-SNPs eligible to use the new
3 exception. You could also lower the minimum number of
4 providers that I-SNPs must have in their network. You
5 could decide that I-SNPs do not need to meet adequacy
6 standards for every provider type covered by the current
7 requirements, with a focus on excluding specialties that
8 are rarely used by long-stay residents. Finally, you could
9 decide that the care patterns for long-stay residents are
10 sufficiently different, that I-SNPs should be allowed to
11 operate without a provider network if enrollees have
12 appropriate protections to ensure adequate access.

13 One challenge here would be that, while
14 stakeholders have said the network requirements are a
15 barrier to expansion, it is unclear how much these options
16 would improve I-SNP availability. As we noted in the
17 meeting materials, there would still be other barriers to
18 the expansion of I-SNPs. For example, there may be limits
19 on the number of nursing homes that participate in I-SNPs
20 because insurers may not want to contract with certain
21 nursing homes, and because certain nursing homes may not
22 want to contract with any insurer.

1 Another area where MA's requirements are a poor
2 fit for I-SNPs are the star ratings. Under the MA payment
3 system, plans that receive a rating of 4 stars or more get
4 a quality bonus equal to 5 percent of their benchmark. The
5 most recent ratings are based on 41 distinct quality
6 measures and use a variety of data sources. Plans that are
7 too new or too small to calculate a rating receive a
8 smaller quality bonus of 3.5 percent.

9 Unfortunately, the star ratings provide limited
10 insight into the performance of I-SNPs. For one, I-SNPs
11 report fewer quality measures, largely because they don't
12 conduct the CAHPS survey, which asks about patient
13 experience, or the HOS survey, which asks about changes in
14 physical and mental functioning. In addition, most HEDIS
15 measures that are used in the ratings exclude I-SNP
16 enrollees over the age of 65 because the measures aren't
17 considered clinically appropriate for an elderly long-stay
18 population. This exclusion applies to about 90 percent of
19 all I-SNP enrollees.

20 Despite the limitations of the star ratings, most
21 I-SNPs still receive a quality bonus. This year 84 percent
22 of I-SNP enrollees are in plans that received some type of

1 quality bonus. That's higher than the corresponding
2 figures for conventional MA plans, at 69 percent, and D-
3 SNPs, at 58 percent. However, I-SNPs are much more likely
4 than other plan types to receive the automatic 3.5 percent
5 bonus for new or small plans. This is particularly true
6 for provider-sponsored I-SNPs, where the nursing homes in
7 the plan's provider network have an equity or ownership
8 stake in the insurer, and which are often relatively small.

9 Overall, the ratings do not appear to pose a
10 major financial disadvantage for I-SNPs. Although many
11 provider-sponsored I-SNPs do not have star ratings and
12 cannot receive the full 5 percent bonus, the impact is
13 mitigated by the fact that those plans instead receive the
14 3.5 percent bonus. In addition, these smaller plans have
15 less year-to-year uncertainty because they can consistently
16 receive the 3.5 percent bonus while larger plans run the
17 risk of receiving a 5 percent bonus in some years but no
18 bonus in other years. However, the ratings are nonetheless
19 a poor fit in terms of promoting better quality.

20 Commissioners could consider various options to
21 improve the quality incentives for I-SNPs. Some options
22 could include relatively modest revisions to the current

1 methodology for the star ratings, such as determining
2 ratings for I-SNPs at the plan level instead of the
3 contract level or modifying which measures are used in the
4 star ratings.

5 Another option would be to explore the use of
6 separate star ratings for I-SNPs, particularly the
7 facility-based plans that exclusively serve long-stay
8 residents. This approach would have advantages and
9 disadvantages. On the one hand, separate star ratings
10 could provide an opportunity to use more patient experience
11 measures and/or measures that are based on nursing home
12 assessment data. On the other hand, the ratings for I-SNPs
13 would not be directly comparable to the ratings for other
14 MA plans, which could generate confusion for long-stay
15 residents, and it would still be challenging to calculate
16 ratings for small plans.

17 The potential impact of separate ratings on I-SNP
18 availability and quality is difficult to assess, because it
19 is unclear how those ratings would affect overall revenues
20 for I-SNPs relative to the current system and because the
21 payment arrangements between I-SNPs and nursing homes
22 typically already include cost- and quality-based

1 incentives.

2 That brings us to the slide you've all been
3 waiting for, the last slide in the meeting cycle. For the
4 discussion I'll be happy to answer any questions about the
5 material in this presentation. We'd like to know if there
6 are additional analyses related to I-SNPs that you think
7 might be worth pursuing. As I mentioned earlier, we do not
8 plan to publish this material in our upcoming June report,
9 but if there is Commissioner interest, we could conduct
10 additional work on I-SNPs in the next meeting cycle and
11 include a chapter on them in our June 2027 report.

12 That concludes my presentation, and I'll now turn
13 it back to Mike.

14 DR. CHERNEW: Eric, thank you, and I think we'll
15 jump right into Round 1, and I think, Tamara, you are the
16 first.

17 DR. KONETZKA: Thanks, Eric. Great chapter. The
18 analysis of E&M visits by nurse practitioners, I really
19 appreciated that analysis. I think, one, it sort of
20 reflects positively or it makes me a little optimistic
21 about the I-SNPs. And also, I found it a very sort of
22 creative way to try to get at, quantitatively, what's going

1 on in these organizations.

2 But I wondered about the billing. I think we
3 often bring up the incident-to billing, and are you
4 actually able to identify sort of consistently all those NP
5 visits in different states?

6 MR. ROLLINS: I think the short answer is that we
7 don't know for certain. And even then, where the nurse
8 practitioners are billing, one of the issues we flagged in
9 the paper is in a lot of cases we believe these are
10 salaried employees. So whether or not they are submitting
11 an encounter for every patient, every time they see them,
12 is unclear. That is another concern that I think we would
13 want to look into if this work continues next cycle.

14 MS. KELLEY: Greg.

15 MR. POULSEN: Let me pile on to what Tamara said.
16 I think this really was a great paper, good information,
17 nicely explained. I particularly liked the clarity of much
18 of the wording, and Figure 1 was a great explanation of the
19 low penetration rates. So I just want to be very positive
20 on that.

21 I have found that 92.7 percent of the people that
22 will read this paper are a little vague on the relationship

1 between Medicare and Medicaid and how they jointly pay for
2 nursing homes and the care there. There is a nice sentence
3 on page 5 that talks about that, but I would really
4 encourage us to maybe create a paragraph that describes
5 what Medicare pays for and doesn't pay. I just think most
6 people are scratching their heads still about what that
7 means, so I think it would be useful just to get that
8 clarification. That was kind of Round 1 in a sense that it
9 isn't more than just a little suggestion. Thanks.

10 MS. KELLEY: Gina, do you have a Round 1?

11 MS. UPCHURCH: Yeah, just brief. On Table 6,
12 where you say how I-SNPs have a large share of enrollees in
13 bonus plans, I'm looking at the 5 percent bonuses that come
14 in it, and there's a big distinction between the provider-
15 sponsored I-SNP and the insurer-sponsored I-SNP, with the
16 empower and insurance I-SNPs getting really high ratings.
17 Can you tell me what we think is causing that? Why are the
18 insurer-sponsored I-SNPs so much more likely to get the
19 five stars than the provider?

20 MR. ROLLINS: They're much larger. They have
21 enough enrollees to report enough data.

22 MS. UPCHURCH: I got you. Thank you.

1 MS. KELLEY: That's all we have for Round 1. So
2 I will go to Round 2, Mike?

3 DR. CHERNEW: And that's going to be Scott.

4 MS. KELLEY: Yes.

5 DR. SARRAN: Thanks, Eric, for continuing great
6 work. You know, I continue to be struck by the opportunity
7 we have to make a really large impact on a core group of
8 beneficiaries with a finite amount of work and a finite set
9 of recommendations that I hope we can get to in next June's
10 report.

11 I've got three points I want to make that lead me
12 to a two-part recommendation.

13 Point one, just to summarize, this is a space
14 characterized by longstanding, pervasive, and deep quality
15 problems. The quality problems are across outcomes,
16 beneficiary experience, and processes of care. And the
17 processes really are a very objective discordance between
18 what are accepted and essentially universally agreed upon
19 geriatric principles of care for a frail beneficiary
20 population versus what actually happens. I mean, it's
21 really objective.

22 Underlying that, we have to conclude there's been

1 no success with the traditionally applied levers for change
2 in this space, traditionally applied for three to four
3 decades, at least. Those levers essentially are regulatory
4 requirements on nursing facilities, with a fair amount of
5 penalties, and a sprinkling of P4P.

6 The other thing that has had no impact
7 essentially is the newer versus three to four decades
8 players in this space -- MA, D-SNPs, ACOs. No impact at
9 all. So the old phrase, continuing to do the same thing
10 and expect different results. We've got to get out of
11 that. So that's point one.

12 Point two, the fundamental problem, my really
13 big, big take, the fundamental problem with where we have
14 been and continue to be is we're trying to hold the wrong
15 entity accountable. Nursing facilities, they don't have
16 the capability, on a number of levels -- financially,
17 structurally, et cetera -- they don't deliver the care.
18 They can't. Trying to hold the physicians accountable,
19 they don't have enough influence. Professional societies
20 have gone down that road, and they agree that's not going
21 to happen. MA plans, ACOs, D-SNPs, they don't have
22 sufficient focus, and they're not going to. So we're

1 holding the wrong people accountable.

2 Why are I-SNPs a great vehicle for being the
3 accountable entity? Because what they can do, and the best
4 ones already do, is they align incentives -- huge -- they
5 bring the players together around a model of care. And
6 you've got to remember, the model of care is easy. You put
7 10 geriatricians in a room, you'll get extreme concordance
8 of what the model of care should look like, which, by the
9 way, should drive the stars measures, and I'll come to that
10 in just a moment.

11 So I-SNPs align incentives, they bring the
12 players together, and by the way, is much, much, much, much
13 more than having NPs. That's a necessary but not
14 sufficient commodity, and it is much, much, much, much more
15 than just the number of visits. Again, necessary but not
16 sufficient.

17 And I-SNPs also use traditional managed care
18 tools in a specific sense. Network, a big one. Benefit
19 plan, huge, huge, and relatively underutilized as a tool
20 for change, but a very powerful one.

21 All right. So that's my second point I just
22 made, which is the fundamental problem is the accountable

1 entity, I-SNPs being the accountable entity.

2 Third bullet point take-home is we've got, as
3 Eric has pointed out so nicely, we've got at least some
4 empirical evidence that I-SNPs are heading us in the right
5 direction. Not huge. Insufficient to sort of make a huge
6 bet on yet, I agree, but at least directionally in that
7 sense.

8 All right. So what's my two-part recommendation,
9 obviously assuming we're continuing with future work. And
10 the recommendations I think should be around what will
11 ensure beneficiary access, because as Eric pointed out only
12 about a third of nursing facilities have an I-SNP
13 available, so the beneficiaries don't even have access to a
14 tool that may be quite positive for them. We should enable
15 growth that is sufficient so we can make a decision about
16 whether this is the right thing to put a big bet on.

17 And, very importantly, we need to do so in a way
18 that ensures us that whatever growth occurs, occurs in a
19 way that aligns the care with, again, the agreed-upon
20 principles of good geriatric care in this space, that
21 ensures that there are safeguards around what may be a
22 number of for-profit plans, because these are very frail

1 beneficiaries, so we owe an extra degree of duty to ensure
2 safety.

3 All right. That said. So my two recommendations
4 for this next body of work would be how do we remove
5 barriers? Eric teed some of them up. Network is an
6 obvious one. Stars is a total round peg/square hole thing.
7 I could talk about that for a long time, but stars needs to
8 be reimaged for this space. And there are other barriers
9 that need to have some work to focus on how those are
10 removed. Some different approaches to risk adjustments,
11 some specific issues in rural environments, et cetera. The
12 point is, number one, we have to think about how do we
13 remove barriers. While, at the same time, number two in my
14 recommendations for fleshing out further work, how do we
15 ensure that this is done in a responsible fashion, that we
16 don't just enable growth of something we think will work,
17 but we enable growth in a way that we are sure will work.
18 And I think that really is possible. And essentially
19 that's going to be around fleshing out our recommendations
20 to CMS about how CMS should use the tools already at their
21 disposal, predominantly, number one, how they enforce the
22 development and execution of, and adherence to model of

1 care. That's a tool they already have. They use it. In
2 my opinion they don't use it strongly enough. And number
3 two, how they develop an I-SNP specific set of stars.

4 And as our discussions around quality measures
5 earlier today reinforced, there are lots of reasons why you
6 have quality measures, and money attached to that. It can
7 help beneficiary choice, et cetera. But in this space,
8 what we really want the quality measures to do is to make
9 sure that the I-SNPs chase that money. So want them
10 powerful, big dollars, and you want them put in ways, or
11 constructed in ways where I-SNPs have to chase that money,
12 and by chasing that money we will get, for our frail
13 beneficiaries, the care we want.

14 So thanks, Eric, and I'm going to guardedly say I
15 look forward to continuing to work on this.

16 MS. KELLEY: Tamara.

17 DR. KONETZKA: Thanks. I share Scott's
18 enthusiasm for this model, and agree with virtually
19 everything he just said. I'll just add and emphasize a few
20 things.

21 I've been studying nursing homes for 30 years,
22 and I have to say all of that time there is one really

1 stubborn problem that people have talked about and have
2 never solved, and that is that nursing homes get no more
3 generous revenues from Medicare, but they're in the same
4 facility as the two-thirds of the people who are there for
5 long stays and are duals and getting their long-term care
6 from Medicaid. And that presents these tensions that we
7 probably have talked about every year in MedPAC in terms of
8 conflicting incentives.

9 So nursing homes is sort of a strap for Medicaid
10 money, have a resident who gets ill, and the nursing home's
11 financial incentives is invariably to send that resident to
12 the hospital, because Medicare pays for the
13 hospitalization. And then maybe if you can get that
14 resident back, for a post-acute stay, and then you get more
15 revenues for the nursing home.

16 So I think this is probably obvious to everybody,
17 but this is a tension and a conflicting incentive that is
18 really bad for patient care. Like we don't want frail,
19 older adults going back and forth to the hospital all the
20 time. It's not good for them. But it's in the nursing
21 home's financial interest.

22 And then on top of that you have most nursing

1 homes, or a large number of nursing homes being
2 understaffed. So even if they sort of know and acknowledge
3 it and want to take care of the resident in the nursing
4 home, it's just easier when you're understaffed to let
5 hospitals deal with certain conditions.

6 So given that intractable problem that has
7 existed for decades, what makes me so excited about I-SNPs,
8 despite not having that much evidence yet, is that it's the
9 one thing that kind of gets at this problem. It's the only
10 model we have that sort of can be applied to and includes
11 long stay, frail, older adults in nursing homes, who are
12 mostly on Medicaid, but are getting their medical care from
13 Medicare, and keeps them out of the hospital more, and has
14 the potential, I think, to really improve care by just sort
15 of adding more staff time through the nurse practitioner
16 model.

17 So I'm really excited about the potential of the
18 model, and I just would like more information, and as Scott
19 said, I think I really want to explore the policy options
20 that would make it easier for nursing home residents to
21 access this and for this model to expand.

22 So a couple of things in particular. I really

1 loved, in the chapter, more attention to what the nurse
2 practitioners are doing. I'd love to keep pushing that. I
3 think a couple of things I'd love to see are just,
4 quantitatively, I think the key or the key difference
5 between a good I-SNP and a bad I-SNP is how those nurse
6 practitioners, and how the model interacts with the
7 existing staff in the nursing home.

8 And so on the one hand you have a model where the
9 staff worked together to actually improve care and prevent
10 the adverse events that land people in the hospital. On
11 the other hand you have just a total gatekeeper model,
12 where the nursing home wants to hospitalize somebody, the
13 nurse practitioner from the I-SNP comes in and says, "Nope.
14 That person is going to stay here." A gatekeeper. Like we
15 don't need to hospitalize that person, without actually
16 changing underlying care. And those are very, very
17 different.

18 I think, quantitatively, we could look just at
19 what happens to the rest of the staffing in the facility.
20 Like when one of these models comes in, do nursing homes
21 adjust their other staffing? But I think, more
22 importantly, it's really the qualitative, and if there's

1 room for it at some point I'd really love to dig a little
2 bit more into what actually happens in these facilities.
3 There was great Evercare evidence, but that's now pretty
4 old. But also, I think it's important to keep track of the
5 heterogeneity of the insurer-led and the provider-led.
6 Those might fall into those categories of sort of better I-
7 SNPs and worse I-SNPs, but it's a little unclear, still, so
8 I'd love to keep collecting that evidence.

9 I agree with Scott that we need to reduce these
10 barriers. I'd say the network requirements are just not
11 applicable most of the time. And the star ratings, I would
12 say, are not only not applicable, but could actually be
13 dangerous. Like some of the things that are in the list of
14 quality measures are things like hemoglobin A1c control for
15 people with diabetes. And it's well known in my vast
16 clinical knowledge, everybody kind of knows that the risk-
17 benefit ratio of treating some of these things as you get
18 old and frail change. So we don't want to overly control
19 hemoglobin A1c in 95-year-old with dementia.

20 So I think that it's just completely a bad fit.
21 So if we could somehow separate the I-SNP model from the
22 rest of what we use in MA to pay bonuses and to judge

1 quality, and to require a specialist in the network, I
2 think that would probably go a long way to encouraging
3 expansion.

4 And finally, we say this every time but it's
5 worth repeating every time. I think we need consumer
6 satisfaction data. It could be the CAHPS measure, but not
7 just for the I-SNP, but like for everybody in the nursing
8 home. And that would be also getting that data for
9 residents who are in the I-SNP.

10 Okay. So I think that's about it. I just remain
11 really positive about this model because it fills such a
12 gap that no other models have filled. And I hope we can
13 sort of simultaneously encourage expansion of the model and
14 continue to monitor it. Thanks.

15 MS. KELLEY: Brian.

16 DR. MILLER: I love this chapter. Thank you. It
17 will become a chapter, hopefully, and so I'm saying I love
18 this chapter. I'm anticipating the excellent chapter form
19 this work.

20 Overarching thoughts and then policy thoughts.
21 Overarching thoughts, if you want to have fun you can go
22 back and read some old papers from CMS and ASPE, and it

1 looks at sort of the disease and functional status and
2 other distribution of the Medicare population. And you
3 realize as we age, we become less alike medically, and
4 maybe more and more alike socially, thinking about what my
5 95-year-old Uncle Fred used to tell me.

6 But Medicare is a population of populations, and
7 that population needs customization, as we're talking
8 about. So I'd point out that they need customized benefits
9 and personalized care, and that's what most people need and
10 want.

11 I'd caution us on our other discussions about
12 standardization, noting that if we had pushed
13 standardization 15, 20 years ago that we would not even be
14 having this I-SNP discussion today.

15 I'd also note that this is an example of where
16 vertical integration can work, and is super positive,
17 because listening to the comments everyone has said,
18 there's a huge positive potential here, and the positive
19 initial results.

20 Our prior discussions in other portions of
21 Medicare have been, at baseline, I think it would be fair
22 to characterize, extremely hostile to all forms of vertical

1 integration. I'd remind us that the reality for many of
2 these problems is actually quite gray. Sometimes vertical
3 integration is good. Sometimes it's bad. Sometimes it's
4 somewhere in between.

5 So I think the I-SNP suggest to us it's a
6 positive success, and really a positive success that maybe
7 we should be a little more judicious than a little more
8 gray in how we approach these issues in other parts of
9 Medicare.

10 I really also like that the I-SNP highlights the
11 positive opportunity for the growth and the role of nurse
12 practitioners and nurses and CNAs. It's also an
13 opportunity for partnership between care delivery,
14 financing, and clinical labor, and this is a way where the
15 post-acute care industry and the managed care industry can
16 work together for the benefit of the Medicare beneficiary.

17 I would suggest this, again, based on my comments
18 yesterday, this is a model that perhaps doctors, hospitals,
19 and health plans should look together to find ways to solve
20 problems, as opposed to pointing fingers at each other.

21 I also agree wholeheartedly with Dr. Sarran's
22 comments about how the prior model hasn't worked. So fee-

1 for-service with heavy-handed regulations of SNFs has not
2 improved care for Medicare members at all, and
3 fundamentally it's collapsed a performance ceiling with the
4 floor while also lowering the floor, which has not been
5 great for the beneficiary. I-SNPs give us this opportunity
6 to fulfill this promise of Medicare for these 1.2 million
7 people living in nursing homes.

8 So specific policy changes. One, I think that
9 the beneficiary education is important, and I think a
10 potential recommendation for us could be that CMS requires
11 SNFs to educate benes or their health care proxy -- could
12 be family or legal guardian -- to require them to educate
13 beneficiaries about the choice of fee-for-service, MA, and
14 I-SNPs. Because if you're not aware that there is an
15 option, you might not pick that option.

16 I also think that institutional beneficiaries
17 have customized needs, because if you're in an institution,
18 by definition, you have residential and community care type
19 requirements, not just community care requirements. So I-
20 SNPs need fit-for-purpose oversight. We hit most of them,
21 I'd say. One is network adequacy, which everyone has
22 talked about. The second is star ratings. And if we want

1 to be proactive in fee-for-service, instead of just saying
2 customized star ratings for I-SNPs we could say star
3 ratings for the institutionalized Medicare population. So
4 those who are living in an institution, whether they are in
5 fee-for-service, general MA, or an I-SNP, you could have a
6 measure set that is specifically for them, targeted on
7 their needs, and that will show us what works in fee-for-
8 service, what works in conventional MA, and what works in
9 I-SNPs. I suspect, based on what we're all saying, we'd
10 probably find a lot of things that work in I-SNPs and maybe
11 not so much that works in the other markets, but we should
12 get those data.

13 And then the third is recognizing that this
14 population has many functional impairments, impairments in
15 ADLs, often has a health care guardian, may or may not be
16 the family, might even be a legal guardian appointed by the
17 state, that we need specific marketing and advertising
18 regulations for this population. Thank you. Great
19 chapter.

20 MS. KELLEY: Betty.

21 DR. RAMBUR: Thank you. I'm very enthusiastic
22 about this chapter and your work, and very enthusiastic

1 about the comments from Commissioners, and hope that this
2 work continues.

3 I just wanted to underscore a few points. When I
4 look at Table 1, I'm going back to what Tamara said about
5 incident to billing. A recent study by A.T. Malhotra and
6 his team suggests that it's between 38 and 54 percent. And
7 I was trying to think if there would be any difference in
8 these populations in terms of that number. But if that
9 holds anywhere near through true, is dramatically
10 underreporting the nurse practitioner delivered care and
11 overreporting the physician. So at least a little caveat
12 about that.

13 I just also want to have on the record a reminder
14 that before I was on this Commission it recommended getting
15 rid of incident-to billing, and the American Association of
16 Nurse Practitioners strongly supports getting rid of
17 incident-to billing. They want to be accountable for the
18 care they give. They want that seen. And they're obvious
19 not the ones that is benefitting from the extra 15 percent.
20 So this is another example where it's difficult to tell
21 what's going on

22 I also, if you can actually get at this when

1 you're looking, I would hypothesize that in a well-
2 functioning model like this, where the nurse practitioner
3 is really embedded as part of that delivery community, you
4 actually have less turnover of the other staff, for a lot
5 of reasons that I could go into. And whether if that's in
6 our lane or if there is a Ph.D. student out there who would
7 want to look at that. I think the model where you
8 mentioned the drop-by would be a problem, potentially, as
9 an outsider. But at one point I worked in this space and
10 had my father in this space when he was repeatedly
11 extracted, against his will, against our wishes. I think
12 it's just so important for all the reasons everyone has
13 said.

14 Really great work, and I look forward to seeing
15 what comes next in terms of recommendations, hopefully down
16 the line. Thanks.

17 MS. KELLEY: Gina.

18 MS. UPCHURCH: Yeah, thank you, Eric. Really
19 clear chapter, and thank you so much for the work, and I
20 really want to encourage us to continue looking at this. I
21 agree that we need to hear beneficiary and family
22 experience from people who are in facilities. It's really

1 our central obligation, so I want to encourage that.

2 And secondly, I had a little shiver go up and
3 down my spine when I saw PFFS plans, private fee-for-
4 service. And so I want to make sure we keep guardrails on
5 it, if it ends up moving that direction that it stay within
6 the SNP world. Because trying to explain to somebody a
7 private fee-for-service Medicare Advantage plan, the
8 provider will see you for your leg today but not your arm
9 tomorrow, it will see you for your arm but not your wife
10 for her arm. It's too much. Private fee-for-service, you
11 can't really explain it. So if we do end up going down
12 that road, to keep it confined to the SNP population.
13 Thanks.

14 DR. CHERNEW: That's all you had. And I have one
15 other person who wants to make a comment, which is Paul.

16 MR. MASI: Just to get in here at the last
17 minute. Thank you for this conversation. This is very
18 helpful. I did want to draw out one thing from the
19 conversation as wrap up this cycle and start planning
20 towards the next cycle, and I'm hearing a lot of interest,
21 and that's very helpful.

22 At the beginning we heard Scott talk about

1 incentivizing I-SNPs to chase the dollars, and Tamara
2 talked about the very stubborn problem of fragmented
3 financing and incentive problems here. And just to have in
4 mind, as I'm finalizing my notes here, I heard that as
5 redesigning and redirecting existing resources in a budget
6 neutral way and not necessarily need for additional
7 Medicare resources here. I'm seeing at least Scott give a
8 big thumbs up, so that's hopeful as we have in mind and
9 start planning for the next year.

10 DR. CHERNEW: Okay. This is going to be work
11 that's going to be ongoing. I think that the obvious point
12 here is there is a lot of enthusiasm, and actually, a
13 tremendous amount of consensus, at least at the top line,
14 with the basic point that the needs and programs designed
15 for beneficiaries that are residing in nursing homes are
16 just different, in a bunch of ways, and the program should
17 acknowledge those difference and the situations that they
18 face. So that will proceed going forward.

19 DR. CHERNEW: For those of you at home you can
20 reach us at meetingcomments@medpac.gov. We really do want
21 to hear all that you have to say. But we are now, as we
22 announced before, having the opportunity for public

1 comment, and I think we have Shannon. You can come and
2 give a public comment, two minutes and then the light will
3 go on. But please come up to the thing. Thank you for
4 joining us.

5 DR. WU: Okay, great. Well, this is actually
6 quite exciting to be here as a policy nerd, and I think
7 especially after seeing all of your faces on the computer
8 screen for the past, I don't know, five to six years. I
9 know Paul had a joke that I deserved a trophy for being the
10 first, I guess the only public member here. But thank you
11 very much for the opportunity.

12 My name is Shannon Wu. I am the Director of
13 Policy at the American Hospital Association. The AHA
14 thanks the Commission for the chance to be here in person
15 to provide public input on a variety of important topics
16 the Commission has discussed during this meeting yesterday
17 and today.

18 In particular, we appreciate that the Commission
19 is interested in examining the incentives that exist in the
20 three main payment systems under Medicare, and specifically
21 the role that Medicare Advantage plays in hospital
22 finances.

1 As we have previously commented in our public
2 letters, we continue to urge the Commission to more
3 carefully examine the role Medicare Advantage plays in
4 enrollee access to care and providers' financial stability,
5 as well as the increasing cost it incurs on the Medicare
6 program.

7 Medicare Advantage has not delivered on its
8 intent to reduce Medicare spending. We believe that the
9 true cost drivers of high spending growth in the Medicare
10 program can be found by examining the MA program. Much
11 more can be done within the MA program to slow down
12 Medicare spending growth.

13 Both our own analyses and the external evidence
14 show that MA imposes materially greater and inappropriate
15 administrative burdens on hospitals and the beneficiaries
16 they serve as compared to traditional Medicare. These
17 policies include prior authorization requirements for a
18 growing array of services, and many hospitals and health
19 systems are forced to dedicate staff and resources to
20 appeal and overturn inappropriate denials on behalf of
21 beneficiaries. We appreciate the recognition of these
22 burdens by some of the Commissioners' comments yesterday.

1 We detail much of the evidence in our October and
2 January letters last and this year to the Commission on
3 these two topics.

4 Medicare Advantage is an important part of the
5 Medicare program. Millions of Americans have chosen this
6 approach to receive Medicare coverage, and many more are
7 expected to over in the next decade. We urge you to
8 carefully consider the role of MA in driving up Medicare
9 spending in order to strengthen the program so that it
10 works for patients and providers who care for them.

11 Thanks very much.

12 DR. CHERNEW: Thank you very much. And again to
13 those of you at home, thank you for joining us, and we look
14 forward to what will be undoubtedly a wonderful cycle next
15 cycle. For me, I just want to thank everybody for all
16 their contributions and all the support, and I look forward
17 to following all of the work that goes ahead in future
18 cycles.

19 Again, thank you. Is there a MedPAC slogan, Go
20 MedPAC, Go Blue? Anyway, thank you, and everybody be safe.

21 [Whereupon, at 12:05 p.m., the meeting was
22 adjourned.]