MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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P R O C E E D I N G S

[10:17 a.m.]

DR. NAVATHE: Welcome, everyone, to the start of our November public meeting. We have an interesting agenda today and tomorrow morning, and we'll be starting with a session on recent changes in the Medicare physician fee schedule that affect primary care. And I will hand it over to you, Geoff.

MR. GERHARDT: Great. Good morning, everyone. Today Chinmay and I will be reviewing some notable changes in evaluation and management codes over the past decade. We want to thank Rachel Burton for her assistance with this project.

The online audience can download these slides from the control panel on the right-hand side of the screen.

First, we'll start with some background.

Many of the changes we'll discuss today had the effect of increasing revenue for primary care-oriented services. Maintaining a strong primary care infrastructure is important. Studies have shown that primary care is linked to healthier populations, more equitable access to

care, and lower health care costs.

MedPAC and others have long been concerned about access to primary care. These concerns include a declining number of primary care physicians, and surveys showing beneficiaries have a harder time finding a new primary care provider than finding a new specialist.

The Commission has expressed concerns that when non-evaluation and management services become overvalued, like with global surgical codes, that E&M services become can relatively undervalued. And the Commission has expressed concerns that large differences in overall compensation between primary care and specialist providers may incentivize fewer providers to go into primary care.

In response to these concerns, MedPAC has made a series of recommendations aimed at supporting and strengthening primary care. I won't run though each recommendation listed on this slide. But as you can see, the Commission has consistently called for policies that would act to provide more resources for primary care clinicians.

In recent years, CMS has made several notable changes to physician fee schedule payment policies to

provide more support for primary care. Today's presentation will focus on those changes.

Part of CMS's approach has been to adopt new billing codes that pay for primary care activities and resources that are not included in payment for other codes. These include new codes to pay for care management and care coordination, as well as other primary care-oriented activities.

In addition, in 2021 CMS substantially increased payment rates for the most commonly furnished evaluation and management services.

While these actions directly affect payment policies under the physician fee schedule, they can have secondary effects on other payment systems, such as the hospital outpatient payments and Medicare Advantage. Those effects are beyond the scope of our analysis, and we will not go into those effects.

Given the size and scope of the changes CMS has made, we sought to measure the impact they had on primary care providers, as well as other clinicians. To do this, we analyzed claims data from 2015 to 2025.

First, we measured aggregate utilization and

spending on the care management and related codes over this period. We then segmented this data to analyze how payments were distributed between different types of providers. We also looked at the impact increasing payment rates for E&M visit codes had on provider revenue. Like our analysis of the care management codes, we attempted to quantify the impact the rate changes had on various types of clinicians.

The next several slides will focus on utilization and spending on the new care management codes.

In recent years, CMS has added almost two dozen billing codes that pay for care management, care coordination, and other related activities. Most of these codes are intended to pay for time and resources spent managing and coordinating care between face-to-face visits. Other codes are intended to pay for additional time or resources that are not included in payments for other E&M codes.

Two notable additions are the advanced primary care management, or APCM, codes, and the visit complexity add-on code. CMS created the APCM codes in response to concerns that billing for individual care management codes

can be burdensome for clinicians and contribute to fractured care across providers. The APCM codes bundle payments for a wide range of care management activities. They are per-beneficiary per-month payments that can be billed by a single designated provider for a patient in a month.

The visit complexity add-on code can be billed together with other eligible E&M visit codes. It effectively increases payment for that visit when the clinician is the focal point for ongoing care of a patient with a complex medical condition.

It's important to note that use of these codes is not limited by clinician specialty. All of these codes can be billed by almost any clinician who meets each code's definition of care responsibilities and clinical requirements.

This table summarizes the care management and related codes that CMS has started paying for over the last decade. As mentioned, many of these new codes pay for care management and coordination by clinical staff, such as nurses and medical assistants, working under the supervision of a physician or care team.

For simplicity, I'll refer to all of these codes as "care management codes" for the rest of the presentation.

This slide tracks fee schedule spending on the codes we reviewed on the previous slide. The timeline starts in 2015, with allowed charges for the transitional care management and chronic care management codes. Together, these codes accounted for a $175 million in fee schedule spending. As the graph shows, over subsequent years spending on these two code sets grew significantly and new care management codes were added.

Utilization of these codes has grown substantially over time, which has driven spending increases. In 2025, the fee schedule spent a total of $2.7 billion on these codes.

The most recent addition, shown on this chart, are the advance primary care management codes I mentioned, which are the partial capitation codes. In their first year of use, these codes were billed a combined 2.5 million times and there was $134 million in spending on these codes.

This slide gives a sense of how utilization of

care management codes was distributed across different types of providers in 2025. For this analysis, we divided clinicians into three categories: primary care physicians, specialist physicians, and advance practice registered nurses and physician assistants.

On average, 28 percent of all providers successfully billed for at least one care management code in 2025. Almost two-thirds of all primary care physicians billed for at least one of the codes that year. Twenty-five percent of all specialist physicians and 31 percent of ARPNs and PAs also billed these codes.

This slide looks at the how growth in total spending on care management codes was distributed among different types of clinicians. As shown on the previous slide, spending on care management codes has grown substantially since 2015 as more codes were added and utilization increased.

In 2025, $1.4 billion in revenue from care management codes was paid to primary care providers. This represents just over half of total spending on these codes. Almost $800 million was paid to specialist physicians, and nearly $500 million went to APRNs and PAs.

This slide compares total fee schedule revenue data on a per clinician basis. It looks at clinicians who billed for at least one care management code in 2025 compared to those who did not. The orange bars show the portion of average total fee schedule revenue that was derived from care management codes.

It is important to note there is wide variation in terms of fee schedule revenue across different clinicians. These data represent averages across all clinicians in a given group. On average, clinicians who did not bill for a care management code had less total fee schedule revenue than those who did.

As shown in orange, revenue from care management codes represented 8 percent of total fee schedule revenue among all clinicians who billed at least one code. Among those who billed at least one code, care management represented 13 percent of total fee schedule revenue among primary care physicians, 4 percent among specialists, and 9 percent among APRNs and PAs.

One thing to note about this slide is that incident-to billing by APRNs and PAs is likely to have affected the distribution of spending between these groups.

These next three slides switch gears a bit and look at utilization and spending at the practice level.

For this analysis we considered each taxpayer identification number to be a practice. The groupings of primary care, multispecialty care, and specially care practices were based on billing patterns of the clinicians who billed under each TIN.

According to our analysis, more than 70 percent of primary care and multispecialty practices billed at least one care management code in 2025. A much smaller share, 13 percent, of specialty practices billed for any of the care management codes.

This figure shows how spending on care management codes was distributed among different types of practices. Of the $2.7 billion in total spending on care management codes, 47 percent went to primary care practices, 23 percent of the total was paid to multispecialty practices, and 23 percent to specialty practices.

This figure shows on average what percentage of each type of practice's total revenue came from care management codes. On average, about 12 percent of primary care practices' revenue derived from care management codes.

The share of practice-level revenue from care management codes was much smaller for multispecialty and specialty practices.

I'll now hand things over to Chinmay.

MR. AMIN: Thank you, Jeff. We will now review the effects of increasing relative values of evaluation and management codes in 2021.

Office/outpatient E&M codes are intended to pay for a clinician's assessment of a patient's health and management of their care. Office/outpatient codes are split into two categories: 99202-99205 are for new patients and 99211-99215 are for established patients.

In 2021, CMS increased relative values of the nine office/outpatient visit codes that most clinicians bill when providing primary care services. CMS acted to increase the work value of these codes. Across all office/outpatient visit codes, relative value units increased by an average of 22 percent.

Because of budget neutrality rules, payment for other services were reduced to offset the increases in spending for E&M. We will see in a subsequent slide how those two changes affected different kinds of providers.

This figure shows spending on office/outpatient codes as a share of total PFS spending in 2025. Office/outpatient visit codes comprise 26 percent of total fee schedule spending, compared to 23 percent for all other E&M services, and 47 percent for all non-E&M services.

The take-away here is that when payment rates for E&M visit codes change, it can have wide ranging effects on fee schedule payment rates and distribution of spending.

This slide shows an example of how the increases in RVUs affected HCPCS code 99214. 99214 accounts for the majority of spending on E&M visit codes. In 2021, the non-facility RVU for code 99214 increased by 26 percent. The effect of this increase was partially offset by a required percent budget neutrality adjustment of negative 6.8 percent. That year there was also a 3.3 percent statutory increase in the conversion factor.

On net, in 2021 the fee schedule's payment rate for 99214 increased from $110.43 to $131.20, about a 19 percent increase.

In subsequent years, further adjustments were made to the code's RVU, budget neutrality adjustments, and conversion factor updates. In 2026, payment rates for this

code are about 23 percent higher than they were in 2020.

This slide shows the growth in aggregate spending per fee-for-service beneficiary between 2020 and 2025 for the office/outpatient codes. As highlighted on the previous slide, there was a large increase in payment rate from 2020 to 2021. Some caution should be used when interpreting these results, since growth in spending was partially influenced by increases in post-pandemic utilization.

Spending per beneficiary increased by 49 percent. As a result, total spending on visit codes grew from $19.7 billion in 2020 to $25.5 billion in 2025.

This figure shows the estimated effects on 2025 fee schedule spending resulting from both the 2021 E&M RVU increases, as well as the required downward budget neutrality adjustment. As a result of the payment rate changes, clinicians with relatively high E&M usage saw net increases in PFS revenue.

For example, among primary care physicians, an average of $4,400 in fee schedule revenue per clinician can be attributed to the changes made in 2021. On average, this represents 5.2 percent of total fee schedule revenue

for each primary care physician.

In contrast, clinicians with relatively low E&M usage saw net decreases in PFS revenue. For example, fee schedule revenue for specialists and "other" practitioners would be an average of 0.8 percent and 3.2 percent higher without the changes in E&M valuations.

Net payments went down for other practitioners, which includes physical and behavioral health providers, as well as podiatrists, optometrists, and chiropractors, because as a group they furnish relatively little primary care.

We will now review and summarize today's findings and turn to your discussion.

To summarize, according to our analysis, the addition of care management codes now accounts for a significant share of overall fee schedule revenue for most clinicians, but primary care physicians were the largest beneficiary.

On net, increasing payment rates for E&M visit codes also increased revenue for primary care physicians, as well as APRNs and PAs. Net revenue among specialty physician and other types of clinicians declined, due to

required budget neutrality adjustments.

We plan to include findings from this analysis in the 2027 March Report to the Congress.

We now turn to your discussion. Some things to consider: Are there questions about the analysis? Is there interest among Commissioners of MedPAC doing additional work on primary care? If so, what should the focus be of that work?

We look forward to your discussion, and I'll hand things back to Amol.

DR. NAVATHE: Thank you, Chinmay and Geoff, for that very informative presentation, and, as usual, nicely done keeping it succinct, as well.

So as Geoff noted in the introductory parts of the presentation, the Commission has a longstanding history of supporting primary care. So this is a continuation of longstanding work, and look forward to hearing the questions and discussion from the Commissioners. Dana, may I hand it to you to run the queue?

MS. KELLEY: Yes. I have Lynn with a Round 1 question.

MS. BARR: Good morning, and thank you, Geoff and

Chinmay. My question is, when you're looking at the codes for chronic care management I think a lot about the annual wellness visit as being really kind of in that bucket. It's frequently performed by ancillary staff, you know, a nurse in a practice or an MA, under incident-to billing to the physician, and it's a large amount of money that I think would influence these numbers.

What's your thought on not including that annual chronic care management visit, because in a lot of ways it's med rec and things like that?

MR. GERHARDT: I mean, you make a good point, and the annual wellness visit is a time in which providers and their patients can talk about the year ahead, how to manage their chronic conditions, all that kind of stuff.

I guess we didn't include it because we were focused on the more sort of discrete care management codes and activities rather than the sort of broader Welcome to Medicare or annual wellness visit. I mean, certainly the numbers, there would be more money if you included those codes. But we have to draw a line. Like regular E&M visit codes can also include elements of care coordination and whatnot. So we were really just focused on that subgroup

that directs most of the attention to care management.

DR. NAVATHE: And Geoff, I think the focus of this work was also on those changes that had been most recent.

MR. GERHARDT: Yeah, that's true. The Welcome to Medicare and annual wellness visits are quite a bit older. They go back prior to 10 years, so they've been around a while.

DR. NAVATHE: Yeah. But that said --

MS. BARR: I would kind of push back on that, because, I mean, as we started working with primary care practices to increase their management of their population that was the first code that -- it was the first one, right, but it was quickly followed by CCM and TCM, and it's always been considered, at least in the ACO world, as part of a package of managing the population as opposed to episodic E&M, from my perspective anyway. So those are just my thoughts.

MR. GERHARDT: No, that's a great point, and we're happy to consider the annual wellness visit moving forward.

DR. NAVATHE: And just so I'm clear, Lynn, you're

suggesting that based on your experience you're saying the kind of uptake or utilization of that AWV visit may have actually been very active during the same time period or may have been dynamic in that same time period that we're seeing the changes?

MS. BARR: They were very definitely related in how we used ROI analysis for the practices on how, okay, so here's the revenue bucket for ancillary staff to assist in managing your population. Annual wellness visits, chronic care management, transition of care management was the first bundle that we used, probably starting in about 2014, I think. It really became kind of a way of redesigning the practice, so I always considered them in one bucket.

DR. NAVATHE: Great. Thanks, Lynn.

MS. KELLEY: Danielle.

DR. PIEROTTI: So I have a question about why APRNs and PAs are pulled out, because they are primary care or specialists. So I don't really understand that categorization.

MR. GERHARDT: Part of the reason we did it is that we do that grouping for other work, like with the payment adequacy work, we do that.

The other thing about APRNs and PAs is a significant number of them actually work in specialty practices, so they might be performing duties related more to specialty than a primary care physician. And because the current way that Medicare designates these APRNs and PAs they don't sort of indicate whether they're in a specialty practice or in a primary care practice. So we tend to just group them together, because we can't bifurcate them that way.

DR. PIEROTTI: So there's no way in the billing to see what practice they're coming from? Because it sort of just makes it like you have primary care, you have specialty, and then you've got this other group, but they are primary care or specialty, right?

MR. GERHARDT: Yeah. And there are algorithms out there that attempt to do that, based on billing patterns and TIN numbers and things like that. But partly for simplicity and partly because we don't know whether those algorithms are actually really accurate, we tend to group them together. But at least we're not trying to convey a message that APRNs and PAs are not serving as primary care providers. That's not a dividing line or a

characterization we are making.

DR. PIEROTTI: I appreciate that as an ideal. It would be amazing to be able to see this data maybe as a stacked bar so you could see the APRNs and PAs within the primary care and within the specialty, or side by side. I think the core point in this analysis was is who is using these care management codes, and, unfortunately, I think we're diluting that impact of understanding, and that may also be a way to respond to this incident billing, the comment made about we're not really sure how incident billing is showing up there.

So being respectful that I don't understand how difficult it is to get this, but if there is a way to move in that direction I would find it veery helpful. Thank you.

DR. NAVATHE: Thanks, Danielle. I very much appreciate that. And Geoff, can you remind me, I think the Commission has a recommendation from a few years ago that would provide for specialty designation for APRNs and PAs, so that would get a better line of sight on to what extent these professionals are focused on primary care relative to other specialties. Can you refresh me on that?

MR. GERHARDT: Yeah. I can't remember when exactly it was made or how it's worded, but we have really pushed for more transparency when it comes to billing by APRNs and PAs. So the whole getting rid of incident-to billing would go a long way towards that, because that is definitely a confounding factor here.

And then to Paul's point, also, try to get a better understanding of what type of practice they work in, what type of work are they actually doing, so that we could have a better understanding that way, as well.

DR. PIEROTTI: I don't mean to belabor the point, but having this clarity of where these levels of practice are is fairly meaningful in certainly looking at patterns of rural care. And the differentiation between the APRN and the PA, I have very little data and only experience, so take it for what that's worth. The APRN tends to gravitate more towards the primary care end, and the PAs tend to gravitate more towards specialty care. And I think that just understanding those patterns of who is providing care where is a part of this, and not being able to incorporate that level of practice within the bigger chunks of primary care and specialty, it's just not giving us a full picture

of what's happening.

So thank you for thinking about it. I appreciate that.

MS. KELLEY: Paul.

DR. CASALE: Yeah. Thank you. Great chapter. I had two questions. The first one was Danielle's question, so I'm not going to repeat it. But just to also emphasize, you know, I don't know when this transparency may happen in terms of the billing, but if there are algorithms or other analytic tools to try to get at this, based on who they're billing under, et cetera, et cetera, to try to get at this whole idea of are they billing under a specialist or primary care I think would be particular helpful. Because, again, in my experience for a lot of the TCM and others, cardiology, they are actually doing those visits, so I suspect there is a lot of activity.

The other question was the 25 percent for the specialty physician billing. I would be interested in understanding sort of which specialists. I assume cardiology does a fair amount of TCM for heart failure, in particular. I would imagine mostly medical specialties. But if that could be broken out I think that might be

helpful to understand that 25 percent activity, which is a not insignificant dollar amount.

But again, thanks for this work.

MS. KELLEY: Tamara.

DR. KONETZKA: Thanks for these really interesting analyses. I know you said you didn't really want to get into the details of this, so I'm going to ask you a question and then I'll make you get a little bit into the details of this. Which is the care management codes, and then I also have the question about the complexity add-on code, that 2211 one. How specifically are those tied to particular activities? Is it really clear when these should be used or when they should not be used? Like is some of this just sort of arbitrary variation in adoption of the codes, or does everybody kind of know when these are available?

MR. GERHARDT: So the code descriptors are pretty clear, and there are people that work for practices that help make sure that the correct code goes with the correct service. So we think of that as less of an issue.

But there are definitely barriers to adoption and use of these codes. The new primary care practice codes

that got introduced, there was recently a study that said around 15 percent of docs that they surveyed use it, 40-some-odd are aware that they're even there, and another 40-odd percent just view them as too burdensome to use.

So what you hope is that as this group of people that don't know about the codes start to learn about them they'll start using them, if appropriate, and that maybe the barriers can go down for that other group to adopt the codes, if they want to.

DR. KONETZKA: What are the burdens? Why are these burdensome to use? Because they have to document certain activities to go along with it?

MR. GERHARDT: So those particular codes on the advanced primary care, they actually require certain pieces of infrastructure. So they require things like 24-hour on-call, you know, certain technologies to be in place. So they actually do have a number of requirements, and if you don't have that stuff you have to get it, which hopefully maybe these codes can help pay for. And then you do have to document stuff. That's ways a pain point for providers.

DR. KONETZKA: So another push towards consolidation.

MR. GERHARDT: I mean, the ironic thing about those codes is that they are supposed to reduce burden, in a way, because they consolidate a bunch of other individual codes. But they do also impose some additional requirements.

MS. KELLEY: Josh.

DR. LIAO: Geoff and Chinmay, thanks for this work. Just a couple of quick Round 1 questions about the dataset you used for some of the work around care management. I understand it's the physician supplier procedure summary dataset. So the first is just some of those they mute the small cells. Were you able to capture those, or were those dropped?

MR. GERHARDT: Yeah. So we get a version of this dataset that is unredacted.

DR. LIAO: Okay.

MR. GERHARDT: So it does not look like the one that you would download publicly from their website.

DR. LIAO: Great. So you have that granularity.

MR. GERHARDT: Yeah.

DR. LIAO: The second is in some of the things you showed, do you filter or look at place of service at

all, or are these all covered?

MR. GERHARDT: So we did look at place of service for the chronic care management codes, and the vast majority of them are performed in the office setting. So we kind of just decided not to worry about setting so much.

DR. LIAO: Got it. And then the last is, my understanding of this dataset, and correct me if I'm wrong, is that they show you what providers bill, what's denied, and what's accepted. So the numbers we're seeing, these are accepted, paid out, allowed amounts. Is that true?

MR. GERHARDT: Yep. These are all successfully billed.

DR. LIAO: Okay. Got it. Thank you.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks for this work. It's really quite interesting, and I'm very supportive that the Commission is looking into this.

One of the things that I found myself kind of puzzling on, looking at Slide 10. So you show that dollars being spent for each of these different codes, but in some prior work -- so I was involved in a research project at RAND with some other teammates, and we looked at the use of

TCM codes and some of the outcomes associated. And I found myself wanting to get a better understanding or unpacking of sort of what's the frequency of use by different physicians and different types of practices, because in that prior work, we found that it was larger practices that were more often using this and not the smaller practices who might need more support, both in terms of their ability to use them, but also support financially to provide care to their patient populations. So I think kind of unpacking that space a bit more would be helpful.

MR. GERHARDT: Yeah, that's a really good point.

We found that clinicians that have relatively low revenue tend not to use these. We saw kind of the same thing at the practice level.

There's a ton more variation in terms of the total revenue and size of practices, but that was a tendency that we found, and we can provide more information about that when we write this up.

MS. KELLEY: Gokhan.

DR. METAN: Thank you for the work.

I have one quick question on Slide 10, especially about the remote monitoring. So I see that the spending

increased significantly. So who bills the $388 million? Do we have an understanding of the breakdown? Is it by specialty or by practice or like vendor arrangements? And also, how concentrated is that $388 million coming from?

MR. GERHARDT: This is for the transitional care management codes? I'm sorry. Which one are you talking about?

DR. METAN: RPM.

MR. GERHARDT: RPM, okay. Remote.

We did not break those apart by specialty. I mean, we do have data that shows by primary care specialty, APR/MPA. We did not separate any deeper than that. We could. We have the data to do it, but we just didn't do it for this analysis.

DR. METAN: Okay. It will be interesting to understand if it is coming from some concentration areas.

Thank you.

MR. GERHARDT: Okay.

MS. KELLEY: Robert.

DR. CHERRY: Yes. Thank you for this report.

Just a clarifying question. Putting nurse practitioners and PAs aside for a moment, in terms of

physicians, how is primary care identified in the context of this presentation? Because it can be variably defined, depending on context.

MR. GERHARDT: So we define it the same way that we do for our work for the March report. It's basically the providers that have been identified as internal medicine and geriatrics; I think family medicine and pediatrics. So those are the groups that we sort of put in the primary care bucket.

You definitely debate, you know, who's in, who should be in and out, but those are the ones we have traditionally used.

DR. CHERRY: And so it doesn't include med-peds as a specialty or OB/GYN?

MR. GERHARDT: No.

DR. CHERRY: Okay.

MS. KELLEY: Okay. I have a Round 1 question from Scott. He is assuming that all of this is based on fee-for-service Medicare data. He wonders if we have any data or insights into how and whether these codes are being used in MA, and for example, are there more barriers for use in MA?

MR. GERHARDT: I will say that this is all fee-for-service data and work. We do not consider MA. MA plans may or may not even be paying for these kinds of codes since they have different types of contracts and relationships with providers.

I know we've just started looking at sort of the encounter data to look at things like this. We can, but that does sort of expand the scope beyond just fee-for-service and the physician fee schedule.

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

MS. BARR: Thank you so much.

So back to Slide 10. The growth rate of chronic care management services, as somebody who's like beat on providers forever to do chronic care management and like measured every one of them and counseled them -- and it's so hard to do, it's so hard to enroll. And then, suddenly, you have this huge hockey stick. What's happening there?

MR. GERHARDT: We didn't do any surveys or whatnot.

I just think as more providers learn about them, get more comfortable with them, their billing departments

are a big factor here. I've talked to a provider about the G2211 add-on code, and she was not personally aware of it. But when she submits her claims to their billing office, they look at it and see whether it would fit the parameters of that code and add it.

And so I think things like that just take a little while sometimes to catch up.

MS. BARR: You have to document beneficiary acceptance. There's co-insurance, right? So what I've seen is a lot of growth in the industry of these remote services, and with the telehealth capabilities where you could actually enroll the patient over the phone. So when you say these site of services in office, you're speaking specifically about the supervising physician, right? And I think that there's actually quite a bit of this that is a business that may or may not be adding $200 million a year of value to the program, and I'm very curious as to how we can go about identifying that and thinking about what's happening in both that space and the remote patient monitoring space.

MR. GERHARDT: Yeah. So you're asking like for us to make a value judgment about like remote patient

monitoring?

MS. BARR: Well, I just don't know if we have the information, right? So, I mean, maybe this is a modifier that needs to be included. If this is really related to the actual primary care physician, is this really helping the patient, or is this just another, oh, there's a new code? And I think if you do some searching on the growth of remote chronic care management businesses that are not actually attached to providers -- like I say, when in Caravan, it was one of our performance metrics to get shared savings. You had to have a minimum of 5 percent of your patients enrolled. That was a hard number for people to get to, and people were constantly saying, oh, but this company says they'll do it and then I'll get my 5 percent. And I'm like, yeah, but you're not actually managing the patient. So we wouldn't allow them to do that. They had to actually do it in the office.

So we don't really know, and when you look at that hockey stick on there, $200 million a year of -- I mean, that flat line before 2021. And, again, you had to have a face-to-face with the patient, right, and established, but you could do it by telehealth for a while,

right? And so I don't know if you still can or not.

So I'm just very curious about that hockey stick, and I think it's something that we need to be thinking about that might actually be not adding value to the patients, but certainly creating new jobs for people. A Medicare jobs program.

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

DR. DILLER: Yeah, I completely agree. So this is a new industry that has been created, outsourcing to companies, or you can do it internally. You can hire a bunch of care managers. I don't know that you can say that it's not adding value, because they are care-managing the patients. But what you can say is that that revenue is not going to the physician or nurse practitioner. It's a new industry. It's new people that are --

MS. BARR: 100 percent, that money is not going to the primary care physician. That's right. Even if they might be billing under it, because they have to, because they've got the established relationship, and so they would have to be the person that actually bills for it. But then they turn all the money over to a company.

MS. KELLEY: Brian, did you have something?

DR. MILLER: Yeah, I fully agree with Lynn. I think while $200 million doesn't seem like a whole bunch of cheese in the Medicare program, the fact that you're seeing this weird, sudden hockey sticks makes you wonder if someone's taking advantage of it.

And I'm completely with Lynn and also Tom. If it is a tech tool or service that is integrating into care and helping, right, like if it's a care manager that then integrates into the clinical practice, or if it's an automated tech tool, right, like if you spend a couple bucks and you get some AI chatbot -- I know Gokhan knows more about this space than I do, but that then helps manage that chronic condition in conjunction with the PCP practice, right? That's huge added value for the beneficiary in the Medicare program. That's a hockey stick we should be excited about.

The hockey stick we shouldn't be excited about is if it's just a company that says, hey, I'm gonna set up some sort of shell-type thing, and you're gonna bill RPM codes. And I definitely know that those companies exist and have grown. I get emails because I'm a practicing physician, and so if someone buys access to all the NPIs,

right, and so I get these random emails from companies telling me that I can increase my practice revenue by contracting with this RPM entity. And the pitch to me is, of course, increase revenue. I'm like, well, I don't run a private practice, and this is really interesting. I can look up your company.

So I'd say if there's a way where we can help differentiate between companies that are tech driven or human care driven that actually do care management versus companies that are just saying like, hey, I can increase your revenue, you're great, right, because that is a divergence, and we want to -- if there is truly a divergence, that's big. We want to think about ways to parse policy, to push people towards the actual care management, whether it's tech or human driven, and away from just a jobs program, the Medicare program. Good term.

MS. KELLEY: Okay. That's all I have for Round 1.

DR. NAVATHE: Well, it seems to me that we've already started Round 2.

[Laughter.]

DR. NAVATHE: But I think this is great. So we

can hear the energy, I think, and passion in your voices.

I think we've already started to touch upon some of the things that we're interested in.

So just to kind of clarify here around what our goal is for this discussion, we have seen an approach taken in terms of adding these types of care management codes, and this is an opportunity for us to look at this data and then assess as a Commission, what does this imply in terms of how primary care is being supported? Do we think that this is an approach that we should continue? Should we continue to think about -- should we continue as MedPAC to recommend areas like we should add on more codes, or should we think more about some of the recommendations we've had previously around per beneficiary per month codes -- sorry -- per beneficiary per month payments, and/or do we need to rethink the kind of paradigm of how primary care should be supported and should be invested in? And so I think that's the kind of the discussion we're hoping to stimulate here, and we're starting to already get there.

And layered in that, I think we can kind of already hear this, but what is the level of enthusiasm to continue to build out this work, especially if we start to

think about things that might be, hey, we need to re-examine the approach, and adding CCM and TCM and APCM codes is not gonna get us there because of whatever reasons, then I think obviously that would take more dedicated work from us. And I think understanding kind of where that sits in your priorities and interests, I think is where we're really keenly interested in listening to you. So, hopefully, that helps clarify kind of where we want you to go in the discussion.

Dana?

MS. KELLEY: Okay. I have Scott first with a Round 2 comment. He says excellent presentation. Thank you.

He's encouraged by the volume and distribution of usage of the new codes. The orders of magnitude seem to be truly meaningful. What might be ideal is to do some qualitative research with PCPs to see if the high-volume users of these codes have enabled substantive changes in how they are able to deliver chronic disease care and what exactly those changes have been.

Similarly, he's asking about PCPs who have not been big adapters of the codes. Why they haven't might be

informative.

At the end of the day, we will want to see if there are actual improvements in care delivery resulting from the use of these codes.

And I have Josh next.

DR. LIAO: So, again, great work.

Let me say that at the top, I would be very enthusiastic about future work in this direction. I realize it's a longer arc. It will take more time, but I'm very enthusiastic.

And my perspective on the table is I'm a primary care-trained general internist. Not only did I practice, there was about a year and a half where I did post-hospital discharge. So I lived and breathed TCM for about that period of time, 70 percent of my practice. So did I call on the right business day? How many days did it pass? Are these people on a surgical global? There were all these things that I worked through. So I have personal experience with I think the benefits of these codes and also some of the challenges there, and I think they're both.

Also, I've had a chance to lead a large group of

primary care doctors, and so I just think this is very important. I'd love to see work continue.

I'm gonna take the moment just to kind of widen my apertures for a minute before I get back to the analysis, and when I think about -- I followed some of these policy changes over the last five or six years pretty carefully. They kind of fall, in my mind, into three buckets. I'm not saying this is the construct, but in future work, I'd love to hang the things that we do on a scaffolding like this.

The first is evaluation, revaluing the work. E&M in 2021 is a great example, but actually, CCM in 2022, when it got revalued is another example. So you're not changing billing requirements, conditions of payment. You're not changing service design. You're just revaluing.

The second is service redesign. APCM is a great example of this. Other codes we haven't talked about, but are in the materials, things like principal illness navigation, caregiver training, community health integration, those are things that I think are new under the sun. It's kind of a second bucket in my mind.

And then the third is conditional on those two.

There's like other changes of conditions of payment. So what do I mean by that? I mean, when G2211 came up, it was restricted in many ways. And then more recently, now it can be used and appended to certain preventive services. That to me is a change in how you use the codes, right, without revaluation, without creating a new service or a bundle.

Other things would be like supervision requirements and behavioral health services, where it was more specific supervision, and now it's more general for incident-to billing.

So just those three buckets, they're not mutually exclusive. Certain policies can have more than one of these, but I would love to see more work kind of bucketed that way, and I think when you do, you'll see that, in my mind, a lot of the work is in these new services over time, compared to the other two buckets, but just some food for thought there.

Against that backdrop, I would love to focus on the care management and care coordination services, in particular, not just because I think there's a lot of new codes there, but also, I think, you know, whether we're

patients, whether we're caregivers or family members, whether we're the clinicians, whether we're leaders operating, guiding, whether we're analyzing data around primary care, I think we know good primary care. We know it's important. You know, when it starts hitting the Starfield C's of on a contact, continuity, comprehensiveness, coordination, and yet I think it's fair to say, historically, we've had a hard time marrying that with what we pay for. That's perhaps obvious, but it's worth stating because I think some of these care coordination codes, issues notwithstanding, as a practitioner or someone who studies this, I think are just important for pushing back against that. And so I'd love to see more work there.

And I really appreciate your work as a kind of a foundational step. So I'll kind of end my comments with a few things that I'd love to see done if possible. This is a big wish list, so not any particular timeline.

But the first would be kind of if we could think about code usage in the context of practice, and so you mentioned you didn't do place of service restrictions. I realized this PSPS dataset is limited, but is there a way

to look at primary care delivering, FQHCs or RHCs? That's, I think by MedPAC numbers, something like 4 million beneficiaries, to look at that versus hospital outpatient departments, which signals something versus physician offices. That would be interesting to me.

Rurality would be important. I think to Lynn's point, the relationship to APMs and ACOs is important. There was a paper in 2025 in Health Affairs that show that when you use TCM, it has some health benefits, but it's pronounced when those billers are in ACOs. Now, what are the dynamics there? I'm not sure, but worth looking at that. So just kind of teasing out practice context, integration, APMs, rurality, place of service, FQs, RHCs, something like that.

The second would be kind of the composition of specialist groups. So I think just double clicking on Paul's point, you know, when you look at RPM, when you look at TCM, CCM, the story is primary care, but the heterogeneity in the specialists is different. I think in some services, the literature suggests that cardiologists, nephrologists, oncologists have a lot of billing. Other is actually non-internists. It's more procedural. So it's

worth teasing out that to I think drive future work.

Third is delivery modality. I mean, there are some services here that are structurally not face-to-face like CCM, BHI, but there are others like AWVs, which I know are not in scope here, TCM, that could be done via telehealth. I actually don't have a good sense of like what is the load of that against not, and so it'd be worth kind of looking at that as well.

Fourth, patient complexity. My understanding of APCM is you can bill it via these three different codes for patients with zero or one chronic condition, two or more, and there's even a wrinkle there for two or more with low-income beneficiaries. I think you probably can't do this in all cases, but where you can, I think it would be useful to look at that patient complexity where possible.

And then the final thing, I alluded to this in my R1 question, but there are non-trivial denials, and we can look at that as a Rorschach test and guess. I don't have a good sense of why. I'll tell you, I think some of it's billing requirements. Some of it is these conflicting things about I thought I was delivering a code, but that patient's in a global, so it gets blocked. It's not a

clean code. Other things, it's not the right patient. I'm not sure, but it may be some of the things that Scott recommended with qualitative work could help us there. I think that would be very useful.

So, again, really great work. I hope this gives you some direction about how to get more texture out of the analysis, but really glad to see it.

Thank you.

DR. NAVATHE: Josh, are you sure there's nothing else you want to add to that list?

[Laughter.]

DR. LIAO: Well, actually, I have -- I'm good.

DR. NAVATHE: One clarifying question for you. So the FQHC, RHCs can bill, I think, on the PFS, but then I think they also can get that kind of bundled rate. So are you saying break out where they do bill PFS and use these codes, or are you saying, hey, I need to also bring in the claims from the FQHC? What are you asking for exactly there?

DR. LIAO: My dream would be the latter, but I left that off the wish list. I think because they can be on the PFS, and my A priority would be it's gonna be low,

there's actually one study from 2025 that suggests it is low, but they do bill there.

What I didn't really appreciate was there was an old G code, G0511, which sopped up all of these codes, CCM, BHI. They retired it, I think, in September of 2025. So it's just, I think, worth identifying that.

But for the purposes of this, not getting my whole wish list, for the PFS, what do we see for FQs and RHCs? There you go.

DR. NAVATHE: Thanks for clarifying.

MS. KELLEY: Brian.

DR. MILLER: So I have some contrarian thoughts, which probably doesn't surprise anybody.

First of all, saying like, I like primary care, I'm a hospitalist, but also happy being a primary care doc. And also really appreciate this super technocratic work done by two giant nerds. So thank you.

We spent 40 years sort of playing with primary care payment. The United Kingdom did a multi-billion-dollar, multi-year pay-for-performance experiment, you know, 15 years ago. And we can put more money into primary care. I'm not necessarily against that. I'm not really

sure it's going to move the needle.

I think the problem is we're still thinking on a one human servicing one other human sort of model for service production. And there's that wonderful paper in Annals of Internal Medicine every couple of years, which comes out and talks about if the PCP did all the things that we said they're supposed to do, what would their day look like? And their day, you know, like you read the papers, it's like 18 hours or something like that. The recent one I think was like 26.7 hours. It was like comically -- well, I mean, it's comical, right? You know, the PCP, poor PCPs, right? They don't deserve that. Whether MD, NP, PA, OB/GYN, whomever.

So I would suggest that we take this work in a different direction, rather than just come up with the same set of recommendations that says that we should pay PCPs more, or we should have more PCPs or whatever. Like that hasn't happened as long as I've been alive. So, if we make that recommendation again, it's probably unlikely to be implemented, and even when that recommendation has been implemented in various components, it has not really been effective.

I think we should think about how we improve the productivity of PCPs. So are there ways that we can automate whole components of service or use technology to automate? Like wouldn't it be great if a tech company could come in and be like I'm doing auto orders for mammography, Cologuard, colonoscopy, like all the cancer-screening tests for your panel, and you as the PCP just click a button and say, yes, I want to order that, or it's automatically ordered. So there's, I think, a lot of stuff we can do to help primary care.

I don't think that that stuff necessarily involves or is best involving more dollars to doctors and nurse practitioners and PAs. It's probably more if we think about how do we pay for and support automation of care delivery, how do we pay for and support tech augmentation of human care delivery, and then, of course, how do we pay for audio-only service, remote video service, remote video service with an exam.

So I would encourage us to push our PCP work towards how do we pay for different types of technology on the physician fee schedule, including human independent technology. You know, my joke is could Apple be a Part B

provider? And my answer is sure, why not?

So that's where I would push us to do that, because I think the other stuff is good, but we've made those recommendations before in various parts of the U.S. And, frankly, other countries have tried it without huge impact.

We have a labor productivity problem.

MS. KELLEY: Cheryl.

DR. DAMBERG: I had a couple of comments. I think this work is terrific, and I think the intent behind adding these codes is directionally correct in terms of greater support for primary care.

And, you know, primary care is in this challenging space of being asked to, you know, manage complex patient populations, people with multiple chronic conditions, needing time and resources to be able to do that. So that's why I'm saying it's directionally correct.

I think my concern -- and, Geoff, I think you said they've added 24 codes -- is that we've added a lot of complexity to kind of this process of just more and more codes, putting more money in the space, which that's okay.

But I think to Amol's earlier question about sort

of what's the right way to go about this, is it population-based payments versus, you know, individual codes, I would hope that the staff could maybe dig in a bit more in that space to try to understand sort of from what I call an on-the-ground operational standpoint of talking to providers to get a better sense of, like, if they had more latitude with these population-based payments, how might that affect the way in which they deliver care to these patients without having to check boxes and say, you know, to Josh's point, all the documentation, to say that I did this and now I can use that code? And maybe this relates to the productivity issue, but it would be nice to step back and think about that. And it might involve some interviews.

The other thing that I would hope could happen -- and I have to confess, I don't know what the broad literature is in this space. I know about the TCM article, because I was on that one, but I think it would be helpful if we could try to synthesize the literature that is already out there about what are some of the outcomes associated with use of these different codes and who's using them and what some of the potential barriers have been to use.

Thanks.

MS. KELLEY: Robert.

DR. CHERRY: Yeah, thank you again for the report.

You know, just high level, generally supportive of strategies that incentivize primary care more holistically.

I think we also need to pay attention to what primary care looks like in vulnerable populations and communities as well. That includes rural areas, inner city areas, as well as communities that may have a disproportionate amount of specialty care. And then coupled with that, then you have long waits for primary care.

We have that safety net index that we developed several years ago, and it would be nice to also understand in the context of this work, how those codes are being used in more vulnerable populations and whether the application seems appropriate or not.

The other thing that I'll mention too is that medical care is a team sport, and so there are a lot of specialists that also support the primary care ecosystem.

And so we have to be cognizant that specialty care is also an important part of care management as well, and I think the reason why you're also seeing specialists use these codes is because you have endocrinologists taking care of the most severe diabetic patients. You have cardiologists seeing really advanced-stage congestive heart failure. You have neurologists seeing patients with Parkinson's disease and MS. So they're involved with care management opportunities as well. So it's good to kind of think about how to support them holistically through these strategies as well.

The other thing about primary care being variably defined, I think it's okay to define it variably, depending on what the problem is we're trying to solve. So we have a standard definition with MedPAC, and I think that's fine. But when you start delving into care management as a population health type of approach, and I think the specialties like OB/GYN, specialties like med-peds probably should be incorporated into the model.

And I would even go further to say that there could be another primary care definition that includes mental health because it's feeling these days like mental

health is a primary care specialty too, because you have psychiatrists, clinical psychologists, licensed clinical social workers that are providing a lot of care also in a holistic manner to make sure that patients are well.

Then a couple -- in addition to that suggestion, one other suggestion too -- and this may be applicable to a number of slides, but visually, it stands out more so in slide No. 12 where we see that rise in spending around these codes. But I think we also need to consider some risk adjustments to that.

The older population is much older than they were in 2015, and there's a lot more acuity associated with the Medicare patient. So I think some risk adjustments around advanced age and acuity, so we can see how steep the rate of rise is, because when you introduce those statistical variables, the rate of rise may not be as steep as what we're looking at. So that's just another suggestion there.

Otherwise, this is great work, and I'm glad that we had an opportunity to actually think about this high level, without getting into a lot of detail with other written materials and to be able to guide the work in the future. So thank you.

MS. KELLEY: Tom.

DR. DILLER: Yeah, thanks. Great work on this in a really, really important topic. I really appreciate that, and so the comments I'm gonna make are, I think, relatively brief.

I think, Josh, you laid out a very comprehensive approach, and I don't disagree with anything that you said with this.

The issue is that we all, I think, believe that primary care is the right thing to do, that it creates value for a population. We, however, have been talking about the same issue for 40-plus years, and the conversations we're having today are the same that we were having when I started as a primary care doctor, literally 40 years ago. And they're continuing to go on.

What we've got is a problem in that we don't have enough physicians going into primary care. We're now pivoting to APPs. That's fine. I think that's a very good situation. However, we still need more physicians in there, and so I think we've got to look at why is that? And is it a purely compensation issue? As others have kind of pointed out, there's a complexity of the work, the 26

hours a day to doing that.

So what I would be looking for, I think, in this is more of an analysis leading to a comprehensive strategy of what do we do to solve the problem? We want better primary care, and how do we get there?

The one area of concern I've got is that the current approach is, from a billing perspective, so complex that it may actually be an inhibitor to things. So do we need to look at a primary care, population-health capitation fee on top of the fee-for-service system? I don't know. But I think that's the work that probably is not going to be produced in the next couple of months, but maybe over the next year or two of what's a good national strategy for dealing with this problem.

So thanks. Thanks for your work on this.

MS. KELLEY: Gina?

MS. UPCHURCH: Yes. I also thank you for this work, and I found myself saying amen to a lot of the comments that came up earlier. So thank you for pulling this out.

Big picture, the U.S. is unique in many ways. One is we have such a fragmented, disjointed system, not

only between primary care and specialists, but where you get your medicines, how you make appointments. Very disjointed. So I think the right hand often doesn't know what the left is doing in our health care system.

The promise of Medicare Advantage, in many ways, was to have somebody that's going to end up saving money if they have better coordinated care and losing money if it's less coordinated care. So that was the promise, in many ways, of Medicare Advantage, and then we end up getting a lot of Medicare Advantage plans that do coordination only. They're not HIDE. They're not FIDE. They don't integrate care management very well. So we haven't really seen the promise with Medicare Advantage either.

The other thing that's unique about the U.S. -- and everybody knows this, but a lot of other countries put -- have a lot more money spent in primary care and less on specialists, because they're going upstream in primary care, is paid to do these things. So I know sometimes we don't look at other countries, but I would like for us to look at how primary care and care management is handled in other countries that seems to fall apart when we come here.

I'm going to call out Scott in this, but forever

-- I mean, my background is geriatric, trained in geriatric -- I believe in team-based care. So I think whether you're talking about older adults, people with end-stage renal disease, ALS, or permanent disabilities, they can have very complex needs. And we have to have and support team-based care.

And the second thing I would say is that we want everybody to work at the top of their license. We don't need physicians, PAs, nurse practitioners to be social workers. We need social workers to be social workers. We need pharmacists to be pharmacists. We want everybody working at the top of their license, and how do we support that in what we do?

I have concerns. Just been to a couple meetings recently where I have seen Lynn, outed my finding recently, was there are a lot of companies, third-party administrative companies, that are popping up to do care management, telling you, like Brian gets his emails, you know, you can bill more, we'll do it. I want to remind us of the enhanced MTM. That was supposed to be a payment to do better care coordination around medicines.

The insurance companies hired call centers,

mostly. The evaluation was pitiful. It didn't work. So, please, let's not go down this road of having people that aren't in relationships with the patients that have complex needs.

AI can help, but I do think it's somewhat relational. So I'm very interested in the outcomes, place of service, not just the code, and the delivery modality. How is it being delivered to the person? I think it's really important that we pay attention to those things.

And, lastly, in bringing it back to the big picture, I do wonder when you asked this -- I do wonder if the PMPM is not a way to get at it a little bit more, because then, as you're building your team, you think who brings value? And as the provider, you're doing that instead of pinging all these different codes. I mean, I'm glad they're there, but we don't want them to be duplicative. Like if you have advanced care planning, well, that's already part of the annual wellness visit. Did it not get covered? Is that why you got to bill for it now? I mean, I think we need to -- and I don't know if it's PMPM, but something needs to happen to put less burden on primary care and give them more support to build team-

based care where everybody can contribute the skillset that they bring to the team that focus on better outcomes.

But thank you for this work and encouraged by it.

MS. KELLEY: Stacie.

DR. DUSETZINA: Thanks very much for this work stream.

I am curious if you're regretting asking such broad questions about our desires for more work.

[Laughter.]

DR. DUSETZINA: So just a couple of points to follow up on things others have said for like additional things I would like to know about this. I mean, it does seem like the dollars are increasing. It's going a lot to primary care.

I think to Paul's initial question, like what specialists are also doing these codes, I think would be very high-value information.

The thing that just keeps sticking on my mind are like are these just like places that are really good at billing, got a lot of this money, and the places that don't really know about this did not get any of the money and actually maybe saw their revenues decrease because of the

budget neutrality rules? So I think digging more into the who is and who isn't, what types of sites of care, what size of groups, because I think that's what -- like in my mind, when you say we want to pay primary care more, I'm often thinking about like smaller practices. That's maybe who's missing out, because they don't have a sophisticated billing system that's automatically updating these codes.

I did really appreciate the point that Lynn made and that Gina made about some of the automation and paying for services. Again, that doesn't feel quite as in the spirit of what you want to do. That could be very high-value care, but to any extent that we could see where those dollars are actually flowing and what the differences are.

I also wanted to say plus-one to Robert's comment about the MSNI and the idea of having more payments go to where lower-income beneficiaries are being treated. That could also be something that we figure out if we're realizing, oh, actually the places that are taking care of kind of more well-off populations, larger populations are the ones really maximizing the code use and then everyone else is not. I think could also help us to point to other solutions that are having dollars flow with beneficiaries

without having people to necessarily have to learn a lot about new codes.

In general, I think Josh's comments also were incredibly helpful about some of the nuances around like new code, new service delivery versus like just change in the payment amount for the code. So I think having some of that disaggregated would be helpful, because that could also help us with the "You already were billing these things, and we increased how much we paid you" seems like everybody could benefit from that versus like "We came up with a new code, and some of you know about it and have billing systems that implemented, and some of you don't."

So I think those would be on my list of things that would help us to move this work forward.

MS. KELLEY: Kenny.

MR. KAN: I'm enthusiastic about the excellent and insightful chapter.

It tells us clearly where the money went. My ask is that the next phase of analysis tells us what the money bought.

Three suggested areas of future follow-up analysis. Number one, analysis that focused on outcomes,

not billing. Care management spending has gone from $200 million to $2.7 billion in 10 years. Office visit spending per beneficiary is up nearly 50 percent since 2020. Yet Slide 3 says the number of primary care physicians is still falling. So did any of this improve continuity, reduce avoidable admissions or make it easier to find a primary care doctor?

Number two, like Gina and Robert, I believe in team-based care. How can we propose payment policies that support team-based care, including multi-specialty practices that focus on primary care? Specialists collected $800 million of the care management dollars. If the goal is primary care, the payment should follow primary care work.

As such, multi-specialty groups that focus on primary care should benefit from increased primary care spend. They account for 30 percent of care management spending, and many of them are where team-based primary care actually happens. The focus needs -- the test should be on what a clinician does, not what kind of group they work in.

And number three, let's learn from what's already

working. Half of Medicare beneficiaries are in Medicare Advantage. Many MA plans and alternative payment models pay for primary care through capitation and value-based contracts, not code-by-code. We should study how much they spend on primary care, how they pay for it, what results they get, and let's bring the best of it into traditional Medicare.

Overall, we've proven we can spend more on primary care. Let us rise to the occasion and answer the question, can we spend smarter?

Thank you.

MS. KELLEY: Tamara.

DR. KONETZKA: I agree with so much of what has been said. So I might be repeating some of it, but maybe thinking about it or organizing it in a slightly different way.

I think that, as Cheryl mentioned, what we've created here -- with good intent to sort of increase reimbursement for primary care, what we've created is a very complex system, right? And complexity leads to a couple of unintended consequences, at least three or four of them.

One is we have this variation in who's using it and who's not using it.

Two, it leads to this kind of outsourcing that we already talked about in Round 1, which to me seems it's not necessarily a bad thing, but we don't know that. It could be a really bad thing, right, and not really improving primary care and the outcomes that we want.

And then the third sort of big unintended consequence to me is we know that complexity increases the incentives for consolidation, and there are some aspects of consolidation that are not bad, that could be good. We do know that consolidation reduces competition and may have some bad effects on what we see in the sector as a whole.

So I would just like us to sort of widen the lens on how we're looking at increasing primary care reimbursement, to think not just about which -- I think it's very important to look at which practices are using the codes and which aren't and which patient populations they have, but sort of widen the lens to the unintended consequences.

I would echo calls from Kenny and Gina and others that I think we want both more qualitative data and

quantitative data to try to inform whether those things are really bad, these unintended consequences. I think we really want data on patient outcomes if we can get it. I mean, we can get it, obviously, but can we reasonably connect it to this at all? I think that's a really challenging problem that we're asking for, but just to sort of see the trends at least in has our increase in primary care actually changed patient outcomes, but as an intermediate step, just how has it changed utilization? As Gina was suggesting, like where is the care management coming from? What mode is it being delivered into, and where are patients receiving this?

And then, finally, given that there are these, I think, very real potential unintended consequences of just adding all of these codes and making this very complex system, I'd really love to return to what MedPAC apparently recommended in the past before my time on MedPAC, which was to move toward these sort of population-based payments, per member per month kinds of payments, and sort of revisit that as an option and see if the unintended consequences there are worse or better than what we're doing now.

Thanks.

MS. KELLEY: Greg.

MR. POULSEN: Thank you very much.

And I'd like to piggyback on a number of points that have been made. Maybe I'll focus mostly on -- well, Tamara's point just a moment ago was really, really a good one, which is focused on what we really want as an outcome, but then also to Brian's point, which I think in terms of the mechanism by which we accomplish it, that can change over time, it hit me really strongly because of some work in my organization that we've been doing lately, that we're working on people with serious asthma and COPD and noticing how frequently they ended up in the ER, being admitted, sometimes in the ICU, and always very expensive when that happened.

And by putting -- giving people connected oximeters, inhalers, and spirometers, we were collecting a whole bunch of data. It was a lot. It was like 2,000 data points per person, which obviously was difficult for human beings to track, but it turns out AI is not -- that's a walk in the park for it. And so being able to track people as they started to go sideways was able to trigger a quick response, either an automated response or from a

respiratory therapist, and the response over now -- we just finished up a year with it, and the ER visits are down 24 percent, hospital admissions down 51 percent, and the total cost per -- I just looked it up. Total cost per year dropped from $36,800 to $15,800 for those folks. I mean, that's more than a 50 percent drop.

And, oh, by the way, the number of coaches that were assigned to take care of those people, to monitor them, the number per patient went from one monitor per 30 people to one monitor to 220 people.

So, I mean, it's really to Brian's point that we now have capabilities that can extend what individual human beings can accomplish, and if used wisely and thoughtfully, it has the potential to improve health and reduce cost. And then what we need to do is to maybe recalibrate the way that we use our human resources. A number of you have made that point, and I think those are well made.

The definition of how many PCPs we need could change as we think about what the role of the PCPs, as a number of people also said, doing their highest and best practice terms. It wasn't too long ago that somebody with severe COPD would have been seeing their primary care

physician as opposed to what we've now done with coaches at a significantly better use of resources, I think, and at lower costs.

So I think we've got some really neat opportunities, and I think that the work that's in the paper that we have helps us to look at all those really good things that we can look forward to.

So thanks much.

MS. KELLEY: That is the end of Round 2, unless I've missed anyone.

DR. NAVATHE: Great. Yes. So thank you for all the comments. So, first off, I think it was fairly uniform support for continuing this work, and I think several kind of buckets of feedback and comments and suggestions. I think there's certainly one stream of empirical suggestions that folks made as well as lit review to look at kind of understanding the current state of who's utilizing these codes.

I don't know that there's a lot of literature around the impact. We heard some desire for what's happening for outcomes, for example, but I think we can certainly take a look at that and see what's there, at

least on the utilization side, perhaps in trying to understand what is changing on the care delivery piece.

I think another thread of comments around trying to widen the aperture a little bit on what is primary care, including behavioral health, tossing a little bit more at the APRN piece, although I will note that that's definitely challenging to a certain extent.

And then comments by folks that were kind of thinking about, well, adding codes itself has some potential trade-offs, and we've been doing this for a long time, and so do we really need to rethink the paradigm here a little bit?

And then we also got snippets in around the technology piece and how can AI and technology help supplement workforce issues, maybe change the paradigm a little bit. And that touches on, to some extent, another work stream that we have, which is around how to pay for software as a medical service and software as a medical device, because we want to be thoughtful also about protecting against inflationary applications of AI. If we think we have potential hockey sticks and CCM codes and where that could go, I think the AI application piece also

is something that we need to be thoughtful about.

But I appreciate the feedback and I think a lot of enthusiasm to continue that work and, to some extent, even rethink a little bit of that paradigm. We may not be stuck to adding code, code, code. So, if we rethink that perhaps with the technology piece as well, that could be informative and helpful for the program going forward.

So we will stop here, and then we will start at 11:45, so just in a couple of minutes with our next session. Thanks.

[Recess.]

DR. NAVATHE: Welcome back, everyone. We're going to go ahead and get started with our next session. This is a continuation of our work on rural care, and we're going to start with a session here, "Charge-Based Coinsurance at Rural Health Clinics." And I will turn it over to Alex.

DR. HARRIS: Good morning. Today, we are returning to our work on charge-based coinsurance at rural health clinics, also known as RHCs. For the audience, a PDF version of the slides is available by clicking on the document icon in the upper right-hand corner of the screen.

We start by providing some context for today's presentation.

In the June 2025 report, the Commission recommended changing charge-based coinsurance at critical access hospitals to coinsurance based on Medicare's payment amount, which would align with how coinsurance is generally structured under the OPPS.

As part of this work, we also conducted analysis of charge-based coinsurance at RHCs, where we found coinsurance to be high and variable, raising concerns about equity for rural beneficiaries. However, changes to coinsurance at RHCs were not part of the Commission's recommendation at the time, in part because RHCs' revenues vary based on patient coinsurance, whereas CAHs' revenues do not.

Since our June 2025 report, we have updated and expanded our analytic work assessing charge-based coinsurance at RHCs.

Our agenda for today is to provide an overview of Medicare's payment system for RHCs; explain the implications of charge-based coinsurance; discuss the implications of charge-based coinsurance in the context of

recent telehealth policies; discuss an alternative approach to charge-based coinsurance; and end with a discussion.

Under the Rural Health Clinics Services Act of 1977, RHCs were established to increase local access to care in rural areas, by providing direct payment for services furnished by NPs and PAs. RHCs must be located in a nonurbanized area that qualifies as a HPSA, MUA, or governor-designated shortage area.

There are two broad types of RHCs, provider-based and independent. Provider-based RHCs are those owned by and operating as an integral part of another Medicare-certified facility, like a hospital. Independent RHCs are freestanding clinics that do not qualify for or have not sought provider-based status.

Historically, RHCs have generally furnished primary care. However, in more recent years, RHCs have had flexibility to provide more specialty care.

In 2025, about 5,200 RHCs provided more than 10 million visits to 2.3 million fee-for-service Medicare beneficiaries. This resulted in more than $2.3 billion in fee-for-service Medicare program spending and beneficiary cost-sharing liability.

Fee-for-service Medicare's RHC payment system generally bundles all professional services furnished in a single day into one payment: a facility-specific, cost-based, all-inclusive rate, or AIR, subject to payment limits, which we will describe on the next slide. Fee-for-service Medicare pays 80 percent of this AIR, subject to payment limits. However, beneficiary coinsurance for RHC services is equal to 20 percent of RHCs' charges, not 20 percent of the AIR.

In certain cases, RHCs may receive multiple payments for services furnished on the same day, such as a qualified medical visit and a qualified mental health visit.

Other services are not paid under the AIR methodology, including certain vaccines, lab tests, and non-mental health telehealth services, which we will discuss later in this presentation.

Prior to 2021, AIRs were subject to national statutory payment limit for independent and provider-based RHCs that were part of a 50-bed hospital. Other provider-based AIRs were not subject to payment limits.

Beginning in April 2021 as part of the

Consolidated Appropriations Act of 2021, independent RHCs have been subject to increasing payment limits; non-specified provider-based RHCs -- those that are part of a hospital with at least 50 beds or that were not enrolled in Medicare as of December 31, 2020 -- have been subject to increasing payment limits, as well.

For all other provider-based RHCs, referred to as specified provider-based RHCs, AIRs are capped at the greater of the RHC's 2020 AIR, adjusted by Medicare economic index growth, or the national statutory payment limit.

The CAA of 2021 also instituted large increases in the national statutory payment limit. Beginning in April 2021, the national statutory payment limit increased by 14 percent to $100 per visit, and will increase incrementally until it reaches $190 per visit in 2028. Cumulatively, from 2020 to 2028, the national statutory payment limit will increase by 120 percent. In 2029 and beyond, the payment limit will increase annually based on growth in the MEI.

Unlike the national statutory payment limit, the limits for specified provider-based RHCs vary substantially

and are generally much higher than the national statutory payment limit. This variation is largely due to substantial differences in costs per visit that predated the CAA of 2021.

Before 2021, the total number of RHCs billing fee-for-service Medicare increased moderately, but the growth was limited to provider-based RHCs. After the payment limits increased in 2021, growth in the total number of RHCs billing fee-for-service Medicare accelerated, driven by continued growth in provider-based RHCs and substantial growth in independent RHCs.

For provider-based RHCs, robust growth in 2020 and 2021 has been followed by declining growth rates. This is consistent with the incentive that provider-based RHCs had to enroll, or at least submit an enrollment application, no later than December 31, 2020, in order to be grandfathered under the older higher payment limits. After that date, hospitals have had fewer incentives to establish RHCs because the payment limits are lower, and equal to independent RHCs.

The change in the number of RHCs over the last several years suggests multiple underlying patterns.

First, the shift from declining to robust growth in the number of independent RHCs, reaching nearly 15 percent growth in 2022 alone, suggests that operators find the new RHC payment limits to be attractive. Some of this growth is related to the entry of private-equity owned RHCs, which we also noted in our June 2025 report.

The entry of independent RHCs into the market may also be due to established clinician practices becoming RHCs as the attractiveness of the RHC payment system increases relative to the physician fee schedule.

I will now turn the presentation to Brian, who will explain how charge-based coinsurance in RHCs may leave Medicare beneficiaries vulnerable to high and variable cost-sharing.

MR. O'DONNELL: As Alex mentioned earlier, fee-for-service Medicare pays 80 percent of an RHC's AIR, subject to payment limits, and beneficiary coinsurance is equal to 20 percent of RHC charges.

Unlike at critical access hospitals, Medicare's program payments remain unchanged as beneficiary coinsurance increases. Therefore, total payments are higher for RHCs with higher charges.

RHCs set their own charges, and their charges are not limited based on their AIRs or payment limits.

This figure uses actual data from 2025 to show that three independent RHCs with the same AIR receive different amounts of total revenues per visit based on their charges. For example, looking at the first column in the figure, the RHC with relatively low charges received $106 in program payments per visit, $26 in beneficiary coinsurance, for a total of $133 per visit.

Now, looking at the far right-hand column, the relatively high change RHC receives that same program payment, $106, but far higher beneficiary coinsurance of $74 per visit, and higher total payments per visit of $181 per visit. This payment formula gives RHCs an incentive to increase their charges and subjects beneficiaries to high and variable cost-sharing liabilities.

On the next slide, we'll look at additional data from 2025.

This slide has a lot of information on it that I'd be happy to unpack on question. For now, I'd like to focus on the two columns outlined in orange. The first outlined column shows the average estimated AIR per visit

by type of RHC. As you can see, AIRs vary across RHCs with specified provider-based RHCs having much higher AIRs. Differences in AIRs reflect underlying differences in costs per visit and could be driven by a number of factors, such has the types of services furnished, the types of clinicians employed, how isolated RHCs are, and the allocation of overhead from the parent providers.

Now, relative to those AIRs, the second outlined column shows that beneficiaries often pay more than 20 percent of the AIR in coinsurance. For example, at independent RHCs, beneficiaries paid 36 percent of the AIR in coinsurance because RHC charges far exceeded their AIRs.

This slide takes the same metric I talked about on the last slide -- beneficiary coinsurance as a share of the estimated AIR -- and looks to see how that metric varies within and across types of RHCs.

As you can see, we observe substantial variation. For example, for independent RHCs, at the 10th percentile, beneficiary coinsurance is 21 percent of the AIR, which means that RHC charges were roughly equal to the AIR. However, at the 90 percent percentile, beneficiary coinsurance represented 54 percent of the AIR, meaning that

RHC charges were set nearly two and a half times as high as the AIR.

The result is that, even within types of RHCs, beneficiaries face substantially different coinsurance rates depending on how RHCs choose to set their charges, which raises a concern about beneficiary equity.

While the last two slides looked at the level and variation of coinsurance, this slide focuses on the growth in beneficiary coinsurance. Beneficiary coinsurance increases based on the growth in RHC charges, and payment limits are, or will be in the future, updated by MEI growth.

So to get a sense of how beneficiary coinsurance may increase, we looked at RHC charge growth over time and compared that to MEI growth. From 2018 to 2025, we found that the average annual MEI growth was 2.8 percent compared with average annual growth of RHC charges per visit of 6.6 percent at independent RHCs, 4.4 percent at non-specified provider-based RHCs, and 6.3 percent at specified provider based RHCs.

And while I present the trends over several years, RHC charge growth has been more rapid in recent

years at independent RHCs, averaging more than 8 percent growth per year in the last three years of our data, at the same time their payment limits have been increasing substantially.

Now, switching gears a bit, in the next few slides I'll talk about how telehealth is paid at RHCs and how charge-based coinsurance affects those services.

RHC services were historically required to be face-to-face, that is, in-person. In 2020, in response to the COVID-19 PHE, Congress temporarily authorized RHCs to furnish telehealth services, at a physician fee schedule equivalent rate. Beginning in 2022, for mental health services, telehealth flexibilities were extended permanently and the payment rate is set at standard RHC AIRs. For non-mental health telehealth services, Congress temporarily extended telehealth flexibilities through 2027, and the payment rate is currently the fee schedule equivalent rate.

The fee schedule equivalent rate was $97 in 2025, which is substantially lower than standard RHC AIRs, which we estimated ranged from an average of $136 per visit for independent RHCs to $277 per visit for specified provider-

based RHCs.

In the last few years, CMS has solicited feedback on how to pay for these services at RHCs in the future, and many in the industry favor paying standard AIRs.

This slide summarizes some the information I discussed in the previous slide about the duration of coverage and payment rates for telehealth services at RHCs. While most of the discussion surrounding telehealth at RHCs has focused on these two topics, the far right-hand column of the table, outlined in orange, shows that beneficiary coinsurance is also substantially affected.

When paid standard AIRs, beneficiary coinsurance is set at 20 percent of RHC charges. When paid at fee schedule equivalent rates, beneficiary coinsurance is capped at 20 percent of the payment rate. This means shifting from fee schedule equivalent rates to standard AIRs could substantially increase beneficiary coinsurance.

This slide provides a high-level background of telehealth use at RHCs. The use of telehealth at RHCs peaked in 2020, declined rapidly from 2021 to 2023, and then declined slightly in 2024 and 2025. This pattern is similar to the trends of telehealth visits billed under the

fee schedule, which the Commission discussed last month.

In 2025, more than 100,000 beneficiaries received at least one telehealth service from a clinician practicing at an RHC. In total these beneficiaries had about 250,000 telehealth visits, and more than 75 percent of telehealth visits at RHCs were for non-mental health telehealth visits paid at the fee schedule equivalent rate. This means beneficiary coinsurance was capped for a large majority of telehealth services in 2025.

The Commission has supported paying RHCs for telehealth services at the fee schedule equivalent rates, and has said that such an approach balances the dual goals of ensuring beneficiary access and prudent fiscal stewardship of the Medicare program.

The Commission has raised concerns about paying RHCs for telehealth services based on standard AIRs because doing so increases beneficiary coinsurance and creates inequities between beneficiaries, which we'll discuss more in a few slides; could discourage in-person care to the extent payment rates are the same and furnishing telehealth costs less; and could create adverse incentives to use RHCs to bill telehealth for populations outside of the

communities typically served by RHCs, which we can discuss more on question.

In this slide, we estimate how beneficiary cost-sharing would have changed if non-mental health telehealth services were paid standard AIRs and coinsurance was therefore based on RHC charges. Using 2025 data, we estimate that shifting from a fee schedule-equivalent rate to standard AIRs would have increased beneficiary coinsurance by $17 to $27 per visit on average, depending on the type of RHC, which translates to increases of between 85 percent to 146 percent per visit.

For example, looking at the far right-hand columns on the figure, we estimate that, at specified provider-based RHCs, the average beneficiary coinsurance per telehealth visit would have gone from $19 per visit to an average of $46 per visit, an increase of 146 percent.

Also, similar to our analysis of coinsurance for all RHC AIR visits, beneficiary coinsurance based on RHC charges would vary substantially for non-mental health telehealth visits, with beneficiaries at 10th percentile of visits paying $20 per visit while those at the 90th percentile paying more than triple that amount, $65 per

visit.

This next section summarizes the policies we discussed today and then presents an alternative to charge-based coinsurance at RHCs.

So first for the summary. We discussed two types of services today. One type was non-mental health telehealth services that are currently paid fee-schedule equivalent rates. For these services, coinsurance is capped and equitable. The Commission supported paying the fee schedule-equivalent rate in its June 2023 report to the Congress.

A second type of service we discussed today was services paid standard AIRs, with charge-based coinsurance. We found that charge-based coinsurance results in high, rapidly growing, and inequitable coinsurance for rural beneficiaries. Therefore, the Commission could consider alternatives to charge-based coinsurance.

One alternative to charge-based coinsurance is to set coinsurance at RHCs equal to 20 percent of the lesser of the AIR, subject to payment limits, or 20 percent of RHC charges. This alternative approach would be aligned with Commission's 2025 critical access hospital cost-sharing

recommendation.

To inform Commissioner discussion, the next slide presents some preliminary statistics on the effects of such a policy on two outcomes: beneficiary coinsurance and total fee-for-service Medicare payments received by RHCs.

We estimate that such a change would have reduced fee-for service beneficiary coinsurance by an estimated 24 percent overall, 44 percent at independent RHCs, 43 percent at non-specified provider-based RHCs, and 13 percent at specified provider-based RHCs. In addition to lowering the level of coinsurance, the change would have substantially reduced variation in coinsurance by bringing down coinsurance at high charge RHCs.

Now looking at it from the perspective of RHC revenues, such a change would have reduced total fee-for-service Medicare payments to RHCs by about 5 percent overall, 14 percent at independent RHCs, 13 percent at non-specified provider based RHCs, and 3 percent for specified provider based RHCs. Because Medicare's program's payments stay the same regardless of beneficiary coinsurance, all the reductions in total revenues are due to declines in beneficiary coinsurance.

That brings us to the discussion. We look forward to Commissioners' questions and comments. In particular, we'd like your feedback on an alternative to charge-based coinsurance at RHCs we discussed today and direction on any potential future analyses you might want. A few analyses that we could consider include additional interviews with RHCs to provide context on the financial impacts of any changes, analyses looking at how potential changes could be phased in, and analyses looking at options to mitigate potential effects on RHCs.

And with that, I'll turn it back to Amol.

DR. NAVATHE: Thank you, Alex and Brian, for that excellent presentation. Dana, I'll turn it over to you to run the queue.

MS. KELLEY: All right. I have Stacie first with Round 1.

DR. DUSETZINA: Great. Thanks very much, Alex and Brian. I think one of the things that I was wondering about as I was reading the chapter was with the payment increases going into place for the all-inclusive rate, when they were setting that do you know to what extent they took into account the variability in the charges and the

coinsurance part for beneficiaries, for kind of deciding like how much to increase the payment?

MR. O'DONNELL: So I've never seen it discussed explicitly, so at the time that was happening I saw kind of the materials that were floating around. And I think the things that they were talking about were kind of projections of the cost per visit, and they had this projection of cost per visit into the future. And they looked at, well, we need to be made whole for X, Y, and Z kind of cost per visit. But I had never seen projections looking at beneficiary coinsurance. So no, I think directly I hadn't seen that being as a consideration.

I think one of the things that we've heard in the past is that historically the AIRs for independents had been quite low relative to the physician fee schedule rate, which, you remember at the time the physician fee schedule office rates got bumped up. This happened at relatively the same time, so there was an argument at the time that the low AIRs for RHCs needed this charge-based coinsurance to make them whole. And that was before this rapid increase in AIRs. So there was that argument before, and then they got these large increases in AIRs, and I haven't

heard much discussion about what that means for beneficiary coinsurance post these large increases.

MS. KELLEY: Gokhan.

DR. METAN: Thank you for this work. I have a couple of quick questions. Most fee-for-service beneficiaries have Medigap or, again, employee-retired coverage. Some of them have Medicaid. And also Medicaid covers 65 percent of unpaid costs showing as bad debt. So some part of the burden may come back to the program again.

Do we have an understanding of what share of the RHC coinsurance is paid by Medigap versus Medicaid versus directly to the beneficiary? Like to understand the direct beneficiary impact of this.

I don't know if you look at the data, but is there a way we can break it down into these?

MR. O'DONNELL: Yes. I don't have the exact answer that I think you're looking for, because I'm taking a step back. We run numbers looking at the share of all beneficiaries that have some type of supplemental coverage, and that number is quite high. So when you're thinking about the effects of this policy, most folks will have supplemental insurance.

So the predominant effect of this is that it increases Medigap premiums, for example. And it's done at a state level, so rural states end up paying more for the Medigap because of this coinsurance issue, or issues it can cause. So that's kind of one thing.

We have looked at bad debts to see, oh, how much bad debts RHCs are getting. RHCs do get 65 cents on the dollar for their bad debts, and we do see a few million payments in terms of bad debts. But it's really, really quite small in terms of bad debts, and in general, we see very little bad debts happening. But you don't really know what's going on under the hood because RHCs are not compelled to treat people based on their ability to pay. So this is a little bit different between some hospitals and RHCs.

So that's the context for which we are talking about this cost sharing.

DR. METAN: Okay. Thank you. My next question is if Medicare can increase the payments to hold harmless for the RHCs. Do we have an understanding of what the cost is that it would put on the system? What would that be?

MR. O'DONNELL: So we do, and you can back it out

with the slides we have here. It's quite modest when you say it out loud. It's something in the order of $100 million a year, and you can kind of do the math to get there. And so the things that we have talked about, and we would like the Commissioners' feedback on, is that in terms of a hold harmless you could think about some kind of potentially adverse incentives if you hold specific RHCs harmless. So you would be rewarding high charge RHCs.

One thing that we're looking for guidance on from the Commission is there is kind of a hold harmless set that specific RHC kind of angle, or there's a kind of more broad hold harmless approach, where in the aggregate you're holding them harmless. Those have different incentives when you think about them one level deeper.

DR. METAN: Okay. Very helpful. Thank you. And my last question is, how do MA plans pay in these circumstances? Do we have any findings or learnings from that part of the ecosystem?

MR. O'DONNELL: I would love to know that, Gokhan.

[Laughter.]

MR. O'DONNELL: The data are tough. We know from

any kind of industry surveys we've relied on. So there are a couple of questions, and it's kind of do MA plans pay this AIR type of methodology, or do they pay RHCs kind of like normal physician offices, under the physician fee schedule. And what we've heard, and what industry surveys have said, is that it's often a mix. So the AIR system is a kind of Medicare construct, and commercial insurers often just pay fee schedule.

Now, MA plans might be a little more likely to pay the AIR because they're kind of tethered to fee-for-service a little closer, but I do think there is a split in the commercial insurance world on how they pay RHCs.

DR. METAN: Okay. Thank you very much.

DR. NAVATHE: And then, Brian, we've also tried to follow up on Gokhan's question. We've also tried to wonder what is the beneficiary cost-sharing situation in Medicare Advantage?

Do you want to say a word or two about that?

MR. O'DONNELL: Yeah.

DR. NAVATHE: Again, we'd love to know, but --

MR. O'DONNELL: Right. So, when we were going through this, kind of that was a natural question, how does

MA plans pay this? And I think, unfortunately, the encounter data, the beneficiary co-insurance fields are not as reliable as the other fields. So we have some concerns about using that. So we don't know from that perspective.

Then we thought about, well, you can go to the plan benefit packages and kind of merge that in with the encounter data and kind of look at it that way. Unfortunately, the plan benefit data don't have RHCs listed as a specific category. So you really don't know how MA plans consider each specific RHC, and so we're kind of blinded from the encounter perspective, and then we're kind of blinded because we don't know kind of how the plans consider each RHCs kind of in the data.

Anecdotally, when we look at -- and we speak to -- we do site visits, and we spoke to RHCs. What we hear, that MA plans, at least sometimes, will do things like co-pays or co-insurance based on the payment rates. So we don't think that the entire MA industry is kind of charge-based co-insurance. We think it's probably something like a mix of -- looks more like traditional physician offices, which could also kind of impact the revenues that RHCs receive for MA patients. But we don't have a 100 percent

clear picture.

MS. KELLEY: Kenny.

MR. KAN: Excellent chapter. Thank you.

Brian, supplementing your response to Gokhan's MA question earlier, I would implore us to further find out what comparable data exists for MA beneficiaries receiving care at RHCs and for MA plans' use of rural primary care networks.

Specifically, I'm more interested, like, how would this analysis differ for MA for a comparable apples-to-apples comparison on access, quality, and spending measures? Because I think the central crux question at the end of the day for this chapter is the policy tradeoff. So any insights that we can glean from that would be helpful.

Thank you.

MR. O'DONNELL: Yeah. And just to echo, I think given the data limitations, it might be tough to deliver on that. But we will kind of double down our efforts on a qualitative basis, at least to go talk to more people and to kind of kick the tires to see if we can get any more information on that.

MS. KELLEY: Lynn.

MS. BARR: Thank you. My favorite subject, rural health clinics.

So one of the things that is the policy question on the table is, you know, if we go to a percent of the AIR instead of charges, then unlike critical access hospitals, the provider is going to have to give up some money, right? And I think it would be really important for your analysis to quantify the huge increase that they've gotten.

So that extra charge is really just a small portion of this really unprecedented increase that they've gotten in payments, and a lot of that was based on a formula, if you recall from the reading of the number -- it was the total costs of the RHC divided by number of encounters during COVID, during 2020. So it was an anomaly year that created these extremely high prices for rural health clinics.

And I think that -- well, I'll get into that in Round 2. But I think the analysis is important so that we can understand sort of what's really the margin here that we're talking about, because if you give them an extra $100 and take $10 away, that's a different question than what we're thinking, oh, we're going to take money away. It

would also maybe encourage us to move more quickly, but we can talk about that a little bit more as well.

I was wondering, as we're talking about the -- we haven't as a Commission really analyzed these high rates that sort of kind of came out of nowhere in rural health clinics, and I think it would be important as we look at the coinsurance to also look at the total bundle of services that are being offered to the patients.

So we have the all-inclusive rate, which is no longer actually all-inclusive. So you have an annual wellness visit and chronic care management, and so there's other coinsurance pieces on this, and there are other components of this. And as we compare the total payment to a rural health clinic to a total payment on a per-beneficiary basis in fee-for-service, I think this will also help us inform our policy decisions if you're able to sort of pull that together more holistically.

So the other Round 1 comment I have, the projected reduction in payments that you have in the -- I think it's the previous slide, which was you looked at 13 percent versus 3 percent, et cetera. What year is that based on? Because, as we're looking at the independents,

the independents are going up quite a bit, right? So I believe that number would be different based on what year you're targeting, and since we're unlikely to change anything immediately, probably before '28, I would imagine would be the earliest we make a change, maybe you want to target those numbers on the 2028 number instead.

MR. O'DONNELL: Yeah. And just to say it out loud, those numbers are based on 2025, and how that will change in the future is dependent on how charges per visit compared to growth in the AIRs. And so for the independent RHCs, for the next few years, their AIRs are going to grow by 10 to 12 percent on a payment-limit basis for the next few years. So it's to the extent to which charges per visit are higher or lower than the growth of AIRs.

To be honest, charge growth has been quite high over the last few years, as I mentioned. So it's been about 8 percent in the last three years, and so it's been quite similar to the growth in the AIR. So they're both growing quite rapidly.

But I understand your point is that it might actually go down to the extent that charge growth goes to more historic levels, and the AIRs continue to increase

quite rapidly.

MS. BARR: Right. And I don't think that would be true for the provider-based clinics. But I definitely think that since you've got that rapid growth in the independent clinics, that that would be a different number.

The interesting point about the charges aren't set for coinsurance, I just want to clarify that, that these clinics aren't setting those charges high so that they get more coinsurance, because that tends to be a pain point with the patients. It has more to do with that's how the commercial plans and MA plans pay them, typically, as a percent of charges, right? So the charges are really set to try to maximize payments from non-Medicare payers, except for potentially Medicare Advantage.

I think the rest of my comments are Round 2. Thank you.

MS. KELLEY: Gina.

MS. UPCHURCH: Full disclosure, this is Round 1.5, probably, but just putting it out there.

We're in the middle of Medicare's open enrollment period, and so I'm seeing lots of trends, and one of them is that Medigap supplement prices are going through the

roof. So I have a little sensitivity to that.

The other thing we're seeing is a big disparity between the drug benefit with Medicare Advantage plans and standalone drug plans, and driving a lot of people to Medicare Advantage plans.

But back to the Medigap. So we know of any -- and this is a broader question. Do we know of any circumstance where, getting at Gokhan's point, secondary coverage, traditional Medicare, is either a Medigap policy that you purchase, your employer, retiree coverage, or you have Medicaid? Do we ever know if we save money somehow in the system, so in a rural health clinic, you lower the cost sharing there, that that Medigap policy lowers their premium rates? I've never seen it happen. I'm just curious.

MR. O'DONNELL: Yeah, I don't think we have a direct answer for you. When we were doing the CAH co-insurance work over the last several years, we spoke to some actuaries from Medigap plans, and -- basically, you're asking, like, do we know kind of how they'll react --

MS. UPCHURCH: Right.

MR. O'DONNELL: -- to lower co-insurance? And

the answer is no. I mean, qualitatively, we think the Medigap premiums would go down, but the exact magnitude is based on how they would respond in the market.

MS. UPCHURCH: Well, one way the magnitude would change is if the MLR was not 65 percent for Medigap policies. It would be more 80, 85 percent. I'm just curious if the MedPACs ever talked about medical loss ratios for Medigap policies. That's a broader question. Okay. I'm not getting into it.

[Laughter.]

MS. UPCHURCH: Okay. Going on to something else. So is there -- I think of community health centers, rural health centers, FQHCs as being in that rubric there. Do we know if there's a -- is there a major reimbursement differential? I mean, this is so complicated. Just rural health centers alone, and then you've got FQHC payments. Then we have fee-for-service and Medicare Advantage. So is there a huge reimbursement difference between rural health clinics and FQHCs, different payment models? I don't know that.

MR. O'DONNELL: Yeah, so two things.

MS. UPCHURCH: Okay.

MR. O'DONNELL: One, on the co-insurance bit, at FQHCs, currently, the beneficiary co-insurance is already capped. So it's capped at 20 percent of the payment rate, and they actually don't pay any deductible either at FQHCs. So, at FQHCs, beneficiaries are more protected from that perspective.

And then to go back to the payment rate question, FQHCs are paid on a PPS basis. So they set a national rate, and it varies based on kind of the location of the FQHC.

So, in general, the FQHC PPS is just north of $200 per visit, and it varies, obviously. So, when you think about on a relative basis, do FQHCs get paid kind of more or less than RHCs, it really varies. So, if you think about an FQHC compared to an independent RHC, the FQHCs get paid more, but relative to the specified provider-based RHCs, which account for about two-thirds of the volume, those can often get paid kind of far more than an FQHC, because, as we saw, the kind of average per-visit payment is something like $277 in 2025.

So whether you're higher or lower depends on what type of RHC you're in.

MS. UPCHURCH: Gracious. Okay.

Sorry. Just two more quick questions.

So, in my mind, our local FQHC, it's a copayment. It's a flat copayment. That's why I was wondering if we've ever looked at rural health clinics as being a copayment, so a person knows when they go in, it's $10. Is that even a thing with rural health centers?

MR. O'DONNELL: So, in fee-per-service Medicare, the FQHC is 20 percent of the coinsurance. Other plans might do it differently. So MA plans often might do a copayment. So we haven't looked at what they get. We don't have, like, systematic data on how the coinsurance varies for other payers at RHCs.

MS. UPCHURCH: And my last question, comment, is in our reading in Tab A, one of my favorite tabs, there was an article that says, who knew Boston was rural? And it talks about private equity firms coming in. So I wondered if we think that private equity entry is playing into what we're talking about here.

MR. O'DONNELL: So the answer is yes. We know there is substantial private equity interest and entrance into the RHC market, and we are working to kind of titrate

our estimate of the exact amount of entry. But, in the last few years, we think it really started kind of post-PHE or increased post-PHE. And we think that in some years, in recent years, it has driven maybe slightly less than or even exceeding half of the entry of independent RHCs that we saw spike.

So, again, we don't have an exact estimate of kind of the entry of PE-owned firms, because it's hard to quantify, and so Alex and I are kind of working on that. But we do know that that's the kind of part of the entry story, and that's why the number has increased. Once we nail down who exactly is owned by private equity, then we can do some more analytics on kind of how their billings kind of might vary based on ownership types and things like that. But it's really just hard. It's hard to kind of nail it down exactly.

MS. UPCHURCH: Well, you've taken a very complex situation and made it as clear as possible. So thank you both.

MS. KELLEY: Sure. On this point, Lynn?

MS. BARR: Just a quick follow-up.

So the huge hockey stick in the rates for rural

health clinics that have increased the co-insurance, your point on Medigap, this would actually give us a way of analyzing the impact of that on Medigap premiums. Have you thought about being able to actually look at how rural Medigap premiums have changed since these new payment policies have been put into place?

MR. O'DONNELL: So we haven't done that analysis to date.

MS. BARR: It could be very helpful in us understanding, like, what is the real cost of this to the beneficiaries? Because, like you say, everybody's like, oh, it doesn't matter. It's all covered by Medigap. But if everybody's insurance went up $100 a year, you know, that would matter.

DR. HARRIS: I do just want to add on that point. Agree, it would be interesting.

I do think it is really hard to isolate a single policy, especially around 2021, you know, trying to isolate, you know, changes in payment limits, for example, as the only thing affecting Medigap premiums. So that's just like another consideration of why an analysis like that would be particularly challenging to say that this

policy has increased or not increased Medigap premiums by X amount.

MS. BARR: I don't know, if anything else, it would, like, have really affected rural in such a unique way, and it's such a big increase on the Part B side. It seems like other things would be equal. I don't know.

But I think that it's very -- this was a very -- I struggle with this policy of really jacking up the rates for primary care. And I'd also be very interested in whether Medicare Advantage is now steering away from rural health clinics, because who wants to pay $400 for a physician visit?

MS. KELLEY: Cheryl.

DR. DAMBERG: I have two questions.

In the chapter, you note that there's faster growth in the average charges per visit at RHCs, and I was wondering, that's compared to MEI growth of 2.8 percent. And do you have a sense of what's driving that? I mean, have you looked at the cost reports to understand what's changing?

MR. O'DONNELL: So, no, we have not looked to see what is driving the underlying charge growth, because the

charges don't have to be tethered to costs or things like that. So we haven't looked, for example, to see whether the kind of implied cost-to-charge ratio has changed over time or anything like that. We could do something like that to see whether that has changed over time, but we haven't to date.

DR. HARRIS: Yeah. And we have seen a similar trend in recent years in critical access hospitals as well.

DR. DAMBERG: Okay, thanks. Yeah, it just seems like "funny money," the charge piece.

And then my other question is -- and I think this is really at the heart of what you're trying to get at with thinking about policy changes. So your initial estimates of revenue loss of 5 percent lower on average to RHCs, do you have a sense of what the impact would be in terms of their delivery of services? Because I'm just trying to get a sense of like how vulnerable are these providers now that they've gotten this big payment increase, right?

And given the substantial bump, are we potentially overpaying them, particularly given the entry of private equity into this space? So that would be my question.

MR. O'DONNELL: Yeah. So I think it's a tough question. It's the right question, but it's tough. And I think the first thing we think about is how that translates into kind of all-payer revenues, and so this 5 percent estimate is just for fee-for-service Medicare. So, when you think about that in terms of their total book of business, it's going to be quite a bit smaller than that. So it's going to be a few percentage points. So that's the magnitude that we're talking about on an all-payer basis.

But then going forward to see how that would affect, I think there's a series of questions we could look at to get to that, but we haven't kind of gone there to date.

DR. DAMBERG: Yeah. I think that would be really helpful, because I also struggle with this notion of holding them harmless if we think they're being overpaid.

MS. KELLEY: I have a Round 1 question from Ben. He is curious how cost sharing is typically paid by beneficiaries at RHCs. Is it correct to assume that higher charges primarily manifest higher Medigap costs or costs of other secondary coverage?

MR. O'DONNELL: Yeah. So I think the general

answer based on our findings, that the vast majority of kind of beneficiaries have supplemental insurance, is that the predominant effect will be higher kind of supplemental premiums for folks living in rural states.

And then the other thing is that for folks who don't have that supplemental coverage, which is a small but kind of non-zero number, kind of we do have substantial kind of access concerns for that group.

MS. KELLEY: Greg.

MR. POULSEN: So thank you very much. Great stuff.

In terms of one of the options, when we look at paying the lesser of 20 percent of AIR, 20 percent of charges, would we do violence if we just did 20 percent of AIR and took away the charges? Because I have seen "lesser-ofs" lead to unintended consequences a million times going back a million years, starting with DRGs when hospitals raised their prices dramatically so they would never get caught in give the less of charges or the DRG. So would we do violence if we just said 20 percent of AIR and made it simple?

MR. O'DONNELL: Yeah, that is something we can

model out going forward.

I do think that in contrast to the critical access hospital analysis where we didn't have a lesser-of policy involved, at least partially because it wouldn't have mattered because the charges were always much higher than 20 percent. I do think for RHCs, you do see a non-trivial share, especially specified provider-based RHCs, that have their charges below the AIR, and so it does matter. There will be an effect if we were to set it just at 20 percent of AIR versus the lesser-of policy. So we can quantify what that number is, but it is going to be a non-zero number and especially for the hospital-based folks.

MR. POULSEN: I appreciate that. Lynn pointed out that the charges are usually based on what people are doing for commercial as opposed to Medicare, and I think that is right, but I think that a lesser-of encourages people to step away from that historical boundary in a way that we wouldn't want. So thanks a lot.

MS. KELLEY: Danielle, Round 1 question?

DR. PIEROTTI: So of all the confusing, complicated things we talk about in this room, you win.

Thank you. And I think I am very confused at a very base issue, specified versus non-specified. I understand independent versus provider-based offices. In my simplified brain, I see that as you are part of a system or you are not.

This subcategory of whether you are a specified or an unspecified appears to make a very big difference in every single one of the graphs and charts in dollars, and as best I understand it, there is some kind of grandfathering that happened at some point for reasons that are mysterious to me.

And my question is, is this going to last forever? Because it seems to be making a very significant difference that I do not fully comprehend why we are holding on to this differentiation.

MR. O'DONNELL: So I will answer your question directly. Then I will give an unsolicited history.

So I think the answer is yes, is that the differentiation between specified and non-specified, that is permanent. So, in the CAA in 2021, they created this category. They basically capped all provider-based AIRs, and that is what the folks who were already kind of either

kind of active at the time and have a hospital of less than 50 beds, they were grandfathered. And so those are the specified kind of RHCs. So that was the first time that all RHCs now had a cap on their AIRs, and this is one of a series of changes that has been made over time to basically cap AIRs.

So, I think, in general, there is a concern with uncapped cost-based services. There are some kind of bad incentives there. So I think over time, starting with the VBA in 1997, they capped RHCs with large hospitals, so RHCs with 50 beds or more. So they were already capped over time.

And then the CAA in 2021, they capped the rest of provider-based. So now everyone in the provider-based category faces a cap, and the caps are different based on when they were essentially capped.

DR. PIEROTTI: I'm just going to beg for simplification.

My other question around this is that since this is theoretically rural, despite Boston, the growth in offices or providers that are falling in this category, can we overlay that with changes in population in the areas

that these providers are popping up?

There are shifts in rural populations going on, and if these are offices and specifically incentivized to provide rural care and we now have these questions about private equity -- and I'll just say it again, Boston is not rural -- could we do an analysis that gives us not just where they're located, because they don't think that's particularly meaningful, but the demographic changes that could be related to, well, now we have a new office in this space because there is a change in a population area? I don't know if that's doable, but --

MR. O'DONNELL: Yeah. So we could do something like that. So we have kind of the date of entry of all these kind of RHCs, and we can look at the zip codes or the counties to look at the population changes.

The things that we've done thus far is that we've looked at the RUCA codes for where these new RHCs are coming online, and in general, it's spread across the map. So you can have RHCs in urban areas. You can have RHCs in micropolitan areas, which is kind of a rural area, but a slightly higher population, or kind of even more kind of rural areas. And we do see a substantial entry in

micropolitan areas in the last few years, and so we've been watching it to see similar -- on a similar thought to what you just said, we've been watching it to see where the growth is, to see whether there are different incentives.

So we can drill down and kind of take our analysis, which has looked at RUCA codes, and we can try to go kind of a step further to see whether it's related to population growth or any other type of those demographics.

MS. KELLEY: Amol, that is all I have for Round 1.

DR. NAVATHE: Great, thank you.

So I just wanted to note that we're going to allow this session to run over. We're supposed to end at 12:50, but a lot of good Commissioner questions, and I think a lot of Commissioner interest, and so we will allow the session to bleed over into lunch.

Then before we adjourn for lunch, we will stop for public comment or at least opportunity for that.

A couple of things, as you consider your comments in Round 2. One is, please try to be mindful of time, of course, given that we'll be running over.

A couple of other things to think about. One is,

several Commissioners, including Lynn, have pointed out that there's obviously the growth that we see. So would it be valuable for us to do some distributional analysis looking essentially at what Lynn was saying as relative to the growth in AIR, particularly delta with MEI? There's going to be a distribution relative to how a 20 percent of AIR would stack up relative to that. So would that analysis be helpful to inform how we might think about 20 percent of AIR or the lesser-of notwithstanding? That's kind of one thing.

The second thing I was curious about. While most of the discussion hasn't focused around this, there is this differentiation for the telehealth between mental health and non-mental health services, and the Commission has done some work and has pointed out on the non-mental health services side. So, to the extent that there's Commissioner interest around that piece, if you could also point that out, I think that would be -- on the mental health services side, kind of aligning that on the PFS piece, that would also be helpful.

MS. KELLEY: Okay. Stacie, I have you first.

DR. DUSETZINA: Great. Thanks so much for this

work.

I'm incredibly supportive of moving forward on reforming any charge-based co-insurance. I think it's nuts to charge people based on charges, because they're not based in reality in a lot of ways.

I would love to see specific analysis that look at changes in charges over time by the type of setting and by ownership. I think it sounds like you're going down that path anyway. I think it's really important, especially with the entrance of a lot of private equity in the space. I'm concerned about that growth.

I do agree with the idea for the telehealth services, especially setting based on PFS. I do not like the hold harmless, because of those issues that you mentioned around that would kind of benefit those that already have the highest charges the most. And I think that that's probably not what type of message you want to send.

And I think I must be on the same wavelength as Gina. I kept thinking, as I was reading the chapter, it feels like getting co-insurance correct here with the AIR seems hard. So should we move to co-pays for setting what

the patient's cost shares are for the services received at these sites? I think it would be more stable and more fair.

I'm okay with the idea of exploring a lesser-of policy, but I think to Greg's point, sometimes that ends up with unintended consequences that maybe we could have been able to see because we've seen it before. But I'm very supportive of moving forward and changing this charge-based co-insurance stuff.

DR. NAVATHE: Stacie, one quick clarification. So recognizing the points that Commissioners have made about share of beneficiaries in fee-for-service who have supplemental, does that change your feeling about this co-pay co-insurance?

DR. DUSETZINA: No. Someone is paying that. It's an employer plan. It's the premiums that people are paying for Medigap, or it's the person themselves. And so I think that the idea of setting that cost based on charges is irresponsible, no matter who's paying for it.

DR. NAVATHE: Right. Not on the charges piece. I'm kind of reflecting on the co-insurance relative to AIR versus a co-pay, because that would be kind of a

difference, but because that dollar amount per se is not being collected a lot of times at that point of care, is there a big inflection point there for you around that?

DR. DUSETZINA: Not necessarily. I mean, I think you'd have to figure out a way to get the co-pays set correctly so that it was not too harmful for the --

DR. NAVATHE: That's my concern. My concern is then like setting that co-pay becomes another challenge, and if there's not a lot of collection happening, then -- although I generally believe and agree with the literature that suggests that individuals understand co-pays better than co-insurance, or it's easier to interact with that system. I was just thinking about it in that context; hence, I wanted to get your thoughts.

DR. DUSETZINA: I guess the thing that makes it difficult with this, you know, you see this huge increase in the AIR over time. So we want to pay more. That does put more burden on the patient proportionally. As we pay more, they're paying 20 percent of that. So whether it's the patient or the Medigap plan, I guess the question is, do you feel like that additional percentage, 20-plus percent coming from whoever, is necessary to keep those

places doing financially as well as they can? Or is that just penalizing patients when we want to pay more for these certain sites of care or their Medigap plan or whoever?

DR. NAVATHE: Got it. Okay.

So, as folks end up, if you end up commenting on this point, I think one of the pieces that is an implication that's worth noting is that if we were going to a 20-percent-of-AIR-type policy, that would have implications for bene supplemental coverage, certainly would potentially have implication for RHC, but would not have implication for the Medicare program. But if we move to a co-pay type of structure, potentially, then as AIR goes up, if co-pay is not going up, which is how I partially heard what you're saying, that also has implication for program spending. So just want to be thoughtful about that as you grapple with the various options here.

MS. KELLEY: Tamara.

DR. KONETZKA: Okay. I want to flip the perspective here a little bit. So we keep talking about what happens if we change this co-insurance and what happens to the payments then and is it enough, et cetera.

I think there are really two separate issues here. One is, how much do we pay our HCs? And we've seen these payment rates go up over time, and I think we want to do more analyses and sort of push the point of like, how much should we be paying them? Are these the right payment rates or not? Is this the right way of setting payment rates?

And part of that is just our normal criteria of do beneficiaries have access to this? Is the quality okay? And are they being efficient enough?

And then there's this sort of added rural piece, right? Do payments need to be high enough to sort of sustain access in areas where maybe the most efficient kinds of payment rates wouldn't be sufficient? And that might vary by the telehealth and the non-telehealth, right?

So. to me, that's one issue that's really important here. These rates are going up. Charges are going up. Rates are going up. And we need to sort of figure out what's the right way to pay them so that we're not overpaying. Clearly, the rapid entry of private equity may be a sign that these health clinics are getting pretty high profit margins right now.

There's a whole separate issue, then, of once we decide what that payment rate should be or how we should pay them, what's the composition of that and the role of beneficiary co-insurance? And nowhere in there does it make sense to arbitrarily charge some beneficiaries more to make up part of that payment, right? It makes no sense whatsoever. It's like saying providers in North Carolina aren't doing well, so now all of a sudden, Gina is going to pay for 100 percent of her care instead of 20 percent. We just should not be doing that to beneficiaries.

And I don't care if most beneficiaries have some kind of supplemental payment. As others have said, this has implications even if Medigap pays it. It has implications for premiums. It has implications for the Medicaid program and Medicaid spending and certainly implications for people who don't have supplemental coverage. So that to me isn't sort of a mitigating factor. I just think we have to have fair co-insurance that is equitable, and this current system is not equitable. So that to me is like there's no trade-offs there. Like that just has to go away.

To me, the thing that I think makes the most

sense is to have something like a 20 percent of AIR. I think maybe getting into some of the copayment and the lesser-of does like make things unnecessarily complicated. I think those are maybe some additional analyses around how much more complicated it would be to have those alternatives would be useful. But something kind of straightforward that seems similar to what we're doing in critical access hospitals, et cetera, like a 20 percent of what we're actually paying them would make a lot of sense.

But I do think like we need to -- we don't want to go backwards. We don't want to say we're going to take away this charge-based co-insurance, and so, you know, let's hold them harmless. That to me is just sort of the opposite of what we should be thinking about. We should be starting to think about how much we want to pay them.

MS. KELLEY: Lynn.

MS. BARR: Thank you. You know, I think we needed more information. It's really important. We're talking about provider-based clinic at $400 a visit, and we're talking about $80 coinsurance. Do you feel differently about that, and the answer is yes. And I don't think that's a crazy number. I mean, I don't know what the

average is for these clinics, but we need that information. Because I really like your idea of a copay on this, because an $80 coinsurance on a clinic visit is going to drive people elsewhere, in one way or the other.

I think the fact that half of these clinics are private equity is extremely concerning. We've never had private equity in rural health clinics, as far as I know, in the history of rural health clinics, up until we suddenly started paying this new policy.

And I don't believe MedPAC had any opportunity to give input on this policy. The Commission has not been asked, "What is the right way to pay rural health clinics?" and it's been an issue for quite a while that these provider-based clinics were charging $200, $300 a visit. But that new rate is now their new floor, right. So the prices have gone up, and I think we need to see what they are and get a better understanding of that.

I think that when you talk about if we held them harmless it would cost 15 percent or 16 percent, 5 percent. Think about that. They've doubled their rates, so we're only going to increase it by 85 percent.

So I think that this is really an area that's

fraught, and I'm really worried about what Medicare Advantage will be doing with these very high prices, and the location of these. I'd love to have all of that information. I'm really glad you guys are doing this work, but I think we need to know, in real dollars, how does this compare to a primary care visit somewhere else, and what are we really talking about in terms of money.

DR. NAVATHE: And Lynn, just so I understand, even when you're talking about copay it sounds like you feel, based on the trajectory of the rates, that there is no increase in program spending warranted her.

MS. BARR: Absolutely. That's correct. I don't favor a hold harmless. And you did ask about the telehealth, and I forgot to comment on that. Given that telehealth is paid at PFS, who cares if there's a little bit of overusage? I mean, this is like a bargain for Medicare if we do telehealth, because it's like $100 versus $200, $300, $400 a visit. And it's also convenient for rural beneficiaries that have a hard time getting there. I think we should extend that forever, because it's a better deal.

DR. NAVATHE: Lynn, the question, to some extent,

was mental health telehealth is paid at the AIR higher rate versus paying at the PFS rate.

MS. BARR: Right.

DR. NAVATHE: So would you support having it paid at the PFS rate?

MS. BARR: PFS rate, absolutely, because that may be the only way some people can afford to go.

DR. NAVATHE: Thank you.

MS. KELLEY: Brian.

DR. MILLER: Okay. Super short comments. I do like rural health care. I enjoyed it when I lived in a village with one stoplight. That was fun. Still had traffic jams.

I'm totally fine to change beneficiary cost-sharing to 20 percent of the actual rate rather than charges. Like don't break the old people. Don't be a jerk to the poor. Don't be mean to the benes.

I don't think, though, if we do that, that it is fiscally responsible to hold rural health clinics harmless. So if we're decreasing beneficiary cost-sharing to 20 percent of the actual rate, from 20 percent of charges, that a hit to RHC revenue, and that's an okay tradeoff.

But we don't have a lot of money left on the Medicare money tree, whether it's SNFs, IRFs, hospitals, doctors, home health, MA plans, or whomever.

So I think if we're going to protect benes by doing this change, that's fine, but RHCs might have to take a haircut then on total revenue. So I'd say we can't have our cake and eat it too. We just have to pick which set of tradeoffs we want, is how I think about it.

That's my shortest comment in four years.

MS. KELLEY: Gokhan.

DR. METAN: I'll make two short comments. The first one is about some of the, again, policy design options. It would really help us to understand these three policy options that we can go with, and seeing the impact on beneficiaries in terms of the savings, what would affect the RHC revenue and Medicare costs. So if we can see the impact on these three costs, maybe side by side, at least three policy alternatives we would like to consider, that would be super helpful.

And then on the telehealth, again, given that Congress will go with post-2027 on this one, I think it would make sense to restate our stance on the PFS equaling

telehealth, using the payment-based coinsurance in either a comment letter or some kind of a June 2027 report, so that we reiterate our stance in the recommendation.

Thank you very much.

MS. KELLEY: I next have a comment from Kenny, who had to step out. He says if we were to cap RHC coinsurance at 20 percent there is a policy tradeoff between a reduction in beneficiaries' liability versus a 5 percent reduction in RHC revenues, concentrated in independent and non-specified provider clinics. He would like more color on how to think about potential access risk with any future payment analyses that we do.

Subsequently, which has been alluded to in passing, to better inform this tradeoff can the staff model a distributional analysis with a holistic phase-in and a beneficiary cap that holds clinics harmless only where access risk is demonstrated.

And I have Cheryl next.

MS. KELLEY: Okay. A lot to chew on in this space. I similarly am concerned about the inequities of these out-of-pocket costs for those being served by RHCs and the fact that it's creating disparities.

And as I read this chapter it kind of reminded me of similar spaces where there's a lot of what I call one-off policymaking without consideration of the whole. And this is creating opportunities for program integrity issues, perverse incentives for gaming, inflating charges, and potential unintended consequences such as the entry of private equity to extract profits due to overpayments. And just like all the confusion around these differences in payments for in-person, telehealth, mental health, it all creates complexity in the rules for both providers and beneficiaries.

Similar to Stacie's comment, I'd be interested in knowing how often RHCs are changing their charges year over year, whether those charges are focused on certain services, and in what type of RHCs this is happening.

I agree that beneficiaries should not be paying 20 percent of the RHC charges, so this obviously creates incentives for the hospitals to increase their charges, although I don't know to what extent we have evidence that that's actually going on, but it seems like that's the incentive that's potentially in play.

I am supportive of the Commission doing further

analyses and working to outline different policy reform options, capping the cost-sharing at 20 percent of payments. And I think it would be helpful to try to understand the impacts, and I think you alluded to this in the chapter, potentially doing interviews with RHCs to understand what the impacts would be.

And I also want to plus-one on Tamara's comment about rethinking what's the right way to pay RHCs and not just automatically defaulting to a hold harmless policy.

And then the other thing that I was curious about is what the effect has been on allowing RHCs to provide specialty services, and has the service mix changed, and is this why we're seeing a lot of variation in the percent coinsurance payments reflect of the total payments to RHCs. And is this also potentially driving the entry of private equity into RHCs, because they can get larger profits on specialty services? So I think that would be helpful to look at.

And I think similar to comments made by other Commissioners I do think we need to keep an eye on private equity and their role in this space, whether that's actually helping improve access or whether it's suggesting

overpayments and extracting profits of the Medicare program.

MS. KELLEY: Robert.

DR. CHERRY: Yeah, thank you, and I'll just be brief. I just wanted to articulate a few principles that I'm entertaining in my head as we move forward with this work. First, the obvious, that any future model that we propose will be uncoupled from the charges that we look at, something that is much more equitable and fair for the members that are involved.

The second principle, just to echo what Greg said, is that we should keep this simple. It could be 20 percent of AIR or some sort of variation thereof, but not make it overly complicated.

But the third principle, too, is from rural clinics and critical access hospitals that there probably, at least temporarily, needs to be a zero sum game. Because I'm concerned if the revenue decreases are significant enough, based on the change in model, that we could put some financial stress on rural systems as an unintended consequence. So we may need to keep them whole, at least temporarily, for a short period of time, and make sure that

they're okay financially.

Those are sort of three principles that I'm entertaining as people consider the work moving forward, so thanks.

MS. KELLEY: That's all I have for Round 2, Amol.

DR. NAVATHE: Great. So I am continually struck by the thoughtful comments that you all make and the great work that the staff do, so thank you for that. Just really wonderful discussion, very rich.

A couple of kind of reflective points. I think a number of Commissioners have pointed out that it would be helpful to do something like a distributional analysis, and I think we can do that kind of looking at the trajectory of how the AIR has grown over time, as well. And then this is a non-exhaustive recap but also some interest in looking at the service mix kind of underneath that AIR. So those are amongst the things that we'll look at as we continue moving this work forward.

I think generally there was strong support from Commissioners around not increasing program spending, so I think that particularly important. And I think kind of generally speaking moving towards a direction that's

similar to 20 percent of AIR, potentially instantiated in the context of a copay as opposed to a coinsurance seems like a direction to pursue, of course, pending some of the distributional analyses and such that we talked about. And then also telehealth kind of in reference to PFS, regardless of mental health and non-mental health.

So those are kind of the broad takeaways. As I pointed out earlier in the day, perhaps, this is something that is going to be ongoing work based on the Commissioner interest here. So I don't think we're going to necessarily get to recommendations very quickly, especially with the additional analytic work.

But thank you so much for the wonderful feedback that you all have given.

DR. NAVATHE: We will bring this session on rural health clinics to a close, and then provide an opportunity now for anybody who is attending in person, from the public, to provide an in-person comment.

[Pause.]

DR. NAVATHE: Okay. Seeing no takers there, those of you who are listening in via the WebX platform, we would also love to hear from you. You can send in your

comments to meetingcomments@MedPAC.gov.

And with that we'll bring our morning session to a close. Thank you.

[Whereupon, at 1:10 p.m., the meeting was recessed, to reconvene at 2:30 p.m. this same day.]

AFTERNOON SESSION

[2:30 p.m.]

DR. NAVATHE: Welcome back to our afternoon session. We will start with "Analysis of Aberrant Patterns of Care Among Hospice and Home Health Providers." I'll hand it over to Kim.

MS. NEUMAN: Good afternoon. Today's session will discuss recent program integrity concerns and trends in hospice and home health. The online audience can download a PDF version of these slides in the control panel on the right-hand side of the screen.

Today's presentation will have five parts. We'll start with background on home health and hospice. Then, we will discuss recent program integrity concerns and CMS efforts to address them. Then we'll walk through some exploratory data analyses of potentially aberrant patterns of care among some providers. Next, we'll discuss trends in the hospice aggregate cap. Finally, we'll conclude with a summary and next steps.

The home health benefit provides beneficiaries with skilled care in the home to recover, maintain function, or slow decline. To be eligible for home health,

a beneficiary must be homebound and need skilled nursing or therapy services. There is no cost-sharing in fee-for-service Medicare for home health services. Medicare fee-for-service paid $16 billion for home health provided to 2.7 million fee-for-service beneficiaries in 2024.

Hospice provides palliative and supportive services for beneficiaries with terminal illnesses who choose to enroll. To qualify, a beneficiary must have a life expectancy of six months of less if the disease runs its normal course. There is no limit on how long a beneficiary can be enrolled in the hospice as long as a hospice physician certifies they continue to meet this criterion.

Beneficiaries who elect hospice choose comfort-focused care and agree to forgo care for their terminal condition from nonhospice providers.

Hospice services generally do not have beneficiary cost sharing, except a hospice may charge limited cost sharing for inpatient respite care and drugs. Medicare paid over $28 billion for hospice care furnished to 1.8 million beneficiaries in 2024.

Before turning to today's discussion of program

integrity, I want to briefly cover a separate hospice topic, a new contractor report on hospice and Medicare spending.

The most important benefit of hospice is its effect on patient care. When the hospice benefit was established, it was also thought that hospice would be less costly than conventional care at the end of life.

Over the years, a number of studies have estimated hospice's effect on Medicare spending. Findings are mixed across studies, in part depending on methodology.

Back in 2015, a MedPAC contractor report looked at this issue and found that although hospice reduced spending for cancer patients, it did not appear to reduce overall Medicare spending.

Recently, the Commission contracted with researchers at the Urban Institute to conduct an updated study.

One thing to note, hospice's effect on Medicare spending does not factor into our December assessment of payment adequacy. Rather, this is a topic of broad interest, and the contractor report is intended to contribute to the evidence base.

The study compares overall Medicare spending for hospice users and nonusers over 18 months. Because hospice users and nonusers may differ in ways that are unobservable to researchers, the study uses variation in distance to hospice providers as a natural experiment, to estimate the effect of hospice.

The study finds results are sensitive to assumptions about hospice's effect on length of life. In a model that did not control for mortality, the study found hospice use was associated with lower overall spending, driven by estimated fewer days alive. In a model that controls for days alive, the study did not find a statistically significant effect of hospice on Medicare spending.

It is important to note that estimates from the study should be interpreted with caution for several reasons. First, the type of methodology the study employs as a way to isolate the effect of hospice from other confounding factors requires researchers to make an untestable assumption. In the case of this study, the assumption is that hospice do not locate strategically in areas with above- or below-average levels or rates of

change in morality or spending.

Second, the results are estimated only for a subgroup of beneficiaries, those whose decision to use hospice is induced by closer proximity to a hospice, and the results are not generalizable to the broad hospice population.

Finally, interpreting estimates of hospices' effect on length of life warrants caution because a reduction in survival time does not necessarily indicate a poor outcome if it reflects a terminally ill beneficiary's preference for hospice care over conventional care

So now I will turn it over to Evan to begin our discussion of program integrity.

MR. CHRISTMAN: Next we will take a look at recent CMS moratoria and program integrity activities for hospice and home health.

The hospice and home health benefits provide valuable care to beneficiaries with significant health care needs, and ensuring that the benefits are not exploited by fraudulent actors is important to the Medicare program.

In recent years, the Commission, CMS, and industry stakeholders have raised significant concerns

about fraud, waste, and abuse in these two benefits. Last spring, CMS also recently released a request for information to the public soliciting ideas for additional program integrity efforts across the Medicare program.

While CMS is pursuing several improvements to address fraud, waste and abuse, concerns remain that more could be done to address this challenge.

In this part of the presentation we will review prior recommendations by the Commission, CMS's recent actions, and other actions to address program integrity, and also review examples of aberrant patterns of care in the two benefits.

We start with a review of prior hospice work. In March 2009, the Commission recommended the face-to-face visit requirement for some hospice recertifications; a requirement that certifications include a physician narrative on the basis for the patient's prognosis; medical review of long stays for providers with a large share of these stays; and that the IG conduct studies of several program integrity concerns.

Subsequently, actions were taken by Congress, CMS, or HHS in each of these areas, including the

establishment of a face-to-face visit requirement for some recertification and a physician narrative requirement.

Next we will take a look at our program integrity recommendations for home health care.

For home health we recommended that Congress direct the Secretary to examine home health agencies with unusual claims patterns, and also to provide additional authority for safeguards such as provider moratoriums and prior authorization programs in high-risk areas.

Subsequent legislation added a face-to-face requirement for home health care, and also created a moratorium authority for the Secretary to stop enrolling new providers when deemed necessary to prevent fraud. In 2013 to 2019, CMS implemented moratoriums for home health and ambulance services.

Our March 2026 Report to Congress also included some discussion of program integrity issues for hospice and home health. We noted that fraud, waste, and abuse is important for many reasons, but one key concerns is it can have an impact on beneficiaries. Beneficiaries can be exposed to unneeded services, and the costs of those services increase Medicare's expenditures, diminishing its

revenues, and in the case of home health, creating upward pressure on premiums. In the case of hospice, beneficiaries may experience difficulty accessing care when hospices enroll them without consent or do not fully explain the benefits focused on comfort care.

Our March report also noted aberrant patterns of utilization and spending in certain parts of the country, and we noted that these patterns may warrant additional review as potential program integrity concerns.

The most recent action by CMS has been the nationwide moratorium on new hospices and home health agencies, announced in May 2026. CMS will have to announce later this month whether the moratoriums will be extended.

CMS cited several reasons for establishing the moratoriums, including the rapid growth of hospices and home health agencies in Los Angeles and the other regions we mentioned earlier. However CMS noted that fraud schemes were viral in nature, and could spread to other areas, and that they were likely not concentrated to the geographies noted so far. As a result, the moratoriums imposed in May for home health and hospice were national, reflecting concerns that state or regional moratoriums could be

evaded.

In addition to the CMS action, two states have also enacted moratoriums. California has a state moratorium on the licensure of new hospices, and Nevada recently implemented moratoriums on state licensure for hospice and home health.

In addition to the moratoriums, CMS has implemented several policies to address fraud in hospice. These include medical review efforts for hospices in six states with 100 percent prepayment review for new hospices in their first year under the program referred to as the Provisional Period of Enhance Oversight, or PPEO. In addition, some existing providers may be subject to selective pre-payment review.

In 2024, CMS expanded the level of scrutiny for new and re-enrolling hospices by designating them as high risk, which triggers additional screening actions by Medicare contractors.

In 2026, CMS also announced several enforcement actions revoking Medicare enrollment for over 200 hospices and suspending payment for over 800 hospices and home health agencies in Los Angeles.

Finally, CMS also simplified the disenrollment process for hospice to help beneficiaries who had been enrolled without their consent or under misleading circumstances.

Finally, we would note that the review choice demonstration program is another tool CMS has used to address program integrity concerns in home health. This is currently in place in five states through 2029. Under this program, the home health agencies in these states have the option for a pre-payment review or post-payment review of their home health claims for six months. Agencies that sustain an affirmation rate of 90 percent or greater are moved to a less intensive level of review.

I would also note that on Tuesday of this week CMS indicated that it would expand the review choice to include California.

Many of the aberrant hospice and home health trends that motivated CMS's actions have been noted by industry stakeholders and professional associations. The industry stakeholders have noted that it supports a variety of enhanced enforcement measures, particularly if the measures are targeted at high-risk practices and avoid

undue burden or ineffective efforts. They noted, that efforts like the PPEO used in hospice could be useful if appropriately targeted, and also asked that CMS also evaluate RCD to determine its effectiveness and potential utility for expansion.

Their comments have also urged CMS to strengthen provider enrollment to increase scrutiny for new hospice and home health providers that seek to enroll in Medicare.

Next we will take a look at some aberrant patterns in home health and hospice.

Before we go further, I would note that these data are intended as examples of the aberrant utilization patterns that occur in fee-for-service, and caution that factors influencing Medicare utilization are complex and multi-faceted. We expect variation across beneficiaries, providers, and regions, and outlier spending or utilization can reflect beneficiaries receiving needed care.

That said, in past instances aberrant patterns have been a tool for identifying program integrity concerns that warrant further analysis. They can be useful tools for determining which program vulnerabilities and geographic areas need to be examined.

The examples Kim and I are about to walk through are intended to be illustrative of these, and are provided as background for today's discussion. They are not the only measures that could be used, and other methodologies might identify different patterns.

Our first example looks at home health. Under the home health benefit, a physician or other eligible practitioner certifies the need for home health care and the home health plan of care, and the practitioner that signs the plan of care is expected to supervise the delivery of the benefit.

In some past home health fraud prosecutions, practitioners ordering care for excessive numbers of beneficiaries was one example of an aberrant pattern that indicated a program integrity issue. In some high-profile cases individual practitioners ordered care for thousands of beneficiaries, an improbably high number.

That said, there is no policy that sets an exact threshold for a high number of beneficiaries. Depending on how it is designed, high-ordering practitioners could reflect the needs of a panel of patients, so again while this example can identify aberrant patterns it should be

interpreted cautiously.

In 2024, about 345,000 practitioners ordered home health care, with the average practitioner ordering care for 8.8 fee-for-service beneficiaries, and the median ordering it for 3.

For this example, we also examined beneficiaries in the top 1 percent, or 99th percentile, which in this case was a practitioner that ordered home health care for 72 or more beneficiaries.

On average, these practitioners ordered care for 149.4 beneficiaries, substantially higher than the overall average of 8.8. Within this top percentile there was substantial variation, with the top practitioners ordering care for hundreds or even thousands of beneficiaries. The top 1 percent also accounted for a disproportionate share of home health utilization, about 20 percent of 30-day home health periods in 2004.

We have selected the 99th percentile as an example, and I caution that other criteria might identify different groups of practitioners. But the high values for some practitioners are consistent with trends that have raised concerns in the past.

As another example, we looked at trends at the home health agency level. While we would expect utilization to vary across home health agencies, in the past home health agencies with high levels of per-beneficiary utilization have raised program integrity concerns.

In 2024, the average home health agency provided 3.5 30-day periods per beneficiary. In contrast, the top 1 percent of agencies averaged 8.5 30-day periods, more than double the national average.

Home health agencies in the top percentile were disproportionately concentrated in California and Texas, states that have been targeted by CMS in recent and past program integrity efforts.

Again, I would caution that these represents an indicator that should trigger additional investigation, and some of the trends may reflect home health agencies that focus or specialize in beneficiaries with higher-than-average home health needs.

Next Kim will take a look at some examples in hospice.

MS. NEUMAN: Thanks Evan. CMS, GAO, OIG, and

others have developed a range of measures that can help identify potentially unusual patterns of hospice care. Because no single measure provides a complete picture, our exploratory analysis draws on several of these approaches, along with some additional measures we developed.

The measures we analyzed cover three broad areas: admissions and certification patterns, discharge patterns, and provision of hospice visits. The measures in our analysis are intended to be illustrative and to give a sense of patterns. An unusual value on any one measure does not necessarily indicate inappropriate care or practices by a hospice, but these patterns may warrant further examination.

The next two slides show the measures we looked at.

In terms of admissions and certification patterns, we looked at four measures, reflecting hospice physicians who certify for atypically large number of agencies; share of hospice days furnished before the last year of life; share of patients with relatively long stays within the calendar year; and share of new fee-for-service patients without an acute care episode in the 18 months

before hospice admission.

We see there is substantial variation across hospices on some of these measures. For example, at the median hospice, no patients were certified by a hospice physician certifying for six or more agencies, compared with nearly all patients at the 90th percentile hospice. As another example, the median hospice furnished 38 percent of its hospice days to patients before the last year of life, compared with 69 percent of days at the 90th percentile hospice.

Next, in terms of discharge we looked at live discharge rates and share of patients with multiple stays in the calendar year. We also see substantial variation here. For example, the median hospice had a live discharge rate of 20 percent compared with 56 percent for the 90th percentile hospice.

We also looked at two measures of the provision of hospice visits, the average number of visits per week and a CMS measure of visits in the last three days life for beneficiaries receiving routine home care. There are substantial differences in the provision of visits by the median hospice and the 10th percentile hospice on both

measures.

For example, the median hospice furnished a registered nurse or social worker visit on at least two of the last three days of life to 62 percent of its decedent patients, compared with 26 percent for the 10th percentile hospice.

We also looked at whether providers with outlier patterns were geographically concentrated. For illustrative purposes, we defined outliers as providers in the top 10 percent on each measure, or the bottom 10 percent for the visit measures. We estimated the share of providers in the state who were in the top or bottom decile. If outliers were distributed uniformly we'd generally expect most states to have 10 percent of providers in the top decile.

Four states were overrepresented across multiple measures: California, Nevada, Texas, and Arizona. California stands out the most. More than 10 percent of California's providers were outliers on every measure, and on one measure the share was as high as 48 percent of providers.

At the same time, outliers aren't limited to

those four states. More than 20 states had at least one providers in the outlier group on specific measures.

So while we see geographic concentration, we also see potentially unusual patterns among some providers more broadly.

We note that our analysis of outliers has been limited to hospices with 30 or more observations for the population relevant to the given measure. When we look at smaller hospices with fewer than 30 observations as a group, we see outlier patterns on several measures, such as live discharge rate and share of days before last year of life.

Finally, we note that there is potential to do further analysis of aberrant patterns if there is Commissioner interest.

Next, switching gears, we'll turn to the hospice aggregate cap. When Congress established the hospice benefit, it created a cap that limits the annual aggregate payments a hospice provider can receive. For 2027, the cap is about $36,000 times the number of patients served. If the hospice exceeds the cap, after the end of the year the hospice must repay the excess to Medicare.

The cap is equivalent to an average length of stay for routine home care patients of 178 days for a hospice with a wage index of 1. Because the cap is applied across all of the hospice patients, those with shorter stays offset those with longer stays, so a hospice can have many patients with long stays before exceeding the cap.

In the March report, we showed that the share of hospices exceeding the cap has been increasing. By 2023, about 28 percent of hospices exceeded the cap, but they served a much smaller share of patients, about 8 percent, of hospice beneficiaries. The March report also showed that above-cap hospices have high margins before the return of overpayments -- an estimate 18 percent -- and that the cap lowers those margins, to an estimated -1 percent.

To follow up on March report, we've done some additional analysis to look more closely at what is driving the trends.

So a couple of additional points before turning to our analysis. The Commission has previously recommended two changes to the hospice aggregate cap. First, the Commission recommended the cap be wage adjusted, which would make it more equitable across hospices located in

areas with different wage indexes.

Second, the Commission recommended reducing the cap by 20 percent as part of its hospice payment update recommendations from 2020 through 2023. Rather than reducing payments across the board, the Commission recommended reducing the cap as a way to focus reductions towards hospices with longer stays and higher margins. Program integrity wasn't the intent of this recommendation, but the approach also generally aligns with prior Commission discussion of hospice program integrity concerns and the cap's rule as a safeguard.

A few recent studies have looked at how hospices respond when they face pressure from the aggregate cap.

Gruber and colleagues estimated that patients in hospices facing cap pressure were somewhat more likely to die within 12 months and to be discharged alive, and were less likely to receive inpatient hospice care.

Coe and Rosenkranz estimated that hospices nearing the cap increased admissions and live discharges modestly, and the effects were smaller post 2012. They did not find a change in service provision, and the additional patients admitted appeared healthier, on average.

Overall, these studies suggest that hospices may respond to the financial incentives created by the cap, although the studies find some differences in patterns of response and effects are generally modest. It is also important to note that the studies do not speak to what would happen if the cap were changed.

This next chart shows our estimates of the share of hospices exceeding the tap. Between 2012 and 2023, the estimated share of hospices exceeding the cap rose from just over 10 percent in 2012 to 28 percent in 2023. The overall trend is driven in growth in above-cap hospices in a few states. In Arizona, California, Nevada, and Texas, the share exceeding the cap increased from about 19 percent in 2012 to nearly 50 percent in 2023. By comparison, the share across all other states declined from about 10 percent to 6 percent.

We also looked at the characteristics of hospices that exceeded the cap in 2023. Above-cap hospices tend to be smaller, and nearly all are for profit, freestanding, and located in metropolitan areas. They are also more likely to be recent entrants to the Medicare program.

They also have longer stays. Most of that

difference reflects longer stays within the same diagnosis category. Above-cap hospices also have a somewhat higher share of patients in diagnosis categories that tend to have longer stays.

We also see some notable differences in the discharge patterns and survival rates of patients served by above-cap hospices. First, newly admitted patients at above-cap hospices were substantially more likely to remain alive 6 and 12 months after admission. At 12 months, for example, 39 percent from above-cap hospices were still alive compared with 12 percent of patients from below-cap hospices.

Above-cap hospices also had substantially higher live-discharge rates, with 47 percent of discharges being live discharges for above-cap hospices compared with 17 percent for below-cap hospices. And among patients who were discharged alive, patients from above-cap hospices also had higher post-discharge survival rates.

Together, these patterns raise questions about whether some patients admitted by above-cap hospices may not meet the hospice eligibility criteria.

In summary, there is some overlap between the

aggregate cap and CMS's program integrity efforts, but the two approaches may complement each other. The cap provides a financial safeguard if some hospices enroll patients for long stays who may not meet hospice eligibility criteria. It also allows Medicare to recover some payments from hospices that exceed the cap and that may otherwise realize substantial margins on long stays.

It is difficult to know exactly how provider behavior would change in the absence of the cap, but long stays among some providers would likely increase.

Finally, we note that the Commission has previously recommended wage adjusting the cap to make it more equitable across providers.

So stepping back, we've talked about a lot today. To summarize, Commission, CMS, and industry stakeholders have expressed concern about fraud and abuse. Program integrity is important both to Medicare program and its beneficiaries. CMS has taken several steps in recent years to address fraud and strengthen program integrity. Our analyses suggest aberrant patterns in certain geographic areas that overlap with CMS program integrity efforts. Going forward, an approach that focuses on outlier

geographic areas and outlier providers appears valuable.

So this brings us to the end of the presentation. We are glad to answer any questions. For the discussion today we would be glad to hear any analytic suggestions you have regarding identifying aberrant patterns.

Commissioners may also wish to may wish to discuss their views on home health and hospice program integrity, such as support for various program integrity efforts and measures.

In addition, Commissioners could consider the policy question of whether the design of the home health and hospice benefits. such as the lack of cost-sharing, contributes to vulnerabilities. As indicated on the slide, we anticipate including some discussion of aberrant patterns of home health and hospice in March 2027 update chapters.

With that we turn it back to Amol.

DR. NAVATHE: Thank you, Kim and Evan. That was very dense with information, but as always, you all have done a very exceptional job of presenting it efficiently.

Dana, I can turn it over to you to run the queue.

MS. KELLEY: Kenny is first.

MR. KAN: Outstanding analysis. Thank you very much.

Three Round 1 questions. Of the 181 hospices revoked out of 871 reviewed, approximately a 20 percent hit rate. How many came back under a new name or owner, and will the proposed owner link revocation rule close that loophole?

MS. NEUMAN: I don't think we know who the 181 are specifically in the information that we have, so I'm not sure that we can answer that question. But let us go back and think about if we have more information we can bring on that.

MR. KAN: Question two, how much cap overpayment is actually collected? I mean, OIG found 4 to 27 percent uncollectible. Who pays when a hospice closes first?

MS. NEUMAN: So the information we have is what you cite, the OIG information. They've done studies where they've gone and audited the max and looked at how much of the funds were uncollectible, and so the statistics you have, 4 to 27 percent, that is what I'm aware of. I'm not sure that we have more in-depth information than that.

Third question, can we see margins for the

outlier hospices compared with everyone else?

MS. NEUMAN: So we could think about if there's ways to do that. Theoretically, yes.

I think that there is some overlap between the hospices that are above cap and some of them that are outliers on the measures, and so that can give you somewhat of a sense, but we could think about if there's different ways to cut it.

MR. KAN: Thank you.

MS. KELLEY: Tamara.

DR. KONETZKA: Great work. There was so much here, and I find it all very interesting. I also have three Round 1 questions.

First of all, we know there are a lot of commonalities across home health and hospice in the sense that it involves sending sometimes nurses and other practitioners out to people's houses. Do you know how many of these organizations across certified home health and certified hospice agencies are the same? Are they the same organizations, and they're doing both?

MS. NEUMAN: I was going to say real quick that in our hospice analysis in the March report, we have broken

out the home health-based hospices, but that may not be the full extent of it, because they may still file a freestanding cost report. And so it's possible that it's even higher than what we reflect in our March report.

MR. CHRISTMAN: Yeah. I mean, we can think about doing that. There's some direct administrative connections where we can find them, and then others, it requires looking at the ownership data, which is a challenge.

DR. KONETZKA: Yeah. I think it would be interesting to know whether being an outlier -- in one predicts being an outlier and the other, for example.

Okay. Second question. I know in the SNF world, for example, I know exactly what goes into the certification process when a new SNF gets certified. I'm wondering about the certification process for home health or for hospice, for that matter. Are there ways in which that certification process should be sort of flagging organizations that have strange things like the same address as many other existing organizations, or is the certification process just way too shallow?

MR. CHRISTMAN: So what to do with accreditation and certification is something that frequently comes up on

this topic, and I'm not sure I have a great answer to your question.

I think, on the one hand, you could have more stringent standards for certification and the competencies that agencies demonstrate before they get certified.

I think just an example of how hard this game is, if the operator of the agency changes, and that could change things too.

So I think that, in general, I know that CMS has been trying to make efforts to exert stronger oversight of accrediting organizations that do a lot of the certification for home health and strengthen the work on that front. But I guess I couldn't comment on whether there are things in that area that could be strengthened.

DR. KONETZKA: It just seems like some of the outlier things we're looking at are things one would have known from the outset.

A third question. Do you have any sense of what drives the geographic concentration of these outliers? In California, for example, is there a certain legal and policy context that you think encourages certain behaviors or a different explanation?

MS. NEUMAN: I would say it's very hard to speak to that issue. We've seen, over time, hot spots in different parts of the country and sort of what factors contribute to them in one area versus another. It's really hard to say.

MS. KELLEY: Stacie.

DR. DUSETZINA: Thank you both for this work.

At risk of asking a very dumb question, I struggle with what does live discharge from hospice mean and just wonder if you could explain. So like if you were discharged from hospice because things suddenly got really bad and you go to the hospital and you die in the hospital, is that a live discharge from hospice? And then kind of what happens on your insurance coverage? Like if you're live-discharged from hospice, do you go back and have like regular Medicare coverage?

MS. NEUMAN: So a live discharge from hospice can happen for a number of reasons. A beneficiary might change their mind about the type of care they want to receive. A beneficiary might -- in a crisis, someone in the family might call the hospital, and they might wind up going to the ER instead of calling the hospice. And that can lead

to the person potentially getting hospital care and possibly dying in the hospital instead of sort of staying with the hospice the whole time.

And there are other kinds of live discharges, but to stick to that for a second, because you asked what would happen in that situation, in that situation, if the beneficiary revokes hospice because they want to have hospital care, then fee-for-service Medicare will cover the hospice care when they are no longer in hospice. That is true for fee-for-service beneficiaries and Medicare Advantage beneficiaries till the end of the month in which they go back to MA. So that's what would happen generally.

Other kinds of live discharge might be move out of area, and then a hospice can make a determination that a beneficiary does not meet the criteria for hospice. Either their condition seems to have stabilized, wasn't as anticipated, and they can be discharged because they don't meet the criteria any longer. So there are a variety of ways it can happen.

DR. PIEROTTI: Can I just add a little bit to that? I think one of the really meaningful things in this data point is live discharge and then still being alive for

a long period of time afterwards, right? Because at its most basic, live discharge from hospice does mean they were alive and hospice care ended for a variety of reasons. But when the person stays alive for a lot longer after that decision, that's when it draws your attention.

MS. KELLEY: Gina.

MS. UPCHURCH: Thanks.

Thank you for this work. Just a couple of questions. The home health benefit, just like the rehab benefit, we talk about somebody improving, maintaining, or preventing loss in function. Did that definition change? Did that change in the last few years, especially the prevention of --

MR. CHRISTMAN: No, it's not. It has not changed.

There was a court case where it was -- I believe the position is that it was clarified, but the substance of it has not changed.

MS. UPCHURCH: Okay. I think it was that clarification that got some attention, that got some changes made.

And then is my understanding -- and Tamara raised

something. You have to be discharged from home health to receive hospice? I mean, you don't have to have had home health before receiving hospice, but if you're going to receive hospice, but you're currently getting home health, you have to be officially discharged from the home health benefit to enroll in the hospice benefit? And how does that work when it's the same agency?

DR. PIEROTTI: It's two pieces of paper.

MS. UPCHURCH: Okay.

DR. PIEROTTI: You're really just ending one episode of care, because the enrollment to hospice requires the patient to attest that this is their choice. And then the physician agrees that they qualify. So it's literally two different pieces of paper.

MS. UPCHURCH: Thank you.

And then, lastly, for Round 1, because we're going in three questions, so I'm keeping up, is that have we looked at -- I know we've talked about this in the past, but case mix or primary diagnosis, particularly with either one, hospice or home health being the big driver of a lot of this. Do we know? For example, people staying a long time in hospice, I think many of them have dementia, right?

So you don't know how long. And then staying a long time in home health, I remember my father went on home health, he had Parkinson's, and they said you'll get unlimited home health. And I was like, oh, really? There's a benefit in Medicare that's unlimited? Okay, that sounds good. Are these related to specific diagnoses, the outliers?

MR. CHRISTMAN: So that, we haven't looked at.

I guess what I would say specifically is that, in general, predicting length of stay in home health from patient characteristics is hard. That's why they pay for care in 30-day units. A beneficiary with the same care could stay on for one term or stay on for 180 days or longer, and the beneficiary is entitled to care as long as they're homebound and have a need for skilled care. And that could apply to a beneficiary like you described.

MS. NEUMAN: I think with hospice, that among providers that have unusual patterns, for example, like live discharge, you're going to see a higher live discharge rate across all diagnoses. So there could be mixed issues, but it's not just mixed.

DR. DUSETZINA: That helps. Thank you so much. Thanks to you both.

MS. KELLEY: Paul.

DR. CASALE: Yeah, thank you for this really interesting work. Lots of interesting data, for sure. Raises a lot of questions.

Just a couple of questions. On the practitioners, the 1 percent of practitioners who account for almost 20 percent of the 30-day home health visits and they average, I guess, 149 fee-for-service. Do we have any data around -- or community data around practitioner ownership in a hospital -- the home health agency?

MR. CHRISTMAN: We don't. That data is something we can think about.

Some of those cases that have been looked into have been cases of, I think, physicians participating in these schemes, according to the reports, and just signing off on claims. I haven't heard anything about ownership.

DR. CASALE: Yeah. Again, anecdotally, in areas where I've worked, I know there are cases where practitioners are -- not necessarily home health. Could be in a skilled nursing facility. I just don't know if that data is available. I don't know how many -- with that 1 percent of practitioners, how many that represents. How

many?

MR. CHRISTMAN: 3,400 practitioners.

DR. CASALE: That's a lot. Okay. Interesting. Okay. Well, that would be interesting if there's some way to get some of that data.

And then on the hospice, you mentioned there are providers -- you looked at the providers that certified for six-plus agencies, right?

MS. NEUMAN: Yeah, hospice physicians who certified for six-plus agencies.

DR. CASALE: Yes. And how many -- for a hospice physician or clinician, on average, how many do they certify for? Do we know?

MS. NEUMAN: I don't have that number right here, but we easily have it. Yeah, yeah.

DR. CASALE: That would just be interesting to look, and maybe it's just the distribution curve around all that that might be helpful.

But thanks very much. This is really interesting data.

MS. KELLEY: Josh.

DR. LIAO: I retracted my comment. The question

was answered.

MS. KELLEY: I'm sorry. Let's go to Cheryl.

DR. DAMBERG: I had a question about all of these different hospices that are hitting the cap and then beyond. So do we know anything about whether the math works to the advantage of these hospices such that -- I mean, it's gameable to some extent if you get your mix of short-stay and long-stay patients, such that even if you kind of overshoot the cap, given the higher margins, they might be able to absorb the repayment.

So I'm just trying to understand the math behind this and whether the structure of the payment system is really kind of facilitating some hospices going down the path of really trying to max out their payments or their payment potential.

MS. NEUMAN: So, in general, when we look at hospice margins by the providers, like share of patients greater than 180 days, we find that margins go up until you get to the highest level where then they start to go down because of the cap. And so it seems like there may be an area of profitability that's very close to the cap on either side of it, and if you get too far on the other

side, then it's going to pull back, but that there can be profitability still exceeding the cap, it seems, to an extent.

I'm not sure that answered your question.

MS. KELLEY: All right. I think that's the end of Round 1.

Gokhan, I'm sorry. Go right ahead.

DR. METAN: Thank you for this work.

I have two questions. The first one is around the CMS moratorium. So based on what we know, do staff have a view on whether the evidence supports extending the nationwide moratorium, narrowing them to high-risk areas or replacing with provider-level screening after November 13? Is there a viewpoint on that?

MR. CHRISTMAN: I don't think we know.

MR. MASI: I think that's maybe for your discussion. Is that fair to say, Evan, for Commissioner discussion?

MR. CHRISTMAN: Yeah. I mean, I think there's definitely an understanding that the risk may vary across the country, but the exact criteria you might use for deciding how you're going to evaluate that risk, I don't

think -- you know, I think that's something we would be interested if you guys have any thoughts on. I don't think -- we haven't identified any.

DR. METAN: Okay. My second question is, in the geographic areas where over-the-cap, high percent live discharge rates, hospices are more prevalent, how are the other hospices impacted within the close proximity, especially the non-profit ones? And the reason I'm asking this question is that players in a region may push some of the cases, less profitable hospice cases, to good players. Good players split money, and then closures and excess problems happen. So do we have any analysis around how are the close geographical impacts happen on the good and bad players?

MS. NEUMAN: So we have not done an analysis of trying to, like, sort of split up the sort of market and see how one set of providers might be affected by another. So that's an interesting thing we could think about doing.

We do hear anecdotally sometimes, though, from hospice providers who will say to us, we're impacted by the practices of these hospices because the discharge patients then need somewhere to go, and we wind up absorbing those

patients. And it can be challenging. So we have heard anecdotally some concerns from some providers about sort of the spillovers.

DR. METAN: Yes, I heard the same anecdotes shared with me directly as well. So I think it might be worth looking into the data and what the story tells us.

Thank you.

MS. KELLEY: I also have Robert with a Round 1 question.

DR. CHERRY: Oh, yeah, thank you.

You know, this is an excellent report. It's also a very disturbing report, too, at the same time. And it's very different, I think, from other reports that we've seen in the past.

My question is more for Paul. It's probably a little bit of a sensitive question, too. So, if we look at, you know, the 1 percent of the providers that's generating 20 percent of the 30-day periods of home health, I think about like the 1 percent of the 1 percent. I can't imagine what that ordering rate must look like. And I don't know if we're working in identified or de-identified data, but I do wonder when we stumble across things like

that, what our obligations are. So I just put it out there because it's a fascinating report, and it's also true, I think, for, you know, like hospice care providers where the majority of their patients are being discharged alive. That's not something you would expect, and if there are extremes like that, what do we do with that information?

MR. MASI: And you said that question was for Amol, right?

DR. CHERRY: Oh, I meant Greg.

[Laughter.]

MR. MASI: After you.

No, I appreciate that question very much. I think, to be clear, we are looking at different measures and analyses that could be helpful to those people who are in a position to monitor the program for the program integrity concerns that we're talking about here today.

But I want to be upfront about kind of the limitations of what we can and can't do here, and here, this is more of an analytic exercise to try to call attention to things that may be worthy of greater scrutiny. And then other agencies with a different role can make the types of decisions that you're talking about.

DR. CHERRY: Thank you, I think.

MR. MASI: Right back at you.

[Laughter.]

DR. NAVATHE: I think to clarify a little bit, I think to some extent, what's important is we're bringing sort of the empirical approach to examine what we see in the program. But the intent of analysis, even the way you kind of described it, you know, if we were to stumble upon something, like we're not OIG. We're not analyzing data with the intent of identifying fraud specifically.

And so I think when you when you use words like what are we obligated to do, I think that implies that we are identifying something affirmatively, and we're not affirmatively identifying fraud.

So I think, to some extent, our goal in this is to transparently share what we find, and part of it is for you all to discuss for us as a Commission to discuss. And I think in spirit, what we're trying as part of this session is to understand how this empirical analysis -- because that's that is obviously a wonderful skill set that our staff has, you know, how that can shed some light on these aspects of the program.

It might be a little might feel like a distinction without a difference a little bit, but I think for us, actually, it feels very -- it's important to kind of draw a bright line between the empirical work that we're doing, that's examining outliers and consistency with patterns that might that might be aligning with what's happening on the enforcement side. But we are not approaching this from the perspective of we are identifying fraud, because that is not within the purview of the commission.

Hopefully, that -- I still think you're unconvinced, but I'm happy to talk to you more about it later.

MS. KELLEY: Okay. I think now that is the Round 1.

Do you want to just go straight to Round 2? All right. I have Stacie first.

DR. DUSETZINA: Great. Thanks very much, and I think thanks to Robert for setting me up for these comments a little bit with his last question.

This is really excellent work, and I feel like when I was reading the paper, I kept struggling with the

issue of like what's our lane versus what's someone else's lane with these issues. And I think part of this is around framing.

So, as I was kind of reflecting on it a little bit more, you know, there are definitely payment issues at play that could be incentivizing bad actors to enter a space and potentially abuse programs. So we have to worry about program integrity, because it can lead to higher spending, and if inappropriate levels of payment are, you know, having people enter, then we also care about that.

I also think it matters a lot for quality of care. So some of the integrity issues that are flagged in the paper around places that have the same billing address and nobody there, it's like, well, what does that mean if a beneficiary signs up for care for one of these places? Like, what kind of care are they getting? How do we know that the quality is there and that they're getting services when they need to?

So I think all of those things make me think it is in our purview to be looking at this, but I think we need to make sure that, you know, should this move forward in some form that is a public document, that that's

explained more kind of in the background so it's clear that this is a -- it's also tied to payment and it affects payment.

In general, one of the things that I think would help a lot -- and this maybe goes kind of to Robert's question about how many people are we talking about would be to have some of those sample sizes. I think you mentioned when you showed the average number of patients in days and things like that, just knowing how many providers or hospices we're talking about could really help, because when you said the number, I was like, oh, that's a lot more than I thought, like the number of providers, for example. So I think that that could just help contextually, that we're not talking about, like, one or two providers. We're talking about, like, hundreds or thousands. So sample sizes would be incredibly welcome.

I think for analytics, I am really interested in this hospice cap work that you're doing. I also think that the data you've shown us on the states and the outliers and how much they're driving those differences, that raises a lot of red flags, a lot of questions for me.

One thing that you mentioned, the wage

adjustment, it kind of made me think, though, wouldn't that just disproportionately benefit places like California? So I think tying in sort of how that wage adjustment might look across the different areas and states could be helpful just contextually, that, you know, you can't do just one of those things. You kind of have to do those in tandem with other reforms.

But I am excited about this work. I think it seems very evident that there's a lot of things happening in this area that are not great, and I think hospice benefits, especially in home health, are super important for beneficiaries and places where we really want to ensure that people are getting very high quality care and that we're not paying incorrectly in a way that results in a lot of entrants who are gaming the system.

MS. KELLEY: Kenny.

MR. KAN: I really, really love this chapter. Most hospices do amazing work, and their own associations are asking for targeted enforcement. CMS has been building the right tools, iris screening, prepayment review, and the Service and Spending Variation Index, which flags unusual care or spending.

I worry, though, that unintended consequences of payment policy, as what Stacie alluded to, may be fueling a minority of bad actors, as suggested by aberrant care patterns from two anecdotes in the paper.

One Los Angeles building housed 112 hospices and 49 home health agencies. That's not a market. It's a mailing address. More than half of California hospices exceeded the cap, and 30 to 40 percent did it in Texas, Nevada, and Arizona, compared with about 6 percent everywhere else. That isn't a payment problem. It's a business model issue caused by a margin link, in my opinion.

What is the margin link? Well, Medicare hospice margins, which MedPAC has done over the years, is about 8-9 percent. The for-profits earn about 14 percent, and non-profits are about minus one. Hospices above the cap earn about 18 percent before repaying, and those with many long stays earn between 16 to 17 percent. So a flat daily rate rewards long, low-visit stays for patients who aren't dying. Those are exactly the outlier patterns in this paper.

You add low start-up costs and a cap debt that

can be escaped by closing, and what do you get? Churn and burn becomes rational.

So, for future follow-up analysis, can we look at shifting fee-for-service from pay-and-chase to prevention? And let's measure the return.

Based on the data, I have six observations and responses on the various questions raised by staff. Number one, CMS efforts. These are appropriate and working. The moratorium is a sensible circuit breaker, and a 20 percent replication rate shows that targeting works. Suggest we extend it where aberrant care patterns suggest fraud.

In terms of measures to use, can we use measures that are hard to gain and tied to eligibility? High-volume certifiers, life discharge, plus survival afterwards, days before the last year of life, no acute care in the prior 18 months. I mean, 45 percent of such records in OIG sample fail eligibility. Can we combine them into one score, validated against revocations, and calibrated to spare honest, rural, and dementia-focused providers?

In terms of geography of providers which you ask, let's do both. Screen first by geography in the four states. Then screen individual providers to mitigate

fraud, waste, and abuse. On the cap, I suggest let's keep it wage adjusted and cut it 20 percent for 2020 and 2023 prior initial and update recommendations, tied the unpaid cap to owners. Typical and non-profit owners, hospices sit well below the cap.

Regarding the urban study, let's be cautious. Its $26,000 in savings and comes largely from patients dying about seven months sooner. That's like saying a car saves gas because you drove it fewer days. Don't use it to pay hospices more or less and check on them, but let's look hardest at long, non-cancer stays.

So this is what I would love to see in the forthcoming 2027 analysis. Measure the return on PPO and RCD. Model a risk-based prepayment trigger with an off-ramp for honest providers. Tighten enrollment screening, perhaps leases, tax returns, ownership history, site visits, before the moratorium lifts.

In closing, I look forward to future follow-up analysis that would help protect the hospice benefit by safeguarding it from the few minority-backed actors who abused it. Let's also ensure in the process we don't penalize honest hospice providers.

Thank you.

MS. KELLEY: Tamara.

DR. KONETZKA: Okay. First, I'll start by saying I'm very supportive of this line of work because I think it's -- these numbers show us it's really important to think about the underlying payment incentives and the payment structure that could lead to fraud, right? And I think that's very much within our lane and what to do about it if we see that it exists.

We look at these numbers, and some of them are really alarming, but I am very cautious in thinking about interpreting these as, you know, these are clear problems or clear fraud. I mean, some of them seem like they must be, right? And my gut is there actually is a lot of fraud here, given the geographic concentration, et cetera.

But there's some things I really want to know a lot more about, and one, Gina touched on. One is the conditions of the patients who are admitted to both hospice and home health, right? In some ways, the cancer hospice patients versus the dementia hospice patients, it's almost a different benefit. It's a very different trajectory. And just because people with ADRD have, you know, long

stays, that it looks like there's more fraud there, but I'm not sure. Like maybe there's just things about the eligibility and the treatment there that are just very different. I think the hospice benefit is really important to people with dementia, and so I want to be very careful about sort of penalizing providers that specialize in sort of hospice care for patients with dementia.

The other thing is even some of the physicians who order a lot of home health, for example, I mean, I can think of, like, medical directors in assisted living facilities or long-term care facilities who are, like, treating hundreds of patients basically and just may have this kind of population that needs a lot of home health or has a lot of these issues.

I know we probably wouldn't, like, collect sort of overall data on that, but just to sort of look, to sort of spot check some of the outliers and what they look like and whether there are any of these unique situations.

So I'd really like us in both the hospice and the home health work to drill down a little bit more to the extent we can on the conditions that people have and their sort of admitting diagnosis for hospice or for home health.

Along those same lines, of course -- Evan will not be surprised that I'll say this -- I'd love to see if the home health outliers are admitting a lot of community-initiated versus post-acute types. Where post-acute, there's a hospital stay before that. It might be sort of easier to check or have data on, or are they just specializing in certain kinds of patients?

And that feeds back into our payment incentives. Are there margins in certain areas or for certain patient groups that are just not well adjusted and sort of invite overuse or fraud? So I'd love to see more drilling down on all of those types of patients and then also the types of providers.

I think the geographic concentration is super interesting. I'd love to know why it starts in certain places. At the same time, my gut feeling is it's probably a game of Whack-A-Mole, and if you figure out what to do in these four states, you're just going to see it pop up in other states, because the same payment incentives are probably there. So I guess I would say we should keep looking nationally and just drill down where we see issues.

I want to say a few things on the report about

whether hospice saves money, and I may disagree a little bit with Kenny here. But my conclusions about that report and that literature broadly and what was brought out in that report, I would -- my conclusions would be a little bit stronger than what was in our summary, and stronger for this reason, about the mortality benefits. So there are all these studies, and the report defined very clearly, there are these studies that assume there's no effect of hospice on mortality.

First of all, that makes no sense. Why would you assume there's no effect on mortality? Hospice patients are foregoing curative care, and unless that curative care is worth zero in longevity, you have to assume that hospice will affect your longevity.

And then just the empirical evidence that comes out of those, if you assume that hospice doesn't affect mortality, you find that hospice costs more. If you let it be endogenous, your results are different, and that tells me that assumption was bad, because you're getting different results when you allow a flexible estimation that allows mortality to be estimated within the model.

So, to me, I wouldn't look at all at evidence and

say it's really mixed evidence. I would say there are these much stronger studies that allowed modeling of mortality, allowed that to be flexible and endogenous to the model, and those are your stronger studies that actually show hospice is saving money. So I think a little bit of the weighting of the evidence based on how strong those study designs were is warranted.

One can still argue with the instrumental variables analysis. I mean, it's all based on entry, stronger than just entry, because it's entry over time that changes how far people have to go or how close they are to a hospice. But entry is not exogenous. We know that.

So one might argue with the exact magnitudes because it's not a perfect instrument, and probably, hospices enter strategically into areas where they think there's going to be enough patients who are going to be profitable to them.

So, yeah, it's not a perfect instrument, but I think it probably reduces some of the unmeasured confounding, and one might question then for that reason the sort of magnitude of that mortality effect. But I think, directionally, I'm very sanguine about those

results, that hospice is actually, on the whole, at least not costing us more, even for people with dementia. It doesn't mean it's always the case. But I think that's important to keep in mind, consistent with the fact that I think it's a really important benefit for people with dementia.

I'd also say you're very careful and circumspect, which is great, in the report about this only applies to people who are sort of compliers with the instrument, people who were induced to use hospice because they were closer to a new hospice rather than farther. So that caveat is true, but I'd also say that group is a really important group for policy. So it's not just that it's not generalizable. It's true, it's not generalizable to the whole hospice population, but it is generalizable to expansions of hospice. If we're worried about hospice getting too big and entering areas and more hospices, that's the group this estimate applies to. So I think, yes, it's a caveat, but it's a very reasonable group to focus on.

So, with all of that, I'd say that I think that we have to be very careful. There's probably clearly still

fraud, but we have to be very careful in naming something fraud.

I personally think the cap on hospice spending is just too blunt a tool. I'm just never in favor of these kinds of tools.

I think if we're going to keep it in the short run, I like the idea of a wage adjustment or input cost adjustment, but I would love to see more work around, can we look at those people with longer stays or very variable stays, like people with dementia, and one sort of -- refine the eligibility criteria? Are there any ways to refine the eligibility criteria to sort of prevent the really super long stays and the fraud?

And two, can we sort of look at these organizations at the certification stage and sort of try to flag organizations that don't look real or authentic -- authentically involved in providing this care from the outset?

I guess I will stop there. I think there are things that we can think about in this work moving forward that would sort of refine the payment system to try to prevent some of these excesses, and I would love to see

more analysis digging into some of the heterogeneity and thinking about those policy solutions moving forward that don't involve a cap.

Thank you.

MS. KELLEY: Okay. I have a comment from Scott. He says, Kim and Evan, thanks for the excellent presentation. He's going to limit his comments to hospice.

He thinks we should all be troubled by the magnitude of the problem of aberrant utilization, collectively representing at best a degree of overfocus on profits rather than care and at worst may represent fraud, waste, and/or abuse.

He's wondering whether these findings, when added to previous presentations documenting an unacceptable frequency of insufficient symptom management and family support at the very end of life, should tee up a reevaluation of the entire structure of the hospice benefit.

When first established, hospice was a generally non-profit response to a pervasive failing of physicians to adequately discuss prognosis and shift and execute care to a comfort focus. We are way past that point in time, and

right now the glaring structural issues are around the artificial distinction between curative and palliative care executed to a comfort focus. We are -- I'm sorry -- around the artificial distinction between curative and palliative care as per our previous discussions around palliative, chemo, radiation, and dialysis, as well as the baked-in discontinuity when a patient and family essentially loses contact with their previous care team. Both of these are serious issues.

Why not step back and do qualitative interviews with thought leaders in hospice, palliative care, oncology, and dementia care, and ask for thoughts on how a reimagined benefit might enable markedly improved care? It seems very possible that a reimagined and restructured approach to palliative and end-of-life care, consistent with thought leaders' principles of best practices, could better address the collective set of clinical and program integrity issues that we've been discussing.

And next, I have Brian.

DR. MILLER: This is a fun topic. Tough topic.

So a couple thoughts, just as clinical thoughts. I still practice.

I actually think that hospice and curative medical care have distinctions. Those distinctions exist for a reason, and there are trade-offs, and that's okay. Patients can't -- patients and doctors -- not patient and doctor -- can't have everything, and there are reasons why. There are things in the hospice benefit, and there's a budget, and that some of those things are not always accessible in a hospice-like setting. And that's a trade-off, and that's okay. There are gradations around that. So patients, if they don't go to inpatient hospice or out -- you know, home hospice aka outpatient hospice, they can also go to a sub-acute rehab, skilled nursing facility with hospice overlay. So there are gradations in between of how people get access to hospice care. I think merging hospice and curative care benefits is not sensible clinically and is also physically irresponsible.

Some thoughts in relation to this chapter I think that are really important is that there are definitely some states that are problematic, and those are red and blue states. It's not like one state's doing the thing that's right and the other states are bad. Like, everybody has problems. We all have problems. We all got, you know --

we all got the fraud, waste, and abuse blues, right? You know, Texas, California, Nevada, Arizona, you got red states, you got blue states, you got purple states. We all have problems. So we should all sort of acknowledge and admit that's not a partisan issue. It's a program integrity and design issue.

I think some other things that aren't in here, which I think would be helpful, is the sort of mobile hospice issue I mentioned. It would be great if you all talked to some physicians, case managers, social workers about that, because that's an abuse of the inpatient mortality statistics for acute care hospitals, and then also hospice length of stay. This is just straight up manipulation of those statistics, and that violates the intent and spirit of the program, I think, as written in statute and executed by CMS.

I think that fraud, waste, and abuse and program integrity brings up important issues for us. One, there's some learning opportunities for us in Medicare. One is like thinking about what other markets do, right? So, we have the WISeR program, which I realize has many problems, but it's a good start. There's a reason why we have

utilization management. Sometimes people don't do things that they're supposed to do, and there are also times when people do things that they're not supposed to do.

So I think looking at other insurance markets, the ACA markets, the employer-sponsored insurance markets, Medicaid managed care, heck, even the VA, and saying they have a utilization management ethos and that exists on a continuum, and maybe we should look at and use program integrity to look at fee-for-service functions and say, do we need some more utilization management in fee-for-service?

The question is, of course, why does that matter? One, like fraud, waste, and abuse cost people money. As Gina pointed out earlier, it goes into Part B premiums, and affordability is a big issue in fee-for-service Medicare.

We've also talked about MA plan overpayment, and so if you have something that's going into the fee-for-service benchmark, that's also going into the MA benchmark, which then aggravates any sort of overpayment that's there.

And then I think the other thing is looking at MA and saying, what do MA plans do? So MA plans can look at variances. They can look at upcoding. They can

automatically screen all claims as they come into the system, and on a prepaid basis, do a targeted review, and you'll have algorithms and rules to flag problematic providers, problematic organizations, or practices that warrant further scrutiny.

Fee-for-service doesn't necessarily have those capabilities on a prepaid basis and is mostly post-pay. So I think it would be helpful to maybe talk to some of the program integrity units at MA plans and say, how do you address this on a prepaid payment basis? What are lessons that we can learn for fee-for-service Medicare?

I think the other thing, which a couple of us were chatting about, was maybe there are some people who are Medicare providers who shouldn't be Medicare providers if they're not behaving particularly well and causing problems. We have an Any Willing Provider Network, and that might be too generous. There might be some people who should get kicked out if they're defrauding the system.

Another couple of things, I agree with Tamara that this highlights benefit design issues. Incentives matter. Home Health doesn't have any cost sharing. If you don't have any cost sharing, and you see that and you're

someone who wants to use an insurance program to extract money where there's not prepayment claim review -- I mean, an area with no cost-sharing is a great way to set up shell companies or hundreds of shell companies at an address. Whether it's in Texas or California. That's a great way to take money from a publicly-funded program. Benefit design matters. Fraud, waste, and abuse then drives Part B premium, and then hospice.

If we're concerned about over-utilization and occasionally abuse of the hospice program from sort of beneficiary selection, a great way to mirror that and see what a different world could be is integrating hospice into the MA benefit, making it part of managed care. And then we can see what those differences are for hospice and managed care and hospice and fee-for-service and have learning across that.

I would keep the aggregate cap. I know it's uncomfortable. There's definitely things we could do to adjust that and improve that, but you know we have capitation in Medicare Advantage and Medicaid MCOs. Probably having capitation is at a cap in this case, and hospice is good.

I know I've talked for a while. Apologies for that, but I'd say to sum this up, we should continue this work. It should be a chapter, and it reveals importance for benefit design issues and then also program structural issues that we could fix and operations.

Thank you.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks.

I'm going to try not to repeat what the other Commissioners have brought up. Many excellent points.

First, let me start out by saying I really appreciate the different measures of aberrant behavior that you've assembled. I thought that was extremely informative.

I wonder if as we're trying to better understand this space whether there's an opportunity to stratify these different measures by things like the start date of the business operations, so newer versus older, and other provider characteristics just so we can get some insights. Maybe that's some low-hanging, not too difficult work to do.

And then one of the things that I wondered, and

maybe it's too early in the process, but CMS made those changes, meaning face-to-face visits and narrative description of the clinical basis for the patient's prognosis. And I was curious whether CMS or MedPAC is evaluating whether or not those actions have been successful or whether they are also in some way, shape, or form gameable. And I recognize that this is early work, and so if that information became available in the future, it would be helpful to add some text around that.

I agree with what other Commissioners have said, that this work really falls within MedPAC's purview, particularly around payment accuracy and getting the payment incentives right. So, definitely, I think we need to rethink that space.

And I think, you know, relatedly, Scott's comment about assembling a group of providers, palliative care physicians, geriatricians, et cetera, to try and reimagine the design of this benefit and maybe getting a better set of incentives could be really helpful to the mix.

I generally think this is -- based on all the information you've provided and all the questions people are asking, this still remains an opaque space to

understand what's really happening. And so I think a couple of places. So, to Tamara's point about spot checking on the outliers to really see, you know, is what we're seeing kind of real in the context of fraud or is it something else, that may be a good explanation for what we're seeing, or the other thing, just trying to get some information from patients about their experiences, particularly from these outlier entities. I know it's challenging to get that information out of patients, but it would just be helpful to sort of understand what their care experiences have been from some of the family members.

I do think given sort of what we've seen, entry of private equity and differences in how this is playing out based on ownership, it would be really helpful to better unpack that to the extent you can. I know trying to understand who owns who in this world is challenging, and I would encourage CMS and others to continue to work to try to build a database where we could understand who owns who and how entities are related, because I think it's not just ownership arrangements within a community, but we're seeing kind of cross-market ownership and that that can have impacts on the way care is delivered and what we spend.

And then I also -- after reading that document, looking at whether hospice has saved money, I would definitely double down on Tamara's comment about weighting the strength of the evidence. I think the way it's presented, I think they're being overly cautious, and I think that there's definitely a signal in there, and I think it needs to be better extracted and spotlighted.

MS. KELLEY: Gina.

MS. UPCHURCH: Thank you so much for this work. Just a couple of comments. Plus-one, or plus-five at this point, on Scott's comments about rethinking the benefit. And just alluding to what Cheryl just reiterated, I do think it's important that we talk to family members as well as the people providing the care and the patients or the beneficiaries as much as we can do that, in rethinking about redesigning particularly the hospice benefit.

I think we assume that the case mix across states would be the same, the same number of people, say, for the home health benefit, have Parkinson's across each state. You know, so therefore it's not a confounder. But I am curious about that, and just looking at the case mix of people that are admitted or receiving home health I think

would be important for us to see, and see if there are any differences there.

And maybe it's the difference in provider certifications and what they feel like is somebody being eligible for home health or somebody being eligible for hospice. Maybe it's the provider's perceptions of what's appropriate there.

About aberrant behavior, I would actually take a little step back and say one of the big problems I think we have in our country is that we have a lack of cost-effective support for care for beneficiaries with complex needs in the home. And so what we find is we have this unofficial long-term care services support system, where we strip people of their income and assets, to get on Medicaid is our answer for long-term care services supports in the home.

So a way to get some help for people, and I think I would be an overuser if I were the provider or I was the person who could certify this, of home health, for sure, because I think a lot of times what we see is the person is homebound, they do need help to continue functioning in the home, and many of them hope to get a home aide, because

they can't afford it otherwise. So they go out, maybe if they're trained they know, okay, there's home health, and maybe you could get me an aide, or I live out of town and I hope Mom can get some help. At least I know several times a week that an occupational therapist is coming. So that's with home health.

With hospice, people are shocked when they hear about hospice not having an aide, really, in the home. I mean, you can get an aide to help bathe you a couple of times, that kind of thing, but that's not giving you an aide until you die with hospice. I mean, it is not that.

And so I think what a lot of people end up needing, you know, that pushes some people towards hospice maybe before they want to go, is some people need adult diapers, and they can't afford them. Some people need that help bathing. Some people need a hospital bed.

So these are the practical things we hear from low-wealth older adults, and when they're making decisions about home health and hospice they need help in the home.

And so I'll just circle back to the comment, and we may need to rethink these benefits as we continue, in the blue leadership, the red leadership, the purple

leadership, of not addressing long-term care services and supports in the home.

And I just wanted to frame it that way, but I really appreciate this work. Thanks.

MS. KELLEY: Danielle.

DR. PIEROTTI: Wow. I think that there is a tremendous amount here in this space that I keep coming back to, is policy and how policy plays into this conversation of fraud and abuse, where we've been asked to frame this.

These datapoints that we're looking at are very meaningful and they do provide an awful lot of arrows pointing in a direction. For policy setting, I think we can take it one step further, and several colleagues have alluded to this, and that is really looking at the conditions of the patient. In the verbiage of hospice, it's the phrase "related conditions." The hospice policy says that hospice provides all of the care for the terminal condition and related conditions. The space where every hospice debates on an every-single-day basis is what's related.

And when you step back from an individual patient

to the agency level, that decision can go everywhere, from everything is related because the human body is the human body and there's no way we can carve something out and say that diagnosis isn't related, to the other extreme that says there is only one diagnosis that is going to result in end of life, so anything else doesn't matter to us.

And this has been the root cause of a tremendous amount of debate and discussion around Part D, and who else is paying for what other services for a patient who is enrolled in hospice.

If there are ways to look at, and Part D may give us insight, to look at what else is happening, or to look at these related conditions, that is a way, from a policy point of view, that I think we can have a better understanding of what's happening out there.

This isn't about the extreme people who have every patient on their rolls for 18 months and then they live for 3 years after live discharge. That's extreme.

But within the policy space, I think that this question comes back to the request of a couple of my colleagues to relook at the benefit and why are people enrolling and not enrolling. When it also hangs on this

possibility of what could Medicare Advantage enrollment be in end of life. Medicare Advantage could be the end of the discussion of related or not related. It could also be the way that hospice becomes just the last 12 hours of care, because we're not going to do anything else in between.

But this is the space that we don't have good data around, and it does matter because the issues of frailty and how long someone lives are related to things like comorbidities. And if their primary diagnosis is cancer but they also have high blood pressure, who is controlling the antihypertensives, and the number of times that that discussion occurs is really common. And that space of, well, it's not really related, but how is your hypertension not related to dying? You can't die and maintain a blood pressure.

But we do have an awful lot of controversy with who is paying for what, and if the hospice isn't going to pay for the med then they don't like to engage in the discussion with the patient to stop it or not stop it.

So these issues of related diagnoses and conditions really do matter in how the care and the benefit is acted on, and makes a difference to these issues of

payment down the line.

I think that it is parallel to the question in home health of how many episodes are enough episodes, and the issues of why are people enrolled in care. Keep in mind, as much as I will advocate, home health is also maintenance, not just restorative.

Kim made the point earlier of maintenance that requires skilled level of care. Which is why we can't just provide the home health aide for someone who just needs help to go to the bathroom or clean up, because that's not considered skilled.

So understanding those diagnoses actually will help us to see what is it that people need and where do they need it, and they give us an opportunity, from a policy perspective, to reimagine what this care at home could be in different sorts of ways.

And finally, I would just say the other space that we're not talking about yet, but I think is part of this discussion, is hospice while someone is in a nursing facility. So I'm carefully not saying SNF, because you can't be skilled level of care and be hospice level of care. You can, however, live in a nursing home, under your

nursing as that's your home, so Medicaid mostly, and be on hospice. And this isn't one of those spaces where you end up with both things being true. Very big opportunity for overuse of the hospice benefit because it's very low service provided, but very high payment, for someone who is intentionally doing that.

It also the place where families can fill in the gap, because their loved one is living in a nursing facility and the care just isn't there to meet their needs. So we can't just go and say if someone is living in a nursing home all hospice is bad, because it could be really meaningful to providing important symptom and life needs while they're in the home. But we've got to go a little bit deeper on these, looking at issues of what's related and what are the frailties and the multiple comorbidities, and how those play into both of these benefits. Thanks.

MS. KELLEY: Robert.

DR. CHERRY: Once again, I really like this report. It has the potential to be a lightning rod, but I like the way it was presented, you know, just the facts, just the data, and what others are kind of kicking it around a bit.

Of course, aberrant patterns doesn't necessarily translate into fraud, waste, or abuse. And I've talked previously about these trends in California. There could be a lot of positive reasons why you may see this degree of utilization, including the fact that some people, they want to be managed at home, and they prefer not to go to other types of facilities. And there could also be, among these 3,400, a good number of medical directors that are ordering as part of their role.

Nevertheless, this is, I think, year 5 for me, and this is probably the closest I think we've come in a report to identifying potential red flags that maybe others might have to look at more thoroughly.

But I do think that we need to study this further and have some degree of confidence, if we can find it, in home health as well as hospice care. I think it's necessary for those that are in population health and are trying to manage utilization well, and if they want to have credible partners to work with. I think we need to do this because we need to manage the total cost of care, and from an efficiency point of view.

And it could also be an access problem, because

if we're just bottlenecking the system with a lot of unnecessary orders, the home health and hospice, those that really need it won't be able to access it.

And sometimes it's hard to unsee what we've seen, but as we approach the payment updates in December and January we still need to be objective and be able to make those assessments based on current law.

I think there probably does need to be further work on this whole situation with the caps and whether or not they're creating unintended consequences, and whether there could be alterative models that would drive better behaviors.

And then just as one final comment, I know we're not the OIG and, of course, we're here to basically make recommendations to Congress that are data driven, based on expert advice. But I think it's something to think about as our data gets more sophisticated we may, in fact, stumble across things, not intentional, based on our work, that we may be in a conundrum to think about what is it that we need to do and who do we need to escalate it to.

But otherwise I'm looking forward to more work on this, and thank you for a really excellent presentation.

MS. KELLEY: Paul.

DR. CASALE: Yeah. Thank you again. Great chapter. Really interesting, important data.

Commissioners have made some really terrific comments. I just wanted to underscore a couple of things, one around hospice. You know, the comments that were made by Tamara and others around looking at clinical conditions, I think that was really important. I think the hospice benefit was originally for cancer patients where their clinical trajectory was more predictable. But even there, with all of the new treatments, that has increasingly become less predictable.

And there are more beneficiaries with sort of end-stage diseases like heart failure, chronic obstructive pulmonary disease, end-stage renal disease, their trajectories are just so variable. So looking at the data, based on clinical conditions, I think would be really helpful.

And then, again, adding my support to what Scott suggested. You know, it seems like a good time to reimagine the hospice benefit. Cheryl mentioned it, as well. Given the clinical care for a lot of these

conditions has evolved over time, and so is the current benefit, can it be redesigned in a way that makes more sense for patients.

And then the other I wanted to underscore is what Stacie said around sample size, around these outliers. I think it would be really helpful, whether it was the practitioners in home health who have the higher number of 30-day home health, or the hospice providers who certify for more than six agencies, et cetera, and then the whole sort of California, Texas, et cetera. How many providers does that represent, and get a sense of the environment, I think would be really helpful.

So again, I'm really looking forward to this work. I think it's really important and terrific, and thanks again for a great report.

MS. KELLEY: Tom.

DR. DILLER: Thanks. A really, really good report, and a lot of really difficult things to grapple with. I basically agree with much of what's been said, and I especially kind of highlight Tamara and Scott, their comments.

What I wanted to do, though, was highlight very

briefly one thing that Kenny brought up initially, and that is that there is a significant disparity in the financial output, if you will, between for-profit and not-for-profit entities. And we keep bumping up against this, as time goes on.

The concern, and it's anecdotal from my perspective, that the not-for-profits oftentimes are community based, they are mission oriented, and the concern that they are kind of a safety net in getting some adverse selection that's coming into it.

So what I don't know is are they just inefficient in not providing good enough care, or are there other aspects that kind of go into that?

So the concern, at the end of the day, is if we were to make policy decisions that would drive them out of business, because they just can't function. So I guess I would urge some analytic approach to trying to evaluate between the for-profit and the not-for-profit world with that, and the differences between those two agencies.

But thanks very much.

MS. KELLEY: Josh.

DR. LIAO: I also want to add my thanks for the

support which I think is important, and as others have noted, jarring. I think other Commissioners have made a lot of good hospice and home health-specific comments, so I won't retrace those here. But I do want to say that I do support including this material in the March update chapters.

Instead I want to just take a minute and maybe step back and express my appreciation for what I think is the kind of progressive analytic work that's demonstrated here. When I think back to how we got here, thinking about 2025 and 2026, and those chapters, finding hospice provider and suppliers really concentrated across certain states, in home health looking at agency growth, spending relative to beneficiary population, utilization, really highlighted atypical patterns, we'll say, in a given county. And I think those analyses led to, I think, some of the things that were presented today, a really rich discussion.

So I just want to pose a question for us, as a Commission, about if and how we might apply this lens to other sectors going forward. I've heard a couple of people mention, hey, if we could stumble upon this we should engage it. I agree with that. But I think maybe we could

be more intentional about that, as well. So measures we already use -- provider supply, utilization, spending variation -- these are inherently, and primarily valuable to informing payment adequacy and access, the things we do through the Commission.

But what I think today's discussion illuminates for me, in the context of the prior March chapters, is that they're the secondary purpose or benefit, which is identifying some early signals that might prompt exploratory, targeted analyses, could be brought to Commission discussion, and then perhaps inform some of the content in our chapters.

Of course, the measures and combos of those measures would have vary by the sector, and the deeper analyses would have to be selective and based on where we think the signals are most informative. But I do think there's value in that.

And I think the real value would be in connecting ongoing monitoring that we do for our purpose to focus exploration and discussion, and then ultimately maybe some findings in our reports. I think that may be obvious, but I just wanted to state that, because that's kind of what I

hear behind many other Commissioners' points.

I think doing that, again, it underscores our primary purpose in strengthening our advice to the Congress. But those other potential benefits would be independent, empirical context, to everything else that's happening. In this case through the executive branch, our analyses are not primarily meant to be but could still corroborate, qualify, add context and detail to those concerns.

Anyway, for all those reasons I'd welcome this type of approach beyond the home health and hospice context in the future. Thanks.

MS. KELLEY: Okay. That's all I have for Round 2, unless I've missed anyone. Amol?

DR. NAVATHE: Great. Thank you to Evan and Kim for the work. Thank you, Commissioners, for a lot of great input.

A couple of reflections. I think you all have made a number of analytic suggestions. I guess a couple that got mentioned many times, so looking at this at the kind of condition composition, but then also perhaps kind of conditioning on the condition to understand kind of

within those categories of patients what those distributions look like I think might be useful.

I think we also heard a little bit about sample size or concentration of beneficiaries in certain places, and that might be associated with some of the geographic variation that we're seeing. And so that's another analytic dimension amongst others that you have suggested.

I think wonderful, wide-ranging conversation, which I won't go back and recap. I think you all hit a number of different elements, and we ourselves will have to go back and kind of look at the transcript and digest some of that.

One clarification, or one kind of point to make. The work that we describe, that Kim described early on, with examining the association between hospice and Medicare spending, in general. I think it is certainly an interesting and important area, in general.

I just wanted to contextualize it that that's not linked to our payment update type of work. So as Josh was saying, we will kind of draw probably aspects of this analysis and incorporate it into our March report/reports perhaps going forward. But I just wanted to kind of place

that context in.

Otherwise, thank you so much for the wonderful input.

DR. NAVATHE: We will close the session on hospice and home here. And next we have the opportunity for anybody in person who is visiting with us to make a public comment. Anybody who would like to come forward and make a comment.

[Pause.]

DR. NAVATHE: Okay. Seeing no takers, for those who are listening through the Web here we would very much like to hear from you, as well. You can reach us at meetingcomments@MedPAC.gov. And with that this will bring our afternoon session to a close. Thank you.

[Whereupon, at 4:18 p.m., the meeting was recessed to reconvene at 9:00 a.m. on Friday, November 6, 2026.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

Friday, November 6, 2026
9:00 a.m.

COMMISSIONERS PRESENT:

AMOL S. NAVATHE, MD, PhD, Chair
GREGORY P. POULSEN, MBA, Vice Chair
LYNN BARR, MPH
PAUL N. CASALE, MD, MPH
ROBERT A. CHERRY, MD, MS
CHERYL L. DAMBERG, PhD
THOMAS DILLER, MD, MMM
STACIE B. DUSETZINA, PhD
BENEDIC IPPOLITO, PhD
KENNY KAN, FSA, CPA, CFA, MAAA
R. TAMARA KONETZKA, PhD
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AGENDA PAGE

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P R O C E E D I N G S

[9:00 a.m.]

DR. NAVATHE: Welcome, everyone, to Day 2 of our November public meeting, and we will be starting with a session on findings from MedPAC's focus groups.

Ledia?

MS. TABOR: Good morning. The online audience can download a PDF version of these slides in the handout section of the Control Panel on the right-hand side of the screen.

Each year, the Commission conducts focus groups with beneficiaries and clinicians in different locations to hear firsthand perspectives on Medicare and other health care topics. For the first time this summer, we also conducted focus groups with pharmacists because they are an important part of Medicare beneficiaries' experience with the health care system.

Today, we'll summarize many of the findings from this year's focus groups. The findings will also be woven into materials discussed this analytic cycle and included in the March and June reports to the Congress.

We would like to acknowledge the contractor team

from NORC at the University of Chicago for all of their work on this project. We would also like to thank MedPAC staff, Renuka Diwan and Shinobu Suzuki for the input on the pharmacist focus groups.

First, I will provide some background on why we do focus groups in our methods. Then Katelyn will summarize findings from our focus groups with beneficiaries, physicians, and nurse practitioners. Then Tara will discuss findings related to prescription drugs with a focus on our first-time pharmacist groups. Then we look forward to your discussion of the findings.

Understanding the experiences and perspectives of Medicare beneficiaries and providers is central to MedPAC's work. A benefit of the focus group approach is that it allows us to ask questions with answers that cannot be easily put into numbers; for example, the "how" and "why" of experiences. The findings provide narratives and real-life examples that are useful as the Commission discusses issues affecting the Medicare program.

Even with these benefits, we want to note that due to the nature of focus group research, our sample size was limited, so findings cannot be generalized to the

communities we studied or to the nation as a whole.

In May to July of this year, we conducted a total of 25 focus groups. Most of the groups were held in person with participants residing around Tampa, Florida; Iselin, New Jersey; and Seattle, Washington. We selected locations in different regions of the country based on several criteria that are discussed in NORC's report.

We held groups with Medicare beneficiaries 65 years or older, not eligible for Medicaid, grouped by enrollment in fee-for-service Medicare or MA, as well as groups of dual eligible beneficiaries.

We also spoke with clinicians that regularly see Medicare patients in an outpatient setting, including groups of physicians across primary and specialty care, as well as nurse practitioners.

Because of the Commission's continued interest in access to rural beneficiaries, we also conducted virtual focus groups with beneficiaries residing in rural areas throughout the country. New this year, we also conducted three virtual groups with pharmacists who work in outpatient settings, for example, chain, independent, and specialty pharmacies across the country.

For all of our groups, we recruited various characteristics to hear a range of perspectives. For example, for the pharmacist groups, we had a mix of pharmacists from urban, suburban, and rural areas.

A core set of research questions and topics of interest informed by MedPAC's analytic agenda guided the development of discussion guides for all of the focus groups. Topics discussed in beneficiary groups included understanding Medicare, the process of choosing coverage, satisfaction with coverage, access to primary care and specialty care, and prescription drugs.

Topics discussed in clinician groups included wait times and referrals, acceptance of new patients and insurance, working with other clinicians, and other topics around the organization of care.

In our first-time pharmacist groups, we discussed a range of topics, including how pharmacists spend time across priorities, insurance topics, impact of reimbursement and product shortages, access in the pharmacist job market, and well-being.

A lot of topics were discussed, and we have only so much time with you today, so we are highlighting just

some of the findings. More detail can be found in the NORC reports and will also be included in our other relevant analytic work.

For example, beneficiaries' perspectives and experiences choosing coverage were discussed in detail in the June 2026 report and in the Commission's continue to work on the complexity of Medicare enrollment decisions for beneficiaries.

I'll now turn it over to Katelyn.

DR. SMALLEY: Thanks, Ledia.

First, I will review some of the findings from our focus groups with beneficiaries, physicians, and nurse practitioners, and then I will turn it over to Tara to discuss what we heard about prescription drugs across all of our focus groups, with a focus on our new groups with pharmacists.

Medicare beneficiaries used a range of sources when choosing their coverage, including agents and brokers, SHIP counselors, and the Medicare Plan Finder website, but often reported feeling overwhelmed by the volume of information about the program.

For example, one beneficiary enrolled in

traditional Medicare noted, quote, "If you have a TV, you can't miss the deadline," while another said that they were bombarded with information before they turned 65. Others described being overwhelmed and frustrated by the number of Medicare coverage options.

As in previous years, fee-for-service beneficiaries generally prioritized avoiding provider restrictions, and MA beneficiaries generally prioritized lower premiums and co-pays.

Overall, beneficiaries in both fee-for-service and MA were satisfied with their coverage, with most rating their experience as excellent or good.

For example, one beneficiary noted that they rated their MA coverage as excellent because they got everything they need, including finding doctors easily.

Dual eligible beneficiaries described more varied experiences, however, with duals more often rating their coverage as good or fair.

In contrast to the beneficiary cited above, one dual eligible beneficiary pointed to difficulty finding specialists that accept their plan as a reason for rating their coverage as fair.

We also spoke virtually to some beneficiaries living in rural areas. Nearly all rural beneficiaries we spoke with reported having local access to primary care, but some reported challenges finding a new PCP, including limited options and long wait times.

As in past years, rural participants described seeking specialty care in the nearest major metropolitan area and, as evidenced by the quote on this slide, recognizing that a tradeoff of living in a rural area is long travel times for care.

Some participants described specialists making periodic visits to their local hospital to reduce travel times for beneficiaries. We will provide more information about access to care at the December meeting, so stay tuned.

Overall, most clinician participants were accepting new Medicare patients, and the majority of those that were also accepted at least some MA plans. Most participants reported not being involved in decisions about insurance. Those that did were more likely to be part of smaller practices or have an ownership stake in their practice.

Clinicians identified similar advantages and disadvantages as beneficiaries with respect to choosing MA versus fee-for-service, including the tradeoffs between lower cost sharing and utilization management and provider networks. For their own purposes, clinicians favored the administrative simplicity of fee-for-service compared to MA.

Perceptions of payment rates were mixed. Some participants cited higher payment rates in MA compared to fee-for-service, while others reported the opposite. This year, our participants spoke more on topics related to MA than fee-for-service. So we will spend the next few slides focusing on those findings.

Many clinicians noted challenges with prior authorization and payment denials in MA, with one PCP describing it as, quote, "feeling like you're jumping through hoops." While many clinicians stated that insurance status did not affect their treatment approach, others described the implications for practice.

For example, one nurse practitioner explained, quote, "Insurance is one of the first things I look at when I open the chart, just to remind myself, like, what am I

going to be able to get covered?" end quote.

MA provider networks were also cited as a challenge by both beneficiaries and clinicians. A few beneficiaries, especially duals, had care disrupted when their specialist stopped accepting their insurance. As one dual eligible beneficiary described, quote, "At one point, I had all of my doctors at the same hospital, and then they called me one by one. We don't take your insurance. They all dropped me, every one of them. I have not found new doctors as of yet," end quote.

Clinicians also cited provider network changes as being challenges for patients seeking care and being unexpectedly left without coverage. Some beneficiaries also reported out-of-date or incorrect provider directories. In the words of one dual eligible beneficiary, maybe 50 percent is correct of their list.

There was a general consensus among the physicians we spoke with that accountability for provider performance is important, and that quality measurement is one piece of that accountability. However, some described quality reporting as ticking boxes, with one characterizing performance incentives as, quote, "payment for paperwork,

not for quality."

Some physicians were frustrated to be held responsible for quality measures that did not align with their specialty, such as a gastroenterologist being held accountable for high blood pressure or depression or clinicians being held accountable for non-clinical aspects of patient experience, like changes to the parking garage or front desk staff.

Many clinicians described receiving regular quality reports from their practice, health system, or insurers, either in their EMRs, regular quality reporting updates, or during practice meetings. However, a few reported knowing that there was quality reporting happening at their organization, but they were not aware of their quality scores or how they compared to their peers.

About one quarter of physician participants reported participating in ACOs, and their knowledge of ACOs was mixed. Some knew that their practice was part of an ACO, but not what that meant, and others were involved in decisions to form or join an ACO. These clinicians generally held a leadership position or ownership stake in the organization.

Participants generally felt that ACOs supported increased care coordination, enhanced quality reporting, and offered financial incentives that enabled practices to invest in, for example, hiring additional staff dedicated to care management.

Many of the physicians participating in ACOs had experienced financial gains, while others had experienced losses.

The majority of physician participants reported working with NPs, and a somewhat smaller share also worked with PAs. Many physicians described NPs and PAs as improving efficiency, increasing capacity, and reducing physician workload, and stressed the importance of adequate training and experience.

NPs described having generally high levels of clinical autonomy, with some working largely independently, with as-needed consultation with physicians, and others reporting working in highly integrated teams.

For example, in the words of one family medicine doctor, quote, "My nurse practitioner has a whole panel of patients, and some of them I haven't seen personally in years. I have my patients. She's just working hand-in-

hand with me," unquote.

While we have been asking about AI for the last several years, this year there was a noticeable increase in the number of clinicians reporting using AI in their practice and the ways they described using it. Clinicians generally appreciated having AI scribes dictate their notes, with one explaining that it allowed them to focus more on interacting with the patient during the visit.

On the other hand, several clinicians raised concerns about accuracy and stressed that while AI tools are helpful, they should always be double-checked.

Some clinicians described having AI assist with scheduling or drafting messages, highlighting two main use cases, one, writing first drafts of patient portal messages and, two, drafting letters to plans to, for instance, appeal prior authorization decisions.

Clinicians cited the ability of the AI to pull in more details from the clinical record than they would be able to remember offhand.

Several physicians described using AI to stay up to date on literature, but because of concerns about their ability to identify incorrect information, cautioned

against students or new clinicians doing so. Relatedly, some clinicians were optimistic about the use of AI in clinical education, while others were more skeptical.

Finally, one physician mentioned using AI assistance during surgical procedures to help identify polyps for possible biopsy. He noted that the AI generated many false positives, so while it was helpful to identify items he might have missed, it was important not to over-rely on it.

At this point, I'm going to turn things over to Tara to discuss findings about pharmacists and prescription drugs.

MS. O'NEILL HAYES: Thanks, Katelyn.

We will now discuss our findings related to pharmacists and prescription drugs.

Pharmacists are an important part of beneficiaries' experience with the health care system. There are more than 337,000 pharmacists in the country, and more than half of them work at an outpatient community pharmacy. The pharmacist workforce is growing steadily, though recent growth is primarily in hospital and inpatient settings.

Pharmacists are often the ones informing patients of their insurance coverage, out-of-pocket costs, medication availability, and other things. Given their unique and important perspective, for the first time this year, we conducted focus groups with pharmacists to get their views on the pharmacy market and patients' access to medications.

The timing of these focus groups was also motivated by recent policy and economic changes that are reshaping the pharmacy landscape and the role of pharmacists. Recent reports of myriad challenges facing the pharmacy industry have garnered Commissioner interest. These potential challenges include financial pressures from insurance coverage and reimbursement changes and growing pressures on pharmacists' workload.

One thing to note for context before diving into our findings is that Medicare payments for pharmacist services are typically billed by and paid to a pharmacist-employing entity, typically a pharmacy. In Part D, pharmacy claims for prescription fills or certain services, such as medication therapy management, are billed to plans. In certain situations, a pharmacy may bill Medicare Part B

directly, such as for certain immunizations or other drugs and supplies, and some pharmacies may bill for the provision of covered diagnostic testing. Finally, some services provided by pharmacists may be billed incident-to an eligible Medicare provider.

As with their medical care, beneficiaries in both fee-for-service and MA were satisfied with their drug coverage, with most rating their experience as excellent or good. Most beneficiaries reported being able to access their drugs through local or mail-order pharmacies, and the concerns we did hear were mostly targeted around high-cost medications rather than broad-based programmatic concerns. Many beneficiaries spoke about their personal relationships with their pharmacists, which several noted was a key reason they used a given pharmacy.

All the pharmacists we spoke to described a wide variety of daily tasks. Beyond dispensing medications and making sure the shelves are stocked; they also manage technicians and interact with patients in various ways. Pharmacists often have to explain a patient's insurance coverage and out-of-pocket costs and counsel patients on how and when to take their medications and review patients'

prescriptions for safety, assessing potential drug-to-drug interactions.

Pharmacists may also have to coordinate with insurers or prescribers if a patient's medication is contraindicated or not covered by insurance. But every pharmacist we spoke to said that caring for patients is the most rewarding part of their job.

Here's a quote that we thought summarized these conversations pretty well. Quote, "I would say helping patients, for sure, is kind of why we all do what we do, right? And then anyone in a retail setting knows the challenges that come with that. So you could go on and on about the daily problems we have, but at the end of the day, if we help people, that's what we can go home happy about."

Several pharmacists noted an increase in their workload following the onset of the COVID-19 pandemic, particularly in providing more services not directly related to medication dispensing. Such services include administering diagnostic tests and giving immunizations, which several noted was because vaccines are revenue-generating, which has become more important as pharmacy

finances change.

Several pharmacists noted they were able to provide more vaccines because of the abilities and efficiencies offered by the pharmacy technicians they work with. Several pharmacists across pharmacy and geographic settings said their pharmacy used to have a greater focus on medication therapy management, but this focus has waned in recent years, largely due to a lack of time and/or staff.

One pharmacist noted MTM consults done properly typically take 30 minutes to an hour. A specialty pharmacist, on the other hand, explained that medication therapy management is an important revenue source for them, so they still conduct them regularly. A few pharmacists also noted that MTM consults are often one of the only ways to identify polypharmacy issues, so cutting back could have consequences from that perspective.

In general, limited resources were a commonly noted challenge among pharmacists, as highlighted by the quotes on the screen.

Many pharmacists reported closures in their area, while a few reported new pharmacies were opening.

Pharmacists talked about how closures in their area would increase patient volume and their workload, often without bringing on additional staff to compensate for the increase.

A specialty pharmacist in a rural area did say they are opening new locations to meet the needs of people currently driving over 20 miles to their nearest pharmacy. Another specialty pharmacist noted that health systems are increasingly establishing their own specialty pharmacies.

Several beneficiaries reported having to switch pharmacies in the past year because of a closure, though no rural beneficiaries reported adverse effects from closures this year. When switching pharmacies, beneficiaries mostly considered distance, store hours, delivery options, and availability of medications used, though several noted their insurance dictated where they went.

In each of our focus groups, medication access concerns were largely limited to more expensive drugs. More than half of participating pharmacists reported limiting stock of high-cost medications, including drugs selected for negotiation, deciding instead to order them as needed based on beneficiary demand because of low

reimbursement rates.

Most clinicians reported access to certain prescription drugs was a major concern for their Medicare patients due to coverage restrictions and out-of-pocket costs. Many beneficiaries reported attempting to fill a prescription that was out of stock, though despite the inconvenience, most said they were able to get their medication within a week or less or from a different nearby pharmacy.

Given the reported decrease in reimbursement rates in recent years, several pharmacists across settings explained that they had to find ways to make up for the losses they accumulate on filling prescriptions. One pharmacist said, quote, "For me, the most challenging part, especially being that I work in an independent pharmacy, is these insurance companies. A lot of them do underpay the pharmacies, and I have to make tough decisions. A lot of times I have to say, okay, I'm losing $100 on this prescription every month, and this prescription has 11 refills, but then I have to look at their other profile, their other medications, and say, well, okay, I can make up for it with these other meds, so I at least break even,

because I don't really like to dismiss patients, but sometimes I've had to do that."

Clinicians seem to understand the importance of prescribing based on patients' formularies and their expected out-of-pocket costs to successful treatment adherence, but pharmacists and clinicians described frustrations with formulary restrictions and insurance claim denials, especially among patients with acute medical needs, noting that prior authorization requirements can delay access to medicines.

Common phrases we heard regarding prior authorization and formulary restrictions included a "struggle," a "pain," and "challenging." GLP-1s were often noted as products having significant prior authorization burdens, and clinicians and pharmacists alike were hopeful that the new Medicare Bridge program would make access easier.

Pharmacists are largely responsible for informing patients of insurance participation and out-of-pocket costs. Several pharmacists noted patients, including those with Medicare and other types of coverage, are often unaware of how much their out-of-pocket costs are going to

be until they fill their prescription.

Pharmacists describe needing to explain to patients whether they are in-network and a preferred pharmacy, particularly at the beginning of each year, and what this entails for patients' out-of-pocket expenses.

Several pharmacists noted having their pharmacy churn in and out of network sometimes results in losing longstanding customers and increases administrative burden transferring patients.

Pharmacists and clinicians all spoke about working with their patients to find the lowest price for their medications. Participants reported many patients have medication access challenges due to out-of-pocket costs, and that this is becoming more common among Medicare beneficiaries.

Many pharmacists agreed they spend significant time checking prices across discount programs and tools, which is both time-consuming and can lead to lost revenue.

Many beneficiaries noted that prescription costs were increasing over time, but for most, the increase in cost was described as minimal and did not affect affordability.

Several clinicians reported the new out-of-pocket cap has increased access to costly medications, though many also reported limitations.

For awareness, the Part D program just recently implemented an out-of-pocket cap for beneficiaries, which was $2,000 in 2025. We consistently heard how the out-of-pocket cap has improved access for beneficiaries needing high-cost medications.

One rheumatologist explained how the cap has expanded the treatment options available to their patients, and an NP noted fewer patients skipping doses. However, some beneficiaries still struggle with cost, and conversations revealed awareness of the new Medicare prescription payment plan, which allows beneficiaries to spread their out-of-pocket costs over the course of the year, is limited. Pharmacists described difficulty explaining it and convincing beneficiaries to enroll.

Despite the benefit of the out-of-pocket cap for patients with higher medication costs, we also heard from many that the deductible, which reached $615 in 2026, is creating upfront affordability challenges for patients.

Clinicians and pharmacists noted that price

concerns seemed to lessen once beneficiaries got past the deductible, typically in the summer. A pharmacist quoted here equated the deductible with the former donut hole as the new financial hurdle for beneficiaries to overcome.

In each of our focus groups, participants discussed ways in which beneficiaries sought to reduce their drug costs, making clear affordability is still a prevalent issue.

And that brings us to your discussion. We can answer any questions, and then Commissioners can discuss their reactions to the findings and provide suggestions for the future.

After the meeting, we will post NORC's full reports of the focus group findings to the MedPAC website.

Thank you, and I turn it back to Amol.

DR. NAVATHE: Thank you, Tara, Katelyn, and Ledia. Very interesting findings and obviously very broad ranging, I think, in a lot of different topics that they touched.

So, Dana, I'll turn it over to you.

MS. KELLEY: Okay, thanks.

Kenny, I have you first in Round 1.

MR. KAN: Thank you for the excellent chapter. Very intriguing findings.

MA plans lost money in 2025 as the lousy MA rates are well below medical inflation. According to a Big Four accounting firm's analysis of year-to-date statutory filings this year, almost all MA plans will continue to lose money this year too. So, to survive, they've had to raise premiums, cut benefits, exit counties and states or MA altogether. Hence, no surprise, based on the recently released MA landscape files, the plan exits will impact approximately 10 percent of MA beneficiaries for this ongoing AEP.

Given this macro MA plan survival backdrop for 2025 and 2026, I found the survey findings very encouraging, as a vast majority of the surveyed benes rated coverage as excellent or good, despite broad affordability concerns.

And now my Round 1 question. How did MA and traditional Medicare fee-for-service enrollees compare? I mean, after all, 86 percent rated coverage as excellent or good. The report also says that the Medicare-only groups were split about evenly between MA and traditional

Medicare. Can you break out the coverage satisfaction ratings by MA versus traditional Medicare?

For the 14 percent who rated coverage as fair, did it come mainly from one group? You know, for MA folks, MA benes, what percentage of them previously had commercial managed care through exchanges, employer group insurance, and to what extent prior commercial coverage could have impacted the MA beneficiary focus group responses?

Thank you.

MS. TABOR: Thanks for the question.

So, to start off, I think, with your last question, we don't have information about the focus group participants' prior coverage. So we can't answer those questions. That's something we could think about, perhaps, for the future.

I would kind of have some concerns about, like, you know, the purpose of the focus groups is to kind of get general senses of how the Medicare population is receiving their care. So I wouldn't want to kind of get too grand, you know, try to draw too many findings from these small numbers.

And then as far as, like, satisfaction between MA

and fee-for-service, you'll see in the report more of a breakdown on the numbers of those, but again, because of the small ends of our focus groups, I would just say, like, generally, both fee-for-service and MA beneficiaries were satisfied with their coverage.

There are differences between what we hear in the groups. A lot of it is why they choose their coverage. The difference between, you know, fee-for-service and MA, like Katelyn mentioned, MA, you know, prioritize kind of the lower premiums and supplemental benefits, whereas fee-for-service beneficiaries traditionally look at their broader provider networks.

So just by nature of, you know, MA coverage versus fee-for-service, we do hear differences between the groups, but I think a general finding is that they both are generally satisfied with care, but, of course, some nuances to that of hearing about problems with coverage.

MS. KELLEY: Gokhan.

DR. METAN: So, first of all, thank you for this chapter. Almost every finding here either corroborates or challenges a current line of analytics that we are looking in different chapters, and as Commissioners, I find this

tremendously useful because it kind of puts the analytic work to test as well from whether it's in line with how people and what people experience, so, really, really appreciate that.

I have two questions. The first one is about the late enrollees. Did any participant pay late enrollment penalties? Did we find any kind of, like, finding as it relates to the late enrollees, especially in Part B?

MS. TABOR: This year, we did not hear anybody paying late enrollment penalties. In the past, we have. But, again, I would say that because of the small numbers, I wouldn't want to, you know, draw too much from that. But, yeah, this year we did not hear anybody.

DR. METAN: Okay. Given we have some body of work going on maybe next year if we can, like, have some participants, you know, from that group to learn more about, you know, why they are kind of, like, incurring those, that would be helpful.

My second question is about the MA terminations. Did beneficiaries affected by plan on network terminations describe, you know, how they find help, you know, either from brokers or SHIP or any kind of, like -- did we learn

anything around that?

MS. TABOR: I would say all of the above, yes.

We did hear from beneficiaries that were experiencing terminations or were about to experience terminations because of some market dynamics going on, and they did describe working with brokers, with SHIPs, or just even contacting their providers' offices to get some guidance as well.

DR. METAN: So it follows the general pattern of where they find help and nothing different there?

MS. TABOR: Yes. Yeah. I would say we didn't hear anything different. Yeah.

DR. METAN: Okay. Thank you.

MS. KELLEY: Josh.

DR. LIAO: Thanks for this work. Just a couple of quick questions about the physician samples. You mentioned there were primary physicians and then specialist physicians. Any sense of kind of the type of specialists that were included, like medical subspecialists versus proceduralists?

MS. TABOR: We did focus on patient-facing specialists, so cardiologists, oncologists, orthopedic

surgeons, rheumatologists, neurologists, as well.

DR. LIAO: Among the primary care -- I noticed there was a section about concierge medicine. You mentioned there were a few. Anything that you would say is even the earliest, earliest of potential signals that you could draw from that versus other primary care, or would you say that's too low, as well?

MS. TABOR: I would say perhaps we can wait until December, when the physician chapter status report is out. I would say a general finding was that, and I would say over the years that the knowledge of concierge medicine is increasing among beneficiaries and physicians. We did hear from some physicians who were in concierge practices and why they chose to participate in those, because they wanted more freedom to be able to have more time with their patients. We also heard from some physicians who had considered it, but then didn't feel like they could have a patient panel that would be willing to pay the concierge fee.

So I would say knowledge is increasing, but what effect it would have, if any, on access is still too hard to say.

DR. LIAO: And my last question is, I know that it sounds like two-thirds of the physicians in the focus groups worked with NPs and a third with PAs. Were those NPs and PAs more in primary care, non-primary care? Any sense of that?

MS. TABOR: That's a good question. I'd have to go back and look at the report for that.

DR. LIAO: Okay. Thanks.

MS. KELLEY: Paul.

DR. CASALE: Yeah. Thank you. This is really interesting. Thank you for doing this work.

Just a few questions. The first one was actually the same one Josh asked about the NPs, how many work with primary care and specialists, so that would be interesting.

The other, you mentioned the beneficiaries you surveyed, at least in Florida, the state of Washington, New Jersey. Were there any differences regionally in responses related to access or the complexity of signing up, that kind of thing? Did you notice any?

MS. TABOR: I think we tried not to. We purposely picked different markets to kind of be able to compare, but we also tried not to compare across the

markets because we do have small numbers. I mean, we heard about some market dynamics. For example, some markets were having some negotiations between leader health systems and health plans, you know, kind of played out in the conversations. But I think we're careful to not make the comparisons across.

DR. CASALE: Okay. And last question. Some of the quotes you pulled out on the beneficiaries, it seemed, and I know you just pulled out a few, that the dual eligible had sort of more challenges with finding care or maybe being dropped from plans. In general, did you find that the dual eligibles may have more challenges?

MS. TABOR: Yes. I would say that's a finding that we find most years, which dual eligible traditionally have more experiences, more touches with the health care system, so they potentially could have more, you know, access issues or other kinds of concerns.

DR. CASALE: Yeah. I was thinking more on the providers. On the provider side, as well, maybe they're not able to get that. Yes, they have more touches, and maybe that leads to more access problems, or maybe more providers are not seeing those patients, et cetera. So

it's worth looking into.

Anyway, thank you very much. This was really interesting.

MS. KELLEY: That's all I have for Round 1, unless I've missed anyone. I'm sorry. Tom, go right ahead.

DR. DILLER: Yes. Just real quick. Great chapter. And I think the interesting aspect for me is nothing in here was real surprising, so I think it's very consistent.

My question is around ACO programs, both from the perspective of the patient, the beneficiary, and the clinicians. Was anybody in like an MSSP program and were they even aware that they were in it, and how did they see the interactions with that program?

MS. TABOR: The beneficiaries?

DR. DILLER: Yeah.

MS. TABOR: This year we did not ask the beneficiaries about their ACO participation.

DR. DILLER: All right. And was there any discussion about that, about being in an ACO from the physicians?

MS. TABOR: Yes, there were. It was about a quarter were participating in an ACO.

DR. DILLER: Any pros or cons, or positives, negatives?

DR. SMALLEY: I would say they were generally positive about their experience. Again, knowledge of what it means to be a part of an ACO varied a lot among the clinicians we talked to.

DR. DILLER: All right. Thanks. I appreciate it.

MS. KELLEY: Did you want to get in here, Amol?

DR. NAVATHE: Yeah. I appreciate a lot of the questions, and I would just remind folks that this is a little bit of a balancing act for us in the sense that we have to constantly remind ourselves that these are not representative samples. So while it's tempting to want to make comparisons, whether it's geographic or about different parts of the program, or about certain features that we are particularly interested in, I think we just have to be careful.

It is a wonderful, broad look and, of course, it gives us this primary data. Even the quotes, I think, are

very rich, so I think it does enrich the discussion a lot. But we have to balance that with just being disciplined about trying not to make these comparisons. And I appreciate, Ledia, you pointing that out. So I wanted to just quickly remind us before we go into our more interpretive phase of the conversation.

MS. KELLEY: Okay. I have Kenny first in Round 2.

MR. KAN: I have to two comment buckets. Bucket number one, I suggest using the qualitative findings to fix MA's execution, not to question its value. So point well taken, Amol. We need to be careful not to extrapolate this very small group of responses to the broader Medicare population. But I still find it helpful just to hear from the ground how MA benes really feel, and what I heard is that seniors choose MA because it saves them money and adds benefits.

And the problems are operational. Slow prior authorization, inaccurate directories, and network disruptions. I believe those are fixable for MA plans. I like future serving work, bearing in mind it's not necessarily representative of the entire population to see

if we can glean insights of how to measure them. Prior authorization turnaround and overturned rates by service, directory accuracy audits, and how often contract terminations force patients to change doctors.

Future focus groups should also ask MA enrollees about the good points of MA, such as care coordination and care managers, so we hear the whole story. That's bucket number one.

In terms of bucket number two, again, being mindful not to extrapolate this survey focus group findings to the entire, you know, 30 million plus MA population. On questions to ask in future focus groups I have five suggestions.

Number one, MA with a traditional Medicare head-to-head. What would make an MA enrollee switch back, and why traditional Medicare enrollees stay out of MA. Can we ask about effectiveness of care coordination and care managers, not just networks?

Number two, prior authorization specifics. Prior auth is not a problem, but slow prior auth is. Which services, how long it took, whether the denial was overturned.

LOCUS, number three, how much they shape the choice and whether people felt pressured.

Number four, cost awareness. Do beneficiaries know what Medicare costs taxpayers and how do they rate premiums against network limits?

And finally, I love the focus groups' responses, so in terms of whether MedPAC should keep the pharmacy groups' responses, yes, but perhaps every two or three years.

Thank you.

MS. KELLEY: Stacie.

DR. DUSETZINA: Thanks very much for this work. Like Gokhan, I always appreciate how much this reinforces a lot of the workstreams that we have going on. It's like it's nice when you hear from people about the things that you're interested in studying in a broader way are actually happening, and things that we should keep digging into.

So I think, to me, the presentation and the chapter kind of reinforce that the focus on network directories and network adequacy are really important to keep moving forward.

I also always feel that when you start to dig in

and ask people about finding a new PCP, that's where the problems always start popping up. And I know that in general when we talk about access to care we kind of look at this broadly. Most people it's fine, but then when it's not it really isn't. So I appreciate how much color you get from focus groups in that space.

Probably no surprise, I'm really glad we added pharmacists and questions around what's going on with the pharmacy benefit. It also reminds, same thing as with the physician interviews, when you asked them about ACOs, and people are like "what do you mean?" You know, it's like we think all these policies and payment decisions are going to be clear to people, and the people actually working in these spaces maybe a lot of times aren't aware of them.

I think the Medicare prescription payment plan is a very good example of that. It's incredibly convoluted. It is a mess. It is a financial arrangement between the patient and their health insurer, and the pharmacist is left kind of trying to explain something that does not work well and is not clear, and is probably not a good idea for a lot of people. So I appreciate the details that came out on that, even though a lot of them were confused by it.

And it's like, well, that makes sense to me.

I think, kind of keeping in mind what Amol said about trying not to dig in too much, like what can we get from these groups and what should we be asking for versus what should go into broader workstreams. I do think I would like to hear, in the future, questions to pharmacists about bypassing the Medicare Part D benefit. So I think you get at that in some ways around the coupons and them searching for lower prices, but that dynamic, we're hearing more and more of that when we talk to beneficiaries. They've already figured out a way to not even need their Part D benefits. So to whatever extent we can get that from people, especially given the issues around deductibles going up so much, I think that's really important.

The other thing, going back to Paul's question around the duals, and maybe we already do this, I was trying to remember, but in the network adequacy work I do think we probably need to separate that group out, considering from at least the interviews you've done it sounds like it's sticking out as a bigger problem for dual eligible beneficiaries.

And I guess when I'm thinking about what could we

ask people, I don't know how easy it would be to get clinicians and practices here, but could more mt make a difference? So are people leaving these networks or dropping dual eligible beneficiaries because of lower reimbursements, and that is, again, a place for the Medicare Safety Net Index payment to come back in.

So these were my small wish list for things in the future, but thank you, as always, for this wonderful work.

MS. KELLEY: Gokhan.

DR. METAN: Again, as Tom mentioned, nothing in this paper was surprising, so that's really good confirmation of how we were feeling about a lot of these questions.

My only comment here is for the future work, I believe that a lot of discussions we had yesterday could benefit from this research, where some of the Commissioners' questions were not really possible to answer from the data or analytic analysis. For instance, the Tab B hospice work can benefit from the hospice enrollment experiences, questions around those. I think Tab B can benefit from, again, the RHC cost sharing questions we had.

And Tab G, again, can benefit from how people learn about Medicare eligibilities.

These are some examples, but if we could plan very strategically some of the questions that Commissioners are wondering about, some of this recent work in the next year's plan, that would be super helpful. Thank you.

MS. KELLEY: Brian.

DR. MILLER: Thank you. So I have four categories of comments, most of which are directed to the people around the table. Thoughts for you all are pretty short. I really like this work, and really appreciate you including the pharmacists. I think doing it every couple of years is helpful because the pharmacists' perspectives, whether it's community pharmacists, CVS pharmacists, in-hospital pharmacists is important, because I think we, collectively, as policy people, often focus on the medical benefit, and then we focus on the direct benefit, and then we don't focus on the people delivering the direct benefit. So I personally really appreciate you doing that, and that's not just because my older sister is a pharmacist, who will beat me up.

That aside, two or three sort of parsings, I

think that would be helpful. One, I realize, and respect our Chair's note that this is not statistically demonstrative of anything. It's like saying that I like Land Rovers and the Chair likes my Land Rover, therefore, 2 out of 17 Commissioners are supportive of Land Rovers. I get that.

But I do think despite the fact that this isn't statistically representative, if we could parse sort of the fee-for-service and the MA responses a bit more, just in how you organize and write about it, because that will help us sort of build off of what Kenny said, which is how can we use this to push fixing policy, to fix MA operations, like slow prior auth is not okay, inaccurate directory is not okay. So if we can figure out where those comments are coming from that will allow us to be targeted in our response.

I think everybody here wants to improve programs, whether it's fee-for-service, ACO, or MA, and that will empower us, I think, as a Commission, to think about things to improve MA, as opposed to just saying it's bad, because it's fine to say it's bad, but something's bad. Like anything's bad. But if we need that, we need to have a

specific targeted solution, so that will help us. Like I can find things about, like about fee-for-service, ACO, and MA. I want us to fix things, be in the business of fixing stuff.

I do actually agree with Kenny on that prior insurance is helpful, because I think it's useful for us if someone has ACA, ESI, Medicaid managed care or TRICARE/VA, whatever it is, and then if they go into Medicare those are all various formulations of managed care. So if you had the VA before, MA actually seems pretty generous and not very restrictive. If you had employer-sponsored insurance from a large company with 250,000 employees, it's probably a very gentle oversight, in which case fee-for-service might feel a little closer to what you had before. And then if you are in MA for economic reasons you're going to be really grumpy. And that's a normal response. So understanding sort of where those benes came from with their coverage prior before, I think would help.

So comments for the rest of us, which I'll be brief because I realize I'm already at a reasonable amount of time. Pharmacists spend a lot of time doing what I sort of call paperwork. I think we want to think about things

that we can push pharmacy practice, whether it's figuring out ways to have them do less paperwork and do more to medication therapy management, whether it's thinking about a behind-the-counter drug channel, whether it's thinking about putting pricing information in their systems. We should think about that, like how do we have pharmacists do pharmacist tasks instead of the pharmacist as secretary, because we have the doctor as secretary and we have the nurse as secretary. And this, to me, was revealing because now we have the pharmacist that's the secretary. You know, they're pretty nerdy. I don't think we want to use them for that. And can we push pricing information back into the EHR so the pharmacist doesn't even have to deal with that?

Benes, I think the bene survey, to me, was super interesting, because yes, people use brokers. They also talk to SHIP counselors. They also went to seminars. They also collected brochures. They also use the internet. They called their family. They also called their friends. They also spoke with former advisors and colleagues. So there's lots of sources of info. I think in our next session we'll talk about strengthening SHIP, which I'm

supportive of.

But I think it's important for us to remember that it's not just brokers or it's not just SHIP. There are lot of sources of info people have. And I think it was 86 percent thought they had good or excellent coverage. That means like overall there's some success there. I do think that there was a problem with sort of specialty access, which came out in some of the comments. And I think that's because if you think about it, you're going to visit your primary care doc, you're going to get your hypertension checked, in a month it doesn't matter. You have a new brain cancer diagnosis, seeing your neuro oncologist a month actually does matter. So I think there's a lot more time sensitivity that we, as a Commission, might not be aware of. So that was really actually helpful to have those beneficiary comments.

The clinician comment I'm very simpatico with, obviously. I'm super biased there. But a couple of things. One, I think we should update some of our questions about MA in response, again, thinking about how does this compare to other managed care programs. Because clinicians seem mad about MA, which it's annoying to have

someone looking over your shoulder. But are they also mad at like ACA plans? Are they mad about ESI plans? Are they mad about Medicare? Or are they just grumpy about utilization management, which is fine for people to be a little grumpy, and we should know that? I'm not sure that's an MA-specific issue, is more of where I'm going with that.

And then there was a really important sentence I wanted to say. Sorry for going on so long. The sentence said, "Clinicians in larger health systems reported feeling more pressure or having compensation tied to referring within their networks." Ouch. So that sort of gets to the point of you can't do your job as a doctor unless you refer within the network in which you are employed. Like you must refer.

I worked at the FTC years ago on hospitals mergers, and got to review corporate documents, and they referred to clinicians sending people outside as leakage. That's bad. The doctor should be sending people to the person they think is the best doctor, and obviously insurance networks have some influence on the relative costs of that. But the idea that clinicians in large

health systems can't send patients to where they think is clinically appropriate to me is a big problem.

And also I'd like to point out, and I'm getting sort of angry, I think this is really hypocritical of large health systems, because they said that physicians can't self-refer to other businesses that they own and operate, but large health systems are requiring physicians, as a condition of employment, to send people to doctors in their system, physical therapists in their system, imaging in their system, labs in their system, DME in their system, home health in their system, and that sounds like a conglomerate that's favoring its own business over what is clinically best for the patient. That is wrong.

So I think if large health systems are going to require that physicians do self-referral as a condition of employment, that's not okay. I don't think that should be allowed. I think if they're going to do that, we need to address self-referral overall, and we need to address it for physician-owned enterprise also. Because if we're going to think that self-referral has clinical benefits, which sometimes it does, then all market participants should be allowed to do that, not just large tax-exempt

hospital systems. Like that's not okay, and that's not appropriate, and that's not good for the Medicare program, and that's not good for the patient. Thank you.

MS. KELLEY: Okay. I have a comment from Ben. He says these interviews raised oft-heard concerns about prior authorization and denials in MA plans. While MedPAC and others have documented aggregate trends in the outcomes, data availability make it difficult to understand the nature of denials, especially for medical services. For example, do they mostly reflect substantive disagreements over medical decision-making or administrative hassle?

He thinks exploring this in future interviews might offer a nice complement to what empirical analyses have shown.

And I have Gina next.

MS. UPCHURCH: First, thank you guys so much. Very informative. And I, with the other Commissioners, really commend the MedPAC for doing this sort of qualitative analysis as well as just looking at crunching numbers.

Full disclosure, I'm a pharmacist, so that's

going to my focus of my comments. I'm just thrilled that my anecdotal experience totally matches the findings that you all came up with, or not came up with but are reporting out.

I think as a MedPAC we are responsible for improving health outcomes for Medicare beneficiaries. We don't talk about that very often. We talk about the structures and systems that support that. But a lot of it is about prevention in my mind and improving health outcomes through prevention, especially with chronic conditions, for older adults and adults with disabilities.

Medications are some of the best tools we have in our toolbox, if necessary and used safely and effectively. Caveats. Big caveats to that.

C. Everett Koop once said, "Medicines don't work in people who don't take them." So medication optimization is around helping people get what they need and avoid what they don't need. One of my other favorite quotes is "sometimes the best medicine is no medicine at all," especially for older adults dealing with polypharmacy issues. So this med optimization is really critical, and pharmacists can and should be playing a central role in

medication optimization.

Unfortunately, we've tied pharmacists, through the years, to the product they dispense, usually. Not always in health systems but certainly at the community level we have tied them to the product they dispense, including generics, where they have a little margin, brands. You rightfully reported many times people lose medicines and will stop dispensing them when they're brand name drugs. And they've made a little margin off of vaccines in more recently in years. But we tie them to the product.

They are extremely well trained. I'm a BS. I'm an old school in pharmacy. I did do a residency in geriatrics, but people go now for six years to get a doctor of pharmacy degree, and many of them now do residencies. Extremely well trained, and are the medication experts that work in teams with providers to make sure meds are optimized.

They don't want to be glorified claims processors and insurance agents. That's not what they are trained to do.

You know, we have the enhanced MTM, and we

reported on it years ago. It was the insurance companies, and I mentioned this yesterday, were responsible for looking to see, does MTM, medication therapy management, really help? We gave it to the insurance companies to do, and they hired people in call centers to call people that they didn't know, and the outcomes were horrible. Not shocking at all.

So enhanced MTM didn't work, so I'm going to suggest we drive that MTM to the local pharmacist. They are trained to do that, and we need to be pushing that. They need to work at the top of their license to support the rest of the team.

Pharmacists should have access to the electronic health records that are local. It can really help them, in a very secure way. They don't even often have access to the internet, because people think they're going to waste their time or something. But pharmacists need to be brought into the 21st century of health care delivery.

Pharmacists are accessible. They're almost on every corner, in urban areas, for sure. Maybe not as much rural. And by the way, the pharmacists in rural settings are often those independent pharmacists that are often

losing money. But they care, and you picked that up. They care about the patients they are taking care of.

They're knowledgeable. They know about formularies. They know about access. They know what costs a lot of money, what doesn't cost a lot of money, and they know about med safety. But we're not tapping it. And they're trusted.

You know, with the vaccines, when we need to get vaccines in arms, who did it during COVID? Who stayed open? It was a lot of pharmacists that did that. They are trusted for that work and other work, and we need to tap them.

So med optimization is a huge part of prevention, and ultimately it's a part of improving the health of our Medicare beneficiaries in our communities. So my two suggestions: drive medication therapy management, pay for it separate from the product, because if you just want to make more money right now you just need to dispense more drugs. That's not what we want. We want med optimization, so we want pharmacists to also be reimbursed, to talk about how you don't need to take that PPI.

You know, in Canada they have ads about stopping

taking medicines as a way to improve health. Not just taking more drugs, which we promote in the United States of America.

So driving more MTM local to pharmacists, and paying them for using their skill set.

And the other thing we need to do, and it wasn't in this report but I think it's really important, is we need to monitor where the money is going. Direct and indirect remuneration fees. PBM plans coming back and snatching money out of pharmacists' coffers. It not only rips off the pharmacist, it rips of Medicare beneficiaries and the Medicare program as a whole. So we need to follow the money in pharmacy and put it in the hands of some people that can make a difference to the lives of people with chronic conditions.

Thank you for this work.

MS. KELLEY: Tamara.

DR. KONETZKA: Thank you. Super interesting. I'll start by agreeing with two specific comments that have come up, that I'd love to reinforce. One is I'd love to see a little bit more information about the duals and why they're a little bit more dissatisfied, especially from the

provider side. We know in the SNF world, for example, that in the states that are the lesser-of states where they might not get the Medicaid copay, that Medicaid covered copay for patients, that SNFs don't love to take on duals for that reason. And it would be great to know, from a wider provider perspective, whether that's a common phenomenon and whether that leads to duals being slightly more dissatisfied, other than their sort of higher sickness levels, et cetera. More touches.

The other thing I'd like to plus-one in on is one of the things that Gina just said, really everything that Gina just said, but one of the things that Gina just said about the potential role of pharmacists in medication therapy management. It is incredibly hard to get physicians to think about, in my experience, to get physicians to think about de-prescribing and reducing polypharmacy.

Because they're used to having a pharmacological solution for a problem, and it really takes somebody to sort of look across all of these medications and think about what patients don't need, especially as they reach older and older ages. And I think it makes a lot of sense

for pharmacists to take on that role, which they can't do unless there's an underlying payment structure that enables to do so. So I'd love to see us explore that a little bit more.

Two other things that I think came out of the focus groups, where I would love to see us, as time allows, add those to the research agenda, I know we have a big agenda, sort of the beneficiary experience and complexity. But one is, that came out in both the providers and the consumer groups, is these disruptions from contract terminations. We've really focused on sort of the transparency issues around that, like getting the networks, the directories to be accurate, and that is all very important.

But it still leaves the beneficiary kind of stuck in the middle of the year. You can have all the information you want, but if your whole health system leaves the plan that you're on, you still have to go through a lot of hoops to try to switch plans or find coverage with a different provider or switch plans to one that includes your provider. That's really a lot to put on the beneficiary. So I'd love to see us explore some

options where we sort of reduce the burden on the beneficiary from that. Are there ways to sort of align the contract negotiations with plan years a little bit better? And I know that's complicated, but I'd love to see us sort of explore whether there are possibilities to do that, to reduce the burden on beneficiaries.

The other thing, and this has come up less often but I found it an interesting aspect of the focus groups, and that was that you can't see the price of your drugs as a beneficiary until you're at the pharmacy. And it just seems like with technology we should be able to solve that. And to the extent that we want people to be able to price shop, we kind of need that transparency.

I mean, it's hard to go to the pharmacy and find out what they drug is going to cost, and say, "Okay, now I'm going to physically go to three other pharmacies in my area and see if I can get the drug for cheaper." And people sometimes do that. But there should be a way to know what the price of your drug is going to be at a particular pharmacy, and you can sort of do that price shopping before you go.

So that's another thing, and it's probably down

the list because there are a lot of really important issues that come up more often, but I would love to see that on our list eventually. Thanks.

MS. KELLEY: Josh.

DR. LIAO: Thanks for this work. I think because of the focus group methods an emphasis on maybe generating hypotheses out of them, even try to create an estimate or generalize it, all kind of focus on just things that stood out, and then maybe their connection to the work we're doing and how it could enhance it. So four things along those lines.

I think the first is kind of the findings on coverage satisfaction, I think what stood out there to me is that there is variation there, but people can be satisfied with their coverage but still have unmet needs underneath that. There is lot of, I think, heterogeneity there that is important to say. so I think in future focus groups and surveys it would be great to get at things, satisfaction, wait times, other things that can tease out those two things, if possible, to further generate hypotheses.

The second is some of the access findings. I

think some of what was in the focus groups really helped me, remind me that we should continue to be rigorous about like access to what, for whom, and under what circumstances. So differences between new versus established patients, primary or specialty care, procedures, I think that really pops out to me. So I think there's a difference between saying we're turning a crank and the output looks okay, but then the effort to turn that crank is getting worse.

So the unmet need is not visible yet, but we're straining. So when you see pharmacists taking on patients with closures without resources, burnout, difficulty hiring, you may not see that in the measures in future work but you can see that it's straining. When I read that physicians need to tap into their own networks to get referrals, that's another example of that. When I hear that PCPs are worried that some of the patients in their communities can't get access because other PCPs are turning to concierge medicine, those are early signals. So I think the more we can see that in future work would be great, and I think we have work streams along these lines.

The third is care coordination. This ties a

little bit to the primary care-related work we talked about yesterday. But some of the comments about these ACOs or other models give us more staff but there's box-checking that's involved. So that tension that some of the Commissioners talked about yesterday around is it really infrastructure or is it capacity? What are we getting for those bodies? Is it in the practice? Is it outside? I'd love to enhance some of that primary care-related work we're doing.

And then, finally, AI. I appreciated reading about that, and I think it's easy to say AI is everywhere and AI is doing everything. But as we pursue our software-as-a-service work, as I last night, very quickly, read the '27 rule that dropped this week and they're calling it software as a medical service now, I just think having a framework to think about AI's importance.

When I look at the findings in AI I see kind of three buckets. One is like the back office stuff. This is like scheduling patients in, doing prior authorization, doing billing, kind of regular office things. And I've heard in prior meetings Commissioners say how does that relate. I think it relates the least. There's been the

workflow things, so it's like AI scribes, EHRs doing things to make my documentation easier as a clinician. Doesn't have a direct impact on payment adequacy per se, but it does, over time, theoretically, and hopefully affect practice expense, physician time, those types of things. So it's important to bucket it that way.

And I think the most relevant, but the least developed, in my view, is the patient-facing stuff. So it's that last item you had around diagnosis, again, what the new final rule I think calls medical analysis. I think that's just something, as we ask about AI, I wouldn't be surprised if the overall trend line goes up, that you're hearing in these qualitative things, in surveys, that there's more, but more of what and in what area I think would be really important as we think about things like new technology add-ons, new tech APCs, et cetera, et cetera. So I would love to see that, as well.

But again, I think four areas where really interesting findings I think connect to our ongoing work. Maybe a few enhancements along those, and I'm really grateful for you guys doing it. Thanks.

MS. KELLEY: Robert.

DR. CHERRY: Yeah, thank you. This is an excellent report. I think you did a great job of selecting a good diverse group of people to be able to have a conversation about their experiences.

I do think the conversations validated, you know, much of the discussions that we've had here within MedPAC, and they've identified a wide variety of issues. You know, literally, if you were to track this all down, chase it all down, it's kind of like boiling the ocean.

So one of the things that I was thinking about when I was reading through these focus groups is, you know, what can we prioritize that's potentially actionable? That's a common theme between all of these groups, you know, the physicians, nurse practitioners, pharmacists, and beneficiaries. And one of the things that was common, I think, between all the groups and also very common in our discussions has to do with the preauthorizations. It's definitely, you know, a common theme here.

So, if you look at physicians and nurse practitioners, you know, those focus groups identified it. We also know that there's a lot of burnout, you know, with all of these groups. And I'm not saying that

preauthorizations is the root cause of burnout, but it's definitely listed as, you know, a driver of increased workload and stress among providers.

The pharmacy group, which I think was a great idea of including them because the pharmacy group really tells the story, I think, the best. So take, for example, a patient. It's now January. They've changed MA plans. They've had a prescription for the last two years. So they show up to their pharmacy. They get it filled, and there's an acute need for it. They're down to their last pill. And the pharmacist says, "Oh, you've been denied your prescription because this new plan, it's not on formulary." So a pharmacist makes a recommendation for a different drug, and then so the patient now has to direct message, you know, through their Epic MyChart to the other physician to say, "I need a new prescription. Pharmacist is recommending this." Physician gets back, writes a new prescription, but we've lost an entire day, right? Patient comes in the next morning, sees the pharmacist has already spent time sorting this out, says everything looks fine except we just ran out of stock with your medication, has to go look in all the systems and says, "Oh, good news. I

found it. It's just 10 miles away." And so now the individual has to go 10 miles away to get their prescription filled. Good news is it's there. It's in stock. And then the bill comes, and now they have to pay twice as much for a new medication that they weren't taking before, because they switched plans and now the copay has gone up.

And, you know, we've all taken care of either patients like this or family members like this or maybe ourselves, and these are very common stories. And it increases the stress for the beneficiary every 30 days because they don't know exactly what's going to happen when they get to the counter and they try to get their prescription, you know, basically renewed again.

So the whole preauthorization process is really problematic, and it's one of the reasons why you identify in the focus group that the fee-for-service patients don't want those restrictions, because they hear about these horror stories and they don't want anything to do with, you know, a managed health care, you know, product.

The other thing that kind of stands out when you kind of put all these themes together between the groups is

-- you had mentioned that, you know, the majority of patients find that their health plan coverage is either excellent or good. But when we look at, you know, patient experience, we don't look at excellent/good. We look at top box scores, right?

So only 28 percent of the patients are saying that their coverage is excellent. If that was a patient experience survey in HCAHPS, that would be a grossly failing grade. We would have a one-star rating, you know, if we had a top box score of only 28 percent.

So I know that the focus groups is not scientific, but it is telling us that the system is broken across multiple different parts. The physician is not happy with the prescription outcome. The pharmacist is not happy because they have to spend all their time trying to navigate this for the patient. Patient is not happy because they have to go to two different pharmacies over the course of two days, and neither of these groups can fix the problem, you know? And it's overwhelming for us too.

But I think, you know, preauthorizations bubbles up, at least for me, you know, towards the top of the story, and I think if we continue to have conversations

about how to improve that so we'd have fewer of these bottlenecks, I think that would be a great plan.

But thank you very much for pulling this all together.

MS. KELLEY: Okay. I have a comment from Scott.

He says, Ledia, Katelyn, and Tara, thanks for the very informative summary.

Reading the materials and listening to the presentation, he tried to step back and synthesize a few high-level take-homes as follows.

First, traditional Medicare largely works for beneficiaries, access, cost, quality, and providers with low administrative burden. That should inform continued discussions about how we move forward as a country in a way that ensures all Americans have access to affordable, high-quality care, and does so with a minimal level of provider abrasion.

Second, where traditional Medicare fails in its promise is the lack of adequate incentives outside of ACOs to create integrated teams -- PCPs, ancillary providers, specialists, community pharmacists -- that are truly needed to deliver on the clinical potential of modern medicine for

the highest-risk beneficiaries. The result is that we have major pockets of serious underperformance in challenging populations; for example, the long-term care living, end-of-life care, ESRD, high social determinants of health.

Three, the MA program has, by and large, the exception being provider-integrated plans, failed to deliver on its originally intended triple aim, and we see that in both the lack of clear clinical superiority of MA as well as the high level of burdens the program imposes on beneficiaries, particularly the sickest and most complex, and providers, especially via clumsily managed prior authorizations and network management.

Therefore, his suggestions are, first, gradually increase the focus on how traditional Medicare can better serve the highest-risk beneficiaries via increasing emphasis on integrated multilevel teams.

Second, continue our focus on how best to increase the accountability of MA plans, re-engineered Stars, tighter scrutiny of PA processes and network management.

And third, perhaps do some focus group work with some of the consistently highest performing ACOs and MA

plans to tease out what helps them succeed and what would make it even easier for them to succeed.

MS. KELLEY: And I have Cheryl next.

DR. DAMBERG: Thank you all for such great work. I really applaud that MedPAC continues to emphasize hearing the voice of beneficiary as well as clinicians and pharmacists. I think the pharmacist was a nice add.

You know, I am going to double down on what Robert just said, particularly around access issues. I think the results are pretty striking in terms of the ability of beneficiaries to find a new PCP when they lose a PCP. And I do think it's concerning that at least the statement about the fact that clinicians were often not taking new patients or for beneficiaries for MA, that the physician was out of network.

I know our network chapter emphasizes that physicians are contracting with many MA plans, but I do think that beneficiaries are experiencing challenges finding physicians. And I appreciate our continued focus on that and trying to think about what are some of the options to try to improve that space for the consumer.

I also thought it was telling -- and I've been

hearing this not just in the Medicare space, but also in the commercial space -- that even if you have a primary care physician, oftentimes you can't get in to see them. And so patients are either being seen by nurse practitioners, which may or may not be a good thing. You know, maybe this is working to the top of the license, and it's helping improve access, better triage going on. But I also think oftentimes patients, when they can't get in to see their primary care physician, are going to urgent care.

So I don't know if that's an opportunity for future questioning. If they have trouble getting in to see their PCP, where do they go for care?

I found the information that you gathered from pharmacists to be really interesting, and I appreciated during your presentation, you provided more color commentary and unpacked the findings more. And I hope whatever you produce for public consumption would contain more of that information, because I found myself, as I was reading it, you know, writing in the margins, so why is that? You know, can you help me understand that better?

I think in terms of areas for future work, in terms of questions you might ask beneficiaries in the

future, something that I think we've struggled with in terms of access -- so if they lose their PCP, what's the length of time they go to try to find another PCP? Is that just a matter of weeks, or is that sort of months? And then, as I mentioned, what do they do in the interim? Where do they, you know, go for care?

I do think, similar to what other Commissioners have raised around contract disruptions, how that affects their ability to have coordinated care and care continuity. So I think kind of digging into that space would be helpful.

And then on the clinician side, again, related to network disruptions, how is that impacting their ability to deliver coordinated care to their patients? This may or may not be within the space, but I do think it would be helpful to ask physicians about quality measures. This is something we've talked about more broadly in terms of the burden and getting their sense about what are the important areas to measure in the quality space, as well as payment adequacy.

And then, lastly, I think in the space that Brian raised around self-referrals, I also think that this needs

greater exploration. We've increasingly seen and continue to see providers consolidating into large health systems. And there's clear evidence that shows that referral paths change once physicians merge into systems, and often, it's resulting in patients receiving care in higher-cost settings. So it has financial implications in the marketplace and for the Medicare program. So that would be something else I would hope that the Commission could think about in the future.

MS. KELLEY: Tom?

DR. DILLER: Yeah. Fairly brief comments in a really good chapter, but suggestions for future focus group topics.

We spend a lot of time trying to understand the experience of beneficiaries and physicians and other care providers in both the fee-for-service and the MA program. CMS, however, is wanting to have 100 percent of patients in some sort of value-based care by 2030. And so CMMI has produced an alphabet of various programs, MSSP being the most predominant one, and we rarely talk about this. So I think in the future, it might be somewhat helpful to get the input from both patients and the physicians about their

experience with these types of programs.

One of the concerns is that oftentimes the patient doesn't even know that they're enrolled in that particular program, that they're being managed in some way, shape, or form. And often, I think the clinicians don't really even know.

So that's my only suggestion with it, but great chapter. Thanks.

MS. KELLEY: Lynn?

MS. BARR: Thank you. Thank you for this great work. I'm a big fan of surveys and focus groups. I do a lot of them myself.

I think that in future cycles, it would actually be helpful for you to do the beneficiary survey report-out and then the focus group report-out in that order in the same meeting so people can kind of keep in their heads what's statistical versus what is anecdotal. And I think it'll help us really kind of understand things better and not struggle to make conclusions about things that aren't necessarily statistically significant, and you can kind of toggle back and forth.

I think the composition of the focus groups is

really important and that there's always dominant players in a focus group, and I'm concerned by not sorting the beneficiaries by type of beneficiary. So rather than putting everybody in the same group, I think you should have a dual eligible focus group, and they're going to be much more able to talk about their issues around other people that are like them. I'd also like to see an ESRD focus group, and I'd like to see a disabled focus group. And that, I think will give us more color on how these individuals are really being dealt with, and you can also, of course, pull that information out of surveys in a similar way, because I think the experiences are extremely different.

I'm very curious about -- I've been watching how the disabled ESRD and duals are being disenrolled from ACOs and how providers are now having two TINs, and they bill those patients under their non-ACO TIN, because it's a lot easier to make money that way. But I want to make sure they're actually still getting care, and so I'd like to know in those focus groups, are you still seeing the same -- you're in an ACO or SNP. Are you still seeing the same provider, or did you actually have to go to a new provider

now because your ACO doesn't want those types of patients in them because they're hurting profits?

I worry about the -- I love the pharmacy work. I worry about how we're taking this really broken system and trying to figure out doing medication therapy management. Do they know what these patients are actually taking? And it seems like a very, very poorly informed process that is extremely complex and time consuming, and I don't understand why we don't improve our system of getting claims data. We all have access in Medicare to our claims data individually. Why can't we just give that to the pharmacist?

And because it's not just what drugs are on the list, but how often am I actually refilling those drugs, or have I refilled those drugs? And so I think we could do a lot better job of managing pharmacy if we started with data.

As I think Kenny said earlier yesterday, we're an insurer, and putting information in the hands of our patients is our job, to make sure that they can take care of their health. And so I really think that we need to start thinking about -- you know, we have the blue button.

We all have individual access to our Medicare claims data. We have a right to it through all the legislation that's been happening, and we're not using this. And it just kind of surprises me that we're not.

Along those lines, I think somebody mentioned the discount cards, right? How confusing is it that I'm on Medicare and then they're handing me discount cards and saying, "Oh, well, GoodRx has a better price than Medicare does, so you should just pay out of pocket for this drug?" And so that fill then is not captured in my claims data. It's not in the ACO data, right? I mean, I think that that's a problem that we should be able to like -- I mean, if GoodRx can sell it for that, I mean, Medicare should be able to cover it. I mean, it's just we want to have a complete claims set, particularly for pharmacy.

I know that in our ACO, one of the things that we looked for were people that weren't refilling their medications at the schedule that they should be filling them on, and we know that med rec without actually claims data is just kind of a shot in the dark. I mean, the patients have no idea what they're taking, and you see a particularly polypharmacy in the elderly.

I appreciate the comments from Brian and Cheryl about in-network versus out-of-network. I think that there's a lot more complexity there as well, because the referral network that I first encountered in ACO world had more to do with who you went to school with than, oh, this is the best doctor. And within a system, there's more oversight of like some doctors refer to lots of specialists, you know, and then they get lots of potentially unnecessary care.

So I think that there's -- referring in-network isn't a bad thing in and of itself, but it's bad to your point if it's abused. Certainly, I've not encountered the doctor that said he was going to lose his job if he referred out of network. I think that they -- but if that happens, that's a terrible thing, and that should be against the law, right? I mean, physicians should be respected and have the right to make the decisions.

I also agree with Brian's comment about pushing the pricing information into the EMR. Again, every patient, we have the capability of every patient pushing all of their claims data into every EMR on a QR code. It's in regulation. We're just not doing it, and so I think we

need to be asking ourselves as Medicare, why are we not using the information we have? Why are we not empowering our beneficiaries, and why are we not giving it to the doctors since we've passed all these laws and regulations that make that possible?

Thank you for this good work. I look forward to watching you virtually next year.

MS. KELLEY: Paul.

DR. CASALE: Sorry. Brian, were you trying to get in here?

MS. KELLEY: Oh, I'm so sorry. Go ahead.

DR. MILLER: Yeah, a quick thing. My point wasn't about insurance networks. It was about health systems requiring doctors to refer within the health system, which is smaller, much smaller than an insurance network.

MS. KELLEY: Paul?

DR. CASALE: Yeah, just a brief comment. I just wanted to underscore and plus-one Tom's comments around keeping an eye on the ACO, particularly the awareness of patients, which I think is really minimal and really keep continuing to ask about that, and certainly on the provider

side as well, in my experiences, particularly for the specialists, minimal awareness, maybe more in primary care.

And then along those lines, we're seeing more mandatory models coming out, again, just to keep an eye on. So the team model started. CJR-X will start for every hip and knee, the ambulatory specialty model. So these are going to be global -- sort of what they are and will be global payments. And again, what is the beneficiary awareness around this?

And I think it ties into the work that we talked about, I think, at the last meeting around global payments and how many visits are happening, et cetera, et cetera. So, again, I think it's potentially future work, particularly as more of these mandatory models are enacted.

So thanks again, great work.

MS. KELLEY: I believe that's all we have for Round 2.

DR. NAVATHE: Great. Well, fantastic discussion, and thank you to the staff for what you prepared, which was terrific.

I will say doing the focus groups is really important because, as many of you said, it gives us an

opportunity to hear directly from the beneficiaries, and I think the quotes that you all brought into the presentation and that are in the broader report that will be released publicly later, I think are just really, really valuable. And I think it does allow us to widen the aperture of how we're kind of understanding and thinking about things.

At the same time, I think widen the aperture, you all did in the conversation, of course. And that's great. That's great. That's part of the intent.

I will say the goal here is not to do any policy development off of what we've heard, because of the points that Ledia and others have made about this not being generalizable.

And I think we heard a lot of support for continuing the periodic inclusion of the pharmacist focus group. So that was really helpful.

I think a number of dimensions that you all wanted to explore a little bit further, whether that was duals, aspects of MA -- we heard a little bit about AI, several aspects of access and how that either going deeper or intersecting with other things.

And one thing I wanted to just point out is that

NORC as the contractor here is sampling based off of characteristics and panels that they have, and so there's a little bit of constraints in terms of our ability just from a resources perspective to be able to construct unique sets of people based off of their historical insurance coverage, which they may not know upfront. And so it might be hard to do some of those pieces.

I'll also just want to be transparent with you all that from a resource perspective, there's only so much that we can do.

So that being said, I think a lot of common themes, and we really appreciate the feedback, and we'll try to continue to improve the value of this work, because I think it is unique.

And then the last point I'll make is -- so we, every so often, kind of periodically, every couple, three years in terms of cycles, do this kind of expressed "let's report on the focus groups" kind of session. But this work is making its way into our other work all the time, and so I just want to reassure you that these elements are being brought into other chapters, other sessions. It's not like we do this once every two or three years and that's the

only time that you're seeing this. You're just seeing it kind of brought into the rest of the work that we're doing, because I know that was stuff that folks had mentioned as well.

So thank you so much. We'll conclude this session, and for the sake of time, since I know people have travel plans, we're just going to go ahead and move directly in to our last session of the morning, which is going to be on the Medicare eligibility notification and the State Health Insurance Assistance Program operations and funding.

[Pause.]

DR. NAVATHE: Are you ready to go? Great. Let's go ahead and get started.

MS. DRUCKMAN: Good morning. I'm here to talk to you today about Medicare eligibility notification and SHIP operations and funding.

Before I start, I'd like to remind the online audience that they can download these slides by clicking on the document icon in the upper right-hand corner of the screen. I'd like to thank Eric Rollins and Krista Cherry for their help with this presentation.

Today's presentation continues the work that the Commission began last year on the complex enrollment decisions that beneficiaries make. Once an individual becomes eligible for Medicare and during certain times of the year or after certain specified situations occur, beneficiaries must make several complex enrollment decisions. It can be difficult for people to understand the requirements and relevant time frames that apply to them. So access to clear and accurate information is especially important. Some choices may lead to lifelong implications like late enrollment penalties or an inability to obtain a Medigap policy without medical underwriting.

Continuing this work, we know that people are working longer and delaying Social Security, so they are not automatically enrolled in Medicare or notified via mail of the need to enroll. The SHIP is a source of free and objective counseling to help people navigate the complexity, but funding has not kept pace with inflation and growth in Medicare enrollment, leading to capacity challenges. This work led to a chapter in our June 2026 report.

Commissioners expressed interest in doing further

work on these issues during this meeting cycle. In October, we reported on the frequency and amounts of late enrollment penalties, and we discussed potential policy directions. Today, we are continuing that work by focusing on Medicare eligibility notification and SHIP operations and funding.

Our first topic is about the notification of Medicare eligibility. Many individuals are not notified by postal mail about Medicare eligibility. As shown on this table, the process for notification and Medicare auto-enrollment depends on whether a person has Social Security retirement benefits at age 64 and 8 months. At that time, the Social Security Administration sends information to CMS so those people may be notified by the mail when they reach age 64 and 9 months. These people will be automatically enrolled in Medicare when they turn 65.

Some people will receive or apply for Social Security during the three-month period before they reach age 65. These people will not receive a prior notification through the mail but will be automatically enrolled at age 65.

Other people who do not belong to these two

groups will not receive a postal mail notification about the need to enroll in Medicare and will not be automatically enrolled. These people need to take steps to enroll in order to avoid late enrollment penalties.

In addition, the full retirement age no longer aligns with the Medicare eligibility age, leading to a notification gap. The Medicare eligibility age is 65. For those born in 1960 or later, the full retirement age for Social Security is 67 years, although individuals can retire early and collect reduced benefits at age 62.

When these ages were aligned historically, most people were notified and auto enrolled in Medicare, but people are working longer and delaying Social Security and may not be notified or auto enrolled. We lack granular data to precisely identify the number of people subject to the notification gap.

Using survey data in 2023, we estimate up to 62 percent of people age 64, about 2.6 million, were not receiving Social Security benefits and would not have been notified through the mail or auto enrolled. Some people may be subject to late enrollment penalties, as 1.4 percent of Part B enrollees and 5.3 percent of Part D enrollees are

paying penalties.

SSA and CMS have collaborated on an outreach campaign to send e-mails to individuals approaching age 65 who are not receiving Social Security in order to help close the notification gap. An e-mail is sent to everyone who has registered an e-mail address with the SSA at age 64 and 9 months, reminding them to enroll and warning about a possible Part B late enrollment penalty. The template e-mail can be found in your meeting materials.

This initial e-mail doesn't reference the possibility of a Part D late enrollment penalty. However, 56 days after this template e-mail is sent, another e-mail is sent which contains more information about the parts of Medicare, including Part D. SSA reports that the campaign exceeds the e-mail marketing benchmarks and industry statistics.

However, a sizable notification gap remains for people who are turning age 65 but are not receiving Social Security benefits. Multimodal notifications through postal mail and e-mail are likely to reach more individuals due to a variety of factors.

Some people age 65 or older may pay more

attention to official notifications sent through the mail than those sent via e-mail. E-mail may not be opened or clicked on for many reasons, such as a lack of understanding of the subject line or e-mail text, failure to appreciate the e-mail's urgency, or suspicion that the e-mail is not an official government communication. We estimate, again, that up to 2.6 million individuals are not notified through the mail.

Excluding individuals potentially receiving an e-mail from the SSA, we estimate about 2 million individuals may not receive any notification through postal mail or Social Security Administration e-mail.

The Commission could consider changes to the notification process. The Commission could consider closing the notification gap by requiring SSA or CMS to notify individuals by mail. This would be to individuals who are age 64 years and 9 months and who are not receiving Social Security and thus will not be automatically enrolled.

The Commission could consider whether additional funding should be appropriated for the mailing by SSA and CMS, which is estimated at about $1.10 per mailing, and

also administrative funding for CMS and SSA activities to prepare and mail the letters may be needed.

Our second topic today is about SHIP operations and funding. The SHIP is an important source of free and objective counseling but has faced capacity challenges as funding has not kept up with inflation and Medicare enrollment.

As we have discussed, it can be difficult for people to understand the Medicare enrollment requirements and the relevant time frames that apply to them, and some choices have lifelong implications; for example, late enrollment penalties.

SHIP is a federal program providing grants to deliver free Medicare enrollment counseling and information assistance to 54 grantees. It assists beneficiaries through individual counseling and community outreach. Just over 10,000 counselors provided individual counseling to nearly 1.2 million beneficiaries in the second half of 2025. SHIP counselors do not receive compensation from insurers.

Before assisting beneficiaries, all SHIP counselors must complete training and certification

requirements. Each grantee chooses their respective training, but most draw from the training modules created by the SHIP Technical Assistance Center. To promote consistency in counselor certification, the Administration for Community Living is developing a new National SHIP Counselor Certification Program.

As discussed earlier today, beneficiary focus groups were conducted this year in Seattle, Washington; Tampa, Florida; and Iselin, New Jersey, and there was a virtual focus group for beneficiaries living in rural areas. Awareness of the SHIP varied. Most beneficiaries in Seattle have used the SHIP or had general awareness of the SHIP, but fewer than 10 beneficiaries in the focus groups were familiar with the SHIP. Two beneficiaries with Medicare Advantage, one dually eligible, thought that SHIP was only for people with Medicaid. Two individuals commented on the help they received from their SHIP.

A dually eligible beneficiary who was enrolled in MA said, "Before I was ready for Medicare, I was helping my sister who had dementia, and at that point, I met with the local SHIP and got all the information for her. So when it became my turn, I just went with the same people."

Another beneficiary enrolled in MA said, "It made the 'Medicare & You' handbook obsolete because they went over everything we needed to know."

As part of our work examining the complexity of enrollment choices in Medicare, earlier this year we conducted interviews with ACL staff that direct SHIP grantees, staff at the SHIP Technical Assistance Center, and counselors and staff from seven different grantees. Interviews were a semi-structured discussion of the experiences of SHIP grantees working with beneficiaries as they make Medicare enrollment decisions.

Grantees said their local knowledge of provider and pharmacy networks helps them assist beneficiaries with a wide range of Medicare needs. Grantees also reported receiving referrals directly from 1-800-MEDICARE, particularly on state-specific questions related to Medicaid eligibility. Interviewees highlighted their ability to meet in person with beneficiaries, allowing for more in-depth conversations and help completing paperwork.

SHIP grantees expressed their ongoing limited capacity. In the interviews, we constantly heard of year-after-year capacity challenges, with one interviewee

describing their counselors as overburdened. One interviewee described the 2025 annual enrollment period, which ran from October 15th to December 7th, as a perfect storm, with an increased number of MA plan terminations and provider network exits in some regions, increased referrals from insurance agents, and the impacts of expanded SHIP outreach and marketing efforts. This enrollment period was for choosing a plan for 2026.

During the AEP, the SHIP grantees often reach limits on the number of counseling appointments they can take from beneficiaries because they're already fully booked. When this occurs, beneficiaries are referred to 1-800-MEDICARE.

During the 2025 annual enrollment period, one SHIP grantee we spoke with reported that they had to stop taking counseling appointments as early as three weeks into the AEP.

SHIP receives federal funding from the Medicare Trust Funds through two sources, discretionary funding provided through annual appropriations and mandatory funding periodically extended by Congress. Discretionary funding is for SHIP operations available to all Medicare

beneficiaries, and it was $55.2 million in 2026. Mandatory funding is for individual counseling and outreach services focused on people with low incomes and living in rural areas, about $15 million in 2026.

Adjusted for inflation, total SHIP funding per beneficiary has declined over time. This figure shows the change over time of appropriated discretionary and extended mandatory SHIP funding per Medicare beneficiary adjusted for inflation. Note that in three years, the funding was for multiple years.

Looking at the single-year appropriations and extensions only, the highest was for $1.82 in 2009, and the lowest was $1.20 in 2026, a decrease of 34 percent.

The Commission could consider MA plan fees as an additional SHIP funding source. SHIP funding sources have varied over the life of the program. In 1997, Congress established user fees for MA plans for the purpose of Medicare enrollment and dissemination of information, as well as the operations of the SHIP, and they later added PDPs.

For a while, these fees supported SHIP, but in 2005, CMS stopped using the fees to fund SHIP and instead

used them to fund education about the new Part D benefits. Congress then resumed annual trust fund appropriations for SHIP. Now known as the National Medicare Education Campaign user fees, these fees fund 1-800-MEDICARE, Medicare.gov, and outreach, among other activities.

In 2026, these fees were assessed at $0.021 percent of MA, MA-PD, and PDP expenditures for a total of $120.3 million.

After examining SHIP funding, we looked at available SHIP performance data to see if certain factors were associated with lower SHIP performance. SHIP grantees are scored on five performance score metrics relative to their peers.

We reviewed five-year performance on one measure to see if the size of the Medicare population or the funding per beneficiary were associated with SHIP performance. We focused on performance measure one, which is client contacts by the percentage of total one-on-one client contacts in person, by email, postal mail, or faxed per Medicare beneficiaries in the state. We used this measure because it counts the number of client contacts as a percentage of Medicare beneficiaries in the state or

territory, which is a key SHIP function.

We found that higher average discretionary funding per beneficiary is associated with better performance. This slide provides a Medicare population quartile grantee comparison using the available performance data. The middle two grantee quartiles had similar average scores on Performance Measure 1 from 2017 to 2021, while the largest quartile had a lower average score and the lowest SHIP funding per beneficiary.

We found that a smaller average funding amount per beneficiary is associated with a lower score on PM1. Of course, this is only one factor of many that may affect a SHIP grantee's performance, including counseling capacity, network structure, staffing, volunteer deployment, state or territory resources and funding, and how they manage their program.

The Commission could consider potential changes to SHIP funding. SHIP, as a source of free and objective information from counselors not compensated by insurers, is an important resource for beneficiaries. But SHIP funding has not kept pace with inflation or the growth in Medicare enrollment, leading to capacity constraints, and additional

SHIP funding could increase grantee capacity. In 2008, MedPAC had recommended increasing funding.

Illustrative examples of additional SHIP funding methods could include options that could be pursued individually or together, including indexing funding to the growth in Medicare enrollment or Medicare spending or another measure, or establishing a dedicated stable funding source, such as with MA plan fees.

I will now summarize some potential policy directions for you, and then we will open it up for your discussion.

In summary, we have a few potential policy directions aimed at reducing enrollment complexity. To close the notification gap, policymakers could consider requiring SSA or CMS to notify individuals by mail when they reach age 64 and 9 months if they are not receiving Social Security benefits. This is estimated to be about 2.6 million people. The Commission could ask Congress to appropriate the necessary funding for the mailing, estimated at about $2.86 million, as well as administrative funding.

To increase capacity for SHIP grantees by

increasing funding, policy directions could be these illustrative examples or others: index the SHIP funding to the growth in Medicare enrollment or Medicare spending or another measure; establish a dedicated stable SHIP funding source, such as with MA plan fees; or other options that the Commission has in mind. These options could be pursued individually or together.

This brings us to the discussion. First, I will be happy to answer any questions about the material in this presentation.

Second, we would like to know whether you are interested in developing these or other policy options, and if you are interested, which of the options that we listed on the previous slide do you think we should focus on?

Third, is there any additional information that is needed to evaluate these specific policy options?

That brings us to the end of the presentation, and I will now turn it back to Amol.

DR. NAVATHE: Thank you, Jennifer, for a fantastic presentation.

So, Commissioners, as you know, we are keenly interested in your feedback around these options and what

additional information we may potentially need and/or the directions you would like to support going forward.

Dana?

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

MR. KAN: Yes.

Jennifer, thanks for the fantastic chapter. I have two Round 1 comments and questions.

First comment, yes to the letter, a $1.10 stamp versus a penalty for life, that is the easiest call we will make this year. It is cheap, targeted, and it fixes the gap created when the retirement age moved.

Number two, regarding SHIP funding, Ohio gets $0.66 per beneficiary, 9 percent below the national average spend of $0.72, and still scores excellent. What is Ohio doing differently? Does it get additional state funding or in-kind staff, run more volunteers, or manage the program more differently? Does it use better technology? Suggest that any future work on this really explore this.

MS. DRUCKMAN: With regard to Ohio, we understand they are very integrated with their state. and they have a lot of state support, but that is something we would like

to look more into.

MS. KELLEY: Gokhan?

DR. METAN: Great work, Jennifer. Again, there are multiple things I learned from this chapter.

I have one question. In the chapter, it is very obvious that the SHIP programs are under capacity, and there is a massive demand for a short-term fix. Again, if the awareness of SHIP programs increases, obviously there will be more demand and such, but given the current awareness levels, what funding level would end the AEP capacity problem for SHIP? Is there any possibility that we can make some analysis to extrapolate how much additional funding would at least be enough for the SHIP programs to meet that demand?

MS. DRUCKMAN: I think that is a great question, we don't have very up-to-date data. We are working on data from 2025 with just a few statistics and some old congressional reports to Congress. If we could get some more updated data, we may be able to take a closer look at that.

DR. METAN: Thank you.

DR. NAVATHE: Yeah. And I will just add, I think

that we can definitely do some kind of, I would say, estimates or kind of back-of-the-envelope math, but that is a little tricky to know, because if people aren't accessing it because it is hard to get access to, then if you open up the access, there might be more people who are able to access. So that gets a little bit tricky for us to do, but I think we can try to get more information on that.

DR. METAN: Sure. I totally understand that, but even a band would orient our minds in terms of the shortage of funds.

DR. NAVATHE: Yep, totally understood. A kind of order of magnitude estimate becomes --

DR. METAN: Exactly. Thank you.

MS. KELLEY: Tamara.

DR. KONETZKA: Thanks, Jennifer, for this great work.

To me, the most striking part of the report or part of the chapter was the fact that we, as a country writ large, spend $8.2 million for SHIP versus $9.5 billion on brokers and agents. Given that, it was just, I think, incredibly striking.

For the past year and a half or so since we

started down this line of discussion, I have been expressing enthusiasm for some kind of MA insurer fee to sort of shift some of that at least into more unbiased advice.

My question for you is -- and I was really pleased to see that there actually is a mechanism for that, which I didn't know, right? It's just not used for it anymore. Were there discussions, or why aren't there fees for Medigap policies and Part D insurers? Why is it all just the MA plans?

MS. DRUCKMAN: It is actually for Part D insurers as well as MA plans. The statute calls for information dissemination, education about Medicare and SHIP.

The problem is there is a statutory cap for how much money can be assessed to the plans, and that has not been updated in many years. So the amount of money that the plans are able to be assessed is not even sufficient to cover things that CMS is paying for, such as 1-800-MEDICARE and the website development and those kind of things.

DR. KONETZKA: Yes. When I was reading the chapter, I was wondering why Medigap was excluded because that is also something consumers have a lot of questions

about and go to brokers for.

MS. DRUCKMAN: That's a great question.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks, Jennifer. This is a great chapter.

I just want to plus-one on what Kenny raised, which is I find myself puzzling with those states that had higher scores. What else is going on besides the amount of spending? I'm guessing you don't have the answer today.

The other thing related to that table -- and I just want to make sure I'm understanding this -- is the column that says discretionary funding per bene. That varies widely across states. Help me understand the allocation process, because I was trying to figure out why it isn't tied to each beneficiary so that states that have more beneficiaries get more money. Help me understand that space.

MS. DRUCKMAN: So it is. The number of beneficiaries is tied to the formula. It's just when the entire formulas work out, it ultimately isn't sufficient to give them the same amount as other states with smaller numbers of beneficiaries.

DR. DAMBERG: That -- pardon me?

MS. UPCHURCH: It's just one of the measures, the number of Medicare beneficiaries. There are other measures for the allocation. So it's just one of them.

DR. DAMBERG: Yeah. So I think somehow or other that process needs to be revisited to ensure equal allocation across benes, perhaps with some adjustment for higher-needs patients, whether they live in rural areas or LIS duals, but there's something funky with that distribution.

MS. KELLEY: Lynn.

MS. BARR: Thank you for taking this on.

My first question, of course, is what century are we in? It just seems so crazy to me that we're like, okay, we need stamps and counselors, and I'm like, well, don't we have data? I mean, where's our app? We're an insurer, right?

So the money that goes to the brokers, right, versus the money that goes to SHIP, where does the money that goes to the brokers come from?

MS. DRUCKMAN: So the MA plans are paying that.

MS. BARR: And so that goes into as part of their

15 percent, or it's their profits is above and beyond that? So, if that money didn't go to them, then they would be restricted on less profit? Is that correct?

MS. DRUCKMAN: Right. It's part of their administrative funding.

MS. BARR: Okay. So it's really coming from the beneficiaries then, right? So it's not really coming from the MA plans, because we have that 15 percent cap that they generally seem to do pretty well on, 25 being that example, of course.

Is there any kind of clarification on why all of that money goes to those beneficiaries, and there's no kind of comparable money going to fee-for-service beneficiaries? Can you help me understand that?

MS. DRUCKMAN: So I think that was the original intent of the user fees, where the SHIP was included in those user fees, but those user fees are capped by the statute as how much could be sent.

MS. BARR: Yes. I'm sorry. And --

MS. DRUCKMAN: And then the SHIP program has moved out of CMS to the Administration for Community Living. So CMS is using the amount that's available under

that statute from 1997 to pay for some of the other program parts, such as 1-800-MEDICARE.

MS. BARR: Was it more even in 1997? I mean, is this something that has just kind of gotten out of control and nobody noticed sort of thing? Because, I mean, the gap between the funding seems very large.

MS. DRUCKMAN: That's a great question. It wasn't yet MA. It was still Medicare Plus Choice back in 1997, and we haven't had a chance to see if there's any data about agent brokers back then, but that's something we could look into.

MS. BARR: That'd be great. That'd be great. It sounds like this is one of those things that just sort of snowballed into, you know, a bad policy, but it wasn't really intended. But then things change, and we can't possibly put our fingers in all the dikes.

Thank you. I look forward to Round 2.

MR. MASI: And, Dana? Oh, no, I'm sorry. I just wanted to follow up on a question that Tamara asked a moment ago about why Medigap is not included in this, and I just wanted to flag that I don't think the federal government has a direct financial relationship with Medigap

plans right now. That's not to say Commissioners can't contemplate such a thing, but that distinction could help us understand why they weren't included in the original user fee.

MS. KELLEY: Robert.

DR. CHERRY: Yes. Thank you for the great report. I have two questions, and the first one, I'm sorry if you've already answered this, but I was trying to figure out on my own if I could figure out the answer to this.

You know, the 2.6 million people that are not receiving Social Security, I imagine they are outside of some sort of statutory or regulatory box. And therefore, could just an email be sent, or are there still legal restrictions that says that they have to have a mail notification?

MS. DRUCKMAN: So I don't think there's any statutory requirements that say there has to be a mail notification. The Social Security Administration and CMS have decided to send an email to everybody whose email address that the Social Security Administration has, which is not the full universe of folks.

DR. CHERRY: Yeah, and I would think that

something's better than nothing. So if cost is an issue, even among the 2.6 million, if they have 2 million people with email addresses, just at least notify those folks if there are financial constraints.

The other question I have, among the options, it's nice to understand what is under HHS's control and what requires congressional actions. So for example, indexing the SHIP funding to Medicare enrollment, does that require, let's say, congressional action, but taking the money from MA plan fees is an HHS action? Because I think it's good to kind of differentiate that as we start to consider what might be the most feasible way of doing this, because one is regulatory and one is a legal action that has to be taken.

MS. DRUCKMAN: So starting with the user fees, all of those funds are used to the maximum allowed under the statute right now for CMS operations. So if more user fees were desired there would need to be examination of changing the statute, sort of raise the cap and make sure the money goes to the SHIP, as well.

And for the discretionary money that's going to the SHIP right now, Congress just allocates an amount to

each year. So really, if you wanted to increase that or change how that allocation is calculated, that would also be action for Congress.

DR. CHERRY: Thank you. I appreciate.

MS. KELLEY: Okay. That is all I have for Round 1. Should we go to Round 2? Okay. I have Kenny first.

MR. KAN: Overall, I support more SHIP funding and have five observations.

Number one, more initial SHIP funding. SHIP fills a real need, and I believe we should recommend more initial SHIP funding. There could be an initial step-up in SHIP funding, given the 28 percent inflation-adjusted decline or enrollment has grown 55 percent.

Number two, technology and people. Just at the initial step-up funding, the use for both technology and people. Many SHIP counselors are overburdened, as they do lots of paperwork. Most of this paperwork can be reduced with better technology and tools. On technology, can we explore or recommend a federal technology platform, Stars system organization, America.gov, GenAI Solutions, Blue Button, solutions that work. And let's also strive to fix the formula inequities. On formula inequities, suggest

that we explore additional weight for rural and low-income beneficiaries.

Number three, after an initial step-up of technology and people, perhaps SHIP funding may be indexed to enrollment growth with a cap and review every few years.

Number four, accountability. As part of this review it would be helpful to tie funding to accountability. Let's look at outcome measures that matter. For example, why is Ohio doing well? Technology investment? Let's look at penalties that are avoided. Extra help and Medicare Savings Program enrollment and beneficiary satisfaction.

And finally, user fees. I'm skeptical of MA and Part D user fees. This is a tax that is passed on to the enrollees while traditional fee-for-service and Medigap users get the same service free. As an alternative, as SHIP serves all Medicare beneficiaries, let's spread the overall cost across all of Medicare, including fee-for-service and Medigap, with pragmatic regulatory or legislative changes if we explore the user fee issue. Thank you.

MS. KELLEY: Gokhan.

DR. METAN: Thank you again. I have five comments to make. The first one is about, again, the notification gap problem. I think we all agree, as Kenny kind of started with his first comment, this is very cheap to close kind of a problem, $1.1 per person for about 2 million beneficiaries. I mean, that's peanuts in the grand scheme of things. So I think Congress should require SSA or CMS to send notification through the mailing to these individuals.

I would like to call out one blind spot in those messages. One of the things that I picked up in the document is that there were some statements in there, current emails, that you must enroll kind of statements. So I think the messaging is important here, because generating a "you must enroll" letter could push some of the enrollees who have employer plans to actually enroll to Part B to avoid penalties, but then trigger some of the Part A enrollment, and then there are HSA tax penalties. So I think the messaging needs to be really refined and careful when these are sent, to watch for those blind spots.

My second comment is, again, SHIP is being asked

to do more with less and less. There is no doubt about that. It almost feels like a plane flying on fumes. So I think there needs to be more funding, and especially in the grand scheme of things where plans are spending billions of dollars every year for agent and broker compensation, and SHIP being funded like, you know, 100 to 200 times less than that number is insane to me. So I think we need to kind of like level the playing field and also bring unbiased help to the enrollees.

My third comment is around funding. Again, it was a surprise to me to learn about the NMEC user fees and the initial purpose of it. So I believe that restoring it will give SHIP adequate funding. And also I support rebates and user fees.

In terms of the SHIP funding recommendation I believe three combinations could serve the best. The first one is a per-beneficiary funding floor for every grantee, with some add-ons for rural and low-income populations. And second, indexing to Medicare enrollment base. And then third, a dedicated source by restoring SHIP's share of the NMEC user fee and indexing the cap.

In addition to that I recommend strongly to tie

funding to accountability. What I mean by that is we need to pair any increase with a request that ACO publish current performance data and update its measures, such as wait times, capacity reached during enrollment period, so future funding can be judged on these results.

My number four comment is a little bit opportunistic. I think we can use plan terminations as an outreach moment for SHIP. Given the scarce resources that SHIP cannot really spend on marketing, and are the first to be cut based on the paper, I think we can consider requiring MA plans for non-renewal and network change notices to including local SHIP contact information. And that reaches people when they most need the objective help, in my opinion, which is the problem covered there.

Last but not least, my fifth comment is around technology. I think when I read the chapter it was one of the very pleasing moments to learn about the efforts from three SHIP grantees on their individual efforts to develop artificial intelligence powered chatbots used by the states to assist counselors and beneficiary with Medicare-related questions, particularly when counselors are unavailable.

I think we should encourage and support these

efforts in bringing technological efficiencies into the process so that we don't simply just stop at throwing more dollars and bodies on the problem but take advantage of the emerging AI wave.

In terms of that I'm supportive of any efforts to provide dedicated funding to increase the technology available to grantees, particularly some grantees are individually working to develop to improve tools using AI already. However, at the federal level would be a more efficient approach in bringing such AI solutions to grantees at scale. Thank you very much.

MS. KELLEY: Brian.

DR. MILLER: Okay. We're going to have fun. I'm a big consumer protection nerd, having worked at the FTC. So first thing, bene notification. I'm going to have some comments, which could be a little critical of all of us, but just still supportive of this recommendation.

I think there is plenty of money in the system at CMS and the Social Security Administration to notify benes. Agencies have little piles of money hidden in various places that they use for stuff. They can probably find one or two million dollars.

I'd also wonder if, as a congressional advisory body focused on big picture policy issues, and even some micro-policy issues, micromanaging administrative tasks at agencies such as mailing notifications might not be the best use of our time, especially in the context that in other conversations we've critiqued MA plans for sending people paper forms and notifications, and we're saying, "Hey, we should require that the government send someone a paper form." That being said, not going to fight about this. Still supportive of the recommendation. So that's bene notification.

Bene awareness. I agree that there are definitely some people who are missed. I'm not sure that 2 million people are unaware, given that employers and even college students are telling me about enrolling, and even people unemployed are telling me about enrolling in Medicare, and they can't wait to enroll in Medicare because they want to retire and they want to stop working. And the joke is, you know, as a millennial we're just waiting for retirement.

So I agree that there's a notification gap. I'm not sure 2 million is the right number. I also realize

it's super hard for us to figure out what that number is, so I would just put some qualification in there. And I appreciate you trying to figure that out, because it's really hard.

Okay, SHIP. Great program. Huge fan of growing it. I do want to correct, I think, a cognitive misunderstanding that we have, which is we're saying SHIP is not biased and that we're worried that brokers, which are compensated by insurers, are biased. I agree broker compensated by insurers are biased. I would also point out that SHIP counselors are paid by the government, which also runs an insurance program, so there is bias there too. So they're both biased. They're just biased in different ways, and that's okay. And SHIP counselors and SHIP programs are not working for free. Everybody has an incentive. So both are biased, but both are good, and SHIP obviously has not been supported as much as it needs to be.

From our survey work we show that benes use a bunch of resources -- brokers, family friends, Medicare.gov, employers, because you all have those pre-retirement counseling sessions which are super important.

And then Congress has made some choices, which

maybe it sounds like we disagree with. Because a lot of SHIP funding there's a dedicated source, but then there's also discretionary funding, and appropriators, year after year, have not found value in increasing that SHIP funding, and that could be due to other competing priorities. But that is probably a signal that we should think about.

States could also fund their own version of SHIP as a supercharger, and they're not doing so, which is also an active or a passive choice.

I do not support raiding infrastructure funding from things like Medicare.gov, Plan Finder, 1-800-Medicare to support SHIP. Systems infrastructure is super important, and we shouldn't defund that to fund other things.

I also don't really think user fees are actually a great idea here. We have user fees at regulatory centers at the FDA, and I can tell you those FDA centers have grown. CDER, over the past 20 years, has grown from 2,500 people to nearly 5,500, if not 6,000, and there definitely hasn't been a proportionate increase in FDA regulatory performance. So user fees are good but cautious, so I wanted to grow that.

But I also really do like SHIP programs and think SHIP is super important, and I think that one-on-one counseling is important.

So your question is, what does grumpy Brian here support after all these grumpy comments? And the answer is that I think we need to elevate the role of the SHIP counselor, and building off of what Gokhan said and Kenny said, I think we need tech tools that will make the SHIP counselors more efficient, and then also capture a wide range of folks before they get to the SHIP counselor and give them additional advice. So we're in an AI wave.

For benes who don't have a cognitive impairment or dementia, et cetera, can we have an AI chatbot do some initial simple counseling, about like what is Medigap? What does collecting fee-for-service Medigap and Part D look like for you, versus, say, your group MA plan, your retiree, Medigap plan, and your group MA plan is probably a retiree plan, or, say, a conventional MA plan. If you're a dual eligible, right, those folks probably should be pushed directly to a one-on-one, in-person SHIP counselor.

So I would say we do need to support SHIP, but I would say that we should support SHIP by directing CMS, and

maybe suggesting funding for CMS, to build broad-based technology tools so we can better filter the benes to get to the SHIP counselor so that the SHIP counselors are doing the most complex counseling, which is needed -- the duals, the QMBs, the SLMBs -- all of the complex people with multiple benefits packages, multiple disabilities, multiple life circumstances, and that the sort of meat-and-potatoes stuff can be taken care of technology.

So I would take care of the technology first, unburden the SHIP counselors to let them then do the complex stuff, and then think about expanding the one-on-one sort of insurance counseling sales model.

MS. KELLEY: Lynn.

MS. BARR: Well, I violently agree with Brian, Gokhan, and Ken that we have really got to look at technology. I mean, every insurance company has an app, except for Medicare. So as I look back at what we have done from a legislative point of view over the last 30 years to put data in the hands of consumers, and yet we don't actually give them an app to have the data in. I think the fact that our SHIP counselors are averaging about 3.0 on a scale of 1 to 5 isn't because they're bad people.

I just don't think they have any information, and it's an impossible job.

So it is about simple technology. We are an insurance company, Kenny. Thank you so much for saying that yesterday. And we have a responsibility to our beneficiaries to support them, to take control over their own decisions. We have SHIP counselors to help people with Alzheimer's and dementia, but most of us should be able to figure this out, if we have data to be able to make the decisions.

We all have access, as Medicare beneficiaries, to our claims data, whether it's Medicare Advantage or whether it's fee-for-service. We also, as Americans, have been granted a right to have our claims data and our health care data, and we should have an app that we could import it into for Medicare, that puts all of this information together.

Medicare already has the information that people are struggling to find, to figure out what providers do I have, what drugs am I taking. We need to build on that claims data so that we can provide a QR code to our providers wherever we go, that has all of our history on

it, all of the drugs we're taking. And our med list in this app. We need alerts that say, "You haven't refilled your drug. What's happening here?" "You are due for your mammogram." "You are due for your colonoscopy."

If you go onto that Blue Button today, which I encourage Medicare beneficiaries to do -- by the way, it's no longer Blue Button. You have to find it under your account. There's a little link to your claims data. So you go into your account on Medicare.gov, and there's a link to your claims data. I'm very healthy. Two years on Medicare, 56 pages, okay. We need to clean that up.

All the drugs are listed as numbers only, so you can't actually tell. There's no like, every pharmacy has a number. Put it in English for people so they understand what's really happening.

And then the preventive schedule that's in the Blue Button, the Medicare claims that we're providing for beneficiaries says that I've never had any preventive care. My doctor would die. He beats me up about this.

So we have the information. Let's make it accurate. We need an app for our beneficiaries. And another function of that app would have our diagnosis

history, our preventive care and reminders that we need preventive care, and pre-populate it with the plan choices, so that we use all of our own data to say, okay, here's my providers. Which plans give me access to my providers? Here are my drugs. Which plans have that on their formulary? And what are my expected costs, my out-of-pocket costs? What happens if it goes out of control?

We have all this information, and the fact that we're not giving it to our patients -- I mean, the cost of creating an app versus another $100 million for SHIP counselors, that don't really know what to do, seems ridiculous to me. An app is like $1 million, right. And then everyone would have the information they need.

So we need to put control of their health care in the hands of the beneficiaries, and start creating a market where people can make good decisions. Thank you.

MS. KELLEY: Gina.

MS. UPCHURCH: Advance warning. I will run long.

First, congratulations to Jennifer and team for a terrific chapter, and I'm so thankful for this important stream of work.

Disclosure, again, I'm Executive Director of

Senior PharmAssist, and one of the four services we offer in Durham, North Carolina, is we are the SHIP coordinating site. Here are the cheat sheets for Durham County alone, and they change every year, details change every year. I'm happy to circulate them around.

Details that I want to share. When we mention Medicare eligibility I want us to always also include ALS. We sometimes ignore that. I want us to add a workstream, and this was talked about earlier, I think Gokhan mentioned, to look at the Medicare experience for those with ALS, end-stage renal disease, and permanent disabilities. They are 12 to 13 percent of the Medicare population.

I work primarily with older adults, Medicare counseling for anybody, but I think we really need to take a look at younger people with disabilities. They can deal with the app. I don't think a lot of the 85-year-olds with dementia can deal with this app you're talking about, but we need both, right. Both kinds of people.

Okay. Choice and navigation. Cheryl's comments yesterday, I would rather simplify the need for choice architecture versus creating more support to navigate the

choices each and every year. Practically, at this time, we need both, but hopefully we can tilt towards creating a framework that doesn't challenge Medicare beneficiaries and those trying to help them every year.

SHIP, just so you know, you saw reports and you saw grades for the state, because the states report to the Administration for Community Living through the Stars program. Don't get me started on why it's called Stars. There's another program called Stars. Two different Stars programs. The state reports to ACL, but we put the contacts at the local SHIP level. I have no incentive to add a bunch of contacts to that piece of paper. I don't get paid more for that.

So you asked the question, why does Idaho or Ohio or whoever do well? They're coding well. They're coding well. Let's incentive to code, and the difference is likely tied to that coding, not actually getting the work done. Hopefully they're related.

Next. SHIP volunteers have no incentive, none, to steer people to certain directions. I don't care if you get a Medigap, Medicare Advantage, Part D from Humana, Blue Cross, it doesn't matter to me. It's irrelevant to why I'm

helping you. I just want to make sure you're in something you want, you can afford, you understand, with the least hassles when I'm helping you sign up.

Payment to SHIP. It's clear consumer education is not a priority. Less than 1 percent of commissions to insurers and brokers. It's a joke.

Medicare counseling is primarily seasonal work. This is important to understand. During the open enrollment, our annual election period, Senior PharmAssist sees over 200 people in a week. Yes, we help people new to Medicare. Yes, we help people that are now retiring. But we have mostly seasonal work, so seven weeks. It's hard to keep volunteers on their toes during that time.

Plus every year there are significant changes annually, and we really need to know them before October 15th, not only the plan detail changes but basic benefit design changes, including the benefit design changing with Part D. All of the variables with Medicare choices change every year. Dental, vision, hearing, they change how they work every single year. And networks can change, between years, and sometimes during the year, which is a nightmare.

Plus Social Security doesn't tell us the A and B

cost sharing and B premiums until midway through the election period. We know all the Part D cost sharing by October 15th, really the end of September. We don't know A and B cost sharing. So we're talking to people about their payments in January, and we don't even know what they're going to be when we're counseling them. That should be known. Social Security should let us know that before we start October 15th.

The CMS Plan Finder is helping some. It's getting better. But even the platform that we use, the Plan Finder, changes every year, and many of the SHIP counselors we use are older adults themselves. Dealing with technology can be hard.

SHIP work means that local ability -- we have to have a local ability to triage. We have some people that know the state health plans, some people that know Duke retiree plans, the IBM plans, some people know special needs plans. You have to have a team of people who can focus in. Very few people can understand all of this.

One request I have of our writing -- so it's matchmaking when we're helping people with SHIP -- is that we strike the word "free." I agree with Brian. We heavily

subsidize. Some states and local governments subsidize SHIP funding.

As an example, Senior PharmAssist gets about $65,000 through four to five grants, with lots of reporting, required trainings, that doesn't include the onerous Stars data entry that we report to ACL, and I'll mention that in a minute. It's tithing. It's 10 percent of what we need to get the work done. So we have to raise money locally to get the work done.

One SHIP job, that we never mention here, and we probably should, is the Senior Medicare Patrol. We are responsible to also educate people about preventive services and fraud and abuse. This is a big deal, and we should be doing a better job of it, but it's becoming a tremendous problem. This job is difficult and becoming more difficult. Simple messages, until a few years ago, we used to say CMS and Social Security will never reach out to you, via a text, a call, email, unless you reach out to them first. Now we can't say that anymore. We are really upset and worried about the uptick in frauds and scams. So I'm wondering if anybody is monitoring this.

It can be devastating to individuals, not only

financially ruining their lives but really making any decent quality of life out of reach for some people who lose all of their savings.

Messaging about Medicare enrollment, critical and complicated. Gokhan hit it nail on the head. Our experience, when people hit 65 the reason they know they have to make a decision is because all of the mailings that arrive at their house from insurance companies. Yes, we need more and better notifications about Medicare options, but they need to be clear messages that explain resources that you can contact for help, including unbiased resources like SHIP, including the Medicare 800 number.

And agents and brokers. We need agents and brokers. We also need to share that they get paid with commissions and they show you a subset of options. And we need to notify folks in that mailing of the low-income subsidy and IRMAA. We don't need everybody shocked that they have to pay more for B and D.

Speaking of agents and brokers, we need transparency in how they are paid, and that they are often only sharing a subset of options. Many are very good at their job, and they should be paid for their work and not

pawns of steering folks to particular MA plans or Medigap policies that are the biggest moneymakers for the insurers. Again, simplifying the system. We will need less of agents and brokers and SHIP volunteers if we can simplify the system.

Note that SHIP cannot enroll anybody in a Medigap policy. Maybe you all don't know that. But we need agents and brokers particularly to help with Medigap policies.

New to Medicare, this is shocking to people, you have to engage at least two agencies, the Social Security Administration and CMS, and maybe three agencies, including SHIP. And if you need a Medigap policy an insurance company or an agent or broker. When we tell folks this, they cannot believe how complicated it is. Let me give some examples.

We talk about Part B and say, oh, you know, you should start your Medicare. It's like "The Three Little Bears." You get it too early, say your spouse is working for a large employer and you start B accidentally, you're wasting your B payments, you may be paying IRMAA when you don't need to be, and the biggest issue in most states, you won't have guarantee issue rights to your supplement when

you want a Medigap policy. If you sign up too late you're going to have lifetime penalties for Part B. You have to have B just right, not too early, not too late.

How about Medicare A? Is it simple? No. Is it premium free? For most people. But all may not want to sign up when they're 65. You're still working for a large employer. It is retroactive six months when you start. If you have a high deductible health plan with an HSA you have this excise tax of 6 percent, if you continue to work, and a simple fix could be for us to say when you're ready to start you're a, tell Social Security you don't want it to be retroactive for six months if you continue working. So the messaging is critical and complicated.

Another example, you stop working for a large employer, you have eight months to get your B in place, but you only have 63 days to get your Part D in place. Too complicated.

CMS Plan Finder and ACL Stars reporting -- this is my last set of comments -- needs to be one consolidated and streamlined into one system. Agents and brokers could use it, and then we could track what they're doing to help people.

The individual contact reporting is extra, duplicative work, post hoc. You've helped somebody with a Plan Finder, they've long gone, and now you've got to get on another separate federal government website to fill out information post hoc. It's not a good use of our resources. SHIP scores are based on reporting, not doing.

And Senior PharmAssist, we don't find it worth a lot of our time. For example, somebody calls me two weeks later and says, "Can you add this drug? It's new." "Can you make sure I'm still on the best plan," even though I helped them two weeks ago. I rerun it and help them, and I'm not going to go back and report it again. That's a waste of my time.

Group outreach and media reporting through ACL makes perfect sense, especially with trying to reach difficult-to-reach folks, those in rural areas, those with limited incomes. But retracing in the Stars platform, what just happened in the CMS Plan Finder, is a waste of precious resources that we could be doing other things to help people.

Finally, there's outreach funding to help hard-to-reach folks, supposed those that are eligible for low-

income subsidy and extra help. But I just want to make clear, and I've said this before, many people do not qualify for these programs, even if their incomes are plenty low, and the government will tell you, "Those people, their incomes are low. They should be eligible." They have saved a little nest egg. Do you know the extra help, to get extra help for Part D, the assets test are $18,000 for a single or $36,000 for a couple. They are never going to get extra help.

So we keep doing this outreach for a lot of people because we have such a strict assets test. If we really want to get more people enrolled in low-income subsidy or SNAP benefits or other things that can improve their quality of life, we need to pay attention to the strict assets test.

I'm done. Thanks.

MS. KELLEY: Okay. I have a comment from Stacie, who says additional outreach to those not enrolled by age 65 is important, though there are important issues for people who are working or otherwise have insurance coverage that others have highlighted. If proceeding with notifications, she would suggest a phased process where the

first attempt is email, and those still not enrolled after additional months get standard mail. This might be most cost effective.

For SHIP counseling, she's very supportive of additional funding.

She also does not understand why the tools and systems used cannot include the Blue Button application information that is available to beneficiaries and CMS, as described in the paper.

Gina has previously mentioned issues with redundancy in the systems and tools that are used to help beneficiaries pick plans. More money for staff who truly help with complex issues, and our outstanding resources and giving them better tools would be great.

And I have Tamara next.

DR. KONETZKA: Great. So I want to start with a comment that Gina touched on, and I think Cheryl mentioned yesterday, which is that we're breaking up this work into smaller bits for tractability, but the sort of elephant in the room is that people wouldn't need quite as much help if we didn't have all this complexity, right? And so if people didn't have to know that the enrollment periods for

Part D are different from Part B and for their Medigap and that the penalties are different and that it matters if you have 20 people in your employer versus 100, if all of that were a little simpler, maybe the SHIP counselors would have to not spend so much increasingly large amount of time with each person. So reducing the complexity is sort of the elephant in the room behind all of this.

In terms of the notifications, I agree completely about having an app. The technology all makes a lot of sense. I think of it more as a short-run/long-run problem, because in the short run, there are a lot of Medicare beneficiaries who don't even have a smartphone, right, or wouldn't know how to download an app. And even in the long run, there's going to be some need for one-to-one, in-person counseling, because a lot of people still are going to be very confused by the information that's on an app, even if they have a smartphone and can do that and just prefer to make these decisions with somebody knowledgeable helping them. But, yeah, in the short run, I think we still need help, and we need notifications.

About the notifications, about people not getting notified when they're 65 just because of the Social

Security, full age being 67 now, I mean, that to me is a no-brainer. We have to do something to notify people. It's just kind of a weird historical accident that we don't notify them.

So, even though it sounds very antiquated, I like Stacie's idea of trying email first and then following up with snail mail for people who haven't enrolled or just doing the snail mail. One way or another, I think that's a good short-term solution.

One thing that was kind of glossed over in the chapter, it kept coming up that people who are on Social Security in time get notified and auto-enrolled, and we're talking about notification, right? And the whole idea of the auto-enrollment, we haven't discussed at all, and I don't actually have a strong opinion about should we think about auto-enrollment for people who wait for Social Security, because I don't have the data on that. Are the people who are auto-enrolling at 65, is that the right group to auto-enroll? Is that what we should be doing for everybody, or should we just skip the auto-enrollment and focus on notifications? I really don't know the answer to that, but it was a part of the chapter over and over that

we do this, and there's this discrepancy, but then we only talk about the notification. So I'd like to dig into that a little bit more.

Let's see. Yeah, moving on to the SHIP part. As I said before, I am a big fan of using MA and probably Medigap as well as Part D user fee or insurer fees to support expanded SHIP funding. It's great. There's already a mechanism for that. I don't know that we want to take away from the other things that those fees are currently funding, like the 1-800-MEDICARE. So, I'd be in support of an expansion of those fees.

I think the Medigap should be included if there's a legal way to do that because SHIP counselors do provide advice on those plans as well as MA plans.

Sorry. I lost that train of thought.

Anyway, I'd be in favor of expanding those fees. As Lynn mentioned, it actually all comes from taxpayers anyway. All of this, the billions of dollars we're spending on brokers and agents, I think that basically we need to affect a shift to some more unbiased information, acknowledging that brokers do play a role. I just think the sort of conflicts of interest involved in brokers is

the problem, and we need to have this sort of more unbiased information available to people, and sort of very clear information on how to contact SHIP should be included in those notifications that we're sending out.

Then the one final comment is just about the SHIP performance. I think Kenny was getting at this a little bit in his comments, but basically, what we see in the chapter and what the performance is measured on is all about volume. And I think there's a lot more to that. So before we -- I don't know -- attach any more implications to that performance, I think we need to think about it a little bit more broadly in terms of how much they're actually helping and what they're all doing.

Thank you.

MS. KELLEY: Cheryl.

MS. BARR: Can I get something in on that point?

MS. KELLEY: I'm sorry, Lynn. Go ahead.

MS. BARR: Maybe I said this to the wrong person.

So I just looked it up on the AARP because I've done some research here. Ninety percent of people over 70 own a smartphone, and on average, they use a minimum of four apps. And shopping is like number three.

[Laughter.]

MS. KELLEY: Cheryl.

DR. DAMBERG: Okay. So I'm going to start out with a preface and then get to my points.

So beneficiaries face myriad enrollment rules and complex choices that are dizzying, and they also face challenges with health insurance and financial literacy, which creates a lot of complexities in the space we're talking about.

And sort of touching on Brian's point, although while most of the population has general knowledge of Medicare, if you really ask them how it works, they don't understand the minutiae that keeps you out of the penalty box or sorting through the various choices. And so the role that SHIPs and brokers play in this space, it's incredibly vital, and I would like to see greater support, particularly for the SHIPs. And I'll get to that in a moment.

Starting with the making sure people stay out of the penalty box, it seems like the low hanging fruit here is this additional mailing.

I think to Gina's point, the ability of CMS to

customize that, given all of these dizzying rules and what applies to you, but we'll leave that to CMS to figure out how best to do that.

And then moving on to the SHIPs. So, in terms of the different possible paths forward, I would like to see MedPAC make some recommendations in this space, some policy recommendations. And I agree with everything that's been laid out here, both in terms of increasing funding, indexing to account for growth in Medicare enrollment, as well as establishing a dedicated stable SHIP funding source.

And I think in that space, as I mentioned in my Round 1 comments, I think really tying the dollar amount to the beneficiary with some possible adjustments would be a nice add-on.

And then I think also in this space, it would be helpful to -- and I'm building off of something that Gina mentioned, which is the funding that SHIPs get is obviously not sufficient, and they are going out and raising additional funding, whether it's from the state or grants. And I think if we could build a better understanding of where SHIPs are getting their funding and how much funding

they actually require to do the job, I think that would be helpful to try to understand how much money needs to be pushed into this space, because the percentage that you had in the chapter, that .021 percent of program expenditures, I mean, that was laughable. It's just like minuscule. So hands down on providing greater focus and really spotlighting the need for greater support in this space.

I also support the need for better technology supports, both for SHIP counselors as well as beneficiaries. But I think the reality on the ground is that you will continue to have, even in the future -- you'll have more beneficiaries going into retirement having computer knowledge. But I think as they continue to age -- and there are a lot of beneficiaries out there that are living on very limited incomes -- they won't have access to computers that are up to date with security software and apps and so it goes. So I think CMS is always going to be in this space of having to cater to different audiences in terms of the types of supports.

The other thing that I have really been interested in -- and I know -- I don't think this has come up, but I think it would be helpful if CMS could work more

closely in partnership with employers to help begin that education process with employees, because I think there is an opportunity for CMS to create toolkits and other materials that employers could download and use to begin that education process to help people stay out of the penalty box and know when they need to sign up and really understand the fact that, despite the fact they've contributed to Medicare their whole life in the form of tax deductions, they've only paid for Part A. Most people don't understand that. Just basic concept.

And then as both Gina and Tamara have pointed out, I am doubling down on the need to simplify this choice environment. It is way too complex. The fact that I as a beneficiary would have to choose between 32 plan choices within my geographic area is crazy, and I would hope that MedPAC would continue to do some work on standardizing the benefit design.

MS. KELLEY: Danielle.

DR. PIEROTTI: Thank you.

I think that this is a very important conversation about beneficiary access at its most basic. There are an awful lot of things on the table here as

potential solutions, and I honestly am not even sure that I would say whether it should be DOL or the -- well I know I'm going to say it's not the employer, but there were lots of people who could be involved in the communication to beneficiaries suggested in these documents.

What I am going to say is, whomever it is has to remember a couple things. First of all, page 9, Social Security Administration has declined to share the metrics for publication but stated that the campaign exceeds email marketing benchmarks. Okay. Well according to Google Gemini, email marketing benchmark is 31 percent open rate. That seems fairly unsuccessful if what we are trying to do is tell people about something that is critical to the next 20 or 30 years of their life and could leave them uncovered and with significant financial penalties that they don't understand.

I also really appreciate the conversation of my colleagues around the idea of apps and using technology and agree that large majorities of people, even in the over-65 category, do have a smart phone. I also need to point out that they cannot read. That -- also, my source here is Gemini, just saying, quickest access, but American literacy

right now is 54 percent of U.S. adults read below a sixth grade level and 21 to 28 percent of U.S. adults are functionally illiterate. So it isn't just a matter of sending something or creating an app. The bigger question is, can they read it?

So, even with an app which has fabulous usability but when I'm on Amazon I'm looking at pictures, I still have to know to download the app, and then I have to be able to read the information. The vast majority of information that we've discussed here as already existing in the world is not actually usable by the vast majority of people. And we have to remember the entire national conversation around how easy it is to be scammed in anything digital.

I am not functionally illiterate. I have a PhD, and I was scammed just trying to get my passport. So, if I can accidentally connect to a link and then enter all my information into a third-party contractor when I thought I was at USA.gov, I'm quite confident my 85-year-old aunt will do the same. So it isn't as simple as saying let's send emails and let's make an app or let's do handouts. We have to remember that people cannot read these things.

To me, that's the most important conversation that we need to have here, because, yes, I think everyone in here is saying, oh, we want to provide information, we want our beneficiaries to be informed and have full partnership in their decision-making. I haven't heard anyone not supporting that in lots of ways. But I need to remind everyone America doesn't read, and they don't have good understanding of the material we're providing them, and so how we provide this information to me is far more important than who's the payer and who's providing it.

If there's pieces coming from CMS and from SHIP and from Medicare Advantage and from the Department of Labor or Social Security, oh, okay, we spend two days a month sitting in this room all holding our heads about how complicated this entire system is, and we are highly literate people. So, if we struggle to sort this out, that has to be our first priority in everything we advocate for, regardless of who the payer is or who the provider is. We must advocate that it is readable and usable by the people intended to get it.

Thank you.

MS. KELLEY: Greg, I think you are the last.

MR. POULSEN: I don't want to take any time here, because we're way past. But I do think that we have not mentioned some of the AI tools that are readily available and incredibly helpful.

I used Claude, but I'm sure ChatGPT or Gemini would do the same thing. It can walk you through some really complicated processes. What it doesn't have is all of the information the government has, but using an agentic approach, Brian talked about that, Lynn talked about that. This is not -- this wouldn't be rocket science to put together something, because the rocket science has already been done, and that would be at a sixth grade level to help us get through it. And it works. I tried it with Claude, and I'm sure it works with the others too.

DR. NAVATHE: Great. Commissioners, thank you. A lot of great input, and I think a lot for us to chew on. As you know this is a work stream that we're going to revisit in the spring.

And, Jennifer, thank you so much for all your work as well.

We will adjourn the Commissioner part of the session here and ask if there's anybody who's attending in

person who would like to come to the microphone and make a comment.

Great. Please come forward, and please keep your comments to three minutes.

MS. WEIDNER: Okay. Hi. My name is great -- is it working? Great. My name is Laura Weidner, and I'm the Chief Advocacy and Government Relations Officer at the Epilepsy Foundation of America.

Epilepsy is the underlying tendency of the brain to produce seizures. Nearly 3.4 million Americans live with active epilepsy, including 1.1 million Medicare beneficiaries. The foundation is committed to supporting provider-directed and person-centered care.

Anticonvulsants, which are now usually referred to as anti-seizure medications, are the most common and cost-effective treatment for controlling and/or reducing seizures. Since there is no one-size-fits-all treatment for epilepsy, people with epilepsy need access to all available treatment options so that with their health care provider's guidance they can find and stay on the treatment or treatments that work best for them.

This needed access to all available treatment

options is why CMS created and Congress confirmed the six Protected Classes Policy, which says that Medicare Part D plans must cover all or substantially all drugs for these classes, including the anticonvulsant class.

To change, deny, or limit access to antiseizure medications can increase a person's risk of subsequent seizures, brain damage, disability, and early death. Each year, 1 in 1,000 people with epilepsy die from sudden unexpected death in epilepsy, or SUDEP. That number dramatically increases to 1 in 150 for people whose seizures are not controlled.

Disruptions in treatment for people with epilepsy also result in higher cost of Medicare and the broader health care system. The annual health care economic burden of epilepsy and seizures on the U.S. is $54 billion. The cost of uncontrolled seizures can be two to ten times higher than that of controlled seizures.

Since many people with epilepsy have comorbidities like mental health disorders, the foundation believes that the Protected Classes Policy must be preserved for all of the six classes, and we work in coalition with the partnership for Part D access to all

work on that together.

As MedPAC considers potential changes, the Epilepsy Foundation of America urges you to preserve Medicare's six Protected Classes Policy because of its utmost importance to people living with epilepsy's health, independence, and medical costs.

Thank you.

DR. NAVATHE: Thank you for your comment.

I'd like to invite up the next individual. Thank you.

MR. VENKITASUBRAMANIAN: Thank you, Chairman Navathe, Commissioners, and the MedPAC team. I'm Akshay Venkitasubramanian, founder of DearBill. Our mission at DearBill is to help more elderly Americans access the public benefits they're entitled to.

As the Commission here considers expanding the SHIP counseling by funding and now as a loan technology also, I'd like to share that we have been trying to work with SHIPs for the past few months and have been running into a roadblock which is we are a private technology company, and there's no national framework for us to work with SHIPs.

So I kindly request the council here to consider a framework for private technology companies like us to also work with SHIPs.

Thank you.

DR. NAVATHE: Thank you for your comments.

For those who are listening in via the web platform, you can also submit your comments to us at meetingcomments@medpac.gov, and we will adjourn the meeting here. Thank you.

[Whereupon, at 12:04 p.m., the meeting was adjourned.]