MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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Ronald Reagan Building
International Trade Center
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Washington, D.C. 20004

Monday, March 2, 2026
10:34 a.m.

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P R O C E E D I N G S

[10:34 a.m.]

DR. CHERNEW: Hello, everybody, and welcome to the March MedPAC meeting, uncharacteristically on a Monday and in a new room, but nevertheless, it's the same wonderful MedPAC.

We are thrilled you could join us. We're going to start this month with a chapter on a mandated report, which is about collecting data on the use of ground ambulances, and for that, we're going to turn it over to Dan.

DR. ZABINSKI: Thank you, Mike.

Okay. So today we'll be covering a mandate in the Bipartisan Budget Act of 2018 that directs MedPAC to use data that was collected by CMS to produce a report on the cost of Medicare ambulance services, and we provided preliminary results last December, and today we'll review those results again and provide a draft recommendation on whether collection of the cost data from ambulance providers should continue. Then in April, we'll return for a vote on a final recommendation.

And for the audience, a copy of the slides can be

accessed through the control panel on the right side of your screens.

So this is actually our third presentation of this material. At the March 2025 meeting, we provided an introduction to the ambulance fee schedule, the AFS, the Ground Ambulance Data Collection System, the GADCS, which was developed by CMS, and a congressionally mandated report on the GADCS.

Then at the December 2025 meeting, we built on the discussion from the March 2025 meeting and provided preliminary results of our analysis of the GADCS data.

Then our plan for this presentation is to discuss the report mandated by the Bipartisan Budget Act of 2018 and provide background information and a description of the Medicare ambulance fee schedule, describe the Ground Ambulance Data Collection System, the BBA of 2018 required CMS to develop, talk about our results from an analysis of the GADCS data, provide an assessment of the GADCS data, then close with the Chair's draft recommendation.

So ground ambulance services that are provided to fee-for-service Medicare beneficiaries are paid under the Ambulance Fee Schedule, or the AFS. The Bipartisan Budget

Act of 2018 required CMS to implement a comprehensive Ground Ambulance Data Collection System that includes data on ground ambulance costs and revenues. CMS has responded to that BBA of 2018 mandate by creating the Ground Ambulance Data Collection System, or the GADCS.

The BBA of 2018 also directs MedPAC to use the data collected by CMS to produce a report that assesses the GADCS and review the AFS payments.

And the motivation for requiring CMS to collect ground ambulance costs and revenue data starts with the fact that the ambulance fee schedule payment adjustments are largely not based on cost data and have not been updated since they were implemented.

Without the cost data, it can't be determined if AFS payments vary appropriately with the cost of providing care to beneficiaries who have different needs in different locations. It's also difficult to know if aggregate AFS payments are adequate to ensure access to care and good value for the Medicare program.

The BBA of 2018 specifies that MedPAC produce a report that includes a recommendation as to whether the collection of the GADCS data should continue or if the data

collection system should be revised, and this report is due June 15, 2026.

At the December 2025 meeting, we presented that in 2002. Medicare payments for ambulance services shifted to the AFS from a system that paid based on cost for organizations that were affiliated with hospitals or based on charges for all other organizations. Because most ambulance organizations are not affiliated with hospitals, at that time, there was little data available for setting the AFS payment rates.

So under the AFS in 2024, about 10,600 ground ambulance organizations provided ambulance services paid under the AFS to fee-for-service Medicare beneficiaries. These organizations provided 11.3 million ambulance transports that resulted in $5.3 billion in payments under the AFS.

And the AFS covers emergency and non-emergency transports from the point of patient pickup to an appropriate medical facility or to the patient's home. Examples of covered transports include unscheduled emergency transports to a hospital emergency department, scheduled non-emergency transports from inpatient care to a

skilled nursing facility, and scheduled repetitive non-emergency transports to and from dialysis facilities.

Finally, the payments under the AFS have two parts. One is for the mileage and one for the services provided during a transport.

And the AFS payments for mileage are a function of a conversion factor of $9.15 in 2026; the location of where the patient is picked up, being urban, rural, or super rural; and an add-on payment of 50 percent for the first 17 miles of a transport that occurs in a rural or super rural area, where super rural are the zip codes located in rural counties that are among the lowest quartile of all rural counties by population density.

Then the payments for services provided during a transport are a function of a conversion factor of $284.56 in 2026, a relative value unit, or RVU, that represents the complexity of the services provided; the location of the pickup being urban, rural, or super rural; and then finally, a practice expense, or PE, GPCI, for the Medicare physician fee schedule that adjusts payments for geographic differences in cost.

So the payment adjustments on the previous slide

largely were not based on cost data and have not been updated, which is the main motivation for collecting the GADCS data.

The GADCS data includes information about the organization's characteristics, service areas, service volume, service mix, their staffing, costs, and revenues.

CMS surveyed ambulance organizations that provided ground ambulance services in 2017, 2018, and 2020, and included about 10,600 organizations. CMS ultimately collected 2022 or 2023 data from 7,572 organizations, as about 1,650 organizations were dropped because they were no longer active, and an additional 1,350 organizations chose not to participate in the survey. And these organizations that chose not to participate had a penalty of a 10 percent reduction in their AFS payment rates for one year.

So we have evaluated the GADCS data and interviewed stakeholders, and based on what we learned about and from the GADCS data, the BBA of 2018 requires the Commission to recommend whether the GADCS data should continue to be collected and whether the data collection system should be revised.

Now, over the next few slides, we'll present

results of our analysis of the GADCS data.

We've analyzed the GADCS data to identify which organization characteristics do and do not affect ground ambulance costs. The most striking finding was that the effect that organization size has on their cost per transport.

Specifically, we sorted the organizations by number of transports and collected them into quartiles, and then in the lowest quartile of the transports, we found the cost per transport was $2,852. And in the highest quartile, it was $914, a ratio of 3 to 1.

Note that MedPAC in 2013 and GAO in 2007 and 2012 also found that number of transports has a strong effect on organization costs.

We also found differences in cost per transport by type of ownership. That is, for-profit organizations had lower cost per transport than government-owned and nonprofit organizations.

We found a smaller difference in cost per transport based on whether an organization serves in urban or rural location. However, organizations that serve super rural areas have higher cost per transport than the

organizations that serve either urban or rural areas.

And we found that many factors contribute to the differences in cost between ground ambulance organizations. For example, the lower cost of for-profit organizations relative to those that are government-owned is likely due to several factors, such as more transports, a less complex service mix, and use of different staffing models in the for-profit organizations relative to the government-owned ones.

And simple tabulations like we did on the previous two slides can't tell us the magnitude of the impact on cost of each of these factors. So to isolate the effect of each cost driver, we did a regression analysis.

And for this regression, we estimated the effects of relevant factors on the natural log of ground ambulance costs for each organization. The benefit of the regression is that it allows us to see the impact of each cost driver while holding all other factors constant.

We found that several explanatory variables were significant, but two really stood out. One was the number of transports provided by an organization, and the second was the location of the organization being urban, rural, or

super rural.

So the regression indicates that costs rise at a slower rate than number of transports, which suggests economies of scale, because the coefficient on the number of transports from the regression is less than 1.0 at 0.71.

What this coefficient tells us is that a 10 percent increase in number of transports increases cost by a smaller rate of 7 percent. So cost per transport decreases as organization volume increases.

The implication is that smaller organizations have higher costs for transport relative to the larger organizations. This is important because the AFS does not have a payment adjustment for low-volume organizations, but the Commission recommended that the AFS add-on payment for the first 17 miles of a rural transport be replaced with an adjustment for low-volume organizations that are located in isolated areas.

Then the second regression result of interest is that the coefficient for rural organizations of negative 0.13 indicates that costs were lower for rural organizations relative to their urban counterparts. However, the AFS has adjustments that increase the payments

for rural organizations relative to urban organizations. The result of lower costs for the rural organizations is due to controlling for the effects of other factors, such as volume.

I also want to mention that the coefficient for the super rural organizations is positive, but not statistically significant from the urban organizations.

So the empirical results that we have presented so far were also presented last December. We did a new analysis that we will now cover, being a preliminary comparison of organization revenues relative to organization costs.

In this analysis, we used revenue from all sources and cost of providing ambulance services to all patients. The measure that we used is organizations' revenue-to-cost ratio. That is, we divided their revenue by their cost.

However, we do have some concerns about the revenue data in the GADCS for several reasons. One is that this is the first year that organizations have submitted revenue data, and there may be some errors. Also, the government organizations receive over half their revenue

from sources that are unrelated to their billing for ambulance services, with local tax revenue being the largest source, and this could be a problem for the revenue data from the government organizations. CMS has expressed concern that organizations may have under-reported revenue from these sources. Finally, we found that some organizations have very large differences between their revenues and costs.

To summarize, because of these concerns about the revenue data, we trimmed the organizations that have the 5 percent most negative and then those that have the 5 percent most positive differences between revenues and costs.

And because of these concerns we have about the GADCS revenue data, we caution how you view these revenue-to-cost ratios on this slide.

Here, we present the median revenue-to-cost ratios of for-profit, non-profit, and government-owned organizations, using both the full GADCS data set and then the trimmed data described on the previous slide.

In addition, we weighted the results that used the trimmed data by the number of transports for each

organization because we were concerned that small organizations may have a disproportionate impact on the results.

As you can see, the trimmed data of three categories have a larger revenue-to-cost ratio, which indicates that service volume has an important effect on the revenues relative to costs.

Also, under both the data sets, the government-owned organizations have lower revenue-to-cost ratios than for-profit and non-profit organizations.

And then when we excluded the government-owned organizations from our analytic sample, we found that revenue-to-cost ratio is very sensitive to the number of transports. We found that high-volume organizations have higher cost ratios than lower-volume -- sorry -- have higher revenue-to-cost ratios than lower-volume organizations. This is true under both the full data set and the trimmed data set.

So in summary, the effect of the number of transports on the revenue-to-cost ratio is another indication of economies of scale.

And now we'll turn to our assessment of the GADCS

data. The GADCS is a comprehensive data set. CMS was able to collect data from 71 percent of the organizations that provided ground ambulance services and has 7,572 records.

In contrast, previous data sets had a few hundred records and excluded ambulance organizations that share costs with emergency responders or with hospitals out of concern about the accuracy of the data from those organizations.

But for the GADCS, CMS was able to work with organizations that share costs and improve the accuracy of the data.

The most important attribute of the GADCS is that it includes detailed cost data that can be used to evaluate the cost of providing ambulance services and assess the accuracy of AFS payments.

In addition, the GADCS includes sampling weights so that nationally representative results can be obtained.

We do, however, have a concern about the size of the GADCS. It has over 600 variables, and many of them are not needed for evaluating ambulance costs.

For example, we used only 150 of these variables in the empirical results discussed earlier. In particular,

data on some GADCS cost categories such as vehicles and facilities are more granular than is needed.

Some might be concerned that the GADCS does not include data on providing care specifically to Medicare beneficiaries. So with this iteration of the GADCS, analysts can only calculate transport costs for all patients and not specifically for fee-for-service Medicare beneficiaries. However, we found that the cost data for all patients is a reasonable approximation of the cost data for fee-for-service Medicare beneficiaries.

Then to inform the recommendations that the BBA of 2018 required the Commission to make, we had discussions with industry stakeholders including ambulance organizations, CMS, RAND, which contracted with CMS for the GADCS, and ambulance trade associations.

In addition -- sorry. In general, stakeholders noted that continued data collection would be beneficial to ensure payment adequacy and accuracy. However, small rural organizations reported difficulty collecting and submitting the cost data and wondered about the usefulness of many of the questions. Also, the survey instrument could be streamlined without loss of effectiveness.

Then the trade associations and the organizations also felt that startup costs have been incurred. So stopping the GADCS at one iteration would be unfortunate, and the quality of the data that the organizations submit should improve as they gain more experience.

So to summarize the presentation, before the GADCS, there wasn't a good data set to assess the adequacy of the AFS payment system, and the GADCS is a good first step in creating a data set that can be used to evaluate the accuracy of AFS payments across patient severity levels and assessing whether aggregate AFS payments are large enough to ensure patient access.

Moreover, stakeholders believe collection of the GADCS data should continue, but the GADCS does have a lot of variables, and it could be improved through streamlining.

And finally, we presented a regression analysis that showed that volume is a strong driver of cost and that the current AFS payment adjustments are not well targeted.

However, MedPAC in 2013 recommended a payment adjustment for isolated low-volume organizations that would produce better targeted payments.

So now we turn to the Chair's draft recommendation. It says, "The Congress should direct the Secretary to continue collecting cost and revenue data from suppliers and providers of ground ambulance services. Data collection should focus on information essential to assessing both accuracy of Medicare payments and Medicare beneficiaries' access to care, and the Secretary should pursue opportunities to streamline data collection to minimize burden on suppliers and providers."

And that concludes the presentation. We will address any questions or comments that you have.

Now we turn back to Mike.

DR. CHERNEW: Dan, thank you so much for that. We were asked to collect some information, do a report, and you've done a really thorough job, so thank you so much.

I think Lynn is first in the Round 1 queue. Is that right, Dana?

Lynn.

MS. BARR: So one of the questions I had was around the people that didn't report. Do you have a breakdown of their characteristics? Was that predominantly rural? Because I noticed that you had that they complained

more than others, you know, about the burden.

DR. ZABINSKI: I don't know about the rural. I do know for-profit and small.

There's a fair correlation between small and rural, and maybe disproportionately represented by rural, but definitely small is an important factor.

MS. BARR: Awesome.

So in the paper, it talks about there's not, you know, a significant difference between rural and urban costs, and there's kind of a language. We talk about, you know, looking at costs versus looking at cost of transport, and you noted in the paper that the cost of actually getting to the patient isn't included in the cost. And so can you elaborate on that a little bit more about, you know, why we don't actually discuss -- if we're looking at cost, why we're not talking about the cost of getting to the patient?

DR. ZABINSKI: I'm not sure if it's true that the cost of getting to the patient is not included in the data.

I mean, the organizations are asked things like, what was your total fuel cost, what was your, you know, total labor costs, and that sort of thing.

MS. BARR: But in your analysis, you didn't actually put that into the analysis, right? That wasn't one of the 150 elements?

DR. ZABINSKI: No. I mean, well, that was how all the data were presented. It's, you know, what was your total cost for, you know, your facilities, your labor, your --

DR. CHERNEW: Can I jump in for a second, Dan?

DR. ZABINSKI: Yeah.

DR. CHERNEW: I think this might answer your question, Lynn. I'm not sure, and it's going to be fun to see if Dan thinks I'm right.

All the costs, getting there, getting back, when there's a transport, when there's not a transport, whatever you've done, all of those costs are in the data.

What's not true -- what is true is when they pay, they don't pay extra if there's not a transport. But you can do the analysis.

So you're trying to explain the total amount of cost and all the costs that are in there. You can explain that based on the number of times you get there, the number of times you bring people back, or any version of that. In

the way that the model works now, you get paid when you transport some of it, not necessarily when you get there. But the analysis that I believe Dan did and the model he ran includes all of the costs. It just models those costs as a function of transports, as a function of -- as opposed to a function of going or not going or any other type of thing.

Is that loosely right, Dan?

DR. ZABINSKI: That's better than loosely. It's pretty spot on.

MS. BARR: So I hear that it's not uncommon for rural providers to have to get ambulances from a distant city, for example, and so that would all be in -- the hourly time and fuel costs and everything would be in the cost analysis data and is not in any way taken out of that. Okay, great. Thank you very much.

I have a couple more. So would it be possible then for you to calculate a cost to arrival? Because I think this is -- you know, there's talk about -- I don't want to get into Round 2, but there's talk about, you know, well, we shouldn't be paying more for rural. And I want to make sure that we're not skewing the data, because this

will be widely quoted in policy, and I want to make sure that we're not misinforming, you know, or accidentally misinforming anyone about the reality.

DR. ZABINSKI: I don't want to say a definite no, that I couldn't do it. But just my recollection of what's in the 600 variables, I don't think it's possible to break out, you know, from the travel to the site versus -- I mean, also, what the cost of -- if there's no transport and separating all that out from what happens when patients are actually picked up and transported. It's just -- it's pretty complex already as it is, and I don't think they went any deeper than what they already have.

DR. CHERNEW: And I want to say just very quickly, I think there's two ways to think about this. There's a model of figuring out the cost where you do an activity-based cost thing. How much did it cost you to get there? How much did it cost you to get back? Did it cost you more to get back if you brought somebody as opposed to if you didn't in a cost allocation way? That's not really what Dan is talking about for much of those things.

There's another way of thinking about this, which is what you might fit into the regression model, which is,

you know, the total cost, all the costs, going there, coming back, all those costs. And you model that as a function of anything you want. You could model it as a function of the number of times you bring people back, the number of times you went up, how many miles you went, the total volume. You can -- very flexible in the regression.

The regression will do the allocation for you. So you don't need to actually capture the literal costs, and so the question about collecting the data is -- in some ways can be thought of as should we get the data that allows us to run a regression, but it doesn't tell you what that regression should actually look like, what variables should be in it, whether they should be percentages or how you do it.

The way you model the costs is a little bit different than the way you collect the data that can then be used to model the costs. But you certainly could, once you have the data, say costs are a function of transports, trips, which is a little bit different, miles, volume, anything you want. But you can't model any of it if you don't have the data.

MS. BARR: I hear you.

I think the purpose of Commissioners is that we lay our real-world experience against the data, and when they don't add up, we have to ask kind of these clarifying questions and maybe get to something that may or may not be relevant. But, again, I hate to see them cut the ambulance add-on payments because of something we publish.

So I just want to make sure we're both clear that we're not talking about there and back from the patient's home. But we're talking about there and back from wherever the actual -- where the ambulance came from.

DR. CHERNEW: Totally understand.

MS. BARR: Yeah. And so we are talking about from the source of the ambulance to the patient's home, to the hospital, you know, and back to the source of the ambulance. Right? I just want to make sure that we're on that same page because it wasn't quite clear. Right?

DR. ZABINSKI: Yeah.

MS. BARR: Okay, great.

So then I have a -- I guess my next question is, so we divided this based on rurality, right, but based on how CMS classified rurality, right? So can you talk a little bit more about that classification of how CMS

declared these four buckets and what validation -- is it three buckets? Three buckets, which is urban, rural, and super rural. And how does that correlate with other, you know -- I mean, is that -- have we validated that as being indicative of where the patient actually lives in some way to make sure that that might also be an artifact?

I'm looking for the artifacts that conflict with the experience, I think, of rural providers of saying this is a lot more expensive for us than in cities. So can you -- have you done any work on that?

DR. ZABINSKI: Well, I can tell you what the definitions are. At the base of it is, okay, Metropolitan Statistical Area -- I'm an economist; I should be able to say statistical, but I can't. MSA. Okay, how about that? We have got MSAs, and that's sort of the linchpin of it all. But then outside of MSA is definitely rural.

Now, they also go a little deeper, though, and look at census -- no census tracts. What's the next, whatever -- one of the censuses. And you have like rural census tracts within MSAs, and they get transferred into rural. So that's your rural definition is non-MSA plus census tracts within MSA that are considered rural.

But then they order the rural counties by population density, and they take the bottom 25 percent, and the ZIP codes in those bottom 25 percent, that are considered the most rural counties, are the super rurals.

MS. BARR: But it is county based, right? So it is county based. I'm just curious, is there any way we could sort of cross-validate patient rurality based on the other definitions we normally use versus these definitions to say does this accurately reflect the rural population and rural beneficiaries?

DR. ZABINSKI: Are you thinking of things like urban influence codes?

MS. BARR: No. The methodology is different from what we use. We're not really looking at the beneficiary ZIP codes. I mean, they are counting them as counties. I'm looking for reasons why the data doesn't seem to make sense, and that was one thing that kind of stood out to me is, oh, here's a different definition than we're used to using. How we validated that that's actually reflective of the population? Because they're just going by the majority, right. So if more than 50 percent of the county is considered rural or super rural, they assign the county.

MR. MASI: Maybe I could jump in here for just a minute. So I think that to the extent that Commissioners are interested in future work to better refine these analyses, I think that's a great thing to talk about in the next round. I think we're trying to emphasize that just for purposes of this exercise we were working with the data that we have. But if there are future ideas for refining definitions of rural for part of this analysis, I think that it's a great thing for Commissioners to talk about.

I think stepping back for a minute, I did just want to level set that the conversation here is not really about revisiting the rural payment adjustments. This is very much, as Mike said, talking about data collection efforts Commissioners use about whether that should continue or not, and then the extent to which there are opportunities to streamline or improve that. I think if there is future work that Commissioners want to do, I think that's a great conversation to have.

Mike or Betty, do you want to get in here?

DR. CHERNEW: Just 10 minutes into our Round 1.

MS. BARR: Okay. I promise then. I cede all the rest of my time for the meeting today. But this is

important because I believe the tone of the chapter is rural is no more expensive than urban, and policymakers pick up what we say and run with it.

DR. RAMBUR: Can I comment on that? In my comments I will address that. I read that a little differently, because of the relationship of volume to cost. And there is no way you can have an economy of scale in a place that doesn't have a lot of people. And I'll have some more questions later.

So I did not read that the same way. I did note that they didn't use frontier county, which is a more traditional measure than super rural, but I assume they are similar.

DR. ZABINSKI: Well, the frontier county, I guess now I'm getting into an area and I'm not -- my footing is not as firm.

DR. RAMBUR: We have to work with that.

DR. ZABINSKI: Well, I'll use frontier state for the PE GPCIs, that geographic area of adjustments, in the AFS.

MS. BARR: But I think to Betty's point, the low volume is much more expensive. The governmental, which is

almost all rural, also governmental is more expensive. So I'm just trying to understand.

DR. CHERNEW: I hear your point about the tenor of the chapter. We can have a conversation about that. I will echo Paul's point that right now it's not about payments. It's about data. But more importantly, we are now about 12 minutes in to Round 1, and we have a long queue.

MS. BARR: All right. I'm out. Thank you.

DR. CHERNEW: Thank you.

MS. KELLEY: Tamara.

DR. KONETZKA: This is actually very quick. First of all, Dan, thank you for being so responsive to our comments last time and adding a lot of important things to the chapter.

My question is about the regression results. It's really just a presentation question, I think. I was at first very confused because the bullet points were basically saying about the complexity, that both BLS and ALS increased costs, and it took me a while to figure out that I think it's all relative to a reference category of BLS non-emergent. Is that correct?

DR. ZABINSKI: Yeah. The reference there -- I mean, there are seven different HCPCS codes that providers can code, and the reference one was the BLS non-emergency.

DR. KONETZKA: Okay. So when you talk about the results in the chapter, discussion of the results, you might want to just make clear that it's relative to this reference. I don't know if that applies to things other than the complexity, but just a clarification. Thanks.

MS. KELLEY: Betty, did you have a Round 1 question?

DR. RAMBUR: Very briefly. It follows up a little bit maybe on Lynn's, and my living at the working surface in rural areas. It's in the literature that 80 percent of rural emergency services are staffed by volunteers and dependent on fundraisers. And one source from the American Medical Journal says all. I was curious if volunteers' work can show up in this data? Is that a piece that's there? Because I think that's really important.

DR. ZABINSKI: Yeah. The volunteers, it's in the data. It's included in the Table 7 regression, the share of the hours worked that are volunteer. So yeah, it's in

there.

DR. RAMBUR: But they don't generate cost that's reflected?

DR. ZABINSKI: Right. Other than -- the organizations are asked, do you pay a stipend for your volunteers, and that's going to show up, but I would think that's not much.

DR. RAMBUR: Okay. Thank you.

MS. KELLEY: Cheryl.

DR. DAMBERG: This is a quick question. I just wanted to check because I think your slide said something different than what I saw on page 26. It said the lower cost for transport for for-profit organizations could also be due, in part, to for-profit organizations providing a higher share of complex services. And I think in your slides you said the opposite.

DR. ZABINSKI: Say that again?

DR. DAMBERG: On page 26 it saying the lower cost for transport for for-profit organizations is due to providing a higher share of complex services, and I think you mean the opposite, right? Because I think your slide said the opposite.

DR. ZABINSKI: Okay, yeah. No, that's right, yeah. Sorry.

DR. DAMBERG: No worries.

DR. ZABINSKI: My bad.

MS. KELLEY: That's all I have for Round 1. Oh, I'm so sorry. Go ahead, Wayne.

DR. RILEY: Dan, thanks. Good work, as usual. A mention was made in the chapter, and I think you just highlighted the issue of the high number of variables, you said 600, but the utility probably of that 600 only came at about 150. Correct? Have you modeled what a minimally accept dataset that would still get usable, actionable data might look like?

DR. ZABINSKI: Let's see. I gave a lot, not models specifically, but I gave a lot of thought. I combed through all 600 of them, and I just wrote down, is this needed or is this not needed. And also, I thought about, particularly like a lot of times it's particular for, when you ask about facility costs and vehicles costs, they get really, really specific on some things. And I don't think they need to drill down that deep. So I thought about, okay, what can they combine. And my recollection was it

like 150, 160, something like that.

DR. RILEY: Thank you.

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

DR. CHERNEW: I suspect Lynn is first in Round 2.

MS. BARR: So I definitely think simplifying this would be great, as small as possible, as small a number of things as possible. I think that it would be important for us to isolate out, to review how we're looking at the classification of urban versus rural versus super rural, and look at actually beneficiaries and where they live and what the costs and access issues are there.

I am concerned about that the policymakers will run with any conclusions we have in this chapter that state that we definitively feel that rural is equal to urban, as I feel it's stated strongly in the chapter, and I think there needs to be a lot more caveats around that, that we're missing a lot of data. I think we should be characterizing who we're missing data from, and just be a lot more cautious that we don't cut the 20 percent add-on payments for rural providers before we actually have all the answers, and proceed with caution. Thank you.

DR. CHERNEW: So when we go around it would be useful if people said if they generally support or generally don't support the draft rec.

MS. BARR: I definitely support the draft recommendation.

MS. KELLEY: Stacie.

DR. DUSETZINA: Thank you. Great work, Dan. I support the draft recommendation, as well. And I think sort of, to Wayne's point there, I was also wondering, is there some way we could help point out what variables actually matter here? I know you said you used 150 out of 600, but it seems an opportunity to think about like which ones actually tell us the most, so we can get to something to suggest what is worth collecting. Because the burden does seem relatively high.

So again, I totally agree. Reduce the burden of data collection, limit the number of variables, limit how much detail if we don't feel it is actually necessary for understanding the costs. But I am very supportive of the recommendation.

MS. KELLEY: Tamara.

DR. KONETZKA: I'm very supportive of the

recommendation. It seems almost a no-brainer. It's such a unique situation where the people who have to actually supply the data are in favor of continued data collection. We don't run into that very often.

I think that clearly it should be a streamlined set of variables, and consistent with what Stacie was just saying, I think it might be worth the exercise of just really listing out the goals of what we want to do with the data and then working backwards from there in terms of which variables are really necessary to achieve those goals.

I also think we're leaving open the question of how often the data should be collected and whether it should be repeated, how many times, and how often. I think that's still, to me, open for debate. It doesn't have to regularly or it doesn't have to be every year, for sure.

My other point is actually similar to Lynn's about sort of nuance in the chapter. I was really kind of uncomfortable with some of the volume discussions, and I think it's just really about tone in the chapter. But for example, on page 32 describing the regression approach, the title is [audio distortion] adjustments to ambulance

payments for relevant factors. So the implication there is that we are going to use these regressions to determine what should be adjusted in the payment, and I don't think we're there at all. There is so much more I would want to know about volume. I think the volume results are super interesting and are a really good start.

But to Lynn's point, there may be areas where low volume is just sort of necessary because of where the ambulance service is located, but there may be other sort of more endogenous reasons for low volume, and we don't necessarily want to compensate that. So I think we just need to know a lot more about the volume and the reasons for low volume before we start tweaking that part of the payment system. And I think the chapter should reflect our great deal of uncertainty and all of the things we might want to refine in that analysis before we figure out if those add-on payments, for example, need to be changed, or if there's a better way to adjust for low volume. Thanks.

MS. KELLEY: Brian.

DR. MILLER: Thanks for this very nerdy chapter. I appreciate it, and I hope that no one is juicing their dataset by filling them ambo tanks with premium gasoline.

So the dataset, just some better thoughts for us, the dataset for ambulance payment was 600 variables and our staff, Dan, thought that a lot of those were unnecessary, and we used 150 variables. So my question is, what is the right number of variables? Six hundred seems like a big number. Even emotionally, 150 variables seems like a big number. Is the right number 0? Is it 10? Is it 100? I don't know.

Looking at other things that the government buys, and that government buys high volumes of other stuff. Whether it's Chipotle burritos or Jimmy John sandwiches for people's lunch, or whether it's military ammunition or gasoline for trucks, the government purchases a lot of things on contracts, millions, sometimes even billions of dollars, without sort of data collection and cost reporting.

The other thing that we need to think about is that regulations that increase administrative burden to receive payment increase the cost for ongoing business, and they also raise barriers to entry for new businesses. And, in fact, our chapter wisely notes that cost reporting for ambulances is challenging for a small enterprise.

In many health care markets we face consolidation from that. We get a loss of price competition and also, more importantly, a loss of non-price competition, which is what beneficiaries experience losses for their medical quality, consumer experience, et cetera. And small businesses, which is where all big businesses originate from -- we tend to forget that -- small businesses are often that source of innovation.

So my thought is, as we are thinking about maintaining or adding regulatory reporting requirements we should think very carefully about that, because large businesses can always bear regulatory reporting requirements, which in some ways protect them by raising the cost of market try, something that the FTC has noted when it looks at regulations.

So I realize that there is a strong impetus to push for continued data collection. My caution would be let's not favor large, incumbent businesses. Can we think about ways to streamline reporting requirements, or as Tamara said, decrease the frequency. Does it have to be every year? Maybe it could be every three years. Maybe it could be every five years. Again, the right answer is

probably not every 10, and it's probably not every year.

And this sort of gets back to the other sort of broader question, which I think other folks were asking, and Lynn wisely, I think, was getting at, which is that we perhaps should think about a market-based mechanism for price, because someone made the decision that 600 data variables was the right number to set price. Somebody made that decision. Someone else has made the decision that 150 variables is the right number to set price. I look at all of this as sort of the evidence of the failure of government price setting. Like we have markets where it's clear in rural areas that there might not be enough financial support for ambulance companies to operate. We all read the news and hear about that, and that's a problem, because it's long distances, bad weather, tough geography.

And then the other thing which folks have mentioned is that ambulance companies do a lot of work without pay, by treating patients in place without transport. When I look at that, that seems like an illegal taking by government of private labor, right, because you're having someone do work and you're not paying them

for it.

So if we want a better ambulance system that works to sort of change care delivery and treat patients in place, and perhaps not take them to the emergency room or hospital if they don't need to because the alternative is to stay at home, and you can't necessarily go to your primary care doc by ambulance or urgent care urgently via ambulance. If you're going someplace in an ambulance you are going via the emergency room, which is a high cost locale, when you might just need some treatment in place.

And so if we want that innovation and we want to adequately, I would say, also support rural areas and recognize that we want competition there to produce innovation in service delivery, I think we want data collection, if we're going to continue it, to be more streamlined, more streamlined not just in terms of the variables but also the frequency in which it's collected, and then use that to get towards a more market-based system where we're paying people for the services they are delivering rather than taking free labor from them.

MS. KELLEY: Josh.

DR. LIAO: Thanks for this material. Just to

start I'm supportive of the draft recommendation. Just a few thoughts. I agree with comments from other Commissioners about I think reviewing adjustment exposition to ensure we are focusing on what I understand to be the focus here, which is data collection, rather than actual adequacy of payment.

And I think, just to state the obvious, I think continue data is essential. The current challenges you have really laid out nicely stem from a lack of historical data, so just continuing things like GADCS seems like we return to those issue again.

I appreciated things that the materials elucidated, like the relationship between variation in both structural factors like geography and volume as well as operational decisions like staffing. So I think those things should be tracked and can be done with continued data collection.

I, like other Commissioners, thought a lot about how to streamline -- I don't have a magic number of variables but I did look through the GADCS a little myself, and I do think that if we are ultimately, at a later stage, thinking about addressing the issue the adequacy of fee-

for-service payments, I do think there is a chance maybe to aggregate up to a level of things like total operating costs, capital costs, overallocation. I do think keeping that at the level of equipment and vehicles, labor, I think probably makes a lot of sense. I don't know what number that is, but I do think things like fuel, insurance, head count, IT systems, DSH patch contracts, lease payments can probably be cut. So I sense that's consistent with what you're thinking, as well.

Anyway, I think taken together, I think this idea that is captured in the draft recommendation I think is wise, and I am supportive, and I appreciate the materials.

MS. KELLEY: Cheryl.

DR. DAMBERG: Dan, thanks for this chapter. It was really well done, and I really appreciate the updates to the chapter since we last reviewed it.

I want to go on record as supporting the Chair's recommendation. I think these data are very important to helping us understand differences in costs, and I agree that there need to be efforts to both streamline the data collection process and have fewer variables.

I think at the last meeting we talked about

potential ways of streamlining of doing it less frequently, you know, maybe every other year, or using a sampling approach. I would support all of those types of strategies.

And then, secondly, I want to plus-one on Tamara's comments about the tone, particularly as it pertains to sort of signaling possible risk adjustment around certain variables. I think it's premature to be in that space.

And then, lastly, if there is to be future work in this space, I was scratching my head, and maybe you know more about the dynamic staffing model, but given that that's a model that's used more often by the for-profit entities that tend to have more basic life support type transports, it seems to me that potentially -- and again, I don't understand this space well -- that they would have more scheduled transports as opposed to emergency transports. So maybe unpacking that would be helpful.

MS. KELLEY: Gokhan.

DR. METAN: First of all, it's virtually almost impossible for me to go against data collection. So from that perspective I support the Chair's recommendation.

I would like to make two comments, one about the data collection, and the second one around regression methodology and analysis.

About the data collection, we should definitely continue collecting the data and look for ways to simplify, especially given some variables may not be aiding in value. We can drop those. But I would like to caution against going and collecting the data at the aggregate and losing the details. If you have detailed data, you can always aggregate, but not vice versa.

So I think the simplification is a good thing, but we should try to collect which variables we truly need and make sure that we continue to collect those detailed data to make informed decisions and build valuable models.

The second comment I would like to make is about the analysis. When I look at the regression model there are a lot of variables in the model and they are at different varying P values. I don't know if any analysis has been done in terms of multicollinearity. And again, for the rest of the Commission members, multicollinearity is essentially when one variables has dependency on other variables.

So essentially, for example, if you have variables in your model that can be expressed as a combination of other variables, the regression coefficients can be unstable, and the model, from the predictive perspective, is still accurate, but the interpretation of the variables could be misleading, because those coefficients are unstable if you try to put the same model on a different set of data, while the rural location coefficient could be very different.

And to Lynn's comments in terms of data analysis and how we can interpret in reality should be consistent, I suggest looking to multicollinearity issues, if there are any. Again, in the paper I don't see any analysis regarding that. But if there are any such issues it may help to kind of make the model better interpretable.

But other than that, thank you very much for this work.

MS. KELLEY: Robert.

DR. CHERRY: Yes. Thank you for the ongoing work and the iterations that have been done with the ambulance chapter.

One thing that you've pointed out all throughout

the work is that there's different levels of ground ambulance transport. There's BLS, ALS. There's specialty transport as well.

And there's also revenue-to-cost differences between for-profit, not-for-profit, as well as governmental. It's likely that those revenue to cost differences is not just related to volume, but also related to the case mix between the different levels of services provided, because these different levels of services indirectly reflect the acuity of the patients as well.

So if not already done so, you may want to consider in a future iteration, adjustments to the for-profit, not-for-profit, and governmental based on the different levels of transport that they provide as well, because you may find that the relative differences between them may be much smaller than what's initially presented.

Otherwise, I agree with the Chair's recommendation.

More specifically, it's hard to know whether the correct number of variables is 50 or 150, but it's certainly not 600. So certainly having a streamlined group of measures that we can assess revenue and costs is

definitely needed.

There's probably also a need -- I've mentioned this previously -- for a core group of clinical measures too for performance improvement purposes and then another set of measures that's just based on locally driven priorities.

So great, great chapter, and I just want to thank you for all the work on this.

MS. KELLEY: I had a brief message from Kenny saying that he supports the Chair's recommendation.

And I believe the last in the queue is Betty.

DR. RAMBUR: Thank you, Dan. Thank you for this important work.

So just for my own benefit, I want to summarize what I think I've heard. It sounds like there's a lot of support, particularly given that the stakeholders are supportive. There's a lot of support for simplifying and to make sure that we're measuring what matters in terms of the variables.

I think I heard some difference of opinion about aggregating versus not aggregating, and we can think that through.

A clear support for thinking about how often we gather the data.

Hear your message on tone, and then the complexity around volume and case mix, I think is the other theme that came forward.

The only thing I want to also add to that is I'm still not clear how the volunteer services and the volunteer fundraising shows up in the cost, and I've been to many bake sales for emergency services. And that does not seem like the way you want to run your emergency services, especially 20 percent of Americans live in rural areas. They do dangerous work of farming and mining and ranching. So I'm not sure if that's in there or if that somehow can be captured, because it may artificially inflate -- or artificially modify the results.

And then the other thing -- and I know that's beyond the scope to put it in the parking lot for another time. As just one example, one report says 41 percent of Wisconsin residents do not have any access or do not have a continuous access to emergency services. So that's another question. If you're not providing it, it doesn't cost anything, right? So I know that's beyond this particular

report, but maybe something to at least make a note of. But at least that's what I'm hearing from all of you.

Michael?

DR. CHERNEW: So first, Betty, thank you. That was a wonderful summary. It makes my job a lot easier.

I'm going to say something in a second, but then I want to go around. Some of you haven't spoken, and I just want to just -- I have a list. I just want to get a few things for you.

But let me, again, emphasize something that's clear -- and again, Betty's summary was great -- is we're now talking about data collection and our basic goal, and again, I think there's a lot of support from stakeholders is it's good to have data collection, but it should be as minimally burdensome as possible. And so that's broadly in the second bullet point streamline, but that includes not just fewer variables, but it could be less often, different ways, a lot of things to do.

So that's my general sense, and just to emphasize, we are not trying -- and I think you all pointed this out. We're not trying to make a comment about how payment should change. That would be for another time and

another way. This is admittedly at least focused to some extent on collecting the data that would allow it to work in the current system.

Brian, I take your point that you might want other types of systems to use. I'm not sure. And as a pretty free market economist myself, who generally considers himself to believe a lot in markets and competition, and competition is a way of revealing information, I'm not sure ambulances would be where I would start, but that is not for me to say. That is for another meeting. So we're not going to talk about that -- well, we can talk about it all you want, but that's not really part of the vote. The vote is not how we should pay ambulances. The vote is whether or not this data would be useful, and I hear a lot of support for that.

So I do want to go around. There were a few other people, and I think at least on my list, I'm just going to do this very quickly.

Paul.

DR. CASALE: Yeah. So I support the recommendation and also support the Commissioners' comments about if we can signal to them that you've done a terrific

job, that staff has, with this data on the streamlining, and is it -- wouldn't it be helpful to them as they're thinking of streamlining to either do further work with MedPAC or reach out to the staff to continue their thinking around streamlining?

DR. CHERNEW: Tom.

DR. DILLER: Yeah, I support the recommendation.

DR. CHERNEW: Greg.

MR. POULSEN: Also support it.

DR. CHERNEW: Wayne.

DR. RILEY: Support.

DR. CHERNEW: Gina.

MS. UPCHURCH: I support the recommendation.

DR. CHERNEW: Scott.

DR. SARRAN: Great work, Dan, and I support the recommendation.

DR. CHERNEW: Anyone I forgot?

All right. Dan, outstanding job. Really appreciate it.

We're going to take a five-minute break, and we're going to come back to talk about -- we're going to come back to talk about a really important and very

challenging issue. So enjoy your break for a few minutes, because it's going to get intense in some ways. Hospice. So see you in a few minutes.

[Recess.]

DR. CHERNEW: Hello, everybody. Welcome back. We have a really interesting and very challenging topic we're about to talk about, which is access to certain complex palliative care services for people in the hospice program. This is a really conceptually complex issue and a very important one.

And we're going to start with Nancy taking us through it. Nancy.

MS. RAY: Thank you.

Good morning. Today we are going to discuss issues related to the provision of certain complex palliative services under the hospice benefit for beneficiaries with end-stage renal disease, ESRD, or cancer. This is the third time that we've had a public presentation about this topic. We first discussed these issues in April 2025 and then in September. This material is intended to be an informational chapter in the upcoming June 2026 report. The informational chapter is not

expected to include recommendations.

Before we begin, I'd like to remind the audience that they can download a PDF of the slides on the right-hand side of the screen.

Here's a roadmap for today's presentation. First, we will discuss some background on hospice, and then we'll briefly review our interview findings and data analysis that we presented in September. We'll conclude with a discussion of potential policy approaches and the advantages and disadvantages of each approach that policymakers could consider.

So first, background on hospice. Hospice provides Medicare beneficiaries with an option for end-of-life care focused on symptom management, emotional support, and quality of life. Enrollment in hospice is voluntary. It is a personal choice made by a beneficiary and their family. Roughly half of Medicare decedents choose to enroll in hospice.

To be eligible, a beneficiary must have a life expectancy of six months or less if the disease runs its normal course as determined by their physician.

When a beneficiary chooses to enroll in hospice,

they agree to receive palliative care for their terminal illness and related conditions under the hospice benefit and forego care for those conditions outside of hospice.

Hospice providers assume financial risk for all services that are reasonable and necessary for palliation of the terminal condition and related conditions. Medicare generally pays the hospice provider a daily payment rate that does not vary based on the number of visits, services, or treatments furnished.

In rulemaking, CMS raised questions about access under the hospice benefit to dialysis for beneficiaries with ESRD and radiation, blood transfusions, and chemotherapy for beneficiaries with cancer. And the agency sought comment on whether hospice payment changes were warranted.

At our November 2023 public meeting, we presented a hospice work plan. Commissioners expressed interest in learning more about access to complex palliative services, including dialysis under hospice.

Based on Commissioner interest and input, our research examines access to hospice for beneficiaries with ESRD and cancer and current experience with the provision

of dialysis, radiation, blood transfusions, and chemotherapy in hospice, and whether the hospice payment system influences access to these services and approaches that policymakers could consider if changes to the PPS are warranted.

Our research involved a literature review, stakeholder interviews, site visits, and data analyses. Based on feedback during the September 2025 meeting from Commissioners, we revised the materials, including fleshing out more about each of the potential policy approaches.

About the role of dialysis, radiation, and blood transfusions in the hospice benefit. For beneficiaries not enrolled in hospice, these services are typically furnished to beneficiaries with the goal of extending life. For some hospice enrollees, however, these types of services may be palliative, and CMS stated that these services, when palliative, can be furnished under the hospice benefit. Thus, their provision under the hospice benefit raises complex issues.

For example, at what point does the purpose of the service become palliative and fall within the scope of the hospice benefit? These determinations are

individualized, specific to the circumstances of an individual patient and the judgment of their physician.

A second complexity concerns the potential effect of the provision of these services on a patient's prognosis and eligibility for hospice. If the service is both palliative and life-extending, the hospice physician would need to determine the service's expected effect on the patient's life expectancy and whether the patient would meet the hospice eligibility criteria while receiving the service.

A third complexity relates to variation across clinicians and providers and their views about whether these services are consistent with the hospice model of care. Some clinicians and hospice providers may view treatments such as dialysis, radiation, and blood transfusions as not palliative, and thus not consistent with the hospice model of care. We added a new text box to the chapter about the different views that we heard about this issue.

Medicare navigates this complexity by leaving it to hospices to decide whether they offer specialized services, relying on the medical judgment of the hospice

physician and preferences of the patient and family.

Grace will now take you through some highlights of our research.

DR. OH: In the next few slides, I'll briefly summarize the key points from our stakeholder interviews and analyses of Medicare data.

MedPAC staff interviewed clinicians, hospice providers, and dialysis facilities, as well as family caregivers to learn more about experiences with these complex palliative services and hospice care.

Among clinicians that we interviewed, there was general consensus that dialysis, radiation, and blood transfusion may be palliative for some hospice patients, but there was less consensus about the role of chemotherapy for palliation in hospice.

Hospices that furnish these services reported multiple reasons for doing so, depending on the patient, such as for symptom relief, to ease decision to transition to hospice, or to help a patient reach a goal, such as attending a family wedding.

Interviewees viewed these services as cost prohibitive for many hospices. Some cited examples of

other high-cost services.

Lastly, interviewees indicated that some dialysis or transfusion-dependent patients do not enroll in hospice, or they enroll very near the end of life due to concerns about withdrawing from these treatments upon hospice enrollment.

Next, we used available Medicare data to look at hospice use patterns among beneficiaries with ESRD and cancer. We found decedents with ESRD are substantially less likely to use hospice, and those that do have much shorter stays than other decedents.

Decedents with cancer are more likely to use hospice, but have shorter hospice stays compared to other decedents. Beneficiaries with blood cancer, particularly those that are transfusion-dependent, have shorter stays than beneficiaries with other cancers.

We are unable, however, to examine how frequently hospice providers furnish certain services like dialysis, radiation, blood transfusions, and chemotherapy, because CMS does not collect this information on hospice claims. Hospices were previously required to report information on the drugs they furnished during hospice stays on claims

between April 2014 and September 2018, but are no longer required to do so.

Looking at the last full year of claims data with drugs furnished during hospice stays in 2017, we found that among hospice enrollees with cancer, most received drugs across many therapeutic classes during their hospice stays, but reported use of chemotherapy drugs was less than 1 percent.

Given these data limitations, we estimated the cost of providing dialysis, blood transfusions, and radiation during a hospice stay by modeling hypothetical scenarios and compared these costs to Medicare's payment for the stay.

We modeled two hypothetical scenarios for each type of treatment with different assumptions about hospice length of stay, treatment frequency, and cost for each service. Our assumptions were informed by the literature, our analyses of Medicare data, and input from MedPAC staff physician. These comparisons are meant to be illustrative only and to give a rough sense of the orders of magnitude.

The estimates across the scenarios suggest the costs of these treatments could constitute a substantial

portion of Medicare's hospice payment for a stay in which they are furnished, ranging between 40 to 50 percent of total hospice payments for the stay for dialysis, 30 to 50 percent for blood transfusions, and 10 to 30 percent for radiation.

For some hospice providers, the hospice payment system may create a disincentive for hospices to furnish palliative dialysis, blood transfusions, and radiation.

For a forthcoming March 2026 report to the Congress, the Commission concluded that the aggregate level of payment for hospice care exceeds the level needed to furnish high-quality care to beneficiaries.

The aggregate Medicare margin was 8 percent in 2023 and projected to be 9 percent in 2026. This suggests budget-neutral payment adjustments may address payment adequacy for some services or stays.

I will now turn it over to Kim for a discussion of potential policy directions.

MS. NEUMAN: As Grace discussed, based on our interviews and data analysis, we've identified potential issues related to Medicare's hospice payment policy and access to certain complex palliative services.

We've explored several different approaches policymakers could consider as potential next steps, which we discussed in September and will discuss in more detail today. These approaches focus on data reporting and payment policy. The approaches would not change the structure of the hospice benefit or the role of the hospice physician in determining the mix of palliative services offered to a patient under hospice.

So this next slide provides an overview of these potential approaches. They include enhanced data reporting, policy changes to the hospice prospective payment system, or a voluntary transitional program for hospice enrollees. We will walk through each approach and some advantages and disadvantages and design considerations.

So before discussing the specific approaches, here are some general principles or objectives that could be considered when evaluating potential policy approaches to address hospice payment accuracy and access to complex palliative services. They include maintaining incentives for efficiency present in the hospice bundled payment approach, targeting any additional payments toward

providers that are furnishing high-cost services in an efficient manner, and structuring any changes to minimize vulnerability to fraud and abuse.

So here's the first approach. To address Medicare's lack of data on the provision of complex palliative services by hospice providers, the Secretary could consider having hospices report data on the provision of these services. This could help policymakers learn more about current access to such services before considering modifications to Medicare payment policy, and if policymakers decide to consider payment policy changes, the data could be used by CMS to structure and model potential approaches.

On the other hand, additional data reporting would increase administrative burden for some providers. However, there is precedent for this type of data reporting via claims, and CMS could keep reporting burden in mind as it designs this approach, considering which services would be subject to reporting and for how long.

Next, we'll discuss two separate changes to the hospice payment system policymakers could consider that are aimed at improving the payment accuracy of the hospice

payment system in a budget-neutral manner. These options are distinct, not intended to necessarily be implemented together.

The first potential approach would establish an outlier payment mechanism in which Medicare pays hospice providers who furnish certain high-cost complex palliative services an outlier payment for a portion of the service's cost above a fixed loss amount.

The advantages of this approach are listed on the slide and include targeting funds to providers furnishing certain complex palliative services, increasing incentives to furnish these services where appropriate for the patient, and maintaining the bundled nature of the hospice payment system and incentives for efficiency.

On the other hand, some stakeholders may view outlier payments, which compensate for a portion of higher costs, as not sufficiently increasing incentives to furnish certain complex palliative services.

If policymakers pursue an outlier policy, there would be a number of design choices to be considered; for example, which services would be eligible for an outlier payment, how to set key parameters in the outlier policy,

and what type of data sources would be used to estimate the cost of outlier services.

Across Medicare's other payment systems, outlier policies take varied approaches on these design issues. We've added a text box in the paper that discusses outlier design options, and we'd be happy to discuss on question.

An alternative approach aimed at improving payment accuracy would be to provide an add-on payment to hospices when they furnish certain costly complex palliative services, such as palliative dialysis, blood transfusions, or radiation, in addition to paying the hospice its daily payment rate. This approach would target funds to providers furnishing these services and would increase incentives to furnish them.

On the other hand, this approach would unbundle some hospice services, potentially undermining the structure of the payment system. In addition, some providers seeking higher payments might offer these services in a manner not consistent with the palliative intent of the hospice benefit.

If policymakers design an add-on payment for hospice providers, there would be a number of design

choices, as shown on the slide; for example, which services would be eligible for an add-on, how would CMS set the add-on payment rate, what size of reduction to the hospice base rate would be needed for budget neutrality, and how would CMS ensure program integrity.

So as an alternative to either of the last two approaches, the Congress or the Secretary through the CMS Innovation Center could consider a transitional program.

Under a transitional program, hospice enrollees would have the option to receive certain complex palliative services, such as dialysis or blood transfusions, paid outside of the hospice benefit for some transitional period or up to a specified number of treatments.

We learned from interviews with clinicians and the literature that dialysis and blood transfusions can be both palliative and life-extending for certain beneficiaries nearing the end of life, and that the prospect of ceasing these treatments upon hospice enrollment may dissuade some beneficiaries who wish to enroll in hospice from doing so, in part, because ceasing these treatments is likely to result in death in a short period.

A transitional program could give dialysis or blood transfusion-dependent beneficiaries who are near the end of life and wish to wean off these treatments while enrolled in hospice an opportunity to do so.

Under this approach, Medicare would pay the non-hospice provider directly for the transitional service while continuing to pay the hospice provider the standard daily rate. This structure may be operationally simpler for some hospices, particularly small providers, because they would not need to contract for the complex service. On the other hand, this structure might lessen hospice's ability to fully manage and coordinate the patient's palliative care.

Design considerations for this type of approach are shown on the slide; for example, what complex palliative services would be eligible for the transitional program and how would the transitional period be defined.

So, to conclude, this slide summarizes key findings and potential policy approaches that could be considered. Findings from our interviews, literature review, and data analysis, which Grace outlined earlier, are listed on the slide.

In light of these findings, the Commission has explored several different approaches that policymakers could consider to address access to certain complex palliative services for hospice enrollees, including enhanced data reporting, changes to the hospice prospective payment system, and a transitional program.

So this brings us to the end of our presentation. We would be glad to answer your questions, and we look forward to your discussion and would appreciate any additional feedback on the materials, which we will incorporate into the Commission's chapter for publication in the June 2026 report.

Let me turn it back to Mike.

DR. CHERNEW: Nancy, Kim, Grace, thank you so much. I know there's a lot to discuss here, and I think Lynn is number one in the Round 1 queue.

Is that right, Dana?

MS. KELLEY: Yes.

MS. BARR: Thank you. Great report.

I just wanted to -- I had a question because of, you know, a lot of -- there's a lot of new dialysis patients at the end of life, and I want to just clarify

that we're talking about patients that already have ESRD or are already getting dialysis, not new dialysis. Is that correct? So this is really strictly -- we're not talking about initiating dialysis on any of these hospice patients in this?

MS. RAY: That is correct.

MS. BARR: Thank you.

MS. KELLEY: Gina?

MS. UPCHURCH: First of all, thank you guys so much. This information just gets better and better. I found myself reading it and having a question, and the next paragraph, you answer the question. So this read really well, and it's very thorough, and if we need to do anything right as the Medicare Payment Advisory Commission, it's getting dying, being as supportive as we can in a dignified death for our fellow citizens.

I have just a couple questions for you. When somebody's enrolling in hospice care, are consumers told there are four levels of hospice care, and we only provide two of the four. So, for example, there's routine home care, general inpatient, continuous home care, and inpatient respite. Are people told proactively, by the

way, the one down the street -- and now, of course, this is a luxury, because some people only have like one hospice option, but if you're in a place that has multiple hospice options, do you know that proactively?

And then the second question related to palliative care that we're talking about, do you know that, oh, this one gives you a little dialysis for palliative care, this one does not? Are you told proactively about these things when you enroll in hospice?

MS. NEUMAN: So first in terms of the levels of care, under the hospice conditions of participation hospice providers are required to be able to furnish all four levels of care. When we look in the data, we don't see that happening, but that is a requirement under the hospice conditions of participation.

MS. UPCHURCH: Interesting.

MS. NEUMAN: In terms of the more complex services like dialysis, blood transfusions, radiation, and I think some of the physicians here might be able to speak to it better than I can, but my understanding is, in general, when hospices and families and the doctors are having conversations about someone being referred, these

kinds of issues come up about what services we can offer you. And especially for a blood transfusion or dialysis-dependent patient, that becomes a part of the conversation. But if you're asking is it publicly available somewhere? No, not that I'm aware of.

MS. UPCHURCH: Okay. That's interesting. So now I'm curious about the answer to the first part, the four levels of service, if they are not being provided by some, what are the repercussions of that? Are there any?

MR. MASI: Brian, do you want to get in here real quick?

DR. MILLER: Yeah, just a quick thing. When you enroll in hospice, if you are in the inpatient setting it's social worker in conjunction with the case manager. In an outpatient setting it might be like the oncology or hematology social worker. Those social workers know way more than the doctors and they know what the local hospices are, which do inpatient, which do inpatient versus home hospice, what that sort of scope is for home hospice, and sometimes that varies, obviously, a bit for geography and arranging DME deliveries.

So even some of the hospice organizations are

really big. Some of them are really small and really local. But the social worker sort of plugs the patient and their family into the area for the organization that covers their geographic area or the choices thereof, and educates them on the scope of services. And often the family has a question about what is included and what is not included, and they ask the social worker who works with the hospice liaisons to figure that out.

So that information is definitely made transparent to the family. It's not like on the Medicare Plan Finder, for example. But as I said, it's a highly localized decision.

MS. UPCHURCH: Right. And I know that, and I appreciate that.

DR. RILEY: Just quickly a comment to that. Josh and I just had a sidebar, because some hospice organizations will accept patients on dialysis, and some will not. So it can be an exclusion or inclusion criteria that the family, through the social worker, will know.

MS. UPCHURCH: Okay. Well, and that was my second question, so thank you. First of all, what are the repercussions of, it sounds like you're support to provide

all four services but some don't. The local social worker should know. I mean, this is all ifs, ands, or buts, that make me a little anxious.

But the second question is these more costly services that may be palliative, on page 25 it says that sometimes they will not admit patients to their hospice. Is that allowed? I mean, forget the extra palliative care. But if you think this person, ooh, they may need these more expensive things, this person has ALS, this person has ascites and we're going to have to drain it, let's not admit, they are participating providers in Medicare but they can refuse to admit hospice patients?

MS. NEUMAN: So my understanding, in general, is that a provider has to have the capacity to be able to care appropriately for a patient. So a provider could see a patient that has complex needs and say, "We don't have the capacity. We don't have the staff." And I don't know if that's entirely unusual to hospice. I think that might also occur in some other settings.

MS. UPCHURCH: That's interesting. Okay. Thank you. And my last question, on page 74, it said that dialysis facilities can charge the hospice provider more

than the fee-for-service rate, and I'm like, how is that allowed? I mean, I know there are non-participating, where you can charge up to 115 percent of the cost, but how are hospice providers having to pay more for things like dialysis? It's on page 74.

MS. NEUMAN: You mean what we heard in our interviews with some of the providers?

MS. UPCHURCH: Yes, mm-hmm.

MS. NEUMAN: Yeah. So I think that it's a negotiation between the two providers.

MS. RAY: Yeah. I mean, it's a negotiation between the two providers.

MS. UPCHURCH: Right. But fee-for-service Medicare is covering it.

MS. RAY: No. Under this circumstance it would be covered under the hospice, thus it's in the bundled payment, just like -- and Kim, tell me if I'm wrong -- just like when the hospice provider provides oral painkillers. I mean, that's up to the hospice provider to negotiate what it pays for those drugs.

MS. UPCHURCH: So they're not using the economy of scales of Medicare at that point. You've moved it over

to a -- okay. I think you've answered my questions. Thank you, guys, again for great work.

MR. MASI: Brian, did you want to get in here, as well?

DR. MILLER: A quick thing on the capacity in hospice. Any organization, whether it's hospice, home health, or the orthopedic surgery in replacing someone's hip, has to have the capacity. So it’s not that the hospice organization is like, I don't want this patient and I want this patient. It's like, I don't have the staff, I don't have the DME, I don't have the geographic coverage. So it can happen with home health. It can happen with anything. It can happen with your local outpatient orthopedic surgeon. So it's not industry specific.

MS. UPCHURCH: And it could include them trying to avoid high-cost patients. It could be both. Thanks.

MS. KELLEY: Tom.

DR. DILLER: Yeah, very good presentation and analysis. My concern is, and I may be incorrect on this, but that some hospices just simply don't provide those services. They say they are out of their scope. And that is especially the case in more rural areas.

There was an assessment done in here, in the document, about the percentage of hospice payments for dialysis transfusions, et cetera. Has there been an analysis done on the incremental costs to Medicare? Because I'm making this assumption that most of the patients that are getting transfusions or dialysis, and maybe radiation treatment, who are not offered that in a hospice program, choose to stay in the Medicare fee-for-service program and forego the benefits of hospice, but Medicare is still paying for those services.

So I don't know that the incremental costs of covering for those, I don't know what that is, and I don't know if you guys have any idea relative to that.

MS. RAY: So we don't have a counterfactual analysis that you're asking for. There is some items referenced about the VA concurrent model that highlights the utilization of services.

MR. MASI: But, Tom, to your point, I think you're raising a great point that the counterfactual here is really complicated to think through. And I think to the extent that if Congress took this up as a legislative effort, or if the agency decided to implement something

here through rulemaking, it's potentially a very challenging analysis for our friends at the Congressional Budget Office.

But I think one thing I would emphasize is that for many of these approaches it could be designed to be budget neutral with respect to like spending under the hospice program, whether that's an outlier pool or some kind of add-on, where Medicare has some experience in implementing those things in a budget neutral manner, at least for spending under that particular payment system.

But I think you're raising a great point that spending beyond that payment system, whether it's on dialysis or other services, would be really complicated to weed through.

DR. DILLER: Yeah, and the follow-up question is what percentage of patients on those services, eligible for hospice, then don't go into hospice, they choose the alternative? And I'm coming from a personal experience. That was the choice that was made. So Medicare still paid for the transfusions, but the beneficiary didn't get the benefit of hospice.

MS. NEUMAN: Yeah, so what we know is we know of

those folks who have blood cancer, for example, and pass away, what share of them get hospice versus not. And what we don't know is how many of them that chose not to get hospice chose because of these services. We don't have a way to get at that.

DR. DILLER: Thanks.

MS. KELLEY: Okay. that's all I have for Round 1, unless I've missed anyone. So we'll go to Round 2.

DR. CHERNEW: That was all I had, too. Let me just say one quick thing to summarize where we are, and then we are going to jump into Round 2. The key issue here is, in some ways, the requirement that you give up certain types of treatment if you join hospice becomes a barrier to joining hospice. That can be bad for some patients, for a bunch of reasons, because hospice is valuable for a lot of patients. On the other hand, if you just opened it up, for example, that anybody could be in hospice you worry not about the savings on the transfusions but you're just providing a lot more expensive hospice services to people. So you want to make sure that people in hospice are appropriate, and that comes up in a lot of our other work.

So I think we're sort of dancing around this

balance, in part, and I think Gina said this at the beginning, we're motivated by beneficiaries getting the right amount of care but we're worried about, in many ways, sort of the fiscal consequences of just making it wide open. Paradoxically, in some cases -- and I want to emphasize the word "some" -- it could actually pay for itself by getting people in the appropriate care, and some of those people will just naturally wean off of -- and I don't know if that's the right word -- certain types of services, and estimating that is challenging, and I think it's a challenge for our friends at the Congressional Budget Office.

But the concern we've had that motivated some of this work was that there were a lot of people that were not getting access to care, which it might both benefit them and potentially be more efficient, and that's kind of where the discussion is with these policy options. So now we're going to get your comments on that. Lynn, I think, again, you're going to be first.

We're not at the stage now where we're making recommendations. You know, I often talk about the cycle to get the recommendations. We have to have a discussion,

then there will be a draft recommendation, and then there will be a vote and stuff. The question is how many of these types of meetings do we have to have before we move to the next phase of that process.

So as we go around, getting some sense of how you feel broadly and some sense about what type of direction one would want to go will be useful in crafting whatever happens, frankly, post me. But there is a tension of who is responsible financially, how the program is structured, and as Paul noted, the design parameters matter. Anything we do could be made budget neutral, with tradeoffs.

Anyway, Lynn, I think you are first, and then we're going to go through Round 2 queue.

MS. BARR: Thank you for this excellent work. I would just like to comment that I do think that this is important that we do offer palliative care to our hospice and that we make sure that the benefit is available to people, regardless of their particular disease. And I am in favor of further exploration of the outliers with a budget neutrality approach.

MS. KELLEY: Scott.

DR. SARRAN: Kudos for great work, especially in

the incorporation of the qualitative interviews, which I think we're seeing more and more are really helpful adjuncts to our decision-making.

Here is how I sort of take away and frame my thoughts and recommendations in terms of next steps. I think we have the opportunity to move fairly quickly to solve a finite problem, and I think that we should have a sense of urgency around that. Because although this impacts a relatively small number of beneficiaries, for those beneficiaries impacted it is hugely important in terms of affecting the ability to deliver on the very promised premise, holy grail, of hospice, which is the ability of a provider and a beneficiary to define, continuously modify, and execute on a jointly developed care plan consistent with beneficiary goals and within the overall framework of palliation.

The problem, as you point out, is created because the cost of certain services that can be, for some beneficiaries, an integral part of that palliative care plan create a barrier. And we could argue about should hospices be forced to deliver services, but they are not, and rather than kind of continuing to go down that road I

think we should think about how we can most quickly solve that. I'd also encourage us to not let perfection be the enemy of good and reaching that useful conclusion.

So the real question then becomes how to remove the barrier that exists today. And a reminder, and this is somewhat of a response to Mike's earlier point, it's not just a barrier potentially at the time of enrollment, meaning some beneficiaries who are essentially denied enrollment in hospice through which they can receive a lot of meaningful services, but it also can frequently be a barrier while they are already enrolled in hospice. For sure, palliative radiation therapy for a newly symptomatic bone metastasis is a fairly common clinical scenario to come up during somebody's hospice stay.

So again, the question, I think, is how do we remove that barrier in a reasonable, expeditious, reasonably prudent, and ideally revenue neutral fashion.

So where I go with this is I don't think the transitional care program really is a good solution, because I think that solves it just at the front end enrollment point in time but not during a subsequent stay. So in my mind I sort of put that to the side.

I'm personally comfortable with either of the approaches, the outlier or the add-on. I think the potential for misuse in gaming for those is relatively small in the scheme of things, for a variety of real clinical reasons. I somewhat prefer the outlier, but I don't think there is huge differences.

So, in conclusion, I would just urge us to move as quickly as we can towards making a recommendation, and if we need, at a point in time, when we're making a recommendation, to land on one or the other, I am comfortable with both. Again, I slightly prefer the outlier. Thanks.

MS. KELLEY: Tamara.

DR. KONETZKA: Thanks for this great work. There are two points I wanted to make for the record. One is I really like the guidelines that you set out in the chapter about what we should be thinking about in terms of potential policy changes in the future. I guess I would add one that I feel very strongly about, and that is consistent and equal beneficiary access to services. I know that there are reasons that different hospices may be able or not able to offer certain services. There may be

capacity issues. There may also be financial incentives. And then this sort of bucket of things we've been discussing as sort of differences in philosophy.

I think that we may never sort of even the playing field completely because of issues like capacity constraints, but I think to the extent possible we should minimize those other differences. I think it's really important when somebody is thinking about choosing hospice that beneficiaries in different places across the country have sort of the same access to the same potential services, whether or not those have been traditionally part of the hospice bundle or not. So I just wanted to add that principle.

I don't quite think transparency is enough. Transparency is good, but I'm not sure how many hospices people always have to choose from and how much variation there's going to be and what each hospice decides is consistent with their philosophy. So I think there should be some sort of guidelines around that.

Beyond that, in terms of the policy options that are discussed in the paper, I do think that I like the idea of transitional care. I would not be opposed to the idea

of an outlier payment. I think the idea of the add-on I like the least out of all of these options, in that I think moving towards unbundling services is probably a bad idea if we're already concerned about financial incentives determining what patients get. So I don't really want to unbundle any of the hospice services.

I like the idea of the transitional care because I think the evidence is pretty promising that that one eases this really big burden of deciding to go on hospice in the first place, which I think we want for more ESRD patients, as well as allowing them to get the sort of concurrent palliative care that they need for a while. I think we could probably tweak the details in terms of how long those palliative services can go on.

I think the evidence is probably insufficient on transitional care right now in that these haven't really been scaled. Like we don't really know what's going to happen to the financial incentives and whether people will sort of continue to use less and less of the sort of nontraditional hospice services over time. So I'd love to see more evidence on that. If, in a short run, outlier payment seems preferable to sort of solve the problem, I

would not be opposed. Thanks.

DR. CHERNEW: Can I just jump in and ask a question? This is a little bit of a Round 1 question. For a lot of these services, palliative radiation and I think dialysis, the hospice itself, as far as I understand, is not actually providing the service. The service would be provided by a local provider that provides those types of services.

The issue here about bundling or unbundling or capacity, it's not really a capacity issue for a hospice to provide those services. They're going to get them somewhere else, where they might have been getting them otherwise. It's really an issue of who bears the financial risk for those services, and if that financial risk is included in the sort of capitated, if you will, per person-ish hospice payment, or whether there is an added payment, and whether that added payment is 100 percent, so then there's no risk to the hospice in providing that service, or whether it's partial, which could be done either through an add-on payment or through an outlier policy, just depending on how you structure it. But both of them have that flavor.

But it really relates to the risk bearing of the provision of these services, I think much more than whether the service is bundled, like it's provided by the same organization or not, or whether there is a capacity. I don't know if what I said was right, because this isn't actually my area, but is that essentially the way to think about it? We are really talking about risk bearing for expensive services, that are people who are covered in a hospice budget, if you will, that's not necessarily able to deal with that heterogeneity or variation very well.

MS. NEUMAN: Yes. So that is a big chunk of it. The bundle is intended to cover all palliative services, and so under the current payment system, the hospice fully bears the risk. And one question is whether there should be different ways to pay that might change who's bearing the risk. So that is one really big and important piece.

Another thing I would say is that the hospice providers are not directly providing these services. That is correct.

When we interviewed hospice providers, they talked about sort of the challenges involved in contracting with outside providers for these services. Bigger

providers had more capacity, found it less challenging than others to do so.

And then also, some patients who get some of these services may need certain kinds of monitoring or different kinds of services, and so there is a piece of it that also involves the capacity of the hospice, if that makes any sense, even though the provider who's directly administering the treatment is not the hospice and is being paid either by the hospice or in some other models in a different way.

MS. KELLEY: Brian.

DR. MILLER: Thank you for -- the three of you for picking up a political-policy hot potato and distilling it into a clear set of policy options for us. I know that's not easy.

So looking at those big-picture policy options, enhanced data reporting disadvantages small providers, favors large incumbent businesses who can bear regulatory costs, as I mentioned. That's a concern on that.

The trend -- because we don't -- there are some large hospice providers. We don't necessarily want to favor them.

I don't think a transitional program is a great idea because it increased costs, and frankly, in the real world, before patients get to hospice, patients, families and physicians can and do scope care. That's appropriate. We should let them do that of their own volition. We don't need to create another specific program for them to make those choices.

And I really, really like the budget neutrality set of options that sort of fits with where our Chair has targeted before, which is targeting existing payment better. To me, this is a targeting problem as opposed to more money into the pot. Margins from our annual payment update, we can debate as to the exact dollar -- or I'm sorry -- percentage of those margins, but the number that we got was 9 percent. So that seems like a healthy margin with additional space that would then benefit from better targeting. And our recommendation, I believe that we voted on unanimously was eliminating the 2.3 percent current law update.

So to me, when I look at this specific problem within that context, it says we should -- better target spending in a budget-neutral fashion so that people can get

more, comma, more equal access to items and services in hospice, as opposed to dumping more money into the hospice sector.

Hospice sector does have some other problems I want to highlight. One is that there is a wide range of sort of fraud, waste, and abuse behavior in the hospice sector -- we've talked about that before -- where rules get bent or broken in the pursuit of profit. Other Commissioners have commented on some of these profoundly unethical corporate practices. So again, that sector probably needs better targeting of spending, more oversight, as opposed to more funds.

I'd also think that, you know, the hospice sector can't really have its cake and eat it too. So if hospice providers want to sort of have other things be carved out and, as Tamara said, unbundled, that's a concern. If we're unbundling high-cost items and services and transferring them to other sectors, that's sort of unfair to HOPDs, dialysis facilities, and hospitals to say, oh, by the way, you know, you are now responsible for these services that hospices previously were financially responsible for.

I'd also note that, you know, the hospice sector

is sort of about trade-offs, and those trade-offs are unpleasant because, you know, to put it no other way, dying sucks. None of us want to die. You know, it's not a fun process. We're trying to make that process better and hopefully less terrible for folks. But there is that trade-off where you're focusing on sort of symptom treatment, sort of lower medical practice intensity with higher symptom and higher labor intensity, and that's a good and a healthy trade-off, and those are real trade-offs. And we should probably make beneficiaries more aware of what those trade-offs are, and other Commissioners have commented on that. I don't think that means we need to dump more money into the sector.

I'd also note that this is the one sector that is not subject to the oversight of managed care. There are many problems with managed care and many things that we have all talked about that we could improve, but hospice should be part of managed care just like it should be part of fee-for-service. We don't want selection at the end of life, right, where benes have to disenroll in order to enroll in hospice. Maybe there's a role to have strong network adequacy requirements and other consumer

protections so that hospice could be part of MA for some beneficiaries, and MA plans could experiment with offering more services to those beneficiaries in sort of that risk-adjusted capitated environment.

So I guess, you know, in conclusion, I love the idea of budget-neutral options to better target patients. I do not like the transitional program, and I worry about enhanced data reporting favoring large companies.

MS. KELLEY: Stacie.

DR. DUSETZINA: Thank you again for this really great work.

I really appreciate the additional data that you added to the chapter and especially on Table 4 where you highlight use of services for people with ESRD at the end of life, and I think it kind of points to some of the potential, you know, like more people in the hospital at the end of their life, more people in the ICU at the end of their life if they haven't elected in the hospice.

So I don't think we have a similar table for people with cancers who potentially would benefit from blood transfusion. So that's maybe a data request, is to potentially add that population to have those mirrored data

points.

You know, I think in general when I consider the different options, I really like the idea of testing a care transitions model for these two populations, because I think hearing from clinicians, at least on the cancer space, I think there is a lot of, like, historically people not being able to transition in a hospice. So having a model, maybe a CMMI demonstration project or something like that, strikes me as it could help us to learn how to transition patients well and to measure things that are important to patients and their families about their goals of care and how well those transitions are happening. So I find that to be a really attractive way of thinking about moving this forward.

I also really like the idea having the payments going directly to the providers rather than having to go through the hospices, because it seems like that eliminates a lot of the concerns around unbundling services, but also kind of eliminates concerns about some hospices not being able to negotiate prices that are as good. So having that out of their hands I think seems like a helpful thing, at least for the hospice and for the other providers.

I think my last comment here is really about the information available to people when they're selecting hospice, and I do understand that this can vary quite a bit by area, and I feel like, you know, the hospice philosophy piece of this doesn't sit that well with me, just that you can get different services depending on where you get your hospice care.

I think people should have the opportunity to at least know that very clearly. So if a hospice is not willing to provide or does not provide those services, that that information should be available in places where people go to seek out information about hospice.

So in, like, the Care Compare website, for example, there are lots of different measures you can use to understand the hospice care you might receive and to be able to compare across different organizations that serve your area. So just being able to flag something like that at a minimum of whether those services are available feels like something we could do in the relatively near future, CMS could do in the near future, while we work towards bigger picture reforms here.

But excellent job as always. Thank you.

MS. KELLEY: Tom.

DR. DILLER: Yeah. I tend to echo some of the things that Stacie just mentioned.

As I think we all know, the problem with fee-for-service is the potential to pay for unnecessary services, that excessive numbers of those occur. And the problem with capitation, which is what the hospice program is, is that necessary services can be limited and not provided in that there's some gamification that goes on within that.

So I guess my concern is the current model, even for hospice payment, the right model -- and we had some of that conversation earlier -- think with this -- all three of the solutions, I think, are viable, but they seem to me to be tweaking the existing problem as opposed to, all right, what do we really need to do here?

I think I would probably favor the transitional model. I don't think it needs to have limits on it, and I think the payments can be outside of the hospice bundle and going directly to the providers. But the outlier payment model also is a viable option.

I think the issue for me, though, is, quite frankly, should the whole thing be blown up and let's start

over? And I don't know that that's not the correct answer.

Thanks.

MS. KELLEY: Robert.

DR. CHERRY: Yes. Thank you for the great presentation and teeing up this very important topic.

Clearly, CMS is also wrestling with the same questions that we are, which is what are the barriers to care for certain types of complex services that are needed for hospice patients, and are those barriers actually related to the payment system?

And I think all of this is actually good to revisit, because over the years, palliative care has evolved as a specialty, and what it means to provide comfort has changed over that time period too, particularly for patients who are entering their final stages of life.

And so blood transfusions, which may have not been a consideration, dialysis which may not have been a consideration or now considerations -- and there's a lot of talk about what is the appropriate use for chemotherapy as far as palliation goes in a hospice care setting. So it's definitely good to revisit all of this.

I also think it's important to provide clear,

potentially actionable feedback to CMS as it also weighs its options as well.

For me personally, I think this is a step in the right direction. I would tend to favor the high-cost outlier model as a reasonable compromise between the current state, which is somewhat limiting, maybe even somewhat antiquated, and the add-on payment model, which may have some unintended consequences in terms of controlling costs.

None of this, though, prohibits us from continuing to look at data and continuing to analyze the issue and provide refinement to the approach.

So thanks again for the discussion and the presentation.

MS. KELLEY: Cheryl.

DR. DAMBERG: Again, I'll pile on thanks for the excellent work in this chapter.

And I also found it particularly helpful to have the contextual information from the interviews with providers and family members. That was terrific.

You know, it's clear that the current payment system is potentially creating these disincentives for

hospices to furnish complex services that may in fact be palliative, and I feel like we've put patients who may be interested in pivoting to hospice in an either/or situation. It's like an on/off switch. So that's the current choice model, which I don't think is optimal for the way in which end-of-life transitions actually happen.

So I'm very supportive of trying to have some of these nearer-term fixes be explored in more detail, including changes to payments, whether those be outlier payments or add-on payments. I probably favor outlier payments over add-on payments, but I think generally, it's directionally correct.

I am also interested in continuing to explore these transitional care program-type models, because I think they start to move away from that on/off switch and may help people move in the direction of palliative care and reduction of services that, you know, aren't necessarily beneficial for improving health status.

In terms of the longer term -- and again, sort of addressing this problem of the on/off switch and sort of having this, you know, potential barrier and sort of where should palliative care sit in terms of who should lead it,

how it should be designed -- I would hope that the Commission could continue to do work in this area, that it would explore some other alternatives. And I don't know whether that would look like providing extra payments to primary care physicians to help people do the transition and maybe coordinate some of that care.

And I have to say I'm not sure whether those types of payments currently exist, but if they don't, what would a model structured like that look like?

And then in terms of data, I recognize that there are burdens to providers of having data collection, but I feel like we don't know enough about this space to really inform good design of policy, but also importantly as we make these shifts to be able to evaluate the impacts, because we know there will be behavioral changes, and we want to better understand those.

MS. KELLEY: Paul.

DR. CASALE: Thanks again for a great chapter.

I appreciate a lot of the comments from my other Commissioners and particularly Robert's comments about the evolution of palliative versus comfort and how that's moving.

And when I think about these services, radiation therapy, dialysis, and blood transfusion, certainly the radiation therapy to me is -- I wouldn't say straightforward, but I understand that you want to relieve pain. The dialysis one, I just find more challenging. As is written in the chapter, for hospice, it could be to reduce symptoms from uremia and fluid overload. Well, those are the exact same reasons why you dialyze someone who's not in hospice, and I think that's reflected in ESRD patients are less likely to use hospice and have shorter stays, because it's that on/off that's really currently with dialysis patients.

So I say that because I think we shouldn't underestimate the potential for gaming particularly around dialysis. I think that's particularly challenging.

And with that, as I think through the policy approaches, I think the transitional care model may allow a better understanding or allow less of that on/off and potentially that gradual move for beneficiaries who are on dialysis to make decisions to whether they want to continue that or not.

Thanks again for a great, great chapter.

MS. KELLEY: Gina.

MS. UPCHURCH: Yeah. Thanks again so much for this work.

I think in some of the reading, we talked about -- transitioning, I love the analogy of the off/on switch. I think a lot of times, as you mentioned with nephrologists and stuff, they're not comfortable. They aren't trained to have conversations and goals of care that would include limited life expectancy and death. And so I think on some level, when you look at the different options that we're talking about here, I'm a little more comfortable with the transitional care, less comfortable with the add-on payments because I do see that can be blown up expenditure-wise and continues to medicalize potentially hospice, which is not what's intended, but whatever we can do to introduce the conversation of goals of care that add meaning to the dying process.

So, you know, if that can be introduced, however it gets introduced as -- you know, as early as possible -- I do think it's tough from personal experience to go from your usual care and the people you have relationships with to a whole new team. So if there's some way in that

transitional period to help with that, I think that would bring a lot of comfort to people as they do transition and having the conversation with somebody they know and trust to begin with. So I just think that's an important thing for us to pay attention to.

I do like the idea of budget neutrality. So one idea that I have is just to go to the providers. I mean, certainly, when you say to providers, should we do this because it may be palliative, they'll all say yes. If you say budget neutrality, what are you giving up? That will be interesting to hear. What are they willing budget neutrality to do less of so you can do more of this? I think that would just be very informative.

I mean, I can think of all sorts of things in hospice that we could do that aren't medicalizing it more, but other things that you could do for patients in the dying process that could bring a quality of care to their lives that we sometimes do not do now. So I just -- it'd be interesting to hear from a cost neutrality, if you're going to do more of this, what is -- let them decide or let them think about and articulate what would you do less of that's in hospice now.

And then the last comment -- and, you know, we've put hospice in the fee-for-service, but we've bundled it. They get a daily rate. So my question is -- other countries have been doing this for a long time. We have a very different health care system than other countries, but what's included in their hospice? What services? How are they focused on palliative care and improving quality of life? Are there things that we can learn from other countries that might inform us as we move forward with this?

But thanks again for the tremendous work.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. Kudos for the great work.

I just wanted to be on the record saying that I think it's absolutely imperative that this work continue to move forward with shorter-term implementable recommendations and then the broader work of really thinking about how people are living and dying and care is being managed. And that's a much longer term, but should have a horizon in terms of our work or your work.

I'm hearing support for budget neutrality, which

I strongly support, and I do worry about gaming in this industry. I worry about gaming in any industry. Anything that can be game will be game. So I think that that's really an important thing for us to think about.

I mean, keeping a grid of what I hear you all saying in terms of who's where -- and it seems like there's less enthusiasm for the add-on and then some strong support for more exploration, transitional, and yet some concerns by some, and then some, you know, strong support for the outlier model and some concerns. So it seems like there's a bit of work to do to more flesh this out. But I think it's really important to be an ongoing line of work, even after this team has ridden their horses into the sunset.

Thanks.

DR. CHERNEW: That was the last person I had in the queue.

Okay. This has been a really rich discussion, and so I want to thank Nancy, Kim, and Grace for prompting it and for all the work they've done and all the Commissioners for their engagement.

I'm going to make two -- four, actually, very quick summary points, and then we're going to break and go

to lunch.

So the first one is -- these are just the four questions I think we have to answer. The first one is, how do we manage access to hospice? Hospice is clearly a valuable service for a lot of people, and we want to make sure that the appropriate people get it, but we don't want to just open it up to everybody.

The second one is, relatedly, if you join hospice, what as a patient do you need to give up, and why? And is that appropriate, and how do we manage that?

Third, who bears the financial risk for all the services that may or may not be palliative, and how do we define it? My big concern is, there's too many nuanced questions. How long will the patient live? Is this palliative or not? And those are just really hard questions to get the delivery system to manage, given all the various administrative costs and differences and subjectivity of those types of things.

And then the third one -- the fourth one, I mean, and the last one is, how do the dollars flow? Do we flow the dollars through the hospice and then it pays out, or do we flow the dollars directly to the providers? I don't

know the answer to that, and honestly, I will not have to come up with the answer to those questions.

But those are the four questions that I think are most important.

If you at home know the answers -- I feel like it's a quiz show. If you at home know the answers, please reach out to us and tell us at meetingcomments@medpac.gov. We would love to hear. In fact, if you don't know the answers and want to raise more questions or make comments about the things that we have said or otherwise explain your views on these topics, reach out to us again at meetingcomments@medpac.gov.

The last thing I'll say for those of you that may be listening this morning and somewhat of a non sequitur is, we are going to explore -- I don't know what's going to happen. We're going to explore allowing some public participation in the April meeting in person. I don't know if that will happen or how it would happen, but stay tuned. People conceptually would be allowed. Right now, we're thinking about just the Friday of the April meeting, be allowed to come and make a statement in public, very brief. I want to emphasize very brief, but one might be able to

read that into the record.

In any case, those are the things we're thinking about, and I very much appreciate the staff and all of the Commissioner comments and those listening at home.

We will be back at two o'clock. We're going to start talking about Medicare Advantage. Again, thank you for listening. We'll be back at two.

[Whereupon, at 12:51 p.m., the meeting was recessed, to reconvene at 2:00 p.m. this same day.]

AFTERNOON SESSION

[2:01 p.m.]

DR. CHERNEW: Hello everybody and welcome back. We have two sessions this afternoon, both of them on Medicare Advantage. And we're going to start with some work on Medicare Advantage network. The ability of plans to create a network is both a great strength of the plans but raises a number of issues worthy of discussion. And we are at the beginning of just trying to understand what's going on with plan networks, and to start walking us through that we are going to have Karen.

DR. STOCKLEY: Thanks, Mike, and good afternoon, everyone. In this presentation, we will be discussing the first phase of our analysis of provider participation in MA networks. Before we begin, I'd like to remind the audience that you can access a copy of these slides in the handout section of the control panel on the righthand side of your screen.

I'm standing in for Katelyn Smalley today, who is an instrumental contributor to this work, but was unable to join us today. I'd also like to thank a number of our colleagues for their assistance with this work, especially

Brian O'Donnell, Stuart Hammond, Ledia Tabor, Eric Rollins, and Andy Johnson. And we'd also like to thank Nathan Graham for his assistance with graphics for this presentation.

Today, I will first present some background and key concepts for MA networks, and discuss our analytic approach. Next, Krista will present our descriptive findings of clinician participation in networks and early findings on how networks change throughout the year, before opening it up for your discussion. This is preliminary work that we will continue in the next analytic cycle, and it is not planned for publication at this time.

When enrolling in an MA plan, beneficiaries agree to use the providers in their plan's network. Plan networks typically include a subset of providers in a local area.

As discussed in our June 2024 report to the Congress, networks can have positive implications for both quality and cost. For example, networks can encourage the use of providers that perform better on those metrics. On the other hand, misapplication of network tools could lead to barriers in beneficiaries' accessing needed care. Assessing provider networks is important to ensure that

plans provide adequate access to the full range of Medicare benefits to their enrollees.

In MedPAC's annual focus groups, both MA and fee-for-service beneficiaries prioritized being able to continue to see the clinicians they already had relationships with. Some MA enrollees described switching plans because a provider went out of network, and some fee-for-service beneficiaries cited the existence of provider networks in MA as a reason for choosing fee-for-service.

In November 2024, Commissioners discussed a workplan for studying how MA plans use provider networks to manage the care that their enrollees receive. Based on Commissioner feedback from that presentation, the workplan includes three aims: first, to analyze provider participation in MA networks; second, to analyze the use of MA provider networks by enrollees; and, third, to assess the impact of MA network adequacy standards on access to care.

In this presentation, we focus on part of the first aim of that work, participation in MA networks among clinicians. In future work, we plan to analyze participation in MA by facilities.

When choosing whether to participate in an MA network, providers face several considerations. At the same time, the Medicare Advantage Organizations, or MAOs, that offer plans are making choices about the providers they are willing to include in their networks. Both sides may evaluate payment rates compared to costs, anticipated patient volume, or whether risk-sharing arrangements provide opportunities for additional revenue gains.

Providers may also anticipate the degree of administrative burden of working with a particular MAO, in terms of prior authorization requirements, quality reporting, or billing. On the other hand, MAOs may consider providers' efficiency or other aspects of past performance. MAOs may also consider whether certain providers are needed to fulfill the network adequacy standards required by CMS.

Provider and plan ownership arrangements may further influence network status, by requiring participation in some instances, such as a health system requiring affiliated clinicians to accept the plan they sponsor, or exclusivity in others, such as Kaiser facilities being out of network for other MAOs.

Local market dynamics could also influence negotiations, including the relative market share of the provider and the MAO.

Provider participation in MA networks can change over time, and sometimes those changes can occur in the middle of a plan year. Beneficiaries typically make plan choices on an annual basis, and remain in the same plan for an entire calendar year. However, plan networks can change during the year for many reasons. For example, provider contracts may be renegotiated, or, a clinician may retire or relocate to a new area not served by the plan.

Commissioners have raised concerns about the potential impact of network changes on beneficiaries. Network changes, particularly when they occur in the middle of the year, have the potential to cause confusion and care disruptions for enrollees. Little is currently known about how prevalent these changes are or how they affect beneficiaries.

Before we go any further, I'd like to introduce a few key concepts for understanding MA networks. In the diagram on the slide, the lefthand side shows a list of 10 hypothetical providers. Moving from left to right, we see

that the network consists of a subset of those providers. Continuing on, we see that this network is used by two plans. When interfacing with CMS, plans are often bundled into a single contract. Networks, plans, and contracts are all elements of an MA parent organization, or MAO.

Much of the research literature focuses on the breadth, or narrowness, of networks, measured by the share of available providers in an area that are part of the network. This network includes 5 out of 10 providers, so it has a breadth of 50 percent. A network with fewer than 25 percent of available providers is generally considered narrow.

MA organizations can offer multiple contracts, each of which can consist of multiple plans. On this slide, the hypothetical MAO offers five plans, bundled into two contracts. CMS requires that HMOs and PPOs are in separate contracts, but there can be wide diversity in the plans under the same contract. More information about this variation and its implications for assessing network adequacy are included in your mailing materials.

Importantly, not every plan in a contract shares the same network. In this example, Contract 1 consists of

three plans, one of which uses Network 1, and two of which use Network 2. Contract 2 consists of two plans, which each use different networks. Network 2 is used by some plans in both contracts.

In this presentation, we measure a concept called provider participation, which considers the share of providers that are in-network for one or more MA plans. This metric can be thought of as the share of providers that an MA enrollee potentially has access to when selecting an MA plan. Provider participation rates are also an indication of the willingness of providers to engage with MA. For example, if 90 percent of clinicians participate in at least one MA plan, beneficiaries would have at least one plan option that provides access to those providers; by contrast, 10 percent of clinicians would be unavailable to MA beneficiaries.

In this example, all providers except one participate in at least one network. This means there is an overall MA participation rate of 90 percent. Providers 2, 3, 5, and 10 are exclusive to MAO 1, meaning they participate only in Network 1 or 2. The rest of the providers participate with both organizations, suggesting

broader engagement with MA.

Our analysis today focuses on the participation of clinicians eligible to bill Medicare independently. That includes physicians, both primary care providers and specialists, and the advanced-practice nurses and physician assistants, APRNs and PAs, who act as primary care providers.

To analyze clinician participation, we first constructed a binary measure of participation in MA: the share of clinicians that participated in at least one MA plan. We estimated how this concept of participation in MA varied, by type of clinician, and by geography. Next, we estimated the share of clinicians that participated with different numbers of MAOs, as a measure of the intensity of participation in MA.

We also analyzed how participation changes within a plan year, which we refer to as mid-year network change. We estimated net changes in network size between the beginning and the middle of the year, and then separately analyzed clinician exits as a share of network size.

This is a preliminary analysis, and we do not attempt to identify the "correct" number of providers in a

network, either per enrollee or overall.

We used several data sources to analyze provider participation in MA networks. First, we used the National Plan and Provider Enumeration System, or NPPES, to identify the universe of all clinician National Provider Identifiers, or NPIs. We then used fee-for-service claims and MA encounter records to identify which NPIs were active.

We used a database of provider directories compiled by Ideon, a private company, to identify MA network participation. Those files include two snapshots of the list of providers included in plan networks as of February 2023 and June 2023.

Our analysis focused on HMO and local PPO networks, and our data captured about 95 percent of MA enrollment in those plans in 2023.

As noted earlier, we defined the participation rate as the share active clinicians who participated in at least one MA network. We defined active clinicians as those who appeared on a combination of at least 100 fee-for-service claims or MA encounter records in 2023. Using that threshold, we include about 70 percent of clinicians

with at least one claim or encounter record.

Defining what constitutes an active level of practice is challenging, and requires balancing two objectives, first, including a large share of the total clinician population, and second, analyzing the participation of clinicians who are truly available for seeing patients.

If we choose a threshold that is too low, we may inadvertently include clinicians who are not seeing patients on a regular basis, and who would thus not be expected to participate in MA networks. If we choose a threshold that is too high, we may inadvertently exclude some clinicians who have low Medicare volume but are otherwise available, such as clinicians in rural areas or in research-intensive specialties.

Your mailing materials include more information on how estimated participation rates change under different thresholds. We welcome feedback on this analytic decision and are happy to discuss in more detail on question.

With that, I will turn things over to Krista, who will discuss our findings.

MS. CHERRY: Thanks, Karen. Starting with

primary care practitioners, we found that most PCPs participated in at least one MA network in 2023. The figure on the slide shows MA participation rates for PCPs in our analysis. The dashed horizontal line shows the overall MA participation rate for PCPs, and each bar shows the rate for the specified PCP type.

Overall, we found that 82 percent of PCPs participated in at least one MA network. Participation rates were similar across physicians, nurse practitioners, and physician assistants practicing primary care.

CMS has network adequacy requirements for MA contracts for some provider types. The requirements consist of minimum provider-to-population ratios and time and distance standards. One provider type subject to these standards is "primary care" and physicians, NPs, and PAs can count toward meeting that network adequacy requirement.

Moving to specialists, we found that 82 percent of specialists participated in at least one MA network, although participation rates varied based on specialty type. For example, emergency medicine physicians participated in at least one MA network 58 percent of the time while cardiologists participated 94 percent of the

time.

Not all specialist physicians are subject to network adequacy standards, so the bars in the graph are colored according to whether that specialty is the standards. Specialties that are not subject to network adequacy standards are different in many ways from the specialties that are subject to the standards, making it difficult to assess whether any difference in MA participation can be attributed to the standards themselves.

We also found that provider participation varied by state. The figure on the slide shows the distribution of state-level MA participation rates by provider type. Each panel presents a histogram showing the number of states falling within participation rate intervals, with the vertical dashed line representing the median state-level rate. The left panel shows state-level participation rates for primary care practitioners. State-level PCP participation ranged from 67 to 93 percent, with a median of 85 percent. Specialist physicians, shown in the right panel, had state-level rates between 66 and 94 percent, with a median of 87 percent.

Motivated to understand this geographic variation, we estimated the association between market factors and a county's MA participation rate with a cross-sectional analysis. The level of rurality of the county had a strong association with MA participation rates, even when holding other factors, like the share of the county on Medicare, constant. For example, rural counties were associated with a 10 percentage point higher MA participation rate than large metro counties for both PCPs and physician specialists.

Next, we analyzed the share of clinicians that participated with various numbers of MA organizations or MAOs. The figure on the slide shows the distribution of the number of MAOs that clinicians participated with. Each bar group shows the share of clinicians who were in-network that number of MAOs, out of all the clinicians who were in-network for at least one MAO. For example, the bars above the number 1 show that out of all the clinicians who were in-network for at least one MAO, just under 15 percent of PCPs and specialists were in-network for only one MAO.

In general, we found most clinicians are in-network for multiple MAOs, indicating broad participation

in MA. Over 74 percent of PCPs and 76 percent of specialists were in-network for 3 or more MAOs.

So far, we have been looking at MA provider networks at a single point in time. But provider networks can change over time, both from year to year, and within the plan year. Providers enter and exit plan networks for many reasons. Some of these reasons may be provider-initiated, such as if a clinician retires, moves, or changes employer. Plans and providers may also wish to renegotiate payment rates or other contract terms. While many organizations negotiate multi-year contracts, terms can sometimes be renegotiated mid-year. We have also heard anecdotally about plans removing providers from networks for poor quality performance or high cost. It is unclear how often changes occur for these reasons.

In cases where the net number of providers stays stable or increases, or when providers are removed for quality or cost of care, network changes may be neutral or positive for the average enrollee. For an active patient of a particular provider, however, that provider's exit from their plan's network would be disruptive, regardless of the cause or availability of new providers, because it

would require them to find new sources of care.

Commissioners have raised concerns that mid-year network changes can be particularly consequential for beneficiaries. Network changes may not align with when beneficiaries can change plans. As you will hear tomorrow in the discussion on the choice environment for Medicare beneficiaries, beneficiaries may only elect to join or switch their MA plan during defined enrollment periods.

While there is a special enrollment period for significant network changes, this is available only to a subset of enrollees, after changes have come into effect, and only at CMS's discretion. Beneficiaries who want to pre-emptively switch plans to maintain continuity of care may run into additional problems, such as a reset of their maximum out of pocket limit.

We therefore wanted to assess how frequently network changes occur in the middle of the year. We looked at provider entries and exits from networks, and overall change in network size, as a share of the size of the starting network. For data availability reasons, we analyzed network changes from February 2023 to June 2023. This analysis should be interpreted as a lower bound of

network changes, since we only looked at part of the year.

When we examined network changes on net, that is taking into account both exits and new additions, we found that network size tends to be relatively stable, but there is some variation.

This slide shows net change in network size as a share of beginning of the year network size for primary care practitioners and specialist physicians. The orange boxes represent the interquartile range, or the 25th to 75th percentile. The solid horizontal line within each orange box represents the median. The vertical lines are values outside the middle 50 percent of the data, and, the dots are outliers. The horizontal dashed line indicates zero, such that values above that line indicate a net increase in network size, and below the line indicate a net decrease. To better visualize the data, we plotted it using a logarithmic scale above and below zero, which is why the numbers on the y-axis are not distributed evenly.

We found that during this time period, the median network had about a 3 percent increase in PCPs and a 1 percent increase in specialists. There was some variation. Networks at the 75th percentile saw net increases of about

6 1/2 percent for PCPs and about 3 1/2 percent for specialists. At the 25th percentile, networks saw no change in overall size for PCPs, and a 1 percent decrease for specialists. Although most changes are small, some outliers saw considerably larger changes.

Because provider exits may be more disruptive for beneficiaries than new entries, we also looked at the share of providers who were in-network in February, who were no longer in that network in June.

This slide shows the percent of PCPs and specialists exiting MA networks as a share of the size of the network at the beginning of the year. As on the previous slide, orange boxes represent the interquartile range, the solid horizontal lines represent median values. The vertical lines are values outside the middle 50 percent of the data, and, the dots are outliers. This plot is also on a logarithmic scale, and because we are looking only at exits, the dashed line representing zero is at the top of the figure.

We again find that on average, the share of providers leaving networks was small, but some variation. The median network had about a 6 percent of PCPs exit and

about 4 percent of specialists exit. There was some variation. At the 25th percentile, about 4 percent of PCPs and 3 percent of specialists exited the network. At the 75th percentile, about 9 percent of PCPs and 7 percent of specialists exited. Although most changes were small, some outlier networks experienced a high share of clinicians exiting midyear, which could be explained by many factors.

To summarize, we found that a majority of clinicians participated in MA. Those that do participate participated widely, with multiple organizations. Over 74 percent of PCPs and 76 percent of specialists participated with 3 or more MAOs.

We find that this participation is not static, however. We observe some provider turnover in MA networks. While general access to providers may remain constant or even improve, some MA enrollees will experience disruption when networks change.

The interpretation of our results is also not straightforward. For instance, relatively high participation rates could imply either that MA facilitates broad access to providers for enrollees, or raise questions that MA networks do not sufficiently filter providers based

on performance. In addition, midyear changes in MA networks can potentially impact beneficiaries and occur for many reasons, such as clinicians moving or retiring, provider-payer contract negotiations, or plans becoming concerned about the performance of the provider.

On that note, we will now turn to your discussion.

First, we are happy to answer your questions about the material. We also look forward to your ideas for refinements to this analysis. Next cycle, we plan to continue conducting analysis outlined in the MA networks workplan, which, depending on Commissioner interest, could involve expanding on this presentation's analysis. It could also involve analyzing MA participation of organizational providers, including hospitals, post-acute care facilities, and NCI-designated cancer centers.

In addition, future work could involve analyzing the use of provider networks by MA enrollees. This might include quantifying the overlap between providers listed in directories as "in-network" and providers used by MA enrollees, and quantifying out of network care. Commissioner discussion will inform how we proceed with

future work.

Thank you, and I'll hand it back to Mike.

DR. CHERNEW: Krista, thank you. Karen, thank you. There is so much here, and it is such a challenging data issue, let alone the challenge in the conceptual aspects of this work. So I am really excited you are doing it. It has been, generally speaking, a priority of mine to understand how the MA market is working, and this is certainly an important part of it.

But we are going to jump into the Round 1 questions, and I think the first person is Lynn.

MS. BARR: Thank you for a very interesting chapter.

I have some clarifying questions. So, when you talk about -- you said 70 percent of clinicians versus -- but the analysis was at the NPI level. Used to be that a lot of clinicians had multiple NPIs. Were you able to -- is that still true, and were you able to -- what -- is it clinicians, or is it NPIs?

DR. STOCKLEY: So we do use the NPI to identify a unique clinician, and my understanding -- were that some -- I'm forgetting the name, but I think those issues you're

talking about, to my memory, were more to do with the provider enterprise that preceded the NPIs. And I -- my understanding was that largely NPIs, at least at a clinician level, were fairly reliable, unique indicators.

I think for facilities, it's kind of another matter where a hospital could have, you know, dozens or more of NPIs that they use for billing. But if you -- if you have anything that we should take a look at or concerns about that, we're happy to take a look.

MS. BARR: It will be interesting hearing from the other -- other people. I know that when we were -- this goes back a ways. So I'm -- I may not be current, but when we were enrolling people in ACOs, there was like, oh my God, there were so many NPIs associated with providers. And so I was curious about -- about that.

Maybe Josh has a --

DR. STOCKLEY: We'll take a look at that.

MS. BARR: Josh?

DR. LIAO: Yeah, I think my understanding is you use Type 1 individual NPIs, and so unless there's like names or under different specialties, each clinician, each human clinician has one Type 1 NPI.

MS. BARR: Okay.

DR. LIAO: But they can assign billing rights to Type 2, which are organizational, and I think -=- but Note 18 does a really good job of explaining that.

So I think we exclude those here. We just focus on --

DR. STOCKLEY: That's right. We're using just the individual-level ones, and it does get a lot messier whenever you're looking at the organizational ones.

MS. BARR: Thank God they got that cleaned up. That has changed. Yeah. Oh, good. That's good news.

MR. POULSEN: If you go back a couple of decades, they did have different by location, especially if they crossed states. But I believe that is now much, much less prevalent.

MS. BARR: I am so glad to hear that, because that was a real nightmare for all of us.

DR. RAMBUR: I was just going to say what Greg had said, but also to underscore that it's not completely precise, although not our problem, because of the "incident to" billing issue.

DR. STOCKLEY: Yeah, that's absolutely right.

MS. BARR: Right. And maybe rural health clinics might have a unique issue as well -- I'm not sure -- because that's where we really ran into it was RHCs. So, anyway, hopefully, that's not an issue anymore.

Just a question. This chapter is about providers. This is really about clinicians. Is there an intention to also look at hospitals and SNFs, et cetera, at another --

DR. STOCKLEY: Yeah, we're planning to return to that next cycle. In fact, this NPI issue is exactly the reason why we're not showing you the facility-level stuff here, because it is just so complicated with all of the NPIs associated with these different facilities --

MS. BARR: Oh my God.

DR. STOCKLEY: -- that we wanted more time to deal with that before we showed you any results for facilities.

MS. BARR: Perfect.

You mentioned in the chapter that adequacy requirements are the same in rural and urban, and there was changes in adequacy requirements with bonuses and stuff like that. So you might want to just look at that, at the

differences now between the two.

DR. STOCKLEY: We'll take a look at the description. I think we have a different description of the requirements for rural areas because the number of providers in rural areas, the thresholds are different.

MS. BARR: And there's now, like, these bonuses they can earn and things like that. So I didn't see it in the chapter, but I might have just blown past it.

And the table you have in the chart where you talk about you pegged -- I think it was 500 patients per PCP and specialist to kind of determine whether, you know -- like, participation rates that, you know, led to that 82 percent. It wasn't in your slides, but it's in the chapter.

I had a question about that because I think, like, when I think about PCPs, you know, they have a lot more visits, you know, and much more limited kind of -- I'm not sure I'd use the same number for PCPs and specialists, and so if you could take a look at that.

And I think that is it for me. Thank you very much. Great work.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thank you very much for this chapter. I'm super excited about this work, and per Mike's comment, this is enormously challenging to unpack. So kudos for trying and getting in there and digging around in the data.

The question that came up for me when I looked at -- when you showed the distribution of providers exiting mid-year is you have plans at the 95th percentile that had like 23 percent exit, and I guess obviously higher. I think it would be helpful to try to understand what's going on with those plans. Are they terminating? Are they merging into another contract? And so I don't know if you know anything about the plan types and can better characterize them, but that was the question I had, is what characterizes them.

DR. STOCKLEY: Yeah, we have started looking into this, and there's not -- we haven't come across, like, one -- there's like some obvious characteristic or artifact, but it is something we'd like to look into more and can come back to you with more information on that.

MS. KELLEY: Paul.

DR. CASALE: Great work. Yeah, challenging

topic.

Just a clarifying question. So on the slide that talked about percentage of clinicians participate in at least one MA network, you had PCPs are like 82 percent and then the NPs and the PAs next to them. Can you discern if the NPs or PAs are practicing primary care or specialty care?

MS. CHERRY: Yeah, that's a good question. Thank you for asking.

So we used the taxonomy codes of the provider to identify the specialty that they were practicing, and so for NPs and PAs, they had to specifically have in their taxonomy code, something related to primary care.

DR. CASALE: Okay. Thank you for that.

And then on the slides on a number of clinicians exiting a plan, for instance, you list PCPs. Does that include the NPs and the PAs within PCPs?

MS. CHERRY: Yes, yes.

DR. CASALE: Okay.

MS. CHERRY: So anytime we say PCP, that's inclusive of NPs and PAs as well as physicians.

MS. KELLEY: Scott.

DR. SARRAN: Great work.

Question. Did you think about -- or how would you think about the feasibility and the usefulness of trying to connect the data you've got with plans' CAHPS scores around access to care and getting -- I think, if I recall right, there were one or two questions in CAHPS, getting care quickly or getting access to care, to see if that helps inform whether there is a correlation between participation rates and the actual, you know, where the rubber hits the road, which, of course, the member experienced in getting access.

DR. STOCKLEY: Yeah, that's a great suggestion.

So all the analysis in this paper is at some kind of geographic level, not at the plan level. But I think in the future, we could definitely come back to doing some plan-level analysis and relating that to different things like CAHPS that we can observe.

MS. KELLEY: Josh?

DR. LIAO: Krista and Karen, thank you. I appreciated your kind of thoughtful approach of how in some ways participation rate is mechanically dependent on how you define this clinician population.

Just a few kind of clarifying questions to frame my thinking. You mentioned 100 claims or encounters. I'm much more familiar with the fee-for-service claim side than the encounter data, but could you tell me what's being counted? So are you collapsing claim lines into claims? Are you taking away administrative, not clinical encounters? Are you taking an NPI and date to kind of reduce that? You know, what are we counting in the 100?

DR. STOCKLEY: So it is at the claim level, so collapsing over claim lines.

And in the encounter data, you can think of, like, operationally that being -- we tried to make it as kind of as similar as possible to kind of collapsing an encounter record to what would be comparable to a fee-for-service claim when we did that. But that said, it's still kind of a little bit subjective, how you end up choosing that threshold and what it means and how it varies by specialty. So very interested in any thoughts any of you all have on ways to assess kind of what the most appropriate thing is there.

DR. LIAO: And a quick follow-up there is did you -- I said to any kind of claim types, so E&M, for example,

versus injection procedures. Did you take any claim types?

DR. STOCKLEY: Yeah, we didn't apply any exclusions.

DR. LIAO: The final question is with the NPI level, any thought or was it possible to look at unique beneficiaries taken care of by a given NPI versus just kind of claims submitted?

DR. STOCKLEY: We did have a version like that. We kind of -- when we first started using these thresholds, we started with a concept that's used by the physician team for the physician update chapter, where when they're accounting clinicians, they only consider clinicians that have had 15 unique encounters with a unique beneficiary. So we did start with that concept, and then we kind of wanted to be able to dial it up and down to look at sensitivity. And thinking forward to when we're going to be doing this facility type analysis, we just thought it would maybe be more easily transferable to do a simple claim level one that would be kind of a consistent threshold. But if you think it would be valuable to do a beneficiary level, we could look into whether that makes a big difference. We only looked at kind of the 15 threshold

and didn't do kind of all the variation around that, but we did with claims.

DR. LIAO: Got it. Thanks.

MS. KELLEY: Lynn, did you want to jump back into Round 1?

MS. BARR: I'm sorry. I forgot one quick question.

Did you look at the participation rates at HMO versus PPO?

DR. STOCKLEY: Do you want to take that?

MS. CHERRY: Yes, we did, and they were similar between the two. I can provide more information.

MS. KELLEY: I'm sorry. I must have missed you. Go ahead, Wayne.

DR. RILEY: [Speaking off microphone.]

MS. KELLEY: Microphone.

DR. RILEY: Well, Lynn's and I think Paul's earlier point, I had a question about the 100-claim threshold. You mentioned that it hits about 73 percent, right? Has there been any consideration to looking at a primary care versus subspecialty?

And the reason why -- those of us who are

internists, we all have had the scenario where Medicare patients before us, and you refer them to certain subspecialties, and the wait is extraordinarily long. Number one poster child, I remember when I was more clinically active, was dermatology. I had a patient who looked like they had a basal cell. You know, I did what I could do, but they really needed to go to derm. And so if we looked at some of the subspecialty breakdown, that may be sort of informative as well. We have both anecdotal evidence of delay to get specialty care, and I know the Commission and you guys have objective data about delay. So any consideration about that?

DR. STOCKLEY: Yeah, there was some difference in how that threshold affected when we looked at primary care providers and specialists separately. I think there was maybe a 5-to-10-percentage-point difference. So, for example, using the 100 threshold, we kept around 73 percent of PCPs, but a lower percent of specialists, like 65 or something like that.

DR. RILEY: It feels lower to us in the exam room. So I just wanted to know if, you know, would this be helpful on an ongoing basis to track that. So thanks.

DR. STOCKLEY: Yeah. And we didn't dig into kind of all the subspecialist level, but we could consider using a different threshold and aim to capture a similar percent of providers. Perhaps we could think about different options to align those.

MS. KELLEY: So I think that's all I had for Round 1, Mike. Shall we start 2?

DR. CHERNEW: I think with Stacie.

MS. KELLEY: Yes.

DR. DUSETZINA: Okay. Thank you so much for this work. I'm really glad we're diving into this.

I'm going to try to keep this as organized as possible, but had a lot of thoughts.

I think one of the things that would be really helpful in the background is that having a little bit of detail about the changes in HMO and PPO availability, because my understanding is that the PPO market is shrinking a bit right now. And I think it makes this work even more important moving forward, thinking about those for new beneficiaries and current beneficiaries.

I want to give a shout-out to the excellent use of figures in this chapter, because the relationships

between the networks and the contracts of the plans and the providers is so complicated, so very well done.

I found the call-out boxes also to be really, really helpful, just describing what was going on. And there were some things in them that I was like, okay, that seems concerning, like, you know, that you would be evaluated over different -- like, 600 counties could be part of a contract, but then you described how those things get evaluated at the county level. So I thought that was very helpful for someone not as familiar with this particular way of setting up plans.

One of the other things that was kind of like news to me was the provider directories now being in Plan Finder. I think that's great.

The other thing that I had just noticed recently was that I think it was in the most recent funding bill that there was a move towards having audits of directories, and I haven't seen that -- like, I don't think it was in the chapter, but it was something that I had just noticed when I was looking at that bill. And they even talked about having an accuracy score on the directories, and these are sort of contextually things that I think will

help with people thinking about understanding their plans and the directories and who they can see.

Your Figure 3 is fantastic for showing the trade-offs between, like, how many -- your claims threshold and how many are retained. But I was wondering a little bit about whether or not there should be a different threshold for specialty and rural. And just, you know, 100 seems like a reasonable cut point, but you do lose a lot. Those figures, again, are very helpful in understanding that you'd have to, like, back it all the way down to, like, 20 claims or something to keep a substantial sample size. So I understand the restrictions there, but kept wondering, like, you know, should that be a smaller number of claims for a specialist?

The last thing I'll say is that I really appreciated the text about the effect of contract disputes on beneficiaries. So, you know, I think at least looking at this slice of it, it doesn't seem as concerning, like, the availability of these types of providers.

But the issue of beneficiaries being told that their provider might leave the network, you know, like, if you're getting care somewhere and you see these signs

posted that your plan is going to break up with, you know, where you go to the doctor, it's really, really stressful for people to have to deal with. So I appreciated having that context in the chapter, because I think even if you don't have those contracts end, it's disruptive for people to think about trying to find new care.

So thank you, again, for this really exceptional work.

MS. KELLEY: Tom.

DR. DILLER: Yeah, several comments that I'll kind of walk through, and the first is just thanks for the great work that's done here.

So I'm involved in the management of a very large physician network and multiple contracts, and as I read through this, first off, it was very, very interesting, but there was virtually nothing in here that I said, oh, that's wrong. You know, so this all aligns with what I'm seeing in real practice and in management of this.

The second thing -- and I wanted to spend a little bit of time -- is there's significant differences that have happened between '23 and '26, where we're currently at, and some of that has to do with the

substantial variation in clinical performance. So plans and networks are now actively measuring performance on cost utilization quality for these providers, and they're starting to take actions with that. And one of the dilemmas is this concept of any willing provider, let's get everybody into the network. What that results in is regression to the mean. And so you're not getting to the higher-level performance.

So what plans and private networks are doing now is they're actively trying to steer patients to higher-performing physicians, and I think that's going to accelerate over the course of the next few years. They're removing lower performers. That is happening, and that may be reflected in some of the data.

But more importantly, what they're also doing is trying to keep their networks relatively robust to meet access standards and things along that line, but divide them into different tiers or different levels and use benefit design changes, such as co-pay structures, in order to move patients to higher-performing physicians in hospitals and whatever.

So, without this, there's little incentive for

low-performing physicians to improve. So what physicians want is access to patients, especially specialists. In value-based care, there's very little engagement with specialists, but what they need is that access to patients, and if they're now in a lower-performing tier, that is going to cause them to start to improve. So I think that's all a positive with it. So that was that comment.

There was a couple of other, just very brief things. On pages 25 to 27, you talk about emergency medicine and anesthesiology groups and the lower participation. That's a national problem, and it's due to consolidation of them into very large national practices and exclusive relationships in hospitals. So it's very difficult to negotiate with some of them; others, easy to negotiate with. But that's part of the dilemma.

And on page 40, you talked about nurse practitioners and PAs that are moving between plans or moving out of the network more frequently, and that is an issue that's well known, and it has to do with nurse practitioners and PAs move from practice to practice more frequently. Physicians are fairly stable, but they will move from one practice to the other, and when that happens,

they may move to a physician that is now not in network, so therefore, they're out of network.

But all in all, it's a fantastic chapter, and I really appreciate the work with that. So thanks.

MS. KELLEY: Brian.

DR. MILLER: Okay. Three categories. One is sort of the environmental scan. I want to remind us all that fee-for-service has no network, because it's an any-willing-provider network. So good, bad, or average or above average or way below average is included with equal access and equal price, which really doesn't make sense from a purchasing perspective.

If we think about the Medicare bene, before they enter Medicare, $150 million in ESI, 15- to $20 million in ACA, $75 million maybe in Medicaid MCO, which is ultra-aggressive managed care. Say everyone has a network, and when they enter Medicare, about half of them go to a network plan, and the other half go to a no-network, unmanaged plan, which is unusual. We think about it from that angle.

In MA, my takeaway from this is that some clinicians leave networks every year, and on average, that

is a small number, but for some plans, it is a bigger number.

From the consumer protection angle, consumers, if there's a significant change in their network, they have an opportunity to switch plans if CMS deems it as such, and maybe that's an opportunity for improvement.

From a network design perspective, PPO, HMO, POS, CPO, et cetera, should probably be made more transparent for consumers. Hopefully, the improvements in the Plan Finder and that natural feedback loop on, shall we say, inaccurate provider directories will help drive improvements from the plan industry.

Building on what Tom said, if we pair network design with benefit design, we can actually begin to finally address cost and quality.

In that vein, my takeaway from this chapter on the environmental scan is that MA is a yet-to-be-fully-tapped tool to drive improvements in price and non-price competition. We haven't really done that fully yet.

Think about regulatory policy opportunities. It seems like CMS could improve as a market regulator, addressing some of the research questions that my

colleagues have mentioned, which is you could get better oversight of MA if you have an MA contract that ties to a plan product that ties to a network. Otherwise, you have this convoluted analytical question, which is not just a research question. It's a regulatory challenge, too, for CMS.

Another opportunity about the provider networks is you can analyze plans that don't have accurate provider networks. So that's maybe something we as a Commission could think about.

Other analytical opportunities, I like the suggestion of slicing and dicing by sort of the network design type, PPO, HMO, regional PBO, et cetera. There's a long three-letter alphabet soup.

And then my bone to pick, which we're already planning to address -- I saw that in the chapter. So I was happy. I like this analysis, and I'm excited about the next analysis, which is looking by facility, because in this analysis -- and we talked about this exhaustively as a group -- something like 50 to 60 percent of clinicians are employed across the board in various specialties. That changes.

So if I, for example, switch networks, Brian Miller has no market power to determine if he switched networks. My hospital employer does, which is fine. I'm happy to cede that power to them, but when a physician is employed by a large group or a hospital or a health system, that network entry or exit is not determined by that individual clinician.

And so I'm curious. I like how this goes from the beneficiary perspective and says, what happens to my doctor? Then the next step we're doing, which is, is it actually a large organization that is responsible for, say, that 20 percent of doctors leaving the plan? It's, oh, there was a dispute with XYZ organization, health system, group practice. I think that that will give us a nice multifaceted approach to see how MA sort of constructs networks and opportunities for regulatory improvements and analytical improvements.

But, on the whole, I really like this chapter, and thank you for doing the analytical sandwich, which was not easy.

MS. KELLEY: Cheryl.

DR. DAMBERG: I found myself, as I was staring

the data -- and I'll sort of pile onto Stacie's comments, all the table and graphs were very helpful -- is kind of thinking about the next steps, and kind of the next step in my mind is that participation in a network is different than a beneficiary actually have access to those providers. And in that space I kept thinking about the issue of providers listed in a plan's network, sometimes there are ghost networks, there is no guarantee that a particular provider listed is actually accepting patients, providers are making decisions about the mix of patients, both Medicare fee-for-service, Medicare Advantage, and commercial that they are taking.

So I am really interested in future analyses that would look at beneficiary use of providers within the network. I don't know if there's an 80/20 rule, where 80 percent of the people are using 20 percent of the providers. And I think extending on a comment made by, I can't remember who, thinking about out-of-network care and what types of services people are going out of network for, what types of providers. Maybe that would give insights as to whether the providers within a given plan's network are sufficient or kind of meeting the needs of beneficiaries.

So that's a space that I would like to see unpacked.

And then the other thing that I'm a little confused about, and I don't know if this operates differently in Medicaid versus, say, the commercial space, but if you think about the analogy being ACOs, that they kind of create a subnetwork within, say, a health system. So for example, like if I go to UCLA, not every provider takes Medicaid within the UCLA health system, at least this is kind of what I've experienced. And I'm not trying to put you on the spot, Robert.

But I think this is true of health systems writ large, is that different providers within the system will take different forms of insurance. And I think this gets back to the beneficiary choice complexity, is oftentimes you think you're signing up for a system and you'll have access to the full complement of the providers in that system, and it may only be a subset.

So I think trying to unpack that a little bit, to the extent that you can link in whether they are part of a health system would be interesting.

MS. KELLEY: Okay. Next, I have a comment from Kenny. He says networks change within the plan year due to

clinician movement, contract negotiations, or performance concerns. The paper's analysis suggests that at the median 5.7 percent and 4.3 percent of a network's PCPs and specialists left the network between the beginning and the middle of the year. It would be helpful for additional analysis to address the following. First, what level of midyear network change is acceptable for beneficiaries while still allowing the MA plan to manage cost and quality? Second, should plans proactively limit midyear churn changes or instead improve communication and transition support when changes occur? And third, how do we distinguish healthy churn from destabilizing churn that's negative for beneficiaries.

And next I have Scott.

DR. SARRAN: So I think a lot of what you've done here is wonderful foundational work. And then I think ahead about what are the areas where we want to apply the foundational work or build on it.

So in the context of knowing that, first of all, what really matters most is the beneficiary's experience and their true access -- this is part of what feeds into that, but that's where the rubber hits the road -- and also

in the context of knowing that plans are probably going through now what will be a multiyear process where they try to manage down their costs. That's just the macro environment. And an implication of that certainly is already being seen and will continue to be seen more, which is disruptions in provider networks, since plans get more willing to undergo the pain of a provider disruption in order to save money.

So in that context I think about four areas where I see our work progressing, if you will. One is, and this is a plus-one to Stacie, the accuracy of provider directories I think is just really critical, because that's what beneficiaries, by and large, have to rely on. And it is more than just the contract being in place, but it's the actual, again, where does the rubber hit the road, is that provider accepting new patients, particularly from that particular plan with whom they may be in the midst of a contract dispute or just in a bad relationship. So that's one.

Second, building off of Wayne, focus on specific provider types where access is either mission critical to ensure a high quality outcome or we have either a known or

an impending, because of changes in the macro medical environment, pending shortage. In my mind those include, not limited to but include cancer centers of excellence -- we know that access to that is a correlation of quality -- psychiatry and mental health, regardless of seeing how many psychiatrists or contractors we know, true access is really quite low. Neurology is a big one. Access is already low, and now that we have some treatments -- I won't editorialize on the deficiencies, but we do have some treatments that may be disease modifying, and those are only going to increase in number and popularity, for both providers and beneficiaries. Neurology is going to be critical for Alzheimer's and dementia. Endocrine as diabetes care both, on one hand, has more possibilities but is also more complex, and therefore outside the domain or scope for most PCPs. So I'd make sure we're thinking ahead about specific specialties.

Third, the whole issue of midyear disruption and remedies available to beneficiaries I think is really critical. I think there will be more midyear disruptions. And as Gina continues to remind us, it's not just the remedy a beneficiary may have in terms of a special

enrollment period but what are the challenges for a beneficiary who really has no viable option for continuity with providers anywhere in MA in their country, and the whole issue of should we be recommending some kind of guaranteed issue of Med-Sup for those. That's obviously a complex issue. But I think it's important to start thinking ahead about that.

And then, fourth, the implications of plans as we're starting to see reinstituting, and this is in the category of a bad zombie idea that should have been killed, but it's coming back. Reinstituting gatekeeper models, where a provider, in order to see a specialist, for example, has to have, God forbid, a faxed referral from a PCP. We know there is some of this at least being teed up by some plans, and that's going to have real implications for access.

So those are, like I say, just four sort of thoughts about areas where we want to be starting to think ahead. Thanks.

MS. KELLEY: Josh.

DR. LIAO: Thanks again for this material. I just quickly will echo what other Commissioners have said

about thinking about by plan type, by clinician type I think is really important.

I want to just focus on giving some feedback related to this question of threshold, again, because I think so much of it depends on that. But I think the use of 100 is a reasonable starting point, really to identify clinicians that are observably in Medicare.

I do think, though, that as other Commissioners have noted, I do think it is likely to be permissive, and if the goal really ultimately is to assess whether MA participation translates into more meaningful engagement with patients and choice, I think we might think about a few other things.

My first concern comes from this question of the claim type, so procedures, injections, not basic. Not that E&M is everything, but it does create the backbone of access and no care for groups like PCPs. So could consider restricting to that. But even if we took that restriction, and I said 100 E&M visits a year, across MA and fee-for-service, if you think about, say, a PCP, most people would say 2,000 to 3,000 visits a year on a panel of 1,800 to 2,000, a few visits per year. So 100 is 3 to 5 percent of

that, so it's a very small number. And to ask ourselves is that reflecting hypothetical capacity of people who are meaningfully engaged in Medicare. So I might say that would be one reason benchmarked against a full PCP workload to raise that number, which I think would be appropriate for other commissioners.

And I think more fundamentally, I think claims volume captures what I would call workload but not necessarily patient breadth and patient engagement in that way. So that was the reason I asked about whether you can measure unique beneficiaries. I think those two together kind of creates a nice complement, because a clinician could generate 100 claims from 100 benes or from just a few very high utilizing beneficiaries, and I think we miss that with just the claims volume.

I think here, too, thinking about 15 or 20 would be potentially low for groups like PCPs. Again, if you think about a full-time panel being 1,800 or 2,000, or 2,500, you might consider something higher than 15, at least as a sensitivity analysis.

I guess what I'm driving at is maybe there is a way to think about denominators to approximate what you

might think of as not just clinicians who are presence but also who are reasonably available to Medicare beneficiaries. And I think you can operationalize that with some kind of joint minimum threshold, so kind of claims volume and unique benes. And I think that might be something to think about. And I think that would help strengthen the analysis that comes from it, just to make sure that the findings are kind of robust to threshold selection.

But great chapter. Thank you.

MS. KELLEY: Paul.

DR. CASALE: Just a couple of comments. I just want to underscore what a lot of my fellow Commissioners said about the challenge of understanding clinicians in the network versus access to that clinician. And my comment was going to be the same as Scott's, this emerging move towards gatekeeper models that I think is particularly concerning.

I just want to follow up on my question around the primary care visits, mentioning lumping NPs and PAs into that analysis. I'm wondering, as more primary care visits are being done by NPs and PAs whether it would be

interesting or helpful to separate those out from the physician, as it relates to exiting plans but more around network size and number of plans they are participating in. There may or may not be something interesting there to look at.

MS. KELLEY: Greg.

MR. POULSEN: Thank you. Again, let me just pile on, great chapter. Good analytics. I also loved the charts and graphs. I am going to pile on to things that a number of people have said, but I want to build it around one sort of point. And that is we talked about the pros and cons of smaller networks, and one of the pros was that smaller networks can select among the most capable or highest value providers in a group.

I think there is a nuance here that we should make sure that we capture, which I think is a big deal. And it's not just the idea of smaller networks. It's the idea of focused or coordinated networks. And it's the idea of folks who work together as a team.

I think that sometimes you can be more selective to get the highest quality folks, but oftentimes highest quality folks are not just found. They are created, by

their ability to work together in a consolidated and coordinated way. I kind of wish Jaewan was here, because we'd have, I think, the same idea from him.

So picking the best may not be as important as the team creation, which can include things like shared information, shared commitments, consistent expectations, standardized practices, standardized approaches. Those things can be incredibly important. Often the best teams are those that work together consistently, not only those that look great individually.

You know, in the olden days, examples of that, there are some modern ones but it becomes political when you mention names, so let me just pick a couple that are now no longer around, but performed really well when analyzed from a performance and overall perspective quality, service, and cost. HealthCare Partners, WellMed, CareMore, just to name a few.

I would give an example that got written up a number of years ago when one organization, it was one of the better ones. This is in the '80s, dealing with ARDS, acute respiratory distress syndrome. And at that time the mortality rate was 90 percent. It was a death sentence.

And this organization decided they wanted to check whether they could use basically heart-lung bypass machines to improve mortality performance.

But before they did that, they did something really clever, and they said, "We're going to all specify how we practice, so we all practice in exactly the same way, so that we can have one arm of our control trial to be consistent, and then we'll do the performance with the heart-lung bypass machine as the other arm." Well, by doing the one arm and making everybody practice consistently and agreeing to do that, the mortality rate dropped from 90 percent to below 60 percent. And they didn't change anything. They just became consistent in what they were doing. So I think we should not understate the kind of performance that can come with teamwork.

I loved Wayne's points about delays in getting through. Cheryl, as well, talking about some of those things, and talking about real access as opposed to on-paper access. Something that I think we would notice is organized groups of people tend to have ways of getting referrals actually happen. People who are working as teams find ways to make those things happen when they are

essential, when they are time critical. And that doesn't show up on paper, but it's very, very real, and it really happens when relationships exist, for whatever reason, and within teams that have coordinated approaches.

Several studies in the last few years have shown significantly better performance, cost quality, and satisfaction among MA plans built around integrated provider groups versus those that may be actually bigger and look better on paper in terms of the number of different specialists that are there. And again, it's because of the coordinated relationships that exist.

I know I'm probably talking too long about this, but I think it's really, really important that when we think about network adequacy we can't just look at numbers, because they really don't tell. Not only do they not tell the whole story, in some cases they hide the real story. And that some of the groups that are y'all come groups may, in fact, have great numbers on paper but in fact perform far suboptimally in just about every metric -- cost, quality, or service.

So I just want to make sure that we're thinking about this. I think that, again, the paper did a fabulous

job of helping us to get the information that we need to know. But there may be some intangibles that may be very, very difficult to gather from available public information, but can be very, very important. So thanks again for this great work, guys.

MS. KELLEY: Robert.

DR. CHERRY: Yes, thank you. This is a really fascinating and interesting topic. We're still very early on in terms of the discovery process, so the narrative around the chapter is still under development. So all this feedback that you're getting will be helpful in terms of filling in some of the missing pieces of the puzzle.

I have a bunch of sort of random thoughts, in no particular order, in kind of reviewing the materials, that may be helpful as you're putting together the narrative.

One has to do with the scope of the problem. It was mentioned that we don't have a lot of data that really tells us what the impact is to the beneficiary when a provider all of a sudden changes plans or is no longer available during the year, and that's true. I would say there is a lot of anecdotal stories among hospitals around how that is impacting patients. You may not be able to get

discreet data, but similar to what Greg was talking about, there may be other ways of being able to get at that information, perhaps through structured interviews. So there may be some elements to this chapter where structured interviews with members, providers, hospitals can fill in some of the missing qualitative gaps, where the quantitative piece is unable to.

The other thing, in terms of the reasons why providers may select a plan, this might not have been explicitly stated but just kind of pulled out a little bit more. Among employed positions, one of the major drivers, too, is where their hospital or health system is going with a particular plan. So if they end up not renewing a contract, that will also change potentially what the provider or that group actually does as an employed practice, as well.

The other interesting thing, too, just looking at the graphics around providers that may be part of multiple plans, we always talk about quality of care, but it also occurred to me how even more difficult it is if providers are part of different plans, how to assess the quality of care, because these plans may be very different from each

other in terms of the types of patients that are served. So there could be differences in risk scores and social vulnerabilities. And there could also be differences in access to care among different types of physicians and other providers that you really need to be part of the team, but maybe are not because there may be access limitations of one plan versus another that a provider may be participating in.

One thing that was a bit surprising to me, although not to Tom, was the emergency medicine physicians lagging behind in their participation rate. But this may be true for other specialties, too, because what is the impact on different members, particularly in the context of surprise billing and all of that. The hospital is in network but all of a sudden, the providers are not part of that particular MA plan.

The other thing that occurred to me, too, is how good are the MA plans with respect to communicating with their members when a provider is retiring or changing locations or not otherwise available. I imagine many of them, as best practices, try to do that, but is there a lot of variability and consistency, et cetera.

And then one final thought. This may be a little bit out of scope, but it also occurred to me, as well, is you may have a provider that all of a sudden in network, or has been in network for a while, but you can't really access that provider because all of a sudden, they're busy and they're panel is now closed to new patients. So even though that provider may be part of a network or different MA networks, they're not really available to the members for that reason.

So those are just some thoughts to kind of contemplate as you continue to think about the chapter and ultimately what it might look like in the future. Thanks.

MS. KELLEY: Lynn.

MS. BARR: Thank you. So just a couple quick comments.

So we talked about, you know, ranking providers, and I think that when you have a provider-based health plan, you can look across a lot of patients, because you've got data across all the different plans. But if you're an MA organization that's all over the country, you know, what you say -- they're in five different MA plans, right?

And we saw this with ACOs. I mean, if I had 50

patients on any one doctor, I was like, oh my God, you know, that was a lot. And so, you know, as we have so many different plans, our patients are getting, you know, cut up, and we can't really -- I couldn't see in our data -- you know, we had 500,000 Medicare beneficiaries. I couldn't tell you who the good doctors were.

And so I think there's operational issues of plans deciding who are good doctors and who aren't, and we all know that socioeconomic determinants of health will affect hemoglobin A1c control and some of the things that we look at. And, you know, it's kind of an easy way to find patients that you don't really want, right? You know, so you exclude those providers, and then the patients who will go to those providers aren't going to sign up for your plan, and that can then affect adverse selection.

So it's not something when you're a provider-based plan, but something that an MA plan or, you know, a commercial plan, you know, could -- it could be a path that could lead to poorer outcomes for the underserved, and I'm concerned about that.

My second comment is on your -- I'm glad you're going to be expanding the analysis and looking at

organizational providers. I think it'll be very important, and I'm really glad you're looking at cancer in particular. I think it'd be very important as you're looking at hospitals and particularly rural hospitals to look at inpatient, outpatient, and swing bed. So when they say the hospital's in the network, but nobody in the community can use that hospital for swing beds if they're in an MA plan, and there may not be a reasonable, quality skilled nursing facility within hundreds of miles, right? But they will be forced to go to that other facility, because it's so much less expensive, and I can't -- I mean, you can't blame them, but the beneficiary should know that should they ever need long-term care, they're not going to get it in their local hospital. So I think thinking about that would be very helpful in your next analysis.

Thanks again for the great work.

MS. KELLEY: Tamara.

DR. KONETZKA: As others have said, congratulations, and thank you for this great work.

I think, you know, there's a lot of decisions that, you know, could be somewhat arbitrary, and you did a great job of sort of distilling the messiness and making

decisions, for example, about how to define participating physicians, and I think you've gotten some suggestions. But, like, anyway, congratulations on making some good decisions and then including sensitivity analyses.

A couple of quick comments. One is in the chapter framing, I was a little bit struck by the sort of interpretation of low participation and high participation being attributed to either, you know, sort of low participation rates could either indicate network management that encourages MA enrollees to seek care from high-quality providers or raises questions about adequate access, right? I felt like the cost and price piece was really missing.

I mean, sometimes networks are really small because the MA plans are just negotiating really low prices that only certain providers will accept, right? And so you mentioned performance a few times, which to me has to include more explicitly sort of the price and cost piece as well. So that's just about the general framing sort of in the intro and in the executive summary.

Second comment about the analytics. Again, I, like others, appreciate a lot of the figures. In some of

the analyses, like Figure 5 in the chapter, when we are looking at the number of plans that providers participate in, I kept wanting some sort of weighting, right? Because there are -- you know, it means a very different thing if you're participating in the dominant plan in the market, you know, versus five plans with equal market share, you know, versus -- and so I know that the number of variables here could explode very quickly. So I'm happy to leave it at your discretion about when you can manage to do this and when not. But in some of those, it'd be really helpful to know, like, how many beneficiaries are affected or, you know, not just how many plans providers are participating in, but how many beneficiaries or what percent of beneficiaries would that cover.

Okay. And then the final thing is really a sort of pie in the sky, future work, things to think about. I think, you know, it's clear that there's a structural imbalance here where beneficiaries can choose once a year or whatever. You know, we'll talk a lot more about that tomorrow morning. Beneficiaries can choose their plans, and many of them choose based on participating providers, and yet plans can change those networks in the middle of

the year. And so that's just this imbalance that seems inherently unfair. I'm not really sure why it was set up to sort of put the entire burden on beneficiaries.

And so one thing I'd love for us to think about -- and I know this could get complex, but the remedy we have right now is maybe if CMS approves it, there'll be a special enrollment period for beneficiaries, right? And as many people have mentioned, you know, that's not costless. I mean, it's really hard to pick a plan in the first place. There's lots of variables, and then having to go through all of that again in the middle of the year, if you lose one of your main providers, you know, if it's even allowed, it's not a great remedy.

And so, you know, I would love for us to think about are there ways to sort of correct the structural imbalance, right? Are there circumstances -- I mean, if your provider retires or moves, that's one thing. There's not much the plan can do about it, not much the beneficiary can do about it. But if it's about sort of price negotiations in the middle of the year, you know, are there ways in which plans would be required, for example, to continue in network coverage for that beneficiary, right,

and then the plan would take on the risk of those mid-year changes?

So again, I know there's lots of complexity in that and lots of things to think through, but, you know, the sort of fundamental imbalance we have right now just seems really unfair. So I'd love to think about ways we could remedy that.

MS. KELLEY: Gina.

MS. UPCHURCH: First of all, thank you so much for this work. I think it's really critical for some of the reasons that have been laid out by fellow Commissioners, and I just want to add a few things to it. And you did such a great job with it.

First of all, as Robert mentioned and several people, and just the imbalance that Tamara just mentioned, it's super stressful for beneficiaries.

And I've told you all this story, but I'm going to remind you of it. So last year, a woman with pancreatic cancer came to see us because she got a notification that her Medicare Advantage plan was going to be out of network with the major health system that she was getting her care from. She was taking care of her husband with end-stage

renal disease, also in the same plans, and her father, who also had cancer. So she came, three people, desperate, and they'd gotten these letters.

By the way, folks get a lot of letters, a letter from the health system going, "We care. That insurance company doesn't seem to care," and then the insurance company sends the exact same letter, "We care. We just don't think your health system cares." It is unbelievable, these letters that come to people.

So I'm concerned, and I don't know how we can get it, the cost that goes into their marketing about how much they care, in the middle of the year, when people are in this odd situation. It was so stressful to them.

At that time, we didn't have a special enrollment. Well, first of all, the special enrollment period for Medicare Advantage switches is after the fact. Well, these people were going to care regularly. They're not going to wait for after the fact. We happened to have a 5-star plan we could get them in. We had to warn them; you're losing all the money you've already paid into the system. The max amount of pocket is not moving with you. I know your drug benefit, the TrOOP does, but not the MOOP.

Trying to explain that to somebody -- okay. So got that explained.

They moved literally after 5 p.m., the last day that they could work it out. They worked it out, and they said, Isn't this wonderful? It was right before Valentine's. I was like, no, it's not wonderful, because we couldn't get people back. So they've gone to this new plan. We couldn't get them back.

So to get at what Tamara is talking about, I think there needs to be basically three special enrollment periods; one, when there's a threat that it may change. Let the person make a choice. Okay, I'm fed up with this insurance company. I'm fed up, you know, whatever. I'm going to go find new providers. Either way, they decide to do it with the threat of it. Two, to undo it, you know, if that -- if that -- they did not end up breaking the contract. Can I get back and not lose my MOOP, basically? And then lastly, after it happens, it doesn't need to be a CMS discretion of significant -- if it's your primary care provider or your specialist, it's significant to you. So there should just be an easier way for people like brokers, agents, SHIPs to be able to help people to fix that power

imbalance.

So I think there needs to be some fairly significant work on special enrollment periods, and creating guarantee issue rights to supplements for people in that situation would be tremendous.

I think the MOOP, the maximum out-of-pocket, needs to move with the individual. They've already paid into the system. Now, you may have a different MOOP with a different insurance company. One could be $3,600; one could be $8,000. Well, you have to deal with that. But I do think the money should be able to move with the individual. I know that's complicated, but it seems like a power imbalance to not have it move.

And lastly, I am so happy that the Plan Finder tool now includes providers. Now, it only includes individuals. It doesn't do the agencies that you can look up, that kind of thing. That would be super helpful.

In particular, I've heard some people refer to different things. One in particular is the rehab facilities -- Lynn was sort of alluding to this -- because I think a lot of people are very surprised when they need rehab. They're like, you mean I've got to go there, not to

this place in town? And I was like, mm-hmm. They don't even think about that ahead of time. So including the agencies or institutions, including rehab facilities would be really important.

And then just to build off Cheryl's comment, ghost networks are real, particularly for behavioral health. I mean, a lot of that's now sort of online call center supports. But for psychiatry and certainly for any behavioral health things, I think it's really important to look at the ghost networks, including, I should add, dental. Like, if there's a dental benefit, where can you go to the dentist? Does anybody -- there's a difference between access and it being in the network, what's accessible. If that can be in the Plan Finder tool, that would be a huge savings of time and energy for people, because a lot of times, even when you call physician practices to say is this a network -- first of all, you need to make it clear that it's Medicare Advantage. You're not talking about commercial. Secondly, PPO versus HMO and the people that answer the phone are not the people who do the contracting, and there's a lot of misinformation. So to have that shared Plan Finder tool of provider directory

is just a huge step forward.

Thank you for this work and looking forward to continuing it. Thanks.

MS. KELLEY: Betty.

DR. RAMBUR: It's always hard to follow Gina. I just wanted to be on the record as sharing my enthusiasm for this work and how important I think it is, and I so appreciate the comments of the Commissioners.

I just want to underscore a few. One is not just looking at the numbers, but what's happening on the working surface, and so to the extent that more qualitative work could be done and really separating out HMO and PPO experiences.

And then, if possible, to triangulate with the CAHPS scores that Scott mentioned would really be an interesting thing, and I don't know how complicated that is. I'll leave that to you to figure out.

In terms of the provider piece, I think a deep dive into this would be very interesting to understand the experience of physicians versus nurse practitioners and PAs, and it does intersect with the local license or the state licensing laws, which are different in different

states. But also, I expect you'd find a lot of other interesting factors as well.

So a lot of enthusiasm for this work, and thank you for the brilliant work you did so far.

MS. KELLEY: Mike, that's all I have.

DR. CHERNEW: Yeah. So again, thank you all. I knew this would be a great discussion. It was a great discussion.

A few quick summarizing things before we take a quick break and come back on another Medicare Advantage topic related to risk adjustment.

So here's my first thought. I think across every comment, it's pretty clear that the core value in the health care system is having people who have a medical issue being able to see a provider. Doctor, nurse practitioner, hospital, like, it just matters. Like, that's where you get the value of the health care system, is from the people that actually provide you health care.

And we're worried about that, and that in order to get the better providers, efficient providers, there's some role potentially for narrower networks. And that came up very clearly.

What is challenging, I think, and going forward is going to be moving this work that's descriptive to work that is normative. And almost all of you jump immediately to some normative -- well, we should worry about this, we should worry about that. And right now, you know, usually descriptive precedes the normative, and since we're in the beginning, this was the descriptive. It will get to the normative.

I see the core issue there, which is both a policy issue and otherwise, some question about how we weight structural things. Do you have enough gerontologists in the local area to make sure that people need a gerontologist can get access to a gerontologist or primary care doctor or surgeon or whatever it is they happen to need versus outcome kind of things? Like, how long do they have to wait? How far do they have to travel? Several people mentioned the travel issue. Or are they satisfied with their access? Which would come up in CAHPS. I think that's a good idea.

But that's sort of a different orientation for trying to figure out what the problem is, and of course, as it's been pointed out, one of the core problems here is all

of the challenging data issues. And so we talked about thresholds.

One thing I thought you were going to say, Betty, which you didn't, because you're a leader in saying this, is the "incident to" billing thing makes it challenging to know, did you get access to a physician or a nurse practitioner? Not always easy to tell what's going on, and then the NPI issues for the provider systems is hard.

So I think there's just a lot of underlying data issues that makes the descriptive work hard, but of course, if you can't do the descriptive work, it's hard to get to normative regulatory rules. And it's possible those rules can be quite onerous or not when you try and do things.

So I think I believe this is actually one of the increasingly important aspects of the American health care system, because the people we care about, the Medicare beneficiaries, are faced with these issues of networks and changing networks and access to networks in ways that I think is just frustrating now and potentially could become much more frustrating.

As pointed out in Greg's comments, sometimes access isn't the same as access, and you care about the

team around those people, and just getting the details of that right. I think going forward as a Commission, we're going to have to be humble in terms of what is actually doable in this space. We're never going to get it really all that right. But I think it's incumbent upon us to make sure that we do our best to at least smooth out the most egregious problems in the system to make sure that people that need access to the health care system kind of get the access that they need in a way that maintains the value of having some type of curated network to manage both costs and outcomes.

So I think going forward -- you guys heard the staff, to Krista and to Karen -- to Tara, I think was the one who did -- Katelyn did this? I'm sorry. My bad. Anyway, to the folks that were doing all of the work, you should hear a lot of enthusiasm and appreciation for both all that was done and how well it was presented. And this, I think, will end up being a topic that will come back again and get in the future. So again, thank you.

We're going to take a five-minute break, and we're going to come back to talk about some nuances of Medicare Advantage risk adjustment. Thank you.

[Recess.]

DR. CHERNEW: All right. Everybody, we are live.

One of the topics of broad interest is the risk adjustment system for Medicare Advantage. We do a lot of work in that area, but this is a slightly different take on that broad topic, which is just to try and think about some issues that we would have to confront. We are not going towards a recommendation, but just raising some issues that CMS would have to confront if they opted to use the Medicare Advantage encounter data as a basis for risk adjustment.

So, Andy, you are going to take us through that. Go ahead.

DR. JOHNSON: Good afternoon. In this session, I will present considerations for implementing the use of Medicare Advantage encounter data and risk adjustment. The audience can download a copy of the slides from the control panel on the right side of your screen.

I will cover four topics during the presentation, which will be followed by a Commissioner discussion: first, the two ways that risk adjustment affects payments

to MA plans; second, the steps to calibrate a risk adjustment model and technical considerations for using MA encounter data; third, key policy decisions when incorporating an MA-based risk model into the MA payment system; and fourth, potential implications of those policy decisions.

To start off, I want to provide a little background about why we are discussing risk adjustment that incorporates MA encounter data.

Implementing an MA-based risk adjustment model has been contemplated for some time. The Social Security Act requires the Secretary to apply an adjustment for coding pattern differences until risk adjustment uses MA diagnostic cost and use data, otherwise known as encounter data.

MedPAC first discussed using Encounter Data for risk adjustment and related implementation challenges in April 2016. In CMS's 2024 report to Congress, the agency reported that it has been developing an MA encounter-based risk model and also that stakeholders have generally supported moving to such a model.

Finally, in the advanced notice for payment rates

in 2026, CMS announced that the agency could start phasing in an MA-based model as early as 2027. However, the agency did not propose implementing an MA-based model for that payment year.

This presentation aims to identify important issues that could arise if using MA encounter data for risk adjustment and to provide context for evaluating these issues.

The Commission has not taken a position on using MA encounter data for calibrating a risk adjustment model. We are not planning to incorporate this material into a chapter for 2026, but we could return to this topic in the future, depending on Commissioner interest.

Now to begin by discussing the two ways that risk adjustment affects payments to MA plans.

Medicare's payments to MA plans start with a bid, which is the amount that a plan expects it will cost to cover Part A and B services, and a benchmark, which is the maximum amount Medicare will pay in a county. Benchmarks are based on projections of fee-for-service spending that are standardized to reflect a beneficiary with average spending risk.

Standardizing fee-for-service spending for benchmarks marked in teal is one way that risk adjustment affects payments to MA plans.

Nearly all plans bid below their benchmark and have a payment rate equal to their bid plus a rebate, which is a percentage of the difference between the bid and the risk-adjusted benchmark. The risk-adjusted benchmark is the standard benchmark multiplied by a plan's risk score highlighted in orange.

So risk scores affect MA payments when risk-adjusting benchmarks to determine the rebate amount and when standardizing fee-for-service spending for benchmarks.

Now we're going to use an illustrative example to walk through the steps for calculating payment to an MA plan for a single county. Starting with the table on the left, the plan's bid is $900 per member per month, and the average risk score is 1.1 before the coding adjustment and 1.035 after the coding adjustment.

On the right, average fee-for-service spending in this county, $1,000, is divided by the average risk score of 1.0, making the standard benchmark $1,000. The payment formula below is the same as the previous slide.

Next, we plug in the amounts for the plan bid, plan risk score after coding adjustment, and standard benchmark into the payment formula. The note at the bottom of this slide explains two assumptions about the county quartile and plan star rating, but those details aren't necessary for understanding the role of risk adjustment.

Finally, we calculate a base payment rate for this plan of $900 and a rebate amount of $88 for a total payment of $988 per member per month in this county. We will return to this example later as we discuss potential ways of incorporating an MA-based risk model into the MA payment system.

Medicare's risk adjustment model uses beneficiary demographic information and diagnoses to produce a risk score for each beneficiary. Risk scores are an index of expected spending that is normalized to 1.0, representing a beneficiary who is expected spending equal to the national fee-for-service average.

The current risk model is developed or calibrated using spending and diagnostic information from fee-for-service claims. Therefore, risk scores reflect the relationship between diagnostic coding patterns and

spending as it exists in fee-for-service Medicare.

All Medicare beneficiaries, including those in MA, have a risk score calculated from this fee-for-service-based model. This generates two payment accuracy issues for Medicare's payments to MA plans. Those are higher MA coding intensity and a favorable selection of beneficiaries into MA plans. Both of these issues increase payments to MA plans relative to what fee-for-service would have spent for the same beneficiaries.

First, diagnoses are not coded with the same frequency in MA and fee-for-service. Higher MA coding intensity leads to higher payments to MA plans and also provides an advantage to plans that code more intensively than other plans. Several studies using a variety of data sources and methods find that differences in coding intensity increase MA risk scores and payments to MA plans.

Second, risk scores do not reflect spending for MA enrollees on average. Instead, risk scores systematically overpredict spending for MA enrollees, leading to higher average payments to MA plans relative to what fee-for-service Medicare would have spent for the same beneficiaries. Because fee-for-service spending is used

for benchmarks, the overprediction for beneficiaries enrolling in MA also increases payments to MA plans. A large number of analyses find that there is a favorable selection of enrollees into MA.

Next, I'll describe the steps for calibrating a risk adjustment model. Risk adjustment models are developed from a beneficiary-level regression that models the association between the outcome variable and a number of explanatory variables. This regression models how the outcome, annual spending on Medicare services, is explained by demographic characteristics and medical conditions based on groups of diagnosis codes.

The output of the model is a set of coefficients, or betas, one for each explanatory variable. An illustrative formula for the model is shown on the slide.

Because the outcome variable is annual spending, the model coefficients are estimated in dollars. To convert dollar-based coefficients to risk score units, each coefficient is divided by the average annual spending. The bottom of the slide shows an example using the coefficient for HCC 38 for diabetes. The coefficient of $1,727 is divided by national average spending of $10,402, resulting

in a coefficient of 0.166 risk score units. That means that a beneficiary coded with HCC 38 is expected to have spending associated with that condition that is equal to 16.6 percent of national average spending per beneficiary.

The steps to calibrating a risk adjustment model on the previous slide are the same, no matter which data source is used. This slide describes the resulting model changes when calibrating a model using fee-for-service claims versus MA encounter data. The middle column shows the current policy using fee-for-service-based model, and the right column shows an MA-based model.

The first two rows show that the data for beneficiary annual spending and diagnoses would change from fee-for-service claims data to MA encounter data. In the third row, the data source for demographic characteristics would remain the same. In the bottom part of the table, we see that the coefficients in an MA-based model would reflect the relationship between spending, medical conditions, and demographic characteristics for the MA population. That means that changing from the current fee-for-service-based model to an MA-based model, coefficients are likely to change.

For example, the coefficient for diabetes was 0.166 in the fee-for-service-based model, but that coefficient for diabetes could be higher or lower under an MA-based model. Changes in coefficients could be due to differences in the efficiency of care provided in MA compared to fee-for-service, or differences in the severity of diseases among beneficiaries coded with the condition.

There are a number of technical considerations for calculating annual spending from encounter data. First, should payments or standardized prices be used to calculate annual spending? Plans report payments to providers for services that are paid on a fee-for-service basis, but they do not report payment amounts for services provided under capitated arrangements. Alternatively, CMS could apply standardized fee-for-service prices to encounter data to calculate annual spending. Second, does the incompleteness in MA encounter data meaningfully affect model accuracy, or would an adjustment to encounter data be needed to address missing encounters? And finally, encounter data may include records for denied claims or for out-of-network care, where plans often apply higher cost sharing or offer no coverage at all. CMS would need to

decide whether to exclude such encounter records when calculating annual MA enrollee spending amounts.

Next, we'll go over three key policy decisions. These policy decisions may arise if implementing an MA-based risk model and continuing to use fee-for-service-based benchmarks.

The first is how to address coding intensity that may affect payments to MA plans under certain scenarios. Second is whether to apply the same MA-based model to be used to calculate fee-for-service risk scores or to use a separate fee-for-service-based model, and finally, if using separate MA-based and fee-for-service-based risk models, would additional normalization factors be used to account for differences between the two populations? We'll discuss each of these over the next three slides.

The first key decision is how to address coding intensity differences that may arise under an MA-based risk model. CMS currently reduces MA risk scores by 5.9 percent to account for coding pattern differences between MA and fee-for-service. However, our analysis has found that this adjustment is insufficient to fully account for such differences.

In 2026, MA risk scores after applying the coding adjustment are projected to be 4 percent higher than risk scores for similar fee-for-service beneficiaries.

One of the motivations for using an MA-based model is to address issues with coding intensity. CMS has indicated that the agency does not intend to apply an adjustment for coding differences under an MA-based model, as would be allowed by statute. If implementing an MA-based risk model, MA and fee-for-service diagnostic coding differences could still affect payments under certain scenarios, which we will discuss in the next section. So policymakers may still need to contemplate approaches to address the effects of any coding differences under an MA-based risk model.

As we discussed at the beginning, risk scores affect MA payments in two ways. First, MA risk scores adjust plan benchmarks for determining a plan's rebate amount, and second, fee-for-service risk scores are used to standardize the fee-for-service spending estimates used for benchmarks.

We assume that an MA-based risk model would apply to the MA risk scores in the MA plan payment formula, but

the second key policy decision is whether the same MA-based risk model would be applied to the fee-for-service risk scores used to standardize the fee-for-service spending estimates and benchmarks.

In the illustrative scenarios we will discuss in the next section, we refer to these approaches as using a single MA-based model or separate MA and fee-for-service-based models.

The third key policy decision arises if using separate MA and fee-for-service risk models. By calibrating two separate models for MA and fee-for-service populations, the risk scores produced by each model could reflect different levels of absolute spending risk. In other words, a 1.0 risk score from the MA-based model may not equal the 1.0 risk score from the fee-for-service-based model. In this scenario, policymakers may need to consider how to align the MA and fee-for-service risk models in a way that accounts for differences between the two populations. Simply setting average MA and fee-for-service risk scores to be equal would eliminate the effects of population differences, such as the differing shares of beneficiaries who are eligible for full or partial Medicaid

benefits.

Normalizing the MA and fee-for-service risk models separately by subpopulations, such as Medicaid benefit eligibility, could help align the two models and account for population differences.

Next, we consider a few illustrative scenarios to help understand the implications of these policy decisions. We will describe three illustrative scenarios that either partially or fully delink the MA payment system from fee-for-service data.

The first two scenarios partially delink from fee-for-service data because they incorporate an MA-based risk model but would continue to use benchmarks based on fee-for-service spending. Scenario 1 applies a single MA risk model, and scenario 2 applies separate MA and fee-for-service based risk models.

Fully delinking MA payments from fee-for-service data would require an MA-based risk model and a new base payment system that doesn't rely on fee-for-service data. The third illustrative scenario assesses one such option.

For each of these three scenarios, we assess whether payments to MA plans are affected by coding

intensity, inaccuracy due to population differences, or favorable selection.

This table highlights the differences between current policy and the first two scenarios. In the first row, we see that fee-for-service spending data is used as the basis for benchmarks in all three cases. In the second and third rows, current policy uses a single fee-for-service-based model, whereas the illustrative scenarios show two different ways of applying an MA-based model.

Under scenario 1, a single MA-based model would be used to generate risk scores for all Medicare beneficiaries. It would produce risk scores used to standardize fee-for-service beneficiary spending for benchmarks and would produce risk scores used for calculating MA plan payment rates.

Under scenario 2, separate risk models would be used. A fee-for-service-based risk model would be used to standardize fee-for-service spending for benchmarks, and an MA-based risk model would be used to calculate MA enrollee risk scores for paying MA plans.

Although we are discussing two options for applying MA-based risk model with fee-for-service

benchmarks, a wide range of policies are possible.

To better understand these scenarios, we return to the earlier example of calculating payment for a plan in a single county. We started with the same numbers from the earlier example and then updated the risk scores to reflect scenario 1, which applies an MA-based risk model to all Medicare beneficiaries.

The risk model would be normalized to the average MA enrollee. So we divided both MA plan and fee-for-service county risk scores by 1.1, which was the average MA plan risk score before coding adjustment in the earlier example.

The average plan risk score is now 1.0, and the average fee-for-service risk score for the county is 0.909.

In the upper right table, we see that the lower fee-for-service county risk score has increased the standard benchmark to $1,100, which is up from $1,000 in the earlier example.

Now looking at the payment formula, we see that although the MA plans' risk score is lower than in the earlier example, that effect is more than offset by the higher standard benchmark amount.

Looking at the yellow-bracketed portion of the equations, we see that the balance of these two effects results in higher risk-adjusted benchmark amount under scenario 1. Therefore, the plan's monthly payment amount is larger under scenario 1 than under current policy. We note that the difference in payment amounts is due to the lack of coding adjustment under scenario 1 when using an MA-based model. If a coding adjustment were applied equally under current policy and under scenario 1, the payment amounts would be exactly the same.

The upshot for scenario 1 is that if a single MA-based risk model is applied to all Medicare beneficiaries and benchmarks continue to be based on fee-for-service spending, then coding intensity will continue to affect payments to MA plans. Coding intensity for MA plans would be the same under an MA-based model, and diagnoses would continue to be coded less -- excuse me -- coding incentives for MA plans would be the same under an MA-based model, and diagnoses would continue to be coded less frequently for fee-for-service beneficiaries.

How much coding intensity would affect payments to MA plans is uncertain. The size of the coding effect

depends on how the coefficients would change under an MA-based risk model.

For example, if average spending for MA enrollees coded with diabetes is lower for fee-for-service beneficiaries coded with diabetes, the coefficient for diabetes may be smaller under an MA-based model. If differences in coding diabetes contributes to differences in coding intensity, then the smaller diabetes coefficient could result in overall differences in coding intensity.

However, if CMS no longer applies a coding adjustment to MA risk scores, all differences in coding intensity would affect payments to MA plans. Under this scenario, policymakers would still need to consider how to address differences in coding intensity.

Now we move to Scenario 2. We again return to our earlier example, but for Scenario 2, we updated the risk scores to reflect an MA-based risk model applied only to MA enrollees. A fee-for-service-based risk model would be applied to fee-for-service beneficiaries, as under current policy.

Each risk model is normalized to its own population. So the MA plan average risk score is now 1.0,

and the fee-for-service county risk score remains at 1.0 as in the initial example.

When calculating payments under scenario 2, we see that a lower MA risk score is not offset by a higher standard benchmark, which remains at $1,000. Therefore, the risk-adjusted benchmark shown under the yellow bracket is lower under scenario 2 than under current policy.

Because scenario 2 uses separate risk models for MA and fee-for-service beneficiaries, differences in coding intensity would not affect payments to MA plans on average. That means that Medicare would not pay more for MA plans overall for coding diagnosis more intensively than providers in fee-for-service.

However, variation in coding intensity within MA would still be an issue. Plans that code more intensively would continue to receive higher risk scores and greater payments than plans that code less intensively.

Using separate risk models could introduce a new source of inaccuracy to MA payments. By normalizing each risk model to its own population, applying separate risk models in the way the scenario 2 does implicitly assumes that the average risk of the MA population equals the

average risk of the fee-for-service population. Or put it another way, it assumes that the 1.0 MA risk score equals a 1.0 risk score in fee-for-service.

However, that may not be true, as there may be differences in demographic characteristics or true disease incidence between the MA and fee-for-service populations that affect spending.

Assuming that a 1.0 MA risk score and a 1.0 fee-for-service risk score are equal would eliminate the effects of differing average risk levels and could result in average payments to MA plans being higher or lower than intended.

Available evidence suggests that inaccuracy due to using separate risk models would be small in the short term. Our analysis has shown that very little of the difference in MA and fee-for-service risk scores are driven by factors other than coding intensity, meaning that population-level differences would introduce a very small amount of payment inaccuracy under current enrollment patterns.

However, this inaccuracy could change in the future if enrollment patterns differ. Separately,

normalizing risk scores for different demographic groups, such as by Medicaid eligibility or institutional status, could further reduce payment inaccuracy due to population differences under this scenario.

Overall, scenario 2 presents a trade-off, eliminating overall effects of MA coding intensity and potentially introducing inaccuracy due to population differences.

To help describe the implications of the illustrative scenarios, we return to this table, which describes the policies under each scenario in the first three rows. In the lower three rows, I will summarize the payment issues that could arise under each. As I mentioned earlier, coding intensity and favorable selection affect payments to MA plans under current policy.

Under scenario 1, using a single MA-based risk model would not eliminate the effects of coding intensity, though the magnitude of the effect may differ from that under current policy.

Under scenario 2, using separate MA and fee-for-service-based risk models presents a trade-off of eliminating the effects of coding differences, but

potentially introducing a new source of payment inaccuracy due to population differences.

Finally, I want to discuss the effects of favorable selection.

Under scenario 1, with a single MA-based risk model, the mechanism of favorable selection of enrollees into MA is essentially unchanged from current policy, though the magnitude of the effect would likely differ.

Using separate MA and fee-for-service risk models under scenario 2 has the potential to reduce the effects of favorable selection, but that would depend on MA and fee-for-service population differences.

Overall, we find that applying an MA-based risk model while using fee-for-service-based benchmarks would not resolve all risk adjustment issues that affect payments to MA plans.

Policymakers could consider fully delinking MA payment from fee-for-service data. That would mean applying an MA-based risk model and using MA data to develop a method for determining the base plan payment amount.

In our June 2023 report, the Commission discussed

options for reducing or removing the use of fee-for-service data for calculating benchmarks. The three options retained the basic bid, benchmark, and rebate structure of payments to MA plans, but it changed how benchmarks would be calculated.

The first option would replace fee-for-service spending estimates with combined MA and fee-for-service spending estimates for each county. The second would use competitive bidding to determine a benchmark amount, and the third would apply an administratively-set growth rate for benchmarks.

The Commission did not reach consensus on any of these three options, but raised general concern about the continued use of fee-for-service data for benchmarks.

For illustrative scenario 3, we consider one option for fully delinking MA payments from fee-for-service data, which makes as few changes as possible from current policy.

Scenario 3 retains the bid, benchmark, and rebate structure, but applies an MA-based risk model and uses benchmarks that are based on MA spending estimates. By retaining the basic bidding structure from current policy,

scenario 3 preserves the existing nature of competition among MA plans and the incentives for plans to lower bids and offer rebate-funded supplemental benefits to enrollees.

MA spending estimates could be calculated from existing MA data sources. For this illustrative scenario, we will assume that MA spending includes amounts for medical spending, plan administrative costs and profit, and a rebate add-on for supplemental benefits. Using benchmarks based on MA spending could result in payments to MA plans being higher or lower than current law, depending on the choice of policies to apply, such as the differing ways to account for plan administration and profit or of determining rebate add-on amounts.

Here, I've added scenario 3 to the far right column of the table I presented earlier. On the top part of the table, the key difference for scenario 3 is in the first row, showing the benchmarks based on MA spending in addition to applying an MA-based risk model. In the lower part of the table, we see that under scenario 3, payments to MA plans would not be affected by coding intensity, inaccuracy due to equating populations, or favorable selection. So scenario 3 reflects a trade-off. By fully

delinking MA payments from fee-for-service data, we eliminate the effects of coding intensity and favorable selection. However, fully delinking from fee-for-service would require a number of technical challenges to establish a risk model and benchmarks based only on MA data.

One final note. Although the overall effects of coding intensity would be addressed under scenario 3, differences in coding intensity among MA organizations would still affect payments to MA plans. So efforts to reduce coding intensity differences would still be needed.

To summarize today's presentation, the current risk adjustment system has major issues affecting payment accuracy, including the effects of coding intensity and favorable selection. There are a number of ways to implement an MA-based risk model while maintaining fee-for-service-based benchmarks, thereby partially delinking MA payments from fee-for-service data.

There are also options for using an MA-based risk model that fully delink MA payments from fee-for-service data. There are a variety of limitations and trade-offs amongst all of these scenarios.

We hope today's presentation provided information

and context for the important issues that could arise if using MA encounter data for risk adjustment.

Now I'm happy to take your questions about this material and look forward to your discussion. As I mentioned earlier, we're not planning to incorporate this material into a chapter for 2026, but we could return to this topic depending on commissioner interests.

Thanks. And I'll turn it back to Mike.

DR. CHERNEW: Andy, thank you. There is a lot here. I'll make a few comments later. But I think we should go to the queue, and if I have this correctly, Kenny, is first, and Dana is going to read Kenny. Is that right, Dana?

MS. KELLEY: Yes. Kenny has -- I think there's only one person in Round 1. And Kenny is first in Round 2, so I'll just do him Round 1 and Round 2.

DR. CHERNEW: Yes. Go ahead.

MS. KELLEY: So this is an excellent overview of key technical policy and implementation considerations in moving to an encounter-based risk adjustment framework for MA.

He first has four points. On accuracy, he agrees

that a replacement encounter-based risk adjustment framework needs to both mitigate incomplete encounter submissions, coding patterns, and intensity differentials between fee-for-service and MA while providing transparency on how this is achieved.

Accuracy point number two; the payment amount is typically zero on the encounter record where the encounter is covered by capitation or salary. Where the payment field is zero, MA plans need transparency on the following: How is the payment calculated or imputed via standardized prices? How to assess accuracy of this payment imputation method? And transparency on CMS-based testing method, for example, predictive ratios, how are these computed?

Given the complexity, he recommends that any move to an encounter-based system allow a three-year phase-in, and he agrees with CMS that the statutory 5.9 percent minimum for coding intensity would go away assuming a three-year phase-in.

He likes the presentation's discussion of the linkage between benchmarks and MA encounter data, a complex issue with no easy answers. Today, MA payments are anchored to fee-for-service costs, while CMS is considering

a future risk adjustment model based on encounter data. This raises key policy questions, whether to fully de-link MA payments from fee-for-service or modernize risk adjustment will retaining and external cost anchor.

The presentation lays out three thoughtful but challenging scenarios. What full de-linking, Scenario 3, gets right, a fully MA-based system addresses two well-documented issues. It eliminates the impact of coding intensity on average payments and removes favorable selection tied to fee-for-service benchmarks. Conceptually, it aligns payments with MA system costs.

Why full de-linking creates new risks? Despite its conceptual appeal, full de-linking introduces significant governance and actuarial risks by creating a circular payment dynamic. Benchmarks would be driven by MA costs that are themselves influenced by prior payment policy, bidding behavior, and coding practices. Over time, higher MA spending could mechanically increase future benchmarks absent a strong external anchor. Payment accuracy would also become highly dependent on encounter data quality, which remains uneven.

Why partial de-linking, or Scenario 2, is more

defensible. Partial de-linking uses MA encounter data to improve risk measurement and reduce coding distortions while keeping fee-for-service based benchmarks as an external anchor. This preserves transparency and keeps payments interpretable.

Overall, while further analysis is needed, Kenny believes Scenario 2 delivers most of the accuracy benefits without redefining the payment standard. From a fiscal, actuarial, and governance perspective, partial de-linking is the more prudent and defensible approach.

I have Lynn next, in Round 2, but do you want to jump in here, Mike?

DR. CHERNEW: I want to say something and then we'll jump to Lynn. So a few of these things are actually going to pick up on some of the themes of what Kenny said, but I just want to sort of lay a framework.

The first thing is I think there are two broad issues, and Andy, you may or may not agree, but you should say if you don't. One of them, what are the coefficients? Based on the data you'll change the coefficients in a whole bunch of ways. So you're going from coefficients where diabetes is priced based on diabetes care in fee-for-

service to one where diabetes is based on diabetes care in MA. The second one is to normalization. So are you linking it to TM or are you not, and how are you dealing with the payment issues.

So those are the two big issues that I think one has to deal with.

I'll say a few substantive things, but I want to emphasize before I do, we are not right now contemplating what the answer to these questions are. We are sort of raising a bunch of issues. It will be for future iterations of the Commission to decide what the right thing to do is. You're certainly welcome to say how you feel about those. I think that will guide folks in the future. But right now, we have one meeting left, this will not be a chapter in June, and we don't have any votes or anything planned. So just to give you some idea of where we are.

But for what it's worth, I think there are two things that you all should think about going forward. The first one is what is the correct coefficient? Should MA plans be rewarded for the efficient care that MA plans provide, or should they be paid what is in fee-for-service, giving them the ability to save money if they can provide

care more cheaply than the fee-for-service system?

And the second one, which I think is particularly important to us going forward is thinking about how to pressure-test whatever scenario you want, allowing for behavioral response, for plans and other groups. I think that's always the core challenge is when you change the system, you change behavior, and you need to pressure-test what is going to go as everybody changes their behavior to adopt the incentives of the new system.

So that's where I personally think we are, but now what really matters is where Lynn thinks we are. So Lynn.

MS. BARR: Thank you for that, Mike. So I just have a few comments related to MA. There are a couple of things that stick out. One of them is our analysis that said all things are not equal. There are provider plans and there are commercial plans, and they do not code the same. I mean, to what extent are we going to start cutting up the universe, but we have to think about those differences and understand them, because just cutting across the board, 80 percent of the volume is concentrated in more commercial plans, and so they're going to basically

drive the coding. So how do we deal with that?

And another question or comment is, you know, are home visits an encounter? Is an encounter in a facility or an office, or is there still going to be enough money to send providers to people's homes to incentivize them? I think that's something we need to think about, like what is an encounter, and is it with your provider or is it with somebody who is assigned for coding?

When I think about the provider-based health plans, I think they act a lot like ACOs, and we haven't really talked about how ACOs also have coding issues. And both the regional adjustment, which is sort of an endless, no holds barred. There's a 3 percent limit on HCC increase, but there is no limit on regional adjustments. So that is also a problem that needs to be addressed.

And it might be a possibility to think about combining provider-based health plans with ACOs to get maybe something that's a little bit closer to normal, or not. I don't know. But I don't think we can talk about risk adjustment without talking about ACOs, because I've been looking at the data, and I think we all realize that, I don't think we really are saving money in the Medicare

assured savings program anymore. I think it's gotten really skewed by coding, and we have to address that problem, potentially think about that problem at the same time, and try to make sense of all of that together.

And then my final comment is how is this going to affect physician compensation, because physicians that are contracted with MA plans get paid a lot for increasing star ratings and increasing HCC. So those payments are going to go away. How is that going to affect overall compensation for physicians? I don't know how much money is in that, but I think that's something that we need to think about, as well.

I think this is great work, Andy. Great job. But it leaves me with more questions. Thank you.

MS. KELLEY: Brian.

DR. MILLER: Thanks for this chapter -- I'm sorry, not chapter, slides. I've read them three times, because I'm very nerdy.

So environmental comments. One, I think this is the discussion that we all collectively should be having. Secondly, it is no surprise, I do think there is some favorable selection in MA, but going back to my prior

comments, I do think we need to correlate that favorable selection model with real-world business practices to stress-test that, because in some circumstances our measurement of favorable selection run contrary to realities where poorer patients have worse health outcomes and use more high-cost resources. Again, I still think there is some favorable selection in MA.

I also know that many folks have had concerns about sort of completeness of MA encounter data, which is completely valid, and I agree with. I went back and looked at our prior discussions. Most of the service markets, the completeness is in the 90s percentage. Sometimes it dips into the high 80s. I would think that if we moved to an encounter-based risk adjustment system, unsurprisingly, plans would probably hit 99 to 100 percent completeness, and we could always penalize them if they didn't. That would be an appropriate sort of place to use the stick instead of the carrot.

So policy takeaways, looking at this I would separate benchmark policy from risk adjustment policy. These are both important issues, they are related, but they are separate and meaty. Part of the reason is, I think,

going around the table there are probably a lot of us who feel very differently about benchmark policy, and there are probably 25 different answers amongst the 17 of us, because some of our answers will change as we hear each other's comments. I do think, though, on improving risk adjustment policy, many of us probably agree and have voiced sort of the same concerns.

Looking at the choices and thinking about what is most effective for us, in sort of the policy lane of the real world, where we have to consider sort of real-world operations and politics, radical incrementalism is usually the most effective strategy for us. It doesn't always seem sexy, but it often gets stuff done. So thinking about the Honda Accord of policies, because I'm a car guy, and first policy principles, my preferences would sit with Scenario 2 and move towards MA risk adjustment based upon MA data, which will address some of the fee-for-service and MA coding intensity differences that we have debated ad nauseum for years, many years, and the policy community has debated for decades. So it would be nice to address that issue more completely.

It would, as pointed out, leave sort of coding

differences between plans, and some of those differences are going to be appropriate, clinically appropriate, and some of those will be inappropriate, abusive, wasteful, fraudulent. And that will actually facilitate CMS's ability to excel as a regulator because instead of debating between fee-for-service and MA coding, they will be looking at MA coding compared to MA coding. So we will inadvertently, or hopefully purposefully, increasing their sophistication and power as an effective regulator.

Facing sort of risk adjustment among fee-for-service data, I think it's clear it has not worked well when county-level MA penetration is increasing. So I look at Scenario 2 as a way for us to both address some of those fee-for-service/MA issues in coding intensity, and then make CMS, or empower CMS to be a more effective regulator at parsing sort of problematic actors from good actors.

MS. KELLEY: Stacie.

DR. DUSETZINA: Thank you so much for this work. I think I'm mainly excited to see more, and more details and more trying to work out the math and the scenarios behind this. Because it is hard looking at just the three different options and thinking through what would the

behavioral response be, because I usually kind of look at these things and think, okay, well, if I were trying to make more money, how would I game this out if I were in that situation?

So I guess my gut reaction is, like Scenario 2, while I agree would be a really important step forward, it feel unsatisfying not to wholly address the problem. So my initial gut reaction is de-link everything. But I would love to see more details about how that would play out.

I think Kenny made a point about needing an external anchor, and I was also kind of thinking along the same lines. Like, you know, what if it just started to lead to higher and higher and higher payments? There's nothing necessarily stopping that. So I think that would be something important to think through.

I think Mike's comment about pressure-testing, like figuring out what are the ways that this could go right and wrong in the different scenarios will be important.

But I'm enthusiastic to see where this work goes. I think it is important. And even if the main spillover effect is to just get better encounter data, I think that

would be a positive thing for everybody.

MS. KELLEY: Greg.

MR. POULSEN: Actually, Stacie just said a great deal of what I was planning to say, so thanks, since she said it well.

I think we are fortunate to be having this discussion now, compared to three years ago, and the reason for that is I think that we have made progress, we as the government, has made progress already, and V28 has made some real improvements compared to where we were. I think there's very little doubt, at least in my mind, that that's the case.

Just to point that out, I used to get, at least once a week I'd get an email saying, "Bring us in. We will work with you, and we will guarantee a 10-for-1 payback in terms of we can increase your coding and you will make 10 times as much as you have to pay us." And I'd get those every week. I don't get those anymore. Now they only want 8-to-1. So it's improved.

But the issue is that care is still separated from the coding intensity, and anything that we can do to close that gap I think is good. My own bias is that having

the additional data that comes from fee-for-service Medicare provides us with a sea anchor that is helpful during doing that process. I know that there are reasons why that's a bad thing as well as a good, but I would lean in that direction, all things considered.

Also, I think Kenny's points were really good, and I'm glad we got those on paper. So thanks, Kenny.

The final one that I would make is if we look at this as changing the motivation for very capable plans, from being really excellent at coding to having to do something else to make money, what's that something else? It's providing higher-value care. So this is not just about fiscal responsibility for the government. It's about care for beneficiaries. And I think the promise of MA, even before it was called MA, was that we would find ways to care for people, to keep them healthier, because that costs less, and therefore the plans make money and the beneficiaries are healthier.

And I think that we've found that there was a path to make money more easily doing something different, which was coding. And to the extent that we can take that discretion away and make the coding automatic or semi-

automatic, it not only is fiscally sound but it's clinical sound, as well.

So I'm just grateful for all this great work. I know it causes me a migraine every time I read these because it is so complicated, and Andy and the rest of the team have done this fabulous work for doing that, because it's hard. It's mentally hard as well as socially hard. So thanks for all the great work.

MS. KELLEY: Robert.

DR. CHERRY: Yeah, thank you. I really appreciate the different scenarios because what it does is it tries to help you differentiate what problem you're trying to solve, and therefore what scenario seems best.

I think one thing I'm still a little confused about in terms of nailing down a scenario, and I think this was tried to be explained in the materials but I'm still not clear, is in terms of how do the rebates work? So if you go to Slide 24, where there is Scenario 1, under Scenario 1 the new payment would be $1,030, but I see that the fee-for-service data shows it at $1,100. So does that mean there's a $70 potential rebate under that scenario, or do the rebates completely disappear since we've normalized

the risk scores to 1.0?

DR. JOHNSON: In the first two scenarios there still would be the fee-for-service based benchmarks. So these two are just showing the different ways in which, if you apply an MA-based risk model to just the MA risk scores that are used for plan payments and not to the fee-for-service, that's Scenario 2, you get one outcome. But if you apply the MA-based model to everyone, as in Scenario 1, you get a different outcome.

So the rebates are still calculated as they are now, and here it's showing that the risk-adjusted benchmark goes up to $1,100, so the rebate is effectively $130 in that Scenario 2.

DR. CHERRY: Okay.

DR. JOHNSON: But the two components are first the risk score affecting the payment to MA plan, but then on the fee-for-service side, it has this other effect of how it plays through the benchmarks, and the action is on the rebate. That changes under Scenario 1 and Scenario 2.

DR. CHERRY: All right. So the rebates under the models would likely still stay then, basically.

DR. JOHNSON: Yes.

DR. CHERRY: On all three scenarios.

DR. JOHNSON: The bidding benchmark structure is all the same.

DR. CHERNEW: Paul?

MR. MASI: I was just going to clarify. Andy, I think your answer is exactly right, and also static. Is that fair to say, that to the extent that if there are changes to how either risk adjustment or benchmarks operate, based on prior empirical work it's likely to expect some kind of plan behavior that could also affect bids, and therefore rebates. Is that fair to say?

DR. JOHNSON: Yes. This is a static example, just showing if you completely switched from fee-for-service based risk model to an MA-based model, and it isn't trying to adjust for any behavioral responses, as they play through the risk model.

DR. CHERNEW: Well, if I understand correctly, in Scenario 3, where it's normed essentially to MA, the rebate amount depends on the bump-up, the 10 percent or whatever it is. Is that basically right? So whether that goes up or down, it's just going to be 10 percent of what the MA fee is, but you bake that in, it's no longer based on -- at

least I think on average it's baked in, and then the plan-specific rebate is then just moving around that particular 10 percent average. But the 10 percent is a parameter. So you can make it 5 percent. You can make it 20 percent. If I under the fee right, which is not a given.

DR. JOHNSON: Yes. In Scenario 3, if you decided to have a 10 percent rebate add-on, that would be 10 percent on average, and it would be higher or lower for different plans. But all three of the scenarios are meant to retain the same sort of rebate determining structure, but which risk model you choose to apply does affect how it affects the MA risk scores and the fee-for-service scores.

DR. CHERNEW: In the first two, that average rebate depends on all the average stuff going on because it's anchored to fee-for-service.

DR. CHERRY: Understood.

DR. CHERNEW: In the third scenario, the average is anchored to a policy parameter, say 10 percent, and then you bounce around that policy parameter.

DR. CHERRY: Got it, okay.

DR. CHERNEW: For better or worse.

DR. CHERRY: Thanks.

MS. KELLEY: Cheryl.

DR. DAMBERG: Andy, thanks for this great work. I'm really happy to see that we're starting to move down the path of really thinking hard about this issue. I know we keep talking about it year over year. So it's nice to see this played out a bit, and I recognize we're nowhere near sort of what the end game might be. But I really appreciate you laying out the different scenarios and the examples.

So I agree with a couple of the Commissioners' comments about needing to anchor it to something, so thinking about that issue, but I just want to make sure I understood. So there's still going to be in play the issue of different coding across plans, right? So we still haven't sorted that problem and kind of had to maybe tamp down on that or --

DR. JOHNSON: That's right. That would be a separate problem that would remain, regardless of which risk models apply.

DR. DAMBERG: Right. So do we think there's sort of another mechanism or layer we can put on top of this to try to address that? I mean, I know you said CMS said that

they weren't going to deal with that issue, and I don't exactly understand why.

DR. JOHNSON: Not necessarily that they wouldn't deal with that issue, but in the advance notice for 2026, they mentioned the potential to implement an MA-based risk model, and they said in that scenario, they would not plan to apply a coding adjustment. And that is in according with what the law says currently.

I wouldn't take that to mean that there aren't other efforts to reduce differences in coding within MA. You know, we've got a recommendation to reduce the use of health risk assessments, consistent with that, reducing chart reviews, which does have some correlation with higher coding plans and the use of those tools. And I think there are a few others as well that could be applied to rebalance the benefits of coding within MA.

DR. DAMBERG: Yeah. Because I think even under scenario 3, there's still going to be an incentive to code more, right? So we still haven't cracked that nut.

MS. KELLEY: Tamara.

DR. KONETZKA: I'm mostly agreeing with what other people said and adding a few details maybe.

I haven't heard anybody express any support for scenario 1. I kind of feel like incrementalism is good, but this is too incremental. Like, it doesn't really solve any of the problems that we want. So I just want to put out there I am not in favor of scenario 1.

I think there are some advantages to scenario 2, and yet scenario 3, moving away from the fee-for-service completely, is conceptually appealing in a number of ways.

I agree there will still be this issue of sort of coding differences within MA. I feel like that's just something that can be dealt with separately. We're going to run into that no matter what scenario -- as we kind of just said, no matter what scenario you pick.

I would say in addition to not using certain sources that are more subject to over-coding, we talked last time I think about -- although I don't like the sort of blunt adjustments to payment based on over-coding, I think you know one could make it based on historical data that sort of looks at what individual plans have done, right? I think there might be a way to use those kind of blunt tools in a way that makes sense to get rid of some of that heterogeneity and coding within MA.

I guess the other thing I would say -- and this is really a plus-one to Greg's comments, which is I think we've gotten very focused on solving problems of coding intensity and solving problems of favorable selection in how we set up this payment system.

And I think, you know, it's really important to keep in mind that, you know, in the beginning, we really thought managed care would save money for Medicare, right? So I think thinking about a system that sort of gets back to the value question and, you know, are there ways to -- are there differences in these scenarios that would really sort of encourage high-value care and encourage sort of low cost, low spending as well?

And along that line, just another detail, I think we would want to be careful not to sort of penalize plans for finding savings, right? Like, that's what we want the whole program to do, and so I don't think you want to just keep lowering the -- if it's based on all MA spending, you don't want to just keep lowering the benchmark because MAs are finding efficiencies if that's the case, right? And so just sort of some big-picture things to keep in mind as we sort of tease out scenarios 2 and 3.

Thanks.

MS. KELLEY: Scott.

DR. SARRAN: Yeah. Great work. And I have to admit, I'm still struggling to get my head completely around all the parts of this.

But on the specific piece about differential coding between MA plans, so not between MA and fee-for-service but between MA plans, this thought that a hundred years ago, rather than focusing on regulating the amount of horse manure on city streets, we would have been better off accelerating the move to mass transit and automobiles, and is there some of the same going on with version creep 24, 28, 32? And what if MA plans' only source of coding was AI-enabled scribes, and then you download from that the diagnosis codes, and it leveled the playing field because plans could be required to use certified vendors, something like that? I mean, similar, you know, the whole analogy where we are today with some of the AI enablements compared to where we were basically 15 to 18-ish years ago with rollout of EMRs, right, then plans would have an incentive to make sure their providers were using those tools. And I bet in the next three years, those tools are going to

become more of a low-cost commodity baked into everybody's EMR or offered by standalone vendors or some combination.

So I just wonder whether trying to put out if we -- if we go further in this work, just trying to tee up some more innovative ways of getting out of this clearly zero-sum game at -- worse than zero-sum game, because plans are spending money on doing coding rather than improving care, whether we should at least be teeing up the transition away from this sort of discretionary coding, right, to uniform coding enabled by what I think will be in the next three to four years, ubiquitous tools, so just a thought.

MS. KELLEY: That's all I have in the queue.

DR. CHERNEW: Great. So there's so much to react to, and I have a little bit of time to do it. So I will try to do some, but I'll try and do it briefly.

So again, Andy, thank you. This is an area that's been of interest to CMS, and it's really good to hear this discussion. Obviously, it'll be up to others as to how far you want to take this, but a few things.

First, in response to an issue that came up, I'll pick up on what Tamara said, but I think several people

noticed this. The external anchor becomes important. What I think it's missed to some extent is the way that works -- and, Andy, correct me if I'm wrong -- is that's typically a county-based anchor. In other words, that's spending in the county. That's what works now.

DR. JOHNSON: Yep.

DR. CHERNEW: And so the challenge is it's not just MA. If there's a county that's a dominant MA plan, then the anchor just basically becomes an aspect of that MA plan spending. It's very different if there's 12 carriers in the county.

DR. JOHNSON: Yep.

DR. CHERNEW: But, of course, the number of carriers in the county can change, and as you consolidate. you end up with a benchmark that's based on the spending of the plan in the county unless you somehow smooth it over. So you need to figure out how you're going to manage that and how that's going to relate to competition and what goes on in that place, getting to my earlier point. That's why it's so important to pressure test it, because of the way that that's going to respond, and I think in places where there's a lot of competition, you can get a very different

set of incentives in places where there isn't a lot of competition. But you just need to -- I think we, or whoever's here in the future, needs to think through it.

The second thing in response to what Scott said, I think the challenge -- so I very much agree that thinking about other data that's not coming from the plans is useful. I think one of the core problems is we want to pay plans more if they're serving patients that need more care, but asking the plans how much care their patients need directly or indirectly is sort of a core problem in the grand scheme of things.

The problem is, at least in general -- and I'll let others in the future weigh in --I am skeptical of, for example, outsourcing to AI scribes, because prompting engineering is just so -- you know, I can just see my visit be a series of questions about have I ever been told I had this, you know, like everything -- that the key point is all the behaviors change once you start behaving. The same is true with EMRs. People think EMR is a source of truth, but a lot of what happens is you can change what's in the EMR if you know how to suspect or whatever you do.

So there is a lot of challenges as to how folks

think about the data, and I think how one manages plans that are better able to do this versus not. Again, I think, as I said in response to an earlier comment, there's just going to need to be some humility at how we go about doing this, because we're just not going to ever get it perfectly right, and we need to be able to figure out how to get rid of the most egregious parts.

I think part of the challenge here, just to finally pick up on another thing Tamara said, it is true -- or I shouldn't say that. That sounds too definitive. I believe it to be true that MA generally has not saved the Medicare program or, for that matter, the taxpayer, more importantly, money. But that's not because plans are not more efficient. I actually think plans are more efficient. If you were to ask me, 10, 15 percent, we could have a long debate, but that's going to be the -- I think the reason is because there's been a real appeal to all the added benefits that you get in MA, out-of-pocket max, lower cost sharing, vision, dental, hearing, a bunch of things. And so payment policy has enabled those extra benefits which has ended up costing money.

So we may have spent more, but we may get more

value, and I don't mean necessarily clinical value, but we might also get some more cost sharing protection value in MA, and therein lies the question. So that's a question for policymakers and for future Commissions. It's not a question for me, but I think that ends up being the trade-off that one has to think through, is to how much one wants to -- how much benefits one wants to support and if one wants those benefits skewed to people that have made the trade-off to join MA or however else you want to distribute those version of benefits, again, a question that I'm not going to opine on as much as frame.

But from where we are now, I think the takeaways from this are we need to think about the normalization. It affects generosity and affects the incentives to join, and we need to think how that fits in with, like, competition and other behavioral responses, and then we really need to think through if the coefficients are Medicare Advantage-based as they are in scenarios 1 and 2, that basically means if MA can gain efficiencies by treating patients with certain conditions, the amount they get paid for that takes the efficiencies out.

They lose the incentive for that because it's

then priced at the -- you know, at the price that all the MA plans get. It's not -- so there's less of an incentive for people who have those conditions to join MA, for example, as opposed to if you priced it what it would cost in fee-for-service, but on the other hand, the payment that's closer to cost.

So there's an appeal in terms of the payments closer to cost. There's a -- what's -- un-appeal? That's not an English word. Anyway, there's a problem because the incentive to attract those people into MA changes if you change the price, and that's just an incentive discussion that's going to have to be discussed.

But I think given the challenges that we've surfaced in the risk adjustment system and a bunch of things that go on and given the general chatter about how to change risk adjustment models, I think it's really important to have this question. And one reason why it's good for this session and I think we'll be going forward is we've -- apart from all this information, we've kind of built some of the capabilities to begin to do these things.

So one thing that's important to MedPAC is to just be able to be where the puck might end up being, and

so I'm not sure I'm going to get this right. Andy's well down the ice. Does that make sense? I don't -- anyway, there's some version of that. It's late. It's hockey. It's snowing. I feel like all the themes are coming together.

So anyway, Andy, thank you. Thanks to all the Commissioners.

To those of you at home, if you want to comment on this or my general ineloquence, you can reach out at meetingcomments@medpac.gov. We will love to hear from you. Reach out to the staff in any other way you want. Many of you know that they are more than willing to meet with folks. They meet with folks all the time.

And again, I said this this morning, and I'll say it again. We have some logistical issues we are working through, so no promises, but we are exploring the possibility of having some in public -- in-person in public comments on the Friday of the April meeting, if we can end up making that work. And so just stay tuned, if that's something that you at home would be interested in doing.

In any case, again, thank you all. We are going to come back tomorrow, and we'll start the morning. We're

coming back at 9:30, if I understand correctly, and we will start the morning discussing how complicated the Medicare program is -- that will be fun and complex -- and then we'll talk a little bit about the setting of Part B premiums, which I think is a broad issue for the public, because all the stuff that happens, it's not just the taxpayers that are paying in general, but people are paying through their Part B premiums. And that's a complicated system which matters. So we'll discuss that.

So again, Andy, thank you. To all the staff, thank you. To all the Commissioners, thank you. Paul, Dana, Stephanie, thank you.

We'll see you all tomorrow at 9:30.

[Whereupon, at 4:44 p.m., the meeting was recessed, to reconvene at 9:30 a.m. on Friday, March 3, 2026.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Rotunda
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

Tuesday, March 3, 2026
9:30 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
BETTY RAMBUR, PhD, RN, FAAN, Vice Chair
LYNN BARR, MPH
PAUL CASALE, MD, PhD
ROBERT CHERRY, MD, MS, FACS, FACHE
CHERYL DAMBERG, PhD, MPH
THOMAS DILLER, MD, MMM
STACIE B. DUSETZINA, PhD
KENNY KAN, FSA, CPA, CFA, MAAA
R. TAMARA KONETZKA, PhD
JOSHUA LIAO, MD, MSc
GOKHAN METAN, MSc, PhD, NACD.DC
BRIAN MILLER, MD, MBA, MPH
GREGORY POULSON, MBA
WAYNE J. RILEY, MD, MPH, MBA
SCOTT SARRAN, MD, MBA
GINA UPCHURCH, RPh, MPH

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P R O C E E D I N G S

[9:30 a.m.]

DR. CHERNEW: Good morning, everybody, and welcome to our March Friday morning session, and we are going to jump right in.

The first session is really important. It's a discussion of the complexities of just how beneficiaries engage with the Medicare program, and it is really remarkable all of the nuances of what goes on.

And so to take us through that, I think we're going to start with Jennifer.

MS. DRUCKMAN: Good morning.

Once an individual becomes eligible for Medicare and during certain times of the year or after specified situations occur, they must make several complex enrollment decisions about their coverage. The complexity of the choices and numerous sources of information make it increasingly difficult for individuals to understand the requirements and relevant time frames so they can make the enrollment choice that is best for them. Some choices can have lifelong implications for as long as the individual has Medicare coverage.

This is the first session planned for this cycle on the complexity of Medicare enrollment decisions for beneficiaries. At the next meeting, the Commission will discuss sources of information available to beneficiaries, including the Plan Finder tool, insurance agents, and SHIP counselors. The information presented at these two meetings is intended for publication in the June 2026 report to the Congress.

Before diving in, we would like to thank Eric Rollins for his contributions to this work.

We'd like to remind the audience that they can download a PDF version of these slides from the top right corner of the screen by the paperclip icon.

During today's presentation, we will cover the following topics. First, I will provide a brief overview of initial Medicare eligibility and enrollment. Next, I will discuss the notification of individuals that they are eligible for Medicare and the potential for late enrollment penalties. Then, Ledia will walk through the factors affecting the choice between fee-for-service Medicare and Medicare Advantage, as well as issues to switching in Medicare Advantage Part D and Medigap. The Commissioners

will then discuss the material presented.

Before we review the details of choices the beneficiaries must make, we start with the beneficiary perspective as shared in our annual focus groups. Beneficiaries often express confusion about the choices and their need for help when making choices. As one person said in one of our focus groups, "When I turned 65, I hadn't prepared myself to educate myself about these plans. As a matter of fact, I just went in thinking, Medicare, all this is going to be short. So a Medicare agent came to my house, and he kind of ran through it and I'm not comprehending all this stuff. He's just throwing all this information at you."

Making these choices can be even more difficult for individuals that are dually eligible for Medicare and Medicaid because they must navigate multiple programs. As one dually eligible person said in our focus group in 2025, "It was truly, truly confusing, and I don't understand how people who are real seniors and are beginning to lose touch -- I don't understand how they do it, because it's confusing for me, and I'm supposed to be relatively smart, I suppose."

Now I will provide a brief overview of initial Medicare eligibility and enrollment. Generally, it's available for people 65 or older, people with a disability including ALS or ESRD, which is permanent kidney failure requiring dialysis or a transplant. Although there are multiple complexities for the under-65 population, in this presentation, we're going to focus on the complexities faced by the 65-and-over population, particularly implications of their retirement choices.

Eligibility based on age means that at age 65, individuals are eligible if they meet certain citizenship, residency and work requirements. At age 65, these individuals are also eligible to enroll in and pay a premium for Part A and/or Part D. Individuals who don't meet the work requirements are able to pay a premium for Part A.

When an individual first becomes eligible for Medicare, they have different periods of time in which they can enroll in Part A, Part B, and Part D, select MA coverage, and purchase a Medigap policy with guaranteed issue.

This chart describes the Medicare initial

enrollment periods and the duration of the periods. For example, the first row notes the initial enrollment period for Part A, Part B, and Part D begins three months before the individual turns 65, goes through the month the individual turns 65, and the next three months for a total of seven months.

Later in the presentation, we will mention the other enrollment periods. The timing of the various enrollment periods can be difficult for individuals to navigate and may increase the complexity of their enrollment choices.

Dually eligible individuals qualify for assistance in payment of Part A and Part B premiums and, in some cases, Medicare cost sharing through the Medicare Savings Programs. There are four Medicare Savings Programs with varying requirements.

Individuals may also qualify for Part D's low-income subsidy, which assists with payment for Part D premiums and cost sharing. Individuals qualifying for the low-income subsidy will be automatically enrolled in a standalone prescription drug plan if they don't have one already.

Now I will turn to the notification, individuals receive regarding Medicare eligibility and enrollment. A growing number of individuals do not receive timely notification of Medicare eligibility and may be subject to late enrollment penalties.

Many individuals are not notified about Medicare eligibility. As shown on this table, only individuals receiving Social Security benefits four months prior to turning 65 will be notified. This notice is sent to these individuals three months prior to turning, 65 and they are automatically enrolled in Part A and Part B at age 65.

If the individuals are receiving or have applied for Social Security benefits during the three-month period before turning age 65, they will be automatically enrolled at age 65 but will not be notified prior to enrollment. Other individuals will not be notified or automatically enrolled and must take steps to enroll.

An additional issue is that the Medicare eligibility age is no longer aligned with the Social Security full retirement age. The full retirement age is the age in which an individual receives the full Social Security benefit. The full retirement age started at age

65 and has slowly increased over the years. For individuals born in 1960 or later, the full retirement age is now 67, two years past 65, the Medicare eligibility age.

The share of 65-year-olds receiving Social Security benefits has decreased from 92 percent in 2002 to 60 percent in 2016. This is because more people are still working at age 65 or are delaying their Social Security benefits. Due to these trends and the mismatch of the full retirement age and Medicare eligibility, an increasing number of individuals are not notified by the government of their Medicare eligibility. Individuals may face gaps in coverage and late enrollment penalties if they do not enroll on time, depending on their circumstances.

Late enrollment penalties, or LEPs, are different in duration and amount for each of Medicare's parts. Individuals may avoid LEPs by using special enrollment periods, depending on their circumstances as we will describe later. In general, relatively few beneficiaries face LEPs.

As shown on this table, about 1.3 percent of Part B enrollees, or about 779,000 people, pay an estimated average LEP of about $54 per month. About 5 percent of

Part D enrollees, or about 2.5 million people, pay an estimated average LEP of about $15 per month. Part B and Part D penalties are permanent lifelong payments for as long as the individual has Medicare coverage.

Ninety-nine percent of beneficiaries do not pay a premium for Part A. Of those who do, about 0.05 percent of Part A enrollees, or about 30,000 people, pay an estimated average LEP of about $45 per month. In contrast to the lifetime penalties for Part B and Part D, Part A penalties are paid only for twice the number of uncovered years.

Beneficiaries who qualify for Medicare or the Medicare savings programs or have ESRD don't pay the Part B penalty. Beneficiaries who qualify for Part D's low-income subsidy don't pay the Part D penalty.

It can be challenging for individuals to understand how other insurance affects Medicare enrollment. To show the complexity of the enrollment process, we highlight one example of an unmarried individual with retiree coverage. This figure shows how late enrollment penalties apply to an individual who enrolled in Part A but decided not to enroll in Part B or Part D because of the retiree health insurance coverage they have from their

former employer.

Individuals who are not working and receiving coverage under an employer's plan will pay a Part B penalty if they do not enroll at age 65, unless a special enrollment period applies. We'll talk about some special enrollment periods later in the presentation.

The penalty will apply even if the individual has other health coverage, such as retiree coverage from a former employer. However, individuals with other coverage can postpone Part D enrollment without a penalty if that other coverage qualifies as creditable. Retiree health insurance with prescription drug coverage is typically creditable for Part D. This means this individual will pay a late enrollment penalty for Part B but will not pay a late enrollment penalty for Part D.

Now we'll turn it over to Ledia.

MS. TABOR: Beneficiaries consider various factors when making a choice of fee-for-service Medicare or MA and the plans within those options, which we will review now in this section.

After a beneficiary has enrolled in Medicare, they must make several complex decisions about their

coverage. If the beneficiary chooses fee-for-service, Medigap can be added to help cover cost sharing. Beneficiaries can choose from 10 standardized plan types, and numerous insurers offer each plan type in most states.

Beneficiaries in fee-for-service can also add Part D prescription drug coverage. Beneficiaries, on average, have 11 standalone PDPs in their region to choose from with differing formularies and benefit structures.

If the beneficiary chooses MA, they must select a plan which varies on cost sharing, supplemental benefits, and provider networks. Most MA plans offer prescription drug coverage. Beneficiaries, on average, have 39 MA plans offered by an average of eight insurers available in their area to choose from.

Beneficiaries in various focus groups and surveys conducted by MedPAC and other researchers report considering various factors when making a choice of fee-for-service or MA and the plans within those options. We will talk about these factors over the next few slides, including financial protection, access to care, and extra benefits. Beneficiaries weigh these factors considering their current health needs as well as future health needs

that may not be evident at initial enrollment.

When choosing Medicare coverage, beneficiaries often cite financial protection as an important factor in the decision. Beneficiaries who choose fee-for-service Medicare and additional coverage pay monthly premiums of roughly an average of $200 a month for a Medigap policy and $44 a month for a standalone prescription drug plan. Medigap policies cover most cost sharing a beneficiary would owe from receiving health care services.

Beneficiaries who choose MA may do so because most MA plans do not charge Part C or D premiums. In 2025, more than three-quarters of MA enrollment is projected to be in a zero premium plan with drug coverage. MA plans may also attract some beneficiaries because they often have a different cost-sharing structure than fee-for-service, including an overall limit on out-of-pocket spending that does not exist in fee-for-service. The maximum pocket limits do have a federal established cap, but plans can set their own limits within them.

Most dually eligible beneficiaries have minimal out-of-pocket costs under either fee-for-service or MA.

Beneficiaries also prioritize access to care when

making their selection. Fee-for-service enrollees have broader access to providers, are largely not subject to utilization management, and the providers have less incentives to coordinate care.

MA enrollees must use in-network providers or pay more for finding care from non-network providers. MA plans require enrollees to obtain prior authorization for at least some services. MA enrollees may also have an opportunity for coordinated and managed care.

The full impact of their choice may not be apparent to beneficiaries at first, particularly for healthy beneficiaries.

In our beneficiary focus groups, we hear from beneficiaries enrolled in MA that they prioritized extra benefits in their Medicare coverage decision-making.

MA plans typically offer a variety of extra benefits that fee-for-service does not cover. Nearly all plans have some dental, vision, and hearing benefits. There's also increasing coverage of non-medical benefits, such as gym memberships and use of flex cards.

Plans can limit their coverage of extra benefits in some circumstances and impose cost sharing.

We hear in beneficiary focus groups that it can be challenging for beneficiaries to understand and compare each plan's package of benefits, and the benefits may not be what they expected when they enrolled.

Next, we're going to talk about issues beneficiaries may face related to switching coverage.

First off, it's worth noting that beneficiaries may want to switch plans for a wide variety of reasons. Some of these reasons could reflect changes in their personal circumstances. For example, beneficiaries might have received a new diagnosis or experienced a recent health-related event, like an injury or a heart attack. Their financial situations may have changed, or their preferences for how they receive health care may have changed, such as switching to a new doctor.

Beneficiaries may also switch due to changes in their current coverage, such as a higher premium or cost sharing, the exclusion of a particular provider from the plan's network, expanded use of prior authorization or other forms of utilization management, changes in how the beneficiary's medications are covered on the plan's drug formulary, or the attractiveness of extra benefits.

At the same time, Medicare has some features that make it harder for beneficiaries to switch plans. Medigap, MA, and Part D largely prohibit beneficiaries from enrolling or changing plans outside of certain limited open enrollment periods, although each sector also has a variety of special enrollment periods or steps that allow beneficiaries in certain situations to switch plans at other times. We will review some examples on the next couple slides.

In the Medigap market, beneficiaries who try to buy a policy outside of open enrollment may also be subject to medical underwriting, where insurers charge a higher premium based on a beneficiary's health status. These kinds of features are primarily intended to prevent or reduce adverse selection.

Another feature that makes it harder to switch plans is the fact that fee-for-service Medicare does not have an annual limit on out-of-pocket costs, while MA does. This imbalance can make it harder for some beneficiaries to switch from MA to fee-for-service because they would either face the risk of incurring high out-of-pocket costs or need to buy a Medigap policy, where they might face high

premiums due to underwriting.

There are several enrollment periods when Medicare beneficiaries can change their coverage. Both MA and Part D have regular open enrollment periods. The two best-known ones are probably the annual enrollment period, commonly referred to as the "open enrollment period," which runs from mid-October to early December, and the MA open enrollment period, which runs from January 1st to the end of March. During the annual enrollment period, beneficiaries can make any change to their MA or Part D coverage.

There is also a set period each year when beneficiaries who missed their initial enrollment period for Part B, Part A if they have to pay a premium, or both can enroll, known as the "general enrollment period."

The MA enrollment period is more limited because it applies only to people who are already enrolled in MA. These beneficiaries can either switch to another MA plan or switch from MA to fee-for-Service.

All programs have special enrollment periods that apply, depending on the beneficiary circumstances.

As for special enrollment period, or SEPs, there

are a variety of SEPs in MA, Part D, and Medigap, and we have just listed some of the more common or relevant ones here. In MA and Part D, there are SEPs for beneficiaries who either gain or lose another source of coverage, such as Medicaid or employer coverage. Beneficiaries are also eligible for a SEP if their MA or Part D plan is no longer available or if they move out of the plan's service area. Under all these SEPs, beneficiaries also have the option of switching to fee-for-Service.

For Medigap, there are two so-called "trial right" periods that let beneficiaries who have been in MA for less than 12 months buy a policy with guaranteed issue and no underwriting. The first applies to beneficiaries who enroll in MA when they first become eligible for Medicare. The second applies to beneficiaries who have Medigap and later switched to MA. Medigap also has SEPs for beneficiaries who are enrolled in MA plans that are no longer available and MA enrollees who move out of their planned service area.

Now to briefly summarize the presentation. In summary, beneficiaries face complex Medicare enrollment decisions. Key challenges are if an individual is not

receiving Social Security at age 65, they will not be automatically enrolled in Medicare or notified of Medicare eligibility and will need to take action to enroll.

Initial decisions related to Medicare enrollment have lifetime consequences of late enrollment penalties or an inability to obtain an affordable guaranteed issue Medigap plan.

Choosing between MA and fee-for-service involves weighing factors of financial protection, access, and extra benefits.

Medicare has features that make it harder to switch between MA and fee-for-service after initial enrollment.

This leads us to your discussion. The Commission will continue discussions of the complexity of Medicare enrollment decisions for beneficiaries next month. with a focus on sources of information available to beneficiaries, including the Plan Finder tool, insurance agents, and SHIP. All of this information is intended for publication in the June 2026 report to the Congress.

We're happy to answer any questions about the material that we've presented. We look forward to the

discussion and we'll turn it back to Mike.

DR. CHERNEW: Thank you both, so much. Just listening to that, it is overwhelming. It makes you want to stay young. In any case, we're going to start with Round 1, and I think Lynn is first in the queue, if I got that right, Dana.

MS. BARR: Thank you for taking this on. I have so many questions. You say that we don't notify the beneficiaries, but I think in reality that when people turn 65, they are inundated by notifications from MA plans that they are turning 65. So while Medicare is not notifying them, they are being notified by people who have an interest in their business, whether it's brokers or MA plans.

So I have some questions. When you're employed, I think it creates a whole other level of complexity, because if you already are covered by your insurer's employment, first of all you're like, oh, I don't need Medicare. I already have health insurance, right. That then does expose you to a lifetime of penalties on Part B. Is that correct?

MS. DRUCKMAN: Not exactly. So if you're covered

by an employer, so you or your spouse or your parent if you are disabled, they're still working, there is a special enrollment period for that. You would not be subject to enrollment penalties for continuing your employer insurance. Where it's tricky is if it's retiree insurance, when you're not longer currently employed. That doesn't count for Part B.

MS. BARR: So why do people stay in employer insurance when they could be in Medicare? What's the incentive there? I don't understand that?

MS. UPCHURCH: I want to clarify something that was just said and just to answer that. It depends on the size of your employer, also. Not only are you actively working, so not COBRA, the size, and large, for somebody 60 and older, is 20 people employed part or full time. Large for somebody who is disabled on Medicare you have to have 100 employees.

So if you have a large employer, you can delay Medicare, start it later without any penalties. If you work for a small employer or, as you mentioned, a retiree, you're in the retiree plan, you need to start Medicare A and B or you will have late enrollment penalties.

MS. BARR: Got it.

MS. UPCHURCH: And the reason the people stay with the employer is because of IRMAA, mostly. People that have higher incomes, because you're still working and you're getting a good income, you don't want an income-related Medicare adjustment amount to join, because B and D, you pay IRMAA. A is mostly premium free to most people, but if you or your spouse has a higher income, you're going to pay more than the standard. And sometimes employer folks have really good coverage for very little cost. It depends on how much your employer is charging you for that. So we have to sit down and do a lot of math with people. How much is your employer charging you? How much are they charging your wife's coverage? And do the math for people. Great question.

MS. BARR: I was just going to say, it seems like a burden on the employers, as well, though, that they are paying for that health coverage where people are entitled to.

One of the questions I had about was LIS enrollment. I noticed on that that LIS enrollment in frontier areas of the country is lower than any other

geography. So part of this is enrolling in Part D and part of it is enrolling in LIS. Is that because there is lack of broker coverage, or do you have any sense of what's happening there, why LIS is not actively being enrolled?

MS. TABOR: I want to consult with our partner team. That's something we can look into and report back.

MS. BARR: Thank you. Does the 10-year employment requirement, does that include your spouse?

MS. DRUCKMAN: Yes.

MS. BARR: Okay. So that takes care of that.

MS. UPCHURCH: And that spouse can be still alive, dead, or divorced. So you can use your spouse's, his work history, to qualify for Social Security and Medicare.

MS. BARR: Okay, great. So we don't then communicate to the beneficiary about reenrollment every year. Is that correct? So Medicare beneficiaries get inundated every year by tons of very threatening messages of them needing to reenroll, if they are in fee-for-service, but that is actually not coming from Medicare. So do you have any idea of how many notifications a Medicare beneficiary is getting every year to tell them that they

need to take action by a certain date?

MS. TABOR: I think you're referring to the marketing that we hear commonly that beneficiaries are receiving, being inundated. That's very consistent with what we hear from beneficiaries in focus groups. Sometimes they say they get 5 or 6 calls a day. I'm sure they're seeing commercials. It's a really hard thing to quantify, but to your point, they are receiving information, especially during the annual enrollment period.

MS. BARR: During the annual enrollment. But then none of that is coming from Medicare, and there is no communication that is coming from Medicare telling them, "You're fine. You're in fee-for-service." We don't communicate to the beneficiaries in any way, telling them they don't have to act.

MS. TABOR: We can add more detail to the paper about this, but HHS does have campaigns during annual enrollment periods to educate consumers. Like they run their own commercials too. So we can provide more detail on that, but I guess I wouldn't want to say that Medicare is not doing any notifying.

MS. BARR: They're doing like general marketing

but not actually direct-to-consumer marketing, because that's not in the stack of mail I'm getting from everyone. I mean, there is a definite impression that if I don't act by the end of the year, I'm going to lose coverage. And does anybody look at that sort of marketing?

MS. TABOR: CMS does have requirements for marketing by MA plans, and they do have a review process. That's something we can provide more detail on in the next version of the paper.

MS. BARR: Is it true of brokers, as well?

MS. TABOR: So this is a teaser for next April, for the next meeting, where we are going to be talking about brokers.

DR. CHERNEW: This is a little bit for time, but because this is so big --

MS. BARR: Okay. It's my last question.

DR. CHERNEW: No, it wasn't about you. I just want everybody to know, we have a whole session next month on the distribution process, to deal with which relates to brokers and all of the other stuff. Because we just couldn't fit all of this material into one session.

MS. BARR: I'm just trying to stay on

notification, but I was not going to go down the broker rabbit hole. But I'm just trying to figure out where all these notifications are coming from, because they are not all from plans. And they all say "I'm from Medicare." Is everybody allowed to say they're from Medicare?

MS. TABOR: I'm going to ask you to hold that question for April. We are going to talk about marketing more.

MS. BARR: Thank you. Thank you very much. Great chapter.

MS. KELLEY: Cheryl, do you have a Round 1 question?

DR. DAMBERG: Oh yes. Thanks. I have to say, when I got to the end of the chapter I learned something that I did not know about the creditable spending that a beneficiary has and how it differs between Part B and Part D. And I'm kind of curious. Is there a reason there's a difference, because this, again, just adds to complexity, confusion, different rules, and nobody being able to sort any of this out.

So if there's any information you could add about if there is some history behind that or rationale. I mean,

I get that point about trying to reduce adverse selection when switching plans, but it seems odd that there are different rules for different types of coverage.

MS. KELLEY: Gina.

MS. UPCHURCH: Thanks. I have lots of Round 2 comments, but some Round 1 ones. There are two waiting periods I have questions about. When somebody is going onto Medicare, if they have ALS, once they get payment for Social Security disability then can immediately start Medicare. If you are permanently disabled you have a 24-month waiting period. With end stage renal disease, you know, the person is already getting dialysis, but we make them wait 3 months. Do we know the history of that, what the purpose of that is?

MS. DRUCKMAN: We do. There is some legislative history. It's in the law how that was set up, and we can include some more of that in the chapter.

MS. UPCHURCH: Yeah. I just don't understand it. Because, I mean, that would be good to know. It's sort of like ALS. I mean, you're in dialysis so you need the help.

MS. DRUCKMAN: I believe it was a budgetary decision.

MS. UPCHURCH: Okay. So I think we should look at that. And then this is sort of shocking, and I learned this at a meeting last year or something. When somebody has guaranteed issue rights to Medigap supplement, there are certain insurance companies that will, even though you have guaranteed issue rights because you're just going on Medigap, they still can use preexisting conditions and not cover those conditions for 6 months. There is a waiting period for preexisting conditions for somebody that has guaranteed rights to a supplement, and I want to know, is there any history to that and why that exists, because that seems highly discriminatory. And you would think with Medicare we would get away with, you know, stop preexisting conditions causes. Is there any history to that?

MS. DRUCKMAN: I don't think we have a lot of history on that. I think that the goal was to encourage people to remain insured is what they were thinking. But we'll see what we can add on that.

MS. UPCHURCH: All right.

DR. RAMBUR: I have a quick question on that. Is that in every state?

MS. UPCHURCH: I just deal with North Carolina.

Every state is so different, so that's a great question. I mean, a lot of the things I'm talking about, because North Carolina basically doesn't have any more -- we use the federal guaranteed issue right rules. Some states have additional guaranteed issue rights. That's a great question.

MS. TABOR: Yeah, I think that's a good point. I think there is probably a lot of state-level variation.

MS. UPCHURCH: And I just want to clarify one thing about trial rights to Medicare Advantage. There are two trial rights. One is when you start Medicare at 65. If you continue working, say you're 68, and then you want to go into a Medicare Advantage plan, you don't have trial rights to be able to get a Medigap policy. It's just when you turn 65 and you start a Medicare Advantage plan you have the 12-month trial right. That's the first thing.

Second thing, the other one that you mentioned about is if you drop, not suspend, but if you drop a Medigap policy for the first time and try a Medicare Advantage plan, you have a 12-month trial period. So just to clarify that, because again, a lot more people are waiting to retire, and they don't start Medicare until

later. They lose that original trial right because they are not just turning 65. Thanks.

MS. KELLEY: Stacie.

DR. DUSETZINA: Great work, you guys. I thought I knew this, and I was like, oh boy, this is even more complicated than I thought.

I did have a question about, on page 8 you talk about reviewing choices for a cohort that was enrolling in 2012, and I wondered why so far back. That feels like 100 years ago.

MS. DRUCKMAN: So this was a MedPAC chapter in the 2019 Report to Congress, where we were able to obtain some data from the Social Security Administration. If the Commission would like us to continue working on this, we'd like to get that data again.

DR. DUSETZINA: Great. Yeah, I think it would be really nice to be able to look at maybe even 10 years later if we have the ability to do something like that.

The only other minor thing, when I read it in the chapter I wondered if there was an error, that the chapter mentioned that automatic enrollment was for Part A and Part B, and I thought it was only for Part A that you had

automatic enrollment, because you had to pay premiums for Part B.

MS. DRUCKMAN: No. You will be automatically enrolled in Part B, and you'll get the option when you get your letter to renounce Part B if you don't want to accept it. But you will be enrolled in both.

DR. DUSETZINA: Okay, great. Thank you.

MS. UPCHURCH: You only get automatically enrolled if you're taking Social Security already. If you turn 65 and you don't do a thing, you don't enroll in a thing.

MS. KELLEY: Paul.

DR. CASALE: Thanks. Terrific chapter, and I always learn so much. On your example of the beneficiary who was in a retiree health program, I know you mentioned this, but deemed not adequate, they are subject to the Part B penalty. Are the employers obligated to inform the employee that this is not adequate coverage and you need to be enrolled in Part B?

MS. DRUCKMAN: There is not a special enrollment period that people can claim because their employer failed to tell them.

MS. KELLEY: Brian, did you have a comment?

DR. MILLER: Yeah. So there's been some discussion in the chapter that the reason for the three-month is because when you require dialysis, some patients their kidneys recover, and it's not just right away. Sometimes people's kidneys recover in a week and sometimes they can recover within a month or two of starting dialysis, and they go back to CKD or chronic kidney disease stage 5, not on hemodialysis. So I think that's the original justification behind that three-month waiting time. There are physical impacts to that, but that's not the rationale. The rationale is that some people who end up on it go back into chronic kidney disease from end stage renal disease. Medical uncertainty.

MS. KELLEY: Tamara.

DR. KONETZKA: So this issue of lack of notification for people when they turn 65 unless they're on Social Security and lack of automatic enrollment, it seems like kind of an easily fixable problem. So my question for you is, why is it not an easily fixable problem? Like Social Security clearly knows if you qualify for Medicare, is you have paid in enough. Social Security clearly knows

how old you are. So is this just a historical artifact or is there actually some obstacle to fixing this?

MS. DRUCKMAN: I believe this is a historical artifact of how this has developed over the years.

MS. KELLEY: That's all I have for Round 1, unless I've missed anyone.

DR. CHERNEW: I have a Round 1 question.

MS. KELLEY: Okay, Mike. Go right away.

DR. CHERNEW: When you're signing up, in several of these situations you need to show you had coverage for various things before. Is there a complicated burden of proof? Like do you have to show pay stubs? Like what do you have to do? I'm just thinking of my dad. Like if you asked my dad a bunch of these questions, if you actually said online, that would just be the end of it.

So I'm just interested in if someone wanted to go do this, how administratively easy is it? What information do you have to gather? How does somebody just navigate it?

MS. DRUCKMAN: So, for example, in the Part D, where you have to show that you had other creditable coverage, I think you would just show the notice of the insurance that you had previously. There is a form. Or

you could show your documentation that you were in a plan previously.

DR. CHERNEW: So you'd have to either go back to your employer or you'd have to have kept your records, and you have to figure out how to upload it in some computer system. Is that basically how you have to do it?

MS. TABOR: You can mail it also. So I think these are potential issues that 1-800-Medicare deals with often, and in certain more complex cases will assign case managers to kind of work through the process. But yes, there is some administrative burden to applying for Medicare.

DR. CHERNEW: I will go into Round 2, and I think the first person in Round 2 is Stacie.

DR. DUSETZINA: Great. Thank you again so much for this work. I think I'm going to go with the, you know, saying a picture is worth a thousand words. So I need a few more pictures in the chapter, because this is so complex as you read through the examples, I think it will help a lot.

A couple of things that I think would be particularly use. As I mentioned in Round 1, more recent

data on enrollment choices. But I kept wanting to see a breakdown of every category where people are, so age versus disabled, dual eligible and the type of assistance, ESRD, ALS.

And then one of the things I think would be especially helpful, you know, looking over time, is whether or not you're in an employer-sponsored plan and is that an MA plan. In one of the things we've found in some of our research is that for enrollees who are in an employer-sponsored Medicare benefit, they don't really switch as much. So maybe that's more generous. But I know that the pattern of those employer-offered benefits has changed over time. So I think something like that, to give a snapshot of what was happening back in 2012, and then in a more recent period would just help with what are the choices people are looking at and how are they shaped by employers as part of it.

And another thing that I always struggle with is the under 65 beneficiaries, and I wondered if some of the timelines that you show around the choice, the options for enrollment and the different choices, if you could do a breakdown of that separately for the under 65 disabled

eligible population. Because I have really struggled with what does your access to Medigap look like for that population, because of the long wait time to even get eligible through disability. So I think that would be really helpful, just to clearly show that those are really different.

My understanding, from talking with patient advocates who are under 65, who have had conditions like cancer, is that getting access to supplemental coverage can be quite challenging for them. So I think that would just be helpful for thinking about whether the coverage is adequate for everybody.

I did love your Medigap plan enrollment figure, and it really was striking that basically 3 plans have all the beneficiaries in them. And I kind of wondered, as we think about trying to simplify things, maybe we don't need 10 different plan types if everybody clusters within 3, maybe 4 maximum. But there are a lot of choices here, and if we can simplify things and have everybody doing really well, that's great.

The only last information request I have is on page 30 you mention that there are some circumstances where

states will allow for Medigap enrollment after the defined window. It would be great to have a note about what are the most common reasons that you would be allowed to enroll outside of that period.

But excellent work. This is even more complicated -- I knew it was complicated. This makes it seem even more complicated. So thank you.

MS. KELLEY: Brian.

DR. MILLER: I love this chapter. It's gotten a lot better. The technocratic information about enrollment period is super helpful, I think, for staff and analysts and researchers.

A couple areas I want us to think about as we set up this discussion of beneficiary choice. They'll help make us more productive.

First is the sort of like environmental level, which is that insurance trade-offs and choices are not new. Some people are making benefit selections, which is either continuing in your current plan or picking a different plan annually. That is not a small number of people. There are 150-plus million people in employer-sponsored health insurance that have annual enrollments who get harassed by

HR. You get asked about vision insurance, disability insurance, health benefits selection, life insurance, critical illness insurance, child care benefits. The level of decision-making people are making is pretty robust. Maybe they're not making the best decision, but they're making decisions.

They also make decisions in other regulated markets. The ACA market, again, not perfect, but 15 million people are picking a plan every year.

So each of these markets has problems, and when they get to Medicare, making a health benefits choice is not a new activity. It might be a different formulation of the prior activity, but this is not a new activity.

Other thing is that Medicare benes make lots of choices every year. They buy hundreds of thousands of homes. They buy cars, which I am fully supportive as a car nut. They buy boats. They buy other insurance, homeowners insurance, boat insurance, rental insurance, auto insurance, sometimes vision insurance. They make thousands of other purchases every day in our capitalist economy. They buy everything from peanut butter to new decks. So people make choices about trade-offs. We need to recognize

that they make these decisions every day. They make health benefits decisions and other insurance decisions and other big purchases with interested financial intermediaries, whether it's a house, car, or whatever.

Things that I think we can specifically add as MedPAC is that we can and should look at the existing marketing literature from business, school, marketing, researchers for other insurance products, and other complex purchases assisted by third-party financially interested intermediaries. People are buying cars every year, electric, gasoline, hybrid, as an example.

I also think we need to be super careful with our assumptions. So I think a lot of our discussion and our sort of tone is that when people turn 65, that they suddenly lack agency and can't make decisions when confronted with lots of choices. I think that assuming that the elderly lack agency is insulting to them. My assumption is that most people are capable until they prove otherwise. You can ask my wife, and I have proven many times that I'm not capable of making good decisions about many things. I'm a different choice.

So the other thing I think we also really need to

be careful about is assuming that everyone must make the optimal choice. So a lot of our discussion is predicated around the fact that people are not picking the perfect plan or the perfect benefits package, and therefore, policy has failed.

In the real world, people have different perceptions about sort of weighting and attributes than what an economist views as the optimal choice. So some people should buy station wagons, but they buy a Porsche or a sports car, and their spouse gets upset with them. Other people buy lots of life insurance, even though they're perfectly healthy, and they have like $3 million in life insurance. And so I think diversity is sort of the name of the game in how people make choices and weighing attributes differently, and so we need to not sort of assume that because people make a suboptimal choice based upon what we measure economically, that the system is broken.

I also think we need to be very careful about anchoring on Medigap. So Medigap is functionally -- if you look at the demographics, I think it's something like 91 percent of Medigap benes are white. It's a huge percentage. It's also a program for wealthy people, and so

it doesn't mean that we shouldn't make Medigap better, but I don't think we should anchor our nationwide policy sort of advice based upon, you know, white wealthy retirees. It's not good for health equity. There are lots of people who are retired and have health benefits.

I think other things we need to think about when we think about Medigap is that Medigap premiums don't fully account for in pricing-induced demand. So that's unfair to the retired working poor and retired middle-class benes, and also, frankly, if we think about this and we think about Medigap -- and I've heard many discussions, and I'm sure we'll have more discussion about guaranteed issuance -- reasonable policy for us to think about, it's going to make Medigap more expensive and make Medigap, again, more of a policy for wealthy people, right?

The Medicare money tree is not doing well, and so if we're going to go down the idea of guaranteed issuance to expand access, we also need to think about ways to make Medigap cheaper.

The WISeR model is one example. There are many problems with the WISeR model, but introducing some utilization review or sort of a network plan into Medigap

might be a way to sort of make Medigap more affordable to a broader range of the population, because that trade-off, when we're thinking about choice and finance -- and trade-off between fee-for-service and MA has traditionally been no you are, no network, assertive you are, assertive network. And instead that trade-off may change from mild you are, mild network, to aggressive network, and aggressive you are.

So I think our choice discussion, again, just to summarize, we need to recognize that people are making lots of choices about other things and that this is not new when they enter Medicare, that just because they don't make the perfect choice doesn't mean that the system is wrong. And I don't think that we need to -- or I think it's wrong for us to anchor on Medigap as the answer. We should make Medigap better, but we shouldn't focus on one demographic population.

Thank you.

MS. KELLEY: I have a comment from Kenny next. The insightful chapter highlights a truth we can all agree on. Medicare is complex. Beneficiaries face confusing enrollment rules, penalties, and an overload of information

in both traditional fee-for-service and Medicare Advantage.

The chapter raises good questions about MA's value proposition, yet it's important to view those concerns in the context of financial protection, accountability, and beneficiary choice.

First, MA offers stronger financial protection. Fee-for-service has no annual out-of-pocket limit, forcing many to buy costly Medigap coverage. MA plans include that protection, often bundled drug coverage, and provide extra benefits like dental, vision, and hearing, all critical for seniors on fixed incomes.

Compared to fee-for-service, MA has a significantly greater proportion of retired working class and middle-class beneficiaries and a higher percentage of Hispanic and African American beneficiaries.

Second, care management isn't a barrier. It's accountability. Networks and prior authorization exist to coordinate care, prevent unnecessary services, and ensure quality. These tools operate under federal oversight and protection. They're not obstacles. They're guardrails for value and sustainability.

Third, more than half of Medicare are choosing

MA. They reaffirm that choice each year during open enrollment. Medicare's complexity deserves attention. We should improve communication, refine the Plan Finder, strengthen marketing oversight, and review Medigap rules. But simplification should not come at the cost of choice to beneficiaries and innovation to health plans.

Medicare must continue to support both models, fee-for-service for broad access, and MA for coordinated financially integrated care. Preserving that choice honors the diverse needs and preferences of America's seniors.

And I have Cheryl next.

DR. DAMBERG: So first, let me just say I'm so grateful that MedPAC has taken on this work. I think this is critically important, and, you know, at the end of the day, beneficiaries are our main audience that we need to be attending to.

And in this space, as you have amply illustrated in this chapter, they face a dizzying array of choices that come at a cost to beneficiaries, but I also see this as a larger cost to society in terms of wasteful spending, in terms of all the complexities that are put in place, the rules, the administrative burden, and all the regulations

to kind of make sure people are complying with all the rules.

So the importance of this work, you know, is just so incredibly important, and I agree with some of the next steps that you've laid out in terms of taking a careful look at Plan Finder, which I think historically has not -- other than, you know, the Part D portion of it -- been all that helpful to consumers to make informed choices -- and also looking at SHIP counselors and the important role they play.

I, in terms of trying to digest everything that's in this chapter -- and, you know, if part of the purpose was to illustrate the complexity of this space, you know, you've amply done that. And so I was wondering, sort of along the lines of what Stacie was recommending. I think this chapter could benefit from adding some figures to illustrate. And, you know, I was coming at this, like, could you set up some decision trees to help people sort of understand the steps and, you know, what the consequences are once they get out, you know, two or three steps in that decision tree?

And then similar to the comment that Tamara made,

it struck me as odd that Medicare and Social Security, once somebody turns 65, that they just don't automatically enroll somebody in Medicare, at least Part A. That seems like a no-brainer. So that would be something I would hope maybe we could think about making that type of recommendation in the future.

The third thing that I struggled with a little bit, I recognize that in the Medigap space, there's standardization within each of those policies. But I also found myself wondering, we know that there's price variability across the Medigap policies, even within the same letter and, you know, trying to understand to what extent people are actually switching between different Medigap policies and rules for switching. So can you only go from sort of a higher tier on risk policy to a lower, or can you go in the opposite direction? And does that, you know, make you vulnerable to underwriting? So just better understanding of that space.

And then I found myself, again, looking ahead to where MedPAC might go. But I know we started to have some discussions about benefit standardization to try to help reduce complexity. So I look forward to that future work.

And then, also, I think this issue of the fee-for-service portion of the market, not having an out-of-pocket max, again, I think it would be interesting if MedPAC could try to model what offering an out-of-pocket max could look like and what the consequences financially would be for people in the fee-for-service portion of the market.

Thank you.

MS. KELLEY: Gina.

MS. UPCHURCH: First of all, shout-out to the Chair who's not here, but to -- oh, you're there. There you are. Good. Thank you. -- for bringing this to the forefront and for the staff for doing a tremendous job with it.

You know, as Cheryl just alluded to or said, bringing consumer choice to the table is really critical. It could be our North Star, as Medicare beneficiaries to be the most important stakeholders in our insurer-provider-beneficiary triangle.

My comments will start wide, go narrow, and sprinkle throughout a few policy suggestions. Reminder, I am a pharmacist, full disclosure, trained in geriatrics,

but I work for an agency that does four things, and one of them is SHIP counseling or Medicare insurance counseling. So we live and breathe this every day.

The beauty of the annual election period. I actually very respectfully disagree very much with Brian. I think Medicare offers way more choice and confusion than most employer-sponsored plans. Usually, you have a few choices. They don't change from year to year necessarily. This is off the charts in terms of choice options.

The beauty of the annual election period. Other than restricted enrollment eligibility for certain special needs plans, Medicare Advantage plans, folks don't have underwriting and can freely switch between traditional Medicare and Medicare Advantage, and they can change their stand-alone drug plans. This freedom is both a blessing and a curse. Not only did the basic benefit designs of Medicare drug and health plans change each year with annual deductibles, premium amounts, and so on, they also change what they cover, how beneficiaries access the care that they need, and at what cost. And they can and do change annually.

Our tagline at Senior PharmAssist is it pays to

compare, and it truly does, and that's very frustrating.

One of the major reasons many people stay with fee-for-service Medicare and Medigap or employer coverage is to avoid the annual chaos, as decision-making paralysis is real. Thanks to Lynn for bringing that into reality.

Insurance stickiness is also real, and that is why some people remain in the same Medicare Advantage plan or stand-alone drug plan, despite there being much better options and less expensive options.

Choice architecture, which can -- you know, I think some graphics would help. I agree with several of the Commissioners about that. Choice architecture with Medicare needs a major remake. There needs to be more standardization and more simplification. We need to simplify health insurance literacy with Medicare and for Medicare beneficiaries.

Now to some details. And this is about federal rights to no underwriting; in other words, guaranteed issue rights to Medigap supplements.

We need to understand what Medicare network changes mean and what they consider significant, especially with midyear terminations. If there is a step and it also

generates a guaranteed issue right to Medigap policies, that needs to be known. It sounds like it's being proposed, but we need to make sure that that's clear to people.

We need to clarify guaranteed issue rights to Medigap when somebody is leaving work. It currently depends, as we talked about earlier, on if the individual is actively working, not COBRA, and the size of their employer. So just to recap that, if working for a large employer and the size varies depending on if you're on Medicare due to age, that's 20 people. If you're on due to disability, your employer has 100 people to be large. So again, if someone is with a large employer and they're still actively working, that employee plan is primary, which means it pays first and Medicare would pay second or is secondary.

So many people delay B, and they do it for two major reasons. You're wasting your money on your Medicare Part B premiums as it's secondary coverage and really doesn't pay anything. And some working folks would have IRMA, as we talked about earlier, if they started paying for Medicare Part B, so very high premiums for B and D with

IRMA.

If you start B, you only have -- and the other reason you don't start B when you don't need to is because once you start B, a clock starts, and you have six months to guaranteed issue rights to Medigap supplements. So if you start B too early -- we talked about late enrollment penalty, the example you gave, but it's also dangerous if you start it too early. You might not only pay those extra costs, but you're putting yourself in a bind because you'll have underwriting when you do retire at that point, and you may not be able to get a supplement. So starting B too early and too late could be a problem, both ways.

You can stop Part B when you realize you made a mistake and start it later, and you won't have a late enrollment penalty then, but you still don't have guaranteed issue rights to a supplement if you start B and start it again.

But starting B too late if retired or working for a small employer comes with late enrollment penalties. However, starting B too early wastes premium dollars and endangers access to Medigap policy when you do retire. It's the Goldilocks. You don't want to start it too early

or too late, and people don't understand. And employers don't often tell them or make it clear to them.

Now to Part A. And I'll have a little difference of opinion with Cheryl on this one. If you're working for a large employer, traditionally people who work 40 quarters or 10 years would start A because it's premium-free. However, now we're seeing more and more people come into our office who are in a high-deductible health plan with an HSA, which you can no longer contribute to your HSA if you have started Part A.

So if you start Part A after your 65th birthday, A becomes retroactive six months, and that means you should not have continued to contribute to your HSA at that point or your FSA. But with HSA, not only were you not supposed to contribute, you have a 6 percent excise tax if you did accidentally contribute to your HSA. And this is very complicated, and you're supposed to talk to tax attorneys, and a lot of people we know don't have tax attorneys. So it's complicated.

People still working often are not told this. They're not told don't start A. Can we clarify -- this is what people are asking me, and I cannot get a straight

answer. Can we clarify if individuals who have premium-free Part A, if they can ask that A not be retroactive? Is that even possible? If not, A should not be retroactive for six months unless someone asks that it be. An individual should be able to stop A if they want to. Right now, they really cannot stop A if they want to. So we just need to clarify that.

Can we also get a clear answer to if someone has Medicare A and is still working for a large employer, if A would ever pay for services? Say if somebody has a high-deductible health plan, would Medicare ever help pay for that high-deductible employer plan? I can't find the answer to that easily either.

If working for a small employer or when a person is not actively working anymore, for example COBRA, that person needs to start A and B, and then the employer coverage pays secondary. We know that. If you work for a small employer or you're retired, you need to get going A and B. If you're still working, it's much more complicated.

Pulling it all together. Due to the complexities often not understood by Medicare beneficiaries and the

people with employers who are supposed to be helping people sort through all of this, we could simplify guaranteed issue rights to Medigap by saying no matter the size of the employer or if the individual is actively working or on COBRA, when someone leaves their employer plan, the employee or the employer's decision, no matter who decides, the employer or the employee, the individual has a special enrollment period and guaranteed issue rights to a Medigap policy for six months. So we can really simplify all of those rules by saying those things.

Almost done.

Also, guaranteed issue rights. It would be helpful to share that smoking status and age influence the price of your Medigap policy, even during guaranteed issue rights, and there are regional differences in prices.

Medigap premiums can increase twice a year. To make matters more complex, there are three different flavors of Medigap policies: community rated; issue age; and attain age, which we probably should mention.

And we should include that the medical loss ratio for Medigap policies is 65 percent, not the normal 80 to 85 percent. So we allow them to make more money.

People with disabilities, when they hit 65, even if they have a Medigap, have to be proactive to be pulled with the other 65-year-olds. So we've had a lot of people that hit 65, and we tell them your premiums are going to go way down, and they go, they didn't go way down. It's like you have to actually tell the insurance company so that you can get pulled with the 65-year-olds. That needs to be more automatic, that people with disability are then able to be grouped with other people for pricing.

Medicare Part D. Currently, the late enrollment penalty can be waived for those with extra help or low-income subsidy. That goes up to 150 percent of the federal poverty guidelines, but you have to have very limited assets to be eligible for that.

I want to suggest a policy that the late enrollment penalty should be waived for individuals up to 200, hopefully 300 percent of the federal poverty guidelines, and there are six reasons why.

Medicare premiums, especially Part D, have grown, and it's a larger percentage of our Social Security payments that people receive. This disproportionately impacts individuals with limited incomes.

Unlike Part D, there is no hold-harmless clause for Medicare Part D. So, when premiums rise, you're just stuck with them.

Changes to 340B payments have some safety-net pharmacies constricting their formularies. So those who depend on these medications have few options.

Number four, many patients at community health centers, FQHC, free clinics, don't sign up for Part D because they think they have coverage. Also, it doesn't make sense for someone struggling to afford things, very basic things, to pay a premium to get a discount on the back end, especially for medicines that are already low cost.

Many of the drug -- number five, many of the drug manufacturer patient assistance programs that many of these people use that use these safety-net pharmacies are shrinking their programs, and this will be important to monitor, especially with the IRAs, drug price negotiations, and now that we're seeing more and more medications sold at cash prices directly from the drug manufacturers. They're getting tighter with their assistance programs.

Currently, those -- and this is the sixth reason.

Currently, those with limited incomes who have a late enrollment penalty cannot overcome those lifetime Part D penalties. Again, the Part D drug benefit began in 2006. That is 20 years ago, 39 cents a month for every month you're out this year. That adds up to -- I know the average. You said 5 percent pay the late enrollment penalty for an average of 15. We see people that owe 50, 60, 70 dollars a month in late enrollment penalty for Part D who just simply don't join because they can't afford to.

Finally, almost, aligning late enrollment penalties. Late enrollment penalties, as we know, decrease adverse selection. A, B, and D. We could think about, for all three of those, someone has to be without coverage for an entire 12 months to incur a penalty, and the penalties are not lifelong penalties but double the number of years that you went without, so that just to standardize that across all A, B, and D.

Counseling related to special needs plans. We need to know -- this is an aside, but special needs plans when we're counseling people, it would be really helpful to know what level of Medicaid do they have. That they have full benefit, dual eligible, MQB-Q, B or E. That matters

in terms of insurance.

Medicare A and B cost sharing -- this is the last point. Medicare A and B cost sharing needs to be announced in September to allow counselors to be ready in October to help Medicare beneficiaries understand their situation and their budget for the upcoming year.

Now we are more than half -- now what happens, we are often halfway through the annual election period before even know A and B cost sharing, and we have to redo all our materials. We've told people old information. That -- it is supposed to come out in September, the A and B cost sharing, and often is in November. That needs to be back in September.

Thank you for the tremendous work, and sorry for the minutiae detail.

MS. KELLEY: Tamara.

DR. KONETZKA: Thank you. I thought I was overwhelmed with complexity after reading the chapter, but after Gina's comments the list gets a lot longer.

So my sense after reading this, some of these things I knew. There were other parts of this that I hadn't know before reading it. And my sense is we can

really group the complexity, this immense complexity, into a couple of categories, at least in my mind.

The first is just stupid complexity, things that are complex because of historical artifact, things that may be low-hanging fruit to try to fix. I mean, I know it's not as easy in this space. But there are a couple of things in this category. One is the notification and automatic enrollment in Part A, at least, although the HSA comments give me pause there. But at least the notification when people are turning 65. That seems like a historical artifact that could be and should be fixed. There's really no reason to keep that discrepancy.

And to that end there are some things in the chapter, and I don't have a prescription for every one of these things on the list, but it would be nice to know how many people are actually affected by this notification. And you may not have that data directly, but it occurs to me of the people who don't sign up for Medicare Part B at age 65 there are really a few big buckets. There are those with other coverage. There are those who don't have other coverage but just choose not to sign up for Part B for some reason. And then those who want Part B but don't sign up

because they don't get notified and they just, whatever, get caught in the trap of this complexity and lack of notification.

So to the extent that we can try to divide people into buckets, whether combining the quantitative data and focus group data or whatever it is, that would be helpful, because that would be a nice step in trying to solve the problem. And maybe you could look at as the Social Security age has increased, how have the number of people in each of those buckets changed. That might be informative as to why.

Other things I would put in the stupid complexity is things like the very different enrollment periods for the different parts. And I know there's probably some reason that the different enrollment periods existed, but it just seems like it would be a lot easier if we didn't have to keep track of all these different rules, and there was a certain set time before and after one turned 65 to sign up for everything.

Similarly, some of the penalty structures. It's not clear to me why the penalty structure has to be very different for Part D and Part B, or do they all have to be

lifetime? Maybe having it exist for a certain set number of years so people aren't really, 20 years later, still paying that penalty for a mistake they made when they were 66. Maybe those could be sort of unified across the different Medicare parts.

Similarly, some of the things Gina was mentioning about definitions of large and small employers. You know, I think it's just a crazy number of sort of contingencies that one has to follow.

Another thing I would put in that bucket would be creditable coverage. You don't have a pay a B penalty if you have employer-sponsored coverage, but retiree coverage doesn't count. Why isn't it just creditable coverage and have that definition clear?

So there's lots of things like that, that I think we might be able to frame as this is complexity that doesn't help anyone satisfy their preferences, that isn't really helping anyone, just creates the opportunity for bad choices.

And then there is more meaningful complexity, things like all the guaranteed issue rules, that I think is harder to solve. So that's sort of the second, because we

know there are tradeoffs between premiums and adverse selection issues and relaxing restrictions around guaranteed issue. So I would love to see some of those rules changed, but I think that's a harder problem.

Okay. So that's basically it. Some of the complexity is just stupid complexity. That might be a way to frame some of these rules and sort of provide a path forward for things that could be solved a little bit more easily and some that will take more analysis and evaluation and thinking over time.

Finally, just tagging onto something Stacie said earlier, this sort of references at the end of the chapter to some of the 2012 recommendations. I guess the ones that struck me were sort of the references to value-based insurance design. I think that we'd need to look at that a lot. I'm not sure it was really helping to have that in the chapter because stuff has happened in that literature. We'd want to update that literature. And the value-based insurance design actually also has potentially increased complexity a lot in what people are paying. So that we either need to beef up or maybe not have it in there.

So that's it. Thank you so much for wading

through this enormous amount of information.

MS. KELLEY: Lynn.

MS. BARR: Thank you. This is such a big topic. So I agree with Brian's comments that we have all, the folks that are employed, have all gone through this annual enrollment period, where it's very important for us to look at our choices, and then those that don't engage in that process are penalized. I mean, you lose coverage. It's a big mistake not to look at your insurance once a year.

But it's one piece of paper, maybe five pages you know, that you're looking at, where you're looking at all of your options, and you've got one point of contact that you can go and talk to. And that is a reasonable process.

So I'm talking about the renewal process and the initial process, as well. Today Medicare is not communicating to the beneficiaries and saying, "Hi, okay. It's your first enrollment period or here's your annual enrollment period. Here's your benefits today. Here's what you should be thinking about. Here are the plans that are available. And here is who you should call."

And that seems like a basic way of summarizing than what we are used to, that give the beneficiary the

opportunity to ask themselves these important questions. Is my drug plan the right drug plan? Should I look at another drug plan? If I'm on fee-for-service and I've got my Medigap policy, am I happy with it? Do I know what policies have changed this year, what my out-of-pocket max is? Things like that, that can help people make good choices on MA plans.

So what I would like to propose is that Medicare creates a standardized form for every Medicare beneficiary every year that says either here's what's available or what you currently have, here's the basic rules that you would find in an employer summary, and here are the potential benefits to changing your plans this year. You know, if you are on a Part D plan, your formulary may have changed. If you're in a Medicare Advantage plan, your network may have changed. Our out-of-pocket max, et cetera. How things have changed for you, and what are the new benefits of these plans.

So having that in one place, and then here are the people you can call to help you make a decision, and here's the contact information for your SHIP counselors. Here's the contact information for the brokers that are in

the area. Here's the contact information for the plans that are in the area, so that you have one place to go. And that we don't allow the beneficiaries to be inundated with marketing materials that are highly confusing. Because one of the most important things you do in an employer plan is if you don't pay attention, you can lose benefits. You can make a big mistake.

So having all these threatening messages coming from all these people forces these beneficiaries to go through this crazy choice system every year. It's not just the first year in Medicare.

So I think that we need to help them. And brokers and plans, they can send the same information to the beneficiaries in the same way. I'm not saying they can't market to them, and then they could add their own little piece to it, and that would help. Because just getting one piece of mail isn't necessary enough. But I do think that we have to take all of this information for every beneficiary, summarize it for them, tell them where to go for help, tell them why they should consider an MA plan, if they don't currently have Part B coverage or they don't currently have Part D coverage, tell them what the

penalties are associated with that and why they need to move forward. And I think that would help us tremendously navigate this difficult process.

Thank you very much for this great work.

DR. SARRAN: Yeah, I'm going to try to be really brief. I'm trying to put a fine point on Gina's and some other people's comments. Let's make sure, please, as we write the chapter, that we highlight the complexities and pitfalls of enrollment timing into A, B, and D for employees. This is different, and I want to make sure we distinguish this from Brian's well-made point about choice architecture and people with different values making different choices, perhaps, than one of us might make. This is about people making mistakes because the decisions are so complex and the pitfalls are so significant. And the mistakes carry a cost in perpetuity. So I think we just need to highlight that this is a serious, unresolved problem.

Secondly, this is a finite issue, and it's around the specifics of the midyear disruptions in MA networks and the remedies available to impacted beneficiaries. We've got a confluence of two or three factors. One is that as

pharma, device manufacturers, and providers deploy more innovations successfully to better manage serious chronic illnesses for beneficiaries, people are living longer with high-cost, treatable conditions, cancer, of course, being the poster child but not the only illustration of that.

But it requires typically access to a high-cost provider, that most of these successful treatments are put into effect at tertiary, quaternary centers, teaching hospitals, et cetera. And as plans are more realistically, over the next couple of years, more cost conscious, and providers are more revenue conscious, we're going to see, I would predict, more midyear terminations. For most people, a guaranteed issue into Medigap is not going to be the best solution because of the high out-of-pocket costs of Medigap, even if it's available, via change in the regs about guaranteed issue.

So I think we should note the availability but the limitations of the regs that currently exist around continuity of care. My understanding is it's finite, I think for 90 days, and I think this is on the beneficiary to have to request it, and it may be available for terminal illness, but how is that defined? The point is there are

some remedies available around that, but I think it's not universally available. It's not necessarily maximally effective. Maybe it's a finite population that this applies to, but for those people it's really important. Thanks.

MS. KELLEY: Josh.

DR. LIAO: Thank you for this work. I just want to, quickly, two things, to underscore Scott's point. I've been thinking a lot about the distinction between reducing noise versus reducing choice. I think some of the other comments from Commissioners highlight that, so I won't repeat them.

But while there is no, perhaps, easy path, this idea of reducing noise to prevent mistakes versus reducing choice, taking options away, I think that's something we should grapple with.

I'll save some of my more summative comments to next month when you bring back information about sites of information and things, but I think today I just want to highlight what I hope one through line is in this work and others, is really this idea that when beneficiaries consider financial protections, they are choosing a

combination of out-of-pocket costs and clinical limitations and choices that all interact. And I think the materials do a great job of highlighting them as a group, and I'd love to see a little more granularity with that.

I think the use case, for example, zero premium plans. As your information shows, as we know from research, these are dominant in the MA market now. Zero premium plans are available to 98 to 99 percent of beneficiaries. In some markets they are the predominant, if not only, choice. Some academic research has shown that in 2019 it was 46 percent of the MA plans nationwide. Now it is up to two-thirds, maybe three-quarters, meaning it is a prevalent choice.

Some of the information that I'm aware of, though, is that beneficiaries sometimes may choose on premium but not realize the downstream costs associated with that. So when we think about out-of-pocket costs, premiums are one of them, but what about downstream cost sharing, you know, copays for specialists, et cetera.

So I want to be clear. I think these plans can offer benefits. I think as other Commissioners have noted there is MOOP, integrated drug coverage, dental, vision.

These can really offer real value. But I think what I want to highlight is that that choice, there is a connection between out-of-pocket costs and clinical impacts utilization management and the like.

So what does that mean to the materials? I would say I would love to see some way of highlighting that the different kinds of out-of-pocket costs and expenses, there are interactions between them. And I think that kind of focus in these and other kind of materials that go in to a chapter would be really helpful. So thank you.

MS. KELLEY: Robert.

DR. CHERRY: Yeah, I thank you for this presentation. It's an art taking a complex topic and presenting it in such a clean way that allows for a structured conversation here.

It's fascinating that so many of us have questions about the enrollment process when someone turns 65, particularly since all of us have a vested interest in understanding and knowing Medicare that we find the enrollment process a little bit elusive.

One sort of small point is that because these materials are publicly facing, and if we have this many

questions about the enrollment process, perhaps putting a link to another federal government agency that has information around the Medicare enrollment process could be helpful, so that as people are looking through the materials, they can also do their own self research, as well. So that might be a little bit of a public service so that people are not sort of asking a lot of the questions that we're asking when they come across the materials.

The other thing, just kind of looking at all this, and it may be a little bit tangential but I'm going to make the comment anyway. To me this is not a binary decision between do you select MA and do you select fee-for-service. To me there seems to be three choices. There's MA, there's fee-for-service, and there's fee-for-service with Medigap. And Medigap may not be, along with fee-for-service when they're coupled together, a viable competitor to MA, but I think we need to pay a little more attention to how Medigap is structured. Does it have the appropriate risk pool and premiums that would allow more of the population to actually select Medigap when they're selecting fee-for-service, because it could be a good option for a lot of people, but probably not the way it's

currently structured.

I've mentioned it before, but I would like to learn a little bit more about Medigap, particularly the demographics of the population, their risk scores, how does that stratify across the different plans types in terms of how someone might select one plan type versus the other. Also the pricing between states and whether that makes a difference too, in terms of the plan selection, because different states have different sort of laws and ways of rolling this out.

So I think we may be getting to some point where we need to start thinking about Medicare in three different buckets instead of two, which makes the enrollment process perhaps even more complicated. But I just wanted to put that out there as we do future work, to pay a little more attention to the Medigap policies and see if there is some input that maybe all of us as Commissioners might have on how that's structured.

Thank you again for this really fascinating work.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you so much. I really, really love this work, and I'm so happy we're taking it on. I

have just a few comments. When I was reading this, I was pondering that E=MC2 explains the universe, right. And yet in this we're just scratching the surface. And I want to really focus on the comments around markets, because to make markets work people have to know what they are purchasing, not just price transparency but also value transparency. And I think this conversation makes it very clear that that's virtually impossible.

I would suggest that this is very unlike other markets because, one, it's life or death, and it's marked with uncertainty. As one small example, I'm a nonsmoker. I'm not remotely interested in lung cancer specialties in my network, until I'm one of the 20 percent of nonsmokers who has lung cancer. Then it becomes the most important thing.

So I would just add to Robert's three buckets. I think there are four, and that includes the difference between MA PPO and HMOs. And I'm very concerned that it's very difficult for people to understand what they're choosing.

I know we're talking about brokers next time, but, frankly, there have been some things in the literature

about the big companies incenting brokers for HMOs. That is perfectly fine for them to do, but do people understand about that incentive? And to go back to a classic market, if I'm purchasing a car, I'm very clear that the manufacturer and the dealer are getting money off of that. I think this is very opaque and very difficult to tell, and it could seem like it's coming from the federal government.

And then, finally, I guess this goes with Robert's comments again, I would also like us to look more deeply at traditional Medicare and Medigap. I maybe should have known but I did not know that there was a recommendation about the out-of-pocket max in 2012, and I think that would be really valuable to resurface. I don't know if it needs to be refreshed. Because capping out-of-pocket max in traditional Medicare could actually enhance positive market competition, because that's a big deal, the out-of-pocket cap.

So thank you so much for these great comments. I've learned a ton. Thanks.

MS. KELLEY: Greg.

MR. POULSEN: Thank you very much. Betty just triggered something. E=MC2 describes the universe with

some, I think more recently would say, quantum mechanics describe the universe, and Werner Heisenberg famously said that anyone who claims to understand quantum mechanics is lying. I think that's probably appropriate here too, with maybe one exception here of somebody who really does understand it.

Thanks very much. This is really, really good stuff. Good write-up on a challenging topic. Well done.

I do agree with Stacie that a diagram or two that shows the decision-making flows might allow people to understand the process in a way that would be useful. So thanks for that.

There were a number of other really, really good points that have been made, and I won't rehash them in the interest of time. But one point that I would like to see made more explicitly, in the chapter we talk about the primary benefits, why people would pick MA, built around the financial protection and lower premiums, lower financial out-of-pockets, copayments, et cetera.

But I would add that MA plans, some MA plans at any rate, also have certain abilities to streamline the care process for people and make it more understandable,

that they provide hand-holding that isn't available in the fee-for-service world, generally speaking. And that it not only simplifies it but it also streamlines the process.

I see a lot of times when people have greater access to specialty care and other needed services, and that process is coordinated and lubricated through the MA programs. So I think that some mention of that would be useful in there.

I had a number of other comments but based on the time, other people have made them effectively, so thanks very much for some great stuff.

MS. KELLEY: That's all I have, Mike.

DR. CHERNEW: That was all I had, and that was all Paul had. But Paul, I think you wanted to say something. So why don't you jump in and I'll wrap up.

MR. MASI: Sure. This is a great conversation. Thank you very much for this feedback. And even though yesterday it snowed, the June report is just around the corner. So I wanted to mention we will take all of this back and review the transcript very carefully.

I did want to set some sequencing expectations with respect to what we'll be able to accomplish and

reflect in this year's work relative to what we'll move forward with continued work in future analytic cycles. I think we're hearing a lot of interest in continuing to grapple with this really important issue. I think many of you are already thinking about policy directions, and that's terrific. But I just want to talk a little bit about, we'll do our best to reflect this conversation in this year's chapter, and then stay tuned for more next year, as well.

DR. CHERNEW: Great. So since Jennifer is coming back in a moment, we're going to take a 10-ish minute break and then we'll come back for the last session. But I do want to wrap up what is so important, echoing a little bit of what Paul said but sort of more broadly. We're not yet at a stage where we're really going to make recommendations, but a few broad observations from this conversation.

The first is to emphasize, for folks at home, I think we all clearly believe that Medicare beneficiaries have agency and they can make their choices, and we support them being able to make their choices, and I think that's an important value that we have, that people can choose

what's appropriate for them.

That being said, we don't need to make the system where we make those choices excessively complicated so it drives them all -- like the level of complexity here that well exceeds what you might expect in a world where you want people to make choices. Figuring out how to adjust that, I will pick up on Tamara's point about silly -- silly complexity? There's just a bunch of stuff that goes on, and you're like, oh, my God. And in simple customer service things, like when you sign up, I've heard people complain they don't get a message back, "You've been successful and now you're going to have coverage." That might not be true. I'm not claiming that. There's just a ton of basic things that you could probably just get better to simplify, including some of the rules and some of the processes.

The key point that I think, and this term came up a lot which is great -- choice architecture matters. We have decades of behavioral economics research to understand the choice architecture matters. So you can't just throw out a bunch of stuff and say everyone is going to get to the same place, no matter how you frame all that stuff.

How you present it, the rules around it influence what people do in ways that are way more dramatic than you would expect. If you auto-assign someone to join retiree coverage, they joint retiree coverage. If you auto-assign them not, they don't. Way more than you would expect, oh, they just didn't make the choice. So it doesn't all have to be optimal, but I think behavioral economics really pushed us forward to understand the salience of choice architecture.

So I think -- I won't be here, but I will say I do think it's incumbent on us, because choice architecture matters, to really think seriously about that choice architecture to make sure that we have a Medicare program that works for beneficiaries and facilitates them making their choices as opposed to de-facilitate. That's not a word, but I'm an economist. Unfacilitates their ability to make those choices.

And not just, by the way, for the beneficiaries, and when I say this, you can maybe tell from my demographics, their families, their kids, all of the people that try and help them. It is a really challenging system.

So going forward I'm sure the Commission will

spend a lot more time on this, and as noted, we have a whole separate session on aspects of the information coming next month.

I'll say this at the end of the meeting, but for those that are here now, please, if you have thoughts on this, reach out to us at meetingcomments@medpac.gov, because we do want to hear particularly about this issue about how we can make the Medicare program just more simple to interact with. I think there's just a real value in simplicity, for everybody involved, and I think we underestimate the cognitive burden and stress associated with complexity in some of these things.

So anyway, that's my take. We're now going to take a 10-minute break. Let's come back at 11:15. So that's eight minutes. You guys just lost two minutes with me rambling. So sorry. Let's come back at a quarter after, and we'll start promptly then. Thanks.

[Recess.]

DR. CHERNEW: All right. Welcome back for our last session of this month. We're going to be talking about the mechanisms by which we set Part B premiums.

I think it's important for folks to understand

that all the decisions that are made about spending influence both the taxpayer and the beneficiary, and a lot of that plays out through Part B. The process by which that happens is useful, and we're going to be putting something out in the payment basics about how that works, and Jennifer's going to go through it. So, Jennifer.

MS. DRUCKMAN: As Mike said, we have prepared a new payment basics document for the Medicare Part B premium. So today we're going to review how the Medicare Part B premium is calculated.

We'd like to remind the audience that they can download a PDF version of these slides from the top right-hand corner of the screen by the paperclip icon.

For those of you who may be unfamiliar with the payment basics, each year MedPAC posts brief overviews of how Medicare payment works. This year we've prepared a new payment basics to describe how the Part B premium is calculated. The payment basics will be posted on the website and updated annually.

In today's presentation, I'll provide a brief overview of key information about Medicare Part B. Then I will describe how the Part B premium is calculated. Next,

I will review the interaction of yearly increases in the Part B premium and Social Security payments that is known as the "hold harmless provision." We will conclude with Commissioner discussion.

First, I'll provide a brief overview of key information about Medicare Part B.

Let's start with a brief reminder of eligibility for Medicare. Generally, Medicare is available for people 65 or older, people with a disability including ALS or ESRD, which is permanent kidney failure requiring dialysis or a transplant. For example, eligibility based on age means that at age 65, individuals are eligible if they meet citizenship, residency, and work requirements.

At age 65, these individuals are also eligible to enroll in and pay a premium for Part B and or/Part D.

Individuals who don't meet the work requirements are able to pay a premium for Part A.

Part B is an optional program. Eligible individuals enroll in the program and pay, or have paid on their behalf, monthly premiums. For example, state Medicaid programs may pay Part B premiums. Medicare Part B pays for a portion of the cost of clinician services,

outpatient hospital services, drugs administered by clinicians, and other ambulatory items and services.

Part B spending also includes a portion of payments made to Medicare Advantage plans that are assumed to reflect Part B services.

Typically, fee-for-service enrollees pay 20 percent coinsurance for Part B items and services.

The Part B account in the Supplementary Medical Insurance Trust Fund pays for Part B items and services. The Part B premium paid by enrollees accounts for approximately 25 percent of Part B costs, with the general fund of the Treasury accounting for approximately 73 percent, and other funding such as interest accounting for approximately 2 percent.

Income from premiums and government contributions are reset each year to cover expected spending and to keep the account adequately financed. For this reason, Part B premiums increase at the same rate as expenditures.

In 2024, total Part B expenditures were $535 billion for items and services furnished to 62 million enrollees. Since 2017, Medicare spending per beneficiary has been growing more quickly for items and services

covered under Part B, as shown by the orange line, than under Part A for inpatient services or Part D for prescription drugs.

For example, there has also been an increase in the number of clinician encounters per beneficiary paid for under Part B, while there has been a decline in the number of inpatient and skilled nursing facility stays for beneficiaries paid for under Part A.

Services shifting from Part A to Part B has reduced pressure on the Medicare payroll tax that funds the Part A Hospital Insurance Trust Fund but increased the pressure on general revenues that fund the Part B expenditures in the Supplementary Medical Insurance Trust Fund. This shift has also put pressure on beneficiary premiums that pay for Part B.

This figure shows the increase in the monthly standard Part B premium over 60 years in nominal dollars. The premium increase is placing a growing burden on beneficiaries. In 2026, the standard monthly premium is $202.90.

Most beneficiaries have premiums deducted from their Social Security benefit, and they are aware of these

increases and the impact on their finances.

As premiums rise, penalties calculated as a percentage of the premium also become more consequential for beneficiaries with delayed enrollments.

Now we will turn to the calculation of the Part B premium.

Before we review the calculations that lead to the Part B premium, it is important to understand the monthly actuarial rates. All insurance companies estimate their expected future spending based on historical data when setting premiums to develop what is known as the actuarial rates.

For Medicare Part B, the monthly actuarial rate is the starting point for determining the amount of the premium and federal funding. Each year, CMS must estimate Part B enrollment and the amount necessary to pay for Part B items and services in the following year. In general, the enrollee premiums are intended to cover 25 percent of Part B spending.

The first formula is for the calculation of the actuarial rates. First, CMS establishes the baseline Part B costs incurred per enrollee for a recent year and based

on historical trends, projected enrollment and Part B spending for the upcoming year. This amount is reduced by the enrollee cost sharing, the deductible and the coinsurance, and a 2 percent sequestration to convert the amount to what Medicare would expect to actually pay. This is then divided by the number of enrollees.

Second, CMS adds administrative costs to the projected Part B costs. Administrative costs are the expenses incurred in administering Part B, including paying benefits and addressing fraud and abuse. Administrative costs are reduced by the interest received on investments held by the Part B account and then divided by the number of enrollees.

Third, CMS determines the contingency margin, which is the amount that provides for variation between actual and projected costs. Annual fees assessed on manufacturers and importers of brand-name prescription drugs reduce the contingency margin. The hold harmless provision that I will describe later may also increase the contingency margin. Typically, the ratio of reserves to anticipated claims used for the contingency margin is about 17 to 20 percent. These three items added together are

divided by two to determine the actuarial rates.

Now that we have the monthly actuarial rates, in order to make sure the premium is only 25 percent of the total amount, we must divide the monthly actuarial rate by two. There is a lot of dividing by two in these formulas.

Next, we need to add a repayment amount. Starting in 2016, the premium has included a repayment amount because Congress has enacted laws to lower the premium amount in certain years by transferring funds from the general fund to the Part B account. To repay the Treasury, a repayment amount is added to the premium. The repayment amount has been as high as $3, but in 2026, the amount is only 20 cents. Once the actuarial rate is divided by two and the repayment rate is added in, we have the amount of the standard monthly Part B premium.

We have been discussing the standard premium amount, but sometimes the premium amount may vary. Individuals with a modified adjusted gross income above a certain amount also pay an income-related monthly adjustment amount, or IRMAA, as part of their premium. In 2026, individuals with incomes greater than $109,000 or couples with incomes greater than $218,000 pay an IRMAA.

individuals who enroll in Part B a year or later after their initial enrollment period may pay a late enrollment penalty unless a special enrollment period applies. Medicare Advantage plans can reduce the amount deducted from an individual Social Security benefit payment by buying down some or all of the standard Part B premium amount. In 2026, 29 percent of beneficiaries enrolled in conventional MA plans are estimated to be in premium reduction plans, with a median premium reduction of $61 per month.

State Medicaid programs may pay Part B premiums for dually eligible enrollees.

Next, I will explain what is known as the hold harmless provision.

Each year, the Social Security Administration announces the cost-of-living adjustment, or COLA, percentage used to increase Social Security benefits. The hold harmless provision applies when the net Social Security payment, after taking out the Part B premium, would be less than last year's net Social Security payment. This provision reduces the amount of the Part B premium to ensure that the dollar amount of the Social Security

benefit does not decline from the previous year.

Because the hold harmless provision reduces the amount of Part B premiums collected from certain enrollees, CMS may need to increase the standard premium amount to reflect foregone revenue, and this is accomplished by adjusting the contingency margin.

The hold harmless provision applies to Part B enrollees with the premium deducted from their Social Security benefit. Approximately, 70 percent of enrollees have their premiums deducted from the Social Security benefit.

Hold harmless does not apply to enrollees whose premium is not deducted from their Social Security benefits, who pay in IRMAA, who are dually eligible, or are new to Part B.

The impact varies by enrollee. An enrollee may be fully held harmless, where the individual pays the same amount as last year, or may pay a variable premium, where the amount of the Part B premium is reduced to avoid causing a decrease in monthly Social Security payment after deducting the standard premium.

Now let's look at two illustrative examples.

The hold harmless provision has a greater likelihood of affecting enrollees receiving lower Social Security benefit payments, as the COLA percentage is applied to a smaller benefit amount, thus increasing the likelihood that the amount in dollars of a Part B premium increase will exceed the value of the COLA.

In the first year of our example, this enrollee's monthly Social Security payment was $600. The first year's monthly standard Part B premium was $148. After deducting the premium, the first year's net Social Security payment was $452.

In the second year, the Social Security COLA is 4 percent, so this enrollee's Social Security payment is $624. In the second year, the standard Part B premium is $108, a 22 percent increase from last year. The net monthly Social Security payment after deducting the standard premium would be $444 before the hold harmless is applied. The hold harmless provision applies in this case because $444 is less than $452. This enrollee's Part B premium is reduced from $180 to $172.

Turning to another enrollee's example, this illustrative example shows when the hold harmless provision

does not apply. This enrollee's monthly Social Security payment was $2,000 in the first year. After a 4 percent COLA, the second year's monthly Social Security payment is $2,080. After deducting the second year's Part B premium, this enrollee's net Social Security payment is more than it was in the first year. So this enrollee will not be held harmless and will pay the standard premium.

Both of these illustrative examples have assumed that there was a 4 percent COLA. However, sometimes the COLA is zero.

This leads us to your discussion. I'm happy to answer any questions about the materials presented. We're interested in any feedback you have on the payment basics and any suggestions for future work.

We look forward to the discussion, and I'll turn it back to Mike.

DR. CHERNEW: Jennifer, thank you.

And for folks at home, I really do encourage you to look at the payment basics. There's one for a whole range of payment systems, and they will both educate you and convince you that the Medicare payment models are very complex.

So I appreciate all the work the staff does to put together the payment basics. I think it's a broad public service. So, Jennifer, in particular, thank you.

We're going to start with Round 1 questions, and I think that is Lynn.

MS. BARR: I pressed on the button this session.

Thank you for this excellent work.

What is the average IRMAA premium? Do you have that information?

MS. DRUCKMAN: I do not. I do know that 8 percent of people are paying an IRMAA, so I'll follow up.

MS. BARR: I think it's SHIP counselors $400, $500 a month, something like that.

UNIDENTIFIED SPEAKER: Max.

MS. BARR: Max, yeah.

So it's significant, right? And I think it's really important to put that out.

And did you say that MA doesn't pay the IRMAA rate? Is that correct? So how does that work if you've got IRMAA and you're in an MA plan? The beneficiary still has to pay the balance of the IRMAA?

MS. DRUCKMAN: Unless the plan is buying it down

for the beneficiary, the beneficiary pays their full Part B premium, including the IRMAA, and then whatever is appropriate for the MA plan. They could be in a zero-dollar MA plan, which may just mean they just pay their Part B premium and their IRMAA and nothing additional for the MA plan, or the MA plan may also buy down some of the Part B premium.

MS. BARR: And I know we have a lot of zero premium plans, but so the MA plan has to pay the entire IRMAA amount? Is that correct?

MS. DRUCKMAN: So when we usually talk about the zero-dollar plans, they usually mean nothing in addition to the Part B premium.

MS. BARR: Got it. Got it.

MR. MASI: Sorry. And just to be real clear, if a Medicare beneficiary enrolls in an MA plan and that beneficiary is liable for an IRMAA, the beneficiary is still liable for the IRMAA. And so the beneficiary is expected to pay it.

As Jen points out, there are many MA plans that will use some of their rebate dollars to buy down the basic Part B premium, but that's a separate consideration from

the IRMAA.

MS. UPCHURCH: Yeah. Can I just add to that too?

MS. BARR: Thank you.

MS. UPCHURCH: Usually, the standard, we -- 25 percent is what the individual pays, but the IRMAA goes from 35 to 50 to 65 to 80 to 85. So even people paying the highest level of IRMAA have subsidized Medicare Part B to some degree.

MS. BARR: To some degree.

MS. UPCHURCH: Yeah.

MS. BARR: Okay. Thank you very much. If you could include that information in the chapter, I think it'd be really interesting for people to understand what is the actual cost to that 8 percent of the beneficiaries and how that all works out. It's a significant number. Thank you.

MS. KELLEY: Greg -- I'm sorry. That's the end of Round 1.

MR. MASI: Tom?

MS. KELLEY: Oh, Tom, did you have a Round 1?

DR. DILLER: Yeah. Very, very quickly.

MS. KELLEY: I'm so sorry.

DR. DILLER: In the document that was produced,

at the bottom of the first page, it talks about the late enrollment penalty, and for those that are still employed with insurance was not listed there. Should that be there, or is that something that -- is there some nuance that it wasn't put there?

MS. DRUCKMAN: We'll take a look at that.

DR. DILLER: Okay.

MS. DRUCKMAN: I think we were just using one example. There are many.

DR. DILLER: Yeah. Okay. Thanks.

DR. CHERNEW: I think it's the end of Round 1, and I think Greg is the first in Round 2.

MR. POULSEN: Thank you.

I really like the paper. I think it was just terrific. I only have a couple of suggestions.

First off, I think it might be useful to insert somewhere -- I'm not quite sure how to do it -- the fact that part B spending doesn't show up in the news very much, because it doesn't have an impact in terms of the insolvency of the trust fund kind of a thing, and yet the impact on the federal budget is incredibly important.

And I would love to see some flavor of the

graphic that we showed in the slides in terms of the relative growth of Medicare's Parts A, B, and D, and I think that would be useful to let people know that this really deserves a lot of attention.

And I would even accelerate that, and I think Stacie is following on to me, and she made this point that because of the tremendous impact that pharmaceuticals have and the amount of really remarkable new pharmaceuticals that are likely to come into being over the next little while, that growth of Part B is likely to continue, maybe even at an accelerated pace compared to the other parts of Medicare.

So if we're looking for people to understand the fiscal implications of Medicare payment, understanding Part B is a big deal. So that would be the point.

Thanks.

DR. CHERNEW: I do want to say one thing before Stacie jumps in.

I think context chapter -- I'm not sure of this -- we have a version of the chart that you asked for. I think that's where we talk about that.

And I think to your point, Part B, we often think

of physician services, which is true, but there are increasingly a lot of expensive drugs that are covered on the Part B side. And that plays into all of this calculation.

MS. KELLEY: Stacie?

DR. DUSETZINA: Thank you so much.

I think, kind of echoing Lynn, I also wanted a little bit more detail on the people with the income adjustments, and I think the Table 1 that you have in the chapter you just presented on is a perfect example as like an appendix to just show what those amounts are.

I also wondered if, like, in the example given, because I think that's one group that the Social Security not going up as much as the premium increase, they have to absorb the premium increase. So it might be helpful to have an example walking through that particular subgroup and reminding people it's 8 percent of beneficiaries.

I kind of try to, like, struggle with, like, should we highlight it that much, because it's only 8 percent, but for that 8 percent, it is a pretty sizable increase.

MS. KELLEY: Gina?

MS. UPCHURCH: Yeah. Also just want to pile on. I'm really thankful we're doing this.

I want to say, oh, what is the last Part B payment update say, you know, and there wasn't one. So this is great that we are creating a Medicare Part B sort of cheat sheet and how the payments work.

Just a couple of things. Getting something that Tom just said, on Footnote No. 5 in the description, special enrollment periods may apply to avoid penalties -- for example, individuals who are covered under insurance provided by the employer when the employer has 20 or more employees -- that needs to say 20 or more employees if 65 and older and 100 employees if disabled. We just need to make that super clear. So just so you will not pay Part B late enrollment penalties if you work for a large employer and you delayed B. Okay. You will if you work for a small employee, or you are retired and not actively working. So we just need to make that really clear to people.

Okay. Number two, you have an illustrative example on the top of page 2 on this handout, and I think the one thing needs to be corrected. It says a person turns 65 on October 10th of 2019 and their B initial

enrollment period concludes February 10th. Now, it's the three months before your birthday month, so it'd be starting July, August, September, your birthday month, October, and then November, December, January. So that -- it would conclude on January 31st. There's 31 days in January? January 31st, right. Okay. Not February 10th. So that just needs to be edited.

Insurance begins the first of a month, which brings me back to some comments yesterday about plans being able to -- Medicare Advantage plans being able to terminate in the middle of the year. We had one locally that terminated in the middle of a month, and why that is ever allowed, I do not understand, because consumers' insurance doesn't start until the first of a month. So they were -- I mean, you really couldn't help a person in that situation.

Okay. And then lastly, I keep asking -- well, I asked at our last sessions that we really would like to know A and B cost sharing, September, early October. So October 15th, we can hit the ground running. telling people how much they're going to pay for A and B, and understanding how the B deductions might help them if

they're in a Medicare Advantage plan, but we don't know them. And I'm beginning to realize that's probably because we don't know COLA yet, because the COLA is used to figure out the hold harmless situation.

So do we know? I think the COLA wasn't known this year till November. When are COLAs supposed to be known? Because that's what's holding up probably the announcement of the Part B premiums. Do we know about that?

MS. DRUCKMAN: I don't know, but I'll check into that.

MS. UPCHURCH: Okay. Thank you so much. And I'm really happy you're creating this cheat sheet. Thanks.

MS. KELLEY: Brian.

DR. MILLER: I love the MedPAC payment basics, potentially the best documents, set of documents in health policy, and I regularly send them to people who are new to the Medicare space. So thank you for making another one and for updating this annually.

So implementation of IRMAA, I found that particularly helpful. I think it's important because it ensures that wealthy retirees pay their fair share, which

is something that many Senators have emphasized, which is a good policy point and something that I think IRMAA does.

And granted, no one likes to pay more money for anything and everyone likes everything to be cheaper, but if you're a wealthy retiree making a couple hundred thousand dollars a year, it's perfectly reasonable for us to ask you to chip in a bit extra to help make the Medicare program sort of physical book of business work better.

And I'm a big fan of bidirectional learning and happy to note that I shamelessly stole the IRMAA policy and applied it to the North Carolina State Health Plan so that employees who make more money pay more dollars. It's a flat percentage. And so I think that IRMAA is really important for sort of economic equity in the Medicare program, and it's something we don't actually spend much time talking about, so really happy to see it here.

I think there's a sort of dynamic flavor thread that I just wanted to pull out very briefly in here. MA has many warts, which hopefully we can collectively help shave off. One of the things I think that they do do well, which I saw in here, which is interesting, is buying down Part B premiums to improve affordability, because if you're

retired, you have fixed income and don't have many financial assets beside your house, which hopefully you're not paying a mortgage, the Medicare beneficiary, but many Medicare beneficiaries are.

And so I noted the stat, which I thought was useful, in 2026, 29 percent of MA plans bought down the premium of an average of $61 per month, is a one-quarter to one-third or Part B premium. So this sort of fits again with the -- we've created a different Medicare program than we intended, right? So MA is functioning to some degree as a safety net for the lower middle class and also the working poor retirees. and fee-for-service with Medigap has become the program for the wealthy. In that context, I think IRMAA is really important because it starts to equalize that a little bit.

But really love this document that you put together. Thank you.

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

MS. BARR: Thank you.

I just want to point out that at a hundred thousand dollars a year, roughly, for somebody that's still

working, that's not a wealthy retiree. That's a really big penalty, and so I think that we need to be a little bit more cautious. It's not necessarily the rich, and most people that are self-employed and have to pay this premium on their own, it's a big burden. And so it's not really completely fair.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks for this great document. I have two brief comments.

I wanted to double down on Greg's comment about maybe having a graphic related to the percent of federal income taxes that was used to pay for Medicare Part B and D and how that's changed over time. I just think these graphics that help illustrate sort of changes over time are particularly instructive for all sorts of stakeholders who will use this document.

The second area where I think you could potentially add another year would be related to Figure 1 and sort of unpacking the components of the growth in Part B. I think it's really instructive to see how much of it is being driven by, say, drugs versus outpatient services versus physician services.

Thank you.

MS. KELLEY: Robert.

DR. CHERRY: Yeah. Thank you for a great report.

I just had some brief feedback on Figure 1 as well, which is interesting because it shows that the Medicare Part B monthly premiums and how it's increased since 1966.

It might be interesting to overlay a couple of other lines on it, such as what the rate of inflation has been if you put a line on there. And then even more interesting is how has the -- what does the net Social Security payments look like over time as well? Because I do wonder whether the Social Security net payouts is losing its purchasing power when you see a premium rise like that and the whole hold harmless provisions. It could be that the net payouts are running much more flat relative to overall inflation and especially in the context of the rise in premium. So it might make for a richer figure to perhaps include those two lines because it would create a narrative that I think you're trying to communicate here.

Thank you.

MS. KELLEY: That's all I have.

DR. CHERNEW: Great. So I'm going to first set some expectations then ask a quick Round 1 question -- I know it's not Round -- and then thank everybody.

So the general expectations point is a lot of the stuff we're talking about now is broad policy things. This is going to show up on our payment basics work, and that is actually, as the name would suggest, payment basics. This is the math of how it works. It's not the policy issues around how it works.

That being said, many of the comments pointed out the policy issues around how it works is actually really important for people, for the country.

The growth in Part B in Part B spending is a really significant portion of the growth in the Medicare program spending. The place that many of those comments may find a home will be in the context chapter.

So we will -- for those of you at home, we will have a context chapter that's going to come out in about 10 days, March 12th. So please mark your calendars for that. But there turns out there will be another March, and so there's more in the context chapter about that.

The other thing where you might find some of this

information if you're at home is in some of the chart book stuff that talks about some information on the financing. So we do a lot of things besides the stuff that you see us doing to try and allow people to understand how the Medicare program is working. The payment basics is obviously one important part, but there's other places.

So that's my expectations for where a lot of this discussion will go.

My question -- and maybe I should know this, but I feel that if I leave the MedPAC Chair position and don't understand this, I really wouldn't have gotten my bang for the buck. Why is all of it dividing by two?

MS. DRUCKMAN: A lot of this is actually set in statute.

DR. CHERNEW: All right, then. I probably should have just not asked that question. I feel like thank you for playing.

Anyway, so, Jennifer, thank you for doing this. I think you hear from around the room that people do find this information useful, and for those of you that have worked on other parts of the payment basics chapters, really thank you. I think there's a lot of ways that

MedPAC helps provide broad information as a resource to people interested in Medicare payments and health policies, in general. And so I think this is quite useful. So again, thank you to you and all the other staff that work on related topics.

For those at home, my obvious meeting closing, which is please reach out to us if you have comments on this, on the choice work, on anything you said yesterday or anything else you really just want to tell us. We are always here, meetingcomments@medpac.gov. As you know, the staff meets with a large number of groups. We really do like feedback, and we want to be able to both hear your thoughts and honestly just tell you what we're doing, so there's nothing that's kind of behind some magical veil of opacity.

So, in any case, we do hope to hear from you in April to even further, what I consider, extensive efforts to be transparent. We are thinking in the Friday meeting that we were exploring the logistics of having people come and being able to say what they want to say to us in person for a brief in-person comment. So we'll see how that works, if we can sort it all out. But in any case, for

those of you at home that might be interested, just stay tuned, and we will try and get information out to people when we have the information.

Other than that, to all the Commissioners, thank you for your attendance and your comments. I think it was a really good meeting, and we will see you all back here in April. So again, thanks.

[Whereupon, at 11:49 a.m., the meeting was adjourned.]