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MedPAC and MACPAC Hold April 2025 Meetings

On April 10 and 11, the Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment Commission (MACPAC) held virtual public meetings, which included the following sessions:

MedPAC

- Reforming Physician Fee Schedule Updates and Improving the Accuracy of Relative Payment Rates (Vote on March 2025 Recommendations) (Pg. 2)
- Structural Differences between the Part D Prescription Drug Plan and Medicare Advantage–Prescription Drug Plan Markets (Pg. 3)
- Assessing the Utilization and Delivery of Medicare Advantage Supplemental Benefits (Pg. 5)
- Exploring the Effect of Medicare Advantage on Rural Hospitals (Pg. 6)
- Paying for Software Technologies in Medicare (Pg. 7)
- Access to Hospice and Certain Services under the Hospice Benefit for Beneficiaries with End-Stage Renal Disease and Beneficiaries with Cancer (Pg. 8)
- Regulations, Star Ratings, and Fee-For-Service Medicare Policies aimed at Improving Nursing Home Quality (Pg. 8)

The full agenda and presentations for the MedPAC sessions are available here.

MACPAC

- Medicaid in Context: Key Statistics and Trends (Pg. 11)
- Medicaid in Context: Payment and Financing (Pg. 12)
- Understanding the Program of All-Inclusive Care for the Elderly (PACE) Model (Pg. 13)

- Panel on Automation and Artificial Intelligence (AI) in the Prior Authorization Process (Pg. 14)

The full agenda and presentations for the MACPAC sessions are available here.

MEDPAC

MEDPAC VOTES ON RECOMMENDATIONS FOR REFORMING THE PHYSICIAN FEE SCHEDULE AND IMPROVING THE RELATIVE ACCURACY OF PAYMENT RATES

MedPAC staff briefly reviewed the March 2025 session presentation and both draft recommendations before the vote:

Draft Recommendation 1: The Congress should replace the current-law updates to the physician fee schedule with an annual update based on a portion of the growth in the Medicare Economic Index (MEI) (such as MEI minus 1 percentage point).

Draft Recommendation 2: The Congress should direct the Secretary to improve the accuracy of Medicare's relative payment rates for clinician services by collecting and using timely data that reflects the costs of delivering care.

Commissioners voted unanimously (17-0) in favor of both recommendations.

After adopting both recommendations, two commissioners added comments. One recommended a cap on total updates to the Physician Fee Schedule citing that in periods of very high inflation, increases in physician pay must be balanced with beneficiary costs. Another commissioner voiced their support for both a floor and ceiling for Physician Fee Schedule updates. They cited a comment letter from the American Occupational Therapy Association arguing low reimbursement is putting the profession at risk, highlighting fewer applicants to Occupational Therapy programs and a growing number of providers refusing to accept Medicare.

MEDPAC INVESTIGATES DIFFERENCES BETWEEN PART D PROGRAMS FOR MEDICARE AND MEDICARE ADVANTAGE

MedPAC staff began this session with a background on the Part D program, which operates through competition amongst private plans that offer varying premiums, cost-sharing terms, drug lists, and pharmacy options. The program has two distinct markets: (1) stand-alone Prescription Drug Plans (PDPs) serving traditional fee-for-service (FFS) beneficiaries and (2) Medicare Advantage Prescription Drug Plans (MA-PDs) that combine medical and drug coverage for Medicare Advantage (MA) enrollees. The Part D market is highly concentrated, with the five largest firms covering 75

percent of all enrollees nationwide. Enrollment has increasingly shifted from PDPs to MA-PDs, mirroring the broader movement away from Traditional Fee-For-Service (FFS) Medicare.

The Commission highlighted several concerning trends in Part D program, including pricing, beneficiary choice, and risk score impacts. Average PDP premiums are now consistently higher than MA-PDs premiums; with an average difference in 2024 of approximately $20 (and growing). There has also been a decline in the number of PDPs offered, which affects the availability of "benchmark" plans that provide premium-free coverage for Low-Income Subsidy (LIS) enrollees. Additionally, PDPs overall have higher gross costs and lower average risk scores compared to MA-PDs. This combination makes PDPs more likely to incur losses compared with MA-PDs. MedPAC staff research found these disparities were due to misalignment between gross costs and risk scores, as risk scores directly impact plan payments and require alignment for accurate payment. The presentation also emphasized that stability in the PDP market is a critical pathway for Part D drug coverage.

MedPAC staff identified policy and regulatory differences that affect costs and payments for PDPs and MA-PDs. First, MA-PDs benefit from additional funding through MA rebates, allowing them to offer lower premiums and enhanced drug coverage, while PDPs lack such funding. Next, MA-PDs also have flexibility PDPs lack to adjust their Part D premiums by reallocating funds after benchmarks are set, helping them meet pricing targets and retain LIS enrollees. MA-PDs can even offer D-SNPs exclusively for LIS beneficiaries, allowing them to provide tailored benefits. Finally, PDPs are unable to offer LIS-only plans, which only makes balancing quality coverage with affordability more difficult. These factors and policies provide meaningful advantages to MA-PDs over PDPs.

MA-PD and PDP costs, coding intensity, and utilization also drive differences between the two markets. In MedPAC staff's analysis comparing risk-standardized costs, which adjust for average expected beneficiary costs, MA-PDs spend less, while PDPs spend more. This results in higher payments to MA-PDs and creates a payment disparity. Based on the latest 2023 data, there is a 16 percent difference in average standardized costs between PDPs and MA-PDs. These differences could be driven by how plans manage spending, such as through cost-sharing tiers, utilization tools, and diagnostic coding practices, as well as variation in coding intensity. In addition, MA-PDs generally offer better formularies than PDPs, covering more drugs and placing more on lower-cost tiers. MA-PDs also have slightly lower utilization rates than their PDP counterparts. Differences in coding intensity also increased MA-PDs risk scores while decreasing them for PDPs—meaningfully contributing to higher overall payments for MA-PDs and explaining part of the gap in risk-standardized costs between MA-PDs and

PDPs. MedPAC staff also stated that despite the effect of coding intensity, the scale of the difference suggests additional, unmeasured factors are at play.

The Part D redesign also affected PDPs more than their MA-PD counterparts. These changes under the Inflation Reduction Act (IRA) increased the portion of Part D spending that is risk-adjusted by shifting costs from beneficiaries' cost-sharing to premiums and Medicare's capitated direct subsidies (risk-adjusted). Despite efforts including the Part D Premium Stabilization Demonstration, PDP premiums varied widely, while MA-PD premiums remained slightly lower due to their ability to adjust rebates. With a 180 percent rise in national average bid amounts in 2025 alone, the importance of risk adjustment continues to grow, as plans with higher risk scores relative to costs receive lower bids and premiums.

Commissioner discussion focused on the challenges and trends in the Part D market, particularly the stability of standalone PDP. Commissioners noted the importance of normalization factors in addressing differences between MA-PDs and PDPs, even though systematic differences remain after adjustments. The rising costs of Medicare Part D, especially due to increased federal subsidies and the impact of the IRA, are central concerns, along with the potential collapse of the freestanding PDP market due to differences in rebates, competition, and structure. The conversation also touched on geographic market definitions, the role of formularies, and the need for greater clarity around risk adjustment and the impacts of drug price negotiations. Acknowledging CMS's actions in Medicare policy, there is growing concern that structural issues, including the competitiveness of MA-PDs, disadvantage standalone plans and exacerbate inequalities, especially as wealthier beneficiaries are shifting towards MA. The discussion urged more explicit policy decisions to address these disparities, including biosimilars and value-based contracting. MedPAC staff plan to publish this material as part of their June 2025 Report to Congress.

MEDPAC REVIEWS MEDICARE ADVANTAGE SUPPLEMENTAL BENEFITS

MedPAC staff reviewed how supplemental benefits are delivered and used in Medicare Advantage (MA) plans. This included a review of findings from plan submissions, stakeholder feedback, and data comparing MA and Special Needs Plans (SNPs). Vertical integration in MA plans and provision of supplemental benefits also raises concerns about data flow, transparency, and financial ties.

Limitations in coding and reporting make it difficult to separate basic services from supplemental ones. For example, vision benefits are underreported due to coding issues. While some plans submit encounter data, the submission rates vary, and the

existing codes do not always align with the services provided. This is especially problematic for benefits like gym memberships or home modifications, where a lack of standardized codes complicates tracking. Staff also found that utilization records for certain benefits were sparse, possibly due to low enrollee use or gaps in data collection.

When comparing plans, MedPAC staff found reporting about benefit details is inconsistent. Some plans allow certain benefits like quarterly card allowances to roll over, but this isn't always clearly communicated. In addition, though plans estimate benefit costs, it's unclear how unused funds are managed or reinvested.

Commissioners raised concerns about data, transparency, and how benefits are delivered. MedPAC staff were unable to answer a commissioner question regarding how many MA enrollees get dental benefits from outside vendors, citing limited data. Other commissioners continued this thread by asking if vendors have data that could be reported to CMS. MedPAC staff responded by highlighting a need for both better data sharing between vendors and plans and clearer guidance from CMS.

Commissioners also pointed out that some codes used for reporting are outdated or do not match how benefits are delivered. They suggested creating new codes that better reflect what services are being offered. Commissioners also had questions about vertically integrated vendors and the impact of these arrangements on benefit utilization.

Several commissioners supported the idea of improving the data collected from third-party vendors and making reporting more consistent. Some said supplemental benefit use should be included in enrollee surveys, and suggested working with CMS and the Consumer Assessment of Healthcare Providers (CAHPS) team to learn more about how people are using their benefits. Other priorities included tracking benefits like home modifications, making cost sharing and reimbursements easier to understand, and development of additional resources to help beneficiaries understand their benefits. All commissioners agreed on the importance of greater transparency and consistency to ensure benefits are useful and rebate dollars are being appropriately spent. MedPAC staff plan to publish this material as part of their June 2025 Report to Congress.

MEDPAC EXAMINES THE ROLE OF MEDICARE ADVANTAGE IN RURAL COMMUNITIES

MedPAC staff presented on the growth of Medicare Advantage (MA) in rural areas, with a focus on the role of MA for rural hospitals and providers. MedPAC staff have periodically visited rural communities, and over the past two years, multiple representatives expressed concern about the increase of MA in their communities, with providers consistently preferring Fee-For-Service (FFS) Medicare over MA. In rural areas with significant MA growth, MedPAC staff found reduced rural hospital inpatient and

post-acute volumes, citing MA beneficiaries are more likely to avoid rural hospitals than their FFS counterparts. However, this growth has not impacted revenues, costs, or profits for rural hospitals. MedPAC staff attribute this to market changes that accompany increased MA proliferation, with increased prices counterbalancing lower FFS volumes. MedPAC staff also reiterated multiple times during the discussion that this research is preliminary.

Commissioners focused on the Critical Access Hospital (CAH) payment rates for the majority of the discussion. Currently, MA plans pay CAHs based on negotiated contracts, or if not contracted, as out-of-network providers. Unlike FFS Medicare, MA plans may not reimburse CAHs at 101 percent of reasonable and allowable costs, with some offering per diem or cost only payments depending on their contract. Despite these options, many MA plans elect to pay FFS rates, with one commissioner questioning the practice if plans can negotiate lower prices. MedPAC staff did not have a direct answer, but highlighted that many CAHs rely on these rates, and can coordinate with their Medicare Administrative Contractor (MAC) before sending the claim to the MA plan. This discussion led several commissioners to question how often MA plans are denying claims. MedPAC staff stated they are unable to directly track this, but have access to information on how many times a claim was filed. Their research found MA plans claims are more likely to file a claim multiple times, compared to many FFS claims being filed only once.

MedPAC Commissioners had varied suggestions for future work in this area. One Commissioner noted that outcomes often differ depending on the type of MA plan, and that, if possible, MedPAC staff should separate their analysis by plan in the future. Another commissioner noted that, if possible, staff should investigate the experiences of beneficiaries and their families with rural hospitals and whether they willingly elect to travel farther distances, or are constrained by what providers are in their MA plan network. In the next stream of work, a commissioner recommended staff look into potential effects of smaller versus larger payers on rural hospital billing. To conclude the session, another commissioner highlighted differences between MedPAC and CMS analyses of MA and FFS Medicare, recommending staff explore why the two diverge. MedPAC staff plan shared they plan to continue their research into this subject based on commissioner feedback.

MEDPAC CONSIDERS COVERAGE FOR MEDICAL SOFTWARE

MedPAC staff presented on the application of software services in a medical context, interviewing stakeholders and providing an overview of Medicare's current coverage. Staff presented two categories of medical software technologies. Software as a Service (SaaS) refers to algorithm-driven software used by clinicians to aid them in providing better and more accurate treatment. Their most common application is to enhance

imaging. Prescription digital therapeutics (PDTs) are software applications used by beneficiaries on their personal devices. Medicare has covered SaaS since 2018, though PDTs had failed to meet Medicare statutory requirements until recently. This changed in January 2025, with the first approval of a PDT mental health treatment under the Physician Fee Schedule.

MedPAC staff conducted a series of interviews with stakeholders, most of whom were medical software developers. Many interviewees reported struggling to convince insurers that their technology was valuable. MedPAC also interviewed an insurer, who stressed that to receive coverage, technology companies must demonstrate net benefits to patients. The insurer highlighted many technologies are promising but lack sufficient evidence as to whether they improve outcomes beyond existing treatments.

In discussion, commissioners questioned the relationship Medicare should have with medical software technologies. Several commissioners advocated an outcome-based approach for evaluating software technologies. One commissioner suggested that SaaS on the hospital/provider side should be bundled into existing payments. When questioned on the effectiveness of the software services in scientific versus marketing literature, MedPAC staff responded that the availability of data varies, with many products lacking strong evidence. Another commissioner highlighted the relatively small portion of current spending on software services, with Medicare currently only reimbursing 19 HCPCS codes.

MedPAC commissioners also considering potential drawbacks to Medicare covering software. One commissioner highlighted that any technology designated medically necessary may invite significant price increases. They added that many services may also charge Medicare significantly more than comparable products widely available for smartphones. Another commissioner followed up on this thread, saying that not everything that improves health is something Medicare should pay for, citing the difference between prescription and Over the Counter (OTC) drugs as an example. Chairman Dr. Michael Chernew concluded the session by emphasizing the opportunities brought by innovation, with MedPAC staff to continue monitoring developments regarding medical technology and conduct additional research based on commissioner feedback.

MEDPAC EXAMINES LOW HOSPICE UTILIZATION AMONG ESRD AND CANCER BENEFICAIRIES

MedPAC staff presented their findings on hospice utilization for people with End-Stage Renal Disease (ESRD) and cancer. For all hospice patients, Medicare pays the same daily rate for each level of care. Hospices also have the flexibility to determine what care they will provide, which when considered with the flat rate reimbursement, raises

concerns about whether beneficiaries are receiving the care they need. Services like ambulance transport add extra costs, with reporting on utilization often incomplete as Medicare does not provide reimbursement for the specific service. MedPAC staff also found certain services may not be available through hospice, as they are at the provider's discretion, and highlighted beneficiary confusion regarding what drugs are covered by hospice or Part D.

MedPAC staff found approximately 31 percent of ESRD patients use hospice, with commissioners asking why utilization is so low. One commissioner noted that payment may be a concern as well as highlighting how uncertainty about the availability of certain services may drive beneficiaries away. With hospice decisions subject to the provider's philosophy, commissioners recommended greater transparency about what services are available. Others added to this stating that the payment structure may not reflect the needs of patients with more complex or unclear prognoses. These difficulties are likely to be compounded in rural areas with fewer choices. Several commissioners requested more information about how patients transition in and out of hospice, and whether they understand the associated tradeoffs. Some commissioners expressed support for investigating alternative palliative care models. Overall, commissioners agreed on the need for greater flexibility, and supported integrating this work with Medicare Advantage efforts. MedPAC staff plan to continue their investigation into this workstream.

MEDPAC OPENS WORKSTREAM INTO NURSING HOME QUALITY

MedPAC staff began this session with a review of relevant Nursing Home regulations and star ratings. To participate in both Medicare and Medicaid, Nursing Homes must meet federal requirements regarding care quality, safety, staffing, and resident's rights, and be assessed for compliance at least once every 15 months by state inspectors. Reports from the Government Accountability Office (GAO) and Office of the Inspector General (OIG) over the last twenty years have identified a variety of issues with the existing survey and certification process, highlighting underfunded and understaffed survey programs leading to delayed and incomplete inspections, alongside overall quality issues. Nursing home inspection ratings are also one of three pillars that comprise the current Nursing Home Quality Star Ratings, alongside staffing and quality measures. Scores in each of these domains are aggregated and compared with peers on either the state or national level, with nursing homes receiving both individual domain scores and a composite score between one and five stars. Research by MedPAC staff showed facilities frequently had higher scores in quality domains, along with lower scores in both the inspection and staffing domains. According to November 2024 data, 24 percent of all Nursing Homes had an overall 1-star rating, while only 18 percent had an overall 5-star rating. Larger shares of both nonprofit and small Nursing Homes received 5-star ratings compared to their for-profit and large peers, respectively.

MedPAC staff also reviewed literature on Nursing Home star ratings, highlighting evidence that some consumers utilize these ratings despite an overall low level of awareness, various potential unintended consequences in response to the star ratings methodology, and how current ratings do not contain any measure of patient experience.

MedPAC staff continued the presentation by examining other Fee-For-Service Medicare policies designed to improve quality in Nursing Homes, including the Skilled Nursing Facility (SNF) Value-Based Purchasing (VBP) Program, the Initiative to Reduce Avoidable Hospitalizations among Nursing Home Residents, Accountable Care Organizations (ACOs), and High Needs ACOs. After a review of the original statutory design of the SNF VBP program and program changes since inception, MedPAC staff reiterated concerns from their June 2021 Report to Congress regarding measure set reliability and the relatively small size of SNF VBP payment adjustments. Despite the average risk-standardized readmission rate increasing in SNFs since the VBP program began in 2019, payment adjustments have continued to decrease from an already limited level of +/- two percent; a level both MedPAC and GAO state is too low to change provider behavior. Next, MedPAC staff provided a brief overview of the Center for Medicare and Medicaid Innovation's (CMMI's) Innovation to Reduce Avoidable Hospitalizations Among Nursing Home Residents. The program, which ran from 2012 to 2020, saw increased program spending alongside a lowered probability of avoidable hospitalizations in its first phase that funded clinical and education activities. However, the initiative's second phase, which offered financial incentives, did not further improve performance. MedPAC staff concluded the session with a review of ACOs and High Needs ACOs, where a group of providers assume responsibility for the cost and quality of care for a group of beneficiaries. Despite limited evidence that traditional ACOs impact Nursing Home quality of care due to limited Nursing Home ACO beneficiaries, High Needs ACOs have shown more promising results. Though limited in scope - with only 13 High Needs ACOs active in 2025 - recent CMS evaluation results have shown these ACOs that focus on serving beneficiaries with complex medical conditions have statistically significant reductions in hospital, emergency department, SNF, and specialty care, alongside evidence of decreased hospitalizations and readmissions.

Commissioners had extensive comments on the presentation, with many focusing on staffing standards and the VBP program. Much of the discussion focused primarily on the effectiveness of staffing regulations, including the Biden-era minimum staffing requirements that were struck down by a federal judge in Texas just a few days prior. Some commissioners expressed that facilities should not be subject to these higher minimum staffing standards if they can effectively manage their facility with fewer personnel while delivering high quality care, while others voiced their disagreement. One commissioner shared they had changed their opinion on staffing regulations

following a review of literature about provider burnout, and now are in support of requirements for additional staffing. Two commissioners focused on the inclusion of inspection results in the VBP program, arguing these are inappropriate. One commissioner recommended removing them entirely from the VBP program, with the other adding inspections should be placed in the Medicare conditions of participation. Commissioners also highlighted the lack of patient experience measures in the VBP program, limited effect and incentives due to small VBP payment adjustments, and the perceived link between inspections and quality.

Outside of the VBP program, commissioners highlighted an overall lack of confidence in the existing long-term care system, voiced strong support for I-SNPs and High Needs ACOs, and touched on a number of other issues. Multiple commissioners referred to the state of SNF/Nursing Home care in the United States as a "crisis", with a large share of low-performing facilities. Commissioners also debated whether the only solution to the existing system was a complete overhaul with significant investment, or whether meaningful changes to the current regime could be made. One commissioner discussed whether the Commission should focus on developing recommendations that are more responsive to the current political climate, with Chairman Chernew emphasizing MedPAC's role of providing Congress all recommendations they believe would be effective. Several commissioners voiced strong support for I-SNPs and High Needs ACOs, with one commissioner discussing the advantages of integrated providers in I-SNPs. One commissioner asked MedPAC staff about the role of Quality Improvement Organizations (QIOs). Staff responded that according to their research, their impact and participation in the space is limited. One commissioner asked for research into drug regimen reviews in facilities, and another highlighted the role of educating the American public about the lack of Medicare coverage for Nursing Home care. MedPAC staff plan to publish this material as part of their June 2025 Report to Congress.

MACPAC

MACPAC PROVIDES OVERVIEW OF SIGNIFICANT MEDICAID TRENDS

In this session, MACPAC discussed significant trends in the Medicaid program regarding Children's Health Insurance Program (CHIP), Long-Term Services and Supports (LTSS), Home and Community-Based Services (HCBS), and behavioral health. Staff reported that Medicaid spending continues to account for a smaller share than Medicare, and in FY 2024, about 88.1 million individuals were enrolled in Medicaid. Both Medicaid and CHIP are associated with both lower uninsurance rates and increased access to care and services. In CY 2024, Medicaid expansion states had an uninsurance rate of 6.5 percent, compared to 9.9 percent for states without the expansion.

Medicaid remains the largest payer of maternity care services, covering 41.2 percent of all births in CY 2023, and is a major funder of LTSS, covering $437.8 billion in associated spending in CY 2022. MACPAC staff also shared new statistics on HCBS, noting that 45 percent of HCBS users are adults, and a quarter are children. Behavioral health services continue to be a mandatory Medicaid benefit for children but are optional for adults.

Commissioner feedback included comments on Federal Poverty Levels (FPLs) and Medicaid eligibility, enrollment and expansion trends, LTSS, and state spending variation. One commissioner highlighted enrollment and spending increases following the Medicaid expansion, emphasizing the staggered adoption of expansion across states. While commissioners acknowledged Medicaid cost growth, they noted that relative to total health expenditures, Medicaid's share has remained flat compared to broader healthcare spending trends.

Many commissioners reiterated Medicaid's central role in funding LTSS and emphasized the importance of rebalancing services toward home and community-based care to reduce reliance on institutional settings. It was also noted that investments in LTSS can help lower downstream hospitalizations and Medicare costs. A commissioner called attention to significant differences in per-enrollee spending, explaining that these variations are largely driven by optional eligibility pathways and benefits like LTSS. Furthermore, states with greater use of HCBS tend to have lower per capita Medicaid costs.

Commissioner recommendations for further research included exploring how state Medicaid spending compares to quality outcomes, concerns about how states will manage Medicaid amidst an aging population driving long-term care needs, and how to best reinforce Medicaid's critical role in sustaining safety-net and critical access hospitals in rural areas.

MACPAC DISCUSSES HOW MEDICAID IS FUNDED

This session focused on Medicaid payment mechanisms such as the Federal Medical Assistance Percentage (FMAP), state funding sources, provider payment mechanisms, and taxes. FMAP is calculated based on a statutory formula, providing higher reimbursement to states with lower per capita incomes. FMAP rates range from a minimum of 50 percent to a maximum of 83 percent, with certain exceptions. Most state administrative costs receive a 50 percent federal match.

MACPAC staff provided an overview of the federal match distribution process. States submit estimated expenditures to CMS, CMS provides matching funds, states then pay providers using federal and non-federal funds, and finally, states and CMS reconcile payments based on actual expenditures. States are typically responsible for financing at least 40 percent of the non-federal share, while up to 60 percent can come from local

governments. Funding sources include state general funds, healthcare-related taxes, intergovernmental transfers (IGTs), and certified public expenditures (CPEs).

The session also covered provider taxes and payments, which state governments can apply – under certain circumstances – to their Medicaid expenditures. Per regulation, all provider taxes above the safe harbor threshold of 6 percent must follow a series of complex regulations with three main tenants: that they are broad-based across a class of healthcare entities, impose a uniform burden, and the state must not guarantee taxpayers receive the same amount in expenditures (or "hold harmless"). Due to this regulation, almost all provider taxes exist below the 6 percent level, though with several exceptions. For example, hospitals pay a tax, with the state using the revenue to reimburse providers for Medicaid expenditures and to receive matching federal funds. Medicaid providers are paid using three primary provider payment mechanisms: managed care and fee-for-service base payments (standard rates) accounting for 60 percent, supplemental payments (beyond base rates) making up the next 20 percent, and directed payments (payments directed through managed care plans) comprising the final 20 percent. Staff also addressed improper payments, noting that about 5 percent of total payments are improper, with nearly 75 percent of those due to insufficient documentation rather than fraud.

Commissioner feedback included discussion on fraud, documentation, provider taxes, upcoding, and the policy impacts of these issues. Commissioners emphasized that insufficient documentation typically reflects program complexity rather than fraud, noting that documentation rules are outdated. They also mentioned pending House proposals that could tie Medicaid cuts to stricter documentation requirements, potentially affecting program function. Commissioners further stressed that provider taxes are a legal and legitimate financing method that should be evaluated based on state implementation and policy intent.

Some commissioners called for increased oversight of practices like directed payments and upcoding, aiming for improved program integrity and fairness. One commissioner questioned the continued use of per capita income as the FMAP metric, suggesting updated measures may better reflect state needs. Finally, commissioners highlighted persistent funding gaps, explaining that federal and state contributions often do not fully cover Medicaid costs at hospitals — with provider taxes frequently supporting other services like nursing homes.

Overall, commissioners focused on how Medicaid supports long-term health and economic outcomes, helps fund uncompensated care, and enables hospitals to serve all patients, not just Medicaid beneficiaries; with these payment mechanisms vital to sustaining our healthcare infrastructure.

MACPAC PROVIDES OVERVIEW OF PACE PROGRAM

MACPAC staff presented on the Program of All Inclusive Care for the Elderly (PACE) Model. The PACE Model serves adults over the age of 55 who qualify for nursing facility care but are able to live in their community with assistance. Under the model, providers receive capitated payments from Medicare Parts A, B, and D as well as state Medicaid agencies to support beneficiaries. Federal and state primarily oversee the program through provider audits. Providers interviewed focused their comments on the lengthy and challenging approval process to become a PACE organization. Additionally, though MACPAC staff analysis concluded the model offers enrollees a comprehensive benefits package; some consumer advocates claim that some PACE programs offer less home-based services than alternative programs.

Commissioners evaluated the program and considered PACE's utility on a broader scale. Some commissioners questioned whether PACE would scale well. One commissioner stated that the model is not for everybody, since many beneficiaries would be better served in an institutional setting or with alternative in-home care arrangements. Another commissioner compared the PACE program's high average cost – $47,000 per beneficiary – to other payment and care models. Several commissioners asked for more information concerning the difference in regulatory requirements between PACE and standard Medicaid programs. Eligibility determination and accessibility were other points of concern. One commissioner also noted a potential conflict of interest, as the same entity that receives payments through PACE also determines whether the individual is safe to live in their community. Despite these concerns, PACE is popular among the commissioners.

Overall, commissioners expressed interest in continuing to explore how the PACE Model can be expanded to serve the patients who could benefit from it, and how to ensure that the program is effective, both in terms of cost and quality of care. MedPAC staff plan to publish this material as part of their June 2025 Report to Congress, and to conduct additional analysis of the PACE program.

MACPAC PANEL LOOKS TO THE FUTURE OF AI

MACPAC staff hosted a discussion on automation and the use of AI in prior authorization (PA). The panel consisted of Sammi Koyejo, PhD and Primary Investigator of Stanford Trustworthy AI research; Heather McComas, PharmD, Director of Administrative Simplification Initiatives at the American Medical Association (AMA); and Wayne Turner, JD, a Senior Attorney at the National Health Law Program.

Panelists began by defining AI, particularly today's large language models like ChatGPT, as a collection of tools trained on datasets that automate decision-making and generate outputs. They also noted that while automation and AI are technically

different, both have evolved significantly over time and should be subject to similar scrutiny. All panelists discussed how AI is growing in capacity to improve both the speed and efficiency of prior authorization. For beneficiaries and providers, quicker decisions mean faster access to needed care while reducing administrative burden and burnout. On the payer side, AI can offer improved operational efficiency and lower administrative costs.

However, panelists emphasized AI in PA does not automatically ensure better outcomes. Areas for concern include accuracy, equity, transparency, and accountability. AI systems often are trained on historically biased data, leading to concerns about increasing disparities. There is also a risk of using a "cookie-cutter" method to assess beneficiaries that overlooks important nuances of certain populations and individuals. One AMA survey cited found 61 percent of physicians surveyed expressed alarm about the increasing number of AI-driven denials. On the payer side, there is ongoing concern about the lack of transparency. As of 2025, only 23 percent of insurers report disclosing their use of AI to physicians, and there are no data sharing requirements. With all these risks, the panel emphasized that AI cannot entirely replace physician's role in PA, and should only supplement it.

Panelists stressed the need for oversight in AI. Transparency, data quality, and regular testing during both development and use are essential. Systems should also be designed with internal checks, as well as the ability for individuals to raise red flags about problematic outcomes or reasonings. Panelists also focused on the need for increased data privacy and cybersecurity protections. The panel concluded by addressing the pivotal role of policymakers in balancing innovation with patient protection. While AI may feel new, panelists pointed out that existing legal and regulatory tools can be applied, such as due process and nondiscrimination laws. Panelists urged law makers to not only regulate AI specifically in the healthcare space, but also the broader AI ecosystem.

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