Executive summary

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By law, the Medicare Payment Advisory Commission reports to the Congress each March on the Medicare fee-for-service (FFS) payment systems, the Medicare Advantage (MA) program, and the Medicare prescription drug program (Medicare Part D).

In this year's report, we consider the context of the Medicare program, including the near-term consequences of the coronavirus pandemic and the longer-term effects of program spending on the federal budget and the program's financial sustainability. We evaluate payment adequacy and make recommendations concerning Medicare FFS payment policy in 2024 for seven FFS payment systems: acute care hospital, physician and other health professional, outpatient dialysis facility, skilled nursing facility, home health agency, inpatient rehabilitation facility, and hospice services. We also include recommendations to redistribute current disproportionate share hospital and uncompensated care payments, and to provide additional resources to Medicare safety-net hospitals and clinicians who furnish care to Medicare beneficiaries with low incomes. Previously, the Commission also considered an annual update recommendation for long-term care hospitals (LTCHs). But as the number of cases that qualified for payment under Medicare's prospective payment system for LTCHs declined, we became increasingly concerned about small sample sizes in our analyses of this sector. As a result, we will no longer provide an annual payment adequacy analysis for LTCHs but will continue to monitor that sector and provide periodic status reports. The Commission also previously considered an annual update recommendation for ambulatory surgical centers (ASCs). However, because Medicare does not require ASCs to submit data on the cost of treating beneficiaries, we have no new significant data to inform an ASC update recommendation for 2024 and thus decided to provide a status report on ASCs instead of an update recommendation. We also review the status of the MA program (Medicare Part C) through which beneficiaries can join private plans in lieu of traditional FFS Medicare. Finally, we review the status of the Medicare program that provides prescription drug coverage (Medicare Part D).

Because of standard data lags, the most recent complete data we have for most payment adequacy indicators are from 2021. Starting in 2020, the ongoing coronavirus pandemic has had catastrophic consequences for many Medicare beneficiaries and has affected health care delivery for all. In this report, we discuss some of the effects of the pandemic and pandemic-related policies on beneficiaries and providers, and we have considered the effects of the coronavirus public health emergency (PHE) on our indicators in 2021 and beyond. As of the writing of this report, the coronavirus PHE is scheduled to end on May 11, 2023. To the extent that the effects of the coronavirus pandemic are temporary or vary significantly across providers in a sector, they are best addressed through targeted temporary funding policies rather than permanent changes to payment rates in 2024 and future years.

The goal of Medicare payment policy is to obtain good value for the program's expenditures, which means maintaining beneficiaries' access to high-quality services while encouraging efficient use of resources. Payment system incentives that promote the efficient delivery of care serve the interests of the taxpayers and beneficiaries who finance Medicare through their taxes, premiums, and cost sharing.

The Commission recognizes that managing updates and relative payment rates alone will not solve what has been a fundamental problem with Medicare FFS payment systems—that providers are paid more when they deliver more services, often without regard to the value of those additional services. In addition, historically, FFS payment systems have seldom included incentives for providers to coordinate care over time and across care settings. To address these problems directly, two approaches must be pursued. First, payment reforms need to be implemented more broadly, coordinated across settings, and pursued as expeditiously as possible. Second, delivery system reforms that have the potential to encourage high-quality care, better care transitions, and more efficient provision of care need to be enhanced and closely monitored, and successful models need to be adopted on a broad scale. Out of recognition of the need for reforms, CMS's Center for Medicare & Medicaid Innovation has been testing and evaluating models such as accountable care organizations and episode-based payments.

In the interim, it is imperative that the current FFS payment systems be managed carefully and continuously improved. Medicare is likely to continue using its current FFS payment systems for some years into the future. This fact alone makes unit prices—their overall level, the relative prices of different services within a sector, and the relative prices of the same service across sectors—of critical importance. Constraining unit price increases can induce providers to control their own costs and to be more receptive to new payment methods and delivery system reforms.

For each recommendation, the Commission presents its rationale, the implications for beneficiaries and providers, and how spending would compare with expected spending under current law. The spending implications are presented as ranges over one-year and five-year periods. Unlike official budget estimates used to assess the impact of legislation, these estimates do not consider the complete package of policy recommendations or the interactions among them. Although we include budgetary implications, our recommendations are not driven by any single budget or financial performance target but instead reflect our assessment of the payment rates needed to ensure adequate access to appropriate care while promoting the fiscal sustainability of the Medicare program.

In Appendix A, we list all of this year's recommendations and the Commissioners' votes.

Context for Medicare payment policy

As described in Chapter 1, Medicare is the single largest health insurer in the U.S. The program covers a substantial share of many health care providers' patients and influences the payment policies of other payers. Yet external forces can also have a substantial impact on Medicare, as seen most recently with the coronavirus pandemic.

Coronavirus disease 2019 (COVID-19) has had a disproportionate impact on the three categories of Medicare beneficiaries—people ages 65 and over, people with disabilities, and people with end-stage renal disease. In addition to facing elevated risks of serious complications and mortality, Medicare beneficiaries have also had to adjust their patterns of health care use over the past few years. Some beneficiaries delayed seeking nonurgent health care at times, while others may have had difficulty obtaining care as providers prioritized resources for the most severely ill. The Congress appropriated several hundred billion dollars in relief funds to health care providers to offset their lost revenues and ensure that they remained viable sources of care during the pandemic. The Congress and CMS also temporarily changed some payment policies. In 2020, those measures doubled the rate of growth in national health care spending. However, by 2021, relief funds tapered off, resulting in lower growth in national health care spending.

Medicare spending grew by a relatively modest 3.6 percent in 2020, then by 8.4 percent in 2021 as patients resumed care; the suspension of a 2 percent payment sequester and a temporary 3.75 percent increase to clinician payment rates (unrelated to the pandemic) also contributed to spending growth in 2021. CMS actuaries estimate that Medicare spending grew at a more typical rate in 2022, 7.5 percent, and project that Medicare spending will grow by about 6 percent to 7 percent per year in 2023 through 2030, resulting in Medicare spending doubling over the next 10 years—rising from $875 billion in 2021 to $1.8 trillion in 2031. Medicare's projected spending growth is driven by an increasing number of beneficiaries (projected to expand from 63 million to 78 million over this period as the baby-boom generation continues to age into Medicare) and continued growth in the volume and intensity of services delivered per beneficiary (rather than price increases).

Despite this projected growth, the Medicare program finds itself—at least temporarily—in a somewhat better position financially than it was a year ago. After an initial economic slowdown at the start of the pandemic, the U.S. economy subsequently experienced strong growth, yielding higher-than-expected Medicare payroll tax revenues. This economic growth has contributed to a delay in the projected insolvency of Medicare's Hospital Insurance (HI) Trust Fund by a few years—to 2028, according to CMS's actuaries. However, to keep the HI Trust Fund solvent over the next 25 years, Medicare's Trustees estimate that the Medicare payroll tax would need to be raised immediately from its current rate of 2.9 percent to 3.66 percent, or Part A spending (which covers inpatient hospital stays and post-acute care following those hospital stays) would need to be permanently reduced by 16.9 percent. Alternatively, some combination of smaller spending reductions and smaller tax increases could be pursued.

Medicare payroll taxes are used to pay for Part A services and constitute only a portion of total Medicare spending (36 percent). The rest of Medicare's spending is largely funded by beneficiary premiums (which finance 17 percent of Medicare spending) and general revenues (44 percent). As Medicare spending increases, it consumes growing shares of the budgets of Medicare beneficiaries and the federal government.

Trends in beneficiaries' health status have the potential to affect Medicare program spending. In recent decades, the share of people ages 65 and over who report being in only "fair" or "poor" health has declined, as has the share of the Medicare population qualifying for the program due to disability. Until the coronavirus pandemic, there was little change in the leading causes of death in the U.S., with the Centers for Disease Control and Prevention finding that heart disease and cancer were the first and second most common causes of death among people ages 65 and over. In 2020, 2021, and 2022, COVID-19 became the third-leading cause of death. CMS actuaries have found that the Medicare beneficiaries who died of COVID-19 in 2020 tended to have high costs and multiple medical conditions, and the remaining beneficiary population was 2 percent less costly than previously expected.

One of the most powerful ways that the Medicare program can control spending growth is by setting prices. Our annual March reports recommend updates to Medicare payment rates for various types of providers, which can be positive or negative depending on our assessment of the adequacy of Medicare payments for each sector. Over the last 10 years, spending per Medicare beneficiary has grown more slowly than spending per privately insured enrollee. Increasing prices have been the main cause of spending growth for the privately insured. Complementing the payment update recommendations in this report, our annual June reports to the Congress typically present broader recommendations aimed at restructuring the way Medicare's payment systems work. For example, the Commission has recommended incorporating value-based insurance design into traditional Medicare's benefit design and changing the formula used to set payments for Medicare Advantage plans. The Commission's full inventory of recommendations, with links to relevant report chapters, is available at medpac.gov/recommendation/.

Assessing payment adequacy and updating payments in FFS Medicare

As required by law, the Commission annually makes payment update recommendations for providers paid under Medicare's traditional FFS payment systems. An update is the amount (usually expressed as a percentage change) by which the base payment rate to all providers in a payment system is changed relative to the prior year. As explained in Chapter 2, to determine an update, we first assess the adequacy of Medicare payments to providers in the current year (2023) by considering beneficiaries' access to care, the quality of care, providers' access to capital, and how Medicare payments compare with providers' costs. As part of that process, we examine whether payments will support the efficient delivery of services, consistent with our statutory mandate. We then make a judgment about what, if any, update is needed for the policy year in question (for this report, 2024).

Providers' financial status and the pattern of Medicare spending in 2020 and 2021 varied substantially from historical patterns. In the spring of 2020, many health care sectors experienced large reductions in the demand for services, resulting in temporary financial distress for some providers. In response, the Congress and CMS extended federal grants to providers and temporarily altered certain Medicare payment policies. At least in part, those actions have offset the short-term financial effects of the coronavirus pandemic for many providers.

To fulfill our congressional mandate to recommend updates to Medicare's payment systems, we must confine our focus to factors that we expect will affect payment adequacy in 2024. To the extent that the effects of the pandemic are temporary or vary significantly across individual providers, they are best addressed through targeted temporary funding policies. Because updates are cumulative—that is, they compound each year—they are not the preferred policy response to abrupt but temporary changes in the demand for health care. Where we expect effects on providers' costs to persist into 2024, the policy year for our recommendations, those changes are noted in each sector's payment adequacy discussion and factor into our estimates of payment adequacy.

To ensure that our recommendations accurately reflect current conditions, the Commission looks

at all available indicators of payment adequacy and reevaluates any assumptions from prior years. We use the best available data—including up-to-date estimates of inflation—and changes in payment policy to project margins for 2023 and make payment recommendations for 2024, accounting for anticipated changes in Medicare payments and providers' costs up to 2024. Because of standard data lags, the most recent complete data we have are generally from 2021. Where possible, we have bolstered our analyses with data from 2022, including interim claims data, information on facility closures, and beneficiary survey data.

In considering updates to payment rates, we may make recommendations that redistribute payments within a payment system to correct any biases that may make treating patients with certain conditions financially undesirable, make certain procedures unusually profitable, or otherwise result in access issues for beneficiaries or inequity among providers. We may also recommend changes to improve program integrity. Our goal is to apply consistent criteria across settings, but because conditions at baseline and anticipated changes between baseline and the policy year may vary, the recommended updates may vary across sectors.

The Commission also examines payment rates for services that can be provided in multiple settings. Medicare often pays different amounts for similar services across settings. Basing the payment for services that lead to similar health outcomes on the rate in the lowest-cost setting would in many cases save money for Medicare, reduce cost sharing for beneficiaries, and reduce the financial incentive to provide services in the higher-paid setting. However, aligning FFS payment rates across settings is not a simple matter. The definitions of services provided and characteristics of beneficiaries served in the different settings must be sufficiently similar to warrant the same payment, and we must try to anticipate unintended consequences.

Our recommendations in this report, if adopted, could significantly change the revenues providers receive from Medicare. Payment rates set to cover the costs of relatively efficient providers—that is, those with lower costs and higher quality—help induce all providers to control their costs and improve quality, thereby helping the Medicare program get more value for its spending. Furthermore, Medicare rates have broader implications for health care spending because they are used in setting payments for other government programs and private health insurance. Thus, while setting prices intended to support efficient provision of care directly benefits the Medicare program, it can also help control health care spending across payers.

Hospital inpatient and outpatient services

General acute care hospitals (ACHs) primarily provide inpatient care and various outpatient services. To pay these hospitals for their facility costs, FFS Medicare generally sets prospective payment rates under the inpatient prospective payment systems (IPPS) and the outpatient prospective payment system (OPPS). In 2021, the FFS Medicare program and its beneficiaries paid general ACHs $182.5 billion for inpatient and outpatient services under the IPPS and OPPS, including $8.3 billion in uncompensated care payments made under the IPPS.

As described in Chapter 3, in 2021, most indicators of hospital payment adequacy remained positive or improved. However, indicators continued to vary substantially across hospitals, and some indicators remained below prepandemic levels. In 2022, input cost increases for hospitals were higher and more volatile than they have been in recent years.

Beneficiaries' access to care**—**In 2021 and 2022, the number of general ACHs that closed was the same as the number that opened, hospitals continued to have excess capacity in aggregate, and those with excess capacity continued to have a financial incentive to serve FFS Medicare beneficiaries. However, some hospitals faced occupancy and staffing constraints at times. In 2021, IPPS hospitals' marginal profit on IPPS and OPPS services (a measure of whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve) was about 8 percent, which is similar to prepandemic levels.

Quality of care**—**In 2021, FFS beneficiaries' risk-adjusted hospital readmission rate improved relative to 2019. However, the risk-adjusted hospital mortality rate remained higher than in 2019, and most patient experience measures declined.

Providers' access to capital**—**In 2021, IPPS hospitals' all-payer operating margin reached a record high of 8.7 percent. However, there was substantial variation

in margins across hospitals. Preliminary 2022 all-payer operating margin data were mixed relative to prepandemic levels.

***Medicare payments and providers' costs*—**In 2021, Medicare's payments to hospitals continued to be below hospitals' costs in aggregate but near costs among relatively efficient hospitals and higher than in 2020. IPPS hospitals' Medicare margin increased in 2021 to –6.2 percent when including a share of federal relief funds (–8.3 percent exclusive of these funds), and the median Medicare margin for relatively efficient hospitals increased to 1 percent (near break-even exclusive of federal relief funds). However, we project that hospitals' Medicare margins in 2023 will be lower than in 2021, driven in part by growth in hospitals' input costs, which exceeded the forecasts CMS used to set Medicare payment rate updates, and in part by the expected expiration of federal relief funds and temporary Medicare payment increases related to the PHE. These federal relief funds and Medicare payment increases exceeded hospitals' additional costs related to COVID-19. We anticipate that reductions in net revenue will be partially offset by other factors, including (1) reductions in hospitals' costs related to COVID-19 as cases decline and hospitals become better at managing cases and (2) the statutory 0.5 percent increase to inpatient operating payments to remove prior temporary reductions for past documentation and coding changes. We estimate that IPPS hospitals' Medicare margin will decrease in 2023 to about –10 percent (similar to the level in 2017) and that the median Medicare margin for relatively efficient hospitals will decrease to modestly below break-even—similar to prepandemic levels.

***Update recommendation*—**The current-law updates to payment rates for 2024 will not be finalized until summer 2023, but CMS's third-quarter 2022 forecasts would result in the IPPS operating base payment rate and OPPS base rate increasing by 2.9 percent and the IPPS capital base payment rate increasing by 2.4 percent. The Commission anticipates that a fiscal year 2024 update to hospital payment rates of current law plus 1 percent would generally be adequate to maintain FFS beneficiaries' access to hospital inpatient and outpatient care and keep IPPS and OPPS payment rates close to the cost of delivering high-quality care efficiently. The Commission's payment update recommendation for 2024 reflects the most recent inflation and other data from 2021, preliminary data from 2022, and projections for 2023. If current projections of input inflation and hospital costs turn out to be inaccurate, these discrepancies will be accounted for in our assessment of payment adequacy in our next recommendation cycle.

***Recommendation on supporting Medicare safety-net hospitals*—**The recommended update to IPPS and OPPS payment rates of current law plus 1 percent may not be sufficient to ensure the financial viability of some Medicare safety-net hospitals with a poor payer mix. As the Medicare program strives to ensure access to care for all beneficiaries and adequately pay providers for that access, additional Medicare payments to Medicare safety-net providers are warranted. Medicare already provides substantial safety-net funding to hospitals, but there are several problems with the way Medicare distributes these funds, including omitting a hospital's Medicare share from its funding formulas in favor of subsidizing Medicaid payments, making supplemental payments only for inpatient services, and having an uncompensated care payment formula that favors hospitals with few FFS Medicare patients. The Commission's view is that Medicare safety-net payments should be used primarily to support Medicare safety-net hospitals—those that provide care to large shares of low-income Medicare beneficiaries. We note that this definition of "safety-net hospital" is Medicare-centric by design; safety-net definitions used by Medicaid and other payers would likely differ.

In Chapter 3, the Commission recommends redistributing the current Medicare safety-net payments (disproportionate share hospital and uncompensated care payments) using the Commission-developed Medicare Safety-Net Index (MSNI) for hospitals. Implementation of this index would better target scarce Medicare resources to support hospitals that are key sources of care for low-income Medicare beneficiaries and may be at risk of closure. In addition, the Commission recommends adding $2 billion to this MSNI pool of funds to help maintain the financial viability of Medicare safety-net hospitals. The FFS portion of the MSNI pool of funds should be distributed to hospitals as add-on payments to Medicare's IPPS and OPPS payments, with commensurate add-on amounts made to hospitals treating Medicare Advantage enrollees.

While most hospitals will see increases in Medicare revenue due to the $2 billion in additional safety-net spending, there are some hospitals that will see reductions. Material reductions in Medicare revenue could occur for hospitals that currently receive high Medicare uncompensated care payments but serve relatively few FFS Medicare patients. In light of these effects, the Congress could phase in the MSNI policy for all hospitals over a set period of time (i.e., transition to the MSNI policy over three to five years). Alternatively, a transition could be managed through a stop-loss policy so that no hospital would experience changes (positive or negative) in Medicare payments due to the MSNI of more than 5 percent in any one year. Both approaches would also allow time for the hospitals facing the most substantial revenue reductions to try to augment revenues from existing sources and request additional financial support from state and local governments, as warranted. To the extent that these hospitals have high cost structures, a transition would allow time to improve efficiencies.

Physician and other health professional services

Medicare's physician fee schedule pays for about 8,000 different types of medical services—ranging from office visits to surgical procedures, imaging, and tests—that are delivered in physician offices, hospitals, nursing homes, and other settings. The clinicians who are paid to deliver these services include not only physicians, nurse practitioners, and physician assistants but also podiatrists, physical therapists, psychologists, and other types of health professionals. In 2021, the Medicare program and its beneficiaries paid $92.8 billion for services provided by almost 1.3 million clinicians, accounting for just under 18 percent of FFS spending.

As described in Chapter 4, in 2021 and 2022, most physician payment adequacy indicators remained positive or improved, but clinicians' input costs grew at rates not seen for many years.

Beneficiaries' access to care—In the 2022 fielding of the Commission's annual survey, Medicare beneficiaries continued to report access to clinician services that was equal to, or better than, that of privately insured people. Other national surveys and our annual focus groups with beneficiaries also suggest that beneficiaries have relatively good access to care. Surveys indicate that the share of clinicians accepting Medicare is comparable to the share accepting private insurance, despite private health insurers paying higher rates. Almost all clinicians who bill Medicare accept physician fee schedule amounts as payment in full and do not seek to obtain higher payments from patients. The supply of most types of clinicians has been growing in recent years, although the composition of the clinician workforce continues to change, with a rapid increase in the number of advanced practice registered nurses and physician assistants, steady increase in the number of specialists, and a slow decline in the number of primary care physicians. These changes have coincided with our annual survey finding that both Medicare beneficiaries and privately insured people report more problems obtaining a new primary care provider than a new specialist. Despite the growth in the overall number of clinicians, the number of clinicians per Medicare beneficiary (including those in FFS Medicare and Medicare Advantage) has remained steady due to beneficiary enrollment growth. The overall number of beneficiary encounters with clinicians increased in 2021 but did not return to prepandemic levels.

Quality of care—In 2021, the coronavirus pandemic compounded difficulties assessing the quality of care provided by clinicians. While we report 2021 rates of ambulatory care–sensitive hospitalizations and emergency department visits and 2021 patient experience data, we have not used these results to assess the quality of care provided to Medicare beneficiaries.

Medicare payments and providers' costs—In 2021, total spending by the Medicare program and beneficiaries on clinician services was $8.1 billion higher than it was in 2020 but $4.4 billion lower than in 2019. In 2021, per beneficiary spending on evaluation and management (E&M) services and on treatments was higher than it was in 2019, while spending on tests, imaging, procedures, and anesthesia was lower. The increase in E&M spending primarily reflects large increases to the payment rates for certain E&M services that were implemented in 2021, while changes in other service categories were driven by a combination of smaller changes in payment rates and reductions in service volume.

In 2021, payment rates paid by preferred provider organization health plans for clinician services were

134 percent of FFS Medicare's payment rates, down from 138 percent in 2020. Between 2017 and 2021, physicians' median all-payer compensation grew by an average of 3 percent per year. However, compensation remained much lower for primary care physicians than for most specialists—underscoring our long-standing concerns about the mispricing of physician fee schedule services and its impact on the number of physicians choosing to practice primary care.

Clinicians' input costs—as measured by the Medicare Economic Index (MEI)—grew by 2.6 percent in 2021 and are estimated to have grown by 4.7 percent in 2022, substantially higher than the recent historical norm of 1 percent to 2 percent growth per year. Growth in clinicians' input costs is projected to remain high in 2023 (3.9 percent) and 2024 (2.9 percent), though these projections are subject to change.

Update recommendation—Given the recent growth in inflation, cost increases could be difficult for clinicians to absorb. However, on the basis of our indicators, current payments to clinicians appear adequate. The Commission recommends that for calendar year 2024, the Congress update the 2023 Medicare base payment rate for physician and other health professional services by 50 percent of the projected increase in the MEI. Because clinicians' practice expenses account for about half of the MEI, this recommendation would help ensure that payment rates keep pace with the growth of clinicians' practice costs. Based on CMS's MEI projections at the time of publication, the recommended update for 2024 would be equivalent to 1.45 percent.

Recommendation on supporting Medicare safety-net clinicians—To promote adequate access to care for all Medicare beneficiaries, the Commission has determined that providing additional financial support for clinicians who furnish care to Medicare beneficiaries with low incomes is warranted. Clinicians often receive less revenue when treating low-income beneficiaries because of the way Medicare's cost-sharing policies interact with state Medicaid payment policies, which likely makes beneficiaries with low incomes less profitable to care for and could put some clinicians at financial risk. At the same time, low-income beneficiaries report having more difficulty accessing needed care than other beneficiaries. The Commission recommends that Medicare make targeted add-on payments of 15 percent to primary care clinicians and 5 percent to all other clinicians for physician fee schedule services provided to Medicare beneficiaries enrolled in the Part D low-income subsidy program.

Ambulatory surgical center services: Status report

Ambulatory surgical centers (ASCs) provide outpatient procedures to patients who do not require an overnight stay. As described in Chapter 5's status report, in 2021, the 6,075 ASCs certified by Medicare treated 3.3 million FFS Medicare beneficiaries. Medicare program and beneficiary spending on ASC services was about $5.7 billion.

The supply of ASCs and volume of services continued to grow in 2021. The number of ASCs grew 2.7 percent, and the volume of ASC surgical procedures per FFS beneficiary—after dropping substantially in 2020—climbed to above prepandemic levels. Numerous factors likely have contributed to this sector's growth, including changes in clinical practice and health care technology that have expanded the provision of surgical procedures in ambulatory settings. The most common service in ASCs, accounting for almost 19 percent of volume in 2021, was extracapsular cataract removal with intraocular lens insertion.

Most ASCs are for profit, and geographic distribution is uneven, with the vast majority located in urban areas and the concentration of ASCs varying widely across states. About 65 percent of ASCs that billed Medicare in 2021 specialized in a single clinical area, of which gastroenterology and ophthalmology were the most common. The remainder were multispecialty facilities, providing services in more than one clinical specialty. From 2016 to 2021, the ASC specialty that grew most rapidly was pain management.

Medicare spending per FFS beneficiary on ASC services rose at an average annual rate of 7.7 percent from 2016 through 2019 and at an average annual rate of 8.7 percent from 2019 to 2021. However, policymakers know little about the costs ASCs incur in treating beneficiaries because Medicare does not require ASCs to submit cost data, unlike its cost data requirements for other types of facilities. The Commission contends that ASCs could feasibly provide such information, and we have recommended since 2010 that the Congress require them to submit cost data.

Outpatient dialysis services

Outpatient dialysis services are used to treat the majority of individuals with end-stage renal disease (ESRD). In 2021, nearly 332,000 beneficiaries with ESRD on dialysis were covered under FFS Medicare and received dialysis from more than 7,800 dialysis facilities. In 2021, Medicare expenditures for outpatient dialysis services totaled $10.0 billion.

As described in Chapter 6, measures of the capacity and supply of outpatient dialysis providers, beneficiaries' ability to obtain care, and changes in the volume of services suggest that Medicare payments are adequate.

Beneficiaries' access to care—Dialysis facilities appear to have the capacity to meet demand. Between 2020 and 2021, the number of in-center treatment stations grew faster than the number of FFS and Medicare Advantage (MA) dialysis beneficiaries. A steep (20 percent) decline in FFS treatments in 2021 is largely due to the removal of the statutory provision that prevented most dialysis beneficiaries from enrolling in MA plans. Between January 2020 and December 2021, the share of dialysis beneficiaries enrolled in MA plans increased from 25 percent to roughly 40 percent. The effects of the pandemic's excess mortality also contributed to the decline in FFS treatments in 2021. An estimated 20 percent marginal profit in 2021 suggests that dialysis providers have a financial incentive to continue to serve Medicare beneficiaries.

Quality of care—FFS dialysis beneficiaries' rates of all-cause hospitalization and mortality increased somewhat between 2020 and 2021, while emergency department use remained steady. The share of beneficiaries dialyzing at home, which is associated with better patient satisfaction, continued to grow.

Providers' access to capital—Information from investment analysts suggests that access to capital for dialysis providers continues to be strong. The number of facilities, particularly for-profit facilities, continues to increase. The two largest dialysis organizations have grown through acquisitions of and mergers with midsize dialysis organizations.

Medicare payments and providers' costs—Medicare payment per treatment in freestanding dialysis facilities (which provide the vast majority of FFS dialysis treatments) grew by 0.9 percent while cost per treatment rose by 1.3 percent. Growth in costs was seen across all cost categories, with the exception of ESRD drugs. The aggregate Medicare margin fell from 2.7 percent in 2020 to 2.3 percent in 2021. (The aggregate margin in 2021 was 2.7 percent including provider-relief pandemic revenues.) We project that the 2023 aggregate Medicare margin will drop to −0.4 percent due to cost growth that we expect will exceed payment updates.

Recommendation—Under current law, the Medicare FFS base payment rate for dialysis services is projected to increase by 1.8 percent in 2024. Given that most of our indicators of payment adequacy are positive, the Commission recommends that, for 2024, the Congress update the calendar year 2023 ESRD PPS base rate by the amount determined under current law.

Skilled nursing facility services

Medicare covers short-term skilled nursing and rehabilitation services for beneficiaries in skilled nursing facilities (SNFs) after an inpatient hospital stay. In 2021, about 14,700 SNFs furnished about 1.7 million Medicare-covered stays to 1.2 million FFS beneficiaries (3.4 percent of Medicare's FFS beneficiaries). In that year, Medicare FFS spending on SNF services was $28.5 billion. Most SNFs are also certified as nursing homes, which furnish long-term care services not covered by Medicare.

In Chapter 7, we examine the adequacy of Medicare's SNF payments. The COVID-19 pandemic has had devastating effects on nursing facility residents and staff. However, owing to federal policies supporting SNFs during the coronavirus PHE and the implementation of Medicare's new case-mix system, SNFs' aggregate financial performance under Medicare was robust in 2021, despite occupancy that has been slow to rebound and ongoing staffing pressures.

Beneficiaries' access to care—Changes in the indicators of access in 2021 were mixed and reflect the impact of the coronavirus pandemic, not the adequacy of Medicare's payments. In 2021, 88 percent of beneficiaries lived in a county with three or more SNFs or swing bed facilities (rural hospitals with beds that can serve as either SNF beds or acute care beds), and nationwide, occupancy rates remain below prepandemic levels, indicating bed availability. However, staffing shortages may constrain capacity for some facilities. Continued waiver of coverage rules

during the PHE tempered the reductions in Medicare volume that began in March 2020. Nevertheless, between 2020 and 2021, Medicare-covered admissions per 1,000 FFS beneficiaries dropped 2.4 percent, while covered days per 1,000 FFS beneficiaries fell 3.7 percent as length of stay declined. Slow-to-return demand for SNF care is likely due, at least in part, to pandemic-related factors, including continued avoidance of the setting and mortality due to COVID-19 among the aged and disabled populations that would otherwise be receiving care in a nursing facility. Decreased volume was also due to the impact of the coronavirus pandemic, not the adequacy of Medicare payments. FFS Medicare remains a preferred payer for SNFs. In 2021, Medicare marginal profit (an indicator of whether SNFs have an incentive to treat more Medicare beneficiaries) averaged 26 percent for freestanding facilities. This profit is a strong positive indicator of beneficiary access to SNF care, though factors other than the level of payment (such as bed availability or staffing shortages) could challenge access.

Quality of care—In 2021, the mean facility risk-adjusted rate of successful discharge to the community from SNFs was 43.5 percent, and the mean facility risk-adjusted rate of hospitalizations was 13.1 percent. The pandemic and PHE-related policies confound our measurement and assessment of trends in our quality measures.

Providers' access to capital—The number of nursing facility transactions in 2021 was lower than it was before the coronavirus pandemic, reflecting a lack of sellers rather than a lack of investor interest. In 2021, the average price per bed increased to a near record level. In 2021, the all-payer total margin—reflecting all payers (including managed care, Medicaid, Medicare, and private insurers) and all lines of business (such as skilled and long-term care, hospice, ancillary services, home health care, and investment income)—was 3.4 percent, which was higher than recent prepandemic averages. The all-payer margin increased during the coronavirus pandemic because of funding that nursing homes received during the PHE and changes in Medicare and Medicaid payments. Without pandemic-related funds, the all-payer margin was –1.5 percent.

Medicare payments and providers' costs—Between 2020 and 2021, Medicare's aggregate FFS spending on SNF services increased 0.5 percent to $28.5 billion, despite fewer covered SNF days. Payments per day increased over 3 percent, while costs per day grew 4 percent. The Medicare margin for freestanding SNFs was 17.2 percent in 2021. Margins varied greatly across facilities, reflecting differences in costs per day, economies of scale, and cost growth. The 2021 Medicare margin for relatively efficient SNFs was 22 percent. We project an aggregate Medicare margin of 10 percent for 2023.

Recommendation—While the effects of the pandemic on beneficiaries and nursing home staff have been devastating, the combination of federal policies and the implementation of the new case-mix system resulted in improved financial performance for SNFs. Medicare's payments need to be reduced to more closely align aggregate payments with aggregate costs. The Commission recommends that, for fiscal year 2024, the Congress reduce the 2023 Medicare base payment rates for skilled nursing facilities by 3 percent.

Home health care services

Home health agencies (HHAs) provide services to beneficiaries who are homebound and need skilled nursing care or therapy. In 2021, about 3.0 million Medicare FFS beneficiaries received care, and the program spent $16.9 billion on home health care services. In that year, 11,474 HHAs participated in Medicare.

As described in Chapter 8, the indicators of Medicare payment adequacy for home health care are generally positive.

Beneficiaries' access to care—Access to home health care was adequate in 2021: Over 98 percent of Medicare beneficiaries lived in a ZIP code served by at least two HHAs. Between 2020 and 2021, the number of HHAs fell by 0.8 percent, continuing a slow decline that began in 2013, but at a lower rate than in prior years. This slower decline suggests that neither the coronavirus pandemic nor the major revisions to the home health PPS implemented in 2020 had a significant impact on HHA supply. In 2021, the number of FFS beneficiaries receiving home health care fell by 1.1 percent, and the number of 30-day periods declined by 2.9 percent. However, the overall number of beneficiaries enrolled in FFS also declined as more beneficiaries enrolled in Medicare Advantage. As a result, the number of 30-day periods per 100 FFS beneficiaries increased by almost

1 percent in 2021, and the share of FFS beneficiaries using home health care increased to 8.3 percent. The average number of in-person visits per 30-day period declined (by 4.7 percent), but some of the decline could have been offset by greater use of virtual visits through telehealth. In 2021, freestanding HHAs' marginal profit—that is, the rate at which Medicare payments exceed providers' marginal costs—was 26 percent, suggesting a significant financial incentive for freestanding HHAs with excess capacity to serve additional Medicare patients.

Quality of care—In 2021, the mean agency risk-adjusted rate of successful discharge to the community from HHAs was 52.2 percent, and the mean agency risk-adjusted rate of hospitalizations was 18.2 percent. The coronavirus pandemic and policies related to the PHE confound our assessment of trends in both quality measures. Further complicating assessment, the home health payment system now uses a shortened unit of payment (a 30-day unit rather than 60 days), which changes the period used in the postdischarge hospitalization measure.

Providers' access to capital—Access to capital is a less important indicator of Medicare payment adequacy for home health care because this sector is less capital intensive than other health care sectors. The major publicly traded for-profit home health companies had sufficient access to capital markets for their credit needs.

Medicare payments and providers' costs—In 2021, home health agencies' average cost per 30-day period decreased by 2.9 percent, in part reflecting a decline in the number of visits per 30-day period. As the number of visits per period declined, Medicare's payment per in-person visit increased by 17.7 percent. Medicare margins for freestanding agencies averaged 24.9 percent in 2021—a historic high—up from 20.2 percent in 2020 and 15.4 percent in 2019. These high margins indicate that the increase in payments in 2021 far exceeded the increase in costs. In aggregate, Medicare's payments have always been substantially more than costs under prospective payment: From 2001 to 2019, the Medicare margin for freestanding HHAs averaged 16.4 percent. The projected margin for 2023 is 17.0 percent, reflecting both a statutory reduction to the base payment rate of 3.5 percent in 2023 (required to maintain budget neutrality following recent changes to the home health payment system) and expected cost growth indicated by the Medicare home health market basket. However, this rate of inflation is high relative to past experience, so margins in 2023 could be higher.

Recommendation—Our review of payment adequacy for Medicare home health services indicates that access is more than adequate in most areas. Home health care can be a high-value benefit when it is appropriately and efficiently delivered. Medicare beneficiaries often prefer to receive care at home instead of in institutional settings, and home health care can be provided at lower costs than institutional care. However, Medicare's payments for home health services are too high, and these excess payments diminish the service's value as a substitute for more costly services. On the basis of these findings, the Commission recommends that, for calendar year 2024, the Congress should reduce the 2023 base rate by 7 percent.

Inpatient rehabilitation facility services

Inpatient rehabilitation facilities (IRFs) provide intensive rehabilitation services to patients after illness, injury, or surgery. Rehabilitation programs are supervised by rehabilitation physicians and include services such as physical and occupational therapy, rehabilitation nursing, speech–language pathology, and prosthetic and orthotic services. In 2021, Medicare spent $8.5 billion on 379,000 FFS IRF stays in about 1,180 IRFs nationwide.

As described in Chapter 9, most IRF payment adequacy indicators remained positive or improved.

Beneficiaries' access to care—Between 2020 and 2021, the number of IRFs and IRF beds slightly increased. The aggregate IRF occupancy rate was 68 percent, indicating that capacity is more than adequate to meet demand. From 2020 to 2021, Medicare cases per 10,000 FFS beneficiaries increased by about 4 percent. Marginal profit, an indicator of whether IRFs with excess capacity have an incentive to treat more Medicare beneficiaries, was 22 percent for hospital-based IRFs and 41 percent for freestanding IRFs—a very strong indicator of access.

Quality of care—In 2021, the mean facility risk-adjusted rate of successful discharge to the community from IRFs was 67.6 percent and the mean facility risk-adjusted rate of hospitalizations was 7.2 percent. The coronavirus pandemic and related policies confound

our measurement and assessment of trends in our quality measures.

***Providers' access to capital*—**Between 2020 and 2021, freestanding IRFs' all-payer total margin grew from 10.2 percent to 14.0 percent, and the largest IRF chain (which accounted for almost a third of all Medicare FFS IRF discharges) continued to open new IRFs and enter joint ventures with other organizations, suggesting strong access to capital. Hospital-based IRFs continued to have strong access to capital through their parent hospitals.

***Medicare payments and providers' costs*—**IRFs' Medicare margin increased to 17.0 percent in 2021, driven by slow cost growth. The Medicare margin for relatively efficient IRFs was even higher, at about 20 percent, as these IRFs were generally able to leverage greater economies of scale. We anticipate that the 2023 margin will decrease to 11 percent, driven in part by the expiration of PHE-related increases in Medicare payments to IRFs.

***Recommendation*—**Given our positive payment adequacy indicators, the Commission recommends that, for fiscal year 2024, the 2023 IRF base payment rate be reduced by 3 percent. This recommendation would continue to provide IRFs with sufficient revenues to maintain beneficiaries' access to IRF care while bringing IRF PPS payment rates closer to the cost of delivering high-quality care efficiently.

Hospice services

The Medicare hospice benefit covers palliative and support services for beneficiaries who are terminally ill with a life expectancy of six months or less if the illness runs its normal course. When beneficiaries elect to enroll in the Medicare hospice benefit, they agree to forgo Medicare coverage for conventional treatment of their terminal illness and related conditions. In 2021, more than 1.7 million Medicare beneficiaries (including almost half of decedents) received hospice services from 5,358 providers, and Medicare hospice expenditures totaled $23.1 billion.

As described in Chapter 10, the indicators of Medicare payment adequacy for hospice services are generally positive.

***Beneficiaries' access to care*—**In 2021, some measures of volume were stable while others declined. The declining measures appear to stem from the effects of changing death rates and patterns of care due to the coronavirus pandemic and are not a reflection of Medicare payment adequacy. In 2021, the number of hospice providers increased by about 6 percent as more for-profit hospices entered the market, a trend that has extended for more than a decade. Total deaths among Medicare beneficiaries increased sharply in 2020 and declined just 0.1 percent in 2021, while the number of Medicare decedents who used hospice declined 1.3 percent. The overall share of Medicare decedents using hospice services decreased slightly to 47.3 percent, but patterns of hospice use among decedents varied by beneficiary characteristics and grew among some groups. Among all beneficiaries (not limited to decedents), the number of beneficiaries who received hospice services and the number of hospice days furnished was stable. For decedents, average lifetime length of stay fell by almost 5 days in 2021 to 92.1 days, similar to the prepandemic level. Between 2020 and 2021, median length of stay declined slightly, from 18 days to 17 days. In 2020, Medicare payments to hospice providers exceeded marginal costs by 18 percent. This rate of marginal profit suggests that providers have a strong incentive to treat Medicare patients and is a positive indicator of patient access.

***Quality of care*—**Quality of care in 2021 is difficult to assess. While we report the most recent data from hospice patient experience and process measures, we have not used those results to inform our conclusions about trends in the quality of care provided to Medicare hospice beneficiaries and their relationship to Medicare payment adequacy. Scores on the Hospice Consumer Assessment of Healthcare Providers and Systems® were stable in the most recent period. Scores on a composite of seven processes of care at admission were generally topped out (meaning scores are so high and unvarying that meaningful distinctions and improvement in performance can no longer be made). The provision of in-person visits at the end of life was stable in 2021, after declining modestly in 2020 due to the coronavirus pandemic. CMS also launched a new claims-based quality measure, based on 10 indicators, that identifies outlier patterns of care among hospice providers.

***Providers' access to capital*—**Hospices are not as capital intensive as other provider types because they do not require extensive physical infrastructure. Continued growth in the number of for-profit providers (an

increase of over 8 percent in 2021) and reports of strong investor interest in the sector suggest that capital is available to these providers. Less is known about access to capital for nonprofit freestanding providers, for which capital may be more limited. Hospital-based and home health–based hospices have access to capital through their parent providers.

Medicare payments and providers' costs**—**Hospice margins are presented through 2020 because of the data lag required to calculate cap overpayment amounts. Between 2019 and 2020, average cost per day increased just 1.1 percent, which helped boost the 2020 Medicare aggregate margin to 14.2 percent, up from 13.4 percent in 2019. With Medicare's share of pandemic-related relief funds included, the estimated 2020 aggregate Medicare margin rises to about 16 percent. In 2021, growth in hospice cost per day increased 4.2 percent. We project an aggregate Medicare margin for hospices of about 8 percent in 2023.

In addition to indicators of hospice payment adequacy, Chapter 10 also assesses the hospice aggregate cap. The cap limits the aggregate payments a hospice provider can receive in a year and functions as a mechanism that reduces payments to hospices with long stays and high margins. We estimate that 18.6 percent of hospices exceeded the cap in 2020; the aggregate Medicare margin for these hospices was about 23 percent before and 8 percent after application of the cap.

Recommendation**—**Based on the generally positive indicators of payment adequacy and strong margins, the Commission concludes that a reduction in aggregate payments is warranted. However, in this sector, with the range of financial performance across hospice providers and the existence of the hospice aggregate cap, there is the potential to focus payment reductions on providers with disproportionately long stays and high margins. Therefore, the Commission recommends that the Congress wage adjust and reduce the hospice aggregate cap by 20 percent while maintaining the current-law update for fiscal year 2024. Under this recommendation, payments would increase for many hospice providers by an estimated 2.9 percent, while payments would be reduced for providers with very long lengths of stay and low costs relative to payments.

The Medicare Advantage program: Status report and mandated report on historical comparison of MA payments to FFS spending

The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than from the FFS Medicare program. As described in Chapter 11, in 2022, the MA program included 5,261 plan options offered by 182 organizations, enrolled about 29 million beneficiaries (49 percent of Medicare beneficiaries with both Part A and Part B coverage), and paid MA plans $403 billion (not including Part D drug plan payments). The Commission strongly supports the inclusion of private plans in the Medicare program. Beneficiaries should be able to choose among Medicare coverage options, as some may prefer to avoid the constraints of provider networks and utilization management by enrolling in the traditional FFS Medicare program, while others may prefer to seek the additional benefits and alternative delivery systems that private plans provide. Because Medicare pays private plans a predetermined rate—risk adjusted per enrollee—rather than a per service rate, plans should have greater incentives than FFS providers to deliver more efficient care.

The Commission remains concerned that the benefits from MA's lower cost relative to FFS spending are shared exclusively by the companies sponsoring MA plans (in the form of increased enrollment and revenues) and MA enrollees (in extra benefits). The taxpayers and FFS Medicare beneficiaries who help fund the MA program through Part B premiums do not realize any savings from MA plan efficiencies. Further, Part B premiums are higher for all beneficiaries than they otherwise would be, and Medicare spends 6 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates into a projected $27 billion in 2023. This amount would be even larger if the favorable selection of beneficiaries in MA plans were taken into account because beneficiaries who choose to enroll in an MA plan tend to be more profitable than beneficiaries who remain in FFS Medicare.

In 1985, payments to private plans were initially set at 95 percent of FFS payments because it was expected that plans would share savings from their efficiencies relative to FFS with taxpayers. But subsequent policies have explicitly elevated payments to MA above the

FFS equivalent and, in the aggregate, private plans have never been paid less than FFS Medicare. MA benchmarks are set above FFS in many markets in part to encourage more uniform plan participation across the country, and quality payments (which the Commission has found do not meaningfully reflect plan quality, from the perspective of enrollees or the Medicare program) further inflate MA payments above FFS. Moreover, MA plans' diagnostic coding practices inflate payments and undermine the goal of plans competing to improve quality and reduce costs. All of these factors lead to government subsidization of increasingly higher levels of extra benefits for MA enrollees. In addition, the Commission finds that the plan-submitted data about beneficiaries' health care encounters are incomplete—or, in the case of many extra benefits, nonexistent—which prevents policymakers from understanding enrollees' use of services and plan efficiencies and limits policymakers' ability to carry out program oversight.

As evidenced by rapid growth in enrollment, additional benefits (including lower plan cost sharing for basic Medicare benefits and reduced premiums for Part D coverage) are attractive to beneficiaries. Nevertheless, for many reasons, a major overhaul of MA policies is urgently needed. First, the use and value of the many supplemental benefits is unclear, and currently such benefits are well above their historical level. As a result, the Commission believes that payments can be reduced without substantial cuts to benefits (which would remain more generous than in the recent past). Second, the disparity between MA and FFS payment disadvantages beneficiaries who—due to medical reasons or personal preferences—do not want to enroll in MA plans that use tools like narrow networks or utilization management policies. Third, the payment-induced growth in MA will increasingly create challenges for setting benchmarks because beneficiaries remaining in FFS may be higher risk (and thus have higher spending) in ways that risk adjustment cannot adequately capture. Finally, because of Medicare's fiscal situation, any expansion of benefits, if desired by policymakers, should be done deliberately, with attention to their value, and in the most fiscally efficient manner. The Commission asserts that the current policy does not meet that standard. Therefore, over the past few years, the Commission has made several recommendations to improve the program. These recommendations call for the Congress and CMS to address coding intensity, replace the quality bonus program, establish more equitable benchmarks, and improve the completeness of encounter data.

Enrollment, plan offerings, and extra benefits— The MA program is quite robust, with growth in enrollment, increased plan offerings, and, for the seventh consecutive year, a historically high level of extra benefits. From 2018 to 2022, the share of eligible Medicare beneficiaries enrolled in MA rose by 3 percentage points per year, from 37 percent to 49 percent. It is likely that a majority of eligible Medicare beneficiaries will be enrolled in MA in 2023. In 2023, the average Medicare beneficiary has a choice of 41 plans (offered by an average of 8 organizations), and the average MA plan enrollee has access to over $2,350 in extra benefits annually that FFS enrollees cannot access without purchasing additional health insurance coverage or paying for the services on an out-of-pocket basis. The rebate amount, which finances extra benefits, has more than doubled since 2018 and, in 2023, accounts for 17 percent of payments to MA plans. At the same time, we do not have reliable information about the extent to which beneficiaries use or value these benefits.

Medicare payments to plans—In 2023, payments to MA plans—including the impact of coding intensity but ignoring any favorable selection—average an estimated 106 percent of projected FFS spending. In addition, MA benchmarks, which represent the maximum amount Medicare will pay an MA plan to provide Part A and Part B benefits, continue to be well above projected FFS spending levels. In 2023, MA benchmarks averaged an estimated 109 percent of projected FFS spending (including quality bonuses but not accounting for MA coding), 1 percentage point above the level in 2022.

The bids that MA plans submit to CMS suggest that plans continue to capitalize on their administrative flexibility and reduce their relative growth in health care costs year over year. Nearly all plans bid below the projected cost of FFS Medicare. For 2023, the average plan bid to provide Part A and Part B benefits was 17 percent less than FFS Medicare would be projected to spend for those enrollees under current payment policies, a record low.

Risk adjustment and coding intensity—Medicare payments to MA plans are specific to each enrollee, based on a plan's payment rate and the enrollee's risk score. Risk scores account for differences in expected

medical expenditures and are based in part on diagnoses that providers code. In FFS Medicare, most claims are paid using procedure codes, which offer little incentive for providers to record more diagnosis codes than necessary to justify providing a service. In contrast, MA plans have a financial incentive to ensure that their providers record all possible diagnoses because those diagnoses raise an enrollee's risk score and result in higher payments to the plan.

Our analysis of 2021 data shows that higher diagnosis coding intensity resulted in MA risk scores that were about 10.8 percent higher than scores for similar FFS beneficiaries. By law, CMS reduces MA risk scores across the board to make them more consistent with FFS coding; CMS has the authority to impose a larger reduction than the minimum required by law but has never done so. In 2021, the adjustment reduced MA risk scores by 5.9 percent. However, we estimate that MA risk scores were still about 4.9 percent higher than they would have been if MA enrollees had been treated in FFS Medicare. In 2021, those higher scores resulted in $17 billion in excess payments to MA plans, and we project that the amount will reach $23 billion in 2023 (if MA coding remains the same as in 2021). We continue to find that coding intensity varies significantly across MA plans and that increasing diagnostic coding allows some plans to offer more extra benefits, thereby attracting more enrollees and undermining plan incentives to improve quality and reduce costs.

The Commission previously recommended changes to MA risk adjustment that would exclude diagnoses collected from health risk assessments (which rely on unverified enrollee-reported data), use two years of diagnostic data, and apply an adjustment to eliminate any residual impact of coding intensity. We find that nearly two-thirds of MA coding intensity could be due to use of diagnoses from chart reviews and health risk assessments, and that these two mechanisms are a primary factor driving coding differences among MA plans.

Quality in MA—The current state of quality reporting in MA is such that the Commission can no longer provide an accurate description of MA quality of care. Beneficiaries lack good information on the quality of care provided by MA plans in their local market, limiting their ability to make informed choices among plans. Further, the 49 percent of eligible Medicare beneficiaries enrolled in MA do not know how their plan's quality compares with quality in FFS Medicare. MA and FFS quality comparisons are also necessary for policymakers to evaluate the quality of care that beneficiaries receive in all sectors. In our June 2020 report, the Commission recommended replacing the current quality bonus program, which is not achieving its intended purposes and is costly to Medicare, with a new value incentive program for MA.

The academic community has devoted growing attention to assessing MA quality and making comparisons with FFS. Notwithstanding the methodological and data issues that are present in many studies, that literature suggests that MA plans likely improve performance on some process measures. Findings are sufficiently mixed on patient experience and outcomes that the Commission cannot conclude that MA plans systematically provide better (or worse) quality compared with traditional FFS Medicare.

Mandated report: Historical comparison shows MA payments were consistently above FFS spending

The Consolidated Appropriations Act, 2023, mandated that the Commission submit a report by March 15, 2023, that compares MA and FFS per enrollee spending for at least the last five years for which data are available. The Act requests that the Commission's analysis use the FFS spending method used to calculate MA benchmarks and compare MA payments with beneficiaries enrolled in both Part A and Part B. In Chapter 11, we use our long-standing prospective method of comparing MA payments with FFS spending from 2004 through 2023 and supplement this analysis with a retrospective method using the available data on actual MA payments and FFS spending (both claims and nonclaims payments) from 2016 through 2019. Our prospective and retrospective methods yielded very similar results: Both found that MA payments were higher than FFS spending from 2016 through 2019. We note, however, that the retrospective and prospective methods likely would not yield similar results when estimating MA payments and FFS spending for 2020 because CMS's projection of FFS spending and MA bid and risk score projections were overestimated during the first year of the coronavirus pandemic. We will continue to update our retrospective comparison of MA payments relative to FFS spending as more recent data become available.

The Medicare prescription drug program (Part D): Status report

As described in Chapter 12, in 2022, Part D paid for outpatient drug coverage on behalf of nearly 50 million Medicare beneficiaries. For Part D plan enrollees, Medicare subsidizes about three-quarters of the cost of basic benefits. Part D also includes a low-income subsidy (LIS) that provides assistance with premiums and cost sharing for more than 13 million individuals with low income and assets.

In 2021, Part D program expenditures totaled $110.8 billion, accounting for about 13 percent of Medicare spending. Of that amount, enrollees paid $14.9 billion in premiums for basic benefits. Medicare spending for the LIS totaled $35.1 billion: $31.3 billion for cost sharing and $3.8 billion for premiums. Beyond program spending, Part D plan enrollees paid $17.9 billion in cost sharing and $7.5 billion in premiums for enhanced benefits.

Since its inception in 2006, Part D has changed in important ways. Part D enrollees have greatly expanded their use of generics, while a relatively small share of prescriptions for high-cost biologics and specialty medications account for a mounting share of spending. A growing share of Medicare's payments have taken the form of cost-based reimbursements to plans through Medicare's reinsurance. As a result, the financial risk that plans bear, as well as their incentives to control costs, has declined markedly. In 2020, the Commission recommended major changes to the Part D benefit design and Medicare's subsidies in order to restore the role of risk-based, capitated payments that was present at the start of the program. In 2022, the Congress passed the Inflation Reduction Act (IRA), which included numerous policies related to prescription drugs; one such provision is a redesign of the Part D benefit with many similarities to the Commission's recommended changes. The changes adopted in the IRA will be implemented over the next several years and are likely to alter the drug-pricing landscape.

About 300 organizations operate Part D plans, but most beneficiaries are enrolled in plans sponsored by a handful of large health insurers. Most of the largest sponsors have their own pharmacy benefit managers (PBMs) that operate mail-order and specialty pharmacies. Formularies (a plan's list of covered drugs) remain plan sponsors' most important tool for managing drug benefits. In Part D, plans and their PBMs reduce benefit costs with postsale rebates and discounts. Generally, pharmaceutical manufacturers pay larger rebates to a sponsor when the sponsor positions a drug on its formulary in a way that increases the likelihood of winning market share over competing drugs. Plan sponsors also use provisions in network contracts with pharmacies that require postsale recoupments or payments for meeting performance metrics. These rebates and pharmacy fees have grown as a share of Part D spending. Going forward, changes in CMS's program rules and changes resulting from the IRA may affect the magnitude of rebates and pharmacy fees.

Enrollment in 2022 and benefit offerings for 2023— In 2022, 77 percent of Medicare beneficiaries were enrolled in Part D plans. An additional 2 percent obtained drug coverage through employer-sponsored plans that received Medicare's retiree drug subsidy. We estimate that among the remaining beneficiaries, just under 10 percent had creditable drug coverage from other sources and less than 12 percent had no coverage or coverage less generous than Part D.

Enrollment in stand-alone prescription drug plans (PDPs) peaked in 2019 at 25.5 million (56 percent of total plan enrollment) but fell to 23.3 million in 2022 (47 percent). Enrollment in Medicare Advantage–Prescription Drug plans (MA–PDs) surpassed enrollment in PDPs for the first time in 2021 and reached 26.5 million in 2022. In 2022, LIS enrollees made up 27 percent of total enrollment compared with 28 percent in 2018.

For 2023, beneficiaries continue to have a broad choice of plans. Plan sponsors offered 3,539 general MA–PDs and 1,254 MA–PDs tailored to specific populations (special needs plans)—5 percent and 11 percent more, respectively, than in 2022. In 2023, plan sponsors are offering 804 PDPs, nearly 5 percent more than the previous year.

For 2023, the base beneficiary premium declined by 2 percent from 2022 to $32.74, reflecting a small decrease in the total average estimated cost for basic benefits after taking postsale rebates and discounts into account. However, individual plans' premiums vary substantially, with PDPs typically having higher premiums than MA–PDs. In 2023, 191 PDPs, roughly

one-quarter of all PDPs, are available premium free to enrollees who receive the LIS, and all regions have at least three premium-free PDPs for LIS enrollees. Most Part D plans use a five-tier formulary with differential cost sharing between preferred and nonpreferred drugs, as well as a specialty tier for high-cost drugs. For 2023, nearly half of all plans had intended to participate in the Senior Savings Model that covers certain insulins at no more than $35 for each prescription of a month's supply. Subsequently, the IRA—passed after plan bids for 2023 had already been submitted—required all Part D plans to provide such a benefit for covered insulin products in 2023.

Part D program spending—In 2021, Medicare program spending on Part D (excluding the $14.9 billion in premiums paid by enrollees) totaled $95.9 billion, up from $93.0 billion in 2020 (an increase of 3 percent). Enrollees whose spending reaches the benefit's catastrophic phase increasingly drive program spending. Medicare's reinsurance (which covers 80 percent of spending in the catastrophic phase of the benefit after rebates) continued to be the largest and fastest-growing component of program spending, totaling $52.4 billion, or about 55 percent of the total. The value of the average basic benefit that is paid to plans through the capitated direct subsidy has plummeted in recent years. In 2023, direct subsidy payments average less than $2 per member per month, compared with payments of nearly $94 per member per month for reinsurance.

Growth in drug prices—In 2021, growth in drug prices accelerated, approaching rates observed before the pandemic. Prices of generic drugs declined, which helped moderate overall price growth. However, generics' share of prescriptions has plateaued at about 90 percent since 2017, and further opportunities for generic substitution may be limited, given the shift in the drug development pipeline toward biologics with longer periods of market exclusivity. Inflation in prices for brand-name drugs and biologics will likely continue to drive spending upward unless the program can achieve meaningful savings from the successful launch of biosimilars and their adoption by prescribers and beneficiaries. In 2021, about 464,000 enrollees filled a prescription that, by itself, was sufficiently expensive to meet the out-of-pocket threshold, up from just 33,000 enrollees in 2010.

Beneficiary access and quality in Part D—According to the 2020 Medicare Current Beneficiary Survey, which is the latest available, 79 percent of Part D enrollees reported overall satisfaction with the program. While satisfaction was quite high regarding the amount paid for drugs, coverage, and participating pharmacies, beneficiaries were less satisfied with their ability to understand the program and the information they received, and 27 percent were not confident their coverage met their needs. Overall, 25 percent of enrollees reported problems with affordability, including 14 percent who did not take their medicine as prescribed because of cost. Although it has long been believed that premiums are paramount among the factors beneficiaries consider when choosing their plan, in 2020, more beneficiaries (30 percent) reported considering their out-of-pocket costs than premiums (26 percent).

The quality of prescription drug care requires a balance between beneficiary access and medication management. For many conditions, effective treatment may hinge primarily on access and adherence to prescription medicines. For this reason, Medicare evaluates Part D plan formularies and network pharmacies. However, one concern is that among beneficiaries without the LIS, high cost sharing for expensive therapies can be a barrier to access. At the same time, Medicare beneficiaries take an average of nearly five prescription drugs and are at higher risk for adverse drug events associated with polypharmacy. Thus, it is also critically important that Part D plans help to manage medication therapies.

By law, Part D plans are required to carry out medication therapy management (MTM) programs and programs to manage opioid use. Between 2017 and 2021, CMS tested an Enhanced MTM model to see if new payment incentives and regulatory flexibilities would spur PDPs to improve their MTM interventions and reduce Medicare spending. Although an evaluation of the entire five-year demonstration is not yet complete, over the first four years, CMS found no significant reductions in Medicare spending for Part A and Part B services, a net increase in Medicare spending after accounting for model payments, and mixed effects on quality measures. ■