CHAPTER 2

Assessing payment adequacy and updating payments in fee-for-service Medicare

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Chapter summary

As required by law, the Commission annually makes payment update recommendations for providers paid under Medicare's traditional fee-for-service (FFS) payment systems. An update is the amount (usually expressed as a percentage change) by which the base payment to all providers in a payment system is changed relative to the prior year. To determine an update recommendation, we estimate the adequacy of FFS Medicare payments to providers in the current year (2024), 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 FFS payments will support access to high-quality care and the efficient delivery of services, consistent with our statutory mandate. We then make a recommendation about what, if any, update to payments is needed in the policy year in question (for this report, 2025) to efficiently support beneficiaries' access to high-quality services. This year, we consider the adequacy of payments in FFS payment systems for the following sectors: acute care hospitals, physician and other health professional services, outpatient dialysis services, skilled nursing facilities, home health care services, inpatient rehabilitation facility services, and hospice services.

In this chapter

- The Commission's principles for assessing payment adequacy
- Payment adequacy analytic framework
- Anticipated payment and cost changes in 2024
- Recommendations for FFS Medicare payment in 2025

Our goal is to identify the base payment rate for each sector that will ensure both beneficiary access and good stewardship of taxpayer resources. We apply consistent criteria across settings, but because data availability, conditions at baseline, and forthcoming changes between baseline and the policy year may vary, the exact criteria used for each sector and our recommended updates vary. We use the best available data to examine indicators of payment adequacy and reevaluate any assumptions from prior years to make sure our recommendations for 2025 accurately reflect current conditions. Because of standard data lags, the most recent complete data we have are generally from 2022. We use preliminary data from 2023 when available.

In considering updates to FFS payment rates, we may make recommendations that address specific concerns with the payment systems, such as biases that may make treating patients with certain conditions or in certain areas 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 where we deem necessary.

The recommendations in this report, if adopted, could significantly change the revenues that providers receive from Medicare. Ideally, payment rates will be set to support access to high-quality care provided by relatively efficient providers—that is, those with lower costs and higher quality—and will help induce all providers to control their costs and improve quality, thereby helping the Medicare program get more value for its spending. Further, while our intent is to set payment rates that support FFS beneficiaries' access to care, the Commission acknowledges that FFS Medicare rates have broader implications for health care spending because they are used in setting payments for other federal and state government programs and private health insurance. Thus, maintaining fiscal pressure on health care providers through payment rate updates can not only benefit the Medicare program, it can also affect spending growth across the health care system.

This chapter introduces our approach to analyzing payment adequacy and making payment update recommendations in FFS Medicare. The Commission also assesses Medicare payment systems for Part C (Medicare Advantage) and Part D (outpatient prescription drug coverage) in the March report each year and makes recommendations as appropriate. Part C and Part D, however, are outside the scope of this chapter. ■

Background

The Commission's goal for Medicare payment policy is to support beneficiary access to high-quality care while obtaining good value for the program's expenditures, which entails encouraging the efficient use of resources funded through taxes and beneficiary premiums. Appropriate payment begins with base payment rates that reflect the costs of efficiently delivering care to the average beneficiary, followed by adequate adjustments for differences in cost due to market-, service-, and patient-level variations. Payment policy can also be a mechanism for encouraging improvements in quality of care, ensuring access for beneficiaries, and pursuing other policy objectives such as ensuring program integrity.

Per statute, the Commission annually undertakes a systematic assessment of payment in sectors that provide services to Medicare beneficiaries.[1] We consider recommendations in seven fee-for-service (FFS) payment systems: acute care hospitals, physicians and other health professional services, outpatient dialysis facilities, skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and hospice providers. Our annual analysis leads to recommendations for updates to FFS Medicare payments in the upcoming year (this year, for 2025). For each sector, we analyze the most recent available data (2022 in most cases) on beneficiary access and quality of care, provider margins and access to capital, and other contextual factors to determine the adequacy of FFS Medicare payment rates. We then consider forthcoming policy and anticipated cost changes to project FFS Medicare payments and provider costs for 2024. Finally, we recommend how FFS Medicare payments for a given sector in aggregate should change for 2025. For each sector, the recommendation is a positive, negative, or zero update relative to current law.

Policy proposals with implications for provider cost and revenue are often being discussed at the same time as we make our recommendations. However, we do not speculate on whether these policies will be adopted, and our recommendations reflect current law only. The Commission updates its payment recommendations annually, and we reflect statutory changes in future assessments of Medicare payments.

Beyond questions of payment updates, we consider how payment rates may affect providers' ability to serve Medicare beneficiaries based on geographic, demographic, and other characteristics. We contemplate whether payment adjustments are necessary to address disparities in access, incentivize quality of care, or otherwise equitably distribute FFS payments across providers in a sector. Recommendations for redistribution across providers are independent of the general payment update. We also make recommendations to improve program integrity when needed. In some cases, our analyses reveal problematic variation in service utilization across geographic regions or providers, and we recommend the introduction or phase-out of payment adjustments to support equitable access to care for beneficiaries and payments to providers in all areas.

We compare our update and other policy recommendations for 2025 with the base FFS Medicare payment rates specified in law to understand the implications for beneficiaries, providers, and the Medicare program. This chapter details our analytic framework for assessing payment adequacy, as well as our principles underlying that framework.

Recent policy changes and environmental context

In any year, factors unrelated to the adequacy of FFS Medicare's payment rates can affect indicators of access to care, quality of care, access to capital, and Medicare payments and providers' costs in the settings where Medicare beneficiaries seek care. The previous chapter discussed the wider health care landscape and policy context. Here, we discuss how that context shapes our payment adequacy analysis.

The public health emergency (PHE) related to the coronavirus pandemic officially expired on May 11, 2023. For the past several years, the direct and indirect effects of the pandemic on beneficiaries, PHE-related policy changes, and emergency funding for providers have made it difficult to interpret some of our indicators of the adequacy of Medicare's payment rates. The Commission recognizes that the coronavirus pandemic has had tragic effects on beneficiaries, as well as damaging impacts on the nation's health care workforce, as clinicians and other health care workers have faced burnout and risks to their health and safety.

TABLE 2–1

Status of pandemic-related Medicare policy changes

Setting	Temporary change	Current status
Hospital	Provided a 20 percent Medicare IPPS add-on payment for discharges with a principal or secondary diagnosis of COVID-19.	Ended with PHE on May 11, 2023.
	Provided an enhanced IPPS payment for eligible inpatient cases that use certain new products authorized or approved to treat COVID-19, effective November 2, 2020.	Expired at the end of FY 2023.
Physicians and clinicians	Added more than 140 new PFS services to the telehealth list.	Some of these services will continue to be covered under Medicare through December 31, 2024.
	Permits clinicians to provide telehealth services regardless of the beneficiary's location.	In effect until December 31, 2024.
	Waived requirements that physicians and NPPs be licensed in the state where they are providing services for individuals who meet certain conditions.	As state PHE orders ended, some states discontinued cross-state licensing waivers. Other states have enacted legislation to make the waivers permanent or extend them for a specified period of time.
Inpatient rehabilitation facilities	Permitted telehealth to fulfill the face-to-face visit and supervision requirements.	Ended with PHE on May 11, 2023.
	Waived the 3-hour rule, which is intended to ensure that patients require an intensive rehabilitation program generally consisting of 3 hours of therapy at least 5 days per week.	Ended with PHE on May 11, 2023.
	Permitted exclusion of patient stays resulting from the PHE for purposes of calculating the applicable thresholds associated with the 60 percent rule.	Ended with PHE on May 11, 2023.
Hospice	Allows the use of telecommunications technology by the hospice physician or NP for the face-to-face visit when such visit is solely for the purpose of recertifying a patient for hospice services.	In effect until December 31, 2024.

Note: IPPS (inpatient prospective payment systems), PHE (public health emergency), FY (fiscal year), PFS (physician fee schedule), NPP (nonphysician practitioner), NP (nurse practitioner). This list of temporary PHE-related Medicare policies is not exhaustive, and it reflects policy as of January 2024. For a comprehensive list of PHE policy changes, see Podulka and Blum (2020). Changes specific to individual sectors and their effects on our payment adequacy indicators are discussed in more detail in each chapter of this report.

Source: Centers for Medicare & Medicaid Services (2020), Podulka and Blum (2020).

In our analysis of each sector, we have identified conceptually and, where possible, empirically how our payment adequacy indicators have been affected by the pandemic, PHE-related policies, and the expiration of those policies. Most of our analyses rely on lagged data and therefore continue to be affected by the pandemic both directly and through policy changes. Where PHE-related policy changes impact our assessment of payment adequacy in a particular sector, our methods for evaluating that impact

are detailed in the relevant chapter of this report. Table 2-1 summarizes an illustrative set of relevant policies. While our most recent measures of payment adequacy indicate that the most pronounced effects of the pandemic have passed, we continue to monitor the health care landscape for further impacts of the pandemic on access, quality, and costs.

However, certain changes in practice patterns in response to the pandemic may prove to be long lasting. For instance, in 2020 and 2021, we saw an increase in the use of telehealth, which initially expanded as an alternative to face-to-face appointments (Medicare Payment Advisory Commission 2023a). In our annual focus groups, beneficiaries and clinicians reported general satisfaction with telehealth visits. The Congress has extended many of Medicare's telehealth expansions beyond the PHE, through December 31, 2024. We addressed the temporary telehealth expansions in our March 2021 and June 2023 reports, noting that any permanent policy changes should consider implications for access, quality, and cost (Medicare Payment Advisory Commission 2023a, Medicare Payment Advisory Commission 2021b). As telehealth claims outside the context of the PHE become available for analysis, we will continue to monitor the impacts of the temporary telehealth expansions.

Macroeconomic trends in the wake of the pandemic, including inflation exceeding market basket updates, rising interest rates, and high labor and supply costs, have implications for the financial health of providers. Broader payment policy changes have added to financial pressures, such as the reinstatement of the full 2 percent sequestration on Medicare payments on July 1, 2022, and declining uncompensated care payments to hospitals. As a result, some of our analyses this year indicate that current-law payment updates may not be adequate for relatively efficient providers in some sectors to furnish high-quality care.

In 2023, for the first time, more than half of eligible Medicare beneficiaries were enrolled in a Medicare Advantage (MA) plan. It is not yet clear to what extent this increasing share in MA will impact the provision of care to FFS Medicare beneficiaries. Chapter 12 of this report presents our assessment of the MA program this year. Here, we focus on our approach to FFS payment adequacy.

The Commission's principles for assessing payment adequacy

The Commission has long maintained that Medicare should institute policies that improve the program's value to beneficiaries and taxpayers. Historically, FFS Medicare policies created strong incentives to increase the volume of services without regard to their value, and disincentives for providers to work together toward common goals. The introduction of new prospective payment systems, alternative payment models like accountable care organizations, and pay-for-performance programs has shifted provider incentives toward the provision of high-value, coordinated care, yet disjointed, inefficient, and low-value care remain a concern.

Payment rates should be sufficient to provide high-quality care for beneficiaries but not exceed the level necessary to do so. We assess the adequacy of FFS Medicare payments for relatively efficient providers. Efficiency is greater if the same inputs are used to produce a higher-quality output, or if fewer inputs are used to produce an output of the same quality. The Commission judges the extent to which payment rates are adequate for relatively efficient providers to achieve high value. Thus our recommendations may indicate an increase, decrease, or no change in payment rates relative to the updates specified in current law.

The Commission is also committed to the accuracy of payments, which might lead us to make recommendations that redistribute payments within or across sectors. These recommendations, which may be budget neutral or involve additional funds, aim to better target FFS Medicare payments. For instance, in 2020, the Commission recommended that CMS replace existing adjustments in the end-stage renal disease prospective payment system (PPS) for low-volume and rural facilities with a single payment adjustment that would direct additional payments to dialysis facilities that are isolated and have low volume. Last year, we recommended that current disproportionate share hospital and uncompensated care payments be redistributed using the Commission-developed Medicare Safety-Net Index, and that additional funding for Medicare safety-net payments

should be authorized to support hospitals that are key sources of care for low-income Medicare beneficiaries (Medicare Payment Advisory Commission 2023b). Our 2018 recommendation to shift payment weights in the skilled nursing facility (SNF) PPS would increase payments for medically complex patients and decrease payments for patients receiving rehabilitation therapy unrelated to their care needs (Medicare Payment Advisory Commission 2018b).

Finally, we note that our primary concern is the appropriateness of FFS Medicare payments, not the adequacy of payments across payers. We situate our analysis in the wider health care and economic context, but we do not seek to set FFS Medicare payments based on over- or underpayments by other payers.

Payment adequacy analytic framework

The Commission bases its payment update recommendations on an assessment of the adequacy of current FFS Medicare payments, alongside forthcoming changes to health care policy and the wider economic landscape. For each sector, we make a judgment by examining indicators of the following: beneficiaries' access to care, quality of care, providers' access to capital, and FFS Medicare payments and providers' costs. The direct relevance, availability, and quality of each type of information vary among sectors, and no single measure provides all the information needed for the Commission to judge payment adequacy. We use a combination of administrative data, surveys, and other sources to inform our assessments, aiming to incorporate as many high-quality data sources as possible. Figure 2-1 illustrates our payment adequacy framework, including examples of the types of indicators used for each sector (as available and applicable).

Beneficiaries' access to care

Access to care is an important indicator of providers' willingness to serve Medicare beneficiaries and the adequacy of Medicare payments. Poor access could indicate that Medicare payments are too low. However, factors unrelated to Medicare's payment policies may also affect access to care, such as coverage policies, changes in the delivery of health care services, beneficiaries' preferences, local market conditions, and supplemental insurance. The measures we use to assess beneficiaries' access to care depend on the availability and relevance of information in each sector. Broadly speaking, we consider provider capacity and staffing, service volume, and FFS Medicare margins as measures of access. Much of our analysis uses claims and other administrative data, but we also use results from several surveys to assess the willingness of physicians and other health professionals to serve beneficiaries and beneficiaries' ability to access physician and other health professional services when needed.

Provider capacity, supply, and staffing

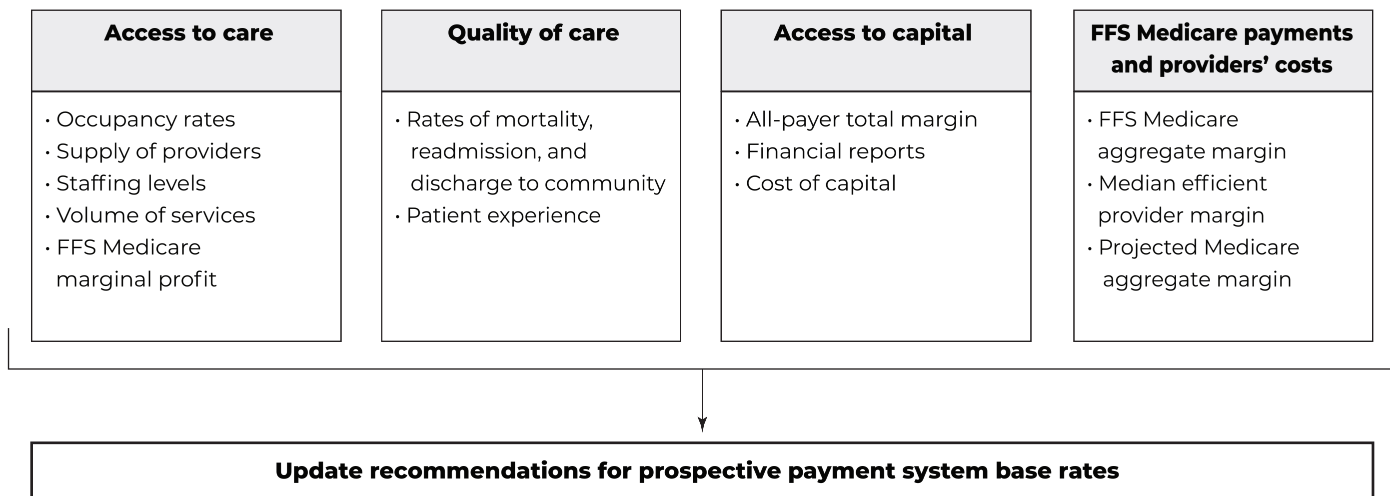
Beneficiary access to care depends in part on providers' ability to meet demand with current supply. Provider shortages, long wait times, and difficulty maintaining staffing levels can indicate inadequate payment rates. Rapid entry into a sector, however, may indicate that payments are more than adequate to cover providers' costs and could raise concerns about the value of the services furnished. Technological changes are also a factor in that they can increase capacity in ways that reduce costs. For example, as a surgical procedure becomes less invasive, it might be more frequently performed in lower-cost outpatient settings, freeing up some inpatient hospital capacity. Likewise, as the prices of new technologies fall, providers can more easily purchase them, increasing the capacity to provide certain services.

We have observed that providers have modulated excess capacity in response to payment policy changes. For example, in 2016, many long-term care hospitals (LTCHs) closed following a significant reduction in Medicare payment rates for certain cases. However, the closures occurred primarily in market areas with multiple LTCHs, indicating that closures were a result of excess capacity rather than a cause of access issues. But provider capacity is not always a clear indicator of payment adequacy. For instance, if FFS Medicare is not the dominant payer for a given provider type (e.g., ambulatory surgical centers), changes in the number of providers may be influenced more by other payers and their enrollees' demand for services and less indicative of the adequacy of FFS Medicare payments.

The PHE had both positive and negative impacts on provider capacity and supply. On the one hand, waivers

FIGURE 2–1

The Commission's framework for assessing FFS Medicare payment adequacy



Note: FFS (fee-for-service). We use multiple measures of margins in our payment adequacy analysis for different purposes. We define "FFS Medicare marginal profit" as ((FFS Medicare payment – costs that vary with volume) / FFS Medicare payment). This marginal profit is an indicator of beneficiary access to care. The "all-payer total margin," defined as ((payments from all payers and sources – cost of providing services) / payments from all payers and sources), is a measure of a sector's access to capital. "FFS Medicare aggregate margin," defined as ((FFS Medicare payments for service – cost of providing service) / FFS Medicare payment for the service), is a sector-wide measure of the relationship between FFS Medicare's payments and providers' costs for services.

Source: MedPAC.

of payment rules, expansion of telehealth access, and supplemental payments supported the expansion of supply in some areas. On the other hand, critical staffing shortages constrained supply, including the ability to use existing infrastructure, in others. Changes in the capacity and supply of providers during the acute phase of the pandemic were not uniform and did not necessarily indicate inadequate FFS Medicare base payment rates. As post-PHE data become available, we will continue to monitor provider capacity, supply, and staffing, including any long-term changes resulting from pandemic policy or practice patterns.

Volume of services

The Commission analyzes the volume of services provided to FFS beneficiaries as another indicator of access. A stable or increasing volume of services relative to the number of beneficiaries indicates adequate access to services and, by extension, payment. However, it does not necessarily demonstrate that those services are necessary or appropriate. A more rapid increase in volume relative to the number of beneficiaries could suggest that FFS Medicare's payment rates are too high. By contrast, reductions in the volume of services can sometimes be a signal that revenues are inadequate for providers to continue operating or to provide the same level of service. In sectors whose services can be substituted for one another, changes in volume by site of service may suggest distortions in payment and raise questions about payment equity.

However, changes in the volume of services are not direct indicators of access; increases and decreases can be explained by other factors such as population changes, changes in disease prevalence among beneficiaries, dissemination of new and improved medical knowledge and technology, deliberate policy interventions, and beneficiaries' preferences. An increase in aggregate volume, for instance, could be attributable either to an increase in services

per beneficiary or an increase in the number of beneficiaries. We analyze per beneficiary service use as well as the total volume of services to isolate these effects.

FFS Medicare marginal profit

Another factor we consider when evaluating access to care is whether providers have a financial incentive to expand the number of FFS Medicare beneficiaries they serve. In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (e.g., the FFS Medicare payment) with its marginal costs. That is to say, the FFS Medicare marginal profit reflects the costs to treat Medicare beneficiaries that vary with volume in the short term. If FFS Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider with excess capacity has a financial incentive to increase its volume of FFS Medicare patients. In contrast, if payments do not cover the marginal costs, the provider may have a disincentive to care for FFS Medicare beneficiaries.

Quality of care

The relationship between quality of care and the adequacy of Medicare payment is not direct. Simply increasing payments through an update for all providers in a sector is unlikely to influence the overall quality of care that beneficiaries receive because there is no imperative for providers to devote the additional revenue to actions that are known to improve quality. Thus, within our framework, we consider whether changes in Medicare's rates would meaningfully affect the quality of care that beneficiaries receive in a particular sector. Indeed, historically, FFS Medicare payment systems created little or no incentive for providers to spend additional resources on improving quality. Over the past decade or more, the Medicare program has implemented quality reporting programs for almost all major FFS provider types and several pay-for-performance programs that tie FFS payment to a provider's performance on quality standards. Throughout the years, there has been a proliferation of measures developed and used in public and private quality programs, which has caused confusion and increased reporting burden. The Commission is concerned that many of these measures focus on processes that are not associated with meaningful outcomes for beneficiaries.

In our June 2018 report to the Congress, we formalized principles for designing Medicare quality incentive programs that address these issues (Medicare Payment Advisory Commission 2018a). In 2019, we applied these principles to recommend a hospital value incentive program that scores a small set of outcome, patient experience, and cost measures (Medicare Payment Advisory Commission 2019). In 2021, we made related recommendations for Medicare to eliminate the current SNF value-based purchasing program and to establish a new SNF value incentive program (Medicare Payment Advisory Commission 2021a).

Providers' access to capital

Providers must have access to capital to maintain and modernize their facilities and to improve patient care delivery. One indicator of a sector's access to capital is its all-payer profitability, reflecting income from all sources. We refer to this amount as the sector's all-payer margin, which is calculated as aggregate income, minus costs, divided by income. All-payer margins can inform our assessment of a sector's overall financial condition and hence its access to capital.

Widespread ability to access capital throughout a sector may reflect the adequacy of Medicare payments, but it is more indicative in some sectors than others. For instance, hospitals require large capital investments, and the ability to finance those investments can indicate the adequacy of payment. Other sectors, such as home health care, are not as capital intensive, so access to capital is a more limited indicator. When FFS Medicare represents a relatively small share of a sector's volume, access to capital is a similarly weak indicator of Medicare payment adequacy. In recent years, access to capital may be more reflective of turbulent credit markets or other macroeconomic phenomena. A fuller discussion of the impact of financial markets on health care providers can be found in this year's hospital chapter (Chapter 3).

FFS Medicare payments and providers' costs

While we do consider all-payer margins as an indicator of providers' financial health, we assess the adequacy of FFS Medicare payments relative to the costs of treating FFS beneficiaries, and the Commission's recommendations address a sector's FFS Medicare payments, not total payments. For providers that

submit cost reports to CMS—acute care hospitals, SNFs, home health agencies, outpatient dialysis facilities, inpatient rehabilitation facilities (IRFs), and hospices—we estimate total Medicare-allowable costs and assess the relationship between FFS Medicare's payments and those costs. This report uses data from 2022 (2021 for hospices, due to data lags).

The coronavirus pandemic and PHE-related policy changes affected FFS Medicare payments and providers' costs from 2020 until the expiration of the PHE in May 2023.[2] However, relief funds are not counted as Medicare revenue because they are not specifically tied to FFS Medicare payments per case. As a result, FFS Medicare margins in those years could appear lower than they would, all else equal, if relief fund revenue were considered Medicare payment. In contrast, supplemental payments or policies to waive Medicare's payment rules may have subsidized providers that would have otherwise exited the market. In our analysis of FFS Medicare payments, we calculate a FFS Medicare aggregate margin exclusive of PHE relief funds (assuming all else equal), as well as a FFS Medicare aggregate margin inclusive of relief funds. To make this latter calculation, for most sectors, we allocated to FFS Medicare payments a portion of relief funds received by a provider, using measures of Medicare's market share in 2019 (such as the ratio of FFS Medicare to all-payer revenue).

Use of FFS Medicare aggregate margins

We typically express the relationship between payments and costs as a FFS Medicare aggregate margin, which is calculated as aggregate FFS Medicare payments for a sector, minus costs, divided by FFS Medicare payments.[3] Margins will always be distributed around the average, and a judgment of payment adequacy does not mean that every provider has a positive FFS Medicare margin. To assess the distribution of payments and any need for targeted support, we calculate FFS Medicare margins for certain subgroups of providers that have unique roles in the health care system or that receive special payments. For example, because location and teaching status enter into the payment formula used to pay acute care hospitals under the inpatient prospective payment systems (IPPS), we calculate FFS Medicare margins based on where hospitals are located (in urban or rural areas) and their teaching status (major teaching, other teaching, or nonteaching).

Multiple factors can contribute to changes in the FFS Medicare margin, including changes in the efficiency of providers, changes in coding that may change payments, and other changes in the product or service (e.g., reduced lengths of stay at inpatient hospitals). Knowing whether these factors have contributed to margin changes may inform decisions about whether and how much to recommend changes to a sector's base payment rate.

In sectors where the data are available, the Commission makes a judgment when assessing the adequacy of FFS Medicare payments relative to costs. No single standard governs this relationship for all sectors, and margins are only one indicator for determining payment adequacy. Moreover, although payments can be ascertained with some accuracy, there may be no "true" value for reported costs, which reflect accounting choices made by providers (such as allocations of costs to different services) and the relationship of service volume to capacity in a given year. Further, even if costs are accurately reported, they reflect strategic investment decisions of individual providers, and Medicare—as a prudent payer—may choose not to recognize some of these costs or may exert financial pressure on providers to encourage them to reduce their costs.

Efficient-provider analysis

In accordance with our authorizing statute, the Commission also, when feasible, computes a FFS Medicare margin for relatively efficient providers.[4] In the sectors for which this analysis is possible, we identify a group of providers—for instance, hospitals—that perform relatively well on a set of quality metrics (e.g., measures of mortality and readmissions) while keeping unit costs relatively low. We refer to the group of hospitals identified by our method as "relatively efficient" because hospitals had to perform relatively better on selected measures of quality and cost for inclusion.

However, our method does not seek to identify all efficient providers. For example, we screen out hospitals that have few Medicare or Medicaid patients or that have poor performance on our measures in a single year, even though these hospitals may be relatively efficient. In addition, we note that the hospitals we identify as relatively efficient perform relatively well in the domains we are measuring. Use of

other quality and cost measures (e.g., hospital-acquired conditions, transition to post-acute care, or spending per episode) to identify relative efficiency likely would yield a different set of hospitals. Still, the median margin for our group of relatively efficient hospitals provides one source of information about whether FFS Medicare's payments are adequate to cover the costs of providing efficient hospital care.

In prior reports, the Commission has also assessed the performance of efficient providers in the SNF, home health care, and IRF sectors, but this report does not include an efficient-provider analysis for these sectors. The Commission plans to revise the cost and quality measures and other criteria to better identify efficient providers in these sectors. We will provide an updated analysis in next year's March report to the Congress.

Appropriateness of current costs

Our assessment of the relationship between FFS Medicare's payments and providers' costs is complicated by differences in providers' efficiency, responses to changes in payment incentives, the introduction of new technologies, and cost reporting accuracy. Measuring the appropriateness of costs is particularly difficult in new payment systems, where past performance cannot be used as a benchmark. Solutions to some policy problems can generate new ones. For example, in 2020, the prospective payment systems for home health services and SNF services were modified to improve payment accuracy. In both settings, the new payment systems (the home health patient-driven payment model and the SNF Patient-Driven Groupings Model) were intended to be budget neutral; that is, they were not intended to raise or lower payments relative to what would have been paid under the former payment systems. However, in both settings, CMS estimated that implementation resulted in payments higher than the budget-neutral amount, due to changes in provider behavior. To assess whether reported costs reflect the efficient provision of service, we examine recent trends in the average cost per unit, variation in standardized costs and cost growth, and evidence of change in the product.

Our analysis focuses on the appropriateness of FFS Medicare payment rates, but ascertaining the "true" costs of care for Medicare beneficiaries is challenging. We find that low margins on FFS Medicare patients can result from a high cost structure that has developed in response to high private-payer rates. Some have argued that in the hospital sector, for example, costs are largely outside the control of providers and that hospitals shift costs onto private insurers to offset FFS Medicare losses. However, this assessment assumes that costs are immutable. In fact, costs vary in response to financial pressure; we and other researchers have found that providers that are under pressure to constrain costs generally have managed to slow their growth in costs more than those who face less pressure (Medicare Payment Advisory Commission 2011, Robinson 2011, White and Wu 2014). In other words, when providers receive high payment rates from insurers, they face less pressure to keep their costs low, and so, all other things being equal, their FFS Medicare margins are low because their costs are high.[5]

Lack of fiscal pressure is more common in markets where a few providers dominate and have negotiating leverage over payers. This situation is becoming more common as providers continue to consolidate. We do not lower payments because of generous payments from private plans or raise them if other payers (for example, Medicaid) pay less. Moreover, we recognize that in some sectors, FFS Medicare itself can, and should, exert greater pressure on providers to reduce costs. We rely on our other indicators of payment adequacy, especially beneficiary access and quality of care, to ensure that FFS beneficiaries are not adversely affected by policy responses aimed at constraining costs.

Anticipated payment and cost changes in 2024

For most payment sectors, we estimate FFS Medicare payments and providers' costs for 2024 to inform our update recommendations for 2025. In general, to estimate payments, we first apply the annual payment updates specified in law for 2023 and 2024 to our base data (2022 for most sectors). We then model the effects of other policy changes that will affect the level of FFS Medicare payments in 2024.

Next, for each sector, we review evidence about the factors that are expected to affect providers' costs. To estimate 2024 costs, we consider the rate of input price inflation or historical cost growth, and, as

appropriate, we adjust for changes in the unit of service (such as fewer visits per episode of home health care) and trends in key indicators (such as changes in the distribution of cost growth among providers). When considering the change in input price inflation, we refer to the price index that CMS uses for that sector.[6] For each sector of facility providers (e.g., hospitals, SNFs), we start with the forecasted increase in a sector-specific index of national input prices, called a "market basket index." For physician services, we start with a CMS-derived weighted average of price changes for inputs used to provide physician services. Forecasts of these indexes approximate how much providers' costs are projected to change in the coming year if the quality and mix of inputs they use to furnish care remains constant—that is, if there were no change in efficiency. Other factors may include the trends in actual cost growth, which could be used to inform our estimates if they differ significantly from the projected market basket.

Recommendations for FFS Medicare payment in 2025

The Commission makes its payment update recommendations for 2025 relative to the 2024 base payment for each FFS payment system, as defined in Medicare's authorizing statute. Recommendations for 2025 reflect the most recent inflation and other data from 2022, preliminary data from 2023 (if available), and projections for 2024. Each year, we replace projections from the previous cycle with actual input inflation and provider costs, and we revise our assessments of payment adequacy accordingly.

The Commission's judgments about payment adequacy, policy changes in the intervening years, and expected cost changes result in an update recommendation for each FFS payment system. The Commission does not start with any presumption that an update is needed or that any increase in costs should automatically be offset by a payment update. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a FFS payment system is changed relative to the prior year. The Commission's recommendations in this report may call for an increase, a decrease, or no change relative to the 2024 base payment. For example, if the statutory base payment for a sector was $100 in 2024, an update recommendation of a 1 percent increase for a sector means that we are recommending that the base payment in 2025 for that sector be 1 percent greater, or $101.

When our recommendations differ from current law or regulation, as they often do, the Congress or the Secretary of Health and Human Services must actively change law or regulation to implement them. The Congress and the Secretary are under no obligation to adopt the Commission's recommendations; in the absence of other action from the Congress and/or the Secretary, current law will continue to apply.

Budgetary consequences

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires the Commission to consider the budgetary consequences of our recommendations. Therefore, this report documents how spending for each recommendation would compare with expected spending under current law. The Commission contends that FFS Medicare payment rates should achieve access to high-quality care for FFS beneficiaries by efficiently allocating the resources funded by taxpayers and beneficiary premiums. Our recommendations are not driven by any specific budget target, but instead reflect our assessment of the level of payment that efficient providers would need to ensure FFS beneficiaries' adequate access to appropriate care. ■

Endnotes

1 The Medicare Payment Advisory Commission is authorized under Title XVIII of the Social Security Act.

2 Some policies have been extended beyond the expiration of the PHE. See Table 2-1 (p. 38) for some examples of such policies.

3 In most cases, we assess FFS Medicare margins for the services furnished in a single sector (e.g., SNF or home health care services) and covered by a specific payment system. However, in the case of hospitals, which often provide services that are paid for by multiple Medicare payment systems, our measures of payments and costs for an individual sector could become distorted because of the allocation of overhead costs or the presence of complementary services. For example, having a hospital-based SNF or IRF may allow a hospital to achieve shorter lengths of stay in its acute care units, thereby decreasing costs and increasing inpatient margins. For hospitals, we assess the adequacy of payments for the whole range of Medicare services they furnish to FFS beneficiaries—inpatient and outpatient (which together account for about 90 percent of FFS Medicare payments to hospitals), SNF, home health care, psychiatric, and rehabilitation services—and compute an overall FFS Medicare hospital margin encompassing costs and payments for all the sectors. The hospital update recommendation in Chapter 3 applies to hospital inpatient and outpatient payments; the updates for other distinct units of the hospital, such as SNFs, are covered in separate chapters.

4 Section 1805[11] of the Social Security Act [42 U.S.C. 1395b–6]:

"Specifically, the Commission shall review payment policies under parts A and B, including—

(i) the factors affecting expenditures for the efficient provision of services in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees, (ii) payment methodologies, and (iii) their relationship to access and quality of care for Medicare beneficiaries."

5 For-profit providers may prefer to keep costs low to maximize returns to stockholders and, indeed, often have higher FFS Medicare margins than similar nonprofit providers.

6 These indexes are estimated quarterly; we use the most recent estimate available when we do our analyses.

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