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Report to the Congress

Medicare Payment Policy

MEDPAC



The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105–33) to advise the U.S. Congress on issues affecting the Medicare program. In addition to advising the Congress on payments to health plans participating in the Medicare Advantage program and providers in Medicare’s traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

The Commission’s 17 members bring diverse expertise in the financing and delivery of health care services. Commissioners are appointed to three-year terms (subject to renewal) by the Comptroller General and serve part time. Appointments are staggered; the terms of five or six Commissioners expire each year. The Commission is supported by an executive director and a staff of analysts, who typically have backgrounds in economics, health policy, and public health.

MedPAC meets publicly to discuss policy issues and formulate its recommendations to the Congress. In the course of these meetings, Commissioners consider the results of staff research, presentations by policy experts, and comments from interested parties. (Meeting transcripts are available at www.medpac.gov.) Commission members and staff also seek input on Medicare issues through frequent meetings with individuals interested in the program, including staff from congressional committees and the Centers for Medicare & Medicaid Services (CMS), health care researchers, health care providers, and beneficiary advocates.

Two reports—issued in March and June each year—are the primary outlets for Commission recommendations. In addition to annual reports and occasional reports on subjects requested by the Congress, MedPAC advises the Congress through other avenues, including comments on reports and proposed regulations issued by the Secretary of the Department of Health and Human Services, testimony, and briefings for congressional staff.

REPORT TO THE CONGRESS

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*Medicare Payment
Advisory Commission*

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March 15, 2024

The Honorable Kamala D. Harris
President of the Senate
U.S. Capitol
Washington, DC 20510

The Honorable Mike Johnson
Speaker of the House
U.S. House of Representatives
U.S. Capitol
Room H-232
Washington, DC 20515

Dear Madam President and Mister Speaker:

I am pleased to submit the Medicare Payment Advisory Commission's March 2024 *Report to the Congress: Medicare Payment Policy*. This report fulfills the Commission's legislative mandate to evaluate Medicare payment issues and make recommendations to the Congress. The report also satisfies additional legislative mandates to report on special needs plans for beneficiaries who are dually eligible for Medicare and Medicaid (D-SNPs) and the new rural emergency hospital (REH) provider designation.

The report contains 15 chapters:

- a chapter that provides a broad context for the report, including the near-term consequences of the coronavirus pandemic and the longer-term effects of Medicare spending on the federal budget and the program's financial sustainability;
- a chapter that describes the Commission's analytic framework for assessing payment adequacy;
- seven chapters that describe the Commission's recommendations on fee-for-service (FFS) Medicare payment rate updates and related issues to ensure that beneficiaries have access to high-quality care and the program achieves good value for taxpayers and beneficiaries;
- a chapter that describes FFS Medicare beneficiaries' access to care in ambulatory surgical centers;
- a chapter that updates the trends in enrollment and offerings for plans that provide prescription drug coverage under Part D;
- a chapter that describes recent trends in enrollment, plan offerings, and payments to Medicare Advantage (MA) plans and discusses related issues such as coding intensity, favorable selection, and market concentration;

- a chapter that describes our methods for estimating coding intensity and favorable selection in the MA program; and
- two chapters containing the congressionally mandated reports on special needs plans for beneficiaries dually eligible for Medicare and Medicaid and the new REH provider designation.

While the public health emergency (PHE) related to the coronavirus pandemic ended on May 11, 2023, Medicare beneficiaries, health care workers, and providers continue to experience lingering effects from COVID-19. Our most recent measures of payment adequacy indicate that the most pronounced effects of the pandemic have passed, but we continue to monitor the health care landscape for further impacts of the pandemic on beneficiary access to care, quality of care, and cost of care.

The Commission is acutely aware of how wider economic volatility in the wake of the PHE has affected providers' financial status and patterns of Medicare spending. Input cost growth exceeded payment updates for most health care sectors in 2022 and 2023, a deviation from the historical trend that has placed strain on many providers. Still, our statutory charge is to evaluate available data to assess whether FFS Medicare payments, in aggregate, are sufficient to support the efficient delivery of care and ensure access to care for Medicare's beneficiaries. In this report, we make recommendations aimed at supporting access to high-quality care for Medicare beneficiaries while giving providers incentives to constrain their cost growth and thus help control program spending. We will continue to monitor the program, and if current projections of inflation in input costs turn out to be inaccurate, we will account for that and new data in our assessment of payment adequacy in our next recommendation cycle.

In light of our payment adequacy analyses, for 2025 we recommend FFS payment updates above current law for acute care hospitals and physician and other health professional services; the payment update specified in current law for outpatient dialysis providers, and payment reductions for three post-acute care sectors (skilled nursing facility, home health, and inpatient rehabilitation facility) and hospice providers. We also recommend providing additional resources to Medicare safety-net hospitals (as well as redistributing current disproportionate share and uncompensated care payments) and to clinicians who furnish care to FFS Medicare beneficiaries with low incomes.

I hope you find this report useful as the Congress continues to grapple with the difficult task of supporting Medicare beneficiaries' access to high-quality care while obtaining good value for the program's expenditures.

Sincerely,

A handwritten signature in black ink, appearing to read "m. chernew", with a long horizontal line extending to the right.

Michael E. Chernew, Ph.D.
Chair

Enclosure

Acknowledgments

This report was prepared with the assistance of many people. Their support was key as the Commission considered policy issues and worked toward consensus on its recommendations.

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Table of contents

Acknowledgments	v
Executive summary	xiii

Chapters

1 Context for Medicare payment policy	3
Introduction	7
National health care spending has grown faster than GDP	7
Medicare spending is projected to double in the next 10 years	7
Medicare faces a financing challenge	16
As Medicare spending increases, so too does beneficiary cost sharing	19
Leading causes of death are heart disease and cancer	21
Life expectancy at age 65 has increased, but some groups of beneficiaries have lower longevity and worse access to care	22
The Commission's recommendations to slow Medicare spending growth and improve access to care	23
2 Assessing payment adequacy and updating payments in fee-for-service Medicare	35
Background	37
The Commission's principles for assessing payment adequacy	39
Payment adequacy analytic framework	40
Anticipated payment and cost changes in 2024	44
Recommendations for FFS Medicare payment in 2025	45
3 Hospital inpatient and outpatient services	51
Background	55
Are FFS Medicare payments adequate in 2024?	56
How should FFS Medicare payments change in 2025?	76
4 Physician and other health professional services	87
Background	93
Are Medicare fee schedule payments adequate in 2024?	93
How should Medicare fee schedule payments change in 2025?	113
Appendix: Key findings from the Commission's 2023 access-to-care survey	117
5 Outpatient dialysis services	131
Background	135
Are FFS Medicare payments adequate in 2024?	137
How should FFS Medicare payments change in 2025?	153
6 Skilled nursing facility services	163
Background	167
Are FFS Medicare payments adequate in 2024?	169
How should FFS Medicare payments change in 2025?	187
Medicaid trends	188
7 Home health care services	201
Background	205
Are FFS Medicare payments adequate in 2024?	206
How should FFS Medicare payments change in 2025?	219

8	Inpatient rehabilitation facility services	225
	Background	229
	Are FFS Medicare payments adequate in 2024?	230
	How should FFS Medicare payments change in 2025?	240
	Improving the accuracy of Medicare's payments	241
9	Hospice services	261
	Background	265
	Are FFS Medicare payments adequate in 2024?	266
	How should FFS Medicare payments change in 2025?	284
	Nonhospice spending for beneficiaries enrolled in hospice	284
10	Ambulatory surgical center services: Status report	297
	Background	299
	Supply of ASCs and volume of services continue to grow	299
	The ASC Quality Reporting Program does not have enough measures for meaningful analysis	305
	Aggregate FFS Medicare payments rose substantially in 2022, continuing a trend	307
	Ambulatory surgical centers should submit cost data	307
11	The Medicare prescription drug program (Part D): Status report	317
	Background	321
	Enrollment and plan choices have continued to grow	327
	Plan sponsors, PBMs, and market concentration	330
	Although moderated by generic use, overall Part D prices have continued to rise	334
	Cost-based payments account for a growing share of program spending	337
	Most Part D enrollees were satisfied	342
12	The Medicare Advantage program: Status report	357
	Background	363
	Robust MA enrollment, plan availability, and rebates	366
	Payments to MA plans far exceed FFS spending due to favorable selection into MA plans and higher MA coding intensity	371
	Industry concentration, integration, and financial condition	387
	Quality in MA	392
	Commission recommendations would address many problems with MA payment policies and the quality bonus program	393
13	Estimating Medicare Advantage coding intensity and favorable selection	415
	Background	421
	Revising the Commission's method for estimating MA coding intensity	421
	Revising the Commission's method for estimating favorable selection into MA	434
14	Mandated report: Dual-eligible special needs plans	467
	Introduction	469
	Background	469
	Comparing the performance of D-SNPs and other plans that serve dual-eligible beneficiaries	473
	Most MMPs will likely convert into D-SNPs	482
	Conclusion	483

15 Mandated Report: Rural emergency hospitals 491
Evolution of Medicare’s support for rural hospitals **493**
Adjusting payment policy to acknowledge the dramatic shift away from inpatient care in rural areas **495**
Medicare’s support for rural hospitals has reduced closures **496**
Rural emergency hospitals: Which hospitals are converting? **498**

Appendix

A Commissioners’ voting on recommendations 509

Acronyms 515

More about MedPAC

Commission members 521
Commissioners’ biographies 523
Commission staff 527

Executive summary

Executive summary

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 end of the coronavirus public health emergency (PHE) and higher-than-usual inflation, and the longer-term effects of program spending on the federal budget and the program's financial sustainability. We evaluate the adequacy of FFS Medicare's payments and make recommendations for how payments should be updated in 2025 for seven FFS payment systems: acute care hospital inpatient and outpatient services, physicians and other health professional services, outpatient dialysis facilities, skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and hospice providers. We provide status reports on ambulatory surgical centers (ASCs), the MA program (Medicare Part C), and the Part D prescription drug program. We also include congressionally mandated reports on special needs plans for beneficiaries dually eligible for Medicare and Medicaid and on a new provider designation, rural emergency hospitals.

The PHE related to the coronavirus pandemic officially expired on May 11, 2023. The Commission recognizes that the pandemic has had tragic effects on beneficiaries and 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. For the past several years, the direct and indirect effects of COVID-19 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. Most of our analyses rely on lagged data (the most recent complete data we have for most payment adequacy indicators are from 2022), and they continue to be affected by the pandemic, both directly and through policy changes. Where PHE-related policy changes affect our assessment of payment adequacy in a particular sector, our methods for evaluating those effects are detailed in the relevant chapter of this

report. 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 to care, quality, and costs.

The Commission's goals for Medicare payment policy are to ensure that Medicare beneficiaries have access to high-quality care and that the program obtains good value for its expenditures. To achieve these goals, the Commission supports payment policies that encourage 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 updating base payment rates alone will not solve what has been a fundamental problem with FFS Medicare's payment systems—that providers are paid more when they deliver more services, whether or not those additional services provide value. 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, broad payment reforms must be implemented expeditiously, coordinated across settings, closely monitored, and scaled when appropriate. In the interim, it is imperative that the current FFS payment systems be managed carefully and continuously improved.

This report contains the Commission's recommendations for updates to the FFS Medicare payment rates specified in current law. For each recommendation, the Commission presents its rationale, the implications for beneficiaries and providers, and how spending for each recommendation 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 high-value care for FFS beneficiaries while promoting the fiscal sustainability of the Medicare program.

In Appendix A, we list all of this year's recommendations and the Commissioners' votes. The Commission's full inventory of recommendations, with links to relevant reports, is available at [medpac.gov/recommendation/](https://www.medpac.gov/recommendation/).

Context for Medicare payment policy

As described in Chapter 1, external forces can have a substantial impact on Medicare spending and the experience of Medicare beneficiaries. To put the information presented in this report in context, this chapter highlights key trends in national health care spending and Medicare spending, and it reviews the factors that contribute to spending growth.

During the recent coronavirus pandemic, the Congress appropriated several hundred billion dollars in relief funds to offset providers' lost revenues and to ensure that they remained viable sources of care. The Congress and CMS also temporarily changed certain payment and coverage policies. In 2020, those measures doubled the rate of growth in national health care spending. However, by 2021, relief funds tapered off, resulting in slower growth in national health care spending.

By contrast, total Medicare spending grew at a slower-than-usual pace during the pandemic. Although Medicare spending increased on COVID-19 testing and treatment and on services that were made more widely available through waivers of Medicare's usual payment rules, this increase was more than offset by decreased spending on non-COVID-19 care. The most common types of care that Medicare beneficiaries reported forgoing in the early months of the pandemic were dental care, regular check-ups, treatment for an ongoing condition, and diagnostic or medical screening tests; some beneficiaries, however, reported forgoing more serious types of care, such as urgent care for an accident or illness.

Spending growth has recently been particularly slow for FFS Medicare, which Medicare's Trustees attribute to a few factors, including lower average morbidity among Medicare beneficiaries who survived

the pandemic. Another factor was joint replacement procedures moving from inpatient to (lower-cost) outpatient settings after their removal from Medicare's "inpatient only" list. In addition, beneficiaries dually enrolled in Medicare and Medicaid (who tend to generate high spending) have increasingly opted to enroll in MA plans rather than traditional FFS coverage, which has helped to reduce FFS Medicare spending per beneficiary.

Between now and the early 2030s, CMS expects total Medicare spending to grow at rates more consistent with historical norms—by 7 percent or 8 percent per year, on average. This growth will double Medicare spending over a 10-year period—rising from \$900 billion in 2022 to \$1.8 trillion in 2031. Medicare's projected spending growth is driven by economy-wide inflation, an increasing number of beneficiaries (which is projected to grow by about 2 percent per year until 2029, as the baby-boom generation continues to age into Medicare), and continued growth in the volume and intensity of services delivered per beneficiary.

Despite this projected spending growth, the Medicare program finds itself in a better position financially than it was in a few years ago. After an initial economic slowdown at the start of the pandemic, the U.S. economy subsequently experienced strong growth in 2021 and 2022, yielding higher-than-expected Medicare payroll tax revenues. At the same time, Medicare beneficiaries used a lower volume of Part A services than expected during the pandemic, and future Part A spending is now projected to be lower than previously expected. As a result, the balance in Medicare's Hospital Insurance Trust Fund has been increasing. The trust fund is now projected to be able to pay its share of Part A services for several more years than was estimated before the pandemic—until 2031 according to Medicare's Trustees or until 2035 according to the Congressional Budget Office.

Yet pressure to restrain the growth in Medicare's overall spending remains. Medicare spending is projected to constitute a rising share of GDP in the coming years, and growth in Medicare spending will cause beneficiaries to face higher premiums and cost sharing over time. Further, a growing share of general federal revenues must be transferred to Medicare's Supplementary Medical Insurance (SMI) Trust Fund to help pay for Part B clinician and outpatient services

and Part D prescription drug coverage. For example, in 2022, 13 percent of all personal and corporate income taxes collected by the federal government were transferred to the SMI Trust Fund to pay for Part B and Part D, and by 2030, 22 percent of all income tax revenues are expected to be transferred for this purpose.

One way the Medicare program has reduced spending growth relative to the commercial market is by setting prices in certain sectors. Our annual March report recommends updates to FFS Medicare payment rates for various types of providers; these updates can be positive, negative, or neutral, depending on our assessment of Medicare payment adequacy for each sector. Our annual June report typically offers broader recommendations aimed at restructuring the way Medicare's payment systems work.

Assessing payment adequacy and updating payments in FFS Medicare

As required by law, the Commission annually recommends payment updates 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 for all providers in a payment system is changed relative to the prior year. As explained in Chapter 2, we determine updates by first assessing the adequacy of FFS Medicare payments for 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. Next, we assess how providers' costs are likely to change in the year the update will take effect (the policy year; here, 2025). Finally, we make a recommendation about what, if any, update is needed for the policy year in question.

The Commission's 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 redistribute payments within a payment system to correct biases that may make treating patients with certain conditions or in certain areas financially undesirable, make certain procedures unusually profitable, or otherwise result in inequity among providers or beneficiaries. We may also recommend changes that could improve program integrity.

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 delivery of care help induce all providers to control their costs. Furthermore, FFS 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 affect 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 the facility share of providing services, FFS Medicare generally sets prospective payment rates under the inpatient prospective payment systems (IPPS) and the outpatient prospective payment system (OPPS). In 2022, the FFS Medicare program and its beneficiaries spent nearly \$180 billion on IPPS and OPPS services at general ACHs, including \$7.1 billion in uncompensated care payments made under the IPPS.

As described in Chapter 3, indicators of hospital payment adequacy were mixed. Overall, general ACHs continued to have the capacity to care for FFS Medicare beneficiaries and a financial incentive to serve them, FFS Medicare beneficiaries' inpatient

mortality and readmission rates improved, and investor demand for hospital bonds remained strong. However, in fiscal year (FY) 2022, IPPS hospitals' aggregate all-payer operating margin fell to the lowest level since 2008, and their overall FFS Medicare margin across service lines declined to a record low, both in aggregate and for relatively efficient hospitals. These low all-payer and FFS Medicare margins were largely driven by higher-than-expected input price inflation in 2022.

Beneficiaries' access to care—Indicators of beneficiaries' access to hospital inpatient and outpatient care were generally positive. In FY 2022, the number of inpatient beds remained stable, hospital employment increased, and the aggregate occupancy rate of ACH beds was 67 percent, indicating available capacity in aggregate. The number of general ACHs that closed was similar to the number that opened in that year. In 2023, hospital employment continued to grow; however, more ACHs closed than opened (18 vs. 11, respectively), with many of the hospitals citing declining patient volume as one of the reasons for closing. The number of closures would likely have been higher if not for a new Medicare policy—the rural emergency hospital (REH) designation—that allows hospitals to convert from full-service hospitals to REHs, preserving beneficiaries' access to emergency services and hospital outpatient services. (We discuss REHs in Chapter 15 of this report.)

The volume of both inpatient and outpatient services per FFS Medicare beneficiary declined from 2021 to 2022. This change, however, primarily reflects shifts in the setting where care is provided and declines in COVID-19 care, rather than a decrease in beneficiary access to hospital care. Hospitals' FFS Medicare marginal profit on IPPS and OPIS services declined from 2021 to 2022 but remained positive at 5 percent in aggregate.

Quality of care—Hospital quality indicators were mixed. FFS beneficiaries' risk-adjusted hospital readmission rate improved relative to pandemic highs, falling to the level it was in 2019 (8.1 percent). The risk-adjusted hospital mortality rate improved to 14.7 percent, about a percentage point lower than in 2019. However, most patient experience measures remained below prepandemic levels by several percentage points.

Providers' access to capital—From 2021 to 2022, hospitals' aggregate all-payer operating margin declined by over 6 percentage points, reflecting

both a decline in federal coronavirus relief funds and higher-than-expected inflation. IPPS hospitals' all-payer operating margin fell to 2.7 percent when including federal relief funds—the lowest level since 2008—and 1.9 percent exclusive of these funds. In addition, preliminary data from large hospital systems suggest that hospitals' aggregate all-payer operating margin in 2023 remained below prepandemic levels. Hospitals' borrowing costs also increased in 2022 and 2023; however, this growth was slower than that of the general market, indicating continued investor demand for hospital bonds.

FFS Medicare payments and providers' costs—From 2021 to 2022, IPPS hospitals' overall FFS Medicare margin (across inpatient, outpatient, and certain other service lines) declined over 5 percentage points to a record low of -11.6 percent, when including the FFS Medicare share of coronavirus relief funds (and declined to -12.7 percent exclusive of these funds). This decline was largely driven by input price inflation exceeding the market basket update, as well as a decline in federal pandemic support, an increase in high-cost outlier stays, and a decrease in Medicare uncompensated care payments. Nonetheless, some hospitals achieved much lower costs while still performing relatively well on a specified set of quality metrics. We refer to the subset of hospitals that meet this mix of cost and quality criteria as “relatively efficient”; the median FFS Medicare margin among these hospitals was about -2 percent (-3 percent exclusive of relief funds).

In FY 2024, hospitals that participate in the 340B drug payment program are scheduled to receive \$9 billion in remedy payments to correct for underpayments in calendar years 2018 through 2021. We project that IPPS hospitals' aggregate FFS Medicare margin will increase to -8 percent inclusive of these remedy payments, and remain at -13 percent exclusive of these payments. Similarly, we project the median FFS Medicare margin among our relatively efficient hospital group to remain at about -3 percent.

Recommendation—The recent volatility in hospital profit margins makes it particularly difficult to assess how FFS Medicare payments should change for 2025. The current-law updates to payment rates for 2025 will not be finalized until summer 2024, but CMS's third-quarter 2023 forecasts and other required updates are currently projected to increase the IPPS and OPIS

base rates by slightly less than 3 percent. We expect hospitals will have a relatively low FFS Medicare margin in 2025 if the update in current law holds.

The Commission contends that increased support is needed to ensure that Medicare beneficiaries continue to have access to ACH services. Therefore, the Commission recommends that, for FY 2025, the Congress update the 2024 Medicare base payment rates for general ACHs by the amount reflected in current law plus 1.5 percent. The Congress should also redistribute existing safety-net payments to hospitals using the Commission's Medicare Safety Net Index (MSNI) and increase the MSNI pool by \$4 billion (which would be distributed to hospitals for both their FFS and MA patients). This recommendation would better target limited Medicare resources toward those hospitals that are key sources of care for low-income Medicare beneficiaries and are facing particularly significant financial challenges.

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 2022, the FFS Medicare program and its beneficiaries paid \$91.7 billion for services provided by almost 1.3 million clinicians, accounting for just under 17 percent of FFS spending. As described in Chapter 4, most physician payment adequacy indicators have remained positive or improved in recent years, but clinicians' input costs are estimated to have grown faster than the historical trend.

Beneficiaries' access to care—In the Commission's annual survey, Medicare beneficiaries continued to report access to clinician services in 2023 that was comparable with, or better than, that of privately insured people. Other national surveys and our annual focus groups with beneficiaries echo these findings. Surveys indicate that the share of clinicians accepting Medicare is comparable with 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 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 (APRNs) and physician assistants (PAs), a steady increase in the number of specialists, and a slow decline in the number of primary care physicians. Despite the growth in the overall number of clinicians, the number of clinicians per Medicare beneficiary (including those in FFS Medicare and MA) has remained steady due to beneficiary enrollment growth.

The number of clinician encounters per FFS beneficiary has increased over time, with faster growth from 2021 to 2022 (3.1 percent) compared with the average annual growth rate from 2017 to 2021 (0.7 percent). Growth rates varied by clinician specialty and type of service. From 2021 to 2022, the number of encounters per FFS beneficiary with primary care physicians declined by 0.3 percent while encounters per FFS beneficiary with specialist physicians increased by 1.3 percent and encounters with APRNs and PAs increased by 10.4 percent.

Quality of care—We report three population-based measures of the quality of clinician care: risk-adjusted ambulatory care-sensitive (ACS) hospitalization rates, risk-adjusted ACS emergency department (ED) visits, and patient experience measures. In 2022, risk-adjusted rates of ACS hospitalizations and ED visits continued to vary across health care markets. Between 2021 and 2022, patient experience scores in FFS Medicare were relatively stable.

Clinicians' revenues and costs—Clinicians do not submit annual cost reports to CMS, so we are unable to calculate their profit margins from delivering services to Medicare beneficiaries. Instead, we rely on indirect measures of how FFS Medicare payments compare with the costs of providing services. In 2022, spending on clinician services by FFS Medicare and its beneficiaries was \$1.1 billion lower than it was in 2021. This decline represents a 1.2 percent decrease in fee schedule spending and is attributable to a 3.9 percent decline in the number of beneficiaries enrolled in FFS Medicare,

as enrollment in MA continued to grow. However, from 2021 to 2022, physician fee schedule spending per FFS beneficiary grew for most types of services.

In 2022, payment rates paid by private preferred provider organization (PPO) health plans for clinician services were 136 percent of FFS Medicare's payment rates, up from 134 percent in 2021. Survey data suggest that providers are increasingly consolidating into larger organizations to improve their ability to negotiate higher payment rates from private insurers (and to gain access to costly resources and help complying with payers' regulatory and administrative requirements). Compensation and productivity data indicate that, while clinicians who work in hospital-owned practices do not necessarily earn more than those working in clinician-owned practices, they do tend to see fewer patients and bill for fewer services.

All-payer clinician compensation appears to be increasing at rates similar to general inflation. From 2021 to 2022, median compensation for physicians grew by 9 percent—a little faster than inflation, which was 8 percent. Over a longer, four-year period that includes the recent coronavirus pandemic (2018 to 2022), physicians' median compensation grew by an average of 3.4 percent per year, slightly less than inflation, which was 3.9 percent over the same period. Median compensation for APRNs and PAs grew more slowly than inflation from 2021 to 2022 (by 5 percent) but kept pace with inflation from 2018 to 2022 (growing by an average of 4 percent per year). Clinicians' input costs—as measured by the Medicare Economic Index (MEI)—grew 4.6 percent in 2022 but are expected to moderate in the coming years. MEI growth projections are 4.1 percent for 2023, 3.1 percent in 2024, and 2.6 percent in 2025.

Recommendation—Under current law, Medicare fee schedule payment rates are expected to decline in 2025, due to the expiration of a 1.25 percent pay increase that will apply in 2024 only and a 0 percent update scheduled for 2025. Given recent high inflation, cost increases could be difficult for clinicians to continue to absorb. Yet current payments to clinicians appear to be adequate, based on many of our indicators.

Given these mixed findings, for calendar year 2025, the Commission recommends that the Congress

update the 2024 Medicare base payment rate for physician and other health professional services by the amount specified in current law plus 50 percent of the projected increase in the MEI. Based on CMS's MEI projections at the time of this publication, the recommended update for 2025 would be equivalent to 1.3 percent above current law. Our recommendation would be a permanent update that would be built into subsequent years' payment rates, in contrast to the temporary updates specified in current law for 2021 through 2024, which have each increased payment rates for one year only and then expired.

To promote adequate access to care for all Medicare beneficiaries, the Congress also should establish safety-net add-on payments for clinician services furnished to FFS Medicare beneficiaries with low incomes, with higher add-on payments for primary care clinicians. We estimate that the recommended safety-net add-on policy would increase the average clinician's fee schedule revenue by 1.7 percent.

We estimate the combination of the recommended update and safety-net policies would increase fee schedule revenue for the average clinician by 3 percent above current law, but the effects would differ by provider specialty and share of services furnished to low-income beneficiaries. We estimate the combined effect of the two policies would increase fee schedule revenue by an average of 5.7 percent for primary care clinicians and by an average of 2.5 percent for other clinicians.

Outpatient dialysis services

Outpatient dialysis services are used to treat the majority of individuals with end-stage renal disease (ESRD). In 2022, about 290,000 beneficiaries with ESRD and on dialysis were covered under FFS Medicare and received dialysis from more than 7,800 dialysis facilities. In 2022, FFS Medicare expenditures for outpatient dialysis services totaled \$8.8 billion. As described in Chapter 5, measures of the capacity and supply of outpatient dialysis providers, beneficiaries' ability to obtain care, and changes in the volume of services suggest that FFS Medicare payments are adequate.

Beneficiaries' access to care—Dialysis facilities appear to have the capacity to meet demand. Between 2021 and 2022, the number of in-center treatment stations

was steady, while the number of FFS and MA dialysis beneficiaries declined (due in part to excess mortality among ESRD patients during the PHE, and in part to an increase in treatments furnished at home). A steep (14 percent) decline in FFS treatments in 2022 was largely due to the removal of the statutory provision that prevented most dialysis beneficiaries from enrolling in MA plans. Between January 2021 and December 2022, the share of dialysis beneficiaries enrolled in FFS Medicare declined from 64 percent to 53 percent. An estimated 18 percent FFS marginal profit in 2022 suggests that dialysis providers have a financial incentive to continue to serve FFS Medicare beneficiaries.

Quality of care—FFS dialysis beneficiaries' rates of all-cause hospitalization, ED use, and mortality held relatively steady between 2021 and 2022. 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.

FFS Medicare payments and providers' costs—FFS Medicare payment per treatment in freestanding dialysis facilities (which provide the vast majority of FFS dialysis treatments) grew by 2 percent while cost per treatment rose by 6 percent. The increase in the cost per treatment is attributable to the growth in labor and capital costs between 2021 and 2022, which was substantially higher compared with these categories' historical cost growth. The aggregate FFS Medicare margin fell from 2.3 percent in 2021 to -1.1 percent in 2022. We project a 2024 aggregate FFS Medicare margin of 0 percent.

Recommendation—Under current law, the FFS Medicare base payment rate for dialysis services is projected to increase by 1.8 percent in 2025. Given that our indicators of payment adequacy are generally positive, the Commission recommends that, for calendar year 2025, the Congress update the 2024 ESRD PPS base payment 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. Most SNFs also furnish long-term care services not covered by Medicare. In 2022, about 14,700 SNFs furnished about 1.8 million Medicare-covered stays to 1.3 million FFS beneficiaries. In that year, FFS Medicare spending on SNF services and swing beds combined was \$29 billion. As described in Chapter 6, the indicators of FFS Medicare payment adequacy for SNF care are positive, indicating sufficient beneficiary access to SNF care.

Beneficiaries' access to care—Changes in the indicators of access to SNFs were positive in 2022, with occupancy and utilization increasing after downturns in 2020 and 2021. In 2022, 88 percent of Medicare 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), the same share as in 2021. The supply of SNFs declined by about 1 percent in 2023. Between 2021 and 2022, both Medicare-covered admissions and covered days per 1,000 FFS beneficiaries increased more than 10 percent. In 2022, FFS Medicare marginal profit averaged 27 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 and 2022, the median facility risk-adjusted rate of successful discharge to the community from SNFs was 50.7 percent, which was 1 percentage point lower (worse) than the period 2018 to 2019. The median facility risk-adjusted rate of potentially preventable hospitalizations was 10.4 percent. Lack of data on patient experience and concerns about the accuracy of provider-reported function data limit our set of SNF quality measures.

Providers' access to capital—In 2022, the average price per SNF bed reached a record high. The all-payer total margin—reflecting all payers and lines of business—was -1.4 percent. Without pandemic-related funds, the all-payer total margin was -4 percent in 2022.

FFS Medicare payments and providers' costs—From 2021 through 2022, FFS Medicare payments per day to

freestanding SNFs increased over 2.2 percent, while growth in costs per day slowed to 1.7 percent. The FFS Medicare margin for freestanding SNFs was 18.4 percent in 2022. Margins varied greatly across facilities, reflecting differences in costs per day, economies of scale, and cost growth. We project a FFS Medicare margin for freestanding SNFs of 16 percent in 2024.

Recommendation—Efficient purchasing of care for the Medicare program would require FFS Medicare's payments to be reduced to more closely align aggregate payments with aggregate costs. The Commission recommends that, for fiscal year 2025, the Congress reduce the 2024 FFS 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 2022, about 2.8 million FFS Medicare beneficiaries received care, and the program spent \$16.1 billion on home health care services. In that year, 11,353 HHAs participated in Medicare. As described in Chapter 7, the indicators of FFS Medicare payment adequacy for home health care were positive in 2022.

Beneficiaries' access to care—Access to home health care was adequate in 2022. Despite the number of HHAs declining by 1.1 percent that year, over 98 percent of Medicare beneficiaries lived in a ZIP code served by at least two HHAs, and 88 percent lived in a ZIP code served by five or more HHAs. In 2022, the volume of 30-day periods declined by 7.5 percent, but approximately 40 percent of that decline can be attributed to the decreased number of beneficiaries in FFS Medicare as enrollment continues to grow in MA. The rate of inpatient hospital stays per 1,000 FFS beneficiaries declined 2.6 percent in 2022. For FFS beneficiaries who use home health care, the average number of in-person visits per 30-day period fell by 15.6 percent between 2019 (the year before CMS implemented major congressionally mandated changes to the HHA prospective payment system (PPS)) and 2022, but some of the decline might have been offset by greater use of virtual visits through telehealth, which we are unable to observe with available data. In 2022, freestanding HHAs' FFS Medicare marginal profit—that is, the rate at which FFS Medicare payments exceeded providers' marginal costs—was 23 percent, indicating

a significant financial incentive for freestanding HHAs with excess capacity to serve additional FFS Medicare patients.

Quality of care—Rates of successful discharge to the community varied by provider type, with lower rates and greater decline observed in for-profit and freestanding agencies. The median rate of potentially preventable readmissions after discharge was 3.88 percent from July 1, 2020, to December 31, 2022, and did not vary significantly across provider types. (Due to a change in the measure calculation, we cannot compare this with a prior period.) Most patient experience measures remained stable in 2022. The Commission continues to have concerns about the accuracy of provider-reported function data.

Providers' access to capital—Access to capital is a less important indicator of FFS Medicare payment adequacy for home health care because this sector is less capital intensive than other health care sectors. Recent years have seen substantial interest in HHAs by private equity and health insurance companies. According to industry reports, investor interest in home health care services slowed in 2023, but the slowdown came after a peak period for HHA mergers and acquisitions in 2021.

FFS Medicare payments and providers' costs—In 2022, FFS Medicare costs per 30-day period in freestanding HHAs increased by 4.0 percent, reflecting a simultaneous increase in costs per visit and reduction in the number of in-person visits per 30-day period. FFS Medicare margins for freestanding agencies averaged 22.2 percent. In aggregate, FFS Medicare's payments have always been substantially more than costs under prospective payment: From 2001 to 2021, the FFS Medicare margin for freestanding HHAs averaged 16.8 percent. We project an aggregate FFS Medicare margin of 18 percent for 2024.

Recommendation—The Commission's review of payment adequacy for Medicare home health services indicates that FFS Medicare payments are substantially in excess of costs. Home health care can be a high-value benefit when it is appropriately and efficiently delivered. However, FFS Medicare's current payment rates diminish that value. On this basis, the Commission recommends that, for calendar year 2025, the Congress reduce the 2024 base payment rate for home health agencies 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 2022, FFS Medicare spent \$8.8 billion on 383,000 FFS IRF stays in about 1,180 IRFs nationwide. The FFS Medicare program accounted for about 51 percent of all IRF discharges. As described in Chapter 8, most IRF payment adequacy indicators remained positive in 2022; however, FFS Medicare margins continued to vary across IRFs.

Beneficiaries’ access to care—Between 2021 and 2022, the number of IRFs stayed constant, and the number of IRF beds slightly increased. Consistent with the previous year, the aggregate IRF occupancy rate was 68 percent in 2022, indicating that capacity is more than adequate to meet demand. From 2021 to 2022, Medicare cases per 10,000 FFS beneficiaries increased by about 4 percent, and total FFS IRF users increased by about 1 percent. Marginal profit, an indicator of whether IRFs with excess capacity have an incentive to treat more Medicare beneficiaries, was 18 percent for hospital-based IRFs and 39 percent for freestanding IRFs—a very strong indicator of access.

Quality of care—In 2021 and 2022, the median facility risk-adjusted rate of successful discharge to the community from IRFs was 67.3 percent, about 2 percentage points higher (better) than the rate for the period of 2018 and 2019. The median facility risk-adjusted rate of potentially preventable readmissions was 8.6 percent and was higher (worse) for freestanding and for-profit providers than hospital-based and nonprofit providers. (Because of a change in the measure calculation, we cannot compare this rate with a prior period.) Lack of data on patient experience and concerns about the accuracy of provider-reported function data limit our set of IRF quality measures.

Providers’ access to capital—Between 2021 and 2022, freestanding IRFs’ all-payer total margin decreased from 13 percent to about 9 percent. The decrease reflects inflation in the greater macroeconomic environment. Despite the decline in the all-payer margin, the largest IRF chain (which accounted for almost a third of all FFS Medicare IRF discharges)

continued to open new IRFs and enter joint ventures with other organizations, suggesting strong access to capital. The extent to which other freestanding IRFs can access capital is less clear. Hospital-based IRFs access capital through their parent hospitals.

FFS Medicare payments and providers’ costs—IRFs’ FFS Medicare margin in 2022 decreased to 13.7 percent due to cost growth that exceeded payment growth. We expect cost growth in 2024 to be lower, more in line with the historical trend, and thus project that the 2024 margin will increase to 14 percent.

Recommendation—FFS Medicare’s payments to IRFs must be reduced to more closely align aggregate payments with aggregate costs. The Commission recommends that, for fiscal year 2025, the Congress reduce the 2024 base payment rate for IRFs by 5 percent.

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. FFS Medicare pays for hospice care for beneficiaries enrolled in both traditional FFS Medicare and MA. In 2022, more than 1.7 million Medicare beneficiaries (including almost half of decedents) received hospice services from about 5,900 providers, and Medicare hospice expenditures totaled \$23.7 billion. As described in Chapter 9, the indicators of FFS Medicare payment adequacy for hospice services are positive.

Beneficiaries’ access to care—In 2022, indicators of beneficiaries’ access to care were positive. In 2022, the number of hospice providers increased by about 10 percent as more for-profit hospices entered the market, a trend that has continued for more than a decade. The overall share of Medicare decedents using hospice services increased from 47.3 percent in 2021 to 49.1 percent in 2022. The number of hospice users and total days of hospice care also increased. For decedents, average lifetime length of stay increased by about 3 days in 2022 to 95.3 days. Between 2021 and 2022, median length of stay was stable, increasing

slightly from 17 days to 18 days. In 2021, FFS Medicare payments to hospice providers exceeded marginal costs by 17 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—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 2022 but remained lower than 2019 levels.

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 at least 10 percent in 2022) 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.

FFS Medicare payments and providers' costs—Hospice FFS Medicare margins are presented through 2021 because of the data lag required to calculate cap overpayment amounts. Between 2020 and 2021, average cost per day increased 4.3 percent. The aggregate FFS Medicare margin for 2021 was 13.3 percent, down slightly from 14.2 percent in 2020. If Medicare's share of pandemic-related relief funds is included, the aggregate FFS Medicare margin rises to about 14.5 percent. Hospice average cost per day increased 3.7 percent in 2022. We project an aggregate FFS Medicare margin for hospices of about 9 percent in 2024.

Recommendation—Based on the positive indicators of payment adequacy and strong margins, the Commission concludes that current payment rates are sufficient to support the provision of high-quality care without an increase to the payment rates in 2025. The Commission recommends that the Congress eliminate the update to hospice base payment rates for fiscal year 2025.

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 10's ASC status report, in 2022, about 6,100 ASCs treated 3.3 million FFS Medicare beneficiaries. FFS Medicare program spending and beneficiary cost sharing on ASC services was about \$6.1 billion.

The supply of ASCs and volume of services continued to grow in 2022. There was a net increase of 13 ASCs in the first quarter of 2022, and the volume of ASC surgical procedures per FFS beneficiary grew by about 2.8 percent. Numerous factors 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 ASC procedure, which accounted for almost 19 percent of volume and 20 percent of spending in 2022, was extracapsular cataract removal with intraocular lens insertion.

Most ASCs are for profit, and geographic distribution is uneven. The vast majority are located in urban areas, and the concentration of ASCs varies widely across states. About 68 percent of the ASCs that billed Medicare in 2022 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 2017 to 2022, the ASC specialties that grew most rapidly were pain management and cardiology.

Medicare spending per FFS beneficiary on ASC services rose at an average annual rate of 8.2 percent from 2017 through 2021 and by 10.0 percent in 2022. 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 reiterate our recommendation that the Congress require ASCs to submit cost data.

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

As described in Chapter 11, in 2023, Part D paid for outpatient prescription drug coverage on behalf of

more than 51 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 nearly 14 million beneficiaries with low income and assets.

In 2022, Part D expenditures totaled \$117.3 billion. Of that amount, Medicare paid \$101.3 billion in subsidies for basic benefit costs and extra help for LIS enrollees and \$0.6 billion in retiree drug subsidies, and enrollees paid \$15.4 billion in premiums for basic benefits. Medicare spending for the LIS totaled \$39.7 billion: \$35.2 billion for cost sharing and \$4.5 billion for premiums. In addition, Part D plan enrollees paid \$18.5 billion in cost sharing and \$9.9 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 biological products (referred to as “biologics” hereafter) and specialty medications account for a mounting share of spending. A growing share of Medicare’s payments has taken the form of cost-based reimbursements to plans through Medicare’s reinsurance and LIS. 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 Budget Reconciliation Act of 2022, 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 reforms to Part D’s benefit structure have begun to be implemented, with more changes coming over the next several years.

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 when the sponsor positions a drug on its formulary in a way that increases the likelihood of gaining market share over competing drugs. Historically, most plan sponsors also used provisions in network contracts with pharmacies that required postsale recoupments or payments for meeting performance metrics. Beginning this year, however, sponsors may no longer recoup payments from pharmacies after the point of sale. Rebates and pharmacy fees have grown as a share of Part D spending, but these legislative and regulatory changes may affect their magnitude.

Enrollment in 2023 and benefit offerings for 2024—

In 2023, 78 percent of Medicare beneficiaries were enrolled in Part D plans. An additional 1 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 comparable drug coverage from other sources and about 11 percent had no coverage or coverage less generous than Part D.

Enrollment in stand-alone prescription drug plans (PDPs) peaked in absolute terms in 2019 at 25.5 million (56 percent of total plan enrollment) but declined to 22.5 million by 2023 (44 percent). Enrollment in MA Prescription Drug plans (MA-PDs) surpassed enrollment in PDPs for the first time in 2021 and reached 29.1 million in 2023. Since 2020, LIS enrollees have comprised 27 percent of total enrollment and in 2022 they accounted for 46 percent of gross program spending.

For 2024, beneficiaries continue to have a broad choice of plans. Plan sponsors offered 3,507 general MA-PDs (a slight decline from 2023) and 1,306 MA-PDs tailored to specific populations (special needs plans, or SNPs; a 4 percent increase). In 2024, plan sponsors are offering 709 PDPs, the fewest since the program began.

For 2024, the base beneficiary premium increased to \$34.70. A recent legislative change capped annual premium increases at 6 percent, so the increase this year was less than the 20 percent increase that would have otherwise been incurred. While this cap is intended to protect beneficiaries from bearing the full cost of plan sponsors’ increased liability under the new

benefit design, cost increases beyond 6 percent will be borne by the Medicare program. Further, although the increase in the base beneficiary premium was capped, individual plans' premiums still vary substantially, with PDPs typically having higher premiums than MA-PDs. In 2024, 126 PDPs, roughly one-sixth of all PDPs, are available premium free to enrollees who receive the LIS, compared with one-fourth of all PDPs last year. This drop in benchmark plans has left 8 regions out of 34 with just 2 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.

Part D program spending—In 2022, Medicare program spending on Part D (excluding the \$15.4 billion in premiums paid by enrollees) totaled \$101.9 billion, up from about \$95 billion in 2021. That amount includes the monthly capitated payments to Part D plans for each enrollee (the “direct subsidy”); the reinsurance amount that Medicare pays plans to cover 80 percent of costs for enrollees while in the benefit’s catastrophic phase; the LIS; and the retiree drug subsidy. Reinsurance continued to be the largest and fastest-growing component of program spending, totaling \$56.8 billion, or about 56 percent of the total. In 2023, direct subsidy payments averaged \$2 per member per month, while cost-based reinsurance payments averaged about \$94 per member per month. However, in 2024, as a result of legislative and regulatory changes, we see a reversal in the trend toward higher reinsurance payments: Direct subsidy payments increased to an average of nearly \$30 per member per month, while average reinsurance payments are expected to decline to about \$90 per member per month.

In 2022, drug list prices continued to rise, approaching rates observed before the pandemic. Decreasing prices of generic drugs continued to 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. Going forward, meaningful savings for biologics will depend largely on the successful launch and adoption of

biosimilars by prescribers and beneficiaries. In 2022, about 482,000 beneficiaries filled a prescription that, by itself, was sufficiently expensive to reach the catastrophic phase of the benefit, up from just 33,000 enrollees in 2010.

Beneficiary access and quality in Part D—Surveys suggest high overall satisfaction with Medicare Part D. At the same time, focus groups show that both prescribers and beneficiaries are acutely aware of high drug costs. Among beneficiaries without the LIS, high cost sharing for expensive therapies can be a barrier to access. However, the redesigned benefit now places an annual limit on beneficiaries’ cost sharing. As a result, going forward, beneficiaries are less likely to face cost-related access issues.

Medicare beneficiaries take an average of nearly five prescription drugs per month and are at higher risk for adverse drug events associated with polypharmacy. By law, Part D plans are required to carry out medication therapy management (MTM) programs and programs to manage opioid use. For years, the Commission has had concerns about the effectiveness of MTM programs, particularly among stand-alone PDPs, which do not bear financial risk for medical spending. A recent evaluation of a CMS demonstration testing an enhanced MTM model found that new payment incentives and regulatory flexibilities surrounding MTM failed to promote better health outcomes for beneficiaries. In addition, the demonstration yielded no significant reductions in Medicare spending for Part A and Part B services, with a net increase in Medicare spending after accounting for model payments.

The Medicare Advantage program: Status report

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 12, in 2023, the MA program included 5,635 plan options offered by 184 organizations, enrolled about 31.6 million beneficiaries (52 percent of Medicare beneficiaries with both Part A and Part B coverage), and paid MA plans an estimated \$455 billion (not including Part D drug plan payments). To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for beneficiaries enrolled in traditional FFS Medicare. We also provide

updates on risk adjustment, risk coding practices, the structure of the MA market, and the current state of quality reporting in MA.

The Commission strongly supports the inclusion of private plans in the Medicare program. Beneficiaries should be able to choose among Medicare coverage options since 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 the additional benefits and alternative delivery systems that private plans provide. As evidenced by rapid growth in enrollment, additional benefits (including lower cost sharing for basic Medicare benefits, a cap on out-of-pocket expenses, and reduced premiums for Part D coverage) are attractive to beneficiaries. Because Medicare pays private plans a partially 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.

When risk-based payment for private plans was first added to Medicare in 1985, payments to private plans were 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 private plans in the aggregate have never been paid less than FFS Medicare because of policies that have increased payments to MA above FFS. As examples, MA benchmarks are set above FFS spending in many markets in part to encourage more uniform plan participation across the country, and payments under the quality bonus program further increase MA payments above FFS (without, the Commission has found, producing meaningful information on plan quality for Medicare beneficiaries or the Medicare program). Favorable selection of enrollees into MA leads to plan enrollees having actual spending that is lower than predicted (independent of the effects of any plan utilization management). MA plans' diagnostic coding practices also increase payments. Currently, the Commission does not quantify the extent to which favorable selection stems from plan behavior, beneficiary preferences, or other reasons, nor the extent to which higher MA coding intensity reflects documenting diagnoses more comprehensively than providers in FFS Medicare do, the fraudulent submission of diagnostic data, or other reasons. Regardless of the causes, favorable selection

of enrollees in MA and higher MA coding intensity increase payments to plans.

When accounting for favorable selection of enrollees in MA and higher MA coding intensity, we estimate that Medicare spends approximately 22 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates into a projected \$83 billion in 2024. The Commission acknowledges that a portion of these increased payments to MA plans are used to provide more generous supplemental benefits and better financial protection for MA enrollees. Nevertheless, the Commission is concerned that the relatively higher payments to MA plans are subsidized by the taxpayers and beneficiaries who fund the program. Higher MA spending increases Part B premiums for all beneficiaries (including those in FFS who do not have access to the supplemental benefits offered by MA plans); the Commission estimates premiums will be about \$13 billion higher in 2024 because of higher MA spending. Further, the Commission is concerned that policies leading to higher MA payments also distort the nature of plan competition on the basis of improving quality and reducing health care costs.

A major overhaul of MA policies is urgently needed for several reasons. First, beneficiaries lack meaningful quality information when choosing among MA plans. Second, Medicare is paying more for MA than for comparable beneficiaries in FFS Medicare. Third, the disparity between MA and FFS payment disadvantages beneficiaries who—for medical reasons or personal preferences—do not want to enroll in MA plans that use tools like provider networks or utilization management policies and instead want to remain in FFS (which includes care provided through alternative payment models). Fourth, the lack of information about the use and value of many MA supplemental benefits prevents meaningful oversight of the program such that we cannot ensure that enrollees are getting value from those benefits. Finally, the continued growth in MA will increasingly create challenges for benchmark setting because beneficiaries remaining in FFS may be higher risk (and thus have higher spending) in ways that risk adjustment cannot adequately capture.

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 MA encounter data. In addition, the growing subsidization of supplemental benefits remains a concern. Because of Medicare's fiscal situation, the subsidization of supplemental benefits, if desired by policymakers, should be considered with attention to their value. In the Commission's view, current policy does not meet that standard. If payments to MA plans were lowered, plans might reduce the supplemental benefits they offer. However, because plans use these benefits to attract enrollees, they might respond instead by modifying other aspects of their bids.

Enrollment, plan offerings, and extra benefits—

Substantial growth in MA plan enrollment, availability, and rebates indicates a robust MA program. From 2018 to 2023, the share of eligible Medicare beneficiaries enrolled in MA rose by 3 percentage points per year, from 37 percent to 52 percent. In 2024, the average Medicare beneficiary has a choice of 43 plans (offered by an average of 8 organizations), and the average enrollee in a conventional MA plan has \$2,142 in extra benefits available from the plan (such benefits are not available to beneficiaries in FFS Medicare unless they purchase additional health insurance coverage or pay for the services out of pocket). The average rebate amount, which finances extra benefits, has more than doubled since 2018 among conventional plans and, in 2024, accounts for 17 percent of payments to MA plans. Although plans are required to submit encounter data for supplemental benefits, CMS does not have reliable information about enrollees' actual use of these benefits.

Medicare payments to plans—As noted above, total Medicare payments to MA plans in 2024 (including rebates that finance extra benefits) are projected to be \$83 billion higher than if MA enrollees were enrolled in FFS Medicare. Payments to MA plans average an estimated 122 percent of what Medicare would have expected to spend on MA enrollees if they were in FFS Medicare. This estimate reflects the impact of higher MA coding intensity (even after the CMS coding adjustment); favorable selection of beneficiaries in MA; setting benchmarks above FFS spending in low-FFS-spending counties; and payments associated with benchmark increases under the quality bonus program

(which the Commission contends does not effectively promote high-quality care).

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 both MA and FFS Medicare, claims include both procedure and diagnosis codes. However, most FFS Medicare claims are paid using only procedure codes, which offers 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 adding new risk-adjustment-eligible diagnoses raises an enrollee's risk score and results in higher payments to the plan. And plans have several mechanisms that do not exist in FFS Medicare to document diagnoses for their enrollees, including chart reviews (which document diagnoses not captured through the usual means of reporting diagnoses) and health risk assessments (which sometimes rely on unverified enrollee-reported data). Coding differences may reflect MA plans documenting diagnoses more comprehensively than providers in FFS Medicare do, the fraudulent submission of diagnostic data, or other reasons. There are no data available to parse the share of higher MA coding intensity due to these or other reasons; however, because the risk-adjustment model is calibrated on FFS claims, relatively higher MA coding intensity—regardless of the reason—increases payments to MA plans above FFS spending.

We estimate that in 2022, MA risk scores were about 18 percent higher than scores for similar FFS beneficiaries due to higher coding intensity (the Commission has adopted a new method of estimating the effects of coding intensity; see Chapter 13). We project that in 2024, MA risk scores will be about 20 percent higher than scores for similar FFS beneficiaries (accounting for the phase-in of the V28 risk-adjustment model). By law, CMS reduces all MA risk scores by the same amount 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 2024, the adjustment will reduce MA risk scores by the minimum amount, 5.9 percent, resulting in MA risk scores that will remain about 13 percent higher

than they would have been if MA enrollees had been enrolled in FFS Medicare. In 2024, higher scores will result in a projected \$50 billion in higher payments to MA plans. We continue to find that coding intensity varies significantly across MA plans, with some plans having coding intensity that falls below the 5.9 percent reduction (and even below FFS levels), and other plans coding far above that amount, including 10 MA organizations having average coding intensity that is more than 20 percent higher than FFS levels. Among the eight largest MA organizations, we estimate a 15 percentage point variation in average coding intensity. Higher coding intensity allows some plans to offer more extra benefits—and attract more enrollees—than other plans. That result distorts both the nature of competition in MA and 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, use two years of diagnostic data, and apply an adjustment to eliminate any residual impact of coding intensity. We find that about half of higher MA coding intensity could result from use of diagnoses from chart reviews and health risk assessments and that these two mechanisms are primary factors driving coding differences among MA plans. Thus, the Commission expects that the recommendation, along with the exclusion of chart reviews from risk adjustment, would improve the heterogeneity in observed coding intensity across MA organizations.

Quality in MA—To make informed choices about enrolling in an MA plan, beneficiaries need good information about the quality and access to care provided by MA plans in their local market. However, the Commission has long been concerned about the ability of the current MA quality bonus program to help beneficiaries meaningfully differentiate across plans and between MA and FFS. Furthermore, the Commission contends that the program does not effectively promote high-quality care and has several other flaws. For instance, it relies on too many measures that do not reflect salient enrollee outcomes or experiences; it distorts improvement incentives with performance thresholds that introduce “cliff effects”; and it evaluates quality for large and sometimes geographically disparate contracts, rather than for plans at the local market level.

In 2024, nearly three-quarters of MA enrollees (23.3 million beneficiaries) were in a plan that received a quality bonus increase to its benchmark, generating about \$15 billion in additional program spending. In its 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. In this report, we focus on the spending implications and other concerns regarding the current quality bonus program. In a future report, we plan to include a more detailed chapter on MA quality and access to care, which will provide more information about the Commission’s approach to these topics, including some empirical analysis of MA plan performance.

Estimating Medicare Advantage coding intensity and favorable selection

Chapter 13 describes the Commission’s methods for estimating the effects of higher MA coding intensity and of a favorable selection of enrollees into MA, including recent revisions to those methods. Estimating the effects of these two factors presents several challenging analytic issues, and we will continue to refine our methods based on the results of our continuing analytic work.

Estimating MA coding intensity—In prior years, the Commission has estimated the impact of higher coding intensity on MA risk scores by comparing changes in MA and FFS risk scores over time for cohorts of beneficiaries with similar age, sex, and MA or FFS enrollment length—the “MedPAC cohort method.” For this report, we revised our cohort method to account for differences in Medicaid eligibility between MA and FFS beneficiaries (which has changed significantly since we first developed our method) and to remove a restriction requiring continuous enrollment in either MA or FFS. These model improvements produced higher estimates of coding intensity compared with our original cohort method.

In the advance notice of payment rates for 2019, CMS requested comment on adopting an alternative method for calculating the MA coding adjustment factor, including the Commission’s cohort method and the demographic estimate of coding intensity (DECI) method (Centers for Medicare & Medicaid Services 2018). The DECI method has produced estimates of coding intensity that are double the estimates

produced by the Commission's cohort method. Therefore, we estimated coding intensity using the DECI method to understand the reasons for the differing coding intensity estimates. We found that by (1) applying this method to complete enrollment, demographic, and risk-score data; (2) accounting for differences in Medicaid eligibility between MA and FFS beneficiaries; and (3) constraining new Medicare enrollees to have no coding intensity, the DECI method yielded very similar estimates of coding intensity (within 1.5 percentage points for all years 2008 through 2021) to our revised cohort method. Because the DECI method includes a greater share of both MA and FFS beneficiaries than the Commission's revised cohort method, we will use the revised DECI method to estimate the impact of coding intensity going forward.

Estimating MA favorable selection—In addition to coding intensity, favorable selection in MA causes payments to plans to be systemically greater than plans' spending for their enrollees. Seeking to both estimate the extent of higher payments that result from favorable selection and incorporate favorable selection into our annual March report to the Congress, the analysis described in Chapter 13 maintains the same analytic framework that we used in our June 2023 report but makes four key technical improvements. In our updated estimates, we continue to estimate that the effect of favorable selection resulted in Medicare payments that were substantially higher for MA enrollees than if those same beneficiaries were in FFS.

The Commission will continue to refine these estimates in future work. We continue to conduct sensitivity analyses of certain aspects of our method, particularly related to how our analysis deals with regression to the mean and attrition of beneficiaries from MA cohorts.

Mandated report: Dual-eligible special needs plans

Individuals who qualify for both Medicare and Medicaid, known as dual-eligible beneficiaries or “dual eligibles,” may receive care that is fragmented or poorly coordinated because of the challenges of navigating two distinct and complex programs. The Bipartisan Budget Act (BBA) of 2018 directs the Commission to periodically compare the performance of several types of Medicare managed care plans that serve dual eligibles but vary in their level of integration with Medicaid. Many of the plan types are variations of the

dual-eligible special needs plan (D-SNP), which is a specialized MA plan. Chapter 14 contains our second report under the BBA of 2018 mandate.

As required by the mandate, we compare plans' performance using quality measures that plans report as part of the Healthcare Effectiveness Data and Information Set® (HEDIS®) and patient experience data that plans collect using the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) beneficiary survey. (We used HEDIS data in our first mandated report, while our analysis of CAHPS data is new.) We find that these data sources provide limited insight into the relative performance of D-SNPs because most HEDIS measures are not tied to clinical outcomes and because HEDIS and CAHPS scores on many measures are fairly similar across plan types. MA plans perform better on some measures than Medicare-Medicaid Plans (MMPs), which are demonstration plans that operate outside the MA program, but those differences could reflect structural differences between the two types of plans. These findings are consistent with our first mandated report and with other Commission analyses that have examined the difficulties of assessing the quality and performance of MA plans.

The landscape of health plans that serve dual eligibles will change in 2025, when the MMP demonstration is scheduled to end. Most evaluations have found that MMPs increase Medicare spending and have had mixed effects on service use. After the demonstration ends, we expect most MMPs to convert into D-SNPs.

Mandated report: Rural emergency hospitals

Historically, Medicare's support for rural hospitals has focused on making inpatient services more profitable. However, inpatient volume has declined dramatically over the past 40 years, especially at rural hospitals. Such declines diminish the impact of Medicare's inpatient-centric support of hospitals and, in the 2010s, contributed to an increase in rural hospital closures. This situation led the Congress to create the new REH designation in the Consolidated Appropriations Act, 2021 (CAA). These entities do not furnish inpatient care, but must meet several other criteria, including having an emergency department that is staffed 24/7 and a transfer agreement with a Level I or Level II trauma center. They are paid fixed monthly payments from

Medicare (approximately \$270,000 per month, totaling \$3.2 million per year in 2023), in addition to rates of 105 percent of standard OPPS rates for emergency and outpatient services.

The CAA also requires the Commission to report annually on payments to REHs, beginning in March 2024. Chapter 15 contains our first mandated report on REHs. Because this program began in 2023, complete REH claims data are not yet available. Therefore, this chapter provides context on the evolution of Medicare's support for rural hospitals, gives background on the REH designation and the hospitals that have converted to REHs, and describes our 2023 site visits to (prospective) REHs to understand

their experiences and decision-making processes. In 2023, 21 hospitals converted to REHs. Before converting, these hospitals often furnished a low (and declining) volume of inpatient care, received enhanced payments from Medicare, were located relatively close to other hospitals, and had financial difficulties. The REH designation has been seen as a way to overcome financial difficulties and retain local access to emergency and outpatient services in communities that cannot support a full-service hospital. The Commission will continue to monitor the new REH designation, including analysis of REH claims when they become available, and consider possible modifications in the future. ■

C H A P T E R

1

Context for Medicare payment policy

Context for Medicare payment policy

Chapter summary

Each March, the Commission reports to the Congress on traditional Medicare's various fee-for-service (FFS) payment systems, the Medicare Advantage program, and the Medicare Part D prescription drug program. To put the information presented in those chapters in context, this chapter highlights key trends in national health care spending and Medicare spending and reviews the factors that contribute to spending growth.

During the recent coronavirus pandemic, the Congress appropriated several hundred billion dollars in relief funds to offset providers' lost revenues and to ensure that they remained viable sources of care. The Congress and CMS also temporarily changed certain payment and coverage policies. In 2020, those measures doubled the rate of growth in national health care spending. However, by 2021, relief funds tapered off, resulting in slower growth in national health care spending.

By contrast, total Medicare spending grew at a slower-than-usual pace during the pandemic. Although Medicare spending increased on COVID-19 testing and treatment and on services that were made more widely available through waivers of Medicare's usual payment rules, this increase was more than offset by decreased spending on non-COVID-19

In this chapter

- National health care spending has grown faster than GDP
- Medicare spending is projected to double in the next 10 years
- Medicare faces a financing challenge
- As Medicare spending increases, so too does beneficiary cost sharing
- Leading causes of death are heart disease and cancer
- Life expectancy at age 65 has increased, but some groups of beneficiaries have lower longevity and worse access to care
- The Commission's recommendations to slow Medicare spending growth and improve access to care

care. The most common types of care that Medicare beneficiaries reported forgoing in the early months of the pandemic were dental care, regular check-ups, treatment for an ongoing condition, and diagnostic or medical screening tests. But some beneficiaries reported forgoing more serious types of care, such as urgent care for an accident or illness. Spending growth has recently been particularly slow for FFS Medicare, which Medicare's Trustees attribute to a few factors, including the lower average morbidity among Medicare beneficiaries who survived the pandemic. Another factor was joint replacement procedures moving from inpatient to (lower-cost) outpatient settings after their removal from Medicare's "inpatient only" list. In addition, beneficiaries dually enrolled in Medicare and Medicaid (who tend to generate high spending) have increasingly opted to enroll in Medicare Advantage plans rather than traditional FFS coverage, which has helped to reduce FFS Medicare spending per beneficiary.

Between now and the early 2030s, CMS expects total Medicare spending to grow at rates more consistent with historical norms—by 7 percent or 8 percent per year, on average. At that rate, Medicare spending will double in a 10-year period, rising from over \$900 billion in 2022 to \$1.8 trillion in 2031. Medicare's projected spending growth is driven by economy-wide inflation, the increasing number of beneficiaries in the program (which is expected to grow by about 2 percent per year until 2029 as the baby-boom generation ages into Medicare), and the increasing volume and intensity of services delivered per beneficiary.

Despite the projected growth in Medicare spending, the program finds itself in a better position financially than a few years ago. After an initial economic slowdown at the start of the pandemic, the U.S. economy subsequently experienced strong growth in 2021 and 2022, yielding higher-than-expected Medicare payroll tax revenues. At the same time, Medicare beneficiaries used a lower volume of Part A services than expected during the pandemic, and future Part A spending is now projected to be lower than previously expected. As a result, the balance in Medicare's Hospital Insurance Trust Fund has been increasing. The trust fund is now projected to be able to pay its share of Part A services for several more years than was estimated before the pandemic—until 2031, according to Medicare's Trustees or until 2035, according to the Congressional Budget Office.

Yet pressure to restrain the growth in Medicare's overall spending remains. Medicare spending is projected to constitute a rising share of GDP in the coming years, and growth in Medicare spending will cause beneficiaries to

face higher premiums and cost sharing over time. Further, a growing share of general federal revenues must be transferred to Medicare's Supplementary Medical Insurance (SMI) Trust Fund to help pay for Part B clinician and outpatient services and Part D prescription drug coverage. For example, in 2022, 13 percent of all personal and corporate income taxes collected by the federal government were transferred to the SMI Trust Fund to pay for Part B and Part D; by 2030, 22 percent of all income tax revenues are expected to be transferred for this purpose.

One way the Medicare program has reduced spending growth relative to the commercial market is by setting prices in certain sectors. Our annual March report recommends updates to FFS Medicare payment rates for various types of providers. Our annual June report typically offers broader recommendations aimed at restructuring the way Medicare's payment systems work. A list of all the Commission's recommendations, with links to relevant reports, is available at medpac.gov/recommendation/. These recommendations are based on the Commission's review of the latest available data and aim to obtain good value for expenditures—which means maintaining beneficiaries' access to high-quality services while encouraging efficient use of resources. ■

Introduction

Every March, the Commission reports to the Congress on traditional Medicare's various fee-for-service (FFS) payment systems, the Medicare Advantage (MA) program, and the Medicare Part D prescription drug program. For context, this chapter highlights key trends in health care spending, for the country as a whole and for the Medicare program in particular. We also review the factors that contribute to Medicare spending growth—including trends in demographics and the volume and intensity of services delivered per beneficiary.

National health care spending has grown faster than GDP

In 2022, \$4.5 trillion was spent on health care in the U.S. This spending accounted for 17.3 percent of the U.S.'s gross domestic product (GDP)—up from 14.9 percent 20 years earlier (Figure 1-1, p. 8). Medicare spending has also grown as a share of GDP over time—making up 3.7 percent of GDP in 2022, up from 2.4 percent 20 years earlier.

National health care spending usually grows faster than GDP, which means this spending as a share of GDP increases over time (Figure 1-1, p. 8). But different spending trends were observed during the recent coronavirus pandemic, with national health care spending as a share of GDP sharply increasing in 2020 and then falling in 2021 and 2022, as it returned to its prepandemic share.

In 2020, national health care spending increased by 10.6 percent due to one-time spending by the federal government on pandemic relief funds for health care providers, a relaxation of Medicaid's eligibility rules during the pandemic that allowed more people to be enrolled in that program than would otherwise be the case, and an increase in spending on public health activities (e.g., for vaccine development) (Hartman et al. 2024). Because this large increase occurred in a year when the country's GDP was shrinking, it resulted in a sharp increase in the share of the country's GDP devoted to national health care spending. (The two main sources of pandemic relief funds for health care

providers were the Paycheck Protection Program and the Provider Relief Fund, which together paid health care providers \$174.6 billion in 2020 (Hartman et al. 2024).^{1,2})

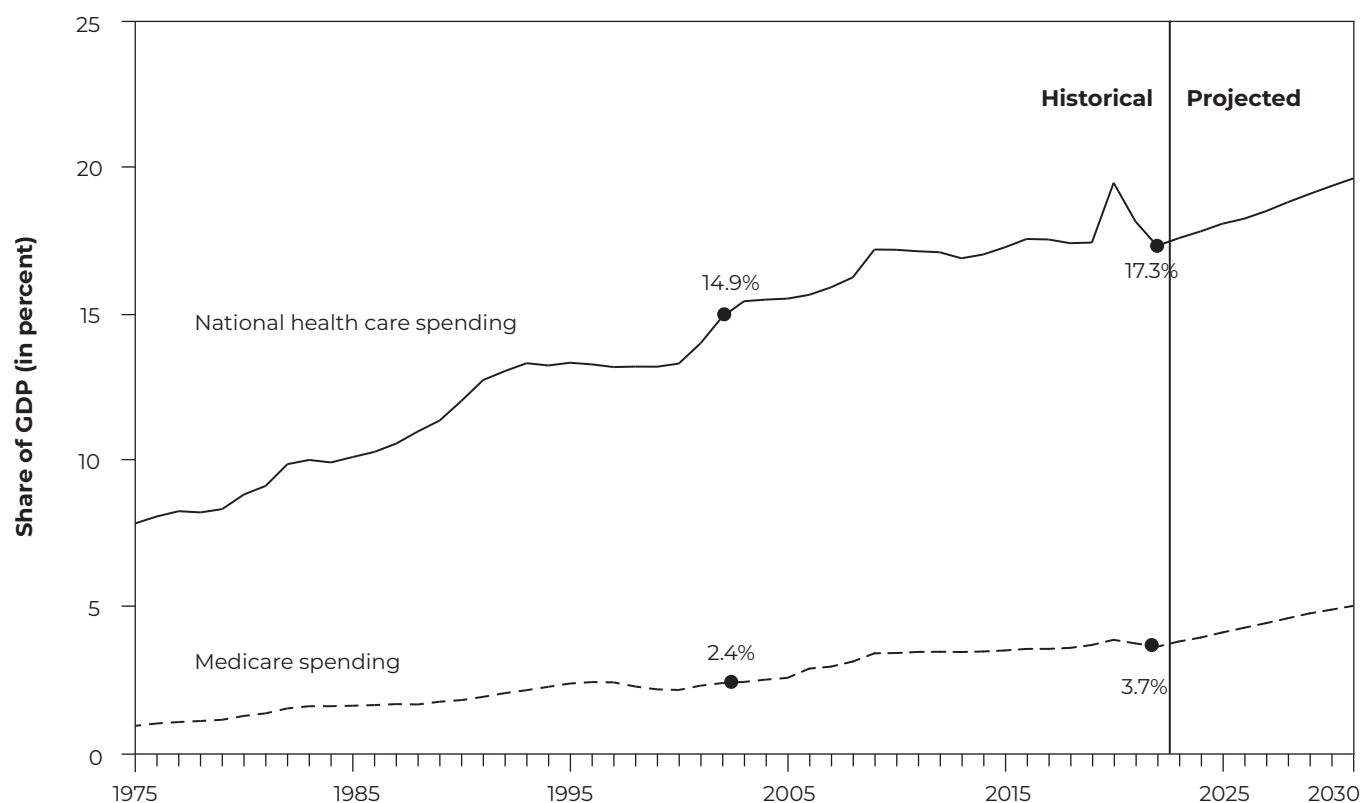
In 2021, national health care spending increased by a more modest 3.2 percent as supplemental funding provided to address the pandemic fell and utilization of health care services by patients rebounded (Hartman et al. 2024). Since this modest spending increase occurred in a year when GDP expanded rapidly (by 10.7 percent), national health care spending as a share of GDP fell in 2021 (Figure 1-1, p. 8) (Hartman et al. 2024).

National health care spending grew by 4.1 percent in 2022—a rate more consistent with prepandemic growth rates—driven by growth in Medicaid and private health insurance spending (Hartman et al. 2024). This increased spending occurred in a year when GDP continued to grow rapidly (by 9.1 percent, due primarily to high economy-wide inflation of 7.1 percent) (Hartman et al. 2024). As a result, national health care spending as a share of GDP is estimated to have fallen for the second year in a row in 2022 (to 17.3 percent of GDP—similar to the share of GDP spent on health care in 2019, before the pandemic began) (Hartman et al. 2024).

Spending trends in 2023 are estimated to have returned to historical norms, with national health care spending growth (5.1 percent) outpacing GDP growth (4.1 percent) (Keehan et al. 2023). As a result, national health care spending as a share of GDP is expected to have grown slightly to 17.6 percent of GDP (Keehan et al. 2023). CMS expects familiar spending patterns to continue through 2031, with national health care spending growing faster than GDP in part because medical prices are projected to grow faster than economy-wide prices over this period (Keehan et al. 2023). For a discussion of the link between private insurers' prices and provider consolidation, see text box (pp. 9–11).

Medicare spending is projected to double in the next 10 years

Medicare is the largest single purchaser of health care in the U.S., accounting for about a quarter of the

**FIGURE
1-1****Health care spending has grown as a share of the country's GDP**

Note: GDP (gross domestic product). The first projected year in the graph is 2023. Pandemic relief funds are counted as national health care spending rather than Medicare spending since they were meant to offset pandemic-related revenue losses from all payers, not just Medicare.

Source: MedPAC analysis of CMS's national health expenditure data (projected data released in July 2023 and historical data released in December 2023), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html>.

nation's spending on personal health care (Medicare Payment Advisory Commission 2023).³ Medicare covers care provided to its beneficiaries in hospitals and skilled nursing facilities, as well as physician and other health care providers' services, home health care, hospice care, lab tests, durable medical equipment, and prescription drugs. Medicare also makes payments to hospitals to help cover the costs of charity care and contributes funding to medical school graduates' residency training programs (see text box, p. 13).

During the recent coronavirus pandemic, Medicare spending grew more slowly than had been expected.

Although spending increased on COVID-19 testing and treatment and on services that were made more widely available through waivers of Medicare's usual payment rules, the increase was more than offset by decreased spending on non-COVID care (Boards of Trustees 2023).⁴ The most common types of care that Medicare beneficiaries reported forgoing in the early months of the pandemic were dental care, regular check-ups, treatment for an ongoing condition, and diagnostic or medical screening tests—but some beneficiaries reported forgoing more serious types of care such as urgent care for an accident or illness (Centers for Medicare & Medicaid Services 2020). Spending has recently grown particularly slowly for

Provider consolidation and increasing commercial prices

Between 2012 and 2022, spending per privately insured enrollee grew by 3.2 percent annually, on average, while spending per Medicare beneficiary grew by an average of 2.6 percent each year—closer to the general inflation rate of 2.5 percent (Bureau of Labor Statistics 2023, Centers for Medicare & Medicaid Services 2023b). Since the faster growth in spending for privately insured people occurred at a time of low growth in their use of health care, we and others have concluded that growth in the prices private insurers pay to providers drove the faster spending growth observed for privately insured people (Health Care Cost Institute 2023, Health Care Cost Institute 2020). Although there is wide variation geographically and by service, private insurers generally pay rates about twice as high as Medicare for hospital services and almost one and a half times Medicare rates for physician services (Chernew et al. 2020, Kaiser Family Foundation 2020, Medicare Payment Advisory Commission 2017, Whaley et al. 2022).

Growth in the prices private insurers pay providers is likely influenced by the growing consolidation of health care providers, which increases their market share and puts them in a stronger bargaining position when negotiating rates with private insurers (Abelson 2018, Baker et al. 2014a, Baker et al. 2014b, Beaulieu et al. 2023, Beaulieu et al. 2020, Cooper et al. 2015, Curto et al. 2022, Department of Justice and Federal Trade Commission 1996, Federal Trade Commission 2016a, Federal Trade Commission 2016b, Gaynor and Town 2012, Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2017, Robinson and Miller 2014, Scheffler et al. 2018, Whaley et al. 2022). Providers may feel they need to increase their leverage with private insurers since insurers, in turn, often have large local market shares: One study found that in 2022, commercial health plans were “highly” concentrated in 73 percent of local markets, up from 71 percent in 2014, according to the Department of Justice and the Federal Trade Commission’s definition (Guardado and Kane 2023).⁵ Insurers with larger market shares appear to

negotiate lower prices with providers, but it is not clear the degree to which these savings are passed down to the purchasers of insurance (Dafny et al. 2012, LoSasso et al. 2023, RAND Corporation 2022, Roberts et al. 2017, Scheffler and Arnold 2017, Trish and Herring 2015).

Hospitals have been consolidating with other hospitals

Hospitals have steadily consolidated over the past several decades. From 2003 to 2017, the share of hospital markets that were “super” concentrated (i.e., with a single dominant system that accounts for a majority of hospital discharges) rose from 47 percent to 57 percent (Medicare Payment Advisory Commission 2020).⁶ According to a recent scan of the literature, there is strong evidence that horizontal hospital consolidation increases prices and health care spending (RAND Corporation 2022).

Hospitals have been acquiring physician practices

By 2016, 92 percent of acute care stays were in hospitals affiliated with physicians in a vertically integrated system (Karaca and Fingar 2020). Between 2016 and 2018, the share of all physicians affiliated with health systems grew from 40 percent to 51 percent (Furukawa et al. 2020).

Some of Medicare’s policies may have created incentives for hospitals to acquire physician practices—through higher payment rates for hospital-owned physician practices and the Merit-based Incentive Payment System’s burdensome reporting requirements. In a 2022 survey, the American Medical Association found that the top reasons physicians gave for selling a practice to a hospital or health system were to obtain higher payment rates, gain access to costly resources, and get help meeting regulatory and administrative requirements (Kane 2023). After controlling for the level of horizontal concentration of physician services, several studies found that hospital-physician integration led to commercial price

(continued next page)

Provider consolidation and increasing commercial prices (cont.)

increases, often in the range of 3 percent to 14 percent (Capps et al. 2018, Curto et al. 2022, Medicare Payment Advisory Commission 2017, Neprash et al. 2015, Whaley et al. 2021). Acquisition of primary care practices by large health systems has also been found to be associated with increased referrals to health systems and increased spending per patient (Sinaiko et al. 2023).

Other types of companies have been acquiring physician practices

Commercial insurers have also acquired physician groups, medical centers, and urgent care facilities as well as their own pharmacy benefit managers, pharmacies, and data analytic firms (Herman 2022). UnitedHealth Group's Optum Health is now reported to be the largest employer of clinicians in the U.S., with 130,000 employed or aligned clinicians (Emerson 2023, UnitedHealth Group 2023). And companies that have not traditionally participated in health care, such as Amazon, have also begun acquiring primary care practices (Landi 2022).

Although just 4 percent of physicians reported private equity ownership in their practice in 2020 (Kane 2021), private equity funds compete with health systems, insurers, and other companies for physician practices and may contribute to increasing consolidation and increasing prices (Federal Trade Commission 2023, La Forgia et al. 2022, Medicare Payment Advisory Commission 2021, Scheffler et al. 2023).⁷ A challenge involved in studying practices with private equity ownership is the lack of a national database containing standardized information on practice ownership, although researchers have begun manually identifying practices with private equity ownership and studying them (Medicare Payment Advisory Commission 2021).

Effect of provider consolidation on quality is unclear

There is limited information on the effects of horizontal and vertical consolidation on quality. Most of the older literature suggests that

consolidation increases prices without improving quality. Some literature suggests that a lack of competition may hurt quality (Gaynor et al. 2017). However, the effect of horizontal consolidation and vertical integration on quality is less clear than the effect of consolidation on price. A study that examined the longitudinal effects of hospital mergers on quality found that “hospital acquisition by another hospital or hospital system was associated with modestly worse patient experiences and no significant changes in readmission or mortality rates. Effects on process measures of quality were inconclusive” (Beaulieu et al. 2020). Meanwhile, a cross-sectional comparison of vertically integrated practices and independent physician practices found that physicians employed by a hospital system received substantially higher prices from commercial insurers (12 percent to 26 percent higher, on average, depending on the service) and had “marginally better” performance on clinical process and patient experience measures than independent practices (Beaulieu et al. 2023). For example, 77.3 percent of system physicians’ patients rated their physician a 9 or a 10 on a 10-point scale compared with 76.0 percent of patients seeing independent physicians (a difference that was statistically significant ($p < 0.001$)). Given the design of the study, we do not know whether the large systems’ slightly better performance on process and patient experience measures is due to the structure and size of the integrated systems or due to the systems’ selection of clinicians.

Providers pursue high payment rates from private insurers regardless of Medicare’s actions

Hospital stakeholders may assert that losses on Medicare patients force them to increase private prices, merge into larger systems with pricing power, or close (Dobson et al. 2006, Fox and Pickering 2008, Frakt 2015, Priselac 2023). However, there is little evidence that low Medicare prices or high shares of Medicare services directly cause hospitals to raise prices (i.e., to use previously unused market power) (Frakt 2015, Ginsburg 2023,

(continued next page)

Provider consolidation and increasing commercial prices (cont.)

White 2013). In addition, while some small hospitals with high Medicare shares have closed (Chernew et al. 2021, Medicare Payment Advisory Commission 2021), most of these closed hospitals had very few patients, and there is no evidence that the closures of these low-volume hospitals resulted in sufficient consolidation to materially affect commercial prices. In fact, a Congressional Budget Office analysis and literature review found that “the share of providers’ patients who are covered by Medicare and Medicaid is not related to higher prices paid by commercial insurers. That finding suggests that providers do not raise the prices they negotiate with commercial insurers to offset lower prices paid by government programs (a concept known as cost shifting)” (Congressional Budget Office 2022).

Providers’ ability to command high prices from private insurers has not hurt beneficiaries’ access to care

To date, the rise in commercial prices has had little direct impact on Medicare prices and enrollee access to clinician services. Even as commercial prices have risen relative to Medicare payments, most clinicians continue to participate in the Medicare program. The National Ambulatory Medical Care Survey found that in 2021, among the 94 percent of nonpediatric office-based physicians who reported accepting new patients, a higher share accepted new Medicare patients (89 percent) than new privately insured patients (88 percent) (Schappert and Santo 2023). And an American Medical Association (AMA) survey of physicians practicing in a wider range of settings (including hospitals) found that in 2022, among nonpediatricians accepting new patients, 96 percent reported accepting new patients and only 2 percent said they accepted only new privately insured patients (American Medical Association 2023b).

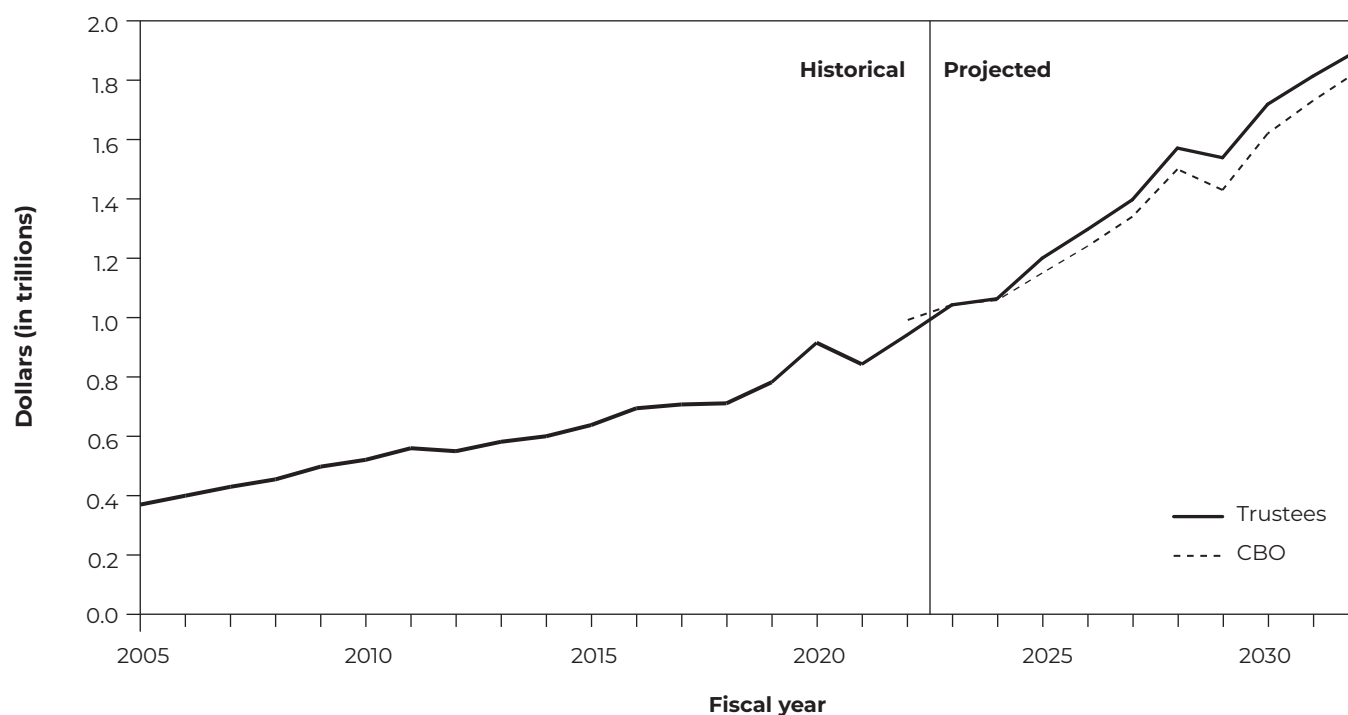
There are many reasons that clinicians may choose to accept fee-for-service (FFS) Medicare despite payment rates that are usually lower than commercial rates. A substantial share of most clinicians’ patients are covered by Medicare,

and if these clinicians opted to accept only commercially insured patients, they might not be able to fill their patient panels. In addition, physicians who are employed by hospitals or health plans may be required to accept Medicare as a condition of employment, and some hospitals may require physicians to participate in Medicare to receive admission and clinical privileges. At the same time, although commercial insurers may offer comparatively high payment rates, commercial insurers often also impose burdensome requirements on clinicians that take time to complete, such as requiring clinicians to appeal denied claims and complete insurers’ prior authorization paperwork. A recent AMA survey found that physicians complete an average of 45 prior authorization requests per week, requiring 14 hours per week, and 35 percent of physicians have dedicated staff who work exclusively on completing prior authorizations (American Medical Association 2023a). In contrast, FFS Medicare generally requires no prior authorization for services and is known as a prompt payer since it is required to pay “clean” claims within 30 days and must pay providers interest on any late payments. The relative lack of utilization management and the administrative simplicity of billing FFS Medicare may help offset the program’s lower payment rates.

If the difference between the prices paid by Medicare and commercial insurers grows larger, it is unclear what the long-term impact would be on Medicare beneficiaries’ access to care. In the case of hospitals, higher private prices enabled by consolidation result in less pressure for providers to constrain costs. These higher costs are then included in hospitals’ cost reports, resulting in lower Medicare profit margins and pressure to increase provider payment rates. If Medicare payment rates do not keep pace with these higher costs, eventually the difference between commercial rates and Medicare rates could grow so large that providers have an incentive to focus primarily on patients with commercial insurance. Thus, in the long term, Medicare beneficiaries’ access to care may in part depend on commercial payer rates. ■

FIGURE 1-2

Medicare spending is projected to double in the next 10 years



Note: CBO (Congressional Budget Office). The first projected year in the graph is 2023. The sharp increase in spending in 2020 includes Medicare Accelerated and Advance Payments paid to providers—payments that were then recouped by the Medicare program in 2021 and 2022.

Source: 2023 annual report of the Boards of Trustees of the Medicare trust funds, Table V.H4; CBO's May 2023 baseline projections for the Medicare program.

TABLE 1-1

Factors contributing to Medicare's projected Part A and Part B spending growth, 2023–2032 (after subtracting economy-wide inflation)

Average annual percent change in:

Medicare Part	Medicare prices (minus inflation)	Number of beneficiaries	Beneficiary demographic mix	Volume and intensity of services used	Medicare's projected spending (minus inflation)
Part A	–0.2%	1.9%	0.1%	1.8%	3.7%
Part B	–1.1	2.0	0.1	4.2	5.1
Total	–0.7	N/A*	0.1	3.1	4.5

Note: N/A (not applicable). Includes Medicare Advantage enrollees. "Medicare prices" reflects Medicare's annual updates to payment rates (not including inflation, as measured by the consumer price index), total factor productivity reductions, and any other reductions required by law or regulation. "Volume and intensity" is the residual after the other three factors shown in the table (growth in Medicare prices, number of beneficiaries, and beneficiary demographic mix) are removed. "Medicare's projected spending" is the product of the other columns in the table. The "Total" row is the sum of the other rows of the table, each weighted by its part's share of total (Part A plus Part B) Medicare spending in 2022 (as measured by shares of gross domestic product). Part D spending growth is not shown.

*Not applicable because there is beneficiary overlap in enrollment in Part A and Part B.

Source: MedPAC analysis of data from the 2023 annual report of the Boards of Trustees of the Medicare trust funds.

Medicare funds physicians' training programs after medical school

The Medicare program is estimated to have provided over \$16 billion in 2020 to help fund residency programs that provide hands-on clinical training to medical school graduates, usually in a hospital setting (Villagrana 2022). Other federal agencies also provide smaller contributions to help train physicians, and hospitals often self-fund some residents as well (Government Accountability Office 2021). There are both benefits and costs to hospitals in operating a residency program. On the one hand, costs include the salaries of residents themselves as well as the salaries of the more senior physicians who serve as faculty in these programs and train residents. On the other hand, benefits of operating a residency program include the higher

hospital fees such hospitals receive from Medicare and the economical clinical labor that hospitals gain access to, since the average first-year resident is paid about \$60,000 per year (Murphy 2022)—much less than nurse practitioners, physician assistants, and physicians who have completed their training (see Chapter 4). Medicare generally does not subsidize training programs for nurse practitioners or physician assistants (Government Accountability Office 2019), whose numbers have nevertheless grown rapidly in recent years—by 41 percent from 2017 to 2022, compared with 2.5 percent growth in the number of physicians over this same period (see Table 4-1 (p. 98) in Chapter 4). ■

FFS Medicare, which Medicare's Trustees attribute to a few factors. One factor is the lower average morbidity among Medicare beneficiaries who survived the pandemic. Another factor is the shift of setting for joint replacement procedures from inpatient to (lower-cost) outpatient facilities after these procedures were removed from Medicare's "inpatient only" list. In addition, beneficiaries dually enrolled in Medicare and Medicaid (who tend to generate a high amount of spending) have increasingly opted to enroll in Medicare Advantage plans rather than traditional FFS coverage, which has helped to reduce FFS Medicare spending per beneficiary (Boards of Trustees 2023).

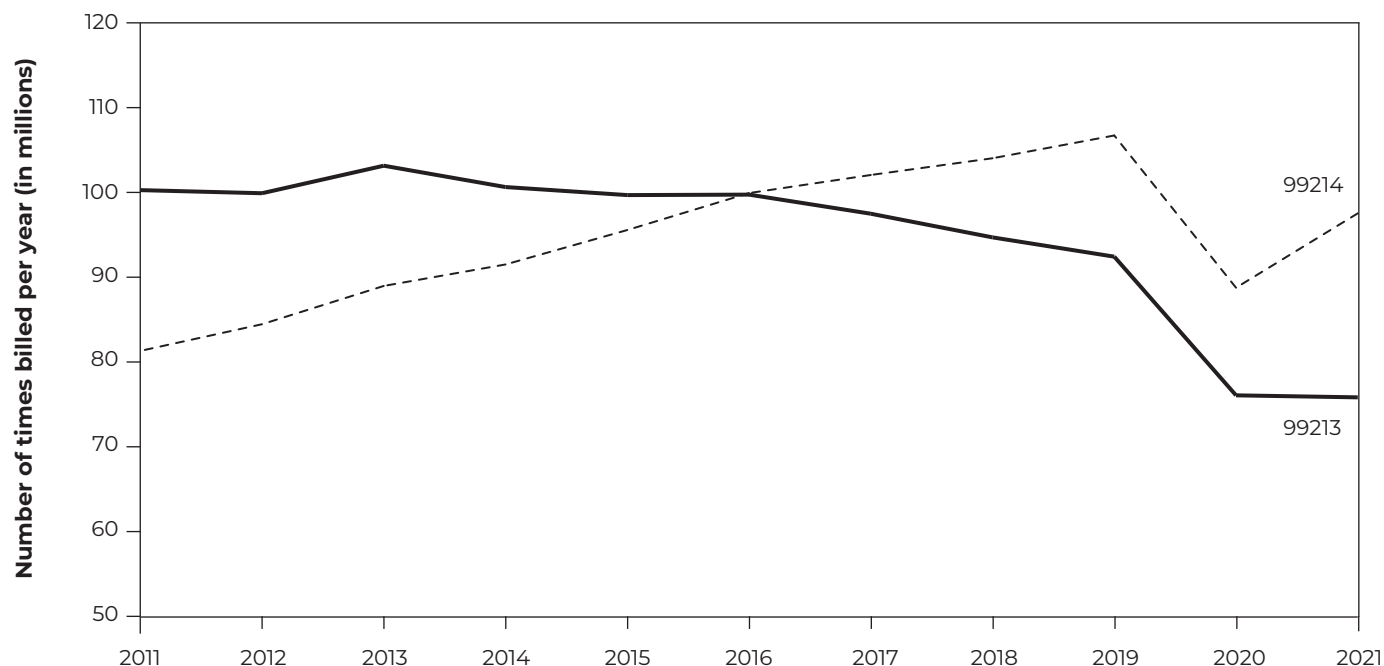
Between now and the early 2030s, CMS expects Medicare spending to grow at rates more consistent with historical norms—by 7 percent or 8 percent per year, on average (Keehan et al. 2023).⁸ This will result in Medicare spending doubling over a 10-year period—rising from over \$900 billion in 2022 to \$1.8 trillion in 2031 (Figure 1-2). (These amounts include Medicare program spending and beneficiaries' premiums but not beneficiaries' cost sharing.)

Several factors drive the projected growth in Medicare's spending over the next decade. The annual report produced by Medicare's Trustees decomposes projected Medicare spending growth into explanatory factors, and we have augmented their analysis by removing the effects of economy-wide inflation (Table 1-1). Table 1-1 shows that Medicare Part A and Part B spending are together projected to grow 4.5 percent faster than inflation over the next 10 years. This increase is not due to Medicare price growth since Medicare's prices are generally expected to grow more slowly than economy-wide inflation over this period (shown in the first column of the table). Instead, the two factors driving Medicare's spending growth are the number of beneficiaries (which is expected to grow by about 2 percent per year, as the baby-boom generation continues to age into Medicare) and the volume and intensity of services delivered per beneficiary (which is expected to grow by an average of 3.1 percent per year from 2023 to 2032).

Volume and intensity of services can increase over time—for example, when newer, higher-resolution computed tomography (CT) scans identify potential

**FIGURE
1-3**

Clinicians have increasingly used billing code 99214 (“moderate” level of medical decision-making) instead of 99213 (“low” level of medical decision-making)



Note: Current Procedural Terminology (CPT) codes 99213 and 99214 refer to office/outpatient visits with established patients involving a medically appropriate history and/or examination; 99213 refers to visits involving a “low” level of medical decision-making and/or 20–29 minutes of practitioner time, while 99214 refers to visits involving a “moderate” level of medical decision-making and/or 30–39 minutes of clinician time. Before 2021, code definitions were more prescriptive about the content of these visits and did not allow time alone to justify the use of one of these codes.

Source: Centers for Medicare and Medicaid Services. Part B National Summary Data Files, 2011–2021. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Part-B-National-Summary-Data-File/Overview>.

issues that might not have been identified by lower-resolution CT scans, and those issues are then pursued through additional clinical workup, increasing volume. The intensity of services delivered can also increase when providers furnish more complex, higher-priced services in place of less complex, lower-priced services. For example, in recent years clinicians treating FFS Medicare beneficiaries have furnished more office visits using billing code 99214 (which involves a “moderate” level of medical decision-making) instead of 99213 (involving a “low” level of medical decision-making), as shown in Figure 1-3.

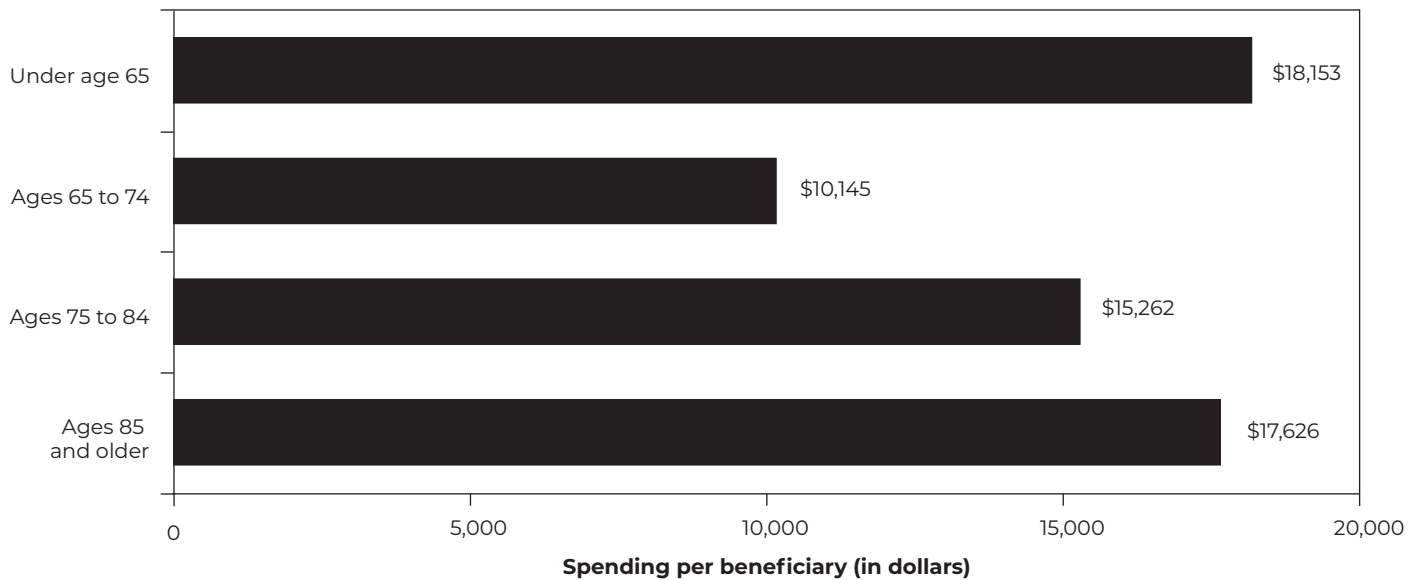
Table 1-1 (p. 12) indicates that the changing demographic mix of beneficiaries in the program is not expected to cause significant increased spending in the next 10 years. The average Medicare beneficiary

has been getting younger in recent years, as the baby-boom generation ages into Medicare (Boards of Trustees 2023). Shifting demographics are not expected to cause a material increase in spending per beneficiary until the 2030s, when baby boomers begin to reach older ages (Boards of Trustees 2023). This aging will have cost implications for the Medicare program because, among beneficiaries ages 65 and over, spending per beneficiary increases with age (Figure 1-4).

Another factor that is driving increased Medicare spending is the growing enrollment in MA plans, which are an alternative to traditional FFS Medicare. The share of beneficiaries enrolled in MA plans has grown rapidly over the past two decades: 52 percent of beneficiaries with both Part A and Part B coverage

**FIGURE
1-4**

Spending per beneficiary was highest for the oldest Medicare beneficiaries and beneficiaries under the age of 65 (most of whom are disabled), 2020



Note: Includes beneficiaries in fee-for-service Medicare and Medicare Advantage dwelling in the community and in institutions. Enrollees under age 65 are eligible for Medicare due to disability (i.e., if they have received Social Security Disability Insurance payments for 2 years or have been diagnosed with amyotrophic lateral sclerosis (Lou Gehrig's disease)), end-stage renal disease, or exposure to environmental health hazards in areas under a corresponding emergency declaration (Boards of Trustees 2023).

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost Supplement file 2020.

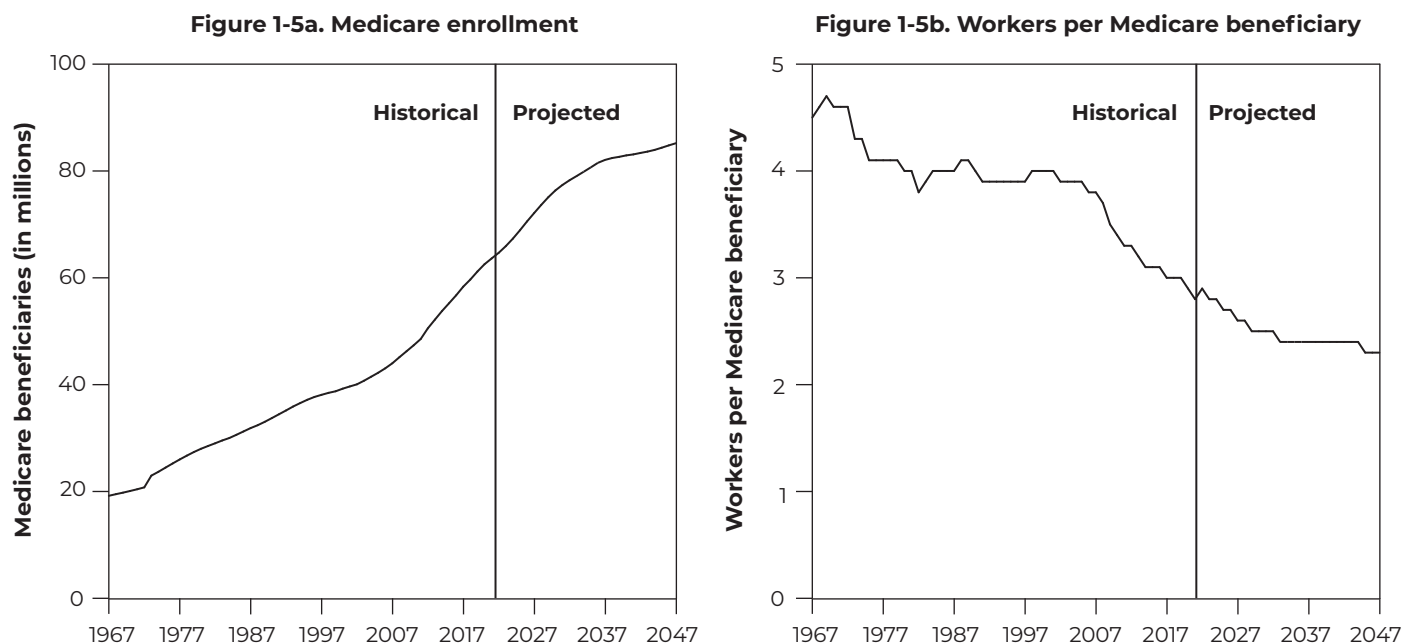
were enrolled in MA plans in 2023 (see Chapter 12).⁹ We estimate that the Medicare program spent substantially more per beneficiary for MA enrollees compared with what spending would have been for these enrollees in traditional FFS Medicare in 2023 (see Chapter 12). The main factors that the Commission has identified as contributing to this higher spending on MA are higher diagnostic coding intensity (since reporting more diagnosis codes for a beneficiary enrolled in MA increases payments to MA plans relative to what would have occurred in FFS) and the favorable selection that plans experience (before any plan interventions) when beneficiaries with lower-than-predicted spending enroll in MA.

MA plans receive monthly capitated payments from the Medicare program and in turn pay health care providers using payment rates that they negotiate

with providers. (In contrast, for beneficiaries in FFS Medicare, Medicare pays health care providers directly for health care goods and services at prices set through legislation and regulation.) MA plans' payments to providers can take the form of FFS payments or can take other forms, such as partially capitated payments. MA plans are required to have a cap on beneficiaries' total in-network annual out-of-pocket spending and typically incorporate Part D coverage for retail prescription drugs. In addition, nearly all MA plans offer supplemental coverage that typically includes reduced cost sharing for many services, and they often provide some coverage for other benefits (e.g., vision, dental, and hearing benefits). In exchange for these benefits, beneficiaries in MA generally agree to a narrower network of providers than beneficiaries in traditional FFS Medicare. In-network services may be subject to utilization management (e.g., prior

FIGURE 1-5

Medicare enrollment is rising while the number of workers per Medicare beneficiary is declining



Note: "Medicare beneficiaries" refers to beneficiaries covered by Medicare Part A (including beneficiaries enrolled in Medicare Advantage plans). More beneficiaries have Part A Hospital Insurance than Part B Supplementary Medical Insurance because Part A is usually available to beneficiaries at no cost. First projected year is 2023. Part A services are financed by Medicare's Hospital Insurance Trust Fund and beneficiary cost sharing.

Source: 2023 annual report of the Boards of Trustees of the Medicare trust funds.

authorization, referrals, and alternative cost sharing). And beneficiaries may face higher cost sharing or no coverage for services if they seek care outside of their plan's provider network.¹⁰

Medicare faces a financing challenge

The entire baby-boom generation will be old enough to enroll in Medicare by 2029 (Keehan et al. 2023).¹¹ By that point, Medicare is projected to have 75 million beneficiaries—up from 65 million beneficiaries in 2022 (Figure 1-5a). Meanwhile, the ratio of workers helping to finance Medicare through their taxes relative to the number of Medicare beneficiaries is expected to continue to decline. Around the time of Medicare's inception, there were 4.5 workers for each Medicare

beneficiary, but by 2022 there were only 2.9 workers per beneficiary, and by 2031 there are expected to be only 2.5 workers per beneficiary (Figure 1-5b).

These demographics create a financing challenge for the Medicare program. Medicare Part A (which covers inpatient hospital stays and post-acute care following those hospital stays) is mainly financed through current workers' Medicare payroll taxes, which are deposited into Medicare's Hospital Insurance (HI) Trust Fund.^{12,13} In some years, Medicare has spent more on Part A services than it has collected through HI Trust Fund revenues—creating annual deficits that cause the trust fund's account balance to decline. In other years, trust fund revenues have exceeded Part A spending (including in 2021 and 2022)—creating annual surpluses that cause the trust fund's account balance to rise. Medicare's Trustees currently estimate

**TABLE
1-2**

Higher Medicare payroll tax or lower Medicare Part A spending needed to maintain solvency of Medicare's Hospital Insurance Trust Fund

To maintain Hospital Insurance Trust Fund solvency for:	Increase 2.9% Medicare payroll tax to:	or	Decrease Part A spending by:
25 years (2023–2047)	3.6%		15.6%

Note: Part A spending includes spending on inpatient hospital, skilled nursing facility, home health agency, and hospice services and includes spending for beneficiaries in fee-for-service Medicare and Medicare Advantage.

Source: MedPAC analysis of Table III.B8 in the 2023 annual report of the Boards of Trustees of the Medicare trust funds.

that, absent any intervention, the trust fund's balance will rise through 2024, then decline from 2025 on, and will fully deplete its balance by 2031 (Boards of Trustees 2023). The Congressional Budget Office (CBO) also tracks the trust fund's financial status and projects that it will be depleted in 2035 (Congressional Budget Office 2023).¹⁴ These are longer time frames than have been predicted in recent years, due to two developments: the amount of Medicare payroll taxes collected each year is now expected to be higher than previously projected (because both the number of workers paying payroll taxes and their average wages are higher than previously projected) and Part A spending in the coming years is now projected to be lower than previously estimated (Boards of Trustees 2023).

There are a number of ways to extend the solvency of the HI Trust Fund. Two that are mentioned by the Trustees are to (1) increase the Medicare payroll tax from its current rate of 2.9 percent to 3.6 percent or (2) reduce Part A spending by 15.6 percent (Table 1-2), which is equivalent to a reduction of about \$65 billion in 2024, and then maintain that lower spending level in subsequent years (Boards of Trustees 2023). Reducing Part A spending by \$65 billion in a single year would require major structural changes to the Medicare program and is not likely to be achieved through incremental payment policy changes. Either of these approaches would extend the solvency of the trust fund by an additional 25 years. A combination of more moderate spending reductions and tax increases is another option.

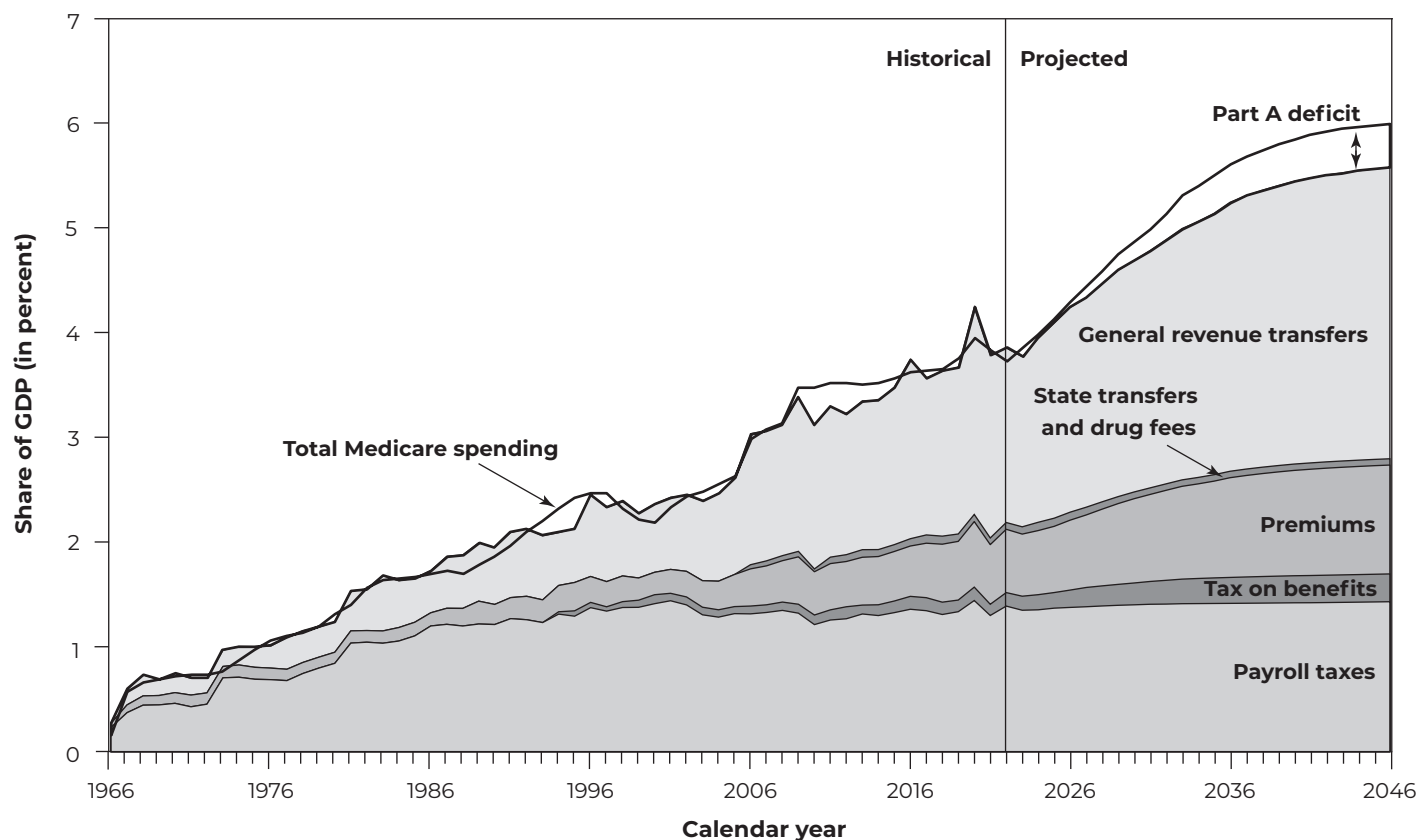
The rest of Medicare spending—under Part B (which covers clinician and outpatient services) and Part D (which covers retail prescription drugs)—is financed through the Supplementary Medical Insurance (SMI) Trust Fund. The SMI Trust Fund is funded by premiums paid by beneficiaries and transfers from the general fund of the Treasury. Since premiums and transfers are intentionally set to cover the following year's estimated spending, the SMI Trust Fund automatically remains solvent. However, Part B and Part D spending have been consuming a growing share of federal revenues. In 2022, 13 percent of all personal and corporate income taxes collected by the federal government (the primary source of federal revenues) were transferred to Medicare's SMI Trust Fund, and by 2030 this share is projected to reach 22 percent (Boards of Trustees 2023).¹⁵

The large and growing share of Medicare spending funded through general revenue transfers (shown in Figure 1-6, p. 18) is a financing challenge. As the amount of general revenues needed to finance Medicare increases, fewer government resources will be available for other priorities, such as deficit reduction or investments that could expand future economic output (e.g., federal investments in education, transportation, and research and development).

The increasing expenditure of general revenues is also a problem because the federal government already spends more than it collects in revenues each year (Figure 1-7, p. 19). The gray line at the top of Figure 1-7 represents total federal spending as a share of GDP; the

**FIGURE
1-6**

General revenue transfers from the federal government are the largest source of Medicare funding



Note: GDP (gross domestic product). First projected year is 2023. Projections are based on the Trustees' intermediate set of assumptions. "Tax on benefits" refers to the portion of income taxes that higher-income individuals pay on Social Security benefits, which is designated for Medicare. "State transfers" refers to payments from the states to Medicare, required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, for assuming primary responsibility for prescription drug spending. "Drug fees" refers to the fee imposed by the Affordable Care Act of 2010 on manufacturers and importers of brand-name prescription drugs; these fees are deposited in the Part B account of the Supplementary Medical Insurance Trust Fund. Graph does not include interest earned on trust fund investments (which makes up 1 percent of the HI Trust Fund's income and is expected to decline in coming years as trust fund assets decline).

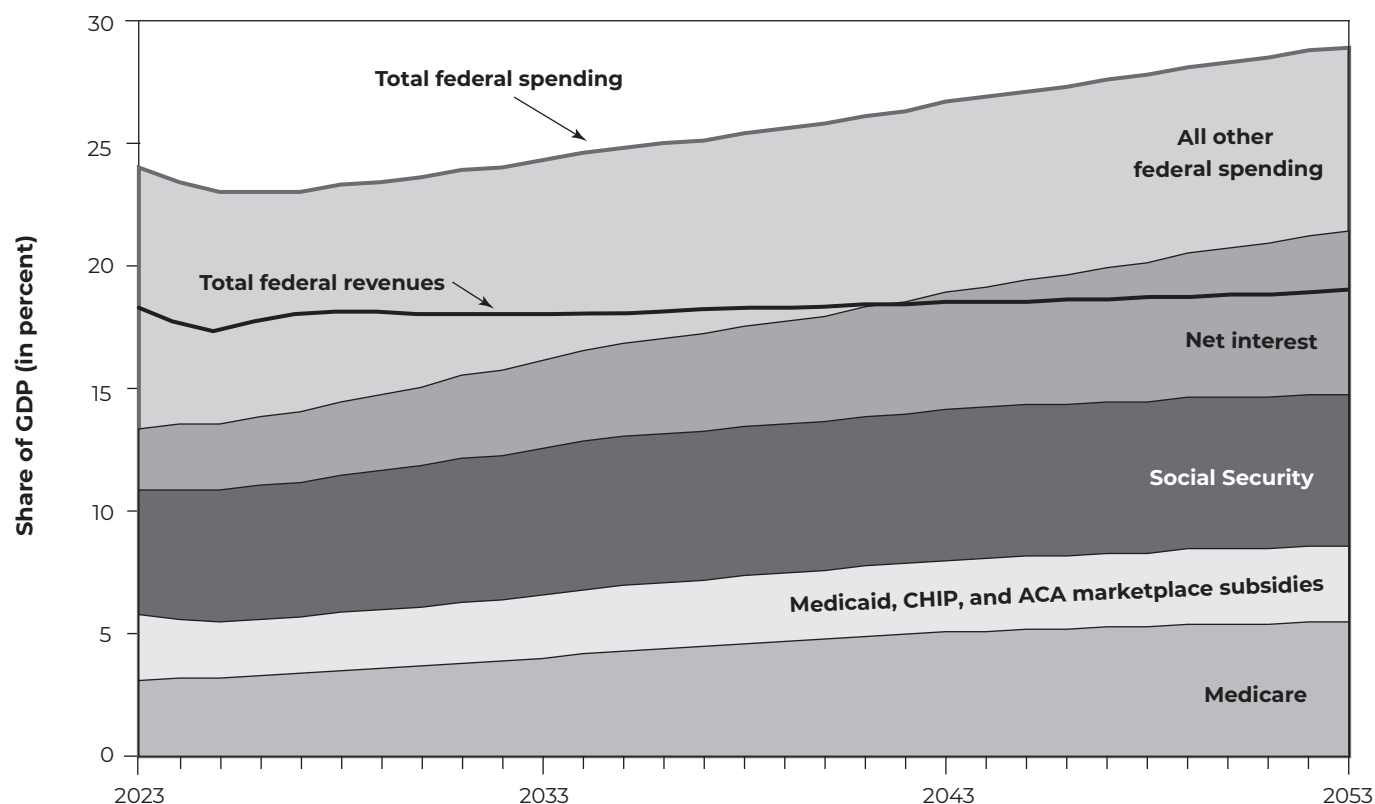
Source: 2023 annual report of the Boards of Trustees of the Medicare trust funds.

black line below it represents total federal revenues. The difference between these two lines represents the budget deficit, which must be covered by federal borrowing. The stacked layers in Figure 1-7 depict federal spending by program. By 2042, federal spending on Medicare and the other health insurance programs shown in the figure (Medicaid, Children's Health Insurance Program (CHIP), etc.) plus Social Security and interest payments are projected to exceed federal revenues. At that point, all other federal spending will need to be financed through federal borrowing.

While these projections are sobering, CMS actuaries caution that they may actually be "overly optimistic" (Office of the Actuary 2023). Medicare spending is projected to grow rapidly through the mid-2030s, then grow at a slower rate in subsequent decades because of various cost-reduction measures specified in current law.¹⁶ CMS actuaries note that if these cost-reduction measures are replaced with more generous payment policies, Medicare spending from the mid-2030s on will increase at a higher rate that is more in line with

**FIGURE
1-7**

Spending on Medicare, other major health programs, Social Security, and net interest is projected to exceed total federal revenues by 2042



Note: GDP (gross domestic product), CHIP (Children's Health Insurance Program), ACA (Affordable Care Act of 2010).

Source: Congressional Budget Office's long-term budget projections, published June 2023.

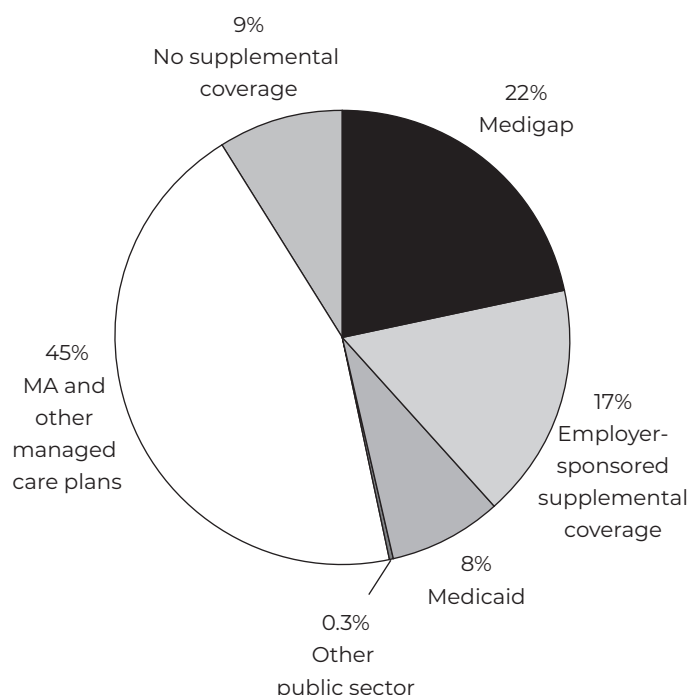
past spending growth. Such growth would mean that by 2046, instead of Medicare spending constituting 6.0 percent of GDP, it could constitute 6.35 percent of GDP. It would also mean that the payroll tax increase or Part A spending decrease needed to maintain the solvency of Medicare's HI Trust Fund (shown earlier in Table 1-2, p. 17) would need to be larger. The Medicare Trustees' long-term spending projections should therefore be viewed as a lower bound of what future Medicare spending could look like and "should not be interpreted as the most likely expectation of actual Medicare financial operations in the future," according to CMS actuaries (Office of the Actuary 2023).

As Medicare spending increases, so too does beneficiary cost sharing

As Medicare spending grows, it affects beneficiaries' ability to afford health care by raising their premiums and cost sharing. Medicare beneficiaries typically do not pay premiums for Part A (Hospital Insurance) coverage, but the annual cost of Part B (Supplementary Medical Insurance) premiums was \$1,979 in 2023, and the average annual cost of Part D prescription drug plan premiums was \$492 (Medicare Payment Advisory Commission 2023). In addition, cost sharing for beneficiaries in traditional FFS Medicare averaged

FIGURE 1-8

Most Medicare beneficiaries reduced their cost sharing through supplemental coverage or enrollment in a Medicare Advantage plan in 2020



Note: MA (Medicare Advantage). Our analysis assigned beneficiaries to the supplemental coverage category they were in for the most time in 2020; beneficiaries could have had coverage in more than one category during 2020. The analysis includes only beneficiaries not living in institutions such as nursing homes. It excludes beneficiaries who were not in both Part A and Part B throughout their Medicare enrollment in 2020 or who had Medicare as a secondary payer. The "MA and other managed care plans" slice of the pie chart includes beneficiaries with employer-sponsored MA plans and beneficiaries dually eligible for Medicare and Medicaid.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Survey file, 2020.

\$396 for Part A services, \$1,621 for Part B services, and \$456 for beneficiaries with Part D coverage in 2021 (Medicare Payment Advisory Commission 2023).¹⁷

The typical Medicare beneficiary has relatively modest resources to draw on when paying for premiums and cost sharing: Researchers estimate that the median Medicare beneficiary had an annual income in 2019 of \$29,650 and savings of \$73,800 (Koma et al. 2020).

Another way of looking at the affordability of Medicare's premiums and cost sharing is by comparing them with the average Social Security benefit received by people ages 65 and over. In 2023, the Medicare Trustees estimate that beneficiary spending on Medicare Part B and Part D premiums and cost sharing consumed 28 percent of the average Social Security benefit (Boards of Trustees 2023). Although 69 percent of people ages 65 and over supplement their Social Security benefits with income from assets (e.g., interest, dividends, rents), pensions, and withdrawals from individual retirement accounts, a sizable minority rely on Social Security benefits as their primary source of income. According to researchers who recently linked 2015 data from the Census Bureau with data from the Social Security Administration and the Internal Revenue Service, Social Security benefits accounted for 50 percent or more of family income for 40 percent of people ages 65 and over. For 21 percent of people ages 65 and over, Social Security benefits made up three-quarters or more of family income, and about 14 percent of people ages 65 and over relied on Social Security benefits for 90 percent or more of family income (Dushi and Trenkamp 2021).

Most beneficiaries reduce their out-of-pocket spending by obtaining supplemental insurance coverage or opting out of FFS Medicare and into an MA plan. In 2020, nearly half of all community-dwelling beneficiaries had FFS Medicare plus supplemental coverage (commonly obtained through Medicaid, a former employer, and/or a Medigap plan they purchased themselves).¹⁸ Another 45 percent were enrolled in an MA plan or other managed care plan (including some who were dually eligible for Medicare and Medicaid). Only 9 percent of beneficiaries were in FFS Medicare without any supplemental coverage to reduce their cost sharing (Figure 1-8).

Approximately one in five Medicare beneficiaries receives help paying their Part B premiums (and, in some cases, help with cost sharing) through their state's Medicaid program (Boards of Trustees 2023, Centers for Medicare & Medicaid Services 2023a). Similarly, approximately one in five Medicare beneficiaries receives help with their out-of-pocket retail prescription drug costs through the Part D low-income subsidy (LIS) (Medicare Payment Advisory Commission 2023).

Beneficiaries of different races and ethnicities tend to have different types of Medicare coverage, according to our analysis of the 2021 Medicare Current Beneficiary Survey. Looking at the three largest race and ethnicity categories, we found that White beneficiaries were much more likely to have FFS coverage coupled with some type of private health insurance (obtained through an employer or purchased individually, such as a Medigap plan): 44 percent of White beneficiaries had this combination of coverage in 2021, compared with 17 percent of Black beneficiaries and 15 percent of Hispanic beneficiaries. Enrollment in MA plans was more common among Hispanic and Black beneficiaries: 62 percent of Hispanic beneficiaries and 59 percent of Black beneficiaries were in MA plans, compared with 43 percent of White beneficiaries. Hispanic and Black beneficiaries were more likely to be dually enrolled in Medicaid and/or receiving the Part D LIS. For example, nearly half of Hispanic and Black beneficiaries received the LIS, compared with 12 percent of White beneficiaries. And among beneficiaries dually enrolled in Medicare and Medicaid, Black and Hispanic beneficiaries were two to three times more likely to enroll in an MA plan than traditional FFS coverage, while White dual enrollees were equally likely to enroll in FFS or MA.¹⁹

Among all Medicare beneficiaries, 7 percent reported having problems paying a medical bill, according to our analysis of CMS's 2021 Medicare Current Beneficiary Survey, but some subpopulations experienced affordability issues at notably higher rates than others.

For instance, among beneficiaries under the age of 65 (most of whom are disabled), 20 percent reported problems paying a medical bill. (Beneficiaries under age 65 tend to require more health care services than beneficiaries ages 65 and over but have lower incomes than them (Cubanski et al. 2016, Medicare Payment Advisory Commission 2023).) Beneficiaries under age 65 who were not dually enrolled in Medicaid, and thus lacked additional help paying for their health care costs, were especially likely to report problems paying a medical bill (24 percent reported this problem).

Among partial-benefit dual-eligible beneficiaries, 23 percent reported problems paying a medical bill. (Partial-benefit dual-eligible beneficiaries receive Medicaid assistance with premiums and, in some cases, cost sharing but do not qualify for additional Medicaid

benefits that full-benefit dual-eligible beneficiaries receive, such as dental care and nonemergency medical transportation.)

Among beneficiaries enrolled in FFS with no supplemental coverage, 14 percent reported problems paying a medical bill.

Affordability problems can be particularly acute for beneficiaries who are prescribed high-priced medicines and have incomes and assets that are modest but too high for them to qualify for Medicaid or the Part D low-income subsidy. One study found that among Medicare beneficiaries not receiving the low-income subsidy who were prescribed high-priced specialty drugs, one in three did not fill prescriptions for anticancer drugs, one in five did not fill prescriptions for hepatitis C curative therapies, and well over half did not fill prescriptions for drugs for immune system disorders and high cholesterol (Dusetzina et al. 2022).

Restraining the annual growth in Medicare payment rates to providers and plans can help beneficiaries more easily afford their prescription drugs and health care since it translates to lower premiums and lower cost sharing for beneficiaries.

Leading causes of death are heart disease and cancer

In most years, the leading causes of death in the U.S.—both among people ages 65 and over and the general population—are heart disease and cancer (National Center for Health Statistics 2022a, National Center for Health Statistics 2022b).

During certain months of the recent coronavirus pandemic, COVID-19 at times displaced heart disease and/or cancer as the leading or second-leading cause of death among the general population (Ortaliza et al. 2022). When looking at annual totals, COVID-19 was the third-leading cause of death in 2020 and 2021 and the fourth-leading cause of death in 2022 (Ahmad et al. 2023, Ahmad et al. 2022, Ahmad et al. 2021).

While 2023 statistics on cause of death are not yet available, it seems unlikely that COVID-19 will continue

to be one of the U.S.'s leading causes of death since by mid-2023 the rate of "excess deaths" directly or indirectly caused by COVID-19 had declined to nearly zero (Centers for Disease Control and Prevention 2023).

CMS actuaries have found that the Medicare beneficiaries who died of COVID-19 in the initial years of the pandemic tended to be high-cost beneficiaries with multiple medical conditions; the surviving beneficiaries are estimated to be healthier and require fewer services, on average. By 2029, actuaries project that this effect will subside and beneficiary case mix will return to a more typical composition (Boards of Trustees 2023).

Life expectancy at age 65 has increased, but some groups of beneficiaries have lower longevity and worse access to care

Since Medicare's early years, life expectancy at age 65 has increased by more than four years. By 2019, a person who reached the age of 65 was expected to live an additional 19.6 years—up from 15.2 years in 1970 (National Center for Health Statistics 2023). But throughout this period, life expectancy has varied by race/ethnicity, and sex. In 2019, among individuals who lived to age 65, Black and American Indian or Alaska Native individuals could expect to live an additional 18.2 years, White individuals could expect an additional 19.5 years, Hispanic individuals could expect another 21.6 years, and Asian individuals could expect another 23.4 years (Figure 1-9).²⁰ Women's life expectancy is approximately 2.5 to 3.5 years longer than men's, depending on the racial and ethnic group (Figure 1-9).

Life expectancy at age 65 has steadily increased over time. But in recent years, life expectancy has declined—largely due to the recent coronavirus pandemic. In 2020, life expectancy for people at age 65 declined by 1.1 years, dropping from 19.6 to 18.5 years (Murphy et al. 2021). Life expectancy at age 65 then declined by an additional 0.1 years in 2021, as the pandemic continued (Xu et al. 2022). Provisional data for 2022 indicate that life expectancy at age 65 rose in 2022 by 0.5 years, from 18.4 to 18.9 years—returning

to the approximate life expectancy observed in 2008 (Arias et al. 2023). (Analyses of the differences in life expectancy by race/ethnicity, or sex in these more recent years are not yet available.)

To examine whether beneficiaries of different races and ethnicities have different access to care, we analyzed CMS's 2021 Medicare Current Beneficiary Survey and the Commission's 2023 access-to-care survey.²¹ For most questions related to accessing care, the share of beneficiaries of different races and ethnicities who reported a particular experience varied by only a small amount.

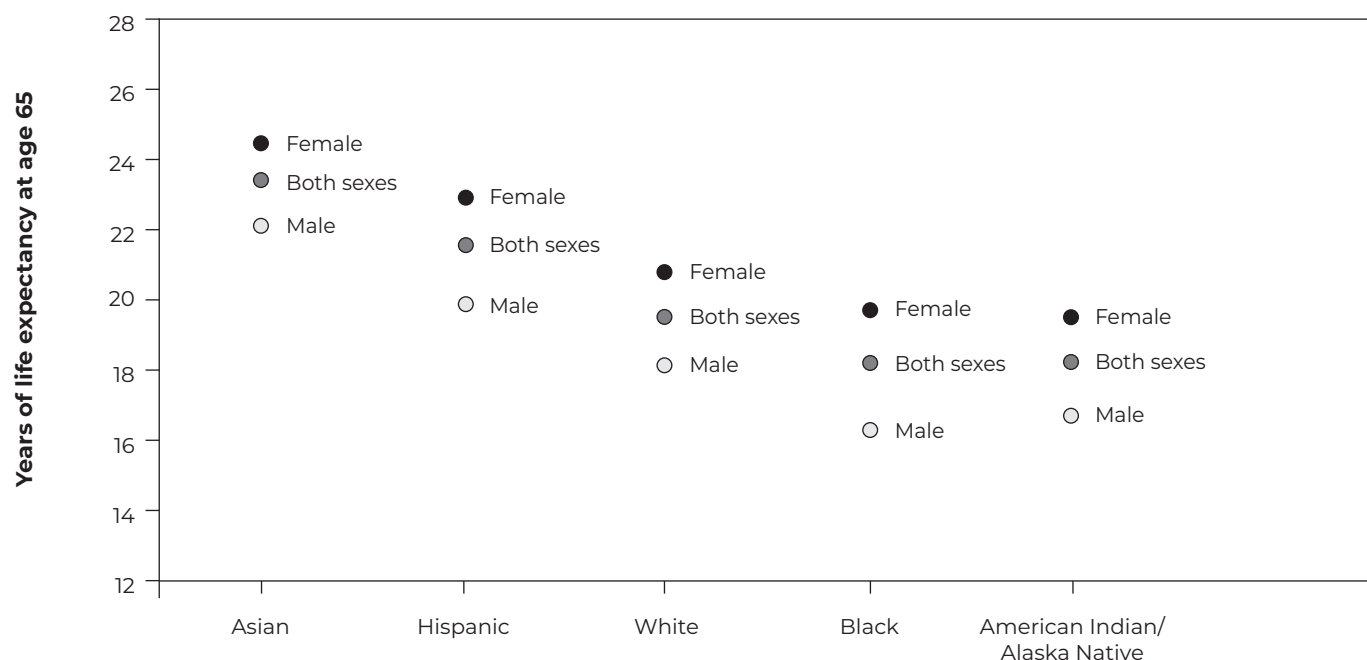
That said, a few substantive differences did emerge—several of which suggest that White beneficiaries may have better access to care than some other racial and ethnic subgroups. For example, CMS's survey found that lower shares of White beneficiaries reported problems paying a medical bill (5 percent) compared with Black beneficiaries (14 percent), American Indian beneficiaries (14 percent), multiracial beneficiaries (13 percent), and Hispanic beneficiaries (8 percent).^{22,23} And the Commission's survey found that White beneficiaries were more likely to report receiving any health care in the past year (95 percent) compared with Hispanic beneficiaries (86 percent) and Black beneficiaries (92 percent). Similarly, we found that White beneficiaries were less likely to report seeing no specialists in the past year (20 percent) compared with Hispanic beneficiaries (37 percent) and Black beneficiaries (33 percent).

A few of our findings suggest that multiracial beneficiaries may have worse access to care than other beneficiaries. For example, CMS's survey found that multiracial beneficiaries were less likely to report having a usual source of care that was not an emergency department or an urgent care center compared with White beneficiaries (88 percent vs. 94 percent) and more likely to report being unsatisfied with the availability of care by specialists (14 percent vs. 7 percent). Multiracial beneficiaries were also more likely to report trouble getting care compared with White beneficiaries (14 percent vs. 7 percent) and more likely to report delaying care due to cost in the past year (12 percent vs. 5 percent).²⁴

Since beneficiaries of different races and ethnicities tend to enroll in different types of Medicare coverage,

FIGURE 1-9

Years of life expectancy at age 65, by race/ethnicity and sex, 2019



Note: Figure shows most recent available data for different combinations of race/ethnicity and sex. "Asian," "White," "Black," and "American Indian/Alaska Native" all exclude individuals with Hispanic ethnicity.

Source: National Center for Health Statistics. *Health, United States, 2020-21*, Table LExpMort, released 2022. https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/Health_US/hs20-21tables/lexpmort.xlsx.

and that coverage could be influencing their experiences accessing care, we further disaggregated the results of CMS's survey to examine the experiences of beneficiaries of different races and ethnicities from among subgroups of beneficiaries who all had the same type of Medicare coverage. In most cases, the differences between the shares of beneficiaries of different races and ethnicities who reported a given experience were small and not statistically significant. But again, some statistically significant differences did emerge. For example, among beneficiaries with higher incomes and assets (i.e., those who were not dually enrolled in Medicaid and Medicare and those not receiving the Part D low-income subsidy), Black and Hispanic beneficiaries were more likely than White beneficiaries to report experiencing problems paying a medical bill and to report being in "fair" or "poor" health. And among beneficiaries with lower incomes

and assets (i.e., those who had full Medicaid benefits and those receiving the Part D low-income subsidy), White beneficiaries were more likely to report forgoing care that they thought they should have gotten compared with Black and Hispanic beneficiaries.

The Commission's recommendations to slow Medicare spending growth and improve access to care

Several aspects of Medicare's payment systems hamper the program's ability to maximize program efficiencies and beneficiaries' access to care. The Commission regularly makes recommendations to address these issues. Our annual March report recommends 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. Our annual June report typically offers broader recommendations aimed at restructuring the way Medicare’s payment systems work. For example, we have recommended changing how payments for MA plans are calculated and adopting site-neutral payments for services that can safely be provided in more than one care

setting. A list of the Commission’s recommendations, with links to relevant report chapters, is available at [medpac.gov/recommendation/](https://www.medpac.gov/recommendation/). The Commission’s recommendations are based on our review of the latest available data and are aimed at obtaining good value for the Medicare program’s expenditures—which means maintaining beneficiaries’ access to high-quality services while encouraging efficient use of resources. ■

Endnotes

- 1 CMS also paid health care providers \$107.2 billion from March 2020 to June 2021 through the COVID-19 Accelerated and Advance Payments Program; the agency recouped 99 percent of these funds by 2023 (Boards of Trustees 2023). These short-term loans are not captured in CMS's national health expenditures data, which reflect Medicare spending on an "incurred" basis and which we rely on for Figure 1-1 (p. 8), but they are included in the Medicare Trustees' spending tallies, which generally present spending on a "cash" basis and which we use in Figure 1-2 (p. 12). Accelerated and Advance Payments affected cash spending but not incurred spending.
- 2 Some of the new funding made available during the pandemic (e.g., the Paycheck Protection Program) was used for fraudulent purposes. As of August 2023, the Department of Justice had seized \$1.4 billion in stolen COVID-19 relief funds and charged over 3,000 defendants with crimes (Department of Justice 2023).
- 3 Although the share of spending accounted for by private health insurance is greater than Medicare's share, private health insurance is not a single purchaser of health care; rather, it includes many private plans, including managed care, self-insured health plans, and indemnity plans.
- 4 The waiver of some of Medicare's rules during the pandemic may have increased the risk of fraudulent Medicare claims. For example, CMS modified its provider enrollment screening process during the pandemic by waiving fingerprint-based criminal background checks for provider types that pose a high risk for fraud, waste, and abuse. After seeing a spike in enrollments by suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), which is a provider type CMS considers to pose a moderate or high risk for fraud, waste, and abuse, CMS reintroduced these requirements in July 2020. It also revoked enrollments for providers found to be ineligible to participate in Medicare—83 percent of whom were DMEPOS suppliers (Government Accountability Office 2022).
- 5 A "highly" concentrated market has a Herfindahl-Hirschman Index (HHI) value above 2,500. The HHI is calculated by summing the squares of individual firms' market shares, thus giving proportionately greater weight to larger market shares (Department of Justice and Federal Trade Commission 2010).
- 6 "Super" concentrated markets have an HHI above 5,000.
- 7 While the share of surveyed physicians who reported private equity ownership in their practices in 2020 was well below 10 percent for most specialties, it was between 10 percent and 15 percent for emergency medicine and anesthesiology (Kane 2021).
- 8 The Inflation Reduction Act of 2022's redesign of the Part D benefit is expected to have a minor impact on future Medicare spending—first increasing spending growth rates and then lowering them. In 2024 and 2025, Part D spending is expected to accelerate as beneficiaries' out-of-pocket spending is reduced (through provisions in the law that eliminate the 5 percent coinsurance that beneficiaries pay in the catastrophic phase of the benefit and cap their annual out-of-pocket drug spending at \$2,000). Starting in 2026, growth in Part D spending is expected to slow, due to the Medicare Drug Negotiation Program and a provision that links drug price increases to the consumer price index (Keehan et al. 2023).
- 9 In addition to MA, other types of private health plans are available to a limited subset of Medicare beneficiaries: Medicare-Medicaid Plans, Program of All-Inclusive Care for the Elderly (PACE) plans, and cost-based (as opposed to capitated) plans. As of July 2023, only about 2 percent of the beneficiaries in private plans are in one of these types of non-MA plans.
- 10 MA enrollees in preferred provider organization plans or HMO point-of-service plans generally have some out-of-network coverage with up to 50 percent coinsurance, but out-of-network care is generally not covered in HMO plans. In cases where medically necessary care is not obtainable in network, all MA plans must allow enrollees to go out-of-network and pay in-network cost sharing. See Chapter 12 for more information on MA plan types.
- 11 Baby boomers are people born in the period between the end of World War II and the mid-1960s.
- 12 Workers and their employers split the cost of the payroll tax (workers pay 1.45 percent and employers pay the remaining 1.45 percent). Meanwhile, self-employed people pay both the worker's and the employer's share of this tax, totaling 2.9 percent of their net earnings. High-income workers pay an additional 0.9 percent of their earnings above \$200,000 for single workers or \$250,000 for married couples.
- 13 The HI Trust Fund's income derives from several sources, including payroll taxes (which made up 89 percent of the trust fund's income in 2022), taxation of higher-income individuals' Social Security benefits (8 percent), interest earned on trust fund investments (1 percent), and premiums collected from voluntary participants (1 percent) (Boards of Trustees 2023).

- 14 According to Medicare's Trustees, if Medicare's HI Trust Fund balance is depleted, "Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs," which they warn could rapidly curtail beneficiary access to care. However, the Trustees note that lawmakers have never allowed the HI Trust Fund assets to be depleted (Boards of Trustees 2023).
- 15 General revenues primarily consist of individual and corporate taxes but also include customs duties, leases of government-owned land and buildings, the sale of natural resources, usage and licensing fees, and payments to agencies (Department of Treasury 2022).
- 16 For example, Medicare's Trustees assume that starting in 2026, clinicians who are not in advanced alternative payment models (A-APMs) will receive lower annual updates to their Medicare physician fee schedule payment rates (0.25 percent per year) than clinicians who are in A-APMs (0.75 percent per year), and that these updates will not be replaced with updates that are more reflective of medical inflation (which is projected to average 2 percent per year in the long term). Medicare's Trustees also assume that bonuses clinicians currently receive for participating in A-APMs will end after 2025 and that positive adjustments to payment rates that clinicians receive if they demonstrate "exceptional" performance under the Merit-based Incentive Payment System (MIPS) will end after 2024—and not be extended through legislative intervention.
- 17 In 2024, beneficiaries will no longer be required to pay cost sharing when they reach the catastrophic phase of the Part D benefit, and in 2025, out-of-pocket costs in Part D will be capped at \$2,000, which is expected to decrease cost sharing. (In 2021, roughly 1.5 million beneficiaries reached the catastrophic phase and would have benefited from this cap.)
- 18 The share of community-dwelling Medicare beneficiaries who report having traditional FFS coverage with public or private supplemental coverage has declined from nearly three-quarters of beneficiaries in 2000 to about half of beneficiaries in 2020, according to our analysis of CMS's Medicare Current Beneficiary Survey data (Medicare Payment Advisory Commission 2022, Medicare Payment Advisory Commission 2019, Medicare Payment Advisory Commission 2018, Medicare Payment Advisory Commission 2003).
- 19 The enrollment statistics in this paragraph are based on our analysis of the 2021 Medicare Current Beneficiary Survey's Survey file for noninstitutionalized beneficiaries enrolled in both Part A and Part B. The statistics in this paragraph are calculated using a different, simpler approach compared with the statistics shown in Figure 1-8, p. 20.
- 20 Hispanic individuals' superior longevity despite worse profiles on some social determinants of health has puzzled demographers for decades and has been referred to as the "Hispanic health paradox." A definitive explanation for this paradox has yet to be identified, but researchers hypothesize that Hispanic individuals' longevity may be due to immigration dynamics (with Hispanics who enter the U.S. tending to be relatively healthy, and Hispanics who leave the U.S. to return to their home countries tending to be older and less healthy), low rates of cigarette smoking, and high levels of family support (Dominguez et al. 2015).
- 21 CMS's 2021 Medicare Current Beneficiary Survey was fielded among about 13,000 community-dwelling Medicare beneficiaries of all ages, and the Commission's 2023 survey was fielded among about 5,000 Medicare beneficiaries ages 65 and over.
- 22 We use "American Indian" as a shorthand here for beneficiaries who are American Indian, Alaska Native, Native Hawaiian, or Pacific Islander, whom we combined together in this analysis to increase statistical power.
- 23 All of the race/ethnicity subgroups we report on are non-Hispanic except the "Hispanic" group.
- 24 The share of multiracial and White beneficiaries who reported a given experience in CMS's survey are statistically significantly different from each other at the 95 percent confidence level. We also observed some potentially meaningful differences in the experiences of American Indian/Alaska Native/Native Hawaiian/Pacific Islander beneficiaries and White beneficiaries in CMS's survey, but these differences were often not statistically significant (which may have been in part due to the small number of surveyed beneficiaries in the former subgroup). Asian and White beneficiaries generally reported similar care experiences in CMS's survey.

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C H A P T E R

2

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

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

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

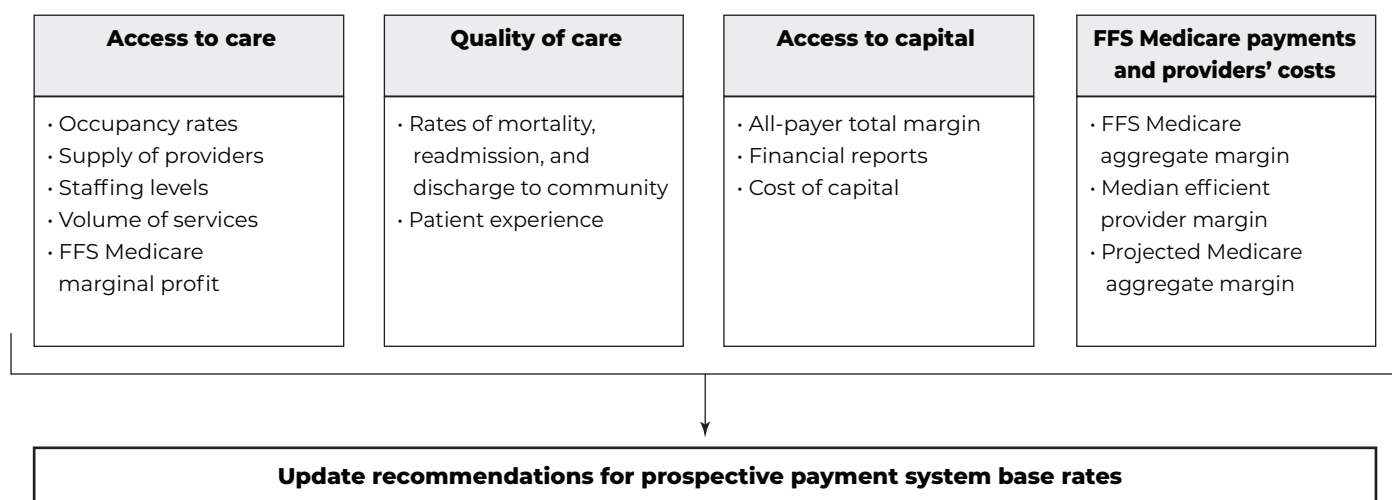
Beneficiary access to care depends in part on providers' ability to meet demand with current supply. Provider shortages, long wait times, and difficulty maintaining staffing levels can indicate inadequate payment rates. Rapid entry into a sector, however, may indicate that payments are more than adequate 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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C H A P T E R

3

Hospital inpatient and outpatient services

R E C O M M E N D A T I O N

- 3** For fiscal year 2025, the Congress should update the 2024 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1.5 percent.

In addition, the Congress should:

- begin a transition to redistribute disproportionate share hospital and uncompensated care payments through the Medicare Safety-Net Index (MSNI);
- add \$4 billion to the MSNI pool;
- scale fee-for-service MSNI payments in proportion to each hospital's MSNI and distribute the funds through a percentage add-on to payments under the inpatient and outpatient prospective payment systems; and
- pay commensurate MSNI amounts for services furnished to Medicare Advantage (MA) enrollees directly to hospitals and exclude them from MA benchmarks.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 2 • ABSENT 0

Hospital inpatient and outpatient services

Chapter summary

General acute care hospitals (ACHs) primarily provide inpatient and outpatient services. To pay these hospitals for the facility share of providing services, fee-for-service (FFS) Medicare generally sets prospective payment rates under the inpatient prospective payment systems (IPPS) and the outpatient prospective payment system (OPPS). In 2022, the FFS Medicare program and its beneficiaries spent nearly \$180 billion on IPPS and OPPS services at general ACHs, including \$7.1 billion in uncompensated care payments made under the IPPS.

Assessment of payment adequacy

During the most recent year of data available, indicators regarding the adequacy of FFS Medicare payments to hospitals were mixed. Overall, general ACHs continued to have the capacity to care for FFS Medicare beneficiaries and a financial incentive to serve them; FFS Medicare beneficiaries' inpatient mortality and readmission rates improved; and investor demand for hospital bonds remained strong. However, in fiscal year (FY) 2022, the aggregate all-payer operating margin among ACHs paid under the IPPS fell to the lowest level since 2008, and their overall FFS Medicare margin across service lines declined to a record low, both in aggregate and for relatively efficient hospitals. These low all-payer and

In this chapter

- Are FFS Medicare payments adequate in 2024?
- How should FFS Medicare payments change in 2025?

FFS Medicare margins were largely driven by higher-than-expected input price inflation in 2022.

Beneficiaries' access to care—Indicators of beneficiaries' access to hospital inpatient and outpatient care were generally positive.

- **Capacity and supply of providers**—In FY 2022, 67 percent of all general ACH beds were occupied by patients receiving inpatient, swing, or observation services, indicating that hospitals had available capacity in aggregate, though there was variation across hospitals. In addition, the number of inpatient beds remained stable, hospital employment increased, and the number of general ACHs that closed was similar to the number that opened. In 2023, hospital employment continued to grow; however, more ACHs closed than opened (18 vs. 11, respectively), with many of the hospitals citing declining patient volume as one of the reasons for closing. The number of closures would likely have been higher if not for a new Medicare policy—the rural emergency hospital (REH) designation—that allows hospitals to convert from full-service hospitals to REHs, preserving beneficiaries' access to emergency and hospital outpatient services.
- **Volume of services**—The volume of both inpatient and outpatient services per FFS Medicare beneficiary declined from 2021 to 2022. This change, however, primarily reflects shifts in the setting where care is provided and declines in COVID-19 care rather than a decrease in beneficiary access to hospital care. In particular, joint replacement procedures continued to shift from inpatient to outpatient settings, and hospital emergency department visits continued to shift to urgent care centers. In addition, fewer beneficiaries were hospitalized with respiratory infections, and fewer COVID-19 vaccines and tests were provided in hospital outpatient departments.
- **FFS Medicare marginal profit**—Hospitals' FFS Medicare marginal profit on IPPS and OPPS services declined from 2021 to 2022, but remained positive at 5 percent in aggregate, indicating that hospitals with available capacity continued to have a financial incentive to provide hospital inpatient and outpatient services to FFS Medicare beneficiaries.

Quality of care—In 2022, FFS Medicare beneficiaries' risk-adjusted hospital mortality rate improved relative to pandemic highs, falling to the level in 2019 (8.1 percent). FFS Medicare beneficiaries' risk-adjusted readmission rate also improved, to 14.7 percent, slightly lower than the rate in 2021 and about a percentage point better than the rates in the immediate prepandemic period.

However, most patient experience measures remained below prepandemic levels by several percentage points.

Providers' access to capital—From 2021 to 2022, IPPS hospitals' aggregate all-payer operating margin declined over 6 percentage points, reflecting both a decline in federal coronavirus relief funds and higher-than-expected inflation. IPPS hospitals' all-payer operating margin fell to 2.7 percent when including federal relief funds—the lowest level since 2008—and 1.9 percent exclusive of these funds. In addition, preliminary data from large hospital systems suggest that hospitals' aggregate all-payer operating margin remained below prepandemic levels in 2023. Hospitals' borrowing costs also increased in 2022 and 2023; however, this growth was slower than that of the general market, indicating continued investor demand for hospital bonds.

FFS Medicare payments and providers' costs—From 2021 to 2022, IPPS hospitals' overall FFS Medicare margin (across inpatient, outpatient, and certain other service lines) declined over 5 percentage points to a record low of -11.6 percent when including the FFS Medicare share of federal coronavirus relief funds (and declined to -12.7 percent exclusive of these funds). This decline was largely driven by input price inflation exceeding the market basket update, as well as a decline in federal coronavirus relief funds, an increase in high-cost outlier stays, and a decrease in Medicare uncompensated care payments. Nonetheless, some hospitals achieved much lower costs while still performing relatively well on a specified set of quality metrics. We refer to the subset of hospitals that meet a mix of cost and quality criteria as “relatively efficient”; the median FFS Medicare margin among these relatively efficient hospitals was about -2 percent when including relief funds (and -3 percent exclusive of these funds). In FY 2024, hospitals that participate in the 340B drug payment program are scheduled to receive \$9 billion in remedy payments to correct for underpayments in calendar years 2018 to 2021. Including these one-time payments, we project that IPPS hospitals' aggregate FFS Medicare margin across service lines in 2024 will increase to -8 percent. However, excluding these one-time remedy payments, we project that IPPS hospitals' aggregate FFS Medicare margin will be about -13 percent, which, exclusive of federal coronavirus relief funds, is similar to the level in 2022. Similarly, we project the median FFS Medicare margin among our relatively efficient hospital group will remain at about -3 percent.

How should FFS Medicare payment change in 2025?

The current-law updates to payment rates for 2025 will not be finalized until summer 2024, but CMS's third-quarter 2023 forecasts and other required updates are currently projected to increase the IPPS and OPPS base rates by slightly less than 3 percent.

The recent volatility in hospital profit margins makes it particularly difficult to assess how FFS Medicare payments should change. Since the start of the coronavirus pandemic in 2020, hospitals' FFS Medicare margin reached a recent high in 2021 followed by a record low in 2022. Hospitals' all-payer operating margin has also fluctuated dramatically, driven by substantial federal coronavirus relief funds followed by substantial inflation that put cost pressure on hospitals.

After evaluating and discussing the payment adequacy indicators listed above, the Commission recommends that, for fiscal year 2025, the Congress increase base hospital payment rates for all hospitals and direct an enhanced pool of special payments to hospitals with high shares of Medicare patients, particularly low-income Medicare patients. These actions are conceptually and directionally consistent with the Commission's 2023 recommendation. However, given the worsened financial circumstances in 2022 and the approximately \$3 billion decline in existing Medicare disproportionate share hospital and uncompensated care payments from 2019 to 2024, the Commission contends that all hospitals—and in particular those serving large shares of low-income Medicare patients—warrant greater support than the Commission recommended last year. Thus, the Commission recommends that the Congress update the 2024 Medicare base payment rates for general ACHs by the amount reflected in current law plus 1.5 percent; at the same time, the Congress should begin a transition to redistribute existing safety-net payments to hospitals using the Commission's Medicare Safety-Net Index (MSNI) and increase the MSNI pool by \$4 billion (which would be distributed to hospitals for both their FFS and MA patients). This recommendation would better target limited Medicare resources toward those hospitals that are key sources of care for low-income Medicare beneficiaries and are facing particularly significant financial challenges. ■

Background

General acute care hospitals (ACHs) primarily provide inpatient care and various outpatient services. To pay these hospitals for the facility share of inpatient and outpatient services, fee-for-service (FFS) Medicare generally sets prospective payment rates under the inpatient prospective payment systems (IPPS) and outpatient prospective payment system (OPPS).¹ (Clinicians who provide services at hospitals are paid separately under the physician fee schedule.) In setting these prospective rates per inpatient stay or primary outpatient service, CMS adjusts IPPS and OPPS national base payment rates for factors generally outside of hospitals' control, such as regional wage rates and patient characteristics. Both the IPPS and OPPS also include separate payments not tied to the base payment rates. The IPPS includes uncompensated care payments to help support hospitals' costs of treating the uninsured. The OPPS sets payments for separately payable drugs based on the manufacturer's average sales price. In 2022, the

FFS Medicare program and its beneficiaries spent nearly \$180 billion on IPPS and OPPS services at general ACHs, including \$7.1 billion in uncompensated care payments made under the IPPS and \$19.1 billion for separately payable drugs (Table 3-1).² FFS beneficiaries' cost-sharing liability totaled 7 percent of hospital inpatient payments and 17 percent of outpatient payments.

The IPPS and OPPS payment rates affect more than FFS Medicare payments for general ACHs. Within the FFS Medicare program, the OPPS is used to pay for outpatient services at certain specialty hospitals and other facilities.³ But more important, most Medicare Advantage (MA) plans pay IPPS hospitals using rates benchmarked to FFS Medicare rates (Berenson et al. 2015, Maeda and Nelson 2017), and hospitals must accept FFS rates for MA enrollees seeking care out of their plan's network. In addition, states have increasingly used FFS Medicare payments to hospitals to set rates in their state employee or state public option plans. Montana, Oregon, and North Carolina offer state employee health plans that are

**TABLE
3-1**

In 2022, FFS Medicare spent nearly \$180 billion on IPPS and OPPS services at general acute care hospitals

	Medicare payment system	
	IPPS	OPPS
Number of hospitals	3,160	3,090
Number of users (in millions)	4.3	16.3
Volume of services (in millions)	6.6	127.4
Total Medicare payments (in billions)	\$111.0	\$68.8
Payments for base-rate-covered services	\$103.9	\$49.7
Other payments*	\$7.1	\$19.1
Beneficiary cost-sharing liability as share of total Medicare payments	7.1%	17%

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), OPPS (outpatient prospective payment system). The number of general acute care hospitals that provided IPPS services is higher than the number that provided OPPS services primarily because Indian Health Services are paid under the IPPS but not OPPS. OPPS services at and payments to post-acute care and other specialty hospitals are not included. "Total Medicare payments" includes the program amount and beneficiary cost-sharing liability (which may be paid by the beneficiary, the beneficiaries' supplemental insurance, or become hospital bad debt). The given year (2022) refers to fiscal year for inpatient services and calendar year for outpatient services.

*In the case of the IPPS, "other payments" refers to uncompensated care payments. In the case of the OPPS, "other payments" refers to payments for separately payable drugs, devices, blood products, and brachytherapy sources.

Source: MedPAC analysis of Medicare Provider Analysis and Review data, IPPS final rule, and outpatient claims data.

benchmarked to FFS Medicare rates (North Carolina State Health Plan 2021, Schramm and Aters 2021). Likewise, Washington, Colorado, and Nevada offer state public option plans that are benchmarked to FFS Medicare rates (Washington State Health Care Authority 2020, Colorado Department of Regulatory Agencies 2021, Nevada Department of Health and Human Services 2021). Given the widespread use of FFS Medicare payment rates as benchmarks, any update to the FFS Medicare base payment amount affects many other payers (White et al. 2013).

Are FFS Medicare payments adequate in 2024?

Based on the most recent available data, indicators have been mixed regarding the adequacy of FFS Medicare payments to hospitals. General ACHs continued to have the capacity to care for FFS Medicare beneficiaries and a financial incentive to serve them; FFS Medicare beneficiaries' inpatient mortality and readmission rates improved; and investor demand for hospital bonds remained strong. However, in fiscal year (FY) 2022, IPPS hospitals' aggregate all-payer operating margin fell to the lowest level since 2008, and their overall FFS Medicare margin across service lines declined to a record low, both in aggregate and for relatively efficient hospitals. These low all-payer and FFS Medicare margins were largely driven by higher-than-expected input price inflation in 2022.

In 2024, hospitals that participate in the 340B drug payment program are scheduled to receive \$9 billion in remedy payments to correct for underpayments in calendar years 2018 to 2021. We project that, including these one-time payments, IPPS hospitals' aggregate FFS Medicare margin across service lines will increase to a level higher than what was observed in the immediate prepandemic period. However, if we exclude these one-time remedy payments, we project that IPPS hospitals' aggregate FFS Medicare margin in 2024 will be about -13 percent, which is similar to the level in 2022 when excluding federal coronavirus relief funds. Similarly, we project that the median FFS Medicare margin among relatively efficient hospitals will remain at about -3 percent.

Beneficiaries maintained good access to hospital inpatient and outpatient services in 2022

In FY 2022, 67 percent of all general ACH beds were occupied by patients receiving inpatient, swing, or observation services, indicating that hospitals had available capacity in aggregate.⁴ In addition, in 2022, the number of inpatient beds remained stable, hospital employment increased, and the number of general ACHs that closed was similar to the number that opened. In 2023, hospital employment continued to grow; however, more ACHs closed than opened (18 vs. 11, respectively), with many of the hospitals citing declining patient volume as one of the reasons for closing.

Adequate hospital capacity in aggregate, but considerable variation

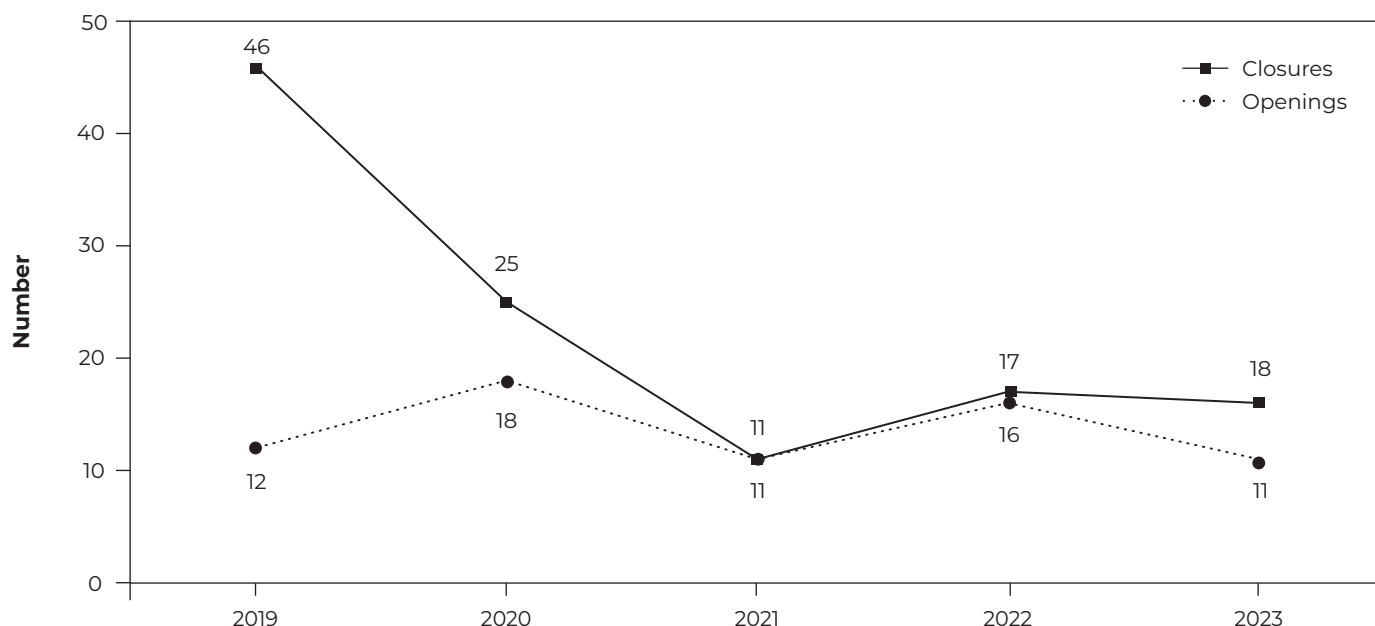
Trends in three metrics suggest that the capacity of general ACHs remained adequate in aggregate to provide inpatient and outpatient hospital services to FFS Medicare beneficiaries:

- **The number of inpatient beds remained steady.** From FY 2021 to FY 2022, the number of inpatient beds at general ACHs was steady at nearly 650,000.
- **Hospitals had available capacity.** In 2022, 67 percent of all general ACH beds were occupied by a patient receiving inpatient, swing, or observation services.⁵ This figure is slightly higher than in prior years but indicates available capacity in aggregate.
- **Hospital employment increased.** After declining in 2020, hospital employment has consistently grown each year; by 2022, it had rebounded above the levels in the immediate prepandemic period. In 2023, hospital employment grew an additional 3 percent to over 6.4 million employees (Bureau of Labor Statistics 2023).⁶

However, consistent with past years, capacity varied considerably across hospitals, with some nearing capacity while others had excess capacity. For example, in 2022, 5 percent of hospitals had occupancy rates of over 85 percent while 5 percent had occupancy rates below 15 percent. These hospitals with significant excess capacity were more likely to be small rural hospitals, while those with higher occupancy rates were more likely to be large hospitals with over 250 beds or more than 100 medical residents.

**FIGURE
3-1**

Number of general acute care hospital closures exceeded openings in fiscal year 2023



Note: "Closure" refers to a general acute care hospital that ceased inpatient services and did not convert to a rural emergency hospital, while "opening" refers to a new location for general acute care inpatient services. The counts do not include the relocation of inpatient services from one hospital to another under common ownership within 10 miles, nor does it include hospitals that both opened and closed within a 5-year period. The number of hospital closures and openings in a given year can change over time as hospitals reopen or dates of closure are updated.

Source: MedPAC analysis of the CMS Provider of Services file and internet searches.

Although hospital employment has increased to above prepandemic levels, some hospitals continued to report staffing shortages. We do not know the complete share of hospitals experiencing critical staffing shortages because only a small share of hospitals reported data to the Department of Health and Human Services in 2023. However, anecdotal reports suggest that staffing shortages in 2023 led to some hospitals temporarily postponing some elective surgeries and reducing their inpatient capacity (Belanger 2023, Chouinard 2023). To address these staffing shortages, some hospitals are attempting to bolster staff recruitment and retention through the creation of workforce development programs (Cooney 2023, Kurman 2023).

Slight decrease in supply of hospitals in 2023

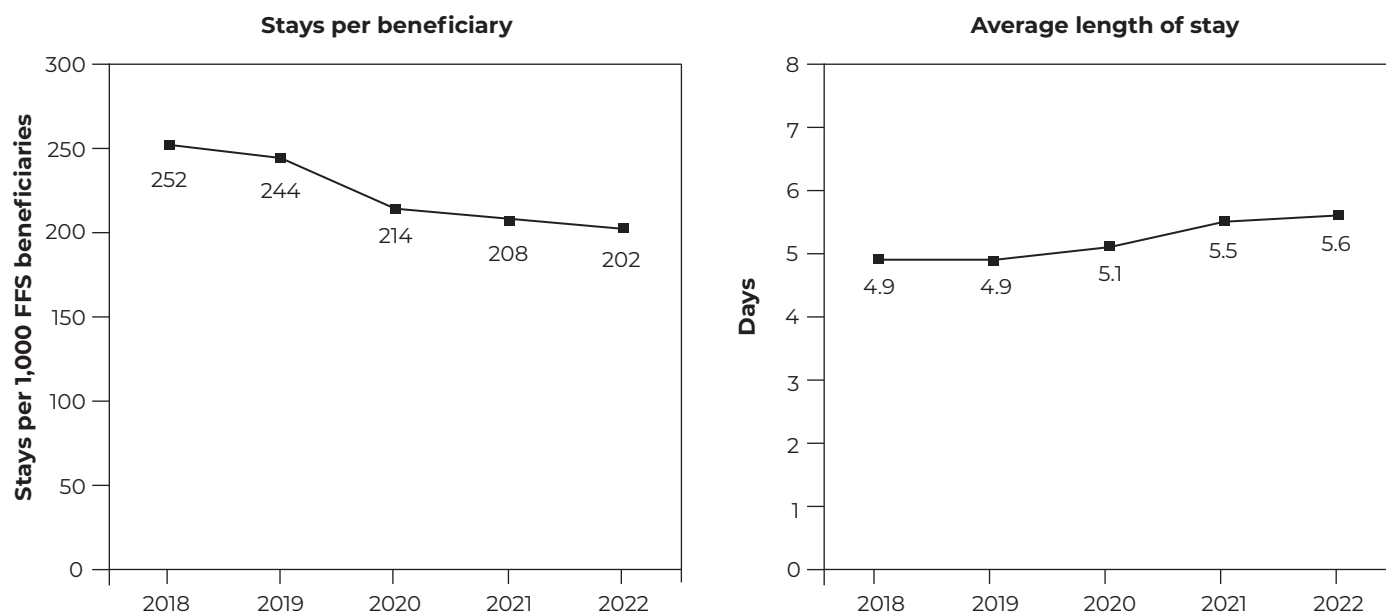
In FY 2023, 18 general ACHs closed and 11 opened, leading to a slight net decrease in the number of hospitals providing inpatient services to Medicare

beneficiaries (Figure 3-1). In addition to these changes, about 20 hospitals converted to the new rural emergency hospital (REH) designation, and some of the hospitals that closed are considering reopening as REHs (see Chapter 15). The decrease in the supply of hospitals in FY 2023 was a contrast to FY 2021 and FY 2022, in which the supply was steady. However, it is similar to the slight decrease in 2020 and markedly smaller than the large decrease in 2019.

The characteristics of the 18 hospitals that closed in FY 2023 varied. Half were in metropolitan areas and half were in micropolitan or other rural areas. Two were critical access hospitals (CAHs) and eight received additional FFS Medicare payments through the Medicare-dependent hospital, sole community hospital, or low-volume hospital programs. Nine of the closing facilities had fewer than 50 beds. Of the 9 micropolitan and other rural closures, all but 2 were

**FIGURE
3-2**

In fiscal year 2022, inpatient stays per FFS Medicare beneficiary continued to decline while length of stay continued to increase



Note: FFS (fee-for-service). Results differ from the results in our March 2023 report because this figure is based on FFS Medicare Part A enrollment during the fiscal year and includes only beneficiaries living in the 50 states and the District of Columbia.

Source: MedPAC analysis of Medicare Provider Analysis and Common Medicare Environment data.

within 25 miles of the next-nearest hospital, suggesting that most beneficiaries who had been served by the closed facilities continued to have access to inpatient and emergency services in their region, though some faced longer travel times. Hospitals that opened in FY 2023 were generally located in metropolitan areas (7 of 11) and, except for 1, were all less than or equal to 25 miles from the next-nearest hospital.

According to hospital press releases, several factors broader than FFS Medicare's payment rates contributed to the financial difficulties of the hospitals that closed in FY 2023. Most of the hospitals that closed cited declining patient volume as a driving factor for the closure. Other contributing factors cited by hospitals included rising labor and supply costs and high levels of uncompensated care.⁷ Declining admissions are often the greatest challenge that rural hospitals face;

the decrease is in part due to rural beneficiaries increasingly using urban hospitals.

A new Medicare payment policy that began in 2023 allowed small rural hospitals to convert to REHs and maintain beneficiaries' access to emergency and hospital outpatient services (see Chapter 15). The number of rural hospital closures would likely have been higher if not for the new REH designation.

Certain types of care continued to shift from inpatient to outpatient settings

From 2021 to 2022, the number of general ACH inpatient stays per FFS Medicare beneficiary declined while the average length of stay increased (Figure 3-2). Both of these changes continued prior-year trends. From 2018 to 2022, the number of inpatient stays per FFS Medicare beneficiary declined 20 percent (from

252 stays per 1,000 FFS Medicare beneficiaries to 202), while the average length of stay increased 13 percent (from 4.9 days per stay to 5.6 days per stay).

The change in FFS Medicare stays per beneficiary from the immediate prepandemic period to 2022 varied significantly across types of inpatient stays:

- **Inpatient stays per FFS Medicare beneficiary for conditions that can be safely treated in outpatient settings declined substantially.** In particular, following the removal of knee replacements and hip replacements from the inpatient-only lists in 2018 and 2020, respectively, the number of inpatient stays per FFS Medicare beneficiary for joint replacements without major comorbidities and complications declined substantially from 2018 to 2022 (from 12 stays per 1,000 FFS Medicare beneficiaries to 3).
- **Inpatient stays per FFS Medicare beneficiary for respiratory infections surged during the pandemic and has begun to fall.** In the immediate prepandemic period, there were 2 stays per 1,000 FFS Medicare beneficiaries for respiratory infections and inflammations with major comorbidities and complications. By 2021, volume had surged to 12 stays per 1,000 FFS Medicare beneficiaries, reflecting the coronavirus pandemic. In 2022, volume fell to 9 stays per 1,000 beneficiaries.
- **Inpatient stays per FFS Medicare beneficiary for critical conditions remained relatively steady.** For example, inpatient stays per capita for septicemia and heart failure both somewhat declined at the start of the pandemic but by 2022 had returned to levels near those of the immediate prepandemic period (at 16 and 10 stays per 1,000 FFS Medicare beneficiaries, respectively).

This shift in the type of inpatient stay resulted in a longer average length of stay. The types of stays that dramatically increased at the start of the pandemic—such as those for severe respiratory conditions—were generally longer stays. In contrast, those that decreased—such as joint replacements—were generally shorter. As the number of respiratory stays began to fall and the rate of decline in joint replacements slowed in 2022, growth in the average length of stay also slowed.

Relatively steady hospital outpatient services per FFS Medicare beneficiary and shift of some services between sites of care

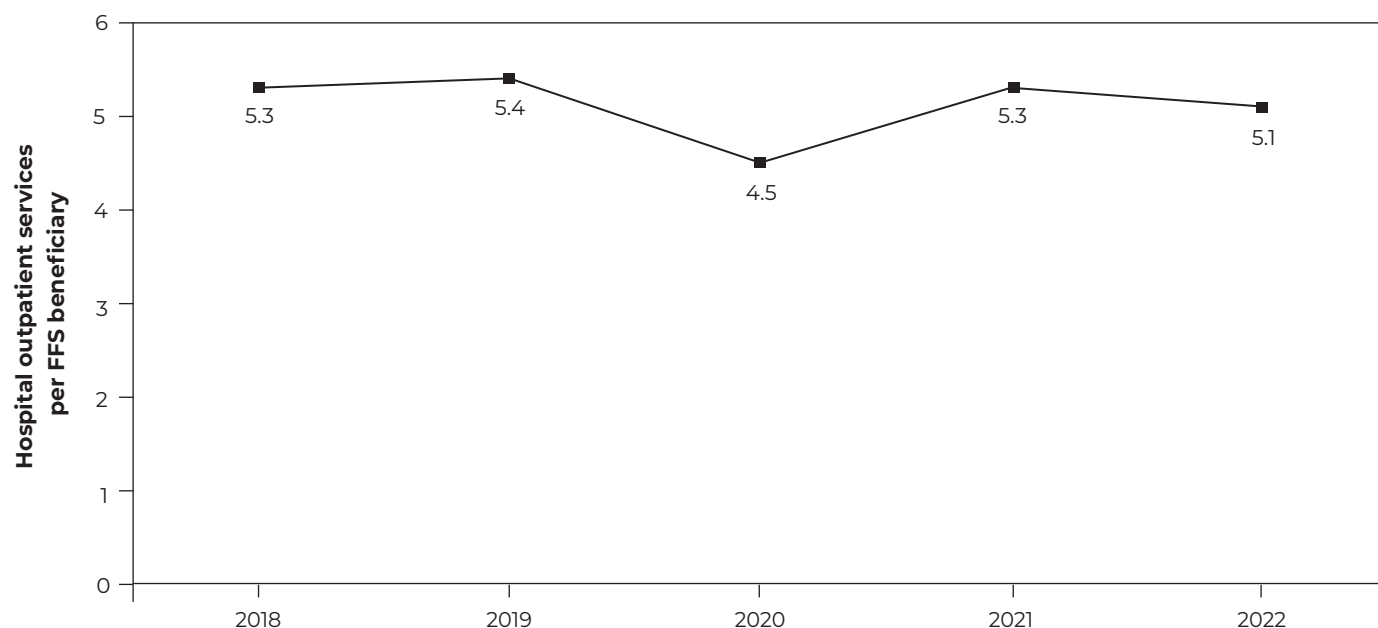
From calendar year 2021 to 2022, the number of general ACH outpatient services per FFS Medicare beneficiary declined slightly but remained near levels in the immediate prepandemic period (Figure 3-3, p. 60). In calendar year 2021, the large increase in outpatient services per beneficiary was in part driven by a surge in COVID-19-related care, including vaccine administration, specimen collection, and chest X-rays. In 2022, this care decreased by 0.3 services per beneficiary (7.7 million services). When excluding this COVID-19-related care, general ACH outpatient services per FFS Medicare beneficiary increased substantially from 2020 to 2021 and slightly from 2021 to 2022 (data not shown).

While many types of hospital outpatient services largely rebounded in 2022 to near prepandemic levels, other types of services remained well below the level in 2019. In particular, emergency department visits per FFS Medicare beneficiary remained about 15 percent below the level in 2019, with most of this care being offset by an increase in urgent care visits. This shift could reflect the beginning of a new normal in which FFS Medicare beneficiaries avoid hospital emergency departments for certain types of care in favor of other settings, such as urgent care centers.

Historically, some services have also shifted from freestanding physician offices to hospital outpatient departments, where payment rates are higher (Medicare Payment Advisory Commission 2021). The Commission contends that, to prevent unwarranted shifts in the volume of services from physician offices to hospitals, the Medicare program should not pay more for services provided in a high-cost setting when it is safe and appropriate to provide those services in a lower-cost setting when doing so does not pose a risk to access (Medicare Payment Advisory Commission 2023a). For example, the Commission has recommended that payment rates for physician office visits should be “site neutral” and that Medicare should not pay hospital-based clinics more for those visits than freestanding clinics because the hospital setting is not necessary for those services. The implementation of site-neutral policies is discussed in more detail in our June 2023 report to the Congress (Medicare Payment Advisory Commission 2023a).

FIGURE
3-3

In calendar year 2022, general ACH outpatient services per FFS beneficiary remained near prepandemic levels



Note: ACH (acute care hospital), FFS (fee-for-service). Results differ from the results in our March 2023 report because this figure is based on FFS Medicare Part B enrollment during the calendar year and includes only beneficiaries living in the 50 states and the District of Columbia.

Source: MedPAC analysis of hospital outpatient claims and Common Medicare Environment data.

Continued financial incentive for hospitals with available capacity to provide inpatient and outpatient services to FFS beneficiaries

In 2022, hospitals' aggregate FFS Medicare marginal profit on IPPS and OPSS services was about 5 percent—below the level in 2021 but similar to the level in 2020. We calculate hospitals' FFS Medicare marginal profit by comparing Medicare's IPPS and OPSS payments with the variable cost of treating an additional FFS Medicare patient. To make a conservative estimate of hospitals' FFS Medicare marginal profit, we use a broad definition of variable costs that is consistent with our prior estimates of the share of costs that varied over a one-year period. We have consistently found that roughly 80 percent of costs are variable; to the extent that a higher share of hospitals' costs are fixed, the marginal profit would be higher. The positive FFS Medicare marginal profit indicates that, in aggregate, IPPS and OPSS payment rates provide financial incentive for

hospitals to furnish inpatient and outpatient services to FFS Medicare beneficiaries, given available capacity.

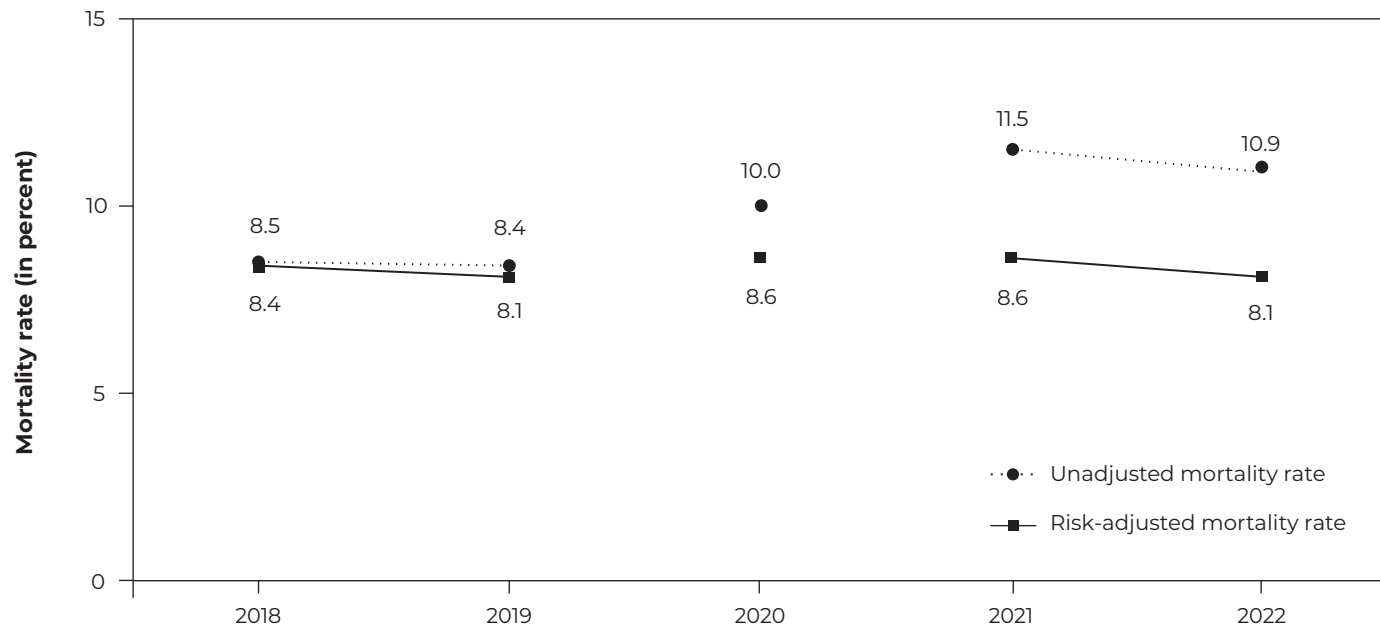
In 2022, the FFS Medicare marginal profit on IPPS and OPSS services continued to vary significantly across hospitals. For-profit hospitals continued to have a much higher Medicare marginal profit than nonprofit hospitals (16 percent vs. 3 percent). Rural nonmicropolitan hospitals also continued to have a much higher Medicare marginal profit than micropolitan or urban hospitals (11 percent vs. 7 percent and 5 percent, respectively), driven by the additional FFS Medicare inpatient payments that most of these rural hospitals receive.

Quality of hospital care in 2022 was mixed relative to prepandemic level

FFS Medicare beneficiaries' risk-adjusted hospital mortality rate improved relative to pandemic

FIGURE
3-4

In 2022, FFS Medicare beneficiaries' hospital mortality rate improved



Note: FFS (fee-for-service). "Mortality rate" refers to the share of inpatient stays at general acute care hospitals that result in a death during or within 30 days after the inpatient stay. The values for 2019 to 2021 are not connected because we cannot draw conclusions on the quality of care in 2020 due to the effects of the coronavirus pandemic.

Source: MedPAC analysis of Medicare Provider Analysis and Review data.

highs, falling to the level in 2019. FFS beneficiaries' risk-adjusted readmission rate improved to about a percentage point better than the immediate prepandemic period. However, most patient experience measures remained below prepandemic levels by several percentage points.

Improvement in hospital mortality rate

From the start of the coronavirus pandemic, FFS Medicare beneficiaries' unadjusted hospital mortality rate increased substantially. However, from 2021 to 2022, FFS Medicare beneficiaries' hospital mortality rate improved on both an unadjusted and risk-adjusted basis (Figure 3-4). The unadjusted mortality rate—defined as the share of inpatient stays at general ACHs that result in a death during or within 30 days after the stay—decreased (that is, improved) by 0.6 percentage

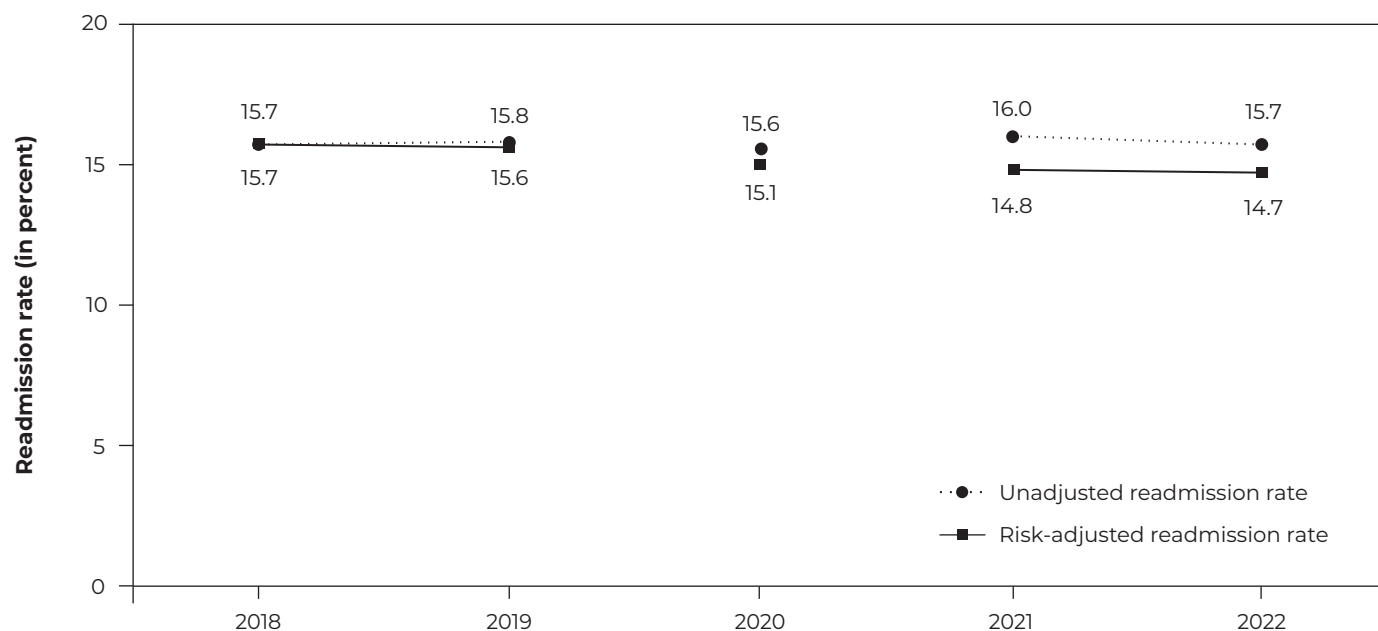
points, from 11.5 percent to 10.9 percent. The risk-adjusted mortality rate improved by 0.5 percentage points, from 8.6 percent to 8.1 percent. Since the start of the pandemic, the risk-adjusted mortality rate has been increasingly lower than the unadjusted mortality rate because beneficiaries admitted to hospitals in recent years tend to have more comorbidities and a higher risk of mortality, and patients with a lower risk of mortality (such as knee-replacement patients) are increasingly moving out of the inpatient setting and thus no longer factor into the average mortality rate.

Improvement in risk-adjusted hospital readmission rate

From 2021 to 2022, FFS Medicare beneficiaries' hospital readmission rate improved on both an unadjusted and risk-adjusted basis (Figure 3-5, p. 62). The unadjusted readmission rate—defined as the share of beneficiaries

**FIGURE
3-5**

In 2022, FFS Medicare beneficiaries' risk-adjusted hospital readmission rate improved slightly



Note: FFS (fee-for-service). "Readmission rate" refers to the share of inpatient stays at general acute care hospitals that result in a readmission for any condition during or within 30 days after the initial inpatient stay. The values for 2019 to 2021 are not connected because we cannot draw conclusions on the quality of care in 2020 due to the effects of the coronavirus pandemic. Results differ from results we published in the March 2023 report because this figure includes critical access hospital stays in the group of initial inpatient stays.

Source: MedPAC analysis of Medicare Provider Analysis and Review data.

over age 65 readmitted to a general ACH within 30 days after discharge—decreased by 0.3 percentage points, from 16.0 percent to 15.7 percent. The risk-adjusted rate of readmissions decreased by 0.1 percentage points, from 14.8 percent to 14.7 percent. Although unadjusted readmission rates were relatively stable from 2018 to 2022, risk-adjusted readmission rates decreased, as did mortality rates, because beneficiaries admitted to hospitals in recent years tend to have more comorbidities and thus a higher expected rate of readmission.

Decline in patient experience measures

Hospital patient experience measures continued to decline in 2022 (Table 3-2). Hospitals collect Hospital Consumer Assessment of Healthcare Providers and Systems® (H-CAHPS®) surveys from a sample of

admitted patients, which CMS uses to calculate results for 10 measures of patient experience included in hospitals' overall ratings.⁸ The H-CAHPS measures key components of quality by assessing whether something that should happen during a hospital stay (such as clear communication) actually happened or how often it happened. In 2022, 70 percent of surveyed patients rated their overall hospital experience a 9 or 10 on a 10-point scale, which is a 3 percentage point decrease from 2018.⁹ Receipt of discharge information had the highest score: 86 percent of surveyed patients answered with the most positive response. The care-transition measure continued to get the lowest score, with only 51 percent of surveyed patients "strongly agreeing" that they understood their care plan when they left the hospital.

**TABLE
3-2**

Hospital patient experience measures continued to decline in 2022

H-CAHPS® measure	2018	2019	2020	2021	2022	Percentage point change, 2018-2022
Share of patients rating the hospital a 9 or 10 out of 10	73%	73%	72%	72%	70%	-3
Share of patients who would definitely recommend the hospital	72	72	71	70	69	-3
Share of patients giving top ratings for:						
Communication with nurses	81	81	80	80	79	-2
Communication with doctors	81	82	81	80	79	-2
Responsiveness of hospital staff	70	70	67	66	65	-5
Communication about medicines	66	66	63	62	62	-4
Cleanliness of hospital environment	75	76	73	73	72	-3
Quietness of hospital environment	62	62	63	62	62	0
Understanding their care when they left the hospital (care transitions)	53	54	52	52	51	-2
Share of patients who received discharge information	87	87	86	86	86	-1

Note: H-CAHPS® (Hospital Consumer Assessment of Healthcare Providers and Systems®). H-CAHPS is a standardized 32-item survey of patients' evaluations of hospital care. The survey items are combined to calculate measures of patient experience for each hospital. The H-CAHPS measures included in the table are "top box," or the most positive, response to H-CAHPS survey items. Each year's results are based on a sample of surveys of hospitals' patients from January to December. Results in 2020 include surveys only from patients discharged July to December 2020 rather than the customary full year. H-CAHPS response rates from 2018 to 2022 range from 24 percent to 26 percent.

Source: CMS summary of H-CAHPS public report of survey results tables.

While H-CAHPS surveys a sample of all hospital patients, not just Medicare patients, the patient experience metrics are inversely correlated with FFS Medicare beneficiaries' risk-adjusted mortality and readmission rates. This relationship suggests that the quality measures are consistent: Hospitals with higher patient experience ratings tended to have better (that is, lower) FFS Medicare mortality and readmission rates.

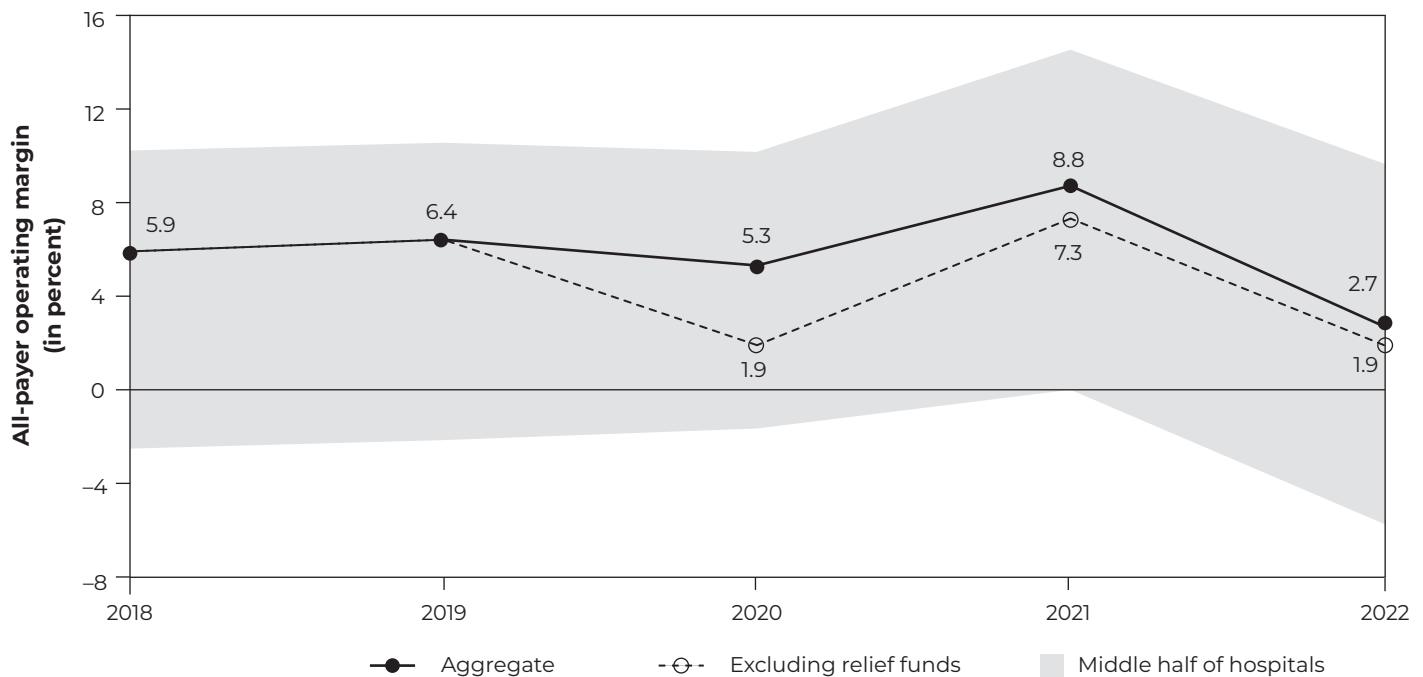
Medicare's hospital quality payment programs should be redesigned

Although FFS Medicare beneficiaries' quality of hospital care improved for some indicators in 2022, the Commission has repeatedly stated that Medicare's hospital quality programs should be redesigned to improve incentives for hospitals to provide high-quality care.

In March 2019, the Commission recommended that the Congress replace Medicare's current hospital quality programs (including the penalty-only programs) with a single, outcome-focused quality-based payment program for hospitals—a hospital value incentive program (HVIP)—that would balance rewards and penalties and have the potential to drive further improvement in hospital quality (Medicare Payment Advisory Commission 2019). Initially, the HVIP could incorporate existing measure domains such as readmissions, mortality, spending per beneficiary, patient experience, and hospital-acquired conditions (or infection rates). A key feature of the Commission's HVIP design is that it accounts for differences in providers' patient populations by incorporating a peer-grouping methodology. Quality-based payments would be distributed to hospitals separated into peer groups

**FIGURE
3-6**

IPPS hospitals' all-payer operating margin fell from a record high in 2021 to a relative low in 2022



Note: IPPS (inpatient prospective payment systems). Hospitals' margins are calculated as aggregate payments minus aggregate costs, divided by aggregate payments. The "all-payer" margin includes payments from all payers. The "operating" margin excludes revenue from investments and donations, and, for 2020 through 2022, these margins are reported with and without federal coronavirus relief funds (Provider Relief Fund payments and forgiven loans from the Paycheck Protection Program). Data are for IPPS hospitals that had a complete cost report with a midpoint in the fiscal year and had non-outlier data as of our analysis.

Source: MedPAC analysis of hospital cost reports.

defined by the social risk of their patient populations, such as the share of beneficiaries receiving the Part D low-income subsidy, used as a proxy for income. Arranging hospitals into peer groups that serve similar populations would make payment adjustments more equitable than existing quality payment programs.

Some indicators of access to capital declined, and preliminary data suggest that hospitals' all-payer margin remained low in 2023

IPPS hospitals' all-payer operating margin fell from a record high in 2021 to a relative low in 2022, driven primarily by higher-than-expected inflation. In addition, preliminary data from large hospital systems

suggest hospitals' aggregate all-payer operating margin remained below prepandemic levels in 2023, and rating agencies have mixed outlooks for the nonprofit hospital sector in 2024. Hospitals' borrowing costs also increased in 2022 and 2023; however, investors reduced the risk premium (above treasury bond yields) that they demanded in order to purchase hospitals' municipal bonds.

Hospitals' all-payer operating margin declined in 2022

From 2021 to 2022, IPPS hospitals' aggregate all-payer operating margin declined from a record high of 8.8 percent to 2.7 percent—the lowest level since 2008 (Figure 3-6). Excluding federal relief funds for

the coronavirus pandemic, IPPS hospitals' operating margin was 1.9 percent, the same level as in 2020, when the pandemic began.¹⁰ As in prior years, there was significant variation within this aggregate: A quarter of hospitals had an all-payer operating margin below –6 percent, while a quarter had a margin above 10 percent.

The roughly 6 percentage point decline in IPPS hospitals' aggregate operating margin resulted from a growth in operating revenue of about 2 percent (including federal coronavirus relief funds) and growth in operating costs of about 8 percent. When excluding relief funds, the growth in operating revenue was about 1 percent. Federal relief funds contributed a much smaller amount to revenue in 2022. Hospitals reported receiving about \$9 billion in these funds, down from \$18 billion in 2021. The operating cost growth in part reflects growth of more than 6 percent in hospitals' salaries per employee and growth in ancillary costs of more than 7 percent.

All-payer operating margin varied across hospital types

While there was variation within types of hospitals, in aggregate, the all-payer operating margin continued to be higher at for-profit hospitals and, to a lesser extent, urban hospitals (Figure 3-7, p. 66).

Compared with the prepandemic period, patterns of all-payer operating margins across groups have changed:

- **For-profit hospitals' operating margin remained above levels in the immediate prepandemic periods, while nonprofits' margin fell below.** In 2022, for-profit hospitals' aggregate all-payer operating margin declined less than 3 percentage points, as their operating revenue grew about 2 percent while they constrained their cost growth to about 4 percent. In contrast, nonprofit hospitals' operating margin declined 7 percentage points; they had a similar growth in operating revenue, but their costs grew about 9 percent. In part, this difference in cost growth resulted from for-profit hospitals constraining the growth in salaries per employee to under 5 percent. In contrast, nonprofit hospitals had a nearly 7 percent growth in average salary. Nonprofit hospitals also had higher growth in ancillary costs, particularly for drugs.

- **Both urban and rural hospitals' operating margin fell below levels in the immediate prepandemic period, but federal coronavirus relief funds narrowed the gap.** In 2022, metropolitan, rural micropolitan, and other rural IPPS hospitals' aggregate all-payer operating margins all declined as their operating revenue grew slower than their costs. However, rural hospitals received targeted relief funds that narrowed the gap between urban and rural hospitals' operating margins in 2020, 2021, and 2022.

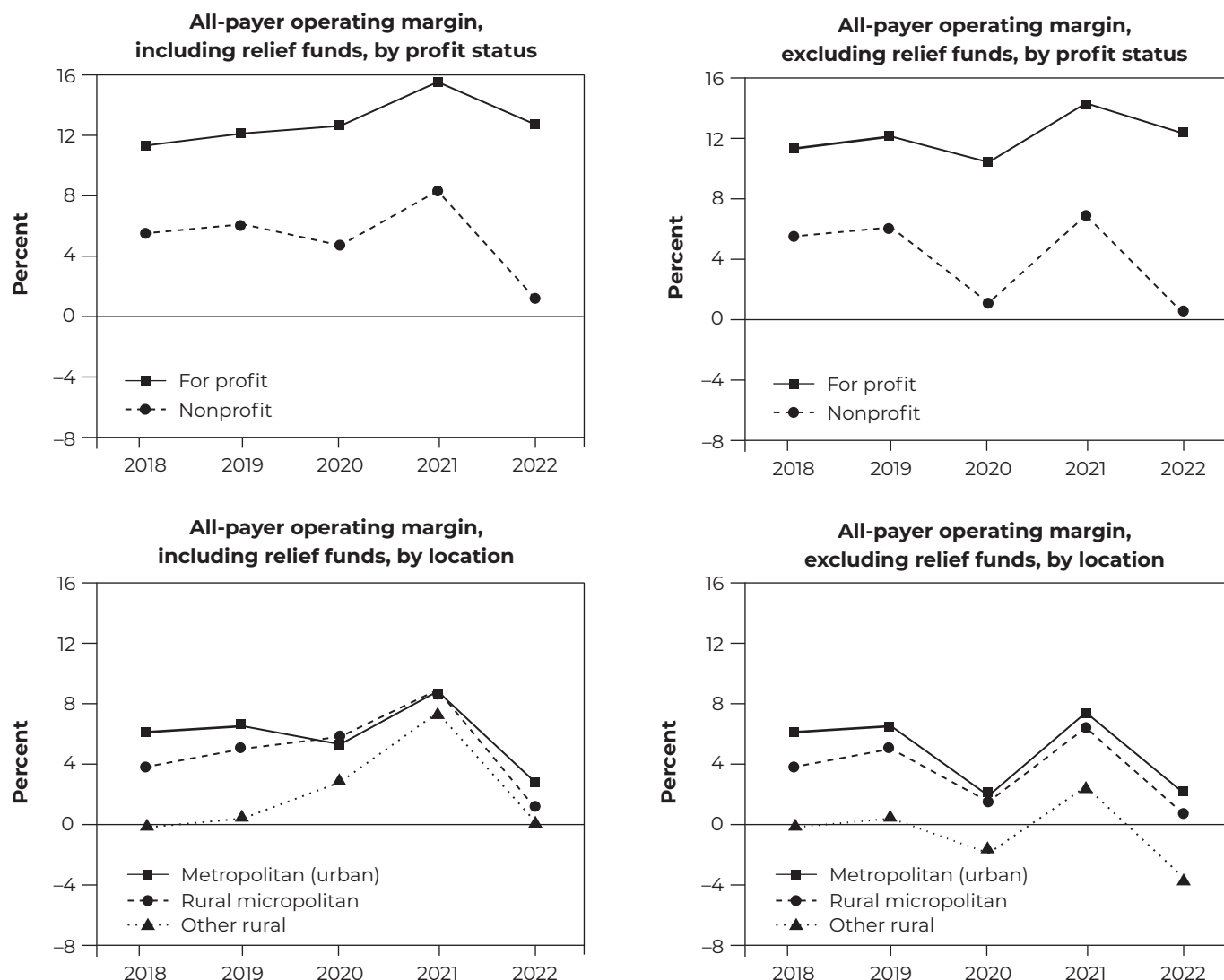
Preliminary data suggest that hospitals' 2023 aggregate all-payer operating margin remained below prepandemic levels

Preliminary data from six large hospital systems suggest that hospitals' all-payer operating margin in 2023 remained below prepandemic levels in aggregate, but with considerable variation. Looking at the most recent quarter of data (July through September 2023), the all-payer operating margin across these six systems varied considerably, ranging from –5 percent to positive 10 percent.¹¹ In aggregate across these six systems, the operating margin declined by 1 percentage point relative to the same quarter in the prior year (2.8 percent vs. 3.9 percent). However, the trends were mixed, with some systems reporting improvements and others reporting declines—relative to both the same quarter in the prior year and prepandemic levels. Several systems attributed their change in operating margin to favorable trends in patient volumes but higher labor and supply costs, as well as the end of federal coronavirus relief funds. The extent to which these factors outweighed the others varied by system.

Looking forward, rating agencies have mixed outlooks for the nonprofit hospital sector in 2024 but generally agree that gradual aggregate improvements in volume and liquidity measures will be tempered by persistent labor challenges—particularly for hospitals already at the lower end of the rating scale (Fitch Ratings 2023, Moody's Investors Service 2023, S&P Global Ratings 2023). Most nonprofit hospitals' credit ratings are expected to remain stable, but the credit gap between the best- and worst-performing hospitals is anticipated to grow, with operational deterioration among a subset of struggling hospitals. A driver of this gap is hospitals' ability to mitigate labor pressure through successfully recruiting and retaining staff, reducing the use of

**FIGURE
3–7**

Magnitude of 2022 decrease in IPPS hospitals' all-payer operating margin varied by type, with less decline among for-profit hospitals



Note: IPPS (inpatient prospective payment systems). Hospitals' margins are calculated as aggregate payments minus aggregate costs, divided by aggregate payments. The "all-payer" margin includes payments from all payers. The "operating" margin excludes revenue from investments and donations and, for 2020 through 2022, is reported with and without reported federal coronavirus relief funds (Provider Relief Fund payments and Paycheck Protection Program forgiven loans). Metropolitan (urban) counties contain an urban cluster of 50,000 or more people; rural micropolitan counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Data are for IPPS hospitals that had a complete cost report with a midpoint in the fiscal year and had non-outlier data as of our analysis. Some results look different from previous reports due to newer data and updated group definitions.

Source: MedPAC analysis of hospital cost reports and census geographic files.

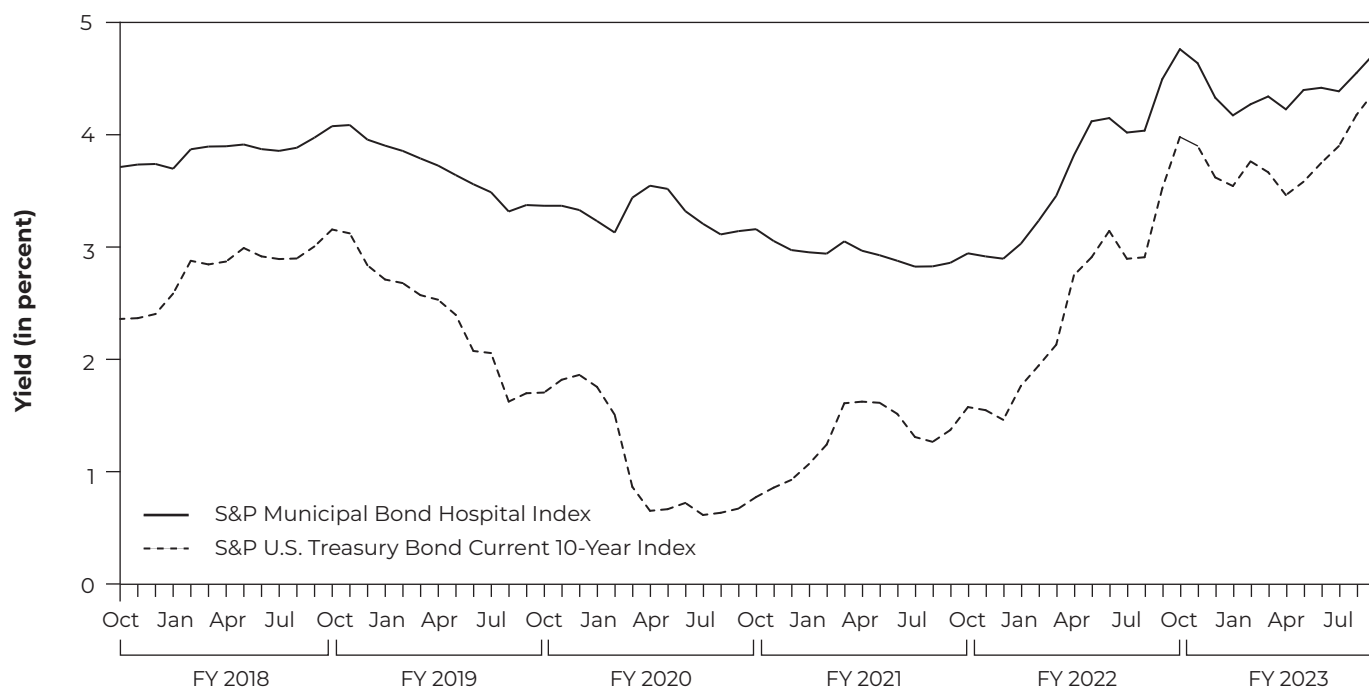
contract labor, and increasing workplace efficiencies. These factors—in addition to variation in volume demand, payer mix, and strength of liquidity metrics—will continue to drive the gap in nonprofit hospital performance and credit ratings.

Hospitals' borrowing costs increased, but by less than the general market

In 2022 and 2023, hospitals' borrowing costs (i.e., costs of accessing capital by issuing bonds) increased, but by less than borrowing costs in the general market

**FIGURE
3-8**

Hospitals' borrowing costs increased in 2022 and 2023, but by less than general market



Note: FY (fiscal year). "Yield" is the average monthly yield to maturity.

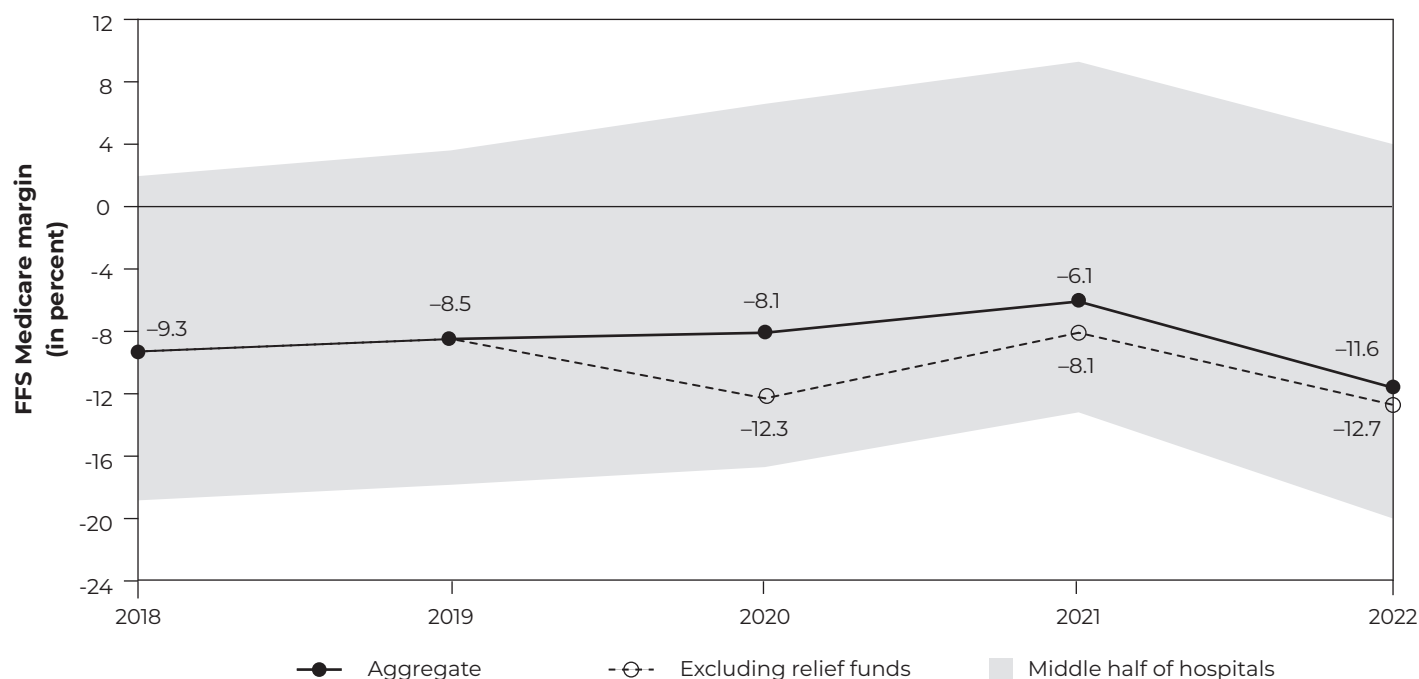
Source: MedPAC analysis of S&P bond data.

(Figure 3-8). During the start of the coronavirus pandemic in spring 2020, the federal government's borrowing costs declined while hospitals' borrowing costs spiked, reflecting investors' demands for a much larger risk premium to hold hospital bonds. By the start of 2021, the general economy began to improve—resulting in higher borrowing costs as measured by yields on treasury bonds—while hospitals' borrowing costs slowly fell. In 2022 and 2023, hospitals' borrowing costs began to climb as the Federal Reserve increased interest rates; however, hospitals' borrowing costs increased by less than the general market. By the end of FY 2023, the yield on the hospital bond index increased to about 5 percent, only slightly above the yield on treasury bonds (S&P Global 2023). This decrease in the risk premium that investors demand suggests that bond investors see little risk of default by the large hospitals issuing municipal bonds and that demand

for hospital bonds remains strong. Since the end of FY 2023, the yield on both hospital and treasury bonds has fallen by similar amounts (data not shown).

FFS Medicare payments to hospitals were lower than hospitals' costs in 2022

In FY 2022, IPPS hospitals' overall FFS Medicare margin across service lines declined to a record low, both in aggregate and for relatively efficient hospitals. This decline largely reflected higher-than-expected inflation that caused hospitals' costs to grow faster than FFS Medicare payments. However, broader payment policy changes also contributed, such as the reinstatement of the 2 percent sequestration on Medicare payments and declining federal coronavirus relief funds, as well as other Medicare payment policies, such as declining uncompensated care payments.

**FIGURE
3-9****IPPS hospitals' FFS Medicare margin across service lines fell to a record low in 2022**

Note: IPPS (inpatient prospective payment systems), FFS (fee-for-service). Hospitals' "FFS Medicare margin" is calculated as aggregate FFS Medicare payments minus aggregate allowable FFS Medicare costs, divided by aggregate FFS Medicare payments. Payments and costs include multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services) as well as direct graduate medical education and uncompensated care payments. Also, for 2020 through 2022, these margins are reported with and without federal coronavirus relief funds (Provider Relief Fund payments and forgiven loans from the Paycheck Protection Program). Data are for IPPS hospitals that had a complete cost report with a midpoint in the fiscal year and had non-outlier data as of our analysis.

Source: MedPAC analysis of hospital cost reports.

Record decline in hospitals' FFS Medicare margin

In 2022, IPPS hospitals' overall FFS Medicare margin across service lines fell to a record low of -11.6, even after accounting for Medicare's share of federal coronavirus relief funds (Figure 3-9).¹² As in prior years, there was significant variation within this aggregate: A quarter of hospitals had a FFS Medicare margin below -20 percent, while a quarter had a margin above 3 percent.

Both FFS Medicare payment policies and broader statutory and environmental changes affected IPPS hospitals' aggregate 2022 FFS Medicare margin across service lines. The key factors that contributed to the 5.5 percentage point decline in hospitals' FFS Medicare margin were the following:¹³

- **Higher-than-expected inflation.** When setting payment rates in summer 2021 for 2022, CMS projected that hospitals' input costs would grow by 2.7 percent in 2022. However, hospitals' input costs actually grew by 5.7 percent, meaning that CMS underestimated these costs by 3 percentage points. Medicare's PPSs generally do not have a forecast error adjustment.¹⁴ Historically, positive and negative forecast errors have tended to balance each other out. As we noted last year, the rapid response to the coronavirus pandemic demonstrated that many hospitals can quickly and substantially lower their costs in response to lower volume. However, hospitals have less ability to constrain costs in response to rapid inflation.

- **Decline in federal coronavirus relief funds.** While hospitals continued to record some federal coronavirus relief funds in their 2022 cost reports, the overall amounts—and therefore Medicare's share—declined in 2022. The decline in relief funds reduced the FFS Medicare margin by nearly 1 percentage point.
- **Reinstatement of sequestration on Medicare payments.** The Congress suspended the 2 percent sequestration on Medicare program payments from May 1, 2020, through March 31, 2022. The Congress partially applied sequestration at a 1 percent reduction from April 1, 2022, through June 30, 2022, and then reverted to the full 2 percent reduction beginning July 1, 2022. Collectively, this phase-in reduced Medicare's payments to hospitals in FY 2022 by less than 1 percent.
- **Increased high-cost outlier inpatient stays.** Medicare's IPPS outlier payments increased by nearly \$0.5 billion in 2022 despite a slight increase in the fixed loss amount (from about \$29,000 to \$31,000), indicating that hospitals' costs for outlier stays grew rapidly. Under the IPPS, Medicare covers a portion of hospitals' costs for high-cost outlier stays: generally 80 percent of hospitals' costs for the stay that are above the sum of the standard IPPS rate and a fixed loss amount. In 2022, outlier payments totaled nearly 7 percent of base IPPS payments, well above the target of 5.1 percent. These unexpectedly large outlier payments were driven in part by an increase in costly stays related to infectious diseases.
- **Decrease in uncompensated care payments.** From 2021 to 2022, CMS decreased aggregate Medicare uncompensated care payments by about \$1.2 billion. This decline resulted from CMS's estimate that disproportionate share hospital payments under prior law and the national uninsured rate would both decline. By design, when CMS estimates a decline in hospitals' share of low-income beneficiaries (i.e., lower disproportionate share hospital payments under prior law) or a decline in hospitals' uncompensated care burden (i.e., the national uninsured rate), Medicare's uncompensated care payments decline.

One countervailing factor that led to higher FFS Medicare payments for some hospitals was the start

of 340B Drug Pricing Program remedy payments. In response to court rulings, CMS reprocessed calendar year 2022 hospital outpatient payments for drugs obtained under the program, resulting in an additional \$1.6 billion paid to participating hospitals (see text box on 340B drugs and outpatient payments, p. 70). Approximately half of these remedy payments were recorded in hospitals' FY 2022 cost reporting periods (because only nonprofit hospitals are eligible for the 340B Drug Pricing Program, and nonprofit hospitals' most common cost reporting period is July to June).

Hospitals' inpatient costs exceeded FFS Medicare payments by a greater amount than their costs for outpatient services did. In 2022, hospitals' inpatient costs per FFS Medicare stay grew three times as fast as IPPS payments per stay: The costs increased 8.3 percent, to \$18,700, while IPPS payments per stay increased 2.7 percent, to \$15,900. Meanwhile, hospitals' outpatient costs per FFS Medicare beneficiary grew moderately faster than OPPS payments per beneficiary: Hospitals' outpatient costs per FFS Part B beneficiary increased 8.1 percent, to \$2,600, while OPPS payments per beneficiary increased 6.9 percent, to \$2,200.

FFS Medicare margin continued to vary across hospital groups, including positive margin among for-profit hospitals

While there was variation within each group of IPPS hospitals, in aggregate, the FFS Medicare margin across service lines continued to be higher at for-profit hospitals, rural hospitals, and hospitals under high fiscal pressure (Figure 3-10, p. 71).¹⁵ Consistent with prior years, for-profit IPPS hospitals and those under high fiscal pressure have been able to maintain relatively higher FFS Medicare margins primarily because they have constrained costs more than nonprofits or hospitals under less financial pressure have. In contrast, rural hospitals—especially those in nonmicropolitan areas—have continued to have a higher FFS Medicare margin primarily because most IPPS hospitals in rural nonmicropolitan areas benefit from one or more special designations that provide additional FFS Medicare payments above IPPS and/or OPPS payments. In addition, both rural hospitals and hospitals with low all-payer margins received targeted federal coronavirus relief funds, causing their FFS Medicare margin including relief funds to disproportionately increase in 2020 and 2021.

Changes in outpatient payments as a result of recent court cases concerning 340B drugs

In calendar year 2018, CMS implemented a policy that reduced the outpatient prospective payment system (OPPS) rates for most separately payable non-pass-through drugs that hospitals obtained through the 340B Drug Pricing Program from the default rate of average sales price plus 6 percent to average sales price minus 22.5 percent. To satisfy budget-neutrality requirements under the Social Security Act, CMS increased the payment rates for all covered OPPS nondrug items and services by 3.19 percent.

Hospitals challenged this policy, and, in 2022, the Supreme Court ruled that the approach CMS used to establish the reduced payment rates for 340B drugs violated parts of the Social Security Act. The Supreme Court remanded this case to the District Court for the District of Columbia, which issued a decision that gave CMS the opportunity to determine a remedy that would fully offset the reduced OPPS payment rates for 340B drugs and the increased OPPS payment rates for nondrug items and services.

CMS estimated that, in aggregate, the 340B drug payment policy lowered OPPS payments to 340B hospitals by \$10.6 billion since fee-for-service Medicare beneficiaries' drug utilization increased faster than CMS expected. CMS also estimated that the 3.19 percent increase to OPPS payment rates for nondrug items and services increased payments

to all OPPS hospitals by \$7.8 billion (Centers for Medicare & Medicaid Services 2023).

CMS concluded that the remedy for the reduced payments for 340B drugs must be budget neutral. Therefore, the agency finalized a plan to provide \$10.6 billion in remedy payments to 340B hospitals and to gradually reduce OPPS payments to recoup the estimated \$7.8 billion in increased OPPS payments for nondrug items and services from calendar years 2018 through 2022.

CMS has already taken a step to address the \$10.6 billion in remedy payments for 340B drugs by reprocessing most OPPS claims for the 2022 payments for 340B drugs affected by the 340B policy. This claims reprocessing has provided 340B hospitals with \$1.6 billion in remedy payments. To address the remaining \$9.0 billion in remedy payments for 340B drugs, CMS finalized a policy to provide one-time lump-sum payments to each affected 340B hospital at the end of calendar year 2023 or the beginning of 2024.

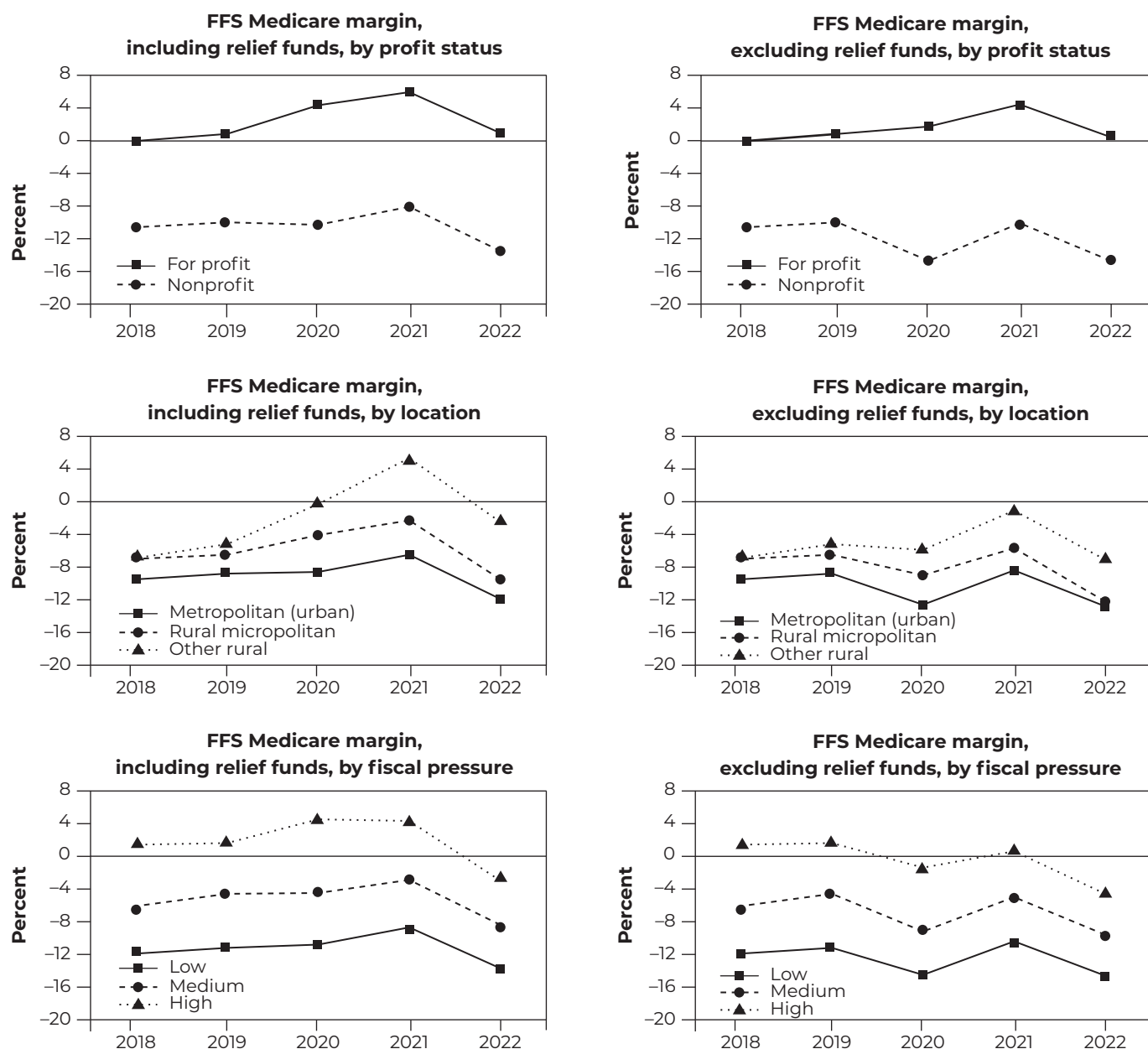
To offset the increased OPPS payments for nondrug items and services from calendar years 2018 through 2022, CMS finalized a 0.5 percent decrease to the OPPS conversion factor beginning in calendar year 2026. The 0.5 percent decrease will remain in place until the \$7.8 billion offset is reached, which CMS estimates will take 16 years. ■

However, the spread in the FFS Medicare margins across groups differed somewhat relative to the levels in the immediate prepandemic period. In particular, only for-profit hospitals were able to maintain a FFS Medicare margin near the levels in the immediate prepandemic period. From 2021 to 2022, for-profit IPPS hospitals' FFS Medicare margin across service lines declined from highs in 2020 and 2021 to a level similar to 2019. In contrast, nonprofit IPPS hospitals' FFS

Medicare margin declined from a level similar to 2019 to a record low. This low 2022 FFS Medicare margin at nonprofit hospitals occurred despite nonprofit hospitals receiving substantial 340B drug remedy payments during their 2022 cost reporting periods. The other group of hospitals that had been able to maintain a positive FFS Medicare margin in the immediate prepandemic period—hospitals under high fiscal pressure—did not maintain a positive FFS Medicare margin in 2022.

**FIGURE
3-10**

IPPS hospitals' FFS Medicare margin varied across groups, including higher margins at for-profit, rural, and fiscally pressured hospitals



Note: IPPS (inpatient prospective payment systems), FFS (fee-for-service). Hospitals' "FFS Medicare margin" is calculated as aggregate FFS Medicare payments minus aggregate allowable FFS Medicare costs, divided by aggregate FFS Medicare payments. Hospitals' FFS Medicare margin includes multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services) as well as direct graduate medical education and uncompensated care payments. For 2020 through 2022, this margin is reported with and without federal coronavirus relief funds (Provider Relief Fund payments and forgiven loans from the Paycheck Protection Program). Metropolitan (urban) counties contain an urban cluster of 50,000 or more people; rural micropolitan counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." "Low fiscal pressure" hospitals are defined as those with a median non-Medicare margin greater than 5 percent over five years and a net worth that would have grown by more than 1 percent per year over that period if the hospital's Medicare profits had been zero. "High fiscal pressure" hospitals are defined as those with a median non-Medicare margin of 1 percent or less over five years and a net worth that would have grown by less than 1 percent per year. Data are for IPPS hospitals that had a complete cost report with a midpoint in the fiscal year and had non-outlier data as of our analysis. Some results look different from prior-year reports' results due to newer data and updated group definitions.

Source: MedPAC analysis of hospital cost reports and census geographic files.

**TABLE
3-3****Relatively efficient hospitals performed better than other hospitals but still had a negative median FFS Medicare margin in 2022**

	Relatively efficient hospitals	Other hospitals
Number of hospitals	135	1,900
Share of hospitals in our study sample	7%	93%
Historical performance, 2018, 2019, 2021 (percentage of national median)		
Standardized Medicare costs per unit	91%	102%
Mortality rate	85	101
Readmission rate	93	101
Performance metrics, 2022 (percentage of national median)		
Standardized Medicare costs per unit	91%	102%
Mortality rate	90	101
Readmission rate	94	101
Share of patients rating the hospital a 9 or 10 (out of 10)	103	100
Median FFS Medicare margin, 2022		
FFS Medicare margin with federal coronavirus relief funds	-2%	-9%
FFS Medicare margin excluding relief funds	-3	-10
Median all-payer operating margin with relief funds, 2022		
	4	3

Note: FFS (fee-for-service). "Relatively efficient hospitals" and "other hospitals" were identified based on their mean performance during 2018, 2019, and 2021 relative to the median hospital's performance during those years (see text box on our identification methodology, pp. 74-75). "Standardized Medicare cost per unit" combines standardized costs per inpatient stay with standardized costs per outpatient service (relative to their respective national medians) using two-thirds and one-third weighting based on the overall inpatient and outpatient shares of Medicare payments in 2021. "Standardized Medicare costs per unit" are standardized for area wage rates, case-mix severity, prevalence of outlier and transfer cases, interest expense, low-income shares, and teaching intensity. "Mortality rate" refers to the (risk-adjusted) share of inpatient stays at general acute care hospitals that resulted in a death during or within 30 days after the inpatient stay. "Readmission rate" refers to the risk-adjusted share of inpatient stays at general acute care hospitals that resulted in a readmission for any condition within 30 days after the initial inpatient stay. "Share of patients rating the hospital a 9 or 10 (out of 10)" is based on Hospital Consumer Assessment of Healthcare Providers and Systems® (H-CAHPS®) survey data collected from patients discharged between January and December 2022. Hospitals' "FFS Medicare margin" is calculated as aggregate FFS Medicare payments minus aggregate allowable FFS Medicare costs, divided by aggregate FFS Medicare payments. Hospitals' FFS Medicare margin includes multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services) as well as direct graduate medical education and uncompensated care payments.

Source: MedPAC analysis of CMS cost report and claims data and CMS's summary of H-CAHPS public reports of survey results tables.

Relatively efficient hospitals' median FFS Medicare margin was negative

Each year, as part of our assessment of payment adequacy, the Commission calculates a median FFS Medicare margin for a group of hospitals that perform relatively well on a set of quality metrics (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 hospitals. 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 Medicare's payments are adequate to cover the costs of providing hospital care efficiently.

In 2022, the median FFS Medicare margin among the IPPS hospitals we identified as relatively efficient was -2 percent when including Medicare's share of federal coronavirus relief funds and -3 percent when excluding these funds (Table 3-3). This margin is lower than the last few years, when relatively efficient hospitals approximately broke even on Medicare (when excluding relief funds). The lower median FFS Medicare margin among relatively efficient hospitals this year is consistent with the lower FFS Medicare margin among all IPPS hospitals discussed above.

As in prior years, we identified a subset of hospitals that were never in the worst third on any quality or cost metrics during the prior three years (using 2018, 2019, and 2021 to limit the effect of the start of the pandemic) and consistently performed in the best third in either costs or mortality. We then assess the adequacy of FFS Medicare payments (using performance in 2022) for these relatively efficient hospitals. This year, we improved the method for identifying relatively efficient hospitals by incorporating hospital outpatient costs and using more rigorous thresholds for quality of care (see text box for more detail on our method, pp. 74-75).

Among our sample of 135 relatively efficient hospitals in 2022, costs per unit (combining inpatient and outpatient costs per unit) were 91 percent of the national median, allowing these hospitals to generate better FFS Medicare margins than the other hospitals in the comparison group (Table 3-3). In 2022, the relatively efficient hospitals also continued to have better mortality and readmission metrics than the national median. The mortality rate for relatively efficient hospitals was better (i.e., lower) than what we published in prior years because we applied more rigorous criteria in our improved methodology. Relatively efficient hospitals also had better patient satisfaction, performing above the

national median on the share of H-CAHPS respondents rating the hospital a 9 or 10 in 2022.

As in past years, relatively efficient hospitals were spread across the country and represented diverse categories of hospitals, including teaching, nonteaching, rural, urban, for-profit, and nonprofit hospitals, as well as hospitals serving large shares of low-income patients. While most types of hospitals were represented in the efficient group, a disproportionate share of relatively efficient hospitals had relatively high inpatient volume. Volume primarily affects our efficiency measures in two ways. First, higher-volume hospitals tended to have lower risk-adjusted mortality rates. Second, we require some consistency of results over three years and remove from the relatively efficient group any hospital that performed in the bottom third on any metric in a single year.¹⁶ Low-volume hospitals may be more subject to random variation that can make them likely to be excluded from our efficient group. The relatively efficient hospitals were also less likely to be located in rural areas and tended to have lower shares of low-income Medicare patients.¹⁷ Among both for-profit and nonprofit hospitals, the shares of hospitals categorized as relatively efficient were generally similar. Although for-profit hospitals tend to have lower costs, nonprofit hospitals tend to have higher quality metrics.

Projected increase in hospitals' FFS Medicare margin in 2024 due to one-time 340B drug remedy payments

In 2024, hospitals that participate in the 340B drug payment program are scheduled to receive \$9 billion in remedy payments to correct for underpayments in calendar years 2018 to 2021 (see text box on 340B drugs and outpatient payments, p. 70). Including these one-time payments, we project that IPPS hospitals' aggregate FFS Medicare margin across service lines will increase to -8 percent. The projection for relatively efficient IPPS hospitals' aggregate FFS Medicare margin would increase to -2 percent. However, excluding these 2024 remedy payments, we project IPPS hospitals' aggregate FFS Medicare margin to be -13 percent, similar to the level in 2022 exclusive of federal coronavirus relief funds. Similarly, we project the median FFS Medicare margin among relatively efficient hospitals to be about -3 percent, in line with 2022. These projections are based on actual payments

Identifying relatively efficient hospitals: Updated methodology

The Commission follows two principles when identifying a set of relatively efficient providers. First, the providers must do relatively well on cost and quality metrics. Second, the performance has to be consistent, meaning that the provider cannot have poor performance on any metric over a period of three years. Our assessment of efficiency is not in absolute terms, but rather relative to a comparison group of other hospitals paid under Medicare's inpatient and outpatient prospective payment systems (IPPS and OPPS).

Our objective is to identify a sample of hospitals that consistently perform at an above-average level on at least one measure (cost or mortality) and that always perform reasonably well on all our measures. Our methodology does not seek to identify all efficient hospitals, only a subsample of relatively efficient hospitals. For example, we screen out hospitals that have few Medicare or Medicaid patients or have poor performance in a single year, even though these hospitals may be relatively efficient.

Categorizing hospitals as relatively efficient

As in prior years, we assigned IPPS hospitals that met minimum volume criteria to the relatively efficient group or the control group according to each hospital's performance relative to the national median on a set of risk-adjusted cost and quality metrics for the three years prior to the most recent

cost report year.¹⁸ Costs were standardized to account for hospital characteristics that affect costs but are generally outside the hospital's control, such as teaching status and shares of patients with low incomes.¹⁹ A hospital was identified as relatively efficient if it met the following criteria in each of the three prior years:

- Risk-adjusted mortality rate or standardized cost was among the best one-third of hospitals in all years.
- Risk-adjusted mortality rate was not among the worst third in any year.
- Risk-adjusted readmission rate was not among the worst third in any year.
- Standardized cost was not among the worst third in any year.

We also use the Hospital Consumer Assessment of Healthcare Providers and Systems[®] survey to require that at least 50 percent of the hospital's patients rated it a 9 or 10 on a 10-point scale (in the year prior to the performance period).

Updated methods

Recently, the Commission undertook a review of the method for identifying relatively efficient hospitals and implemented two substantive improvements:

(continued next page)

and costs from the most recent year of complete data (2022); partial data from 2023; and policy, inflation, and coronavirus pandemic-related changes that took place in 2023 and are anticipated in 2024.

When we exclude one-time 340B drug remedy payments, we expect IPPS hospitals' FFS Medicare margin in 2024 to be similar to the level in 2022. We

anticipate this result because we project several factors that roughly offset each other, including:

- **Increase in 340B drug payments starting in 2022 and projected continued volume growth.** In 2022, as a result of recent court rulings, CMS increased the payments for 340B drugs from average sales price minus 22.5 to average sales price plus 6 percent. Because only nonprofit hospitals are eligible for

Identifying relatively efficient hospitals: Updated methodology (cont.)

- **We incorporated Medicare outpatient costs:**

Historically, we considered only inpatient costs per stay in assessing hospital costs, but outpatient services are a growing share of Medicare payments to hospitals. To better capture hospitals' overall Medicare costs, we combined standardized costs per inpatient stay with standardized costs per outpatient service (relative to their respective national medians) using two-thirds and one-third weighting based on the overall inpatient and outpatient shares of Medicare payments in the most recent prior year (see Table 3-1 in the Commission's March 2023 report (Medicare Payment Advisory Commission 2023b)).²⁰ This combined metric was used to determine whether hospitals met the cost criteria to be classified as relatively efficient.

- **We defined thresholds for quality of care more rigorously:** To determine the thresholds for classifying hospitals on risk-adjusted mortality and readmissions measures, we considered only the hospitals in our analysis file instead of all general acute care hospitals (which we had done in prior years). Our analysis file contained IPPS and OPPS hospitals with valid cost and claims data during baseline and performance years that met annual volume minimums and served at least a minimal

amount of Medicaid patients.²¹ The removal of small hospitals, such as critical access hospitals, resulted in higher quality on average, making it more difficult for a hospital to exceed the threshold and be classified in the top third.

To assess the effect of methodological differences on results, we applied the prior methods to the same data. We found that our improved method resulted in identifying relatively efficient hospitals in 2022 that had a median fee-for-service (FFS) Medicare margin that was about 3 percentage points higher than the prior method and a median mortality rate 1 percentage point lower. (Applying our improved method to the most recent data that was available last year (2021 data) resulted in relatively efficient hospitals having a median FFS Medicare margin 1 percentage point higher than the results reported last year.) The more rigorous criterion for high-quality care also contributed to classifying a smaller number and share of hospitals as relatively efficient than in the past (7 percent compared with 15 percent).

The updated method better represents both the costs and quality of hospitals used in the analysis, thereby improving the identification of a group of relatively efficient hospitals for use in assessing the adequacy of Medicare's payments. ■

the 340B drug payment program and most of these hospitals' cost reports are from July to June, the higher payment rate was in effect for only part of hospitals' 2022 cost reporting periods. However, these higher payments are scheduled to be in effect for all of 2023 and 2024. We also project the volume of 340B drugs to continue to grow.

- **Increase in hospital productivity and coding.** Prior to the pandemic, hospitals' costs per inpatient stay grew about 1 percentage point slower than their input costs and case mix, reflecting a combination

of increased hospital productivity and/or higher coding. While this pattern changed during the pandemic, we expect it will revert to the norm in 2024, with hospitals able to resume prepandemic levels of productivity and/or coding.

- **Phase-out of special Medicare payment policies in 2022 and 2023.** During the pandemic, the Congress suspended the 2 percent sequester on Medicare payments. During 2022, the Congress began to partially reapply the sequester. These lower payments were applied to a portion of hospitals'

2022 cost reporting period but are scheduled to be in effect for all of 2023 and 2024. Special Medicare payment policies to support hospitals during the pandemic—the additional 20 percent payment for COVID-19 inpatient stays and payments for new COVID technologies—both expired in 2023.

- **Underestimate of input price inflation in 2023.** When setting payment rates in summer 2022 for 2023, CMS projected that hospitals' input costs would grow by 4.1 percent in 2023 based on data available at the time. However, based on actual data through the second quarter of 2023, hospitals' input costs grew by 4.8 percent, 0.7 percentage points more than expected. Actual inflation for the rest of 2023 and 2024 is not yet known; we use CMS's current estimates of input price inflation because they represent the best estimates available at this time.
- **Declines in Medicare's uncompensated care payments in 2023 and 2024.** Medicare's uncompensated care pool in 2022 was \$7.2 billion (prior to sequestration), declined in 2023 to \$6.9 billion, and will decline again in 2024 to \$5.9 billion. These declines reflect CMS's projections of a decrease in disproportionate share hospital payments and in the national uninsured rate.
- **End of statutory increase to inpatient payments in 2024.** The Medicare Access and CHIP Reauthorization Act of 2015 required that, for 2018 through 2023, inpatient operating payments be increased by 0.5 percentage points to reverse prior temporary reductions for past documentation and coding changes.

There are no currently scheduled FFS Medicare policy changes or anticipated environmental factors that would materially change hospitals' FFS Medicare margin in 2025 relative to 2024.²²

Like all projections, ours are subject to uncertainty. In particular, there is uncertainty about whether the coronavirus pandemic will continue to abate and about the accuracy of CMS's estimates of future input price inflation. For 2025, there are additional unknowns, such as the level of Medicare's uncompensated care payments and how hospitals will spend the scheduled \$9 billion in 340B drug remedy payments they receive in 2024. We will update with data on actual experience

in our next recommendation cycle. We will also continue to look for additional measures of payment adequacy to include in future recommendation cycles.

How should FFS Medicare payments change in 2025?

Under current law, CMS sets the percentage update to IPPS and OPPS payment rates based on CMS's forecasts of market basket increases less a forecasted increase in productivity, as well as any other statutory or policy updates. The final hospital updates for 2025 will not be set until summer 2024. However, based on current CMS forecasts through the third quarter of 2023, the 2025 updates would include:

- a 2.8 percent increase in the IPPS operating and OPPS base payment rates (resulting from 3.1 percent growth in the market basket less 0.3 percentage points in productivity), and
- a 2.5 percent increase in the IPPS capital base rate, plus a forecast error adjustment.

Our hospital payment adequacy indicators were mixed and suggest that FFS Medicare payments to general ACHs were below costs for most hospitals. We also project that this disparity will persist under current-law updates.

In considering how Medicare payments to general ACHs should change in 2025, the Commission contends that scarce Medicare resources should be used efficiently. To meet this goal, Medicare should aim to balance several objectives:

- support hospitals with payments high enough to ensure beneficiaries' access to care;
- maintain payments close to hospitals' cost of providing high-quality care efficiently to ensure value for taxpayers;
- maintain fiscal pressure on hospitals to constrain costs;
- minimize differences in payment rates for similar services across sites of care;

- be cautious about how much emphasis is placed on a single year of data, especially in volatile periods; and
- avoid implementing large, across-the-board payment rate increases to support a subset of hospitals with specific needs.

Given the recent volatility in hospital profit margins, it is particularly difficult to assess how FFS Medicare payments should change in 2025. Since the start of the coronavirus pandemic in 2020, hospitals' FFS Medicare margin reached a recent high in 2021 followed by a record low in 2022. Hospitals' all-payer operating margin has also fluctuated dramatically, driven by substantial federal coronavirus relief funds followed by substantial inflation. Periods of volatility and rapid inflation make it extremely difficult for hospitals to constrain costs or plan for the future.

Last year we concluded that payment adequacy indicators for hospitals were generally positive when looking at historical data. However, we projected declines in hospitals' finances due to unanticipated increases in input price inflation. In recognition of this projection and out of particular concern for the effect on hospitals that serve large shares of low-income Medicare beneficiaries, in March 2023 the Commission recommended a record-high update to IPPS and OPPS payments for fiscal year 2024—equal to current law plus 1 percent—as well as transitioning existing safety-net payments to the Commission-developed Medicare Safety-Net Index (MSNI) and adding \$2 billion to the MSNI pool (to be split between FFS and MA) (see text box on safety-net hospitals, p. 78). This recommendation was not enacted. As expected, in 2022, hospitals' all-payer and FFS Medicare margins fell dramatically, reflecting a historically difficult financial year.

Looking forward, we expect hospitals' FFS Medicare margin to improve in 2024 because the nonprofit hospitals that participate in the 340B drug program are scheduled to receive \$9 billion in 340B remedy payments (equivalent to 5 percent of all IPPS and OPPS payments). However, the 2024 remedy payments are a one-time adjustment. Therefore, we expect that hospitals will once again have relatively low FFS Medicare margins in 2025 if current law holds.

RECOMMENDATION 3

For fiscal year 2025, the Congress should update the 2024 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1.5 percent.

In addition, the Congress should:

- **begin a transition to redistribute disproportionate share hospital and uncompensated care payments through the Medicare Safety-Net Index (MSNI);**
- **add \$4 billion to the MSNI pool;**
- **scale fee-for-service MSNI payments in proportion to each hospital's MSNI and distribute the funds through a percentage add-on to payments under the inpatient and outpatient prospective payment systems; and**
- **pay commensurate MSNI amounts for services furnished to Medicare Advantage (MA) enrollees directly to hospitals and exclude them from MA benchmarks.**

RATIONALE 3

Hospitals' payment adequacy indicators were mixed, based on the most recent available data. Hospitals maintained excess capacity in aggregate, maintained a financial incentive to serve FFS Medicare beneficiaries, improved their mortality and readmission rates, and maintained strong access to bond markets. However, IPPS hospitals' aggregate all-payer operating margin and their FFS Medicare margin both declined in 2022. While some hospitals were able to maintain a positive FFS Medicare margin, many were not. For 2024, we project that IPPS hospitals' FFS Medicare margin will increase to -8 percent, inclusive of the 340B remedy payments scheduled for that year. Excluding these one-time payments, we project that the 2024 margin will be about -13 percent and that the relatively efficient hospitals' median FFS Medicare margin will be about -3 percent.

The Commission continues to underline the importance of prudently using scarce Medicare resources by targeting them toward Medicare safety-net hospitals. Therefore, we contend that the best balance is a small update above current law to all general ACHs and more significant support to Medicare safety-net hospitals (as defined in our June 2022 and March 2023 reports). Similar to last year,

Supporting Medicare safety-net hospitals through the Commission-developed Medicare Safety-Net Index

Because 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 computation of disproportionate share and uncompensated care per claim add-on amounts 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 fee-for-service (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 measure of “safety-net” status is Medicare-centric by design; safety-net definitions used by Medicaid and other payers would likely differ.

The Commission-developed Medicare Safety-Net Index (MSNI) is computed using three components: (1) the share of a hospital's Medicare volume associated with low-income beneficiaries (identified as those who receive the Part D low-income subsidy); (2) the share of revenue the hospital spends on uncompensated care (bad debts and charity care); and (3) the share of total volume associated with Medicare beneficiaries. The Commission found that the MSNI is a better indicator of the financial

status of hospitals serving large shares of low-income Medicare beneficiaries than the current disproportionate share hospital metric.

Our March 2023 report modeled the effects of redistributing the nearly \$12 billion in 2019 disproportionate share and uncompensated care payments via the MSNI, and of adding \$1 billion in FFS MSNI payments. On net, the policy change was expected to increase FFS payments by about 0.5 percent on average, with rural hospitals' payments increasing by 2.3 percent on average and government hospitals experiencing a decline of 1.5 percent on average. In general, hospitals with a large share of low-income Medicare patients (often rural hospitals) would have gained Medicare revenue, and hospitals with few Medicare patients but large shares of Medicaid and uninsured patients (often government hospitals) would have received less Medicare revenue under last year's proposal, using 2019 data for modeling purposes. As we discussed at length in last year's report, the financial effects of the proposed policy are to redirect Medicare safety-net funding toward supporting Medicare patients (Medicare Payment Advisory Commission 2023b).

However, since 2019, existing safety-net payments have steadily decreased; for 2024, CMS estimated that safety-net payments will be slightly over \$9 billion, about a \$3 billion decline from 2019. Because the pool of dollars to be redistributed has declined, hospitals with relatively few Medicare patients, which had benefited under the old policy (often government hospitals), will have less to lose in a redistribution of existing funds. ■

the recommendation would redistribute Medicare's current safety-net payments (disproportionate share and uncompensated care payments) using the Commission-developed MSNI. However, in recognition of the worsened financial performance in 2022 and the roughly \$3 billion decline in existing Medicare

disproportionate share and uncompensated care payments from 2019 to 2024, the Commission contends that all hospitals warrant greater support than the Commission recommended last year, with the largest increase in payment rates directed toward hospitals serving high shares of low-income Medicare patients.

Our recommendation would increase IPPS and OPPS base payment rates for all hospitals by 1.5 percent above current law. In addition, the recommendation would add \$4 billion to existing disproportionate share and uncompensated care payments and redistribute the total pool of dollars through the MSNI. About half would go to hospitals for their care of FFS beneficiaries and half for MA beneficiaries. This roughly \$2 billion of FFS MSNI payments would be similar to a 1.3 percent increase to IPPS and OPPS base payments. The combined effects of the two parts of our recommendation would effectively increase IPPS and OPPS payments by 2.8 percent more than the current-law update.

While our recommended 1.5 percent increase to IPPS and OPPS base rates would affect all hospitals equally, the shift from the current disproportionate share and uncompensated care payment model to the MSNI model would have distributional impacts. The current disproportionate share and uncompensated care payments are primarily used to partly reimburse hospitals for the bad debts and charity care costs of non-Medicare patients. The problems with the current safety-net payments are discussed in detail in our March 2023 report to the Congress (Medicare Payment Advisory Commission 2023b). The hospitals that tend to benefit most from this system are disproportionate share hospitals with high uncompensated care costs but relatively few FFS Medicare patients. In contrast, the new MSNI payments would be distributed through an add-on to FFS Medicare payment rates (and an add-on to what FFS payments would have been for MA beneficiaries), so Medicare dollars would follow Medicare patients. The hospitals that would benefit most from the new MSNI approach are hospitals with high shares of Medicare patients and, in particular, high shares of low-income Medicare patients.

While all major categories of hospitals (e.g., teaching, nonteaching, rural, urban, for profit, nonprofit, government) would see increased Medicare payments under our recommendation, the largest gains would be for rural hospitals. Rural hospitals tend to have high Medicare shares and high shares of low-income Medicare patients. On average, we expect that the recommendation would increase rural hospitals' FFS Medicare payments by about 5 percent more than current law, almost double the 2.8 percent average across all hospitals. In contrast, some large government

hospitals have relatively few Medicare patients. While some government hospitals would receive large increases in Medicare payments, in aggregate we expect that our recommendation would increase government hospitals' FFS Medicare payments by about 1 percent over current law.

The Commission recommendation specifies that MSNI payments for MA enrollees be made directly to hospitals and excluded from MA benchmarks. This method would be similar to the way indirect medical education payments are currently made to hospitals for their MA patients. Making MSNI payments for enrollees directly to hospitals would reduce current incentives for MA plans to steer patients away from hospitals that receive high levels of safety-net payments from Medicare.

The Commission anticipates that a 2025 update to hospital payment rates of current law plus 1.5 percent and about \$2 billion in FFS MSNI funds (since about half of the \$4 billion in additional MSNI funds would go toward services for FFS beneficiaries and about half toward services for MA beneficiaries) would generally be adequate to maintain FFS beneficiaries' access to hospital inpatient and outpatient care. These funds would raise IPPS and OPPS payment rates close to the cost of delivering high-quality care efficiently. We expect the additional MSNI funds to be immediately distributed in 2025 and future years; the \$4 billion add-on could grow annually by the hospital market basket.

IMPLICATIONS 3

Spending

- This recommendation would increase spending relative to current law by \$5 billion to \$10 billion in one year and \$25 billion to \$50 billion over five years.

Beneficiary and provider

- We expect that this recommendation will help ensure Medicare beneficiaries' access to care by increasing hospitals' willingness and ability to treat beneficiaries, especially those with low incomes. ■

Endnotes

- 1 Throughout this chapter, we use the term “FFS Medicare” as equivalent to the CMS term “Original Medicare.” Medicare uses different payment methodologies to pay certain other general ACHs for services provided to FFS beneficiaries and to pay for certain services at general ACHs. For example, Medicare pays about 1,350 small rural hospitals designated as critical access hospitals based on their costs and pays about 50 general ACHs in Maryland based on an all-payer global budget. Medicare also pays separately for services provided to FFS beneficiaries in separate hospital units (such as hospital-based psychiatric units and post-acute care units) and for certain costs (such as hospitals’ organ acquisition costs and direct costs of graduate medical education). These payment methodologies are beyond the scope of this chapter.
- 2 Unless otherwise noted, all years referring to inpatient services refer to fiscal year while those referring to outpatient services refer to calendar year, consistent with when CMS updates these payment systems. Under the IPPS and OPPIs, FFS Medicare pays the prospective rate minus any beneficiary cost-sharing liabilities. Medicare reimburses hospitals for 65 percent of bad debts resulting from beneficiaries’ nonpayment of cost sharing after hospitals have made reasonable efforts to collect the unpaid amounts. (A more detailed description of the IPPS and OPPIs can be found in our *Payment Basics* series at <https://www.medpac.gov/document-type/payment-basic/>.)
- 3 Medicare uses the OPPIs to pay for the facility share of providing outpatient services at post-acute care hospitals (i.e., long-term care and rehabilitation hospitals), at certain specialized short-term acute care hospitals (i.e., psychiatric, cancer, and children’s hospitals), and at community mental health centers.
- 4 While this chapter focuses on assessing the adequacy of FFS Medicare’s IPPS and OPPIs payment rates, we include all general ACHs—defined as ACHs paid under the IPPS, as well as critical access hospitals and ACHs in Maryland and U.S. territories—in our indicators of beneficiaries’ access to care because they also provide inpatient and outpatient general ACH services.
- 5 The denominator includes all “available” beds, which is generally the same as the number of licensed beds and does not necessarily mean the bed was fully staffed throughout the cost reporting period.
- 6 Hospital employment includes all persons on the hospital payroll, potentially including physicians.
- 7 We reviewed the press releases, websites, and regulatory documents of closing hospitals to identify the factors that facilities listed as contributing to their decision to close. When those sources were not available or did not provide sufficient detail, we considered popular press coverage that included quotations from hospital representatives. We did not independently verify all the factors cited by each facility.
- 8 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.
- 9 The H-CAHPS response rate for 2022 was 24 percent. The response rate for other provider-focused CAHPS surveys are similar (i.e., the Home Health Care CAHPS response rate was 24 percent and the Hospice CAHPS response rate was 29 percent).
- 10 IPPS hospitals’ all-payer total margin in 2022 was lower than the operating margin (1.5 percent when excluding relief funds), reflecting investment losses. In contrast, the all-payer total margin in 2021 was higher than the operating margin (9.2 percent when excluding relief funds), reflecting investment gains.
- 11 We reviewed financial statements for six large hospital systems: three nonprofit systems and three for-profit systems (Ascension 2023, Ascension 2022, CommonSpirit 2023, CommonSpirit 2022, Community Health Systems 2023, Community Health Systems 2022, HCA Healthcare 2023, HCA Healthcare 2022, Tenet Health 2023, Tenet Health 2022, Trinity Health 2023, Trinity Health 2022). Together, these six systems represent over 20 percent of all IPPS hospitals.
- 12 Because distinct units within hospitals can affect the margin of inpatient and outpatient service lines based on where they treat patients (e.g., having a skilled nursing facility in the hospital can allow earlier discharges from the inpatient unit), our FFS Medicare margin includes multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services) as well as direct graduate medical education and uncompensated care payments. It does not include payments the Medicare program makes directly to teaching hospitals for their care of MA beneficiaries. In addition, because federal coronavirus relief funds were intended to help cover lost revenue and payroll costs—including lost revenue from FFS Medicare patients and the cost of staff who helped treat these patients—we report a FFS Medicare margin including a portion of these relief funds (based on FFS Medicare’s share of 2019 all-payer operating revenue).

- 13 Hospitals' cost reporting periods vary. In calculating IPPS hospitals' 2022 FFS Medicare margin, we use cost reports with a midpoint in 2022, of which about 30 percent began in July 2021 and 40 percent began in January 2022. However, in the discussion that follows, we primarily focus on changes during FY 2022 because that is the period for which CMS sets IPPS payments.
- 14 There is an automatic forecast error correction in the inpatient capital PPS. When setting rates for FY 2022, CMS also underestimated the inpatient hospital capital market basket, which was further reduced by an automatic forecast error correction to remove CMS's overestimate in FY 2020.
- 15 We categorized hospitals as under "high fiscal pressure" if they had a median non-Medicare margin of 1 percent or less over five years and a net worth (assets minus liabilities) that would have grown by less than 1 percent per year over that period if the hospital's Medicare profits had been zero.
- 16 We do not adjust our costs per inpatient unit for economies of scale. However, we excluded all hospitals with fewer than 300 Medicare inpatient stays and fewer than 900 Medicare outpatient services from our analysis. Teaching hospitals tend to have higher costs per unit, but we standardize costs per unit by adjusting for the effect of case mix, outlier cases, and the cost of training residents. After these adjustments, teaching hospital costs, on average, are similar to nonteaching hospital costs.
- 17 We adjust costs per unit for the share of Medicare patients that are low income (patients that receive the Part D low-income subsidy or are dually eligible for Medicare and Medicaid in the year). However, we do not adjust readmission or mortality metrics for patient income, in keeping with our policy of not adjusting quality metrics for income.
- 18 We separate years of data used to assign providers to the relatively efficient group and the performance year metrics to prevent random variation in a single year from affecting both assignment to the efficient group and the efficient group's median margin.
- 19 The characteristics include (1) average patient severity; (2) relative labor costs (as measured by the Commission's recommended alternative wage index); (3) low-income status; (4) teaching intensity; and (5) outlier index (measured as the Medicare outlier payments' share of base payments). For each hospital, we standardized Medicare costs per unit by removing the effect of expected costs, given their characteristics, on actual costs. Since high outlier costs can indicate either unmeasured differences in illness severity or high-cost structures, we standardize only for a portion of the estimated effect of outliers on costs.
- 20 We standardized outpatient cost per service using the same set of hospital characteristics as used for standardizing inpatient costs per stay.
- 21 We require hospitals to have at least 300 inpatient stays and 900 outpatient services in each year of the baseline. In prior years, we required 500 inpatient stays and had no requirement for outpatient volume. We continued to require that Medicaid patients compose a minimum share of hospital days.
- 22 The 0.5 percent reduction to the OPPS conversion factor will begin in calendar year 2026.

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C H A P T E R

4

Physician and other health professional services

R E C O M M E N D A T I O N

- 4** The Congress should:
- for calendar year 2025, update the 2024 Medicare base payment rate for physician and other health professional services by the amount specified in current law plus 50 percent of the projected increase in the Medicare Economic Index; and
 - enact the Commission's March 2023 recommendation to establish safety-net add-on payments under the physician fee schedule for services delivered to low-income Medicare beneficiaries.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Physician and other health professional services

Chapter summary

Medicare's physician fee schedule pays for about 8,000 medical services provided across a variety of care settings. These services include office visits, surgical procedures, imaging, and tests and are delivered in physician offices, hospitals, nursing homes, and other settings. The clinicians who are paid to deliver these services include not only physicians, advanced practice registered nurses (APRNs), and physician assistants (PAs) but also podiatrists, physical therapists, psychologists, and other types of health professionals. In 2022, the Medicare program and its beneficiaries paid \$91.7 billion for fee schedule services provided by almost 1.3 million clinicians, accounting for just under 17 percent of spending in Medicare's traditional fee-for-service (FFS) program.

Assessment of payment adequacy

In 2022 and 2023, most clinician payment adequacy indicators remained positive or improved, but clinicians' input costs are estimated to have grown faster than the historical trend.

Beneficiaries' access to care—In the Commission's annual survey, Medicare beneficiaries reported access to clinician services in 2023 that was comparable with, or better than, that of privately insured people. Our findings are consistent with several recent national surveys that have

In this chapter

- Are Medicare fee schedule payments adequate in 2024?
- How should Medicare fee schedule payments change in 2025?

found that people aged 65 and older (almost all of whom have Medicare coverage) report better access to care than younger adults and that Medicare beneficiaries of any age are more likely than privately insured people to rate their insurance coverage positively. Surveys also indicate that the share of clinicians accepting Medicare is comparable with the share accepting private insurance, despite private health insurers paying higher rates. Almost all of the 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 billing Medicare's physician fee schedule has been growing in recent years, although the composition of the clinician workforce continues to change. Over the last several years, the number of APRNs and PAs has increased rapidly, and the number of specialists has steadily increased, but the number of primary care physicians has slowly declined. Although the overall number of clinicians has grown in recent years, the number of clinicians per Medicare beneficiary (including those in FFS Medicare and Medicare Advantage) has remained steady due to increasing beneficiary enrollment.

The number of clinician encounters per FFS beneficiary has increased over time, with faster growth from 2021 to 2022 (3.1 percent) compared with the average annual growth rate from 2017 to 2021 (0.7 percent). Growth rates varied by clinician specialty and type of service. From 2021 to 2022, the number of encounters per FFS beneficiary with primary care physicians declined by 0.3 percent while encounters per FFS beneficiary with specialist physicians increased by 1.3 percent and encounters with APRNs and PAs increased by 10.4 percent.

Quality of care—We report three population-based measures of quality of clinician care: risk-adjusted ambulatory care-sensitive (ACS) hospitalization rates, risk-adjusted ACS emergency department (ED) visits, and patient experience measures. In 2022, risk-adjusted rates of ACS hospitalizations and ED visits continued to vary across health care markets. Between 2021 and 2022, patient experience scores in FFS Medicare were relatively stable.

Clinicians' revenues and costs—Clinicians do not submit annual cost reports to CMS, so we are unable to calculate their profit margins from delivering services to Medicare beneficiaries. Instead, we rely on indirect measures of how FFS Medicare payments compare with the costs of providing services. We find that updates to fee schedule payments have grown more slowly than clinicians'

input cost growth, but increases in the volume and intensity of services furnished by clinicians have resulted in higher physician fee schedule spending per FFS beneficiary. Physicians' compensation has increased at rates similar to the general rate of inflation, which may be partially due to growth in private insurance payment rates and to growth in the volume and intensity of services clinicians have furnished per FFS beneficiary over time.

From 2021 to 2022, physician fee schedule spending per FFS beneficiary grew for most types of services. Among broad service categories, growth rates were 2.2 percent for evaluation and management services, 3.0 percent for imaging, 2.5 percent for other (i.e., nonmajor) procedures, 5.7 percent for treatments, and 6.8 percent for tests. Spending per FFS beneficiary declined by 0.2 percent for major procedures.

In 2022, spending on clinician services by FFS Medicare and its beneficiaries was \$1.1 billion lower than it was in 2021. This decline represents a 1.2 percent decrease in fee schedule spending and is attributable to a 3.9 percent decline in the number of beneficiaries enrolled in FFS Medicare, as enrollment in Medicare Advantage continued to grow.

In 2022, private health insurance preferred provider organization (PPO) payment rates for clinician services were, on average, 136 percent of FFS Medicare's payment rates—up from 134 percent in 2021. Survey data suggest that providers are increasingly consolidating into larger organizations to improve their ability to negotiate higher payment rates from private insurers (and to gain access to costly resources and help complying with payers' regulatory and administrative requirements). Compensation and productivity data indicate that, while clinicians who work in hospital-owned practices do not necessarily earn more than those working in clinician-owned practices, they do tend to see fewer patients and bill for fewer services.

All-payer clinician compensation appears to be increasing at rates similar to general inflation. According to SullivanCotter's annual compensation surveys, we found that, from 2021 to 2022, median compensation for physicians grew by 9 percent—a little faster than inflation, which was 8 percent; median compensation for advanced practice providers (e.g., nurse practitioners, PAs) grew by 5 percent. Over a longer, four-year period that includes the recent coronavirus pandemic (2018 to 2022), median compensation for physicians grew by an average of 3.4 percent per year—a little less than inflation, which grew by an average of 3.9 percent per year over this period; median

compensation for advanced practice providers grew by 4.0 percent per year over this period.

Compensation remained much lower for primary care physicians than for most specialists in 2022; we are concerned that comparatively low payment rates for the services that primary care physicians tend to provide may be reducing the appeal of a career in primary care. Starting in 2024, a new add-on payment is available to primary care clinicians (and some specialists) for visits furnished to patients with whom a clinician has an ongoing relationship.

Clinicians' costs, as measured by the Medicare Economic Index (MEI), grew by 1 percent to 2 percent per year for several years before the coronavirus pandemic. MEI growth then increased to 2.5 percent in 2021 and to 4.6 percent in 2022. However, MEI growth is expected to moderate: It is projected to be 4.1 percent in 2023, 3.1 percent in 2024, and 2.6 percent in 2025, although these projections are subject to change. These expected increases in clinicians' input costs are larger than the increases in FFS Medicare payment rates scheduled under current law.

How should fee schedule payment rates change in 2025?

Under current law, Medicare fee schedule payment rates are expected to decline in 2025, due to the expiration of a 1.25 percent pay increase that will apply in 2024 only and a 0 percent update scheduled for 2025. Given recent high inflation, cost increases could be difficult for clinicians to continue to absorb. Yet current payments to clinicians appear to be adequate, based on many of our indicators.

Given these mixed findings, for calendar year 2025, the Commission recommends that the Congress update the 2024 Medicare base payment rate for physician and other health professional services by the amount specified in current law plus 50 percent of the projected increase in the MEI. Based on CMS's MEI projections at the time of this publication, the recommended update for 2025 would be equivalent to 1.3 percent above current law. Our recommendation would be a permanent update that would be built into subsequent years' payment rates, in contrast to the temporary updates specified in current law for 2021 through 2024, which have each increased payment rates for one year only and then expired.

To promote adequate access to care for all Medicare beneficiaries, the Commission also recommends that the Congress establish new permanent safety-net add-on payments for clinician services furnished to FFS Medicare

beneficiaries with low incomes. (We define “low-income” beneficiaries as those dually enrolled in Medicaid and Medicare or receiving the Part D low-income subsidy.) This policy should be consistent with the Commission’s March 2023 clinician safety-net recommendation, which called for add-on payments of 15 percent for primary care clinicians and 5 percent for all other clinicians for fee schedule services furnished to low-income FFS Medicare beneficiaries. The Commission determined last year that providing this additional financial support is warranted since clinicians often receive less revenue for treating low-income beneficiaries because of how Medicare’s cost-sharing policies interact with state Medicaid payment policies. Yet the cost to clinicians of treating low-income Medicare beneficiaries is likely to be at least as much as, if not higher than, the cost of caring for other beneficiaries. As a result of less revenue and potentially higher treatment costs, these beneficiaries are likely to be less profitable to care for, and therefore could have difficulty accessing care.

We estimate that the Commission’s recommended safety-net add-on policy would increase the average clinician’s fee schedule revenue by 1.7 percent. The increase for each clinician would vary by their specialty and share of services furnished to low-income beneficiaries. Because primary care clinicians would receive higher add-on payments than non-primary care providers, safety-net payments would increase fee schedule revenue for primary care clinicians by an average of 4.4 percent and for non-primary care clinicians by an average of 1.2 percent.

We estimate that the combination of the recommended update and safety-net policies would increase fee schedule revenue for the average clinician by 3 percent. The effects would differ by provider specialty, with fee schedule revenue increasing by an estimated 5.7 percent, on average, for primary care clinicians and by an estimated 2.5 percent, on average, for other clinicians. ■

Background

To determine fee-for-service (FFS) Medicare payment rates for clinician services, CMS uses a list of relative values for about 8,000 services, known as the physician fee schedule. These relative values are multiplied by the physician fee schedule's conversion factor (a fixed dollar amount equal to \$32.74 in 2024) to produce a total payment amount for each service.¹ Medicare's physician fee schedule pays for a wide range of clinician services for FFS beneficiaries, including office visits, surgical procedures, and diagnostic and therapeutic services. When these services are delivered in certain facilities, such as hospitals or ambulatory surgical centers, CMS makes an additional payment through that facility's payment system to pay for nonclinician costs like nursing services, medical supplies, equipment, and rooms (discussed in separate chapters of this report). In such instances, the physician fee schedule payment rate is reduced, but it is normally more than offset by the additional fee Medicare pays through the other payment system (e.g., through the hospital outpatient prospective payment system).

Physician fee schedule spending constitutes just under 17 percent of spending in FFS Medicare (Boards of Trustees 2023).² In 2022, the FFS Medicare program and its beneficiaries paid \$91.7 billion for physician fee schedule services, which is \$1.1 billion less than in 2021. This decline represents a 1.2 percent decrease in fee schedule spending and is largely attributable to a 3.9 percent decline in the number of beneficiaries enrolled in FFS Medicare, as enrollment in Medicare Advantage (MA) continues to grow.

In 2022, almost 1.3 million clinicians, including physicians, advanced practice registered nurses (APRNs), physician assistants (PAs), therapists, chiropractors, and other practitioners, billed the Medicare physician fee schedule for services. The number of clinicians billing the fee schedule in 2022 was the same as in the previous year.

Are Medicare fee schedule payments adequate in 2024?

To assess whether FFS Medicare payments for clinician services are currently adequate, we examine indicators

in three categories: beneficiaries' access to care, the quality of their care, and clinicians' revenues and costs. In 2022 and 2023, most physician payment adequacy indicators remained positive or improved, but clinicians' input costs grew faster in this period than the historical trend.

Beneficiaries' access-to-care indicators remain relatively positive

Although we cannot say that *all* Medicare beneficiaries have timely access to the care they need, in the Commission's 2023 survey, Medicare beneficiaries continued to report access to care that is comparable with, or better than, that of privately insured people. The share of clinicians accepting Medicare is high and comparable with the share accepting private insurance. Almost all clinicians who treat FFS Medicare beneficiaries accept the physician fee schedule's payment rates as payment in full, despite having the option to balance-bill beneficiaries for higher amounts as a "nonparticipating" provider or to forgo all Medicare payments and choose the price they charge patients by electing to "opt out" of the program. The overall number of clinicians billing FFS Medicare has grown in recent years; adjusting for growth in the number of Medicare beneficiaries (including those in FFS Medicare and MA), the number of clinicians billing Medicare has remained steady. The composition of the clinician workforce continues to change, with the number of APRNs and PAs growing rapidly, the number of specialists growing at a more modest rate, and the number of primary care physicians slowly declining. The number of clinician encounters per beneficiary increased in 2022 to above prepandemic levels for most types of services.

Most beneficiaries reported relatively good access to clinician services in surveys and focus groups

One way we assess Medicare beneficiaries' access to care is by examining data from our annual survey of Medicare beneficiaries ages 65 and over and privately insured people ages 50 to 64. Our 2023 survey was completed by over 10,000 respondents in the summer of 2023 and, as with prior years, was weighted to produce nationally representative results.³ We also draw on findings from local focus groups that we conduct to ask beneficiaries and clinicians about their experiences with health care.⁴

The Commission's survey and focus groups include Medicare beneficiaries in both FFS Medicare and in MA plans. We believe this group is representative of the experiences of FFS beneficiaries because in our analyses of data from the Medicare Current Beneficiary Survey (MCBS) and in research by others, MA enrollees and FFS beneficiaries tend to report comparable experiences accessing care (Koma et al. 2023, Ochieng and Fuglesten Biniek 2022).

Although we cannot say that all Medicare beneficiaries have timely access to the care they need, consistent with last year, our 2023 survey found that Medicare beneficiaries reported access to care that was comparable with, or better than, that of privately insured people (see Table 4A-1 in this chapter's appendix for some of our key findings for Medicare beneficiaries vs. privately insured people, p. 118). (Throughout this section, the shares of Medicare beneficiaries and privately insured people who reported a given experience are statistically significantly different from each other at the 95 percent confidence level unless otherwise noted, in keeping with prior years.)

Relatively high satisfaction with overall access to care Our 2023 survey found that the vast majority of Medicare beneficiaries ages 65 and over (94 percent) and privately insured people ages 50 to 64 (91 percent) had received some kind of health care in the past 12 months. Among these survey respondents, a higher share of Medicare beneficiaries was satisfied with their ability to find health care providers who accepted their insurance (96 percent) compared with privately insured people (91 percent). In addition, among beneficiaries who had received health care, a higher share of Medicare beneficiaries was satisfied with their ability to find health care providers that had appointments when they needed them (87 percent) compared with privately insured people (77 percent). (We included these questions in our survey for the first time this year.) In our focus groups, Medicare beneficiaries also reported high satisfaction with their insurance coverage, with the vast majority of participants rating their coverage as “excellent” or “good” (Campanella et al. 2023).

Nearly all Medicare beneficiaries have a primary care provider Our 2023 survey found that 96 percent of Medicare beneficiaries reported having a primary care provider, compared with 92 percent of privately

insured people. This finding is consistent with what we gathered from our focus groups, in which nearly all beneficiaries we spoke to reported having a usual source of primary care. Only a few beneficiaries we spoke to reported not having a primary care provider, often because their provider had retired or left the practice and the beneficiary had not yet found a replacement.

Our survey found that a slightly lower share of Medicare beneficiaries reported receiving most or all of their primary care from a nurse practitioner (NP) or PA (19 percent) compared with privately insured people (22 percent). In our focus groups, although most beneficiaries had a physician as their designated primary care provider, a few beneficiaries saw an NP or PA as their primary care provider. Those who had an NP or PA as their regular primary care provider cited a variety of reasons, including switching from a physician to an NP or PA as their primary care provider when their physician retired, choosing to see an NP in their practice when they had communication issues with their physician, or generally preferring NPs and/or PAs to physicians.

Medicare beneficiaries report fewer problems finding a new clinician than privately insured people In our 2023 survey, 12 percent of Medicare beneficiaries and 15 percent of privately insured people reported looking for a new primary care provider. Among those respondents, a smaller share of Medicare beneficiaries reported a “big problem” finding one (23 percent) compared with privately insured people (33 percent); an additional third of each group reported a “small problem” finding one. These amounts are equivalent to 7 percent of all Medicare beneficiaries and 10 percent of all privately insured people experiencing some kind of problem finding a new primary care provider.

In our focus groups, many beneficiaries reported seeking a new primary care provider in recent years, and the ease of getting a new clinician varied. Beneficiaries we spoke to who were seeking a new primary care provider described looking online; calling new practices to try to make an appointment; asking a current provider or friends for referral; and, in a few cases, seeking out NPs and PAs, who often have more availability than physicians. Across clinicians in our focus groups, nearly all were accepting new Medicare patients. Those clinicians who were not accepting

new patients said that they had full patient panels, and generally their practices would open to new patients again when capacity allowed.

About a third of respondents reported looking for a new specialist in the past 12 months, and among those looking, a smaller share of Medicare beneficiaries reported a “big problem” finding a new specialist (13 percent) compared with privately insured people (18 percent). An additional quarter of each group reported a “small problem” finding a new specialist. These figures are equivalent to 11 percent of Medicare beneficiaries and 15 percent of privately insured people experiencing some kind of problem finding a specialist. In our focus groups, beneficiaries’ experiences accessing specialty care varied, with reported wait times ranging from a few days to six months, depending on the specialty, location, and demand for the provider.

Most patients looking for a new mental health professional experience problems finding one This year, we included questions in our survey about access to mental health professionals. We found that only a small share of people tried to get a new mental health professional in the past 12 months—3 percent of Medicare beneficiaries and 7 percent of privately insured people. However, among those looking for a mental health professional, a majority experienced problems finding one (63 percent of Medicare beneficiaries and 70 percent of privately insured people—not a statistically significant difference, given how few people looked for this type of clinician). These figures are equivalent to an estimated 2 percent of Medicare beneficiaries and 5 percent of privately insured people experiencing a problem finding a mental health professional.

Shorter waits for appointments for an illness or injury compared with routine care Among survey respondents who needed an appointment for regular or routine care, a smaller share of Medicare beneficiaries reported that they “usually” or “always” had to wait longer than they wanted to get such an appointment (13 percent) compared with privately insured people (23 percent). People had less difficulty getting an appointment for an illness or injury; only 8 percent of Medicare beneficiaries reported “usually” or “always” waiting longer than they wanted to get this type of

appointment, compared with 15 percent of privately insured people. One possible theory for our finding that fewer Medicare beneficiaries reported excessive waits for appointments is that Medicare beneficiaries are more likely to be retired and thus may have more scheduling flexibility, which might allow them to be seen sooner than privately insured people working full-time.⁵

In our focus groups, most beneficiaries described having timely access to primary care. For a routine checkup or follow-up visit, beneficiaries reported wait times ranging from a few days to 30 days. Many focus group participants reported that they can often be seen by their primary care provider within a few days for acute issues or sick visits. Some beneficiaries across groups reported going to urgent care instead of seeing their primary care provider when they had acute but nonemergency health needs. Using urgent care outside of their clinician’s business hours was a common scenario shared by beneficiaries.

Patients sometimes forgo care, but not necessarily due to difficulties accessing care In our 2023 survey, a smaller share of Medicare beneficiaries reported forgoing care that they thought they should have gotten in the past 12 months (20 percent) compared with privately insured people (27 percent). The most common reasons Medicare beneficiaries did not obtain such care were that they did not think the problem was serious (reported by 5 percent of beneficiaries overall); they just put it off (which another 5 percent reported); or they could not get an appointment soon enough (which 4 percent reported). Only 1 percent of Medicare beneficiaries said they put off care because they could not find a doctor who would treat them, and only 1 percent said they put off care because they thought it would cost too much.

Beneficiaries with lower incomes report obtaining less care In our 2023 survey, Medicare beneficiaries with household incomes of less than \$50,000 per year reported obtaining less care than beneficiaries with household incomes of \$80,000 or more. Lower-income beneficiaries were less likely than higher-income beneficiaries to have obtained any type of health care in the past 12 months (91 percent vs. 97 percent) and more likely to have forgone care that they thought they should have gotten (23 percent vs. 17 percent). They were also less likely to have seen multiple

specialists (44 percent vs. 64 percent) and less likely to have tried to find a new specialist (26 percent vs. 38 percent) in the past 12 months.

Lower-income beneficiaries were also more likely to get most or all of their primary care from an NP or PA (22 percent vs. 14 percent of higher-income beneficiaries), and they were less likely to report that they usually or always had to wait longer than they wanted for appointments for regular or routine care (11 percent vs. 15 percent of higher-income beneficiaries, among those needing this type of appointment) or for illness or injury care (7 percent vs. 10 percent of higher-income beneficiaries, among those needing this type of appointment). Since our survey questions ask for a subjective assessment of whether a wait was longer than a respondent wanted and not for an objective count of the number of days or weeks a respondent had to wait for an appointment, we cannot discern whether lower-income beneficiaries actually experienced shorter waits for appointments or whether they simply had different expectations about how quickly they should be able to be seen.⁶

There were no statistically significant differences in the shares of Medicare beneficiaries of lower and higher incomes who had the following experiences: were satisfied with their ability to find providers that accepted Medicare and were satisfied with their ability to find providers that had appointments when they needed them (among respondents who received care in the past 12 months); had a primary care provider; looked for a new primary care provider or mental health professional; or had problems finding a new primary care provider or mental health professional (among those looking). (See Table 4A-2, p. 119, in this chapter's appendix for key survey results broken out by beneficiaries' household income.)

Concerns about access to care among low-income beneficiaries prompted the Commission to recommend in March 2023 that the Congress enact a safety-net add-on payment for fee schedule services delivered to these beneficiaries (see text box on supporting clinicians who furnish care to Medicare beneficiaries with low incomes, pp. 114–115).

Differences in access by race/ethnicity in our survey

Black and Hispanic Medicare beneficiaries had care experiences similar to those of White beneficiaries,

according to most questions in our survey.⁷ We did, however, find some differences by race and ethnicity related to obtaining care. Smaller shares of Hispanic beneficiaries (86 percent) and Black beneficiaries (92 percent) reported receiving any health care in the past year compared with White beneficiaries (95 percent). Smaller shares of Hispanic beneficiaries (35 percent) and Black beneficiaries (44 percent) reported seeing multiple specialists compared with White beneficiaries (55 percent). And a smaller share of Black beneficiaries reported looking for a new specialist (23 percent) compared with White beneficiaries (33 percent). (See Table 4A-3, p. 120, in the appendix for additional survey results for White, Black, and Hispanic beneficiaries.)

Mix of clinicians seen by beneficiaries in rural and urban areas varies somewhat

Urban and rural Medicare beneficiaries reported comparable experiences and satisfaction levels on most questions in our survey, but we observed differences between them in the mix of clinicians they saw. A higher share of rural Medicare beneficiaries reported receiving all or most of their primary care from an NP or PA (29 percent) compared with urban beneficiaries (17 percent). A smaller share of rural beneficiaries reported seeing multiple specialists in the past year (42 percent) compared with urban beneficiaries (55 percent). And a smaller share of rural beneficiaries reported trying to find a new specialist in the past 12 months (23 percent) compared with urban beneficiaries (34 percent). (See Table 4A-4, p. 121, in this chapter's appendix for additional survey results for rural and urban beneficiaries.)

Other surveys also find that Medicare beneficiaries have relatively good access to care

Our 2023 survey's overall finding that Medicare beneficiaries reported access to care that is comparable with, or better than, that of privately insured people is consistent with a 2023 KFF survey that compared the experiences of Medicare beneficiaries (of any age) with individuals who had employer-sponsored insurance, Marketplace plans, and other coverage. KFF's survey found that, compared with privately insured people, Medicare beneficiaries were more likely to rate their insurance positively, less likely to report issues affording medical bills, and less likely to report delaying or forgoing a visit to a doctor's office because of the cost (Pollitz et al. 2023).

Our survey findings are also consistent with several federally funded surveys that find that Medicare-aged

people report better access to care than younger adults—which could mean that gaining Medicare coverage makes it easier for some people to access health care. For example, the Medical Expenditure Panel Survey has found that around age 65, when most people gain eligibility for Medicare, there are fewer reports of being unable to access necessary care and being unable to get needed care because of cost (Jacobs 2021). The National Health Interview Survey has found that delaying or forgoing needed care due to cost was more common among adults under the age of 65 than adults over 65 (National Center for Health Statistics 2021). And the Behavioral Risk Factor Surveillance System survey has found that, compared with people with employer-sponsored or individually purchased health insurance, Medicare beneficiaries are more likely to have a personal physician, less likely to have medical debt, and more likely to be very satisfied with their care (Wray et al. 2021).

CMS's 2021 MCBS produced findings similar to those of the Commission's survey. For example, 93 percent of FFS beneficiaries (of all ages, not just those ages 65 and over) reported having a usual source of care that was not a hospital emergency department or an urgent care center, 95 percent felt their usual care provider usually or always spent enough time with them, and 93 percent were satisfied with the availability of care by specialists. A relatively small share (6 percent) reported experiencing trouble getting care in the past year—more often due to cost, as opposed to clinicians not accepting Medicare.

Beneficiaries under age 65 report worse access to care than beneficiaries ages 65 and over One subgroup of Medicare beneficiaries that reports notably worse access to care in CMS's survey is beneficiaries under age 65 (most of whom are disabled). For example, our analysis of the 2021 MCBS found that these beneficiaries were twice as likely as beneficiaries ages 65 and over to report having trouble getting health care (14 percent vs. 6 percent) and to report forgoing care that they thought they should have gotten (12 percent vs. 6 percent). They were four times more likely to report having a problem paying a medical bill (20 percent vs. 5 percent). Part of the reason for these difficulties may be that beneficiaries under age 65 tend to require more health care services than beneficiaries ages 65 and over, yet have lower incomes than

beneficiaries ages 65 and over (Cubanski et al. 2016, Medicare Payment Advisory Commission 2023a).

We saw a number of other, smaller differences between beneficiaries under age 65 and beneficiaries ages 65 and over on MCBS questions. For example, beneficiaries under age 65 were somewhat less likely to report having a usual source of care that is not a hospital emergency department or an urgent care clinic compared with beneficiaries ages 65 and over (90 percent vs. 94 percent). They were also less likely to report that their usual care provider spent enough time with them (92 percent vs. 95 percent). Beneficiaries under age 65 were less likely to report seeing their usual care provider in the past 12 months compared with beneficiaries ages 65 and over (88 percent vs. 92 percent) despite being much more likely to report being in “poor” or “fair” health (49 percent vs. 16 percent). Beneficiaries under age 65 were also less likely to report being satisfied with the availability of care by specialists (87 percent vs. 93 percent) and less likely to report being satisfied with the ease with which they can get to a doctor from where they live (91 percent vs. 96 percent).

The number of clinicians billing Medicare has increased, but the mix has changed

From 2017 to 2022, the total number of clinicians billing the fee schedule increased by an average of 2.4 percent per year. This increase ensured that the number of clinicians serving the Medicare population grew commensurately with Medicare enrollment (including those in FFS Medicare and MA). Therefore, the number of total clinicians per Medicare beneficiary remained stable, although the mix of clinicians has changed over time.

We limited this part of our analysis to clinicians who billed for more than 15 Medicare beneficiaries in a given year. This minimum threshold helps us (1) better measure clinicians who substantially participate in Medicare and therefore are likely critical to ensuring beneficiary access to care and (2) avoid year-to-year variability in clinician counts (i.e., because we exclude clinicians who billed for one or two beneficiaries in one year but may not have billed for any beneficiaries the following year).⁸ As a point of reference, studies suggest that primary care physicians' patient panels range from 1,200 to 2,500 patients per physician (Dai et al. 2019, Raffoul et al. 2016).

**TABLE
4-1**

The number of clinicians billing Medicare's physician fee schedule has increased and the mix of clinicians has changed, 2017–2022

Year	Number (in thousands)					Number per 1,000 beneficiaries				
	Physicians					Physicians				
	Primary care specialty	Other specialties	APRNs and PAs	Other practitioners	Total	Primary care specialty	Other specialties	APRNs and PAs	Other practitioners	Total
2017	140	455	218	168	981	2.6	8.5	4.1	3.1	18.4
2018	139	462	237	174	1,012	2.5	8.4	4.3	3.2	18.5
2019	138	468	258	180	1,045	2.5	8.4	4.6	3.2	18.7
2020	135	468	268	172	1,044	2.4	8.2	4.7	3.0	18.2
2021	134	473	286	180	1,073	2.3	8.1	4.9	3.1	18.4
2022	133	477	308	185	1,103	2.2	8.0	5.2	3.1	18.5

Note: APRN (advanced practice registered nurse), PA (physician assistant). "Primary care specialty" includes family medicine, internal medicine, pediatric medicine, and geriatric medicine, with an adjustment to exclude hospitalists. Hospitalists are counted in "other specialties." "Other practitioners" includes clinicians such as physical therapists, psychologists, social workers, and podiatrists. This table includes only physicians with a caseload of more than 15 fee-for-service beneficiaries in the year. Beneficiary counts used to calculate clinicians per 1,000 beneficiaries include those enrolled in fee-for-service Medicare Part B and those in Medicare Advantage, based on the assumption that clinicians generally furnish services to beneficiaries in both programs. Numbers exclude nonperson providers, such as clinical laboratories and independent diagnostic testing facilities. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and 2023 annual report of the Boards of Trustees of the Medicare trust funds.

Using our threshold, we found that the total number of clinicians billing the fee schedule between 2017 and 2022 grew from about 981,000 to 1,103,000 (Table 4-1). Over the same period, the total number of clinicians per 1,000 beneficiaries (including those in FFS Medicare and MA) increased slightly from 18.4 to 18.5.⁹ (In 2020, the ratio of all clinicians to beneficiaries declined to 18.2 due to the effects of the pandemic.¹⁰)

While the total number of clinicians billing the fee schedule rose between 2017 and 2022, trends varied by type and specialty of clinician. Since 2017, the number of primary care physicians billing the fee schedule has slowly declined—yielding a net loss of about 7,000 primary care physicians by 2022. As a result, the number of primary care physicians per Medicare beneficiary declined over the period from 2.6 to 2.2. The total number of specialist physicians increased over the 2017 to 2022 period from 455,000 to 477,000, but because of growth in the number of Medicare

beneficiaries, the ratio of specialist physicians to beneficiaries decreased from 8.5 to 8.0. Over the same five-year period, the number of APRNs and PAs billing the fee schedule grew rapidly from about 218,000 to 308,000, or from 4.1 per 1,000 beneficiaries to 5.2 per 1,000 beneficiaries.¹¹ Meanwhile, the number of other practitioners, such as physical therapists and podiatrists, also increased, but the ratio of these practitioners per 1,000 beneficiaries was stable.

Most clinicians accept Medicare Several data sources suggest that the share of clinicians who accept Medicare is relatively high and comparable with the share who accept private health insurance, even though Medicare payment rates are usually lower than private health insurers' payment rates.

In a 2022 survey by the American Medical Association (AMA), among nonpediatric physicians accepting new patients, 96 percent reported accepting new Medicare patients; 2 percent said they accepted only

new privately insured patients (American Medical Association 2023b). The AMA survey found that acceptance of Medicare varied by clinical setting and by medical specialty. Among those accepting new patients, larger shares of physicians in hospital-owned practices accepted Medicare (98.6 percent) compared with physicians in private practice (94.1 percent), although both shares were high. And among those accepting new patients, larger shares of specialists accepted Medicare (e.g., 99.6 percent of internal medicine subspecialists, 99.4 percent of general surgeons, 98.7 percent of radiologists) compared with family medicine physicians (94 percent)—but again, all of these rates were high. (One specialty with notably low acceptance of Medicare was psychiatry: Among those taking new patients, only 80.7 of psychiatrists accepted new Medicare patients.)

A survey that focuses on the subset of physicians who work in office-based settings also found that comparable shares of physicians accepted Medicare and private insurance. In 2021, the National Ambulatory Medical Care Survey found that, among the 94 percent of nonpediatric office-based physicians who reported accepting new patients, 89 percent accepted new Medicare patients and 88 percent accepted new privately insured patients (Schappert and Santo 2023).

Looking from the perspective of patients trying to find a new provider, a 2023 KFF survey confirmed that health care providers accept privately insured patients and Medicare beneficiaries at similar rates. This survey specifically found that similar shares of people with Medicare, employer-sponsored insurance, and Marketplace coverage encountered a doctor or hospital that was not covered by their insurance or encountered a doctor who is covered by their insurance but did not have available appointments (Pollitz et al. 2023).

CMS administrative data also confirm that a high share of clinicians accept Medicare. In 2022, 98 percent of clinicians billing the physician fee schedule were participating providers, meaning that they agreed to accept Medicare's fee schedule amount as payment in full. Clinicians who wish to collect somewhat higher payments (of up to 109.25 percent of Medicare's payment rates) can "balance bill" patients for additional cost sharing if they sign up as a nonparticipating provider and choose not to "take assignment" on a

claim, but very few clinicians choose this option: In 2022, 99.7 percent of fee schedule claims were paid at Medicare's standard payment rate. If they elect to opt out of the program, clinicians can choose the price they charge patients and bill beneficiaries directly for their services but receive no payment from Medicare. Consistent with prior years, the number of clinicians who opted out of Medicare as of September 2023 (31,600) was extremely low compared with the 1.3 million clinicians who participated in the program in 2022 (Centers for Medicare & Medicaid Services 2023c).¹²

There are many reasons that clinicians may choose to accept FFS Medicare despite payment rates that are usually lower than commercial rates. A substantial share of most clinicians' patients are covered by Medicare, and if these clinicians opted to accept only commercially insured patients, they might not be able to fill their patient panels. In addition, physicians who are employed by hospitals or health plans may be required to accept Medicare as a condition of employment, and some hospitals may require physicians to participate in Medicare to receive admission and clinical privileges. At the same time, though commercial rates may be comparatively high, commercial insurers often impose burdensome requirements on clinicians that take time to complete, such as requiring clinicians to appeal denied claims and complete insurers' prior authorization paperwork. A recent AMA survey found that physicians complete an average of 45 prior authorization requests per week, requiring 14 hours per week, and 35 percent of physicians have dedicated staff who work exclusively on completing prior authorizations (American Medical Association 2023a). In contrast, FFS Medicare generally requires no prior authorization for services and is known as a prompt payer since it is required to pay "clean" claims within 30 days and must pay providers interest on any late payments. The relative lack of utilization management and the administrative simplicity of billing FFS Medicare may help offset the program's lower payment rates.

The total number of clinician encounters per beneficiary grew from 2017 to 2022

We use the quantity of beneficiaries' encounters with clinicians as another measure of access to care. We use a claims-based definition of encounters.¹³ Clinicians

**TABLE
4-2**

Total encounters per beneficiary were higher in 2022 compared with 2017, and the mix of clinicians furnishing them changed

Specialty category	Encounters per FFS beneficiary			Percent change in encounters per FFS beneficiary	
	2017	2021	2022	Average annual 2017–2021	2021–2022
Total (all clinicians)	21.5	21.6	22.3	0.1%	3.1%
Primary care physicians	3.7	3.1	3.1	–3.7	–0.3
Specialists	12.7	12.3	12.4	–0.8	1.3
APRNs/PAs	2.0	2.7	3.0	8.0	10.4
Other practitioners	3.2	3.5	3.7	2.3	6.7

Note: FFS (fee-for-service), APRN (advanced practice registered nurse), PA (physician assistant). We define an “encounter” as a unique combination of beneficiary identification number, claim identification number (for paid claims), and national provider identifier of the clinician who billed for the service. We use the number of FFS Medicare beneficiaries enrolled in Part B to define encounters per beneficiary. Numbers do not account for “incident to” billing—meaning, for example, that encounters with APRNs/PAs that are billed under Medicare’s “incident to” rules are included in the physician totals. Components may not sum to totals due to rounding, and percent change columns were calculated on unrounded data.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and 2023 annual report of the Boards of Trustees of the Medicare trust funds.

submit a claim when they furnish one or more services to a beneficiary in FFS Medicare. For example, if a physician billed for an evaluation and management (E&M) visit and an X-ray on the same claim, we would count that as one encounter. About 98 percent of beneficiaries enrolled in FFS Medicare had at least one encounter in 2022.¹⁴

The total number of encounters per FFS Medicare beneficiary grew from 21.5 in 2017 to 22.3 in 2022 (Table 4-2). The average annual growth rate was 0.7 percent, although encounters for some types of services declined over the period (data not shown).

Change in the number of encounters per beneficiary varied by specialty and type of provider The number of encounters per beneficiary furnished by primary care and specialist physicians declined from 2017 to 2022, and the number of encounters per beneficiary provided by other types of clinicians increased (Table 4-2).¹⁵ Encounters with APRNs and PAs grew the fastest. (The declines observed over the 2017 to 2021 period were largely due to the effects of the pandemic, when encounter volume fell sharply

for almost all services. Data for 2022 indicate that encounters for most providers and types of services have begun increasing again.)

The 3.7 percent average annual decline in encounters per beneficiary with primary care physicians over the 2017 to 2021 period slowed in 2022, falling by just 0.3 percent that year. Encounters per beneficiary with specialists also fell over the 2017 to 2021 period, from 12.7 to 12.3, but grew by 1.3 percent in 2022. APRNs and PAs saw the largest increase in encounters, which grew by 10.4 percent in 2022. There was broad growth across different types of services in APRN and PA encounters: From 2021 to 2022, APRNs and PAs delivered 11.2 percent more E&M services, 13.1 percent more “other procedures,” 10.6 percent more treatment services, 16.3 percent more imaging, and 11.2 percent more tests (data not shown). The exception was anesthesia, for which encounters with APRNs and PAs fell by 1.4 percent.

The number of encounters with APRNs and PAs has grown rapidly, but we are likely undercounting the number of fee schedule encounters provided by these

**TABLE
4-3**

Encounters per FFS beneficiary across service types, 2017–2022

Type of service	Encounters per FFS beneficiary			Change in encounters per FFS beneficiary	
	2017	2021	2022	Average annual 2017–2021	2021–2022
Total (all services)	21.5	21.6	22.3	0.1%	3.1%
Evaluation and management	12.8	12.7	13.0	–0.1	2.2
Major procedures	0.2	0.2	0.2	–0.7	2.2
Other procedures	2.3	2.3	2.3	–0.4	2.6
Treatments	2.4	2.7	2.9	2.6	7.9
Imaging	4.1	4.1	4.2	–0.5	2.9
Tests	2.0	1.9	2.0	–0.9	2.8
Anesthesia	0.5	0.5	0.5	0.0	–0.5

Note: FFS (fee-for-service). We define an “encounter” as a unique combination of beneficiary identification number, claim identification number (for paid claims), and national provider identifier of the clinician who billed for the service. We use the number of FFS Medicare beneficiaries enrolled in Part B to define encounters per beneficiary. Values by type of service do not sum to the total because encounters with multiple service types are counted separately for each type of service but counted only once for the total. For example, if an imaging service and a test are billed in the same encounter, we count that as one encounter for imaging and one for tests (for a total of two encounters), but we count the services as one encounter for the total row. All numbers in the table are rounded, but unrounded data are used for calculations.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and the 2023 annual report of the Boards of Trustees of the Medicare trust funds.

clinicians due to “incident to” billing, under which Medicare allows services furnished by APRNs and PAs to be indirectly billed as “incident to” a physician visit, using the national provider identifier of a supervising physician if certain conditions are met. One study used Medicare claims data to estimate that in 2018, about 40 percent of office visits provided by APRNs and PAs were indirectly billed incident to a physician visit (Patel et al. 2022). The Commission has previously recommended that the Congress require APRNs and PAs to bill Medicare directly, eliminating “incident to” billing for services they provide, which would allow a more accurate count of the number of beneficiary encounters with different types of clinicians (Medicare Payment Advisory Commission 2019). These changes would also enable policymakers to better understand whether services provided by APRNs and PAs are disproportionately substituting for primary care services or specialty care services.

From 2017 to 2021, the number of encounters per beneficiary declined for almost all types of services—mostly as a result of decreases experienced during the pandemic (Table 4-3). Then, from 2021 to 2022, encounters for most types of service grew, with some differences across broad service categories. For example, the number of E&M encounters per beneficiary provided by all clinicians rose 2.2 percent, from 12.7 to 13.0. Over the same time period, anesthesia encounters fell by 0.5 percent, while encounters involving treatment (such as physical therapy, treatment for cancer, and dialysis) increased most rapidly (7.9 percent).

Quality of clinician care is difficult to assess

The quality of care provided by individual clinicians is difficult to assess for a few reasons. First, Medicare does not collect clinical information (e.g., blood pressure, lab results) or patient-reported outcomes

TABLE
4-4

Distribution of risk-adjusted rates of ambulatory care-sensitive hospitalizations and emergency department visits across hospital service areas, 2022

	Risk-adjusted rate per 1,000 FFS beneficiaries			
	10th percentile (high performing)	50th percentile	90th percentile (low performing)	Ratio of 90th to 10th percentile
Ambulatory care-sensitive hospitalizations	21.1	30.0	40.9	1.9
Ambulatory care-sensitive ED visits	37.2	61.7	96.7	2.6

Note: FFS (fee-for-service), ED (emergency department). Lower rates are better. To measure population-based outcomes for FFS Medicare beneficiaries, we calculated the risk-adjusted rates of admissions and ED visits tied to a set of acute and chronic conditions per 1,000 FFS Medicare beneficiaries in hospital service areas (HSAs). There are about 3,400 Dartmouth-defined HSAs. The average population of FFS Medicare beneficiaries in each HSA is about 10,000 beneficiaries. We excluded any HSA with fewer than 1,000 FFS Medicare beneficiaries.

Source: MedPAC's analysis of 2022 FFS Medicare claims data.

(e.g., improving or maintaining physical and mental health) at the FFS beneficiary level. Second, CMS measures the performance of clinicians using the Merit-based Incentive Payment System (MIPS), which, in March 2018, the Commission recommended eliminating because it is fundamentally flawed (Medicare Payment Advisory Commission 2018b). For example, MIPS allows clinicians to choose what measures to report from a catalog of hundreds of measures, which makes it harder to compare clinicians since only a few clinicians may report a certain measure. Also, many clinicians are exempt from reporting quality data for MIPS (e.g., if they see 200 or fewer Medicare beneficiaries or bill Medicare for \$90,000 worth of services or less), so there is a sizable share of clinicians for whom CMS has no quality information. Third, for claims-based measures, Medicare's "incident to" policies obscure the ability to determine who actually performed a service because a substantial portion of services performed by APRNs and PAs appear in claims data to have been performed by physicians. As noted above, in June 2019, the Commission recommended requiring APRNs and PAs to bill the Medicare program directly.

We report on the quality of the ambulatory care environment for beneficiaries in FFS Medicare using outcome measures that assess ambulatory care-

sensitive (ACS) hospitalizations and emergency department (ED) visits, as well as patient experience measures (using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)).¹⁶ This approach is consistent with the Commission's principles for quality measurement (Medicare Payment Advisory Commission 2018a).

Effectiveness and timeliness of care outside the hospital: ACS hospitalizations and ED visits

The Commission developed two claims-based outcome measures—ACS hospitalizations and ED visits—to compare quality of care within and across different populations (i.e., FFS Medicare in different local market areas), given the adverse impact on beneficiaries and high cost of these events. Two categories of ACS conditions are included in the measures: chronic (e.g., diabetes, asthma, hypertension) and acute (e.g., bacterial pneumonia, cellulitis). Conceptually, an ACS hospitalization or ED visit entails hospital use that could have been prevented with timely, appropriate, high-quality care. For example, if a diabetic patient's primary care physician and overall care team work effectively to control the patient's condition, an ED visit for a diabetic crisis could be avoidable.

Consistent with previous years, in 2022, the distribution of risk-adjusted rates of avoidable

hospitalizations and ED visits per 1,000 FFS Medicare beneficiaries varied widely across Dartmouth-defined hospital service areas (HSAs).¹⁷ This variation signals opportunities to improve the quality of ambulatory care (Table 4-4). The HSA at the 90th percentile of ACS hospitalizations had a rate that was almost twice the HSA at the 10th percentile. The HSA at the 90th percentile of ACS ED visits had a rate that was 2.6 times the HSA in the 10th percentile. Relatively poor performance on a local market's ACS hospitalization and ED visit measures indicates opportunities for improvement in those ambulatory care systems, while relatively good performance on the measures can indicate best practices for ambulatory care systems.

The median risk-adjusted ACS hospitalization and ED visit rates per HSA were relatively consistent from 2021 to 2022 (data not shown). However, the risk-adjusted rates went down (improved) substantially in 2021 and 2022 compared with 2019. For example, in 2019 the median ACS ED visit rate per HSA was 98.6 per 1,000 FFS beneficiaries compared with a median rate of 61.7 per 1,000 FFS beneficiaries in 2022 (Medicare Payment Advisory Commission 2021). Overall, ED visits for services unrelated to COVID-19 have declined since the start of the coronavirus pandemic, so we would expect some accompanying decline in ACS ED visits. Also, the national influenza rate during the 2021 to 2022 flu season was lower than prepandemic years because of isolating and social distancing, so there were likely fewer ED visits for the flu (which is an ACS ED visit). It is difficult to untangle whether and how much of the decline in ACS ED visits is due to these and other changes in ED use or because of improved quality of care.

Disparities in rates of risk-adjusted ACS hospitalizations and ED visits for FFS beneficiaries with different social risks We have found disparities in rates of ACS hospitalizations and ED visits across different groups of Medicare beneficiaries, which could indicate differential access to high-quality ambulatory care (Medicare Payment Advisory Commission 2023b). For example, beneficiaries receiving the Part D low-income subsidy (a proxy for low income) had rates of ACS hospitalization that were 1.3 times higher than those of other beneficiaries. Black beneficiaries had a rate of ACS ED visits that was 2.1 times higher than that of Asian/Pacific Islander beneficiaries. Outcomes for low-

income beneficiaries were worse across race/ethnicity categories. However, even within income categories, differences across the race/ethnicity groups persisted. For example, among non-LIS beneficiaries, Black beneficiaries had a rate of ACS hospitalizations that was 1.8 times higher (worse) than that of Asian/Pacific Islander beneficiaries.

Patient experience scores

The Agency for Healthcare Research and Quality's CAHPS surveys generate standardized and validated measures of patient experience. CAHPS surveys measure a key component of quality of care because they assess whether something that should happen in a health care setting (such as clear communication with a provider) actually happened and how often it happened, from the patient's perspective. When patients have a better experience, they are more likely to adhere to treatments, return for follow-up appointments, and engage with the health care system by seeking appropriate care. CMS annually fields a CAHPS survey among a subset of FFS beneficiaries to measure beneficiaries' experience of care with Medicare and their FFS providers.

Between 2021 and 2022, FFS CAHPS measure scores were relatively stable. The 2022 FFS CAHPS measure score for "getting needed care and seeing specialists" was 80 (score on a scale of 0 to 100) and the score for "getting appointments and care quickly" was 75; both measures have been trending downward over the past five years (Table 4-5, p. 104). The score for "rating of health plan (FFS Medicare)" was 83, which has been stable over the past five years. The "rating of health care quality" score returned to the prepandemic score of 85. In 2022, 77 percent of surveyed beneficiaries reported receiving an annual flu vaccine, a measure that has improved over the years.

Clinicians' revenues and compensation have increased, but inflation has been higher than usual

Clinicians do not submit annual cost reports to CMS, so we are unable to calculate their profit margins from delivering services. Instead, we rely on indirect measures of how Medicare payments compare with costs of providing services. We find that Medicare payment rate updates have grown more slowly than clinicians' input cost growth, especially in the last few

**TABLE
4-5****Medicare FFS CAHPS® performance scores, 2018–2022**

CAHPS composite measure	2018	2019*	2020	2021	2022	Score change, 2018–2022
Getting needed care and seeing specialists	83%	–	83%	81%	80%	–3
Getting appointments and care quickly	77	–	78	75	75	–2
Care coordination (e.g., personal doctor always or usually discusses medication, has relevant medical record, helps with managing care)	85	–	85	85	85	0
Rating of health plan (FFS Medicare)	83	–	84	83	83	0
Rating of health care quality	85	–	86	87	85	0
Annual flu vaccine	74	–	77	77	77	3

Note: FFS (fee-for-service), CAHPS® (Consumer Assessment of Healthcare Providers and Systems®). Questions in rows 1 to 3 have responses of “Never,” “Sometimes,” “Usually,” and “Always.” CMS converts these to a linear mean score on a 0 to 100 scale. Questions in rows 4 and 5 have responses of 1 to 10, which CMS also converts to a linear mean score on a 0 to 100 scale. The question in row 6 is a yes/no response.

*CMS halted collection of the 2019 beneficiary experience survey at the start of the coronavirus pandemic in 2020.

Source: FFS CAHPS mean scores provided by CMS.

years, but increases in the volume and intensity of services furnished by clinicians have resulted in higher physician fee schedule spending per FFS beneficiary. Physicians’ all-payer compensation has increased at rates similar to the general rate of inflation, which may be partially due to growth in private insurance payment rates as well as to growth in the volume and intensity of services clinicians have furnished per Medicare beneficiary over time.

Medicare’s conversion factor has not grown in recent years, but payment rates for E&M visits have increased substantially

Payment rates are updated each year by updating the fee schedule’s conversion factor.¹⁸ (All other things equal, increasing the conversion factor by 1 percent results in a 1 percent increase to payment rates.) In most years, the update to the conversion factor reflects two factors: (1) a percentage specified in statute (which may be zero) and (2) if necessary, a budget-neutrality adjustment. The budget-neutrality adjustment is

a percentage arrived at by CMS to ensure that any changes it has made to the relative values of particular billing codes in the fee schedule do not, in and of themselves, increase or decrease total physician fee schedule spending.

The statutory update to the conversion factor is currently specified in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (shown in the “Update” rows of Table 4-6). MACRA specified that clinicians’ payment rates were to be updated by 0 percent from 2020 to 2025. Starting in 2026, payment rates will increase by 0.75 percent per year for clinicians in advanced alternative payment models (A-APMs) and by 0.25 percent per year for all other clinicians.¹⁹ (Examples of A-APMs include accountable care organization models that require providers to take on some financial risk.)

In 2021, CMS increased the payment rates for office and outpatient E&M visits, upon the recommendation of the AMA/Specialty Society Relative Value Scale

**TABLE
4-6**

Physician fee schedule payment rate updates, adjustments, and bonuses under current law

	2021	2022	2023	2024	2025	2026 and later
A-APM clinicians						
Update	0%	0%	0%	0%	0%	0.75%
A-APM bonus (one time)	5%	5%	5%	5%	3.5%	N/A
Other clinicians						
Update	0%	0%	0%	0%	0%	0.25%
MIPS adjustments (one time)*	(-7% to +1.8%)	(-9% to +1.9%)	(-9% to +2.3%)	(-9% to +9%)	(-9% to +9%)	(-9% to +9%)
All clinicians						
Payment increase (one time)	3.75%	3.0%	2.5%	1.25%	N/A	N/A
Sequestration (one time)	0%	0% (3 months), -1% (3 months), -2% (6 months)	-2%	-2%	-2%	-2%

Note: A-APM (advanced alternative payment model), N/A (not applicable), MIPS (Merit-based Incentive Payment System). "One time" adjustments apply in a given year only and are not included in subsequent years' payment rates. A-APM bonuses and MIPS adjustments are based on clinicians' A-APM participation and quality measure performance from two years prior. The annual change to the conversion factor (a fixed dollar amount) for Medicare's physician fee schedule is based on (1) the updates specified in law (e.g., 0 percent plus a one-time increase of 1.25 percent in 2024); (2) expiration of one-time increases (e.g., the one-time increase of 2.5 percent in 2023); (3) CMS's budget-neutrality adjustment (e.g., -2.2 percent in 2024), which ensures that changes to the relative values of particular billing codes in the fee schedule do not change total physician fee schedule spending by more than \$20 million (not shown); and (4) the -2 percent sequester (which applies for one year at a time and is not built into subsequent years' payment rates).

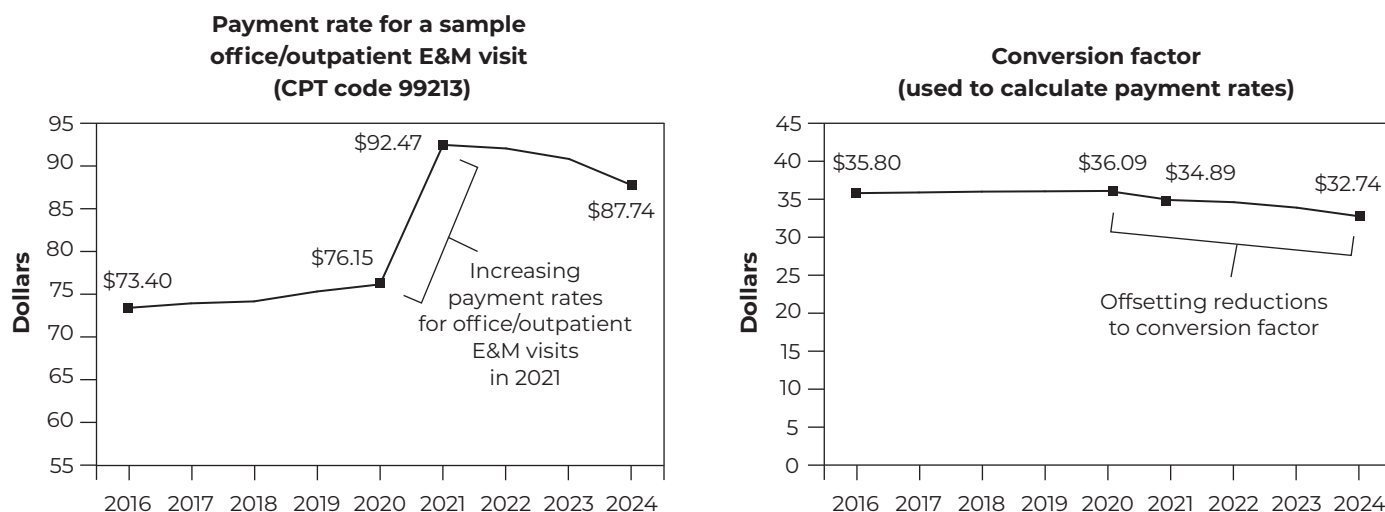
*Includes \$500 million of additional MIPS adjustments per year for "exceptional" performance through 2024. The maximum positive MIPS adjustments shown for 2021-2023 are the highest adjustments actually made in those years, while the maximum adjustments for 2024 and onward are theoretical maximums specified in law. In 2024, the maximum MIPS adjustment is up to +9% plus \$500 million for exceptional performance (not shown).

Source: MedPAC analysis of the Medicare Access and CHIP Reauthorization Act of 2015; the Coronavirus Aid, Relief, and Economic Security Act; the Consolidated Appropriations Act, 2021; An Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes; the Protecting Medicare and American Farmers from Sequester Cuts Act; and the Consolidated Appropriations Act, 2023; also CMS's final rules for the physician fee schedule for the payment years shown.

Update Committee (the RUC). Increasing the payment rates for these billing codes required an offsetting -6.8 percent budget-neutrality adjustment to the fee schedule's conversion factor. To avoid a reduction of this size to the conversion factor (and, thus, to payment rates) in 2021, the Congress subsequently passed laws that provided a series of one-year-only increases to the conversion factor that decline in size from 2021 through 2024 (shown in the "Payment increase (one time)" row of Table 4-6). These increases effectively

phase in the 6.8 percent reduction to the conversion factor over time. As a result, payment rates for office and outpatient E&M visits (which are provided by a wide variety of clinicians) have increased substantially (shown at left in Figure 4-1, p. 106), while the conversion factor has declined (shown at right in Figure 4-1, p. 106).

In 2024, part of the 3.4 percent decline in the conversion factor that year (captured at right in Figure 4-1, p. 106) is also offsetting the cost of a new add-on

**FIGURE
4-1****Increases to payment rates for office/outpatient E&M visits
required offsetting decreases to the conversion factor**

Note: E&M (evaluation and management), CPT (Current Procedural Terminology). The "office/outpatient E&M visit" code set refers to CPT codes 99202–99205 (new patients) and 99211–99215 (established patients). CPT code 99213 refers to a visit involving a low level of medical decision-making; if time is used for code selection, 20–29 minutes are spent on the date of the encounter. Payment rates shown for 99213 are nonfacility national payment rates. The right graph captures a budget-neutrality adjustment made to the conversion factor in 2024 to account for the cost of a new add-on code (G2211).

Source: Centers for Medicare & Medicaid Services, 2023, "Search the physician fee schedule" (interactive billing code payment rate look-up website), <https://www.cms.gov/medicare/physician-fee-schedule/search/overview>.

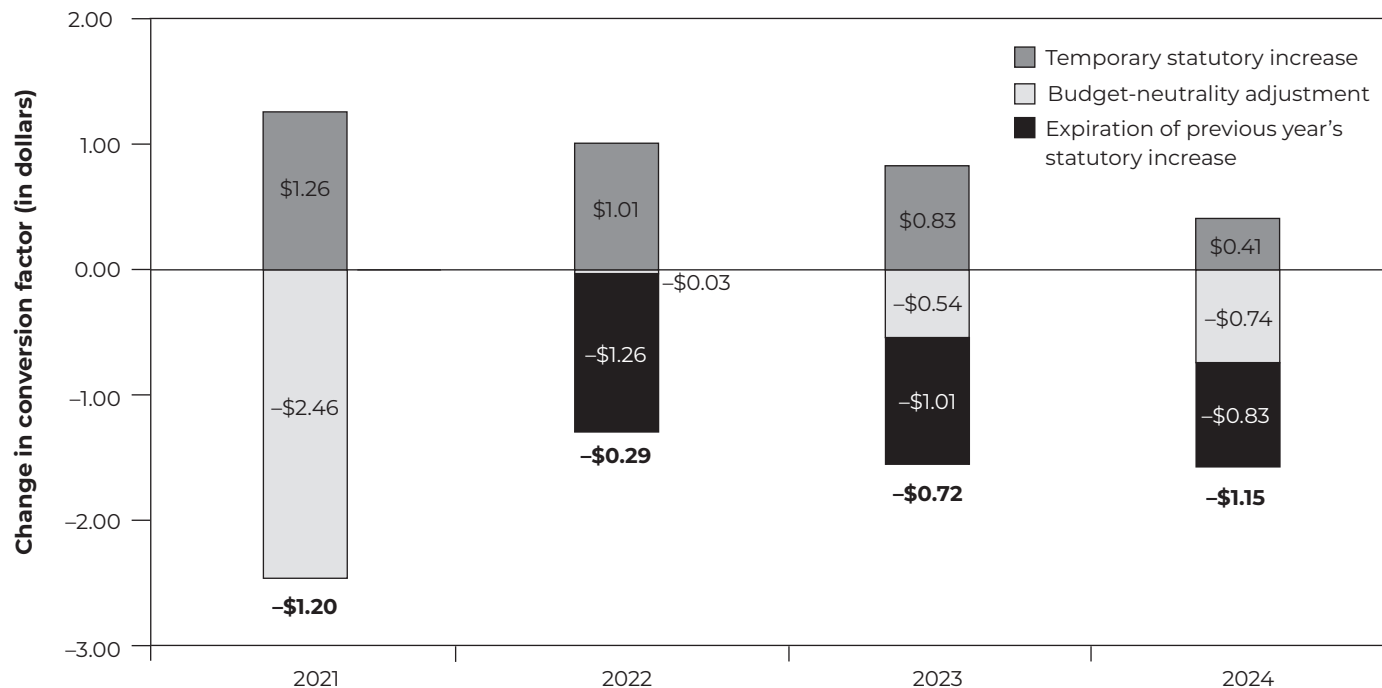
code that will add another \$16 to the payment rate for office/outpatient E&M visits provided by clinicians who have an ongoing relationship with a patient (which will be in addition to the payment amount shown at left in Figure 4-1). This add-on code is expected to be used by primary care clinicians and by specialists treating a patient's serious or complex medical condition (Centers for Medicare & Medicaid Services 2023b).²⁰

Figure 4-2 shows net annual changes in the conversion factor resulting from budget-neutrality adjustments and temporary one-year statutory increases over the 2021 to 2024 period. In 2021, CMS's required budget-neutrality adjustment of $-\$2.46$ was partially offset by $\$1.26$ resulting from the Congress's temporary statutory increase of 3.75 percent, for a net change in the conversion factor of $-\$1.20$. In 2022, a net change in the conversion factor of $-\$0.29$ was due to the combined effects of the expiration of the 2021 temporary increase ($-\$1.26$), a small budget-neutrality adjustment ($\$0.03$),

and the Congress's temporary statutory increase of 3 percent ($\$1.01$). For 2023, a net change in the conversion factor of $\$0.72$ resulted from the combined effects of the expiration of the 2022 temporary increase ($-\$1.01$), a budget-neutrality adjustment of $-\$0.54$, and the Congress's temporary statutory increase of 2.5 percent ($\$0.83$). If the current-law statutory update and budget-neutrality adjustment scheduled for 2024 are in effect, the conversion factor will be reduced by $\$1.15$ and will be $\$3.35$ less than what it was in 2020 (latter data not shown).

Allowed charges per beneficiary grew at about the same rate from 2021 to 2022 as during previous years

Despite the recent reduction in the conversion factor, the total payments that clinicians received per FFS beneficiary grew from 2021 to 2022, in part because clinicians continued to increase the volume and/or intensity of services they deliver. We measure the total

**FIGURE
4-2****Recent declines in the conversion factor are the result of several countervailing effects**

Note: Changes shown for 2024 are based on information published in the final physician fee schedule rule for that payment year. Components may not sum to totals due to rounding.

Source: Centers for Medicare & Medicaid Services 2023b, Centers for Medicare & Medicaid Services 2022, Centers for Medicare & Medicaid Services 2021, Centers for Medicare & Medicaid Services 2020.

payments a clinician receives using allowed charges (which include Medicare payments and beneficiary cost sharing) for services furnished to FFS beneficiaries that are paid under the physician fee schedule.²¹

We also present changes in units of service per beneficiary. For most types of service, a unit of service represents one individual service, such as an office visit, surgical procedure, or imaging scan. A difference between a change in allowed charges and a change in units of service means that a factor other than volume is affecting the amount of allowed charges being generated. For example, if providers substitute high-resolution computed tomography (CT) scans for regular CT scans, the allowed charges for imaging services would increase at a higher rate than would units of service for imaging. However, there are other

reasons that changes in allowed charges can diverge from changes in service units. For example, increases in allowed charges may be attributable to increases in Medicare's payment rates for certain services. Also, decreases in allowed charges could be related to the movement of services from freestanding offices to the outpatient hospital setting where fee schedule payments are lower.

As measured by units of service per beneficiary, the volume of clinician services grew somewhat more quickly over the 2021 to 2022 period (4.0 percent) than it did during the prepandemic years covering 2017 to 2019 (2.4 percent) (Table 4-7, p. 108).²² Volume growth during both periods of time varied by type of service, but growth rates were higher in 2022 than during the 2017 to 2019 period, except for major procedures and anesthesia.

**TABLE
4-7****Growth in allowed charges per FFS beneficiary varied by type of service, 2017–2022**

Type of service	Change in units of service per FFS beneficiary		Change in allowed charges per FFS beneficiary		Share of 2022 allowed charges
	Annual average 2017–2019	2021–2022	Annual average 2017–2019	2021–2022	
All services	2.4%	4.0%	2.9%	2.8%	100.0%
Evaluation and management	1.2	2.4	2.3	2.2	51.6
Imaging	1.8	3.0	2.7	3.0	10.8
Major procedures	1.8	0.1	3.6	–0.2	7.2
Other procedures	2.0	3.2	3.7	2.5	12.8
Treatments	6.7	10.0	5.7	5.7	10.0
Tests	1.9	2.7	1.9	6.8	4.7
Anesthesia	1.7	0.8	1.9	0.7	2.5

Note: FFS (fee-for-service). We use the number of FFS Medicare beneficiaries enrolled in Part B to define units of service and allowed charges per beneficiary. Components may not sum to total allowed charges due to rounding.

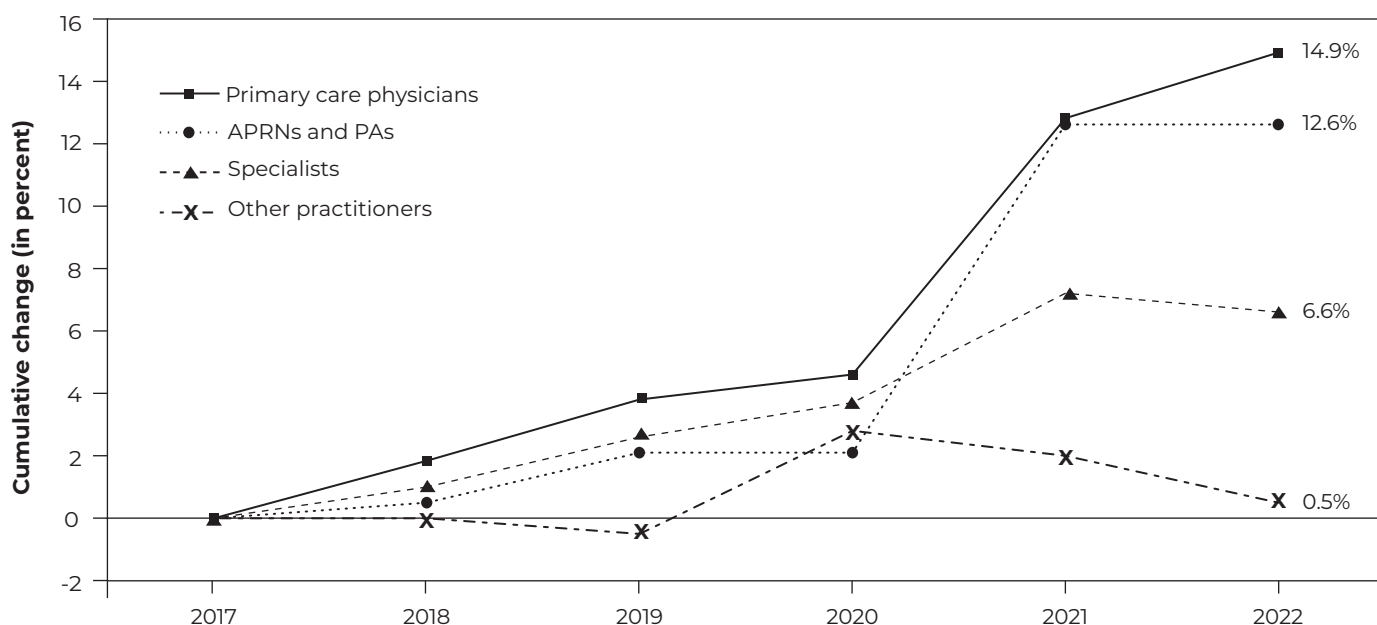
Source: MedPAC analysis of Medicare claims data for 100 percent of FFS beneficiaries and the 2023 annual report of the Boards of Trustees of the Medicare trust funds.

From 2021 to 2022, across all services, allowed charges per beneficiary rose by 2.8 percent. Among broad service categories, growth rates were 2.2 percent for E&M services, 3.0 percent for imaging services, 2.5 percent for other procedures (i.e., procedures that are not considered major procedures), 5.7 percent for treatments, 6.8 percent for tests, and 0.7 percent for anesthesia. Allowed charges per beneficiary for major procedures fell by 0.2 percent. For most categories, growth in allowed charges from 2021 to 2022 was similar to the rate of growth in the years immediately prior to the pandemic. The exceptions were major procedures, other procedures, and anesthesia, which grew more slowly from 2021 to 2022 than over the 2017 to 2019 period. Most of the slowdown occurred among cardiac and vascular surgical procedures, which have experienced lower annual volume growth than they did prior to the pandemic.

Over the entire 2017 to 2022 period, treatments had the highest rate of growth in allowed charges among the broad service categories. The treatments category includes services such as administration of dialysis

and cancer treatments, physical therapy, and spinal manipulation. Increases in physical, occupational, and speech therapy services were the primary drivers of growth: Spending per beneficiary on these types of treatments rose by 13.4 percent from 2021 to 2022 and grew by more than 50 percent over the 2017 to 2022 period (data not shown). The increase in allowed charges in the treatment category is mirrored by increases in service units for these types of services. The growth in volume and spending may be related to provisions in the Bipartisan Budget Act of 2018 that made changes to the application of Medicare's outpatient therapy caps and the process of getting exemptions from those caps.

Increases or decreases in allowed charges can result from changes in volume, changes in payment rates for individual services, changes in the intensity of certain services (e.g., furnishing a higher-intensity E&M visit rather than a lower-paying, less intensive E&M visit), and movement of services from freestanding offices to hospitals. Given the complex nature of factors that contribute to changes in allowed charges, it can be

**FIGURE
4-3****Cumulative change in allowed charges per unit of service from 2017 to 2022**

Note: APRN (advanced practice registered nurse), PA (physician assistant).

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries.

challenging to explain why spending has changed over time. One way to better understand changes in spending trends is to calculate changes in allowed charges per unit of service. When calculated on a per beneficiary basis, such an approach removes changes in volume (but not changes in intensity) as a factor driving changes in spending. Figure 4-3 shows cumulative changes in allowed charges per unit of service from 2017 to 2022 by type of provider. Among primary care physicians, spending per unit of service was 14.9 percent higher in 2022 than it was in 2017. Over this period, cumulative growth in spending per unit increased by 12.6 percent among APRNs and PAs, by 6.6 percent for all specialist physicians, and by 0.5 percent for other practitioners.

Among primary care physicians, specialists, and APRNs and PAs, the largest single-year increase in spending per unit of service occurred in 2021. This growth was largely driven by increases in Medicare payment rates for office/outpatient E&M visits (see, for example,

Figure 4-1, p. 106). Among primary care physicians and APRNs and PAs, a large portion of fee schedule revenue comes from E&M services. The degree to which specialists bill for E&M services varies across types of specialties, but in aggregate the increase in E&M payment rates was enough to cause a substantial increase in spending per unit of service during 2021, despite a decrease in the fee schedule's conversion factor. Other practitioners (which include physical therapists, podiatrists, and optometrists) generally do not bill for E&M services, so they were not as affected by the increase in E&M rates.

Average payment rates of private insurance preferred provider organizations remained higher than Medicare payment rates for clinician services

We compare rates paid by private insurance plans with Medicare rates for clinician services because extreme disparities in payment rates might create an incentive

for clinicians to focus primarily on patients with private insurance and avoid those with FFS Medicare coverage. For this analysis, we used data on paid claims for enrollees of preferred provider organization (PPO) health plans that are part of a large national insurer that covers a wide geographic area across the U.S.²³ In 2022, the average PPO payment rate for clinician services was 136 percent of FFS Medicare's average payment rate, up from 134 percent in 2021. The growing difference between Medicare and private-payer rates resumes a long-standing trend after the difference lessened in 2021, which was likely due to a substantial increase in Medicare payment rates for E&M office/outpatient visits in that year (a rate increase that appears not to have been immediately matched by private plans).²⁴

The ratio in 2022, as in prior years, varied by type of service. For example, private insurance rates were 104 percent of Medicare rates for care management/coordination E&M visits but 195 percent of Medicare rates for CT scans.

The gap between private insurance rates and Medicare rates has grown over the last decade as Medicare rates have increased more modestly than private insurance rates: In 2011, private insurance rates were 122 percent of Medicare rates. Nevertheless, as we note earlier, the vast majority of clinicians continue to participate in the FFS Medicare program.

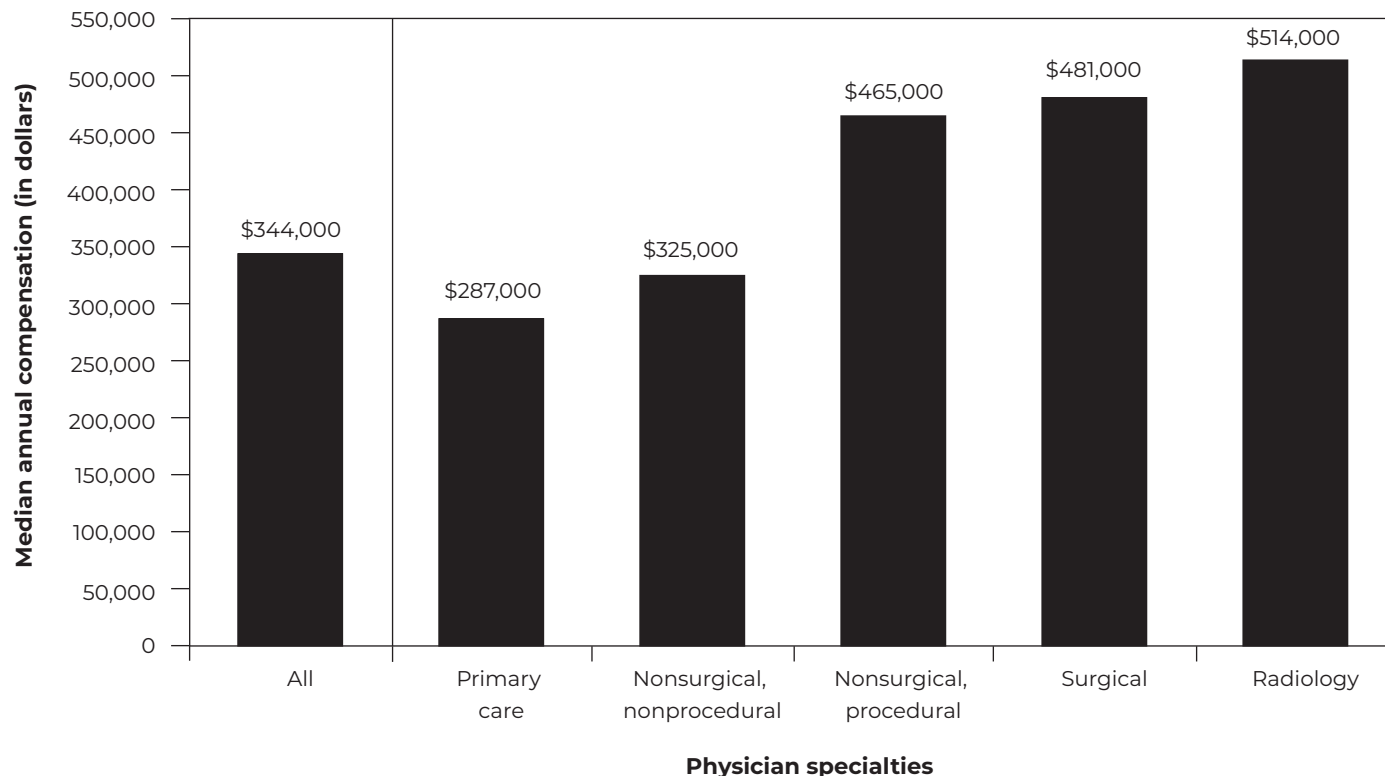
The growth in private insurance rates probably results from greater consolidation of physician practices and hospitals' acquisition of physician practices, which gives providers greater leverage to negotiate higher prices for clinician services with private plans. In recent years, the number of physicians joining larger groups, hospitals, and health systems has risen sharply. For example, according to an AMA survey, from 2012 to 2022, the share of physicians who were either directly employed by a hospital or were part of a practice with hospital ownership increased from about 29 percent to 41 percent (Kane 2023).

Studies show that private insurance prices for physician services are higher in markets with larger physician practices and in markets with greater physician-hospital consolidation (Capps et al. 2018, Clemens and Gottlieb 2017, Neprash et al. 2015). Similarly, the Commission has found that independent

practices with larger market shares and hospital-owned practices have received higher private insurance rates for E&M visits than other practices in their market (Medicare Payment Advisory Commission 2017). The AMA survey found that the top reason physicians gave for selling their practice to a hospital was to enhance their ability to negotiate higher payment rates with payers (cited by 80 percent of physicians working in practices acquired by hospitals); other commonly cited reasons were to improve access to costly resources and get help complying with payers' regulatory and administrative requirements (cited by about 70 percent of respondents in these practices) (Kane 2023).

Compensation and productivity data indicate that clinicians who work in hospital-owned practices do not necessarily earn higher compensation, but they do tend to see fewer patients and bill for fewer services than clinicians in physician-owned practices (Medical Group Management Association 2023, Medical Group Management Association 2022, Whaley et al. 2021). A recent Medscape survey of employed physicians found that the most appealing aspects of working as an employed physician were not having to run a small business and having stable income, while the top drawbacks were loss of autonomy, more workplace rules, and potentially less income (McKenna 2022).

The AMA survey found that, as of 2022, 47 percent of physicians worked in a physician-owned practice, 31 percent worked in a hospital-owned practice, 10 percent worked as an employee or contractor in a hospital setting, 4.5 percent worked for a practice owned by a private equity group, and the remainder worked in various other arrangements. (Some insurers also increasingly employ clinicians. UnitedHealth Group's Optum Health is now reported to be the largest employer of clinicians in the U.S., with 130,000 employed or aligned clinicians (Emerson 2023, UnitedHealth Group 2023).) The AMA survey also found that 44 percent of physicians reported an ownership stake in their practice in 2022—down from 53 percent in 2012. The share of physicians with an ownership stake may decline further in the coming years since a decreasing share of younger physicians report ownership interests, and female physicians (whose share of the physician workforce has been increasing) are also less likely to report ownership interests (Kane 2023).

**FIGURE
4-4****Compensation for primary care physicians is much lower than for most specialists, 2022**

Note: Figure includes all physicians who reported their 2022 annual compensation in the survey ($n = 106,376$). All numbers are rounded to the nearest thousand. "Compensation" refers to median total cash compensation adjusted to reflect full-time work and does not include employer retirement contributions or payments for benefits. The primary care group includes family medicine, internal medicine, and general pediatrics. The nonsurgical, nonprocedural group includes psychiatry, emergency medicine, hospital medicine, endocrinology and metabolism, nephrology and hypertension, neurology, physical medicine and rehabilitation, rheumatology, and other internal medicine/pediatrics. The nonsurgical, procedural group includes cardiology, dermatology, gastroenterology, pulmonology, and hematology/oncology. The surgical group includes general surgery, orthopedic surgery, cardiovascular and cardiothoracic surgery, neurological surgery, ophthalmology, otolaryngology, urology, obstetrics/gynecology, and other surgical specialties. Certain nonsurgical, nonprocedural specialties (endocrinologists, rheumatologists, psychiatrists) had lower median compensation than primary care physicians.

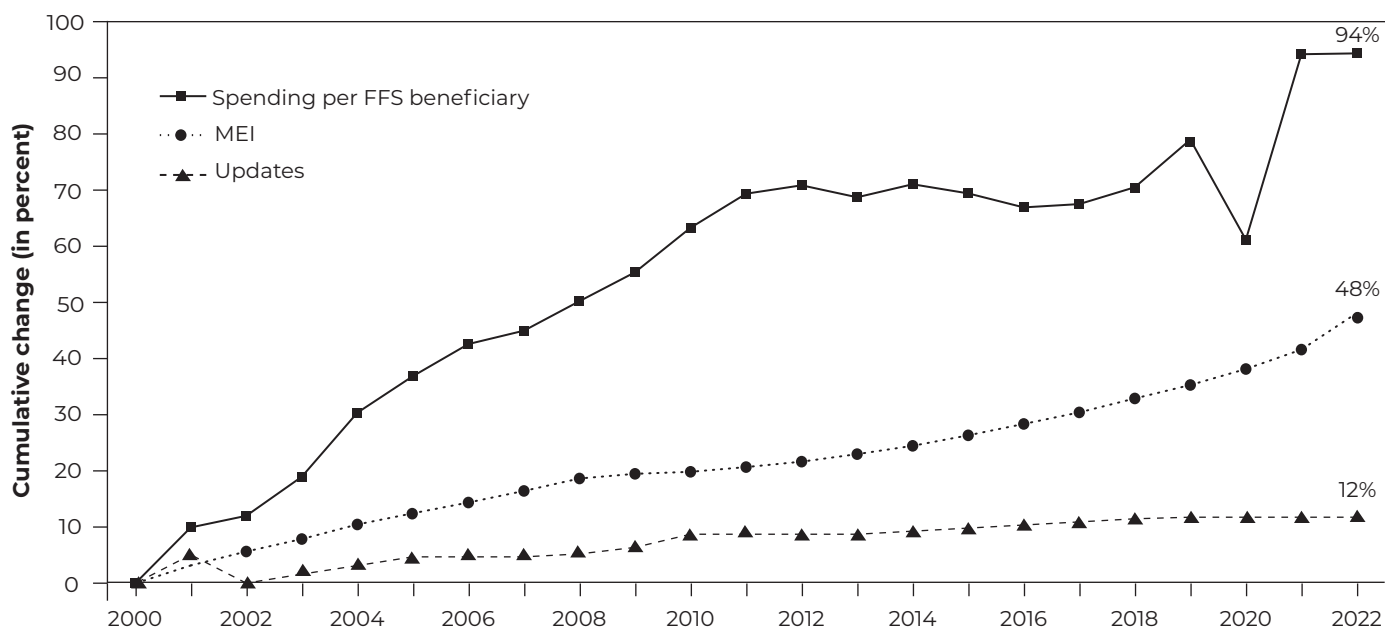
Source: SullivanCotter's Physician Compensation and Productivity Survey, 2023.

Median compensation grew by 9 percent for physicians and by 5 percent for advanced practice providers from 2021 to 2022

Since the Commission lacks data that would allow us to calculate clinicians' all-payer profit margins from delivering services, we use clinician compensation data as a rough proxy for profitability. Relatively high clinician compensation levels indicate that total revenues are greater than costs. These compensation levels also give some assurance that providing clinician services is profitable and that there is an incentive for

individuals to pursue careers as clinicians. We note, however, that Medicare constitutes only a portion of the revenue most clinicians receive, since clinicians usually accept a variety of types of insurance—making clinician compensation an indirect measure of Medicare's payment adequacy.

After relatively modest rates of growth during the pandemic, clinician compensation appears to have strongly rebounded from 2021 to 2022. According to SullivanCotter's latest clinician compensation and

**FIGURE
4-5****Physician fee schedule spending per FFS beneficiary grew substantially faster than the MEI or fee schedule payment updates, 2000–2022**

Note: FFS (fee-for-service), MEI (Medicare Economic Index). The MEI measures the change in clinician input prices. MEI data are from the new version of the MEI (based on data from 2017). Spending per FFS beneficiary is based on incurred spending under the physician fee schedule. The graph shows increases to payment rates in nominal terms. Fee schedule updates do not include Merit-based Incentive Payment System adjustments, advanced alternative payment model participation bonuses, and payment increases of 3.75 percent in 2021 and 3.0 percent in 2022 because they are one-time payments not built into subsequent years' payment rates.

Source: MedPAC analysis of Medicare regulations and Trustees' reports.

productivity surveys, from 2021 to 2022, median compensation grew by 9 percent for physicians—a little faster than inflation, which grew by 8 percent according to the consumer price index for all urban consumers (CPI-U) (Bureau of Labor Statistics 2023b). Over this same period, median compensation grew by 5 percent for advanced practice providers (e.g., NPs, PAs).^{25,26} By 2022, median compensation was \$344,000 for physicians and \$131,000 for advanced practice providers.²⁷ As we show in Figure 4-4 (p. 111), physician compensation varied substantially by specialty in 2022, with primary care physicians earning a median compensation of \$287,000 while radiologists earned a median of \$514,000.

The high growth rate in physician compensation from 2021 to 2022 was observed across most specialty

categories, including nonsurgical, nonprocedural specialties (which saw growth of 10 percent) as well as nonsurgical, procedural specialties; surgical specialties; and primary care specialties (which all saw growth of 9 percent). Compensation grew less for radiology (6 percent) and pathology (5 percent).

There was similar consistency in the growth rate of advanced practice provider compensation across specialties. Among these types of clinicians, those practicing in nonsurgical, nonprocedural specialties; nonsurgical, procedural specialties; and surgical specialties all saw 5 percent growth in median compensation from 2021 to 2022. Clinicians and those practicing in primary care specialties and radiology saw 4 percent growth.

Over a four-year period (from 2018 to 2022), median compensation grew at lower rates. For physicians, median compensation grew by an average of 3.4 percent per year—more slowly than CPI-U inflation, which grew by an average of 3.9 percent per year over this period (Bureau of Labor Statistics 2023b). For advanced practice providers, median compensation grew by an annual average of 4.0 percent over this period.²⁸

Growth in input costs accelerated in recent years but is projected to moderate in 2025

We report the growth in clinicians' input costs because it helps us understand the extent to which Medicare payment rate updates and clinician revenues are keeping pace with the costs associated with running a practice. The Medicare Economic Index (MEI) measures the average annual price change for the market basket of inputs used by clinicians to furnish services, after adjusting for economy-wide productivity. The MEI consists of two main categories: (1) physicians' compensation and (2) physicians' practice expenses (e.g., compensation for nonphysician staff, rent, equipment, and professional liability insurance).²⁹

MEI growth was 1 percent to 2 percent per year for several years before the coronavirus pandemic and was 2.1 percent in 2020.³⁰ MEI growth then increased to 2.5 percent in 2021 and 4.6 percent in 2022. However, MEI growth is projected to moderate in the coming years—to 4.1 percent in 2023, 3.1 percent in 2024, and 2.6 percent in 2025.³¹

Over the longer term, cumulative MEI growth has far exceeded updates to physician fee schedule payment rates. For example, from 2000 to 2022, the MEI increased cumulatively by 48 percent compared with 12 percent for fee schedule updates. However, the volume and intensity of clinician services delivered each year has increased, which has resulted in fee schedule spending per FFS beneficiary growing by 94 percent over the same time period (Figure 4-5). This contrast suggests that growth in volume and intensity has helped offset the gap between MEI growth and annual updates.

Unlike the changes in fee schedule updates and MEI growth (which represent price changes), the growth in fee schedule spending per FFS beneficiary represents the combined effects of changes in price, volume, and

intensity. Because increases in volume and intensity generally increase costs (e.g., furnishing an additional service may require clinicians to purchase additional supplies), the growth in fee schedule spending per FFS beneficiary should not be interpreted as profit growth.³² Nonetheless, the substantial growth in fee schedule spending per FFS beneficiary suggests that simply comparing changes in fee schedule updates to MEI growth is insufficient to capture changes over time in clinicians' ability to provide services to Medicare beneficiaries.

How should Medicare fee schedule payments change in 2025?

Under current law, payment rates are expected to decline in 2025, due to the expiration of a 1.25 percent pay increase in 2024 that applies for one year only and a 0 percent update specified in current law for 2025. Although most of our payment adequacy indicators are positive, expected cost increases in 2025 could be difficult for clinicians to absorb.

In addition, as discussed in our March 2023 report to the Congress, the Commission is concerned that 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. Since these lower payments could put clinicians who furnish care to low-income beneficiaries at greater financial risk and reduce access to care for these beneficiaries, Medicare should provide additional support to clinicians who serve this population.

RECOMMENDATION 4

The Congress should:

- **for calendar year 2025, update the 2024 Medicare base payment rate for physician and other health professional services by the amount specified in current law plus 50 percent of the projected increase in the Medicare Economic Index; and**
- **enact the Commission's March 2023 recommendation to establish safety-net add-on payments under the physician fee schedule for services delivered to low-income Medicare beneficiaries.**

The Commission's March 2023 recommendation to support clinicians when they care for low-income Medicare beneficiaries

In our March 2023 report to the Congress, the Commission recommended instituting a new Medicare safety-net (MSN) add-on payment for clinicians who treat low-income beneficiaries (Medicare Payment Advisory Commission 2023c). Specifically, the Commission recommended that the Congress enact an add-on payment under the physician fee schedule for services provided to Medicare beneficiaries who are dually enrolled in Medicaid and Medicare and to beneficiaries who receive the Part D low-income subsidy (LIS) (as proxies for low income).³³ The add-on payments would equal the allowed charge amounts for physician fee schedule services furnished to these beneficiaries multiplied by 15 percent when provided by primary care clinicians and 5 percent for all other clinicians. The MSN add-on could be made as lump-sum payments to clinicians, rather than applied to individual claims, and should not be subject to beneficiary cost sharing.

The Commission contends that Medicare should provide additional financial support to clinicians who care for low-income beneficiaries because treating these beneficiaries can generate less

revenue, even though the costs required to treat them are likely the same as for other beneficiaries, if not higher.

The revenue for treating beneficiaries with low incomes is often lower than the revenue clinicians collect for treating other beneficiaries because clinicians are prohibited from collecting cost-sharing amounts (either the annual Part B deductible or 20 percent coinsurance) from most beneficiaries who are dually enrolled in Medicaid and Medicare. In addition, state Medicaid programs are allowed to pay less than the full Medicare cost-sharing amount if paying the full amount would lead a provider to receive more than the state's Medicaid payment rate for the service.³⁴ One study found that 42 states limited Medicaid payments of Medicare cost sharing when Medicaid's fee schedule amount was lower than Medicare's rate (Roberts et al. 2020).

We estimate that in 2019, providers did not collect about \$3.6 billion in revenue due to these policies. Applying an MSN add-on to physician fee schedule payments would help to make up for a portion of clinicians' lost cost-sharing revenue when they treat

(continued next page)

RATIONALE 4

Overall, access to clinician services for Medicare beneficiaries appears to be comparable with, or better than, that of privately insured individuals, though quality of care is difficult to assess. Physician fee schedule spending per beneficiary dropped sharply in 2020 due to the pandemic, but spending since then has largely recovered and is now growing at rates close to prepandemic levels. Clinicians' all-payer compensation grew rapidly in 2022, but clinicians' input costs grew faster in 2022 than in previous years. While projected

to moderate by 2025, input cost growth is projected to remain slightly above the low levels experienced for several years prior to 2021.

Current law calls for payment rates to decline from 2024 to 2025 because of the expiration of a 1.25 percent pay increase that applies only to 2024 payments. The Commission is concerned that such payment levels may make it difficult for clinicians to absorb recent and continued cost increases. Then again, aggregate payments appear adequate on the basis of many of our indicators. Therefore, given these mixed findings, the

The Commission's March 2023 recommendation to support clinicians when they care for low-income Medicare beneficiaries (cont.)

these low-income beneficiaries, and it would thus reduce the financial risk involved in treating these patients.

Some clinicians treat a disproportionate share of low-income beneficiaries. In 2019, 9 percent of primary care clinicians and 8 percent of non-primary care clinicians who billed the physician fee schedule had more than 80 percent of their claims associated with beneficiaries receiving Part D's LIS. Across all primary care physicians, 28 percent of total allowed charges were associated with LIS beneficiaries. The share of allowed charges associated with LIS beneficiaries was slightly lower for non-primary care physicians (25 percent), but higher for nurse practitioners (41 percent). While the Commission recognizes that all clinicians who furnish care to beneficiaries with lower income are at risk of lower revenue, we support providing a higher add-on rate for services furnished by primary care clinicians (including practitioners such as nurse practitioners and physician assistants) because even though they typically serve as a beneficiary's primary point of contact with the health care system, primary care clinicians generally receive less total compensation than specialists and thus have a greater need for safety-net payments.

Using 2019 data, we estimate that a 15 percent safety-net add-on payment for primary care clinicians and a 5 percent add-on for other clinicians would have increased the average clinician's fee schedule revenue by 1.7 percent. The increase for each clinician would vary by their specialty and share of services furnished to low-income beneficiaries: Safety-net payments would increase total fee schedule revenue for primary care clinicians by 4.4 percent and non-primary care clinicians by 1.2 percent. Because Medicare does not have an existing program to provide financial support to clinicians when they furnish care to beneficiaries with low incomes, and because clinician payments are subject to relatively low statutory annual updates in the near term, the Commission asserts that the MSN add-on should be funded with new spending and not offset by reductions in fee schedule payment rates. The Commission emphasizes that MSN add-on payments should not be extended to Medicare Advantage (MA) plans or included in MA benchmarks because many LIS beneficiaries are already enrolled in plans designed for dual enrollees, and plans can operate their own initiatives to support clinicians who serve low-income beneficiaries. ■

Commission recommends that the Congress raise the physician fee schedule base payment rate in 2025 by half of the projected increase in the MEI.

The MEI is currently projected to grow by 2.6 percent in 2025, so this recommendation would yield an estimated increase in payment rates of 1.3 percent (50 percent \times 2.6 percent = 1.3 percent) above current law. These MEI growth figures are projections, are subject to uncertainty, and could be larger or smaller than actual MEI growth.

In addition to the recommendation for an across-the-board increase to the base payment rate, the

Commission contends that, for reasons set forth in last year's physician update chapter, it is important to provide additional financial support to clinicians when they furnish care to low-income beneficiaries (see text box on the Commission's 2023 recommendation) (Medicare Payment Advisory Commission 2023c). Our recommendation would therefore also call for the Congress to enact add-on payments to clinicians for physician fee schedule services furnished to low-income Medicare beneficiaries. These new add-on payments should be consistent with the clinician safety-net recommendation in our March 2023 report.

We estimate that the recommended safety-net add-on policy would increase the average clinician's fee schedule revenue by 1.7 percent. The increase for each clinician would vary depending on their specialty—with primary care clinicians receiving higher add-on payments than other clinicians—and depending on the share of services they furnish to low-income beneficiaries. On average, safety-net payments would increase Medicare fee schedule revenue for primary care clinicians by 4.4 percent and for other clinicians by 1.2 percent.

We estimate that the combination of our half-of-MEI payment update and our safety-net add-on payments would increase the average clinician's Medicare fee schedule revenue by 3 percent, with revenue increasing by an average of 5.7 percent for primary care clinicians and by an average of 2.5 percent for other clinicians.

Spending

- This recommendation would increase program spending relative to current law by \$2 billion to \$5 billion in 2025 and by \$10 billion to \$25 billion over five years.

Beneficiaries and providers

- We expect that this recommendation will help ensure FFS Medicare beneficiaries' access to care by maintaining clinicians' willingness and ability to treat them. This recommendation may increase clinicians' willingness and ability to treat beneficiaries with low incomes. ■

4-APPENDIX A

Key findings from the Commission's 2023 access-to-care survey

**TABLE
4A-1****Medicare beneficiaries reported access to care that is comparable with, or better than, that of privately insured people, 2022 and 2023**

Survey question	Medicare beneficiaries (ages 65 and older)		Privately insured (ages 50–64)	
	2022	2023	2022	2023
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, “How often did you have to wait longer than you wanted to get a doctor’s appointment?”				
For routine care				
Never	55% ^{ab}	49% ^a	40% ^a	37% ^a
Sometimes	32 ^{ab}	39	40 ^a	40
Usually	8 ^a	9 ^a	12 ^{ab}	14 ^a
Always	4 ^a	4 ^a	8 ^a	8 ^a
For illness or injury				
Never	67 ^a	65 ^a	58 ^a	55 ^a
Sometimes	26	27 ^a	29	30 ^a
Usually	4 ^a	6 ^a	8 ^a	10 ^a
Always	3 ^a	2 ^a	5 ^a	5 ^a
Not accessing a doctor for medical problems: “During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?”				
Yes	18 ^a	20 ^a	24 ^a	27 ^a
Looking for a new provider: “In the past 12 months, have you tried to get a new...?” (Share answering “Yes”)				
Primary care provider	11	12 ^a	14	15 ^a
Specialist	26 ^b	32	29 ^b	33
Problems getting a new provider: Among those who tried to get an appointment with a new primary care provider or specialist in the past 12 months, “How much of a problem was it finding a primary care provider/specialist who would treat you?”				
Primary care provider				
No problem	46	45 ^a	38	32 ^a
Share of total insurance group	5	5	5	5
Small problem	32	32	33	35
Share of total insurance group	4	4 ^a	5	5 ^a
Big problem	22	23 ^a	29	33 ^a
Share of total insurance group	2 ^a	3 ^a	4 ^a	5 ^a
Specialist				
No problem	68 ^a	64 ^a	59 ^a	54 ^a
Share of total insurance group	18	20	17	18
Small problem	22	23	26	28
Share of total insurance group	6	7 ^a	7	9 ^a
Big problem	10 ^a	13 ^a	15 ^a	18 ^a
Share of total insurance group	3 ^{ab}	4 ^a	4 ^{ab}	6 ^a

Note: Totals may not sum to 100 percent because of rounding and because the table excludes the following responses: “Don’t know” and “Refused.” Survey sample sizes are approximately 4,000 Medicare beneficiaries and 4,000 privately insured people in 2022 and approximately 5,000 of each group in 2023; sample sizes for particular questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage. Due to a recent change in MedPAC’s survey methods, results from 2022 onward (shown above) may not be directly comparable with prior years (which are not shown but are available in prior years’ chapters).

^aStatistically significant difference between Medicare beneficiaries and the privately insured in a given year (at a 95 percent confidence level).

^bStatistically significant difference between 2022 and 2023 within the same insurance category (at a 95 percent confidence level).

Source: MedPAC’s access-to-care surveys conducted in the summers of 2022 and 2023.

**TABLE
4A-2**

Lower-income Medicare beneficiaries reported obtaining less care than higher-income beneficiaries in 2023

Survey question	Medicare beneficiaries (ages 65 and older)			Privately insured (ages 50–64)		
	Lower income	Middle income	Higher income	Lower income	Middle income	Higher income
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, “How often did you have to wait longer than you wanted to get a doctor’s appointment?”						
For routine care						
Never	53% ^a	46% ^b	44% ^{ab}	44% ^a	42%	34% ^{ab}
Sometimes	35	43 ^b	41 ^b	37	37	42
Usually	8 ^a	7 ^a	11 ^{ab}	11 ^a	14 ^a	16 ^{ab}
Always	4 ^a	4 ^a	4 ^a	8 ^a	7 ^a	9 ^a
For illness or injury						
Never	66 ^a	67 ^a	63 ^a	57 ^a	56 ^a	54 ^a
Sometimes	27	25	27	29	29	31
Usually	5	6 ^a	7	8	10 ^a	10
Always	2 ^a	3	2 ^a	6 ^a	5	5 ^a
Not accessing a doctor for medical problems: “During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?”						
Yes	23 ^a	17 ^{ab}	17 ^{ab}	28 ^a	31 ^a	25 ^a
Received any health care: “Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?”						
Yes	91 ^a	97 ^{ab}	97 ^{ab}	82 ^a	90 ^{ab}	93 ^{ab}
Availability of providers who accept your insurance: Among those who received health care in the past 12 months, “How satisfied or dissatisfied have you been with your ability to find health care providers that accept Medicare/your insurance?”						
Satisfied (“very” or “somewhat”)	96 ^a	96 ^a	96 ^a	88 ^a	91 ^a	92 ^{ab}
Availability of timely appointments: Among those who received health care in the past 12 months, “How satisfied or dissatisfied have you been with your ability to find health care providers that have appointments when you need them?”						
Satisfied (“very” or “somewhat”)	89 ^a	87 ^a	86 ^a	76 ^a	77 ^a	77 ^a
Have a primary care provider: “A primary care provider is the doctor you see in an office or a clinic for routine medical care, medical check-ups, or when you first experience a medical problem. Do you have a primary care provider that you go to for this type of care?”						
Yes	96 ^a	96 ^a	97 ^a	89 ^a	92 ^a	93 ^{ab}
See specialists: “How many different specialists, if any, have you seen in the past 12 months?”						
0	31 ^a	20 ^{ab}	13 ^{ab}	45 ^a	36 ^{ab}	32 ^{ab}
1	26	24 ^a	23 ^a	24	30 ^a	29 ^a
2+	44 ^a	55 ^{ab}	64 ^{ab}	31 ^a	34 ^a	39 ^{ab}

Note: “Lower income” refers to respondents with household incomes of less than \$50,000 per year, “middle income” refers to respondents with household incomes between \$50,000 and \$79,999, and “higher income” refers to respondents with household incomes of \$80,000 or more. Totals may not sum to 100 percent because of rounding and because the table excludes the following responses: “Don’t know” and “Refused.” Sample consists of approximately 5,000 Medicare beneficiaries and 5,000 privately insured people, but sample sizes for particular questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage.

^aStatistically significant difference between Medicare beneficiaries and the privately insured within the same income category (at a 95 percent confidence level).

^bStatistically significant difference between lower-income respondents and middle- or higher-income respondents within the same insurance group (at a 95 percent confidence level).

Source: MedPAC’s access-to-care survey conducted in summer 2023.

**TABLE
4A-3**

Few statistically significant differences in White, Black, and Hispanic Medicare beneficiaries' survey responses in 2023

Survey question	Medicare beneficiaries (ages 65 and older)			Privately insured (ages 50–64)		
	White	Black	Hispanic	White	Black	Hispanic
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, “How often did you have to wait longer than you wanted to get a doctor’s appointment?”						
For routine care						
Never	49% ^a	56%	49% ^a	37% ^a	52% ^b	30% ^a
Sometimes	39	36	36	40	35	44
Usually	9 ^a	5	10	15 ^a	8 ^b	14
Always	4 ^a	2	5 ^a	8 ^a	5	12 ^a
For illness or injury						
Never	66 ^a	70	57	55 ^a	68 ^b	47
Sometimes	26 ^a	24	33	31 ^a	23	33
Usually	6 ^a	4	8	10 ^a	5	12
Always	2 ^a	1	2 ^a	5 ^a	3	8 ^a
Not accessing a doctor for medical problems: “During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?”						
Yes	19 ^a	18	23	26 ^a	19	33
Received any health care: “Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?”						
Yes	95 ^a	92 ^b	86 ^b	91 ^a	92	85 ^b
Availability of providers who accept your insurance: Among those who received health care in the past 12 months, “How satisfied or dissatisfied have you been with your ability to find health care providers that accept Medicare/your insurance?”						
Satisfied (“very” or “somewhat”)	96 ^a	94	96 ^a	91 ^a	93	87 ^{ab}
Availability of timely appointments: Among those who received health care in the past 12 months, “How satisfied or dissatisfied have you been with your ability to find health care providers that have appointments when you need them?”						
Satisfied (“very” or “somewhat”)	87 ^a	89	87 ^a	76 ^a	83 ^b	74 ^a
Have a primary care provider: “A primary care provider is the doctor you see in an office or a clinic for routine medical care, medical check-ups, or when you first experience a medical problem. Do you have a primary care provider that you go to for this type of care?”						
Yes	96 ^a	97	96 ^a	92 ^a	94	89 ^a
See specialists: “How many different specialists, if any, have you seen in the past 12 months?”						
0	20 ^a	33 ^b	37 ^b	34 ^a	42 ^b	37
1	25	23	28	28	27	35
2+	55 ^a	44 ^{ab}	35 ^b	39 ^a	31 ^a	28 ^b

Note: “White” refers to non-Hispanic White respondents, “Black” refers to non-Hispanic Black respondents, and “Hispanic” refers to Hispanic respondents of any race. Totals may not sum to 100 percent because of rounding and because the table excludes the following responses: “Don’t know” and “Refused.” Sample consists of approximately 5,000 Medicare beneficiaries and 5,000 privately insured people, but sample sizes for particular questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage. Questions about looking for a new provider and problems finding a new provider are no longer shown in this table due to small cell sizes.

^aStatistically significant difference between Medicare beneficiaries and the privately insured within the same race/ethnicity category (at a 95 percent confidence level).

^bStatistically significant difference between White and Black or Hispanic respondents within the same insurance group (at a 95 percent confidence level).

Source: MedPAC’s access-to-care survey conducted in summer 2023.

**TABLE
4A-4**

Few statistically significant differences between urban and rural Medicare beneficiaries' survey responses in 2023

Survey question	Medicare beneficiaries (ages 65 and older)		Privately insured (ages 50–64)	
	Urban	Rural	Urban	Rural
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, “How often did you have to wait longer than you wanted to get a doctor’s appointment?”				
For routine care				
Never	47% ^{ab}	56% ^{ab}	36% ^{ab}	45% ^{ab}
Sometimes	40	34	40	38
Usually	9 ^a	7	15 ^a	11
Always	4 ^a	3	9 ^a	7
For illness or injury				
Never	65 ^a	66	54 ^a	60
Sometimes	27 ^a	27	31 ^a	29
Usually	6 ^a	5	10 ^a	7
Always	2 ^a	2	5 ^a	4
Not accessing a doctor for medical problems: “During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?”				
Yes	20 ^a	20	27 ^a	27
Looking for a new provider: “In the past 12 months, have you tried to get a new...?” (Share answering “Yes”)				
Primary care provider	12 ^a	12	16 ^{ab}	10 ^b
Specialist	34 ^b	23 ^b	34 ^b	27 ^b
Problems getting a new provider: Among those who tried to get an appointment with a new primary care provider or specialist in the past 12 months, “How much of a problem was it finding a primary care provider/specialist who would treat you?”				
Primary care provider				
No problem	45 ^a	44	33 ^a	28
Share of total geographic group with this insurance	5	5	5	3
Small problem	33	27	35	38
Share of total geographic group with this insurance	4	3	5	4
Big problem	22 ^a	30	32 ^a	34
Share of total geographic group with this insurance	3 ^a	3	5 ^a	3
Specialist				
No problem	66 ^a	55	54 ^a	50
Share of total geographic group with this insurance	22 ^{ab}	12 ^b	18 ^a	13
Small problem	21 ^{ab}	33 ^b	28 ^a	27
Share of total geographic group with this insurance	7 ^a	7	10 ^a	7
Big problem	13	12	18	22
Share of total geographic group with this insurance	4	3	6	6

Note: “Urban” respondents reside in an urban or suburban part of a metropolitan statistical area (MSA); the Census Bureau defines MSAs as having at least one urbanized area with a population of 50,000 or more and including adjacent territory that has a high degree of social and economic integration as measured by commuting ties. “Rural” respondents reside outside of an MSA. Totals may not sum to 100 percent because of rounding and because the table excludes the following responses: “Don’t know” and “Refused.” Sample consists of approximately 5,000 Medicare beneficiaries and 5,000 privately insured people, but sample sizes for particular questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage.

^aStatistically significant difference between Medicare beneficiaries and the privately insured within the same area type (at a 95 percent confidence level).

^bStatistically significant difference between urban and rural respondents within the same insurance category (at a 95 percent confidence level).

Source: MedPAC’s access-to-care survey conducted in the summer of 2023.

Endnotes

- 1 For further information, see the Commission's *Payment Basics: Physician and Other Health Professional Payment System* at https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_Physician_FINAL_SEC.pdf.
- 2 Although most clinician services are paid under the physician fee schedule, some are paid under the payment systems for federally qualified health centers and rural health clinics.
- 3 Our survey is fielded among a sample drawn from the Gallup Panel. The Gallup Panel is a probability-based panel generated via random-digit-dial or address-based sampling. Approximately 8 percent of people invited to join the Gallup Panel do so. When they join, they specify which language they would like to receive surveys in and through what mode they would like to receive surveys. Our survey was fielded via web or mail and in English or Spanish, depending on panelists' preferences. We paid most respondents a \$5 incentive to complete the survey. We oversampled Black and Hispanic respondents. Among eligible individuals invited to complete our survey, 50 percent completed it. Questions asked of all Medicare beneficiaries ages 65 and over ($n = 4,991$) have a margin of error of ± 1.7 percentage points at the 95 percent confidence level, and questions asked of all privately insured people ages 50 to 64 ($n = 5,527$) have a margin of error of ± 1.9 percent.
- 4 We annually conduct focus groups with beneficiaries and clinicians in different parts of the country to provide more qualitative descriptions of beneficiary and clinician experiences with the Medicare program. During these discussions, we hear from beneficiaries and providers about variation in experiences accessing care. In summer 2023, we conducted four focus groups with Medicare beneficiaries in each of three urban markets. Two of the groups in each market were composed of beneficiaries dually eligible for Medicare and Medicaid. We also conducted three virtual focus groups with beneficiaries residing in rural areas. In addition, we conducted three focus groups with clinicians in each of the three urban markets: primary care physicians, specialist physicians, and primary care nurse practitioners and physician assistants.
- 5 By design, some of the questions in the Commission's survey ask for respondents' subjective assessments of the degree to which their care needs were met, rather than for data that may be difficult to recall. For example, respondents use their own judgment when determining whether they are able to schedule timely appointments. Subjective responses can be useful measures for tracking beneficiary experience and perceptions, particularly over time.
- 6 Compared with beneficiaries with higher incomes, those with lower incomes are less likely to have had access to employer-sponsored health insurance prior to joining Medicare (Bureau of Labor Statistics 2023a). Instead, lower-income beneficiaries are more likely to have been uninsured prior to joining Medicare or covered through Medicaid or a Marketplace plan, both of which often have narrower provider networks than employer-sponsored insurance (Graves et al. 2020, Kaiser Family Foundation 2022, Schappert and Santo 2023). As a result, lower-income beneficiaries may have previously had fewer options when searching for a clinician who could see them promptly and thus may be more accustomed to long waits for appointments.
- 7 Multiple-race individuals are included in our definition of "Hispanic" this year; last year, such individuals were inadvertently excluded from our "Hispanic" group.
- 8 A substantial number of clinicians billed for 15 or fewer beneficiaries in a given year, but they accounted for a small share of services and allowed charges. For example, in 2022, about 19 percent of clinicians who billed the fee schedule billed for 15 or fewer beneficiaries, but these clinicians billed for less than 1 percent of total allowed charges. Further, we note that this threshold does not account for whether clinicians are practicing on a full- or part-time basis.
- 9 We used the number of total Part B beneficiaries, including those in FFS Medicare and MA, to calculate the ratio of physicians and other health professionals per 1,000 beneficiaries because we assume that clinicians generally furnish services to beneficiaries covered under both programs.
- 10 The decline in clinicians per beneficiary during the pandemic largely reflects clinicians who temporarily or permanently stopped furnishing care and a reduction in the number of beneficiaries seeking care, which resulted in fewer clinicians meeting the threshold of treating more than 15 beneficiaries.
- 11 APRNs include clinical nurse specialists, nurse practitioners, certified registered nurse anesthetists, and certified nurse midwives.
- 12 Clinicians who opted out of Medicare were concentrated in the specialties of behavioral health (43 percent), oral health (27 percent), and primary care (12 percent) (Centers for Medicare & Medicaid Services 2023c).

- 13 Specifically, we define an “encounter” as a unique combination of beneficiary identification number, claim identification number (for paid claims), and national provider identifier of the clinician who billed for the service.
- 14 This number is based on our count of beneficiaries who had at least one encounter recorded in claims data and the total number of FFS Medicare beneficiaries enrolled in Part B from the 2023 Medicare Trustees’ report.
- 15 Practitioners can submit claims under more than one specialty. For those practitioners, we use the specialty associated with the plurality of allowed charges billed to the physician fee schedule.
- 16 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.
- 17 The roughly 3,400 Dartmouth-defined HSAs are a collection of ZIP codes whose residents are hospitalized chiefly in that area’s hospitals.
- 18 Payment rates for a service can also change because of adjustments to the relative value units for that service.
- 19 MACRA also specified two types of additional payments for clinicians: (1) an annual bonus for clinicians with a sufficient share of patients or payments in A-APMs and, (2) for clinicians not participating in A-APMs, payment adjustments through the Merit-based Incentive Payment System (MIPS), which can be positive or negative depending on a clinician’s performance on measures of quality, cost, participation in clinical improvement activities, and use of health information technology such as an electronic health records. Beginning in 2026, the A-APM bonus will no longer be available, but MIPS payment adjustments will continue for clinicians not participating in A-APMs. In 2023, about 227,000 clinicians (roughly 17 percent of participating providers) received MACRA’s A-APM participation bonus (Centers for Medicare & Medicaid Services 2023a). Another 600,000 clinicians received a positive MIPS adjustment, worth up to 2.34 percent (slightly higher than in past years) (Centers for Medicare & Medicaid Services 2023d). About 23,000 clinicians received a negative MIPS adjustment to their payment rates, up to -9 percent (Centers for Medicare & Medicaid Services 2023d). Another 74,000 clinicians received a neutral (0 percent) MIPS adjustment because their MIPS score was the same as the MIPS performance threshold. We estimate that over 460,000 clinicians were ineligible for A-APM bonuses or MIPS adjustments (e.g., because they saw a low volume of Medicare beneficiaries).
- 20 The right graph of Figure 4-1 (p. 106) captures a budget-neutrality adjustment made to the conversion factor in 2024 to account for the cost of the new add-on code (G2211). The left graph of Figure 4-1 does not show the add-on code (G2211), which adds \$16.05 to the payment rate for certain visits with new or established patients when a clinician serves as the continuing focal point for all needed health care services and/or provides ongoing care related to a patient’s single, serious condition or a complex condition.
- 21 Allowed charges are a function of the physician fee schedule’s relative value units and conversion factor plus other payment adjustments, such as those determined by geographic practice cost indexes.
- 22 We are excluding data from 2020 and 2021 because volume (and allowed charges) declined sharply in 2020 due to delayed or forgone care during the pandemic and then increased almost as sharply in 2021. Given the anomalous nature of those two years, we do not believe they are representative of long-term trends in practice patterns.
- 23 The private insurer’s payments reflect the insurer’s allowed amount (including allowed cost sharing). The data exclude any remaining balance billing and payments made outside of the claims process, such as bonuses or risk-sharing payments. Only services paid under Medicare’s physician fee schedule were included, and anesthesia services were excluded. Data do not include Medicare Advantage claims.
- 24 We conclude that the narrowing of the overall difference between Medicare and private-payer rates from 2020 to 2021 was likely due to E&M payment changes because, over that period, the ratio of Medicare to private-payer rates for E&M office/outpatient visits fell from 127 percent to 114 percent.
- 25 The SullivanCotter compensation data are limited in that a majority of the provider organizations that contributed compensation data for this survey are affiliated with a hospital or health system.
- 26 The growth rates reported in this statement were calculated using a sample restricted to staff clinicians who were in SullivanCotter’s sample in both 2021 and 2022.
- 27 The dollar amounts reported in this statement were calculated using all staff clinicians in SullivanCotter’s 2022 sample.
- 28 Average annual growth rates from 2018 to 2022 were calculated using consistent cohorts of staff physicians and staff advanced practice providers who were in SullivanCotter’s samples in 2018, 2019, and 2022.
- 29 The index’s cost categories (e.g., physician compensation, medical equipment) and cost weights (each category’s share of total costs) were previously based on physicians’ expense

data from 2006. However, CMS recently updated the MEI's cost categories and cost weights using data on physician offices from 2017 gathered from the Census Bureau's Services Annual Survey, along with data from other sources (Centers for Medicare & Medicaid Services 2022).

- 30 MEI growth data included in this chapter differ from those published in physician fee schedule rules because of methodological differences. MEI growth data included in this chapter reflect the MEI growth that occurred or is projected to occur in a given year. In contrast, MEI growth data in fee schedule rules reflect the most recently available actual historical data at the time of publication. For example, the 2024 MEI growth figure published in the fee schedule final rule uses data from the second quarter of 2023. Thus, the MEI measures published in fee schedule rules represent lagged measures of input cost growth.
- 31 MEI growth projections in this chapter are as of the third quarter of 2023 and are subject to change.
- 32 We do not calculate profit margins for clinicians (as we do for other types of providers who bill Medicare) because clinicians do not submit cost reports to CMS.
- 33 The Commission's definition of low-income Medicare beneficiaries includes all beneficiaries who receive full or partial Medicaid benefits and beneficiaries who do not qualify for Medicaid benefits in their states but receive the Part D low-income subsidy (LIS) because they have limited assets and an income below 150 percent of the federal poverty level. Collectively, we refer to this population as "LIS beneficiaries" because nearly all Medicare beneficiaries who receive full or partial Medicaid benefits are also automatically eligible to receive the LIS. About 19 percent of Medicare FFS beneficiaries with Part B coverage are LIS beneficiaries, but they account for roughly 25 percent of all allowed charges billed under the physician fee schedule.
- 34 These policies are referred to as "lesser-of" policies because state Medicaid programs pay the lesser of (1) Medicare's cost-sharing amount or (2) the difference between the state Medicaid fee schedule and the Medicare program's payment for a service.

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C H A P T E R

5

Outpatient dialysis services

R E C O M M E N D A T I O N

- 5** For calendar year 2025, the Congress should update the 2024 Medicare end-stage renal disease prospective payment system base rate by the amount determined under current law.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Outpatient dialysis services

Chapter summary

Outpatient dialysis services are used to treat most individuals with end-stage renal disease (ESRD). In 2022, about 290,000 beneficiaries with ESRD on dialysis were covered under fee-for-service (FFS) Medicare and received dialysis from more than 7,800 dialysis facilities. In 2022, FFS Medicare expenditures for outpatient dialysis services totaled \$8.8 billion.

Assessment of payment adequacy

Our payment adequacy indicators for outpatient dialysis services are generally positive, including beneficiaries' access to care, the supply and capacity of providers, volume of services, and access to capital. The 2022 aggregate FFS Medicare margin was below zero due to the growth of providers' cost per treatment, particularly labor and capital costs, which outpaced the growth in the ESRD prospective payment system (PPS) payment per treatment.

Beneficiaries' access to care—Measures of the capacity and supply of providers, beneficiaries' ability to obtain care, and changes in the volume of services suggest that access to dialysis services remains adequate.

- **Capacity and supply of providers**—The capacity of dialysis facilities appears to exceed demand. Between 2021 and 2022, the number of in-center treatment stations was steady while the number of Medicare

In this chapter

- Are FFS Medicare payments adequate in 2024?
- How should FFS Medicare payments change in 2025?

beneficiaries on dialysis (in both FFS Medicare and Medicare Advantage (MA)) declined (which is partly linked to the excess mortality experienced by ESRD patients during the coronavirus pandemic), and the share of total treatments furnished by freestanding dialysis facilities in the home continued to increase.

- **Volume of services**—The 14 percent decline in FFS treatments provided in 2022 is largely due to the shift of beneficiaries on dialysis from FFS Medicare to MA, following the removal of a statutory provision that had prevented most dialysis beneficiaries from enrolling in MA plans. Between January 2021 and December 2022, the share of dialysis beneficiaries enrolled in FFS Medicare fell from 64 percent to 53 percent. At the same time, the per treatment use of ESRD drugs in the payment bundle (particularly erythropoiesis-stimulating agents used in anemia management) has continued to decline since 2010.
- **FFS Medicare marginal profit**—An estimated 18 percent marginal profit in 2022 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, emergency department use, and mortality held relatively steady between 2021 and 2022. 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. Under the ESRD PPS, the two largest dialysis organizations have grown through acquisitions of and mergers with midsize dialysis organizations.

FFS Medicare payments and providers' costs—Between 2021 and 2022, FFS Medicare payment per treatment in freestanding dialysis facilities (which provide the vast majority of FFS dialysis treatments) grew by 2 percent while cost per treatment rose by 6 percent. The increase in the cost per treatment is attributable to the growth in labor and capital costs in this period, which was substantially higher compared with these categories' historical cost growth. Consequently, the aggregate FFS Medicare margin fell from 2.3 percent in 2021 to -1.1 percent in 2022. We project a 2024 aggregate FFS Medicare margin of 0 percent.

How should FFS Medicare payments change in 2025?

Under current law, the FFS Medicare base payment rate for dialysis services is projected to increase by 1.8 percent in 2025. Given that our indicators of payment adequacy are generally positive, the recommendation is that, for calendar year 2025, the Congress update the 2024 ESRD PPS base payment rate by the amount determined under current law. ■

Dialysis treatment choices

Dialysis replaces the filtering function of the kidneys when they fail. The two types of dialysis—hemodialysis and peritoneal dialysis (PD)—remove waste products from the bloodstream differently. Most dialysis patients travel to a treatment facility to undergo hemodialysis three times per week, although patients can also undergo hemodialysis at home. Hemodialysis uses an artificial membrane encased in a dialyzer to filter the patient's blood. By contrast, PD, the most common form of home dialysis, uses the lining of the abdomen (peritoneum) as a filter to clear wastes and extra fluid and is usually performed independently in the patient's home or workplace five to seven days a week.

Each dialysis method has advantages and drawbacks; no one method is best for everyone. People choose a particular dialysis method for many reasons, including quality of life, patients' awareness of different treatment methods and personal preferences, and physician training and recommendations. Some patients switch methods when their conditions or needs change. Although most patients still undergo in-center dialysis, home dialysis remains a viable option for many patients because of such advantages as increased patient satisfaction, better health-related quality of life, and fewer transportation challenges compared with in-center dialysis. ■

Background

End-stage renal disease (ESRD) is the last stage of chronic kidney disease (CKD) and is characterized by permanent, irreversible kidney failure. Patients with ESRD include those who are treated with dialysis—a process that removes wastes and fluid from the body—and those who have a functioning kidney transplant. Because of the limited number of kidneys available for transplantation and the variation in patients' suitability for transplantation, about 70 percent of ESRD patients undergo maintenance dialysis (see text box on dialysis treatment choices). Patients receive additional items and services related to their dialysis treatments, including ESRD drugs and biologics to treat conditions such as anemia and bone disease resulting from the loss of kidney function.

In 2022, about 290,000 ESRD beneficiaries on dialysis were covered under fee-for-service (FFS) Medicare, while roughly 240,000 ESRD beneficiaries on dialysis were enrolled in Medicare Advantage (MA). About 7,865 dialysis facilities provided outpatient dialysis services to FFS beneficiaries on dialysis. The dialysis

sector is highly consolidated, with two large dialysis organizations (LDOs)—Fresenius Medical Care and DaVita—dominating the industry. In 2022, these LDOs accounted for three-quarters of facilities and Medicare FFS treatments. Moreover, in 2022, the five largest dialysis organizations accounted for roughly 85 percent of facilities and Medicare FFS treatments.

Since 2011, FFS Medicare has been paying facilities using a prospective payment system (PPS) bundle that includes ESRD drugs (for which facilities previously received separate payments) and services (for which other Medicare providers, such as clinical laboratories, previously received separate payments).^{1,2,3} In 2022, spending for outpatient dialysis services under the ESRD PPS was \$8.8 billion. This total includes nearly \$4.7 million in add-on payments associated with a new ESRD drug (Korsuva) and a new type of ESRD home hemodialysis equipment (Tablo Hemodialysis System). Additionally, in 2021 (the most recent data available), Part D spending for ESRD oral-only drugs that have not yet been included in the PPS—several phosphate binders—totaled \$0.8 billion for FFS beneficiaries on dialysis.

**TABLE
5-1****FFS beneficiaries on dialysis are disproportionately young, male, and Black compared with other Medicare FFS beneficiaries, 2022****Share of FFS beneficiaries:**

	Dialysis beneficiaries	Other beneficiaries
Age		
Under 45 years	10%	3%
45–64 years	34	8
65–74 years	29	50
75–84 years	20	28
85+ years	7	10
Sex		
Male	57	47
Female	43	53
Race/ethnicity		
White	48	81
Black	31	8
Hispanic	8	3
Asian	5	3
All others	8	5
Residence, by type of county		
Urban	84	80
Micropolitan	9	11
Rural, adjacent to urban	5	5
Rural, not adjacent to urban	2	3
Frontier	1	1

Note: FFS (fee-for-service). “Other beneficiaries” excludes beneficiaries on dialysis and those who have received a kidney transplant. “Residence” reflects the beneficiary’s county of residence in one of four categories (urban, micropolitan, rural adjacent to urban, and rural nonadjacent to urban) based on an aggregation of the Urban Influence Codes. Frontier counties have six or fewer people per square mile. Totals may not sum to 100 percent due to rounding.

Source: Data compiled by MedPAC from enrollment data and claims submitted by dialysis facilities to CMS.

Characteristics of fee-for-service beneficiaries on dialysis, 2022

Compared with other Medicare FFS beneficiaries, FFS beneficiaries on dialysis are disproportionately younger, male, and Black (Table 5-1). In 2022, 73 percent of FFS dialysis beneficiaries were under 75 years old (with 44 percent under 65 years old), 57 percent were male, and 31 percent were Black. By comparison, among other FFS Medicare beneficiaries, 61 percent

were under 75 years old (with 11 percent under 65 years old), 47 percent were male, and 8 percent were Black. A greater share of dialysis beneficiaries resided in urban areas compared with other FFS beneficiaries (84 percent vs. 80 percent).

FFS beneficiaries on dialysis are more likely to have full Medicaid benefits than all other FFS beneficiaries (39 percent vs. 13 percent). FFS Part D enrollees on dialysis

are more likely to receive the low-income subsidy than all other FFS Part D enrollees (65 percent vs. 26 percent). In addition, in 2021, FFS dialysis beneficiaries were less likely to have coverage from other sources, such as Medigap and employer-sponsored health plans (35 percent vs. 62 percent) and as likely to have no supplemental coverage (about 24 percent for each group in 2021).

Over the last decade, the adjusted rate of new ESRD cases, or incidence rate (which includes patients of all types of health coverage who initiate dialysis or receive a kidney transplant), has declined. Between 2011 and 2021 (the most recent year of data available), the adjusted incidence rate decreased by 1 percent per year, from 393 per million people to 366 per million people (United States Renal Data System 2023). This decline may be attributable to factors including better management of ESRD-related comorbidities but also to the excess mortality during the coronavirus pandemic. We estimate that about 66,000 FFS beneficiaries began dialysis in 2022 (a decline of nearly 7 percent compared with 2021).

Medicare pays for dialysis services under the ESRD PPS

To treat ESRD, dialysis beneficiaries receive care from two principal providers: (1) the clinicians (typically nephrologists) who prescribe and manage the provision of dialysis and establish the beneficiary's plan of care and (2) facilities that provide dialysis treatments in a dialysis center or support and supervise the care of beneficiaries on home dialysis.⁴ While our work in this report focuses on Medicare's payments to facilities, it is important to recognize that facilities and clinicians collaborate to care for dialysis beneficiaries. Indeed, many dialysis facilities are operated as joint ventures between dialysis organizations and physicians. Joint ventures allow participating partners to share in the management of dialysis facilities and in their profits and losses. Both the LDOs and midsize provider groups, including American Renal Associates and U.S. Renal Care, have established joint ventures with physicians.⁵

Medicare pays dialysis facilities for services provided to FFS beneficiaries under the ESRD PPS. Facilities are paid for a bundle of services provided during a single dialysis treatment, including ESRD drugs, laboratory tests, and other ESRD items and services.⁶ For adult

dialysis beneficiaries, the base payment rate does not differ by type of dialysis—in-center dialysis versus home dialysis—but rather by patient characteristics (age, body measurement characteristics, onset of dialysis, and selected acute and chronic comorbidities) and facility factors (low treatment volume, rural location, and local input prices).⁷ Medicare pays facilities furnishing dialysis treatments in the facility or in a patient's home for up to three treatments per week, unless the additional dialysis treatments are reasonable and necessary and there is documented medical justification for more than three weekly treatments.

Under the ESRD PPS, Medicare also makes separate add-on payments in certain circumstances for new drugs, devices, and equipment.⁸ CMS used a transitional drug add-on payment adjustment (TDAPA) to pay for new injectable calcimimetics from 2018 through 2020; in 2021, these drugs were included in the ESRD PPS's payment bundle. Currently, CMS pays a TDAPA for Korsuva (an antipruritic) through March 31, 2024, and for Jesduvroq (used to treat anemia) through September 2025.⁹ CMS will apply a post-TDAPA payment for Korsuva beginning April 1, 2024, for three years. In 2022 and 2023, CMS used a transitional payment adjustment for new and innovative equipment and supplies (TPNIES) for the Tablo Hemodialysis System.¹⁰ Unlike for ESRD drugs, a substantial clinical improvement standard is used to determine eligibility for a TPNIES add-on.¹¹

Are FFS Medicare payments adequate in 2024?

To address whether payments for 2024 are adequate to cover the costs to efficiently provide care and determine how much providers' costs are likely to change in the update year (2025), we examine several indicators of payment adequacy. We assess beneficiaries' access to care by examining the capacity of dialysis facilities and changes over time in the volume of services provided. We also examine quality of care, providers' access to capital, and the relationship between Medicare's payments and facilities' costs. Most of our payment adequacy indicators for outpatient dialysis services are positive.

However, the aggregate FFS Medicare margin fell from 2.3 percent in 2021 to -1.1 percent in 2022 because cost growth (particularly for labor and capital services) outpaced payment growth. We project a 2024 FFS Medicare margin of 0 percent.

Beneficiaries' access to care: Indicators continue to be positive

Our analysis of access indicators—including the capacity of providers to meet beneficiary demand, changes in the volume of services, and the marginal profitability of treating FFS Medicare dialysis beneficiaries under the PPS—shows that beneficiaries' access to care remains generally favorable.

Capacity has exceeded demand from dialysis patients across all insurance types

In 2022, there were 7,865 dialysis facilities nationwide. FFS Medicare accounted for 41 percent of all treatments furnished by providers.¹² Growth in the number of dialysis facilities and in-center treatment stations alongside growth in the number of dialysis beneficiaries suggests that, between 2018 and 2021, provider capacity exceeded FFS beneficiaries' demand for care. During that period, the number of facilities and their capacity to provide care—as measured by dialysis treatment stations—each grew by 2 percent annually (Table 5-2), compared with a 6 percent decline in the annual growth of the number of FFS dialysis beneficiaries (data not shown). In-center capacity during the period also exceeded demand from all dialysis patients, across all insurance types, not just FFS beneficiaries, as the number of dialysis patients of all types of health coverage grew 0.2 percent per year (data not shown) (United States Renal Data System 2023).

The number of facilities' in-center treatment stations grew more slowly between 2021 and 2022 compared with the annual growth from 2018 through 2021 (0.1 percent per year vs. 2 percent per year) but exceeded growth in the number of dialysis FFS or MA beneficiaries (which declined by 1 percent between 2021 and 2022). The slower growth of in-center capacity and the number of facilities from 2021 to 2022 compared with 2018 through 2021 may be attributable to factors including the following:

- The excess mortality among ESRD patients during the coronavirus pandemic and the decline

(by 1 percent per year) in the incidence of ESRD during the past decade.

- The decline in total treatments (across all payers) and in-center treatments furnished by freestanding dialysis facilities. Between 2020 and 2022, total treatments declined by 1 percent per year and total in-center treatments declined by 2 percent per year.
- The increase in the use of home dialysis. Researchers have shown that the implementation of the ESRD PPS was associated with an increase in home dialysis use among patients starting dialysis (Lin et al. 2017).
- Recent facility closures by the two LDOs that together account for three-quarters of all treatments furnished in the U.S. The closures aim to optimize their facilities' capacity utilization that has been impacted by, for example, the increasing use of home dialysis and a decline in their patient census in some markets (DaVita 2022b). Both LDOs reported that most patients treated at a facility that closes receive care at another of the chain's clinics.
- The financial incentives associated with the Center for Medicare & Medicaid Innovation's (CMMI's) mandatory ESRD Treatment Choices (ETC) Model. This model rewards dialysis facilities and clinicians who are part of the model for increasing home dialysis use and kidney transplantation among adult dialysis beneficiaries and penalizes facilities and clinicians who do not.¹³

Our analysis of claims and enrollment data suggests that beneficiaries affected by facility closures between 2021 and 2022 obtained care elsewhere.

Based on data from Medicare claims, freestanding dialysis cost reports, and CMS's Dialysis Facility Compare database, 53 percent of facilities offered home dialysis in 2022, up from 50 percent in 2014. Among facilities that offered home dialysis, the share of total treatments furnished in the home rose from an average of 24 percent in 2014 to 30 percent in 2022.

For-profit, freestanding facilities provide most dialysis treatments: In 2022, freestanding facilities furnished 96 percent of FFS treatments, and for-profit facilities furnished 89 percent (Table 5-2). Between 2021 and 2022, capacity at freestanding and for-profit

**TABLE
5-2**

Increase in the number and capacity of freestanding and for-profit dialysis organizations but low growth between 2021 and 2022

	2022				Average annual percent change			
	Total number of FFS treatments	Total number of facilities	Total number of stations	Mean number of stations	Number of facilities		Number of stations	
					2018–2021	2021–2022	2018–2021	2021–2022
All	30.7 million	7,865	138,100	18	2%	–0.2%	2%	0.1%
Share of total								
Freestanding	96%	95%	96%	18	2	0.1	2	0.3
Hospital based	4	5	4	14	–1	–5	–2	–5
Urban	86	84	87	18	2	0.1	2	0.4
Micropolitan	10	10	9	16	0.3	0	0.2	–0.1
Rural, adjacent to urban	3	4	3	14	–0.3	–2	0.2	–2
Rural, not adjacent to urban	1	2	1	12	–2	–2	–0.2	–2
Frontier	0.3	0.4	0.2	10	0	0	0.2	–1
For profit	89	89	90	18	2	0.2	2	1
Nonprofit	11	11	10	17	–1	–2	–0.4	–2
Two largest dialysis organizations	75	75	76	18	2	–0.2	2	–0.2
All others	25	25	24	17	1	0.4	0.3	2

Note: FFS (fee-for-service). Provider location reflects the county in which the provider is located, by county type (urban, micropolitan, rural adjacent to urban, and rural nonadjacent to urban), based on an aggregation of the Urban Influence Codes. Frontier counties have six or fewer people per square mile. Totals may not sum to 100 percent due to rounding.

Source: Data compiled by MedPAC from the Dialysis Compare database from CMS and claims submitted by dialysis facilities to CMS.

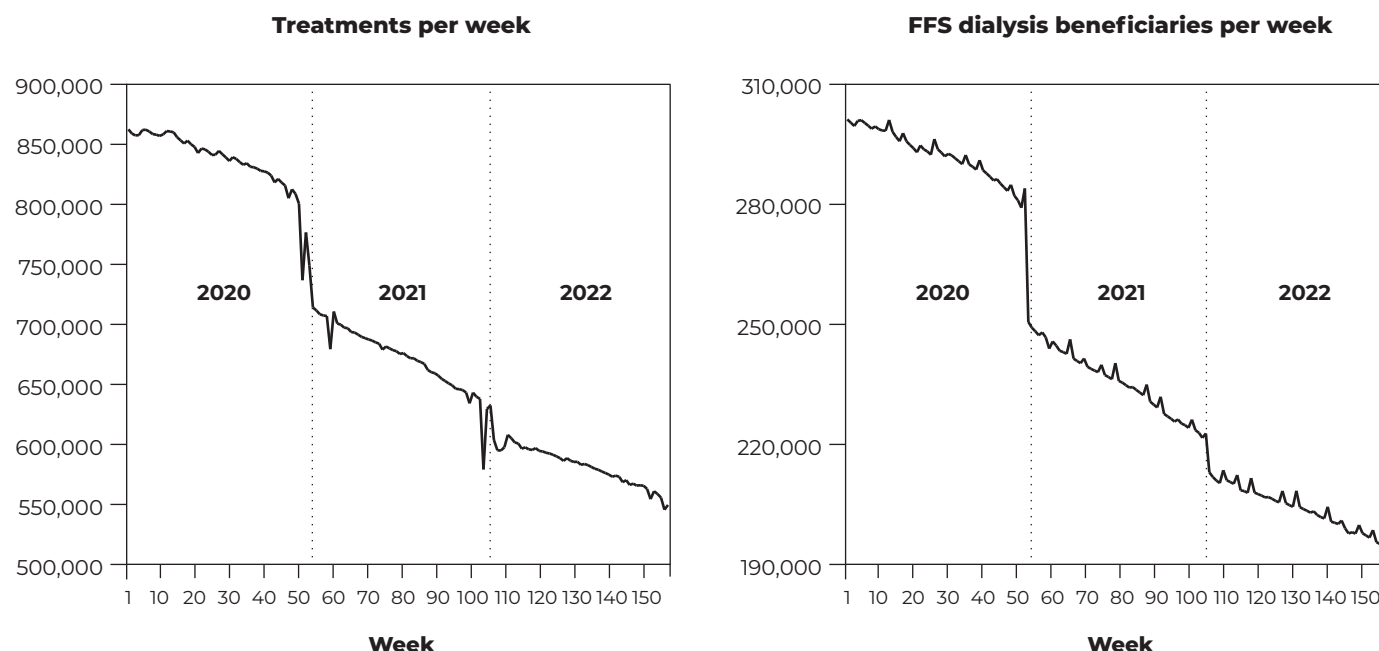
facilities grew by 0.3 percent and roughly 1 percent, respectively, while capacity at hospital-based facilities fell by 5 percent, and capacity at nonprofit facilities fell by 2 percent.

The capacity of facilities in urban and rural areas in 2022 was generally consistent with where FFS beneficiaries on dialysis lived: 86 percent of FFS treatments were provided in urban areas and 87 percent of dialysis stations were located in urban areas. Between 2021 and 2022, capacity at urban

facilities grew by 0.4 percent, while capacity at all rural facilities declined by 0.7 percent (data not shown). In June 2020, the Commission recommended that the Secretary replace the current low-volume payment adjustment and rural adjustment with a single payment adjustment—a low-volume and isolated (LVI) adjustment—to better protect isolated, low-volume dialysis facilities that are critical to ensuring beneficiary access. The Commission found that the facilities that would receive the LVI adjustment would be more appropriately targeted

**FIGURE
5-1**

Between 2020 and 2022, weekly number of FFS beneficiaries on dialysis and dialysis treatments declined



Note: FFS (fee-for-service). The decline between 2020 and 2021 in the weekly number of FFS beneficiaries and treatments is largely attributable to the coronavirus pandemic, which slowed the initiation of dialysis by new patients and caused excess mortality among beneficiaries with end-stage renal disease (ESRD). The decline since 2021 is largely attributable to enactment of the 21st Century Cures Act, which permitted beneficiaries with ESRD to enroll in Medicare Advantage plans starting in 2021. The variation in the weekly number of beneficiaries and treatments may be linked to seasonal factors.

Source: MedPAC analysis of claims submitted by dialysis facilities to CMS.

compared with current policy (Medicare Payment Advisory Commission 2020).

Dialysis marginal profitability suggests that financial incentive to serve Medicare beneficiaries remains

Another measure of access is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. In considering whether to treat a patient, a provider with excess capacity compares the revenue it will receive (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider has a financial incentive to increase its volume of Medicare beneficiaries if it has the capacity

to do so. In contrast, if payments do not cover the marginal costs, the provider could have a disincentive to care for Medicare beneficiaries.¹⁴

Medicare payments in 2022 exceeded dialysis facilities' marginal costs by 18 percent, a positive indicator of patient access in that facilities with available capacity have a financial incentive to treat Medicare beneficiaries.

Decline in the volume of FFS dialysis treatments reflects shift of beneficiaries on dialysis to Medicare Advantage

In 2020, the coronavirus pandemic slowed the initiation of dialysis by new patients and caused excess mortality

among patients with ESRD. As a result, the number of FFS beneficiaries on dialysis and FFS dialysis treatments provided each declined by 3 percent between 2019 and 2020. The decline in the number of FFS beneficiaries on dialysis and FFS treatments accelerated considerably in 2021 and 2022, after the enactment of the 21st Century Cures Act, which eliminated restrictions on MA enrollment for beneficiaries with ESRD (see text box on share of dialysis beneficiaries enrolled in MA, pp. 142–143).¹⁵ As beneficiaries with ESRD shifted to MA in 2021 and 2022, the number of FFS beneficiaries on dialysis fell 13 percent per year, on average, and the number of FFS treatments fell 14 percent per year. Figure 5-1 shows the effect of both the pandemic and the statutory change on the weekly number of FFS dialysis beneficiaries and treatments. The effect of removing the statutory bar is highlighted by the roughly 8 percent drop in the number of FFS dialysis treatments in December 2020 and January 2021 and the additional 23 percent drop in FFS treatments furnished in January 2021 and December 2022. Some variation in the weekly number of beneficiaries and treatments is also linked to seasonal factors.¹⁶

Overall, in 2022, about 290,000 FFS beneficiaries on dialysis received 30.7 million dialysis treatments. Although FFS beneficiaries and treatments declined between 2021 and 2022, the number of dialysis treatments per beneficiary per week remained steady at 2.9 (data not shown).¹⁷

Use of most ESRD-related drugs has declined, with no sustained negative changes in beneficiaries' outcomes

Under the ESRD payment method used before 2011, certain ESRD-related drugs were paid according to the number of units of the drug administered; in other words, the more units of a drug provided, the higher the Medicare payment. The Congress increased the incentive for dialysis providers to be more judicious in providing ESRD drugs by broadening the payment bundle in 2011 to include ESRD-related drugs that previously were billed separately. We examined changes between 2010 and 2022 (the most current year for which complete data are available) in the use per treatment for the leading ESRD drugs and aggregated them into four therapeutic classes: erythropoiesis-stimulating agents (ESAs), iron agents, bone and

mineral metabolism agents (including vitamin D agents and the two calcimimetics, cinacalcet and etelcalcetide), and other products.¹⁸

As shown in Figure 5-3 (p. 144), most of the decline in the per treatment use of ESRD drugs occurred in the early years after ESRD drugs were included in the bundle. (For Figure 5-3, we estimated per treatment use by multiplying drug units per treatment reported on CMS claims by each drug's 2022 average sales price (ASP) plus 0 percent—i.e., holding price constant.¹⁹) For example, between 2010 and 2011, use per treatment across all therapeutic classes declined by 23 percent. Most of this decrease was due to declining ESA use, which also fell by 23 percent per year during the same period. Some of the decline in ESA use may have stemmed from clinical evidence showing that higher doses of these drugs led to increased risk of morbidity and mortality, which resulted in the Food and Drug Administration changing the ESA label in 2011. Although the ESRD PPS affected use of certain ESRD-related services, particularly the provision of drugs paid under the bundle, CMS has concluded that the agency's claims-based monitoring program has revealed no sustained negative changes in beneficiary health status (Centers for Medicare & Medicaid Services 2019).

Between 2021 and 2022, holding price constant, the use of all ESRD drugs in the four categories declined by 4 percent. This decline is linked to lower use of certain drugs in the ESA and bone and mineral metabolism categories (Table 5-3, p. 145). The Commission has reported a shift over time in the use of ESAs and vitamin D agents (paricalcitol, doxercalciferol, and calcitriol) due to price competition among the products within each category (Medicare Payment Advisory Commission 2022).

Quality of outpatient dialysis care is generally stable or improving for most measures

In 2021 and 2022, FFS dialysis beneficiaries' use of the emergency department (ED) and rates of hospitalization and mortality remained stable. Results of process measures that assess dialysis adequacy and anemia management (hemoglobin levels) and blood transfusion rates remained generally stable. Use of home dialysis and the number of kidney transplants increased during this period.²⁰

Since 2021, the share of beneficiaries on dialysis enrolling in Medicare Advantage plans has accelerated

Historically, Medicare beneficiaries with end-stage renal disease (ESRD) generally had traditional fee-for-service (FFS) coverage because they were prohibited from enrolling in Medicare Advantage (MA) plans. However, beneficiaries who enrolled in a managed care plan before being diagnosed with ESRD could stay in the plan after they were diagnosed. Over time, the share of dialysis beneficiaries enrolled in MA gradually increased. Between 2018 and 2020, the share of dialysis beneficiaries in MA rose from about 23 percent to 27 percent, while the share of dialysis beneficiaries in FFS Medicare fell from about 77 percent to 73 percent (Figure 5-2; FFS data not shown).

Beginning in 2021, the 21st Century Cures Act permits dialysis beneficiaries to enroll in MA plans. As a result of this statutory change, enrollment of dialysis beneficiaries in MA plans increased between December 2020 and January 2021 from 27 percent to 36 percent (Figure 5-2). By December 2022, the share of dialysis beneficiaries enrolled in MA plans was 47 percent.

The increase in MA enrollment by beneficiaries on dialysis since January 2021 is likely linked to the same factors that have increased MA's popularity among non-ESRD beneficiaries, including the availability of extra benefits (e.g., dental, hearing, and vision services) and lower cost-sharing liability. Given the magnitude of total health care expenses incurred by dialysis beneficiaries annually (for dialysis and other outpatient and inpatient services—averaging nearly \$99,000 in 2021, with beneficiary out-of-pocket expenses averaging \$13,400), these beneficiaries face significant out-of-pocket expense. Thus, they might enroll in an MA plan because such plans generally offer reduced cost sharing and are required to offer a maximum out-of-pocket (MOOP) limit on annual spending.²¹ The mandatory MOOP limit was \$8,300 for in-network services in 2023 (and \$12,450 for in- and out-of-network services covered by preferred provider organizations (PPOs)), but most plans can elect to offer a lower MOOP

limit. In 2023, the average MOOP was \$4,835 for in-network services (and \$8,659 for in- and out-of-network services covered by PPOs) (Ochieng et al. 2023). Beneficiaries who have full Medicaid coverage (about 39 percent of Medicare beneficiaries with ESRD compared with 13 percent of other Medicare beneficiaries) have their cost sharing covered by Medicaid but may still enroll in an MA plan for the extra benefits offered.

In addition, some dialysis organizations, including both large dialysis organizations (LDOs) and a midsize dialysis organization (U.S. Renal Care), offer online educational and informational resources about Medicare coverage options under MA. For example, each LDO has partnered with companies (SelectQuote and Chapter) that aim to help ESRD beneficiaries explore their insurance options, including comparing options across MA plans. Each LDO provides online links to these companies on their website. The extent to which new and existing beneficiaries on dialysis are using such services is unknown.

Beneficiaries preferring FFS Medicare may seek to limit cost-sharing liability by purchasing a Medigap policy; however, beneficiaries with ESRD, particularly those under age 65, may face difficulties obtaining Medigap insurance. FFS dialysis beneficiaries are less likely to purchase a Medigap plan than all other FFS beneficiaries (20 percent vs. 40 percent in 2021) because of:

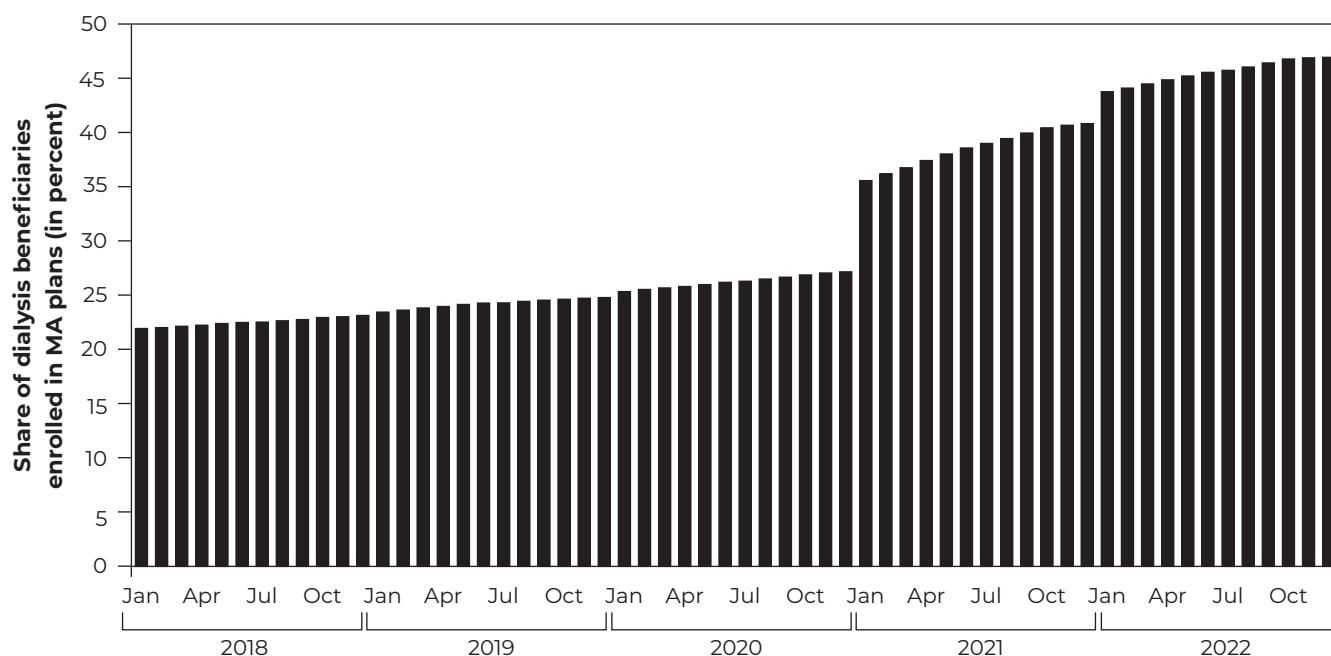
- Constraints in federal guaranteed-issue rights in obtaining these supplemental plans. Medicare beneficiaries have guaranteed-issue rights for Medigap plans—meaning that a plan must be offered regardless of their age, sex, or health status—when they turn 65. However, about half of individuals with ESRD become eligible for Medicare before reaching age 65, and federal guaranteed-issue rights do not extend to those beneficiaries at the time of their initial enrollment in Medicare.²²

(continued next page)

Since 2021, the share of beneficiaries on dialysis enrolling in Medicare Advantage plans has accelerated (cont.)

FIGURE 5-2

The share of beneficiaries on dialysis enrolling in MA plans continued to increase between 2021 and 2022



Note: MA (Medicare Advantage). Beginning in 2021, the 21st Century Cures Act permits dialysis beneficiaries to enroll in MA plans.

Source: Data compiled by MedPAC from CMS enrollment data.

- The affordability of a Medigap plan. Even though beneficiaries with ESRD who are under 65 must be offered at least one Medigap plan in 35 states, the insurer can charge a higher premium based on age, sex, or existing health conditions, depending on state insurance rating rules.²³

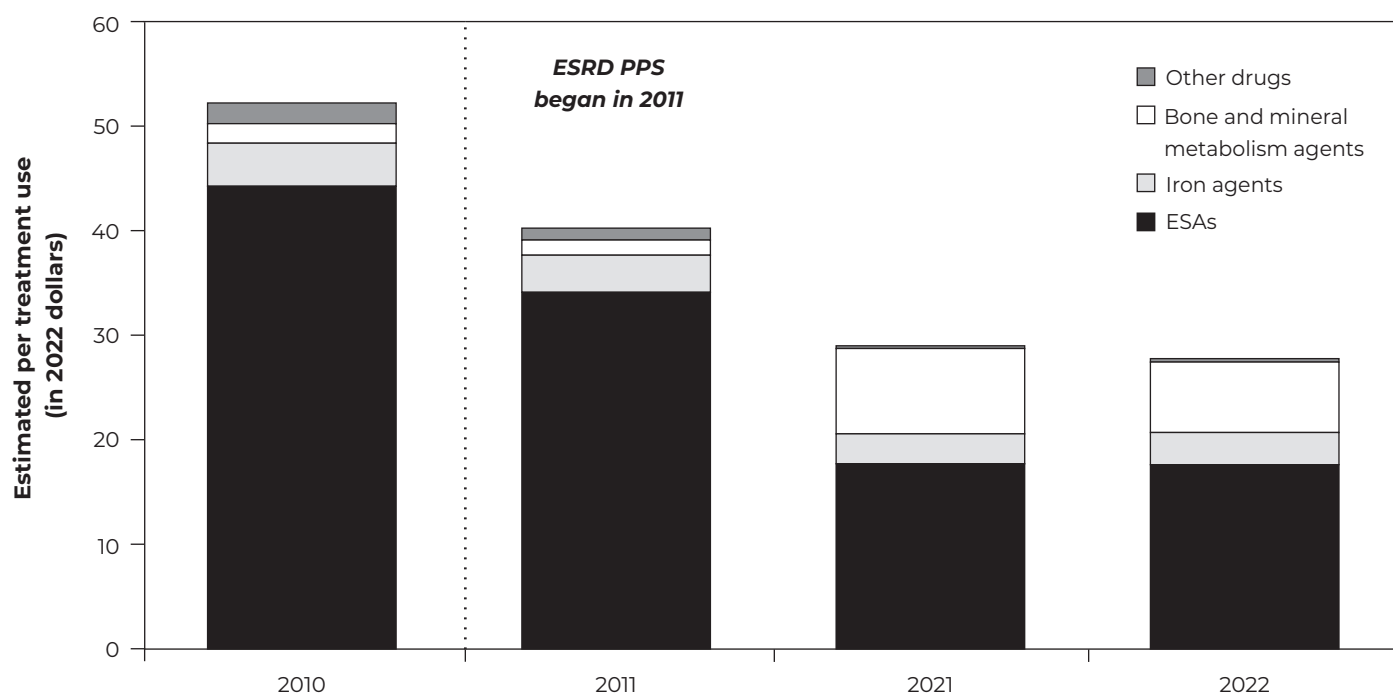
In addition to conventional MA plans, dialysis beneficiaries residing in selected geographic areas

have access to ESRD special needs plans (SNPs) (specifically, C-SNPs, a type of SNP for individuals with chronic conditions). As of November 2023, few dialysis beneficiaries—about 4,400—were enrolled in 14 ESRD SNPs in 9 states (Arizona, California, Connecticut, Georgia, Kentucky, Michigan, New Jersey, Texas, and Virginia). ■

Quality under the ESRD PPS

Analysis of the most recent five-year period for which we have available claims and enrollment data for FFS dialysis beneficiaries found the following:

- In 2020, as the coronavirus pandemic took hold, mortality averaged 1.9 percent per month, up from an average of 1.6 percent in 2018 and 2019. The rate of mortality per month remained elevated in 2021 and 2022, averaging 2.0 percent.²⁴

**FIGURE
5-3****Use of ESRD drugs paid under the ESRD PPS has declined**

Note: ESRD (end-stage renal disease), PPS (prospective payment system), ESA (erythropoiesis-stimulating agent). To estimate drug use by therapeutic class, we hold the price of each drug constant and multiply drug units reported on claims in a given year by 2022 average sales price (ASP) plus 0 percent (or CMS's outlier limit if ASP data are not available). ESAs include epoetin alfa, epoetin beta, and darbepoetin. Iron agents include iron sucrose, sodium ferric gluconate, ferumoxytol, and ferric carboxymaltose. Bone and mineral metabolism agents include the vitamin D agents calcitriol, doxercalciferol, and paricalcitol and the calcimimetics cinacalcet and etelcalcetide. Other drugs include daptomycin, vancomycin, alteplase, and levocarnitine. Before the ESRD PPS was implemented, Medicare paid dialysis facilities separately for vitamin D agents and drugs in the ESA, iron, and other groups; since 2011, these products have been included in the ESRD PPS bundle and paid under the base payment rate. Prior to 2018, Medicare covered the available calcimimetic under Part D. Beginning in 2018, Medicare began to pay for all calcimimetics under the ESRD PPS. Per statutory and regulatory provisions, the ESRD PPS paid for calcimimetics (1) using a transitional drug add-on payment policy in 2018, 2019, and 2020, and (2) under the base rate as of 2021.

Source: MedPAC analysis of 100 percent claims submitted by dialysis facilities to CMS.

- Between 2018 and 2022, the share of FFS dialysis beneficiaries admitted to a short-stay hospital (beneficiaries with at least one admission in a given month) ranged from 12 percent per month to 14 percent per month. During the same period, 30-day readmission rates on an annual basis remained relatively steady at 21 percent of admissions.
- In 2020, 2021, and 2022, the share of FFS dialysis beneficiaries who used the ED on an outpatient basis (beneficiaries with at least one ED visit in a given month) averaged 10 percent per month, down from an average of 12 percent per month in 2018 and 2019.

Beneficiaries' fluid management is related to factors such as the adequacy of the dialysis procedure, defined as having enough waste removed from their blood. According to the Commission's analysis, between 2018 and 2022, between 97 percent and 98 percent of hemodialysis beneficiaries and between 92 percent and 93 percent of PD beneficiaries received adequate dialysis.

We assess the quality of anemia management by examining changes over time in (1) beneficiaries' hemoglobin level, as assessed by a blood test that measures the level of hemoglobin, the protein that

**TABLE
5-3**

Under the ESRD PPS, use per treatment of ESRD drugs has declined

Dialysis drug	Mean units per treatment*			Aggregate percent change	
	2010	2021	2022	2010–2022	2021–2022
ESAs					
Epoetin alfa (reference biologic)	5,214	1,051	1,031	–80%	–2%
Darbepoetin alfa	1.26	0.9	0.9	–31	1
Epoetin beta	N/A	4.2	4.3	N/A	4
Epoetin alfa (biosimilar)	N/A	111	84	N/A	–24
Iron agents					
Sodium ferric gluconate	0.15	0.05	0.05	–65	8
Iron sucrose	16.0	13.7	14.8	–7	8
Bone and mineral metabolism agents					
Paricalcitol	2.3	0.2	0.2	–93	–3
Doxercalciferol	0.9	1.2	0.8	–11	–38
Calcitriol	0.13	0.01	0.01	–91	7
Cinacalcet	N/A	49.4	38.3	N/A	–22
Etelcalcetide	N/A	2.0	1.7	N/A	–11
Antibiotics					
Daptomycin	0.22	0.08	0.10	–53	30
Vancomycin	0.02	0.01	0.01	–53	24
Other drugs					
Levocarnitine	0.010	0.001	0.002	–76	232
Alteplase	0.020	0.003	0.003	–86	9

Note: ESRD (end-stage renal disease), PPS (prospective payment system), ESA (erythropoiesis-stimulating agent), N/A (not applicable [because drug not available in the U.S.]). Individual units per treatment are rounded; the aggregate percent change is calculated using unrounded units per treatment.

*Each drug is reported using its own drug units.

Source: MedPAC analysis of claims submitted by dialysis facilities to CMS.

carries oxygen in red blood cells, and (2) frequency of red blood cell transfusions.²⁵ Lower hemoglobin levels (which suggest underuse of ESAs and iron agents) can increase the frequency of red blood cell transfusions, while higher hemoglobin levels (greater than 12 g/dL) among patients maintained on higher doses of ESAs can increase their risk of death and cardiovascular events (congestive heart failure, myocardial infarction, and stroke). We found that, between 2018 and 2022, median hemoglobin levels have remained constant, averaging 10.5 g/dL. During this period, the share

of FFS dialysis beneficiaries with lower hemoglobin levels (less than 10 g/dL) rose from 29 percent of beneficiaries to 31 percent of beneficiaries, while the share of FFS beneficiaries with levels between 10g/dL and 12g/dL fell from 66 percent to 63 percent. During this period, the share of beneficiaries with higher hemoglobin levels (exceeding 12 g/dL) ranged from 5 percent to 6 percent of FFS beneficiaries on dialysis.

We see fluctuation in rates of blood transfusion. Between 2018 and 2020, the proportion of FFS dialysis

**TABLE
5-4****Between 2021 and 2022, the number of kidney transplants increased**

	2018	2021	2022
Total transplants	21,167	24,670	25,500
Share of transplants from live donors	30%	24%	23%
Share receiving a transplant			
White	46	42	41
Black	26	29	29
Hispanic	19	20	20
Asian	7	7	8
Other	2	2	2

Note: Components may not sum to 100 percent due to rounding. Individuals receiving a kidney transplant include individuals with ESRD on dialysis (which replaces the filtering function of the kidneys when they fail) and individuals who receive a kidney transplant before their kidney function deteriorates to the point of needing dialysis.

Source: Organ Procurement and Transplantation Network.

beneficiaries receiving a blood transfusion declined from an average of 2.5 percent per month to 2.4 percent per month. In 2021 and 2022, the share of FFS dialysis beneficiaries receiving a blood transfusion increased to an average of 2.7 percent per month.

Access to home dialysis

Researchers have shown that the ESRD PPS is associated with an overall increase in the use of home dialysis (Lin et al. 2017). Between 2018 and 2022, the share of beneficiaries dialyzing at home steadily increased from 11 percent per month to nearly 16 percent per month. While we are encouraged by this increase, differences by race persist: Black beneficiaries are less likely to use home methods. Although about 31 percent of Medicare FFS beneficiaries with ESRD are Black, only 24 percent of beneficiaries who dialyze at home are Black. Between 2018 and 2022, the proportion of beneficiaries undergoing home dialysis training was relatively small but increased slightly, ranging from a monthly average of 0.7 percent to 0.9 percent of FFS beneficiaries on dialysis.

Researchers have identified many factors that affect the use of home dialysis, both clinical (e.g., patients'

other health problems and prior nephrology care) and nonclinical (e.g., patients' social circumstances and knowledge about treatment options as well as physicians' training and preference). For example, nephrology trainees reported low and moderate levels of preparedness for managing patients on home hemodialysis and PD, respectively (Gupta et al. 2021). Some beneficiaries report that they were never informed about their dialysis modality options. Facility factors, such as unused in-center capacity or additional in-center shifts and dialysis facility staff experience, can also affect use of home dialysis (Walker et al. 2010). During the coronavirus pandemic, however, both LDOs and midsize providers reported that their patients showed increased awareness of and interest in home dialysis.²⁶

Some clinical and nonclinical factors affecting home dialysis use are amenable to intervention. For example, between 2008 and 2018, under an integrated care delivery system (Kaiser Permanente Northern California), PD use among new dialysis patients more than doubled, from 15 percent to 34 percent. To augment the use of home dialysis, the health care system implemented a multidisciplinary, system-wide

approach that increased patient and family education, educated health care professionals about the importance of PD, adopted operational improvements, monitored outcomes, and shared best practices with staff (Pravoverov et al. 2019).

Access to kidney transplantation

Kidney transplantation is widely regarded as a better ESRD treatment option than dialysis in terms of patients' clinical outcomes and quality of life. In addition, transplantation results in lower Medicare spending. In 2021, average Medicare spending for patients on dialysis (nearly \$98,000) was more than twice the annual spending of those who had a functioning kidney transplant (nearly \$44,000 in 2021) (United States Renal Data System 2023). However, demand for kidney transplantation exceeds the supply of available kidneys. Besides donation rates, factors that affect access to kidney transplantation include the clinical allocation process; patients' health literacy, clinical characteristics, and preferences; the availability of education for patients; clinician referral for transplant evaluation at a transplant center; communication between the dialysis facility and the transplant center; and transplant center policies.

Between 2018 and 2022, according to the Organ Procurement and Transplantation Network, the number of kidney transplants increased by 5 percent per year, to 25,500 (Table 5-4).²⁷ The increase was mostly due to an increase in the number of deceased donor transplants. During this period, the share of transplants for Asian, Black, and Hispanic patients rose modestly (Table 5-4). According to researchers, a kidney allocation system implemented in 2014 by the United Network for Organ Sharing led to a narrowing of the disparities in national kidney transplant rates among White, Black, and Hispanic patients on the transplant waiting list (Melanson et al. 2017).

Providers' access to capital: Growth trends indicate that access is adequate

Dialysis providers need access to capital to maintain and modernize their facilities and to improve patient care delivery. In general, current growth trends among dialysis providers indicate that the dialysis industry is attractive to for-profit facilities and investors, with the

two LDOs and other renal companies appearing to have adequate access to capital. For example:

- In 2022, Fresenius Medical Care completed a three-way merger that includes Fresenius Health Partners (its value-based care division), Interwell Health, and Cricket Health. The new company, which will operate under the Interwell Health brand, will focus on services for individuals with earlier stages of kidney disease and anticipates managing the care of roughly 300,000 individuals in the U.S. with kidney disease, with more than \$11 billion in costs under management by 2025 (Landi 2022).
- In 2023, DaVita launched a kidney care-focused medical device company with Medtronic that specializes in developing novel kidney care products and solutions, including home-based products to make different dialysis treatments more accessible (DaVita 2023a).
- In 2023, DaVita Venture Group (an ancillary service of DaVita) continued to fund select venture capital investments in early-stage companies, including (1) acquiring a transplant software company to create greater connectivity among transplant candidates, transplant centers, physicians, and care teams; (2) investing in a company that offers advance care planning and virtual palliative care; and (3) investing in a new pharmaceutical company to bring ESRD drugs to market (DaVita 2023a).

Another indicator of the industry's relatively good access to capital is that, during the past decade, several companies—both small and large—have entered the renal care field to improve treatment of individuals with CKD and ESRD, including Outset Medical (in 2010), Cricket Health (in 2015), Somatus (in 2016), and CVS (in 2018). Most recently, in 2022, Satellite Healthcare Inc., a nonprofit, midsize outpatient dialysis chain, and Dialyze Direct, a provider of home hemodialysis services in skilled nursing facilities (SNFs), announced their letter of intent to collaborate on opportunities such as offering home hemodialysis and CKD management to patients in SNFs (Satellite Healthcare 2022). Another recent investment highlighting good access to capital involves MA plans that are expanding kidney care. Gold Kidney Health Plan, which offers MA special needs plans developed by nephrologists,

announced that the company received \$60 million from a health care investment group (Chicago Pacific Founders) to increase its ability to offer MA plan choices to patients with kidney disease (Gold Kidney Health Plan 2022).

In public financial filings, the two LDOs reported generally positive financial performance related to their dialysis business for 2023, including improvements in productivity and earnings growth (DaVita 2023b, Fresenius Medical Care 2023b). Since 2010, these organizations have grown through large acquisitions of and mergers with other dialysis facilities and other health care organizations. For example, during this period, both LDOs acquired midsize for-profit organizations: DaVita acquired Purity and Renal Ventures and Fresenius Medical Care acquired Liberty Dialysis. The LDOs have entered into value- and risk-based programs with private payers to provide care to commercial and MA ESRD and CKD patients. Under these arrangements, the companies' financial performance is based on their ability to manage a defined scope of medical costs within certain parameters for clinical outcomes (Fresenius Medical Care 2022). Both LDOs are participants in CMMI's current Kidney Care Choices Model.

The two LDOs, in addition to operating three-quarters of all dialysis facilities, are each vertically integrated (DaVita 2023a, Fresenius Medical Care 2023a). For example, other health care services that one or both LDOs operate include an ESRD-related laboratory, a pharmacy, and centers that provide vascular access services; they both provide ESRD-related care coordination and disease management services to government and nongovernment payers (including MA plans); and they operate dialysis facilities internationally. One LDO manufactures, acquires, in-licenses, and distributes ESRD-related pharmaceutical products (e.g., phosphate binders and iron replacement products) and manufactures dialysis products (hemodialysis machines, peritoneal cyclers, dialyzers, peritoneal solutions, hemodialysis concentrates, bloodlines, and systems for water treatment) and nondialysis products, including acute cardiopulmonary and apheresis products. This LDO supplies dialysis facilities that it owns, operates, or manages with dialysis products, and it sells dialysis products to other dialysis service providers.

Another positive indicator of the dialysis sector's strong access to capital is its all-payer margin. Using cost report data submitted by freestanding dialysis facilities to CMS, we found that the 2022 all-payer margin was roughly 14 percent. The all-payer margin is affected by the revenues that providers derive from furnishing care to patients with all sources of coverage, including FFS Medicare, MA, other government payers, and commercial payers, as well as to patients with acute kidney injury.²⁸ Although commercial payment rates vary, average rates established under commercial contracts are generally significantly higher than Medicare rates. According to one LDO, patients with commercial coverage (including hospital dialysis services) account for 10 percent of its treatments and about 32 percent of its U.S. dialysis patient revenues, while patients with government coverage account for 90 percent of its treatments and 68 percent of its U.S. dialysis patient revenues (DaVita 2019). The Commission found that, accounting for age and wage index differences (geographic location), in 2018, the prices MA plans paid for dialysis services were on average about 14 percent higher than FFS Medicare rates (Medicare Payment Advisory Commission 2021). Researchers estimated commercial and Medicare revenue per treatment for dialysis services in 2017 and found that commercial revenue per treatment was nearly four times greater than Medicare revenue per treatment (Childers et al. 2019). The increase in FFS labor and capital costs and decrease in total treatment volume experienced in 2022 may also have been a factor in the decline of the all-payer margin, which was lower in 2022 than in 2021 (14 percent and 17 percent, respectively).

Medicare payment and providers' costs: Increased costs in most cost categories contributed to decline in FFS Medicare margins

Between 2021 and 2022, total FFS spending for outpatient dialysis services dropped by 12 percent, due predominantly to a sharp decline in the number of FFS dialysis beneficiaries, as dialysis beneficiaries' enrollment in MA plans soared. Medicare's payment per FFS dialysis treatment increased 2 percent while total cost per treatment rose by nearly 6 percent in 2022. In 2022, the aggregate FFS Medicare margin decreased to -1.1 percent.

Medicare payments for outpatient dialysis services

In 2022, FFS per capita annual spending for outpatient dialysis services remained steady relative to the previous year, increasing by 0.5 percent to roughly \$30,300. Total FFS Medicare spending for these services, however, declined 12 percent from 2021, to \$8.8 billion. The decline is predominantly due to MA plans' increasing enrollment of dialysis beneficiaries beginning in 2021. Specifically, between 2021 and 2022, the total number of FFS beneficiaries on dialysis and FFS treatments declined by 13 percent and 14 percent, respectively. A statutory update (of 1.9 percent) increased the base ESRD PPS payment rate in 2022.

Between 2020 and 2021, Part D spending for ESRD oral-only phosphate binders declined for FFS dialysis beneficiaries

Phosphate binders, currently covered under Part D, will be the last oral-only drug group to be included in the ESRD PPS bundle in 2025 (the inclusion of oral-only drugs in the ESRD PPS bundle has been delayed by statute); therefore, we track Part D spending for this group. Between 2020 and 2021 (the most recent year for which data are available), spending for phosphate binders furnished to dialysis FFS beneficiaries declined by 16 percent to \$0.8 billion.²⁹ The decline in total spending for phosphate binders for FFS dialysis beneficiaries is linked to the substantial increase in dialysis beneficiaries enrolling in MA in 2021. Among FFS beneficiaries on dialysis who used phosphate binders, per capita spending in 2021 and 2022 remained flat at about \$4,300 per patient. Similar shares (roughly 70 percent) of FFS dialysis beneficiaries with Part D coverage were prescribed phosphate binders in 2020 and 2021, and Part D spending for phosphate binders accounted for a similar share of their Part D spending in each year (ranging from 34 percent to 36 percent). Medicare spending for ESRD drugs under Part D is not included in the Commission's analysis of dialysis facilities' financial performance under the ESRD PPS.

As of January 1, 2025, the Secretary will have the authority to include phosphate binders—currently covered under Part D—in the ESRD PPS bundled payment.³⁰ Their inclusion is intended to better manage drug therapy and improve beneficiaries' access to these medications since some beneficiaries lack Part D coverage or have coverage less generous than the

Part D standard benefit. Including phosphate binders in the ESRD PPS bundle might also improve provider efficiency.

Providers' costs for outpatient dialysis services under the ESRD PPS

To assess the appropriateness of costs for dialysis services paid for under the ESRD PPS, we examine whether aggregate dialysis facility costs reflect costs that providers would incur in furnishing high-quality care. For this analysis, we used 2021 and 2022 cost reports and claims submitted to CMS by freestanding dialysis facilities. For those years, we looked at the growth in the cost per treatment and how the total volume of treatment affected that cost.

Cost growth under the PPS Between 2021 and 2022, total cost per treatment rose by nearly 6 percent, from \$270 per treatment to nearly \$286 per treatment. Though ESA and supply costs declined by 3 percent and 1 percent, respectively, costs rose sharply for:

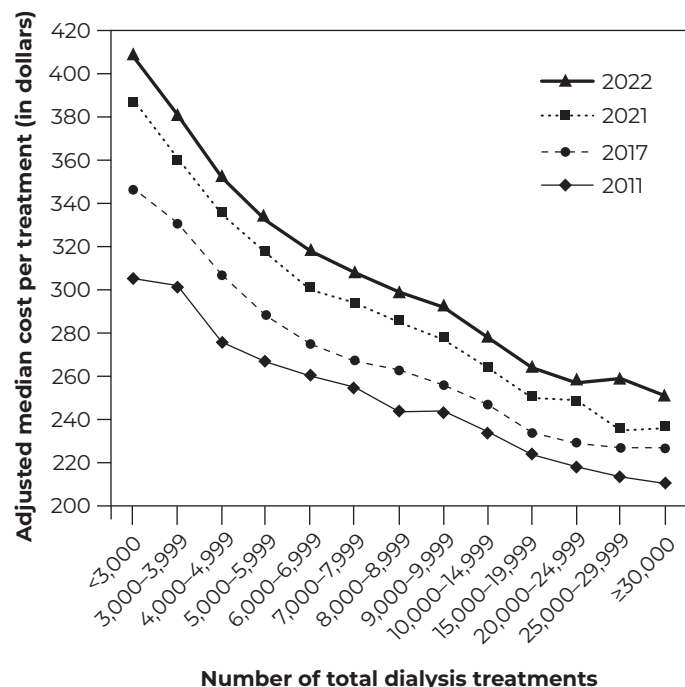
- capital, labor, and administrative and general expenses, which each rose by 7 percent and accounted for 19 percent, 34 percent, and 27 percent of the cost per treatment, respectively, in 2022; and
- ESRD drugs (other than ESAs), which rose by 9 percent and accounted for 3 percent of cost per treatment in 2022, and labs, which rose by 10 percent and accounted for 1 percent of providers' cost per treatment in 2022.

Historically, dialysis facilities have experienced lower cost growth than they did between 2021 and 2022. For example, between 2018 and 2021, total cost per treatment increased by 0.4 percent per year, with labor and capital cost per treatment rising by 3 percent and 4 percent per year, respectively. Likewise, cost growth was low between 2014 and 2017: Total cost per treatment increased by 0.6 percent per year, with labor and capital cost per treatment each increasing by 3 percent per year.

Variation in cost growth across freestanding dialysis facilities shows that some facilities were able to hold their cost growth well below that of others. For example, between 2021 and 2022, per treatment costs fell by 0.5 percent for facilities in the 25th percentile

**FIGURE
5-4**

**Higher-volume freestanding
dialysis facilities had lower
cost per treatment, 2011-2022**



Note: Cost per treatment is adjusted to remove differences in the cost of labor.

Source: MedPAC analysis of cost reports submitted by freestanding dialysis facilities to CMS and the end-stage renal disease wage index files.

of cost growth, compared with a rise of 11 percent for facilities in the 75th percentile. The growth in cost per treatment is related to facility size. Between 2021 and 2022, the growth in the total cost per treatment was higher for the smallest facilities (e.g., facilities furnishing fewer than 4,000 treatments had cost growth averaging 8 percent) compared with all other facilities (with cost growth averaging nearly 6 percent).

The extent to which some of the variation in costs among facilities results from differences in the accuracy of facilities' reported data is unknown. Our analysis of cost report data shows substantial variation in selected categories as reported by the five largest dialysis organizations. For example, in 2022, labor cost varied by \$49 per treatment, and capital costs varied by \$42 per treatment. The Commission estimated, based

on findings from CMS's audit of facility cost reports, that unallowable costs reported by dialysis facilities could have amounted to about 4 percent of total reported costs in 2018 (Medicare Payment Advisory Commission 2022). If 4 percent of reported costs are unallowable, the estimated aggregate FFS Medicare margin would be understated by nearly 4 percentage points.

Cost per treatment is correlated with facility service volume To examine the relationship between a facility's cost per treatment and the total number of treatments a facility furnishes, we adjusted the cost per treatment to remove differences in the cost of labor across geographic areas and included all treatments regardless of payer. Our analysis showed, in each year from 2011 through 2022, a statistically significant relationship between the total number of treatments and cost per treatment (correlation coefficient equaled -0.5) (Figure 5-4). That is, the greater the facility's service volume, the lower its costs per treatment. In each year, facilities that qualified for increased Medicare payment due to low volume had substantially higher cost per treatment for capital as well as administrative and general services compared with all other facilities.

The trend in the aggregate FFS Medicare margin for freestanding dialysis facilities

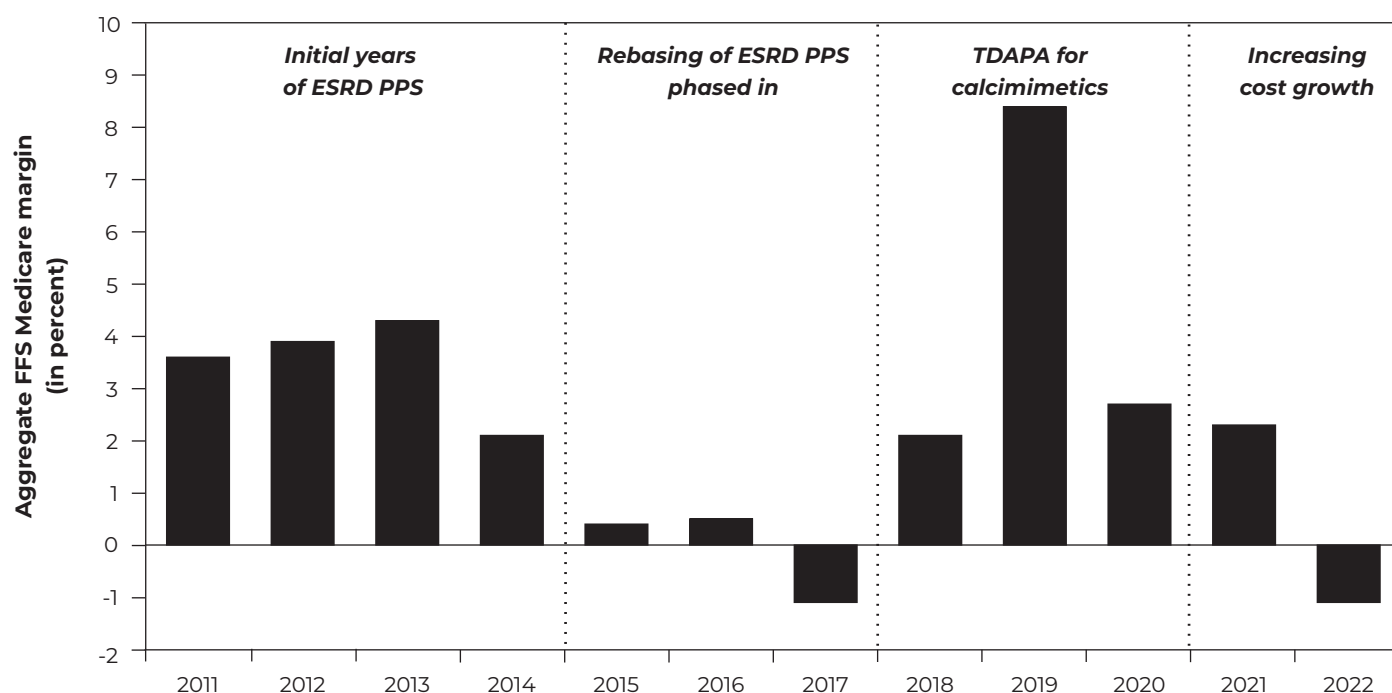
The Commission assesses current payments and costs for FFS dialysis services for freestanding dialysis facilities by comparing Medicare's payments with facilities' Medicare-allowable costs. The latest and most complete data available on payments and costs are from 2022.

The aggregate average FFS Medicare margin reached 8.4 percent in 2019 (the highest since the ESRD PPS was implemented in 2011) but has since declined, falling to 2.7 percent in 2020 and 2.3 percent in 2021. Dialysis facilities' FFS Medicare margin fell further in 2022, to -1.1 percent.

Dialysis facilities' financial performance under the ESRD PPS has been variable due to statutory and regulatory changes as well as the use and profitability of certain ESRD-related drugs (Figure 5-5). During the initial years of the ESRD PPS, the aggregate FFS Medicare margin increased as providers furnished fewer ESRD drugs per treatment. Between 2014 and 2017, facilities' financial performance under FFS

**FIGURE
5-5**

Aggregate FFS Medicare margin declined in 2022 due to increasing cost growth



Note: ESRD (end-stage renal disease), PPS (prospective payment system), TDAPA (transitional drug add-on payment adjustment). Pandemic-related federal relief funds are not included in the data presented in this figure.

Source: Compiled by MedPAC from cost reports and claims submitted by facilities to CMS.

Medicare reversed, and the aggregate FFS Medicare margin declined from 2.1 percent to -1.1 percent because of statutorily required payment adjustments to account for the decline in ESRD drug use under the ESRD PPS. Provisions in the statute required CMS to rebase the payment rate in 2014 (reducing the payment rate by about 3.4 percent) and limit payment updates from 2015 through 2018.

In 2018 and 2019, however, the aggregate FFS Medicare margin increased due to the profitability of the calcimimetics paid under the TDAPA policy—to 2.1 percent in 2018 and to 8.4 percent in 2019 (Figure 5-5).^{31,32} In 2020, the aggregate FFS Medicare margin decreased to 2.7 percent (3.7 percent when including FFS Medicare's share of pandemic relief funds) because cost per treatment increased and the

TDAPA payment declined from average sales price (ASP) plus 6 to ASP plus 0. In 2021, the aggregate FFS Medicare margin declined again to 2.3 percent, due to increasing cost per treatment for all cost categories (except ESRD drug costs).

The aggregate FFS Medicare margin further declined to -1.1 percent in 2022, partly attributable to growth in labor and capital costs, which both increased by 7 percent between 2021 and 2022, well above the historical average. Both LDOs reported a challenging labor market in 2022, and the high growth in labor costs in 2022 may be linked to staff shortages, high turnover rates, higher-than-normal merit increases, higher incentive compensation, increased utilization of contract labor, and lower productivity due to higher training costs (DaVita 2022b, Fresenius Medical Care

**TABLE
5-5****In 2022, the aggregate FFS Medicare margin of freestanding dialysis facilities varied by treatment volume**

Provider type	Aggregate FFS Medicare margin	Share of freestanding dialysis facilities	Share of freestanding dialysis facility treatments
All	-1.1%	100%	100%
Urban	-0.4	84	88
Rural	-4.5	16	12
Treatment volume (quintile)			
Lowest	-24.1	20	7
Second	-13.4	20	13
Third	-5.0	20	18
Fourth	1.6	20	24
Highest	7.4	20	39

Note: FFS (fee-for-service). Components may not sum to 100 percent due to rounding.

Source: Compiled by MedPAC from cost reports and claims submitted by freestanding dialysis facilities to CMS and the Dialysis Compare database.

2022). In addition, total treatment volume declined between 2021 and 2022, with a material (negative) impact on this sector's FFS Medicare margin (and all-payer margin). Each LDO experienced a 2 percent decline in total treatment volume between 2021 and 2022. Unlike in previous years, add-on payments (for the drug Korsuva and for the Tablo Hemodialysis System) did not have a material effect on dialysis facilities' FFS Medicare margin because of the low use of these services.

The aggregate FFS Medicare margin varies by treatment volume

Aggregate FFS Medicare margins in 2022 decidedly varied by treatment volume: Facilities in the lowest volume quintile had margins below -20 percent, while facilities in the top volume quintile had margins of over 7 percent (Table 5-5). Urban facilities averaged higher margins than rural facilities (-0.4 percent vs. -4.5 percent). Total treatment volume accounted for much of the difference in margins between urban and rural facilities: Urban dialysis facilities are larger on average in terms of the number of treatment stations and total treatments provided. For example, in 2022, urban

facilities averaged roughly 10,700 treatments, while rural facilities averaged about 7,500 treatments (data not shown). Higher-volume facilities had lower cost per treatment (Figure 5-4, p. 150).

Although some rural facilities have benefited from the ESRD PPS's 23.9 percent low-volume adjustment and 0.8 percent rural adjustment, the Commission has found that neither adjustment appropriately targets low-volume, geographically isolated facilities that are critical to beneficiary access (Medicare Payment Advisory Commission 2016, Medicare Payment Advisory Commission 2015, Medicare Payment Advisory Commission 2014). The Commission's recommendation to replace the current low-volume payment adjustment and rural adjustment with a single low-volume and isolated adjustment, where low-volume criteria are empirically derived, would better protect isolated low-volume rural facilities that are necessary for beneficiary access (Medicare Payment Advisory Commission 2020).

Projecting the aggregate FFS Medicare margin for 2024

We project that the aggregate FFS Medicare margin will slightly increase in 2024, to 0 percent. To estimate 2024

margins using 2022 data, the Commission considers providers' historical cost growth and policy changes affecting payments effective in 2023 and 2024. These factors include:

- statutory updates to the dialysis base payment rate (based on the ESRD market basket offset by a productivity adjustment) of 3.0 percent in 2023 and 2.1 percent in 2024;
- reductions in payments of 0.16 percent in 2023 and 2024 due to the ESRD Quality Incentive Program; and
- reductions in payments in 2023 and 2024 due to the ETC Model (CMMI's mandatory model), which CMS estimates will total \$2 million in 2023 and \$10 million in 2024.

Factors not considered in this projection that might have a positive effect on providers' financial performance include:

- add-on payments in 2023 for a new ESRD drug that treats anemia, which could affect providers' financial performance; and
- both LDOs' increasing treatment volumes and productivity efficiencies in 2023.

How should FFS Medicare payments change in 2025?

Most payment adequacy indicators—beneficiary access to care, quality of care, provider access to capital—for outpatient dialysis facilities are adequate, though the projected FFS Medicare margin for 2024 is low. Still, dialysis facilities continue to become more efficient under the ESRD PPS, as measured by declining use of most injectable dialysis drugs with little to no measurable impact on beneficiaries' health outcomes. Facilities have additional incentives to maximize the efficiency of their in-center capacity utilization: Demand for home dialysis has increased, and ESRD incidence has slowed over the past decade.

We note that, since 2020, in addition to the base payment rate, Medicare includes a TDAPA under the ESRD PPS that pays dialysis facilities for certain new

drugs and biologics based on the product's ASP for a two-year period. The new anemia drug paid under a TDAPA beginning in August 2023 may increase FFS Medicare payments relative to facilities' costs. Specifically, CMS does not reconcile the cost and utilization of the new drug (which is paid under a TDAPA) within an existing functional category (e.g., anemia category) with the cost and utilization of the drugs already included in the functional categories that are paid under the ESRD PPS payment bundle.

Under current law, Medicare's base payment rate under the ESRD PPS will be increased in 2025 based on the forecasted increase in the ESRD market basket less a forecasted increase in productivity. The final update for 2025 will not be set until summer 2024, but CMS currently forecasts a 1.8 percent increase in the base payment rate. The final 2025 update will include newer forecasts of growth in input prices and productivity and thus could be lower or higher than the current projected update.

In addition, in 2025, CMS will have statutory authority to pay for phosphate binders under the ESRD PPS. Currently, phosphate binders are paid under Part D. Covering such products under the ESRD PPS may have a positive effect on providers' financial performance. Three of the five largest dialysis organizations operate their own pharmacies (Government Accountability Office 2023). According to these organizations, operating their own pharmacies offers advantages such as managing costs and maintaining greater control of and more complete information on their patients' prescriptions (Government Accountability Office 2023). Moreover, one dialysis organization established a company (Vifor Fresenius Medical Care Renal Pharma) that, since 2014, markets a phosphate binder (Velphoro) as well as other renal dialysis drugs prescribed to dialysis patients. In 2021, Part D spending for Velphoro by FFS dialysis beneficiaries was \$260 million.

RECOMMENDATION 5

For calendar year 2025, the Congress should update the 2024 Medicare end-stage renal disease prospective payment system base rate by the amount determined under current law.

RATIONALE 5

Our indicators of payment adequacy are generally positive, including beneficiaries' access to care, the

supply and capacity of providers, volume of services, and access to capital. Providers have become more efficient in the use of dialysis drugs under the ESRD PPS. Indicators of quality of care have generally remained stable. The aggregate FFS Medicare margin was -1.1 percent in 2022 and is projected to be 0 percent in 2024. We are uncertain about the effects of the add-on payments for new renal dialysis drugs in 2023 and 2024, but our prior analysis showed that add-on payments for calcimimetics between 2018 and 2020 contributed to a substantial increase in provider profitability during that period. The two LDOs, both of which are publicly traded companies, recently made optimistic statements about their dialysis business; for example, each reported increasing treatment volume and decreasing mortality, and both achieved productivity gains in 2023 (DaVita 2023c, Fresenius Medical Care 2023b).

FFS Medicare margins tend to be lower in low-volume and in rural dialysis facilities, in spite of the payment system's low-volume and rural adjustments, which increase payments by 23.9 percent and 0.8 percent, respectively. Previous Commission analyses have found that neither adjustment appropriately targets low-volume, geographically isolated facilities. The Commission has held that payments to rural providers should target facilities that are critical for beneficiary

access (that is, facilities that are both low volume and isolated). Further, the magnitude of rural payment adjustments should be empirically derived, and the adjustments should encourage provider efficiency. In June 2020, the Commission recommended that the Secretary replace the current low-volume and rural payment adjustments with a single payment adjustment that considers both a facility's distance to the nearest facility and its treatment volume, thereby directing extra payments to the low-volume and isolated facilities that are most necessary to ensure beneficiary access to care (Medicare Payment Advisory Commission 2020).

IMPLICATIONS 5

Spending

- This recommendation would have no effect on federal program spending relative to the statutory update.

Beneficiary and provider

- We expect beneficiaries to continue to have good access to outpatient dialysis care. We do not anticipate any negative effects on beneficiary access to care. This recommendation is expected to have a minimal effect on providers' willingness and ability to care for Medicare beneficiaries. ■

Endnotes

- 1 In this chapter, the term *beneficiaries* refers to individuals covered by Medicare, and *patients* refers to all individuals (across all types of health coverage) who have ESRD.
- 2 Throughout this chapter, we use the term *FFS Medicare* as equivalent to the CMS term *original Medicare*.
- 3 In this chapter, the term *drugs* refers to both drugs and biologics. The term *biologics* refers to biological products.
- 4 Clinicians receive a monthly capitated payment established in the Part B physician fee schedule for outpatient dialysis-related management services (which include managing the dialysis prescription and prescribing ESRD drugs); payment varies based on the number of visits per month, the beneficiary's age (adult vs. pediatric beneficiaries under 20 years of age), and whether the beneficiary receives dialysis in a facility or at home.
- 5 Some have raised concerns that joint ventures between dialysis organizations and physicians create financial incentives for participating physicians that could inappropriately influence decisions about patient care (Berns et al. 2018). Under federal disclosure requirements, a dialysis facility must report certain ownership information to CMS and its state survey agency but is not required to disclose such information to its patients, researchers, or members of the public.
- 6 In 2011, CMS delayed including ESRD oral-only drugs (which, at the time, included calcimimetics and phosphate binders paid for under Part D) in the ESRD PPS bundle to give facilities additional time to make operational changes and logistical arrangements to furnish these products to their beneficiaries. Subsequently, Section 204 of the Stephen Beck, Jr., Achieving a Better Life Experience Act of 2014 delayed including oral-only renal dialysis drugs in the ESRD PPS bundled payment until January 1, 2025. However, with the availability of an injectable calcimimetic in 2017, CMS no longer considered these drugs oral only. From 2018 through 2020, calcimimetics were paid for under the ESRD PPS using a transitional drug add-on payment adjustment; beginning in 2021, these drugs were included in the ESRD PPS's payment bundle.
- 7 For pediatric dialysis beneficiaries (age 17 years and under), the base rate is adjusted for age and type of dialysis.
- 8 New drugs ineligible for a separate add-on payment include generic drugs, which the Food and Drug Administration (FDA) approves under Section 505(j) of the Federal Food, Drug, and Cosmetic Act, and drugs approved for a new dosage form (e.g., pill size, time-release forms, chewable or effervescent pills); drugs approved for a new formulation (e.g., new inactive ingredient); drugs approved that were previously marketed without a new drug application (NDA); and drugs approved that changed from prescription to over-the-counter availability. CMS will identify these drugs using the NDA classification code that the FDA assigns to a given drug.
- 9 During the TDAPA period, CMS pays for Korsuva and Jesdubroq using the average sales price. In 2024, CMS will begin a post-TDAPA policy that adds three years to the time that facilities receive add-on payments for new ESRD drugs in an existing ESRD functional drug category. The post-TDAPA will be case-mix adjusted, set at 65 percent of payments for the given dialysis drug, applied to all PPS payments, and paid for three years. Thus, both add-on payments (the TDAPA and post-TDAPA) provide increased payments for five years for new ESRD drugs in an existing functional category.
- 10 CMS sets the new item's payment rate at 65 percent of the price that the Medicare administrative contractors establish.
- 11 The Commission's *Payment Basics* series provides more information about Medicare's method of paying for outpatient dialysis services (see Outpatient Dialysis Services Payment System, available at https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_dialysis_FINAL_SEC.pdf).
- 12 This figure is based on the Commission's analysis of Medicare and total treatments reported by freestanding facilities on cost reports submitted to CMS.
- 13 Beginning in 2021, the ETC Model applies to certain dialysis facilities and managing clinicians who furnish monthly capitated payment services. CMS selected participants according to their location in randomly selected geographic areas (hospital referral regions), stratified by region, to account for approximately 30 percent of adult dialysis beneficiaries. CMS adjusts participants' payment upward or downward based on their home dialysis and kidney transplant rates. CMS estimated that the Medicare program would, on net, save \$28 million over the ETC Model's six-year duration through decreased payments to dialysis facilities.
- 14 If we approximate marginal cost as total Medicare costs minus fixed building and equipment costs, then marginal profit can be calculated as follows: Marginal profit = (payments for Medicare services – (total Medicare costs –

- fixed building and equipment costs)) / Medicare payments. This comparison is a lower bound on the marginal profit because we do not consider any potential labor costs that are fixed.
- 15 Some portion of the decline in 2021 in the number of FFS dialysis beneficiaries and treatments may also have been due to the ongoing effects of the coronavirus pandemic. According to one of the LDOs, the overall number of patients that the company treated in 2021 fell by about 0.5 percent from 2020, primarily due to an increase in mortality rates because of COVID-19. These rates were partially offset by patients starting dialysis (DaVita 2022a).
 - 16 For example, researchers have reported that all-cause mortality among dialysis patients is significantly higher in winter compared with other seasons.
 - 17 Medicare pays for up to three dialysis treatments per week, with exceptions made with medical justification (Centers for Medicare & Medicaid Services 2023).
 - 18 These drug classes accounted for nearly all ESRD drug spending (about 97 percent) in 2010, the year before the new payment method was implemented.
 - 19 To measure changes in the use of drugs in the payment bundle, we combine drugs within and across therapeutic classes by multiplying the number of drug units reported on claims in a given year by each drug's 2022 ASP, with one exception. Because 2022 ASP data were not available for cinacalcet, we used CMS's TDAPA payment limit for the fourth quarter of 2020. By holding the price constant, we account for the different billing units assigned to a given drug.
 - 20 While this section focuses on changes in individual quality metrics, it is worth noting that Medicare has implemented numerous programs that aim to improve the quality of care for late-stage chronic kidney disease and ESRD. A discussion of these programs can be found in the Commission's March 2023 report to the Congress at https://www.medpac.gov/wp-content/uploads/2023/03/Ch6_Mar23_MedPAC_Report_To_Congress_SEC.pdf.
 - 21 MA plans negotiate with medical providers and facilities that join their network (i.e., in-network providers) to determine the amount that the MA plan will pay the provider or facility for providing care to plan enrollees; the negotiated payment amount may differ from the amount paid under FFS Medicare. If a plan enrollee receives care from a provider or facility that is outside of the plan's network, the provider is paid the amount they would have received under FFS Medicare.
 - 22 Once beneficiaries with ESRD turn 65, for a 6-month period that begins on the first day of the month in which they turn 65 (and are enrolled in Medicare Part B), they can purchase a Medigap plan without regard to their age, sex, or health status. Outside of the federal guaranteed-issue window, Medigap plans offered to beneficiaries with ESRD are limited; 35 states require insurers to offer at least one Medigap plan to beneficiaries under age 65, but only 30 states require insurers to offer a plan to those entitled to Medicare due to ESRD rather than because of disability (AARP 2022, American Kidney Fund 2022).
 - 23 Some FFS dialysis beneficiaries get financial assistance from the American Kidney Fund, a nonprofit organization whose funding sources include dialysis providers and pharmaceutical manufacturers, via need-based grants to pay for health insurance premiums, prescription medications, and other items and services.
 - 24 Mortality rates for adult patients on dialysis (adjusted for age, sex, race/ethnicity, primary cause of ESRD, and duration of ESRD) increases with age. In 2021, the adjusted mortality rate was 91 per 1,000 patient years (1,000 PYs) for individuals between the ages of 18 and 44, 150 per 1,000 PYs for individuals between the ages of 45 and 64, 232 per 1,000 PYs for individuals between the ages of 65 and 74, and 304 per 1,000 PYs for individuals 75 years and older (United States Renal Data System 2023).
 - 25 Blood transfusions are of concern to patients because they (1) carry a small risk of transmitting blood-borne infections to the patient, (2) may cause some patients to develop a reaction, and (3) are costly and inconvenient for patients. Blood transfusions are of particular concern for patients seeking kidney transplantation because they increase a patient's alloantigen sensitization, which can require a patient to wait to receive a transplant.
 - 26 See our March 2020 report to the Congress for more information on the factors that affect use of home dialysis and the factors associated with some patients' discontinuation of home dialysis (available at http://www.medpac.gov/docs/default-source/reports/mar20_medpac_ch6_sec.pdf?sfvrsn=0).
 - 27 Individuals receiving a kidney transplant include individuals with ESRD on dialysis (which replaces the filtering function of the kidneys when they fail) and individuals who receive a kidney transplant before their kidney function deteriorates to the point of needing dialysis.
 - 28 Since 2017, dialysis facilities are able to furnish dialysis to beneficiaries with acute kidney injury (AKI), as mandated by the Trade Preferences Extension Act of 2015. AKI is the

sudden loss of kidney function, typically caused by an event that leads to kidney malfunction, such as dehydration, blood loss from major surgery or injury, or the use of medicines. In 2022, Medicare spending for outpatient dialysis services for FFS beneficiaries with AKI was nearly \$73 million, a decline from nearly \$80 million in 2021. Medicare pays facilities the ESRD PPS base rate adjusted by the PPS wage index for the treatment of beneficiaries with AKI. In addition, for beneficiaries with AKI, Medicare pays dialysis facilities separately for drugs, biologics, and laboratory services that are not renal dialysis services.

- 29 Between 2017 and 2019, the FDA approved generic versions of several types of phosphate binders (including lanthanum, sevelamer carbonate, and sevelamer hydrochloride).
- 30 Statutory changes (in the American Taxpayer Relief Act of 2012; the Protecting Access to Medicare Act of 2014; and the Stephen Beck, Jr., ABLE Act of 2014) delayed until January 1, 2025, the inclusion of oral-only ESRD drugs in the ESRD PPS bundled payment.

- 31 In 2019, there was an anomalous increase compared with prior years in non-ESRD-related drug costs for facilities associated with a dialysis organization.
- 32 The sharp increase in the aggregate FFS Medicare margin in 2019 was driven by the availability of generic versions of the oral calcimimetic in 2019. There is a two-quarter lag in the data used to set ASP-based payment rates under the TDAPA policy, which can result in a difference between the average provider acquisition cost for a drug and the ASP used to set the Medicare payment amount for a quarter. When prices increase or decrease, it takes two quarters before that change is reflected in the ASP data that Medicare uses to pay providers. When newly available generic drugs enter the market, their ASPs are often substantially lower than their brand counterparts, but payment amounts remain at the higher brand level for typically two quarters (or more).

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C H A P T E R

6

Skilled nursing facility services

R E C O M M E N D A T I O N

- 6** For fiscal year 2025, the Congress should reduce the 2024 Medicare base payment rates for skilled nursing facilities by 3 percent.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 1 • ABSENT 0

Skilled nursing facility services

Chapter summary

Medicare covers short-term skilled nursing and rehabilitation services for beneficiaries in skilled nursing facilities (SNFs) after an inpatient hospital stay. Most SNFs also provide long-term care services not covered by Medicare. Medicare makes up a small share of the overall volume for the average SNF. In 2022, about 14,700 SNFs furnished about 1.8 million Medicare-covered stays to 1.3 million fee-for-service (FFS) beneficiaries. Medicare FFS spending on SNF services in SNFs and swing beds combined was \$29 billion in 2022.

Assessment of payment adequacy

Overall, our indicators of payment adequacy were positive.

Beneficiaries' access to care—Changes in the indicators of access in 2022 were positive, with occupancy and utilization increasing from downturns in 2020 and 2021. But access to SNF care may be affected by ongoing workforce challenges.

- **Capacity and supply of providers**—The supply of SNFs declined about 1 percent in 2023. In 2022, 88 percent of Medicare beneficiaries lived in a county with three or more SNFs or swing bed facilities—the same share as in 2021.

In this chapter

- Are FFS Medicare payments adequate in 2024?
- How should FFS Medicare payments change in 2025?
- Medicaid trends

- **Volume of services**—Between 2021 and 2022, Medicare-covered admissions and covered days per 1,000 FFS beneficiaries both increased more than 10 percent. Stays per FFS beneficiary in 2022 were lower than in 2019, but covered days per FFS beneficiary were higher.
- **FFS Medicare marginal profit**—In 2022, the FFS Medicare marginal profit (an indicator of whether SNFs have an incentive to treat more Medicare beneficiaries) averaged 27 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 and 2022 period, the median facility risk-adjusted rate of discharge to the community from SNFs was 50.7 percent, which was one percentage point lower (worse) than the rate for the 2018 and 2019 period. The median facility risk-adjusted rate of potentially preventable readmissions was 10.4 percent and did not vary across provider types. (Due to a change in the measure calculation, we cannot compare this to a prior time period.) Lack of data on patient experience and concerns about the accuracy of provider-reported function data limit our set of SNF quality measures.

Providers' access to capital—In 2022, the number of nursing facilities acquired was higher than in 2021. The average price per SNF bed reached an all-time high. In 2022, the all-payer total margin—reflecting all payers and all lines of business—was –1.4 percent. Without pandemic-related funds, the all-payer total margin was –4 percent in 2022.

FFS Medicare payments and providers' costs—From 2021 through 2022, FFS Medicare payments per day to freestanding SNFs increased over 2.2 percent, while cost growth slowed to 1.7 percent. The FFS Medicare margin for freestanding SNFs was 18.4 percent in 2022. Margins varied greatly across facilities, reflecting differences in costs per day, economies of scale, and cost growth. We project a FFS Medicare margin for freestanding SNFs of 16 percent in 2024.

How should Medicare payment rates change in 2025?

Efficient purchasing of care for the Medicare program would require Medicare's payments to be reduced to more closely align aggregate payments with aggregate costs. The Commission recommends that, for fiscal year 2025, the Congress reduce the 2024 Medicare base payment rates for skilled nursing facilities by 3 percent.

Medicaid trends

As required by the Affordable Care Act of 2010, we report on Medicaid use and spending and non-FFS Medicare margins. Medicaid finances most long-term care services provided in SNFs, and some state programs also cover the copayments on SNF care for beneficiaries who are dually eligible for Medicare and Medicaid and who stay more than 20 days in a SNF. Between 2022 and 2023, the number of Medicaid-certified facilities declined 1 percent, to about 14,500. FFS Medicaid spending (federal and state) was \$40.2 billion in 2022, 4.8 percent more than in 2021. The average non-FFS Medicare margin (which includes all payers, funds related to the public health emergency, and all lines of business except FFS Medicare SNF services) was -6.5 percent, a decrease compared with 2021. The reduction in overall financial performance reflects lower reported pandemic-related relief funds, expiration of the sequestration suspension, and the expiration of temporary Medicaid payment increases in many states, but it does not reflect the adequacy of Medicare FFS payment rates. ■

Background

Skilled nursing facilities (SNFs) provide short-term skilled nursing care and rehabilitation services such as physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services. SNF patients include those recovering from surgical procedures such as hip and knee replacements or from medical conditions such as infections, stroke, and pneumonia. In 2022, the program spent about \$27 billion for 1.84 million FFS Medicare-covered SNF stays under the SNF prospective payment system (PPS). In addition, the program paid \$2 billion for SNF care provided in swing beds, but most of those stays are not paid under the SNF PPS. (See the text box on skilled nursing facility care provided in swing beds.)

Medicare coverage and payment

Medicare covers up to 100 days of SNF care per spell of illness after a medically necessary inpatient hospital stay of at least three days.¹ To qualify for Medicare coverage, a beneficiary must need daily skilled nursing or rehabilitation services.² Medicare's SNF PPS pays SNFs for each day of service.³ For beneficiaries who qualify for SNF care, Medicare pays 100 percent of the daily amount for the first 20 days. Beginning with

day 21, beneficiaries are responsible for copayments through day 100 of the covered stay.⁴ In 2024, the copayment is \$204 per day.

FFS Medicare's daily payments to SNFs are determined by adjusting base payment rates for geographic differences in labor costs and for case mix. CMS implemented a new SNF PPS case-mix system, the Patient-Driven Payment Model (PDPM), on October 1, 2019. The PDPM was intended to address two problems with the prior case-mix system. First, the PDPM considers more comorbidities and conditions than the prior case-mix system and recognizes and pays for the higher costs associated with medically complex patients. Second, under the prior case mix system, payments for therapy were based primarily on the minutes of therapy that a patient received, which encouraged providers to furnish more therapy services to receive higher payments. Under the PDPM, payments for therapy disciplines are based on patient characteristics and, for PT and OT, on function scores, which are determined from information on a standardized patient assessment instrument called the Minimum Data Set (MDS). As we reported last year, the share of FFS Medicare SNF stays receiving any PT or OT were similar pre- and post-PDPM implementation, but the number of PT and OT minutes per stay dropped

Skilled nursing facility care provided in swing beds

With approval from CMS, certain Medicare-certified hospitals, typically small, rural hospitals, and critical access hospitals (CAHs), may provide skilled nursing services in the hospital beds normally used to provide acute care services. These are called swing beds. In 2022, about 4 percent of SNF care was provided in swing beds. That year, the Medicare program paid nearly \$2 billion for about 70,000 Medicare-covered swing bed stays. Skilled nursing facility (SNF)-level services of non-CAH swing bed facilities are paid under the SNF prospective payment system (PPS). The SNF-level services of CAHs with swing beds are

exempt from the SNF PPS and are paid based on 101 percent of reasonable costs. In 2022, 88 percent of swing bed stays were in CAHs and 12 percent were in short-term acute care hospitals. Spending on CAH swing beds accounted for 97 percent of program spending on swing beds, owing to the much higher average daily rate (about \$2,400 per day) for CAH swing bed days compared with the average SNF PPS daily rate (about \$540 per day) paid for swing bed days provided in short-term acute care hospitals. Unless otherwise specified, analyses in this chapter do not include swing beds. ■

**TABLE
6-1****Freestanding SNFs and for-profit SNFs accounted for the majority of facilities, FFS Medicare stays, and FFS Medicare spending in 2022**

Type of SNF	Facilities	Medicare-covered stays	Medicare spending
Total number	14,691	1,842,676	\$27 billion
Freestanding	97%	98%	98%
Hospital based	3	2	2
Urban	73	84	86
Rural	27	16	14
For profit	72	76	79
Nonprofit	22	21	18
Government	5	3	3

Note: SNF (skilled nursing facility), FFS (fee-for-service). Totals may not sum to 100 percent due to rounding and missing values. Table includes covered stays and program spending in SNFs and does not include swing beds. For swing bed information, see the text box on p. 167.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review files for calendar year 2022.

after the PDPM was implemented, consistent with the PDPM's elimination of incentives to provide more therapy to receive higher payments (Medicare Payment Advisory Commission 2023c).

SNF sector profile

A skilled nursing facility is a provider that meets Medicare's requirements of participation for Part A coverage of SNF care and agrees to accept Medicare's payment rates. Medicare's requirements relate to many aspects of staffing and care delivery, such as requiring a registered nurse in the facility for 8 consecutive hours per day and licensed nurse coverage 24 hours a day; providing PT, OT, and SLP services as delineated in each patient's plan of care; and providing or arranging for physician services 24 hours a day in case of an emergency.

FFS Medicare accounts for a small share of most nursing facilities' total patient days

Most SNFs (96 percent) are dually certified to provide Medicare Part A-covered SNF care and Medicaid-covered long-term care. FFS Medicare-covered SNF days typically account for a small share of a facility's total patient days. Long-term care services, which

are less intensive, typically make up the bulk of a facility's business. Medicaid pays for most of this care. In freestanding facilities in 2022, FFS Medicare-covered days made up just 10 percent of facility days in the median facility compared with 63 percent of facility days paid by Medicaid. Given FFS Medicare's relatively high payment rates, the program made up a larger share of facility revenue (17 percent) on average, consistent with shares in 2021.

SNFs are overwhelmingly freestanding, and the majority are for profit

In 2022, 97 percent of facilities were freestanding, and they accounted for 98 percent of FFS Medicare SNF stays and 98 percent of spending (Table 6-1). Seventy-two percent of providers were for profit. Rural facilities make up the minority of SNFs, SNF stays, and SNF spending. (About 20 percent of FFS beneficiaries live in rural counties.) About 4 percent of SNF care was provided in swing bed facilities.

Freestanding SNFs vary in size. In 2022, the median SNF had 100 beds, while 10 percent of facilities had 176 or more beds and 10 percent of facilities had 50 beds or fewer. Nonprofit facilities and rural facilities are generally smaller than for-profit and urban facilities.

**TABLE
6-2**

Supply of SNFs continued to decline in 2023

						Average annual change	
	2019	2020	2021	2022	2023	2019–2023	2022–2023
Count of Medicare-participating SNFs	15,291	15,154	15,080	14,945	14,775	–3.4%	–1.1%
Count of certified beds (in millions)	1.62	1.61	1.61	1.60	1.58	–2.3	–0.8

Note: SNF (skilled nursing facility). Counts include active providers serving Medicare beneficiaries during the calendar year in Medicare-certified SNFs in the 50 states and the District of Columbia. Counts do not include nursing facilities that are not Medicare certified. Change was calculated using unrounded numbers.

Source: MedPAC analysis of active provider counts from CMS's Quality, Certification and Oversight Reports (QCOR), accessed on October 16, 2023.

However, the majority (58 percent) of small facilities (under 50 beds) in 2022 were in urban areas.

The SNF sector is fragmented and characterized by independent providers and regional chains. Complex ownership structures can make it difficult to identify common ownership of facilities and to determine the profitability of a SNF and its ancillary businesses and affiliated entities (Harrington et al. 2021). For example, SNFs may have separate operating companies and asset and property companies, which may have common ownership. In late 2022, to better identify common ownership of SNFs, CMS began publicly releasing detailed information on Medicare-certified nursing facilities—including direct and indirect facility owners, changes of ownership, and common ownership across affiliated entities. A recent study of the period from 2013 to 2022 found that investments by real estate investment trusts (REITs) in SNFs grew before leveling off with the start of the coronavirus pandemic and that private equity (PE) investment in SNFs peaked in 2015 and gradually decreased through 2022 (Stevenson et al. 2023).⁵ Using CMS data supplemented with proprietary data sources, authors estimated that PE- and REIT-invested facilities were 5 percent and 9 percent, respectively, of U.S. SNFs in 2022 (Stevenson et al. 2023). This research as well as a report from the Government Accountability Office noted errors in the CMS ownership data (Government Accountability Office 2023, Stevenson et al. 2023). In November 2023, CMS issued a final rule defining PE and REIT ownership and requiring nursing facilities to disclose information

about entities with operational, financial, or managerial control, including whether they are PE or REIT investors (Centers for Medicare & Medicaid Services 2023b).

Are FFS Medicare payments adequate in 2024?

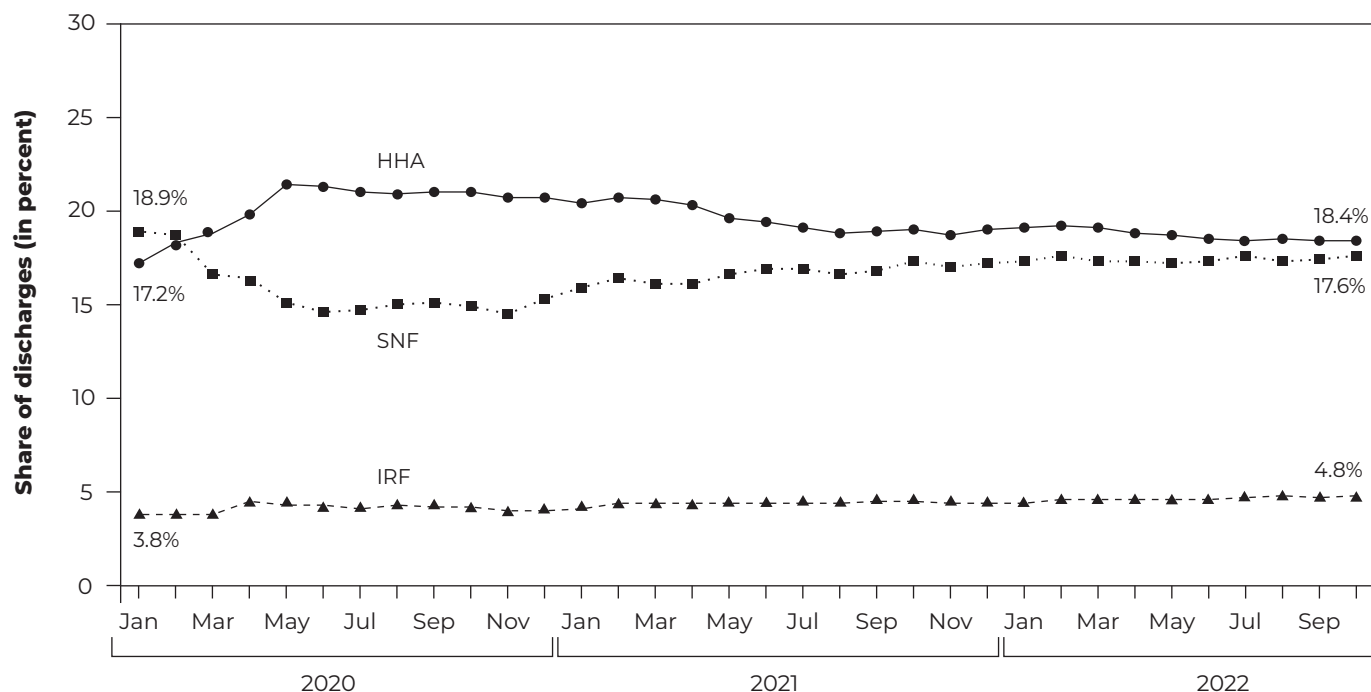
To examine the adequacy of Medicare's FFS payments, we analyze beneficiaries' access to care (including the supply of providers and volume of services), quality of care, providers' access to capital, Medicare FFS payments in relation to costs to treat Medicare beneficiaries, and changes in payments and costs. Overall, our indicators of payment adequacy were positive.

Beneficiaries' access to care: SNF supply declined slightly, and occupancy and utilization increased

To assess access to SNF care, we consider the supply and capacity of providers and evaluate changes in service volume. We also assess whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve.

SNF supply declined slightly in 2023

In 2023, the number of SNFs participating in the Medicare program (through October) declined about 1 percent from 2022 to 14,775 (Table 6-2). The modest decline in the number of SNFs over time (less than

**FIGURE
6-1****Monthly share of FFS Medicare inpatient discharges to SNFs, home health agencies, and IRFs, January 2020 to October 2022**

Note: FFS (fee-for-service), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility), HHA (home health agency). Figure includes discharges from acute care hospitals paid under the inpatient prospective payment system.

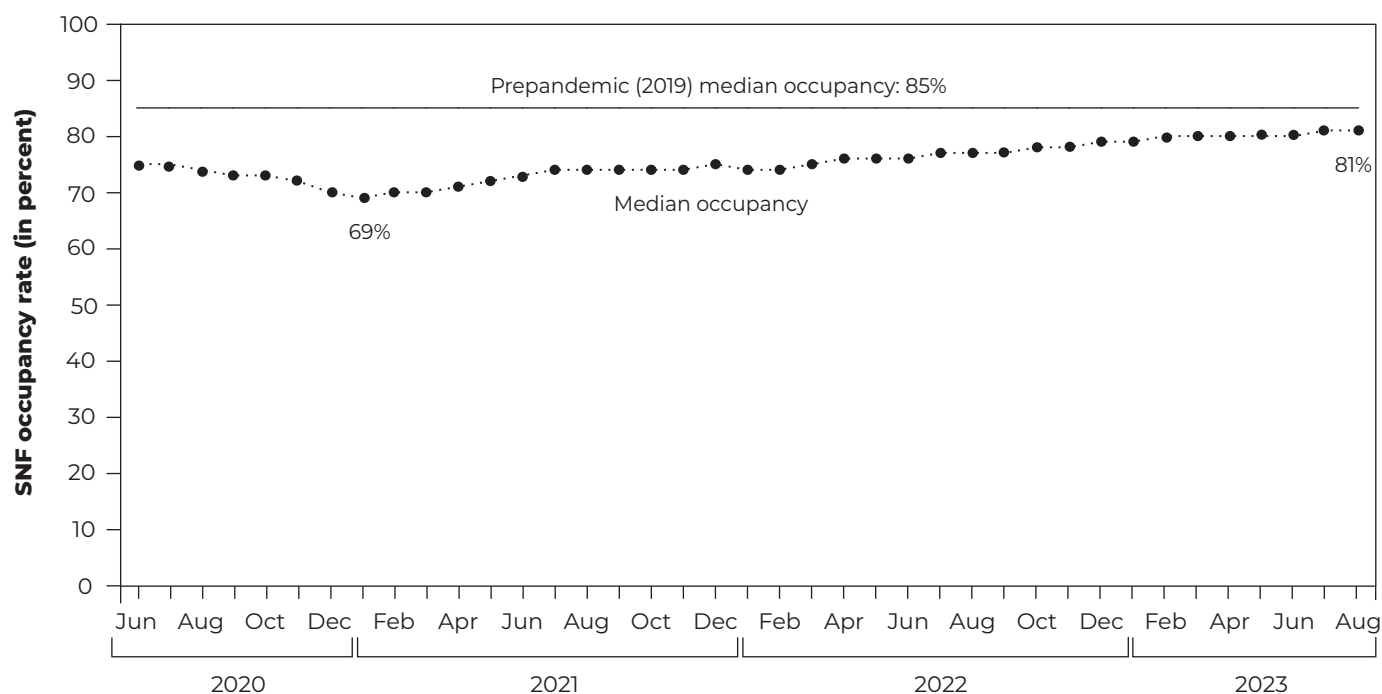
Source: MedPAC analysis of Medicare Provider Analysis and Review data.

1 percent per year between 2017 and 2021 (Medicare Payment Advisory Commission 2023a)) is likely related to several factors affecting demand for nursing home care, such as states shifting to more home- and community-based long-term care, reportedly low Medicaid payment rates for long-term care, and patient preference for receiving care in non-SNF settings when possible.

In 2022, 88 percent of Medicare beneficiaries with Part A coverage lived in counties with three or more SNFs or swing bed facilities, and 5.8 percent of beneficiaries lived in counties with no or only one SNF or swing bed facility. These shares in 2022 are the same as in 2021. The presence of a facility alone does not ensure access because a facility may not have available capacity. For example, if a beneficiary lives in an area with very high occupancy, they may have a harder time accessing SNF care close to home. As of August 2023, about 6 percent of beneficiaries lived in a county where the average SNF occupancy rate was greater than 90 percent.

About 45 percent lived in a county where the average SNF occupancy rate was between 80 percent and 90 percent, and about half lived in a county where the average SNF occupancy rate was lower than 80 percent. Even if a facility has an available bed, some beneficiaries may encounter access problems if they need specialized services or long-term care, as discussed below.

When a SNF terminates participation in the Medicare program, access could be affected if beneficiaries must travel long distances to another facility.⁶ Among SNFs that terminated participation in Medicare between 2018 and 2023, the average travel distance to the next-closest SNF or swing bed facility (active in 2023) was greater for terminated SNFs in rural areas than for SNFs in metropolitan areas. For SNFs that closed in metropolitan areas, the median travel distance to the closest SNF or swing bed was less than two miles; for

**FIGURE
6-2****SNF occupancy steadily climbed in 2022 and 2023, though not to prepandemic levels**

Note: SNF (skilled nursing facility). Data include SNFs in the 50 states and the District of Columbia.

Source: MedPAC analysis of data from the Nursing Home COVID-19 Public File from CMS.

SNFs in rural areas, the median travel distance was about six miles.⁷

The rate of SNF use after an inpatient discharge increased in 2022 after pandemic-related declines

In January 2020, immediately prior to the pandemic, SNFs were the most common first post-acute care (PAC) destination after discharge from an inpatient hospital stay, accounting for 18.9 percent of FFS discharges (Figure 6-1). That same month, 17.2 percent of inpatient stays were discharged home with home health care. As the number of inpatient discharges dropped starting in March 2020, the share of beneficiaries discharged from a hospital to a SNF also declined. At the same time, the share discharged to home health care and inpatient rehabilitation facilities increased. Although by September 2022 SNFs had not regained their prepandemic share of FFS discharges, they had gradually recovered some of the share of discharge volume lost during the pandemic.

SNF occupancy and utilization increased in 2022

Before the public health emergency (PHE), between 2010 and 2019, median occupancy rates for freestanding SNFs were declining—from 88 percent to 85 percent, based on cost report data. Occupancy rates also varied by state. In 2019, median state occupancy rates ranged from 62 percent to 95 percent. Nationally, average occupancy fell during the coronavirus pandemic due to death, move-outs, and avoidance of the setting. SNF occupancy hit its lowest point in January 2021, when the median occupancy rate was 69 percent (Figure 6-2). After that point, occupancy steadily increased. By August 2023, the median national SNF occupancy rate was 81 percent, one-quarter of SNFs had higher than 90 percent occupancy, and one-quarter of SNFs had occupancy of 67 percent or less. By state, median occupancy rates ranged from 63 percent to 93 percent as of August 2023.

SNF employment remained below prepandemic levels but showed gains through July 2023

As occupancy declined in 2020 and 2021, the number of SNF employees also fell steeply. According to the Bureau of Labor Statistics, between March 2020 and the pandemic low in April 2022, the number of employees in the SNF sector declined nearly 18 percent (Bureau of Labor Statistics 2022).⁸ Overall employment in the sector has been growing since the second quarter of 2022. By July 2023, employment in the SNF sector was 10 percent lower than in March 2020.

While we do not have empirical data on the extent to which staffing shortages may have constrained access to SNF care or how widespread the effects may have been, SNFs have reported limiting admissions, and hospitals have reported discharge delays and difficulty transitioning patients to SNFs, though delays are not exclusive to FFS Medicare patients (Stulick 2022b). In a report by the Massachusetts Hospital Association drawing on survey data from hospital case managers, the most commonly reported reason for discharge delays (of all patients) to PAC settings were “administrative delays and prior authorization decisions from commercial insurers, especially national Medicare Advantage plans” (Massachusetts Health & Hospital Association 2023). (FFS Medicare does not require prior authorization.) The report also cited discharge delays related to staffing shortages at PAC providers; patients’ lack of guardianship or health care proxy designations that make it difficult to approve transfers; patients’ needs for specialized services; and patients’ needs for long-term care, particularly if a patient has a dementia diagnosis or behavioral health care needs (Massachusetts Health & Hospital Association 2023).

For all FFS Medicare cases discharged to a SNF, the average length of stay in an acute care hospital (ACH) paid under the inpatient prospective payment systems was about a third of a day longer in October 2023, the latest month for which we have complete data, compared with January 2020. During this same period, ACH length of stay also increased for FFS beneficiaries being discharged to other PAC settings and for beneficiaries who did not receive care in a PAC setting after an ACH discharge. The increasing length of stay nationally could be a function of several factors, including increased patient severity (as discussed in the chapter on payment adequacy for hospital services) and discharge delays, which could be more pronounced

in some markets or for some patients who need specialized services or long-term care.

SNF admissions and days increased in 2022

SNF use among FFS Medicare beneficiaries was in decline for years prior to the pandemic. Between 2010 and 2019, covered admissions per FFS beneficiary fell 18.5 percent and covered days fell 25.2 percent (Medicare Payment Advisory Commission 2021c). Several factors likely contributed to this decline, including a contemporaneous reduction in inpatient hospital stays needed to qualify for SNF coverage. Although we cannot quantify the extent of this effect on overall FFS Medicare SNF use, the proliferation of alternative payment models may have also contributed, either directly or through spillover effects.⁹

During the first two years of the pandemic (2020 and 2021), SNF utilization per FFS beneficiary declined sharply. Between 2019 and 2021, admissions per FFS beneficiary fell 12 percent and days per FFS beneficiary fell 6 percent. Because hospital capacity was constrained during the pandemic, volume reductions might have been even steeper absent the PHE-related policy that waived the three-day-stay requirement for SNF coverage.

In 2022, the volume of FFS Medicare stays increased in SNFs. The number of SNF stays and covered days increased nearly 7 percent between 2021 and 2022 (not shown). Per FFS beneficiary, SNF admissions were up more than 10 percent between 2021 and 2022 to 54 per 1,000 FFS beneficiaries (Table 6-3). Compared with 2019, covered admissions per FFS beneficiary were 3.1 percent lower in 2022, but covered days were 7 percent higher, owing to longer lengths of stay. Because the SNF PPS pays on a per diem basis, longer lengths of stay result in increased revenue. Increased length of stay could have been driven by a number of factors, including changes in patient acuity and case mix during the pandemic. We will continue to monitor length of stay to see whether these changes persist or revert to lower prepandemic levels.

SNFs with available capacity continued to have a strong financial incentive to admit Medicare beneficiaries

Another measure of access is whether providers have a financial incentive to expand the number of FFS Medicare beneficiaries they serve. In considering

**TABLE
6-3**

SNF admissions and days increased in 2022

Volume measure	2019	2020	2021	2022	Change	
					2019–2022	2021–2022
Covered admissions per 1,000 FFS beneficiaries	55	50	49	54	–3.1%	10.3%
Covered days per 1,000 FFS beneficiaries	1,447	1,429	1,361	1,500	3.6	10.2
Covered days per admission	26.1	28.5	28.0	28.0	7.0	–0.1

Note: SNF (skilled nursing facility), FFS (fee-for-service). Data are for the calendar years and include SNFs in the 50 states and the District of Columbia. Data do not include swing bed stays. Results shown differ from those reported in prior years due to a change in the source. To be consistent with other sectors, we use our own analysis of claims data to assess utilization.

Source: MedPAC analysis of calendar year 2019–2022 Medicare Provider Analysis and Review and Common Medicare Environment data.

whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e., the FFS Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider has a financial incentive to increase its volume of Medicare patients. In contrast, if payments do not cover the marginal costs, the provider may have a disincentive to care for FFS Medicare beneficiaries.¹⁰

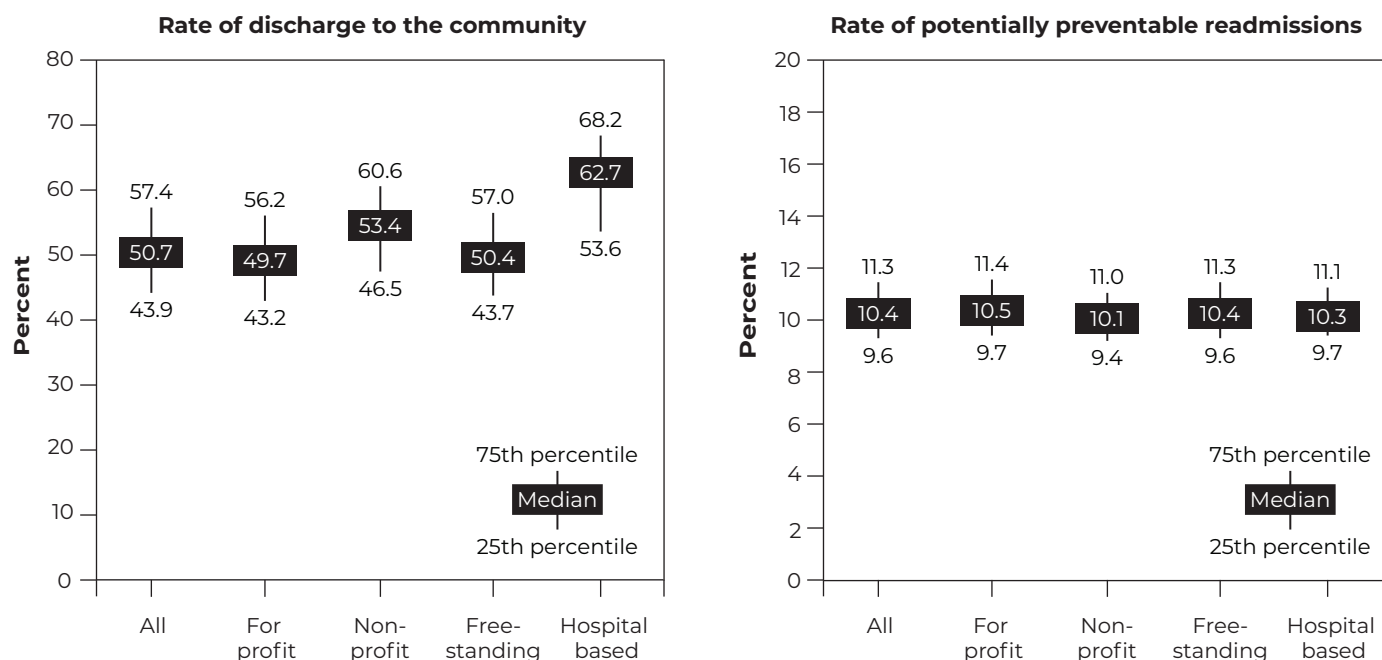
In 2022, the FFS Medicare marginal profit among freestanding SNFs was 27 percent, indicating that facilities with available beds had a strong incentive to admit Medicare patients. This high marginal profit is a strong positive indicator of beneficiary access to SNF care. FFS Medicare is a preferred payer in this sector, although some SNFs that specialize in Medicare patients may avoid FFS Medicare beneficiaries who are likely to require long stays and exhaust their Medicare benefits.

Quality of care: Discharge to the community and potentially preventable readmissions

The Commission prioritizes quality measures tied to clinical outcomes in our assessment of payment adequacy. This year, we report two outcome measures for SNFs: risk-adjusted potentially preventable hospital readmissions after discharge and risk-adjusted discharge to the community. We are replacing

prototype cross-sector measures developed by the Commission, which we have previously used in our analysis of payment adequacy, with these similar claims-based outcome measures developed by CMS. CMS outcome measures are the product of a transparent, expert-informed measure development process and have undergone public notice. They have been and will be refined over time to incorporate improvements. CMS publicly reports facility-level measures after providers have the opportunity to review the data. The measures are updated annually and cover a 24-month period. The most recent available data, released in October 2023, cover the period from the fourth quarter of 2020 through the third quarter of 2022 (fiscal year (FY) 2021 through FY 2022).

The measure of discharge to the community is a SNF's risk-standardized rate of FFS Medicare residents who are discharged to the community after a SNF stay, do not have an unplanned readmission to an acute care hospital or long-term care hospital in the 31 days following discharge to the community, and remain alive during those 31 days (higher rates are better) (RAND Corporation and RTI International 2019).¹¹ Baseline nursing facility residents—those who were nursing facility residents prior to their Part A-covered SNF stay—are excluded from the measure because discharge to the community may not be a safe or expected outcome for these patients (RAND Corporation and RTI International 2019). SNFs can improve their rate of discharge to the community by

**FIGURE
6-3****Median and interquartile range of SNFs' risk-standardized rates of discharge to the community and potentially preventable readmissions in FY 2021 and FY 2022**

Note: SNF (skilled nursing facility), FY (fiscal year). Data include SNFs in the 50 states and the District of Columbia and cover 24 months (fiscal years 2021 and 2022 combined). The measure of discharge to the community is a SNF's risk-standardized rate of FFS Medicare residents who were discharged to the community after a SNF stay, did not have an unplanned readmission to an acute care or long-term care hospital in the 31 days following discharge to the community, and remained alive during those 31 days. Higher rates are better. The measure of potentially preventable readmissions after discharge is calculated as the risk-adjusted percentage of patients discharged from a SNF stay who were readmitted to a hospital within 30 days for a medical condition that might have been prevented. Lower rates are better. Rates are computed from Medicare claims for eligible Medicare Part A-covered SNF stays and do not include swing bed stays.

Source: MedPAC analysis of claims-based outcome measures from CMS's Provider Data Catalog.

providing recuperative nursing care, rehabilitation to improve functional ability, discharge planning care and coordination, and patient and family education. In FY 2021 and FY 2022, the national average observed rate of discharge to the community was 49.7 percent (not shown) and the median facility risk-standardized rate of discharge to the community was 50.7 percent, which is a slight decline compared with the FY 2018 and FY 2019 rate of 51.7 percent (not shown). In FY 2021 and FY 2022, one-quarter of facilities had a risk-standardized rate below 43.9 percent and one-quarter had a rate above 57.4 percent (Figure 6-3).

Readmissions expose beneficiaries to hospital-acquired infections and increase the number of transitions between settings. They also unnecessarily increase

Medicare spending. A SNF can reduce the number of potentially preventable hospital readmissions by preventing complications, providing clear discharge instructions to patients and families, and ensuring a safe discharge plan. Potentially preventable readmissions after discharge are calculated as the percentage of patients discharged from a SNF stay who were readmitted to a hospital within 30 days for a medical condition that might have been prevented (lower percentages are better) (RTI International 2016). During the FY 2021 and FY 2022 period, the national average observed rate (not shown) of potentially preventable readmissions was 10.5 percent. The median facility-level risk-adjusted rate of potentially preventable readmissions was 10.4 percent (Figure 6-3). This rate is not comparable with earlier periods

because CMS updated the list of diagnosis codes in diagnosis categories that are considered potentially preventable readmissions but which were excluded in the original development of this measure. This change makes the measure more comprehensive but incomparable with previous time periods.

Readmissions and discharge to the community measures assess key outcomes of SNF care, but they do not capture all aspects of quality in SNFs. Ideally, we could also measure other outcomes and the experience of SNF care for Medicare beneficiaries in a Part A stay. However, lack of data on patient experience and concerns about the validity of function data derived from the MDS limit our set of quality measures, as discussed below.

Patient experience data are not collected for SNF patients

The Medicare program does not collect data on beneficiaries' experience of their SNF care, nor on their informal primary caregivers' experiences. In 2021, the Commission recommended that the Secretary finalize development of and begin to report patient experience measures for SNFs. The Commission also noted that such measures should become part of the measure set for the SNF value incentive program (see text box on improving value-based payment to SNFs, p. 177) (Medicare Payment Advisory Commission 2021b). CMS proposed adopting a patient experience survey in the SNF proposed rule for 2024 but opted not to implement this provision in the final rule (Centers for Medicare & Medicaid Services 2023c).

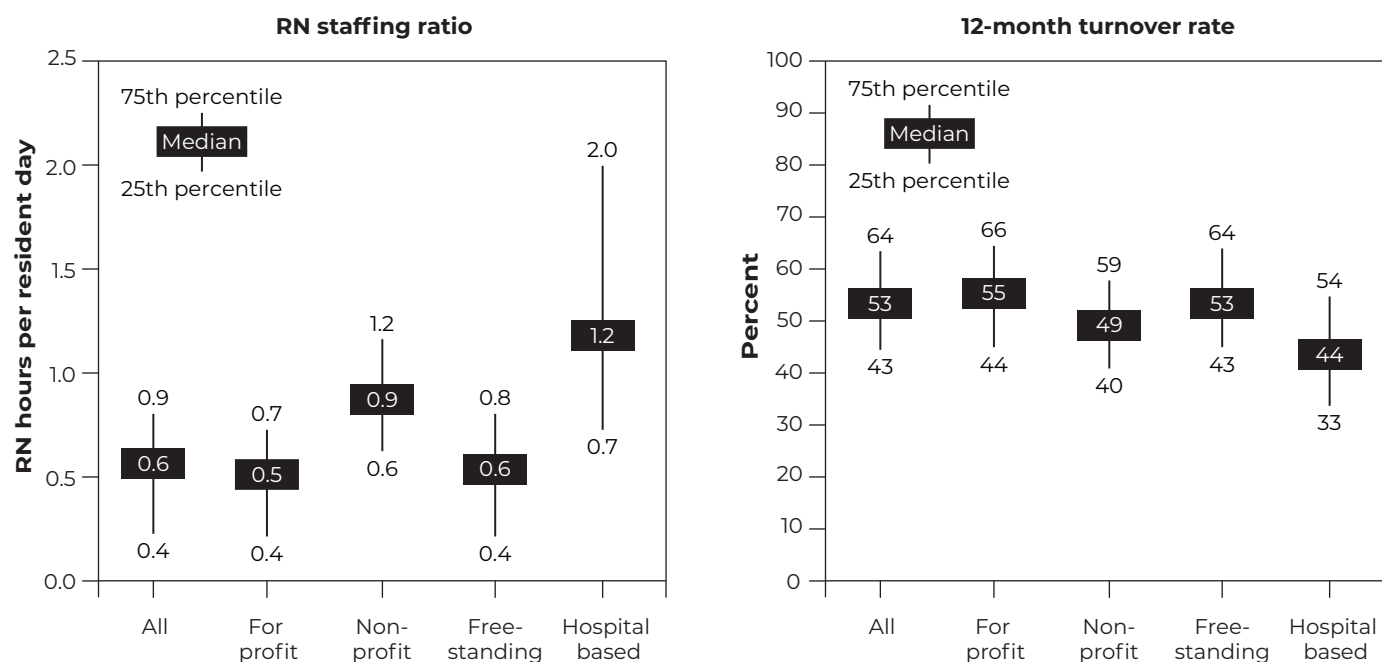
Although not a direct measure of patient experience, the number and continuity of staff can impact quality of life and patient safety in a SNF (National Academies of Sciences 2022). In addition, the clearest evidence to emerge from research on the effects of SNF staffing is the positive correlation between registered nurse (RN) staffing levels and outcomes (Armijo-Olivo et al. 2020, Clemens et al. 2021, Jutkowitz et al. 2023) and turnover and outcomes (Gandhi et al. 2021, Loomer et al. 2022, Zheng et al. 2022). However, from the Commission's perspective, nursing facility staffing ratios and turnover are difficult to interpret as specific quality measures for Medicare-covered stays because they apply to the entire facility and not just to Medicare-covered stays.

RN staffing ratios and staff turnover rates vary by facility and among categories of SNFs. In 2022, the

median SNF provided 0.6 RN hours per resident day (HPRD), as shown in Figure 6-4 (p. 176). Freestanding SNFs had lower median case-mix-adjusted RN staffing (0.6 HPRD) than hospital-based SNFs (1.2 HPRD), and for-profit SNFs (0.5 HPRD) had lower median case-mix-adjusted RN staffing than nonprofit SNFs (0.9 HPRD) and government SNFs (0.7 HPRD). Although the staffing ratios are adjusted for acuity, some of the differences we observe could nevertheless reflect the mix of long-stay residents and short-stay PAC patients in a facility. The 12-month nursing staff turnover rate as of the fourth quarter of 2022 was 53 percent for the median SNF, as shown in Figure 6-4.¹² One-quarter of facilities had turnover rates greater than 64 percent—meaning nearly two-thirds of their nursing staff left the facility in a 12-month period.

Patient function is a key SNF outcome, but the Commission has questioned the accuracy of function information reported by PAC providers

Maintaining and improving patients' function is a key outcome of post-acute care. SNFs assess and record information on each beneficiary's level of function at admission to and discharge from a SNF using the MDS.¹³ We analyzed SNFs' risk-adjusted share of short-stay patients who gained independence in function between admission to and discharge from the SNF and found that the mean facility share of patients who made improvements in function increased almost 9 percentage points between 2019 and 2023, even as the overall number of therapy minutes declined.¹⁴ However, because provider-reported function data are used to assign patients to case-mix groups to adjust payment, the Commission has raised concerns about the validity of PAC function data. As we reported in our June 2019 report to the Congress, PAC providers' recording of functional assessment information, such as change in mobility, appears to be influenced by incentives in the applicable payment systems (Medicare Payment Advisory Commission 2019). Thus in our 2021 recommendations for an alternative quality incentive program—the SNF value-incentive program (see text box, p. 177)—the Commission noted that provider-reported patient assessment information (such as functional status) should not be included until CMS has a process in place to regularly validate these data (Medicare Payment Advisory Commission 2021b).

**FIGURE
6-4****SNFs' median and interquartile range of acuity-adjusted RN staffing ratios and total nursing staff 12-month turnover rates, 2022**

Note: SNF (skilled nursing facility), RN (registered nurse). Staffing ratios for the year are determined by averaging the quarterly values for each provider for the calendar year. All Medicare- and Medicare/Medicaid-certified SNFs with valid data are included.

Source: MedPAC analysis of quarterly nursing facility staffing measures from CMS's provider data catalog.

Because functional outcomes are critically important to patients receiving PAC, the Commission has discussed strategies to improve the assessment data, the importance of monitoring the reporting of these data, and the use of alternative measures of function (such as patient-reported surveys) that do not rely on provider-completed assessments (Medicare Payment Advisory Commission 2019). Beneficiaries and policymakers have a strong interest in objective information about SNFs' effectiveness in improving or maintaining their patients' functional abilities. The ability to monitor patient function is especially important given the reduction in therapy minutes that beneficiaries are provided since the implementation of the PDPM. (See the related discussion about decreased therapy minutes on pp. 167–168.)

Providers' access to capital remains adequate

Access to capital allows SNFs to maintain, modernize, and expand their facilities. The vast majority of SNFs are part of nursing facilities. Therefore, in assessing SNFs' access to capital, we look at the availability of capital for the entire facility. Because Medicare makes up a minority share of most SNFs' revenue, access to capital generally reflects factors other than the adequacy of Medicare's payments, such as the adequacy of Medicaid payment rates.

Capital in this sector is less likely to finance new construction than to update facilities or finance purchases of existing facilities because of state certificate-of-need (CON) laws that limit bed supply.

The SNF value-based purchasing program

As part of the Protecting Access to Medicare Act of 2014 (PAMA), the Congress enacted a skilled nursing facility (SNF) value-based purchasing (VBP) program that began adjusting payments to providers in October 2018. PAMA mandated the use of a single measure (30-day all-cause hospital readmissions) to gauge the quality of care that SNFs provide to fee-for-service (FFS) beneficiaries. Subsequently, in the Consolidated Appropriations Act, 2021, the Congress granted authority to the Secretary to add up to nine more measures to the SNF VBP program.

In June 2021, the Commission made two recommendations in a mandated report evaluating the SNF VBP program (Medicare Payment Advisory Commission 2021b). First, the Congress should eliminate Medicare's current SNF VBP program and establish a new SNF value incentive program that:

- scores a small set of performance measures,
- incorporates strategies to ensure reliable measure results,

- establishes a system that minimizes cliff effects in distributing rewards,
- accounts for differences in patient social risk factors using a peer-grouping mechanism, and
- completely distributes a provider-funded pool of dollars.

Second, the Commission recommended that the Secretary finalize patient experience measures for SNFs and begin to report the data.

Under its authority to expand the measure set, CMS adopted additional measures for the SNF VBP program in the SNF prospective payment system final rules for fiscal year (FY) 2023 and FY 2024 (Centers for Medicare & Medicaid Services 2022b). Three new measures will be added in fiscal year 2026, and an additional five new measures will be added in FY 2027 (Centers for Medicare & Medicaid Services 2022b). ■

Currently, 35 states and the District of Columbia maintain some form of CON program (National Conference of State Legislatures 2023). Similarly, at least 13 states have a moratorium, most commonly for long-term care providers, on certain activities and capital expenditures such as expanding the number of long-term care beds in a facility.

Each year, Irving Levin Associates produces data and commentary on the volume of SNF transactions and the price per bed. These indicators provide information on buyer interest and their willingness to invest in the sector. In 2022, the average price per SNF bed rose to a record high of \$114,200, which was 17 percent higher than the 2021 average price of \$98,000 (data not

shown) (Irving Levin Associates LLC 2023a, Irving Levin Associates LLC 2022). The prices reported are based on arm's length transactions in which a willing buyer and a willing seller agree on a price with the property exposed to the market. Reported prices include the real estate and business operations, including any licenses.¹⁵ In 2022, the number of SNF transactions was 104, compared with 139 in 2021. Although there were fewer transactions in 2022, the number of facilities and beds involved in these deals was higher in 2022 than in 2021 (Table 6-4, p. 178).

In 2022, buyers saw a favorable reimbursement environment that they could maximize in acquired facilities (Irving Levin Associates LLC 2023a). In

**TABLE
6-4****The number of publicly announced SNF transactions, 2018–2022**

	2018	2019	2020	2021	2022
Number of transactions	206	186	150	139	104
Number of facilities	351	365	265	258	381
Number of beds	43,550	42,043	31,900	31,300	43,500

Note: SNF (skilled nursing facility).

Source: Irving Levin and Associates Senior Care Acquisition Report 2019–2023.

addition, for buyers, “the ancillary businesses surrounding the SNF, from staffing agencies to therapy companies to food providers, all add revenue streams to the parent company and provide more opportunities for profit as they add more patients under their operational umbrellas” (Irving Levin Associates LLC 2023a). As debt became more expensive in 2023, the average price per bed dropped to \$106,800 for the four quarters ending in mid-2023 (Irving Levin Associates LLC 2023b). While this price is still high by historical standards, analysts expect the average price to continue falling in 2024, “especially for struggling assets” (Irving Levin Associates LLC 2023b).

The Department of Housing and Urban Development (HUD) is an important lending source for this sector. Section 232 loans help finance SNFs by providing lenders with protection against losses if borrowers default on their mortgage loans. In 2023, HUD financed 196 projects, compared with 269 projects in 2022 (Department of Housing and Urban Development 2023, Department of Housing and Urban Development 2022). The total HUD-insured amount in 2023 was \$2.9 billion, compared with \$3 billion in 2022 (Department of Housing and Urban Development 2023, Department of Housing and Urban Development 2022). In addition to HUD and commercial bank loans, a minority of facilities access capital via private equity, as discussed above (ATI Advisory 2022).

The SNF sector remains attractive for investors because of demand stemming from the aging population and the setting’s relatively lower costs compared with other institutional PAC such as

inpatient rehabilitation facilities. Any reluctance to invest in this setting does not reflect the adequacy of Medicare’s FFS SNF payments: Medicare remains a preferred payer in this sector.

All-payer total margins decreased in 2022

In 2022, the estimated all-payer total margin for freestanding SNFs (reflecting all lines of business, all payers, and investment income) was –1.4 percent, down from 3.4 percent in 2021. In 2022, 51 percent of SNFs had negative all-payer total margins, up from 40 percent in 2021. Higher all-payer total margins in 2020 and 2021 were due to the general and targeted funding that SNFs received during the PHE, the PHE-related changes in Medicare policies, and the increases in Medicaid rates made by many states, some of which were temporary. Provider relief funds were reported in 2022, though the amounts in aggregate were about half of what they were in 2020 and 2021, contributing to the reduced all-payer total margin. Without these additional funds, all-payer total margin in 2022 would have been about –4 percent.

Because the all-payer total margin includes Medicaid-funded long-term care, the overall financial performance of this setting is heavily influenced by state policies regarding the level of Medicaid payments, including base rates and supplemental payments. A 2023 Medicaid and CHIP Payment and Access Commission study found that nursing facility profitability under Medicaid varies by facility and across and within states, and it lacks transparency (see the text box on Medicaid nursing facility payments relative to costs, pp. 180–181).

While some have argued that Medicare SNF PPS rates should remain high to subsidize lower rates from other payers, particularly Medicaid, the Commission has long held that subsidizing Medicaid or other payers with Medicare payment rates that are far in excess of providers' costs is poor policy for several reasons, discussed below.

Higher Medicare payment rates could create undesirable incentives for providers that harm patient care and exacerbate inequities

The differential between Medicare's payment rates and those of other payers such as Medicaid encourage providers to select patients based on payer source. It also encourages providers to rehospitalize dual-eligible facility residents (those enrolled in both Medicare and Medicaid) to qualify them for a Medicare-covered SNF stay at a higher payment rate, and to extend the length of a Medicare-covered SNF stay to receive additional payment. Higher FFS Medicare payment rates could further encourage providers to enter or leave certain markets to maximize utilization of the highly paid services, which could in turn limit access to non-Medicare-covered services for some patients, particularly dual-eligible beneficiaries.

Researchers have found that, compared with other SNF users, Black, Hispanic, and dual-eligible beneficiaries are more likely to use lower-quality facilities (Sharma et al. 2020, Zuckerman et al. 2019). Facilities that specialize in high-revenue Medicare-covered PAC services (as opposed to long-term care services) also care for fewer Black and Hispanic patients and patients on Medicaid, further limiting the reach of Medicare-funded subsidies (Werner et al. 2021). As some SNFs have increased their share of Medicare admissions, increased specialization in PAC may exacerbate existing racial and economic disparities in access to high-quality SNF care (Werner et al. 2021).

Medicare subsidization of other payers through Medicare's PPS payments results in poorly targeted subsidies

Facilities with high Medicare volume currently receive the most in "subsidies" through higher Medicare payments, while facilities with low Medicare volume—potentially the facilities with the greatest financial need—receive the least. Thus, higher Medicare payments do not target assistance to those facilities with high Medicaid volumes.

Medicare's subsidization of Medicaid does not differentiate among states with relatively high or low Medicaid payments

States establish Medicaid rates to nursing facilities, and those rates vary across and within states. Medicare's high payment levels encourage states to maintain low Medicaid payments or further reduce them. Lower Medicaid rates, in turn, increase a facility's reliance on the higher Medicare rates, creating pressure to raise Medicare rates even more—essentially creating a growing Medicare funding stream for long-term care, which is not a covered Medicare benefit.

Maintaining or raising Medicare's payments to subsidize other payers exerts pressure on an already fiscally challenged Medicare program

If policymakers wish to provide additional support to certain SNFs, they could do so through a separate, targeted policy. It is important for providers that treat large shares of Medicaid patients to be supported, but that cost should be Medicaid's responsibility and not be funded by the Medicare program.

Medicare payments and providers' costs: FFS Medicare margins remained high in 2022

In 2022, the aggregate FFS Medicare margin for freestanding SNFs was 18.4 percent, an increase of less than 1 percentage point compared with 2021. FFS Medicare margins for individual facilities varied considerably across providers, as they have in prior years.

Trends in FFS spending and cost growth

In 2022, FFS Medicare spending on care in SNFs was \$27 billion, an increase of 8.4 percent compared with 2021. This increase in overall spending is a function of rebounding volume (see discussion on pp. 172–173). Program spending in 2022 also reflects continued excess payment resulting from the implementation of the PDPM case-mix system starting in 2020. CMS estimated that the new case-mix system, though intended to be budget neutral, increased payments compared with what would have been paid under the old case-mix system (Centers for Medicare & Medicaid Services 2022a). CMS identified this overpayment starting in FY 2020, but it opted not to make an adjustment for overpayments (totaling 4.6 percent) until FY 2023 and FY 2024 (Centers for Medicare & Medicaid Services 2022a).¹⁶

Medicaid nursing facility payments relative to costs vary widely and appear to fall short of the cost of care, but better data are needed

States have flexibility to determine Medicaid nursing facility (NF) payment policy, including setting Medicaid base payment rates.¹⁷ Information about Medicaid rates and their relationship to costs has been limited. A 2023 Medicaid and CHIP Payment and Access

Commission (MACPAC) study examined Medicaid NF payments at the facility level and estimated how those payments compare with facility-level, Medicaid-specific costs (Medicaid and CHIP Payment and Access Commission 2023b). MACPAC found a wide range, both within and across states,

(continued next page)

Between 2021 and 2022, the average payment per day in freestanding SNFs increased 2.2 percent, while costs per day increased 1.7 percent. Changes in payments per day in 2022 reflect the combined effect of the market basket increase to the base rate and an increase in case mix, as well as the reinstatement of the 2 percent sequester starting in April 2022.¹⁸ The relatively lower growth in costs per day reflects more covered days over which to spread fixed costs. Routine costs per day increased in 2022, but the rate of growth moderated compared with 2021, when growth in costs per day increased 4 percent. Total cost growth in 2022 reflects both a higher-than-historical average growth in routine costs per day and partially offsetting reductions in ancillary costs per day. The growth in routine costs reflects increased labor costs in 2022, which may have been driven by higher wages, use of contract labor, and a greater decline in lower-paid nursing aide staff relative to higher-paid nursing staff. Wage data for the SNF sector from the Bureau of Labor Statistics show that hourly wages in the sector grew nearly 5 percent in 2022 (Bureau of Labor Statistics 2023). While still higher than historical rates of growth, 2022 wage growth was lower than in 2020 or 2021, when it was over 8 percent per year.

In contrast to routine costs per day, ancillary costs per day declined between 2021 and 2022. Under the PDPM, providers no longer receive additional payments for providing additional minutes of therapy. Between 2021 and 2022, minutes of therapy per discharge decreased

about 11 percent in aggregate and a greater share of all therapy minutes were provided in a group setting or concurrently. The reduction in ancillary costs per day between 2021 and 2022 is consistent with the reduced amount of therapy minutes and increased group and concurrent therapy we observe.

Consistent with past years, cost growth and level of costs varied by ownership. In 2022, nonprofit providers reported larger increases in cost per day compared with for-profit providers (2.3 percent vs. 1.8 percent). In 2022, nonprofit providers had 17 percent higher costs per day than for-profit providers, in part because they are smaller and have a lower average daily census, so they cannot achieve the same economies of scale as larger, for-profit facilities. Nonprofit SNFs also have higher average nurse hours per resident day than for-profit SNFs.

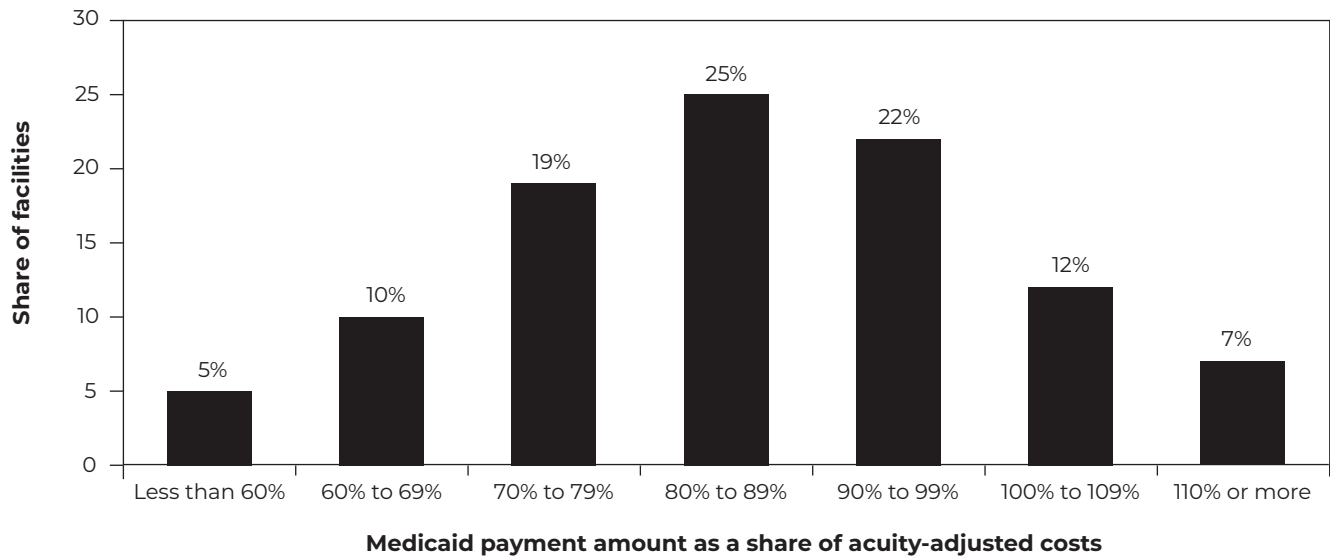
The FFS Medicare margin for freestanding SNFs remains high

The FFS Medicare margin is a key measure of the adequacy of the program's payments because it compares Medicare's FFS payments with providers' costs to treat FFS beneficiaries. In 2022, the FFS Medicare margin for freestanding SNFs was 18.4 percent, not including federal relief funds.¹⁹ For the 23rd consecutive year, the FFS Medicare margin for freestanding SNFs was 10 percent or higher (Figure 6-6, p. 182). While the PDPM better recognized medical complexity as it relates to resource use and reduced incentives to provide more therapy, it also

Medicaid nursing facility payments relative to costs vary widely and appear to fall short of the cost of care, but better data are needed (cont.)

FIGURE 6-5

Distribution of Medicaid base nursing facility payment amounts as a share of nursing facilities' acuity-adjusted costs, 2019



Note: Base payments include resident contributions to their share of costs. Analysis excludes Alaska, New Hampshire, and Idaho because of unreliable or missing data. Managed care-allowed amounts in California, Massachusetts, New Jersey, Rhode Island, and Virginia were not available, so only fee-for-service Medicaid spending is included for these states. Payment amounts do not include Medicaid supplemental payments.

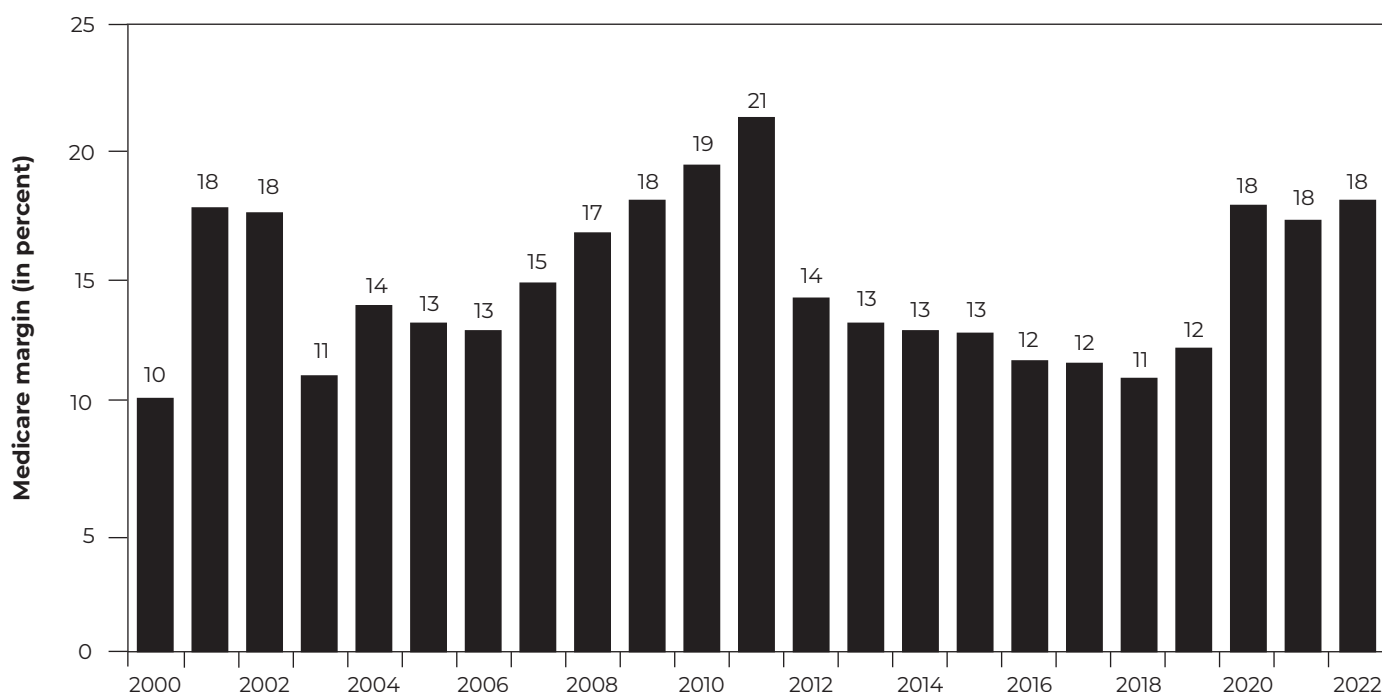
Source: Abt Associates analysis for the Medicaid and CHIP Payment and Access Commission of the Transformed Medicaid Statistical Information System (T-MSIS), Medicare cost reports, and the Minimum Data Set Medicaid and CHIP Payment and Access Commission (2023b).

in base payments (not including supplemental payments) compared with acuity-adjusted costs in 2019. The median NF had base payment amounts that were 86 percent of costs. Fifteen percent of facilities had base payment amounts less than 70 percent of costs, while one-fifth of facilities had base payment amounts that covered at least 100 percent of costs (Figure 6-5).

Because NFs in 23 states also receive supplemental Medicaid payments in addition to base payment amounts, base payment amounts alone do not reflect total Medicaid payments to nursing facilities.²⁰ However, supplemental payments are not reflected in Figure 6-5 because facility-level

supplemental payment data used in this study were not reliable for nearly all states. For two states with reliable supplemental payment data, MACPAC found that supplemental payments substantially increased payments, making Medicaid a profitable payer for more facilities in these states (Medicaid and CHIP Payment and Access Commission 2023a).

MACPAC's analysis showing the variability in Medicaid base payment rates and profitability of Medicaid at the facility level lends further support to the Commission's long-held principle that higher across-the-board Medicare fee-for-service payments would provide poorly targeted Medicare subsidies. ■

**FIGURE
6-6****Freestanding SNFs' aggregate FFS Medicare margin
has been 10 percent or higher since 2000**

Note: SNF (skilled nursing facility), FFS (fee-for-service). FFS Medicare margin is calculated as aggregate FFS Medicare payments minus aggregate FFS Medicare costs, divided by aggregate FFS Medicare payments. The margins for 2020, 2021, and 2022 exclude pandemic-related federal relief funds.

Source: MedPAC analysis of freestanding SNF cost reports, 2000–2022.

set payments too high. (As mentioned above, CMS estimates that payments were 4.6 percent higher than intended because of the PDPM.) Indeed, following implementation of the PDPM in 2019, the SNF FFS margin jumped from 12 percent to 18 percent and remained at about that level through 2022.

In 2022, hospital-based SNFs (which account for 2 percent of program spending on SNFs) continued to have substantial negative FFS Medicare margins (data not shown). The FFS Medicare margin for hospital-based SNFs was –56 percent (compared with –36 percent in 2021 and –48 percent in 2020). Hospital administrators consider their SNF units in the context of the hospital's overall financial performance and mission. Hospitals with SNFs can lower their inpatient lengths of stay by transferring patients to their own

SNF beds, thus making inpatient beds available to treat additional inpatients.

FFS Medicare margins varied widely in 2022

FFS Medicare margins for freestanding SNFs varied widely across SNFs: One-quarter of SNFs had FFS Medicare margins that were 28.9 percent or higher, and one-quarter had margins that were 4.4 percent or lower (Table 6-5). The differences in FFS Medicare margins between for-profit and nonprofit facilities have persisted for years. The disparity reflects differences in costs per day and, to a lesser extent, payments per day. Compared with for-profit facilities, nonprofit facilities were smaller (fewer beds and lower volume) and had lower payments per day, higher costs per day, and higher growth in costs per day between 2021 and 2022. The FFS Medicare margins for urban

SNFs were 1 percentage point higher than those for rural SNFs in 2022. While rural SNFs are smaller on average than urban SNFs, the majority of facilities with fewer than 50 beds are urban, and small rural SNFs have, on average, higher margins than small urban SNFs. Differences in FFS Medicare margins partly reflect the economies of scale that larger SNFs achieve. Facilities with 20 to 50 beds had a lower average FFS Medicare margin compared with facilities with 100 to 199 beds. And low-volume facilities (bottom quintile of total facility days) had a lower average FFS Medicare margin than high-volume (top quintile of days) facilities. SNFs with the lowest cost per day (the bottom 25th percentile of the distribution of cost per day) had a FFS Medicare margin that was nearly 30 percentage points higher than SNFs with the highest (in the top 25th percentile) cost per day.

SNFs in the top quartile of the distribution of FFS Medicare margins appear to pursue cost and revenue strategies. Compared with SNFs in the lowest FFS Medicare margin quartile, high-margin SNFs have lower standardized costs per day and per discharge. High-margin SNFs also have lower total nursing and RN hours per resident day compared with low-margin SNFs, and this difference is reflected in their lower routine costs. High-margin SNFs are also more likely than low-margin SNFs to care for beneficiaries with low incomes: They had, on average, a higher share of Medicare-covered SNF stays attributable to beneficiaries receiving the Part D low-income subsidy and higher shares of total Medicaid-covered facility days. (For additional discussion about the relationship between LIS share and financial performance, see the text box on a Medicare safety-net index for SNFs, pp. 184–185.) Facilities with a higher Medicaid mix may keep their costs lower, in part through lower staffing, contributing to their higher FFS Medicare margins. High-margin SNFs also have longer lengths of stay, which yield additional revenue under the SNF per diem payment system, and higher nursing case-mix index. Economies of scale also affect the difference in financial performance. In 2022, high-margin SNFs had more beds and higher daily census on average.

Information suggests Medicare Advantage rates are lower than FFS payments for SNF care, but better data on MA payments and use are needed

We do not have comprehensive information on Medicare Advantage (MA) enrollees' use of SNFs, MA

**TABLE
6-5**

Variation in freestanding SNF FFS Medicare margins persisted in 2022

Provider group	FFS Medicare margin 2022
All providers	18.4%
25th percentile of FFS Medicare margins	4.4
75th percentile of FFS Medicare margins	28.9
For profit	22.0
Nonprofit	1.1
Urban	18.5
Rural	17.5
Frontier	13.3
Cost per day: High	3.2
Cost per day: Low	33.0
Small (20–50 beds)	–1.2
Large (100–199 beds)	20.6
Low facility volume	0.3
High facility volume	24.7
Low LIS share	3.3
High LIS share	29.1

Note: SNF (skilled nursing facility), FFS (fee-for-service), LIS (low-income [drug] subsidy). Except for the margins at the 25th percentile and 75th percentile, the FFS Medicare margins in the table are aggregates for the facilities included in the group. All margins exclude pandemic-related federal relief funds. "Frontier" refers to SNFs in counties with six or fewer people per square mile. "Facility volume" comprises all facility days. "High facility volume" is the top quintile of total facility days, and "low facility volume" is the bottom quintile of total facility days. "Low LIS share" is the bottom quartile of the LIS-beneficiary share of FFS Medicare stays, and "high LIS share" is the top quartile of the LIS-beneficiary share of FFS Medicare stays.

Source: MedPAC analysis of 2022 Medicare freestanding SNF cost reports and SNF Medicare Provider Analysis and Review and Common Medicare Environment data.

plans' SNF payment rates, or SNFs' costs for MA-enrolled beneficiaries. Given the paucity of data, we instead compared Medicare FFS and MA payments reported from secondary sources. Two sources

Assessing the need for a Medicare safety-net index for SNFs

The Medicare program strives to ensure access to Medicare-covered services for all beneficiaries and to provide adequate payment to health care providers to ensure that access. Access to care for low-income Medicare beneficiaries is a particular concern because they often have the greatest health care needs and the fewest personal resources to address them. One way to support access to Medicare-covered services for low-income Medicare beneficiaries is to pay providers more to care for them if the cost to provide care for low-income beneficiaries is higher than the average payment rate.

The Commission developed a two-part framework to identify Medicare safety-net providers and evaluate whether new Medicare safety-net funding might be warranted in a given health care sector (Medicare Payment Advisory Commission 2022). According to the safety-net framework, additional Medicare payments to support safety-net providers serving low-income beneficiaries²¹ may be appropriate if:

- low-income beneficiaries (beneficiaries receiving the Part D low-income subsidy (LIS)) are at risk of negative outcomes without additional funding;

- Medicare is not a materially profitable payer in the sector; and
- current payment adjustments cannot be redesigned to adequately support safety-net providers.

In our March 2023 report to the Congress, we applied our Medicare safety-net index framework to hospitals and clinicians, and we recommended additional payments to safeguard access for the vulnerable population (Medicare Payment Advisory Commission 2023c). Because these recommended safety-net payments are funded with Medicare dollars, the Commission's hospital and clinician safety-net policies target Medicare payments to ensure access to Medicare-covered services for Medicare beneficiaries. The Commission's method of gauging safety-net status is Medicare-centric by design; safety-net definitions used by Medicaid and other payers likely will differ.

In April 2023, we applied the Commission's Medicare safety-net index framework to skilled nursing facilities (SNFs) and home health agencies (Medicare Payment Advisory Commission 2023a). We showed that SNFs vary in the extent to which they care for low-income Medicare beneficiaries. For half of SNFs,

(continued next page)

reported MA rates that are 21 percent to 26 percent lower than FFS rates (Ensign Group 2023, National Investment Center for Seniors' Housing and Care 2023). An analysis released by a PAC sector consulting firm using proprietary SNF claims data found that MA payments per day were below the FFS benchmark per day in 12 markets (Zimmit Healthcare Services Group LLC 2023). We do not know whether the lower average daily payment by MA plans relative to FFS rates, as reported in these data sources, reflects differences in service intensity, lower payments for the same service, or some combination. We also do not know how

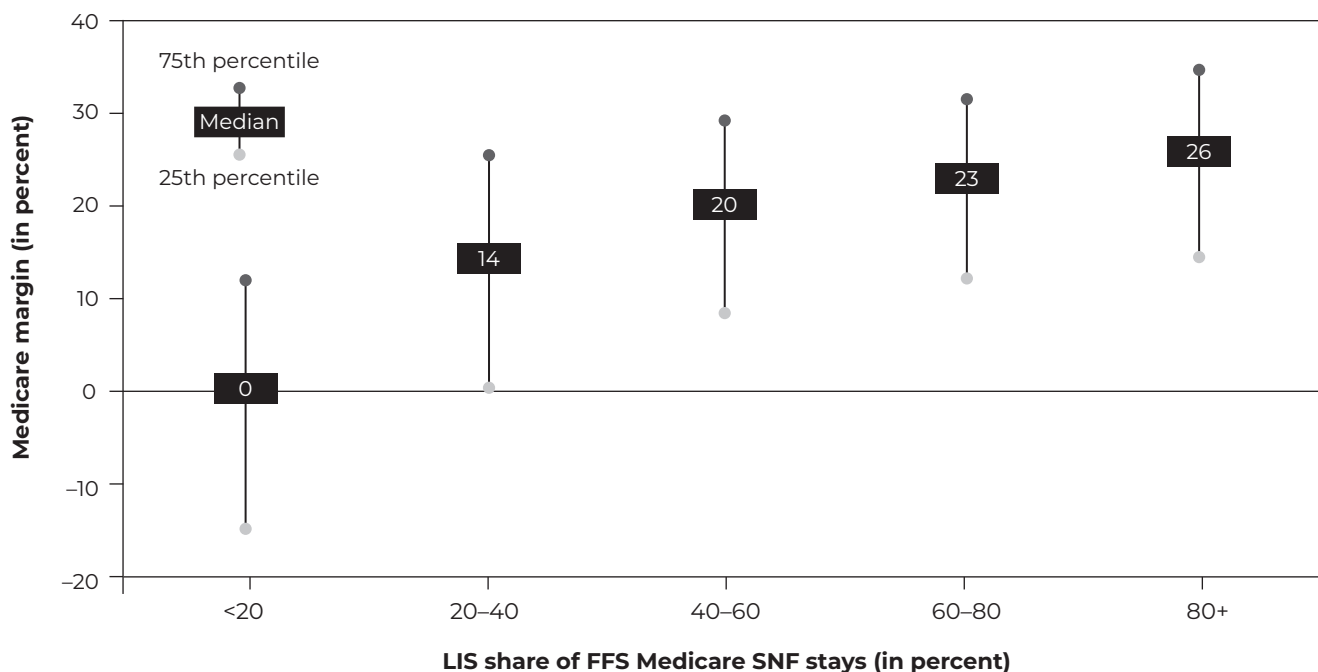
representative these sample rate differences are of the FFS-to-MA ratios for all SNFs. And finally, we do not know the extent of MA claims denials for SNF care.

For future update cycles, we will have finished an internal assessment of the completeness of PAC encounter and assessment data for MA enrollees. Once we determine the completeness of the encounter data, we will have more information about the feasibility of using them to analyze MA enrollees' use of SNFs, MA plans' SNF payment rates, SNFs' shares of patients with

Assessing the need for a Medicare safety-net index for SNFs (cont.)

FIGURE 6-7

Freestanding SNFs with higher shares of LIS Medicare volume had higher median FFS Medicare margins, 2021



Note: SNF (skilled nursing facility), LIS (low-income subsidy), FFS (fee-for-service).

Source: MedPAC analysis of Medicare freestanding SNF cost reports, SNF Medicare Provider Analysis and Review, Common Medicare Environment data.

LIS fee-for-service (FFS) beneficiaries comprised at least 49 percent of the Medicare-covered SNF stays in 2021. For the quarter of SNFs with the highest share of LIS FFS stays, LIS FFS beneficiaries made up 68 percent or more of Medicare-covered stays in 2021.

Using the framework, we grouped SNFs into cohorts based on the share of FFS Medicare-covered stays they provided to LIS beneficiaries and examined the FFS Medicare margins for these cohorts. Freestanding SNFs with greater shares of FFS Medicare stays attributable to LIS beneficiaries had higher median FFS Medicare margins than freestanding SNFs with lower LIS shares, on average (Figure 6-7).

The higher average FFS Medicare margins among SNFs with greater shares of LIS beneficiaries is driven in part by these SNFs' lower average standardized Medicare costs per day compared with providers that have lower LIS volume. These SNFs have greater total volume (measured as average daily census) than SNFs with smaller shares of LIS beneficiaries, so they may achieve economies of scale that could lower their costs per day. Based on these results, we concluded that, although some SNFs care for large shares of FFS LIS beneficiaries, their need for additional Medicare safety-net payments is not indicated by our finding that facilities with higher LIS shares also have higher average FFS Medicare margins than facilities with lower LIS shares. ■

TABLE
6-6

SNF updates and forecast errors for fiscal years 2022–2024

	2022	2023	2024
Updates based on forecasts			
Market basket	2.7%	3.9%	3.0%
Productivity	–0.7	–0.3	–0.2
Forecast error correction	–0.8	1.5	3.6
Parity adjustment	N/A	–2.3	–2.3
Total	1.2	2.7	4.0
Actual market basket			
Market basket	6.3	5.5*	3.2*
Forecast error	3.6	1.6*	TBD*

Note: SNF (skilled nursing facility), N/A (not applicable), TBD (to be determined). CMS makes forecast error corrections when its estimate of the market basket differs from the actual market basket by at least 0.5 percentage points (either too high or too low). This correction is lagged two years. *Actual market basket for 2023 and 2024 (and related forecast error) will be updated again prior to fiscal year 2025 (and fiscal year 2026) rulemaking.

Source: MedPAC analysis of SNF final rule for fiscal years 2022–2024 and CMS Office of the Actuary forecast from the third quarter of 2023 (with actual data through the second quarter of 2023).

MA-covered SNF stays, and how MA beneficiaries' use and payment compares with that of FFS beneficiaries.

Projecting payments and costs for 2024

To project the FY 2024 FFS Medicare margin for freestanding SNFs, the Commission considered the relationship between SNF costs and Medicare payments in 2022 as a starting point. To estimate costs, we used CMS's Office of the Actuary's (OACT's) estimates of the market baskets for 2023 and 2024 (based on a third-quarter 2023 forecast). The annual market basket indicates how SNFs' costs will change in those years (Table 6-6). OACT's estimate of the SNF market basket increase was 5.5 percent in FY 2023 and 3.2 percent in FY 2024. The market basket estimates reflect the costs associated with higher wages and economy-wide inflation. The estimates of cost growth could be low or high depending on how actual costs differ from the projections. CMS makes forecast error corrections to payment updates when its estimate of the market basket differs from the actual market basket by at least 0.5 percentage points (either too high or too low).

To estimate payments in 2023 and 2024, we assumed the payment updates specified in the final rules for those years. The updates include the market basket with productivity adjustments and forecast error corrections. We also included the impact of a parity adjustment of –2.3 percent that CMS applied in 2023 and 2024 to correct for an estimated overpayment of 4.6 percent resulting from the implementation of the new case-mix system in 2020. We did not consider additional changes in payments for potential changes in patient acuity or the recording of patient characteristics that would raise or lower payments.

The projected FFS Medicare margin for 2024 for freestanding SNFs is 16 percent. We expect the margin to decline in 2024 relative to 2022 because projected cost growth will exceed payment changes—a combination of payment updates, reinstatement of the sequester, and adjustments CMS made to the case-mix indexes—in 2023 and 2024. Different assumptions about changes in costs, case mix, and revenues could raise or lower the projection.

How should FFS Medicare payments change in 2025?

In 2025, current law is expected to increase payment rates by 2.5 percent (an estimated market basket increase of 2.8 percent minus a productivity adjustment of 0.3 percent). CMS will revise its estimates before the publication of the FY 2025 final rule, expected before August 1, 2024. In addition to the market basket update, CMS corrects for overestimates and underestimates of the SNF market basket two years prior to the rule-making year (2023 in 2025 rulemaking). If it determines that it over- or underestimated the market basket by more than 0.5 percentage points in FY 2023, it will apply the correction in FY 2025. Currently, the correction would result in an increase to account for the 1.6 percentage point underestimate (5.5 percent minus 3.9 percent). On net, if all these changes are implemented, the update would be a 4 percent increase in 2025 relative to 2024.

The FFS Medicare margin in 2024 will depend on many factors. On the payment side, the update to the payment rate may not accurately capture any real changes in patient acuity or the recording of patient characteristics that raise payments (with no effect on costs). Costs may increase more or less than the market basket estimates, in part depending on the extent to which providers adjust their costs based on changes in volume, in general and in response to the resumption of the three-day-stay requirement that was waived during the coronavirus PHE. Because we project the margin in 2024 based on current law, our projection does not include any changes to staffing requirements.

The combination of excess payments under the PDPM, lower cost growth, and rebounding FFS Medicare volume in 2022 have contributed to improved financial performance for SNFs paid under FFS Medicare. FFS Medicare margins were high again in 2022, and FFS Medicare remains a preferred payer for SNFs. The FFS Medicare margin indicates that the SNF PPS exerts too little pressure on providers to control costs.

RECOMMENDATION 6

For fiscal year 2025, the Congress should reduce the 2024 Medicare base payment rates for skilled nursing facilities by 3 percent.

The level of Medicare's payments indicates that a reduction is needed to better align aggregate payments with aggregate costs. The freestanding SNF FFS Medicare margin was 18.4 percent in 2022. With the parity adjustment in 2023 and 2024 to correct for excess payments because of the new case-mix system, we project that the freestanding SNF FFS Medicare margin will be 16 percent in 2024. As such, FFS payments will remain more than adequate to ensure beneficiary access to SNF care even if payments are lowered. A 3 percent reduction to the base rate is needed, in part, to offset CMS's automatic forecast error correction to the payment update. We estimate that the correction will provide an additional 1.6 percent increase in 2025 due to underestimating the market basket in 2023.

Although the overall FFS Medicare financial performance of SNFs is good and projected to remain so, the share of providers that operated at a loss in 2022, as well as the large difference in FFS Medicare margins between nonprofit and for-profit SNFs, indicates that not all providers do well financially under the SNF PPS. In the interest of responsible fiscal stewardship of the Medicare program, it is not sound policy to raise payments for all providers to address the poor performance of some. Nor does the Commission support differential updates for providers based on ownership status or geographic location. Instead, the Congress could consider other approaches to redistribute FFS Medicare's payments. For example, as the Commission recommended in June 2021, the Congress should replace the value-based purchasing program with a value-incentive program that includes larger incentive payments, which would direct funds to facilities that perform well on quality and resource use measures (Medicare Payment Advisory Commission 2021b).

IMPLICATIONS 6

Spending

- Current law is expected to increase payment rates by 2.5 percent in 2025. This recommendation would lower program spending relative to current law by between \$2 billion and \$5 billion over one year and between \$10 billion and \$25 billion over 5 years.

**TABLE
6-7**

The number of active nursing facilities certified as Medicaid providers declined slightly from 2022 to 2023

	2019	2020	2021	2022	2023	Percent change 2022-2023
Number of facilities	14,965	14,840	14,756	14,630	14,463	-1.1%

Note: The figure for 2023 was calculated through October; it does not include data from the full calendar year. Counts include active providers serving Medicaid beneficiaries in the calendar year for Medicaid-certified facilities in the 50 states and the District of Columbia. Counts do not include SNFs that are not Medicaid certified.

Source: MedPAC analysis of active provider counts from CMS's Quality, Certification and Oversight Reports (QCOR) online reporting system.

Beneficiary and provider

- We do not expect this recommendation to have adverse effects on beneficiaries' access to SNF care. Given the current level of payments, we do not expect the recommendation to affect providers' willingness or ability to care for Medicare beneficiaries.

Medicaid trends

Section 2801 of the Affordable Care Act of 2010 requires the Commission to examine spending, use, and financial performance trends in the Medicaid program for providers with a significant portion of revenues or services associated with Medicaid. We report on nursing facility (the term we use for Medicaid-certified facilities that provide long-term care, also commonly called nursing homes) spending trends for Medicaid and financial performance for non-Medicare payers. Medicaid revenues and costs are not reported in the Medicare cost reports. In a joint publication with the Medicaid and CHIP Payment and Access Commission, we report on characteristics, service use, and spending for dual-eligible beneficiaries (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2022).

Medicaid covers long-term care and a portion of the skilled nursing care furnished to beneficiaries who are dually eligible for Medicaid and Medicare. Medicaid pays the dual-eligible beneficiaries' Medicare copayments that begin on day 21 of a SNF stay and for any skilled care for beneficiaries who exhaust their

Part A coverage (that is, if their Part A stay exceeds 100 days). Medicaid also pays for long-term care services that Medicare does not cover.

Count of Medicaid-certified nursing facilities

The number of Medicaid-certified nursing facilities has been declining steadily for years. Between 2016 and 2019, the number of active nursing facilities decreased 1.1 percent per year (data not shown). Historically, factors contributing to closures included shifts away from institutional care toward home- and community-based care, overexpansion of supply in states with no certificate-of-need laws (such as Texas), and low Medicaid rates. During the pandemic, the rate of nursing facility terminations slowed.

Between 2022 and October 2023, the number of active Medicaid-certified nursing facilities declined 1.1 percent from 14,630 to 14,463 (Table 6-7). We do not know whether the providers that terminated participation in the Medicaid program remained open but no longer accepted Medicaid patients, closed, or were purchased by another entity and remained open. Between January and October 2023, 10 providers opened and 111 terminated (data not shown).

Spending

In 2022, Medicaid FFS spending on Medicaid-funded (combined state and federal funds) nursing facility services totaled \$40.2 billion. This increase of 4.8 percent relative to 2021 likely reflects returning long-term care volume in 2022. Prior to the pandemic, FFS Medicaid spending on nursing facility services had

**TABLE
6-8**

Freestanding SNFs' all-payer total margins fell and were negative in 2022

Type of margin	2018	2019	2020	2021	2022
All-payer total margin	-0.3%	0.6%	3.1%	3.4%	-1.4%
Non-Medicare margin	-3.2	-2.2	-0.8	0.1	-6.5

Note: SNF (skilled nursing facility). "All-payer total margin" includes the revenues and costs associated with all payers and all lines of business and includes the federal pandemic-related relief funds reported in 2020–2022. The non-Medicare margins reflect the profitability of all lines of business and all payers, exclusive of FFS Medicare-covered SNF services.

Source: MedPAC analysis of Medicare freestanding skilled nursing facility cost reports for 2018 to 2022.

been in decline for years, in part due to a shift away from institutional long-term care and an increased use of managed care organizations, whose data are not reflected in these spending numbers. As of the second quarter of 2023, 24 states operated Medicaid managed care for long-term services and supports (ADvancing States 2023).

The Families First Coronavirus Response Act, enacted on March 18, 2020, provided a temporary 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP), retroactive to January 1, 2020, through the end of 2022.²² Many states used at least a portion of this FMAP increase to raise nursing facility rates temporarily. A few states significantly and permanently (not tied to temporary enhanced FMAP or the PHE) increased Medicaid nursing facility funding in their state budgets for 2022 to 2023 (Gifford et al. 2021). Pennsylvania and Nebraska increased the base rate to nursing facilities by 17.5 percent and 15 percent, respectively (Stulick 2022c, Zorn 2022). Illinois increased funding by \$700 million (Reiland 2022, Stulick 2022a). Maryland increased payment rates by 8 percent (Maryland Department of Health 2022). California increased Medicaid rates by 4 percent (California State Assembly 2022). Still more states, including Colorado, Kentucky, Montana, and North Carolina, increased nursing facility rates in their 2023 to 2024 budgets (Marselas 2023, North Carolina Department of Health and Human Services 2023, Patrick 2023, Towhey 2023). Texas increased its Medicaid funding for nursing facilities by \$900 million, its first increase in funding in a decade (Grebbin 2023).

Some states have tied recent nursing facilities' rate increases to wages for direct care staffing. A report from November 2022 found that at least 19 states were implementing strategies to address wages for direct care workers through reporting, enforcement policies, or both (National Governors Association 2022). For example, Florida, Illinois, and North Carolina made staff wage increases a condition of receiving increased Medicaid reimbursement rates (Musumeci et al. 2022, Reiland 2022). Florida and North Carolina specified that the minimum wage of nursing facility staff must be increased to \$15 an hour as a condition of the rate increase. Massachusetts and North Carolina directed nursing facilities to dedicate most of their rate increase (75 percent to 80 percent) toward improving wages for direct care staff (Musumeci et al. 2022).

States also continue to use provider taxes to raise federal matching funds. In 2022, 45 states and the District of Columbia levied provider taxes on nursing facilities to increase federal matching funds (Gifford et al. 2021). The augmented federal funding may be split with the nursing facilities to increase their payments.²³

Freestanding SNFs' all-payer and non-Medicare margins fell and were negative in 2022

All-payer total margins reflect all payers (including all FFS Medicare, MA Medicaid, and private insurers) and all lines of business plus investment income. In 2022, the all-payer margin for freestanding SNFs was -1.4 percent (Table 6-8). The reduction in overall financial performance reflects lower pandemic-related relief funds, the end of the sequestration suspension, and the

expiration of temporary Medicaid payment increases in many states.

In 2022, freestanding SNFs' all-payer total margins varied considerably. The median was -0.5 percent; 25 percent of SNFs had all-payer total margins of -9.5 percent or lower, and 25 percent of freestanding SNFs

had all-payer total margins of 6.6 percent or higher; 51 percent of freestanding SNFs had negative all-payer total margins. Non-Medicare margins reflect the profitability of all lines of business and all payers, exclusive of FFS Medicare-covered SNF services. The non-Medicare margin for freestanding SNFs in 2022 was -6.5 percent. ■

Endnotes

- 1 A spell of illness ends when there has been a period of 60 consecutive days during which the beneficiary was not an inpatient in either a hospital or a SNF. Coverage for another 100 days does not begin until a beneficiary has not had hospital care or skilled care in a SNF for 60 consecutive days. Observation days and emergency room stays do not count toward the three-day hospital stay requirement. During the coronavirus public health emergency from January 2020 through May 2023, CMS waived the requirement for a three-day prior hospitalization for coverage of a SNF stay for fee-for-service beneficiaries whose care was affected by COVID-19. CMS also authorized renewed SNF coverage without having to start a new benefit period for certain beneficiaries who recently exhausted their SNF benefits. These waivers allowed facilities to “skill in place” beneficiaries who required skilled care without having to transfer them to a hospital for a three-day hospital stay, which helped retain hospital capacity for COVID-19 patients.
- 2 Skilled services must be ordered by a physician, require the skills of technical or professional personnel, and be furnished directly by or under supervision of such personnel.
- 3 The program pays separately for some services, including certain chemotherapy drugs, certain customized prosthetics, certain ambulance services, and radioisotope services. All physician services are paid separately under Part B.
- 4 Throughout this chapter, “beneficiary” refers to an individual whose SNF stay is paid for by Medicare Part A. Except where specifically noted, this chapter examines FFS Medicare spending and service use and excludes services and spending for SNF services furnished to beneficiaries enrolled in Medicare Advantage plans.
- 5 REITs are corporate entities that own real estate that they lease back to the health care provider, who is responsible for rent, maintenance, insurance, and taxes.
- 6 Providers that terminated participation in the program may remain open but no longer accept Medicare patients, may have closed, may have been purchased by another entity, or may have been terminated by the program.
- 7 The travel distance is determined using ArcGIS software and is defined as the driving distance determined by the best path on the street network, rather than a straight-line distance.
- 8 BLS data capture changes in hours for employed staff and counts of employed staff. Those data do not account for wages or counts of contract labor. Using Payroll-Based Journal data, we found increased use of contract nursing hours per resident day through 2022.
- 9 Many alternative payment models target the use of PAC to lower spending, either for an episode of care—such as a surgical procedure that is part of a bundled payment—or the total cost of care for assigned populations in a given year, as in the case of accountable care organizations (ACOs) (Haas et al. 2019, Schotland et al. 2023). Evidence from evaluations of the Comprehensive Care for Joint Replacement and the Bundled Payments for Care Improvement Initiative (Model 2), both of which included PAC spending in the episode of care, indicates that they reduced spending largely by reducing institutional PAC use (Barnett et al. 2019). Studies have found that ACOs reduced SNF stays and length of stay for assigned beneficiaries, resulting in modest program savings (Colla et al. 2019, McWilliams et al. 2017). Researchers have also found evidence of ACOs’ spillover effects for all Medicare beneficiaries, including lower readmission rates, shorter SNF stays, and less Medicare spending on SNFs, both in hospitals and in SNFs participating in ACOs (Agarwal and Werner 2018).
- 10 If we approximate marginal cost as total Medicare costs minus fixed building and equipment costs, then marginal profit can be calculated as follows: $\text{Marginal profit} = (\text{payments for FFS Medicare services} - (\text{total FFS Medicare costs} - \text{fixed building and equipment costs})) / \text{FFS Medicare payments}$.

This comparison is a lower bound on the marginal profit because we do not consider any potential labor costs that are fixed.
- 11 Community, for this measure, is defined as home/self-care, with or without home health services, based on Patient Discharge Status Codes 01, 06, 81, and 86 on the Medicare FFS claim.
- 12 Calculation of the annual turnover measures requires six consecutive quarters of Payroll-Based Journal staffing data. Data from a baseline quarter (prior to the first quarter covered by the turnover measures) along with the first two quarters covered by the turnover measures are used for identifying employees who are eligible to be included in the turnover measure. For the total nurse turnover measures, the annual turnover percentage is calculated using this formula: $\text{Turnover} = \text{total number of employment spells that ended in turnover} / \text{total number of eligible employment}$

- spells. An individual's employment spell is considered to end in turnover when they have a period of at least 60 consecutive days in which they do not work at all during the 12 months covered by the turnover measure (e.g., January to December 2022). For additional information, see Centers for Medicare & Medicaid Services (2023a).
- 13 The function items can be found in Section GG of the MDS. The MDS 3.0 Data Item Set and MDS 3.0 Resident Assessment Instrument Manual are available on the CMS website, <https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual>.
 - 14 The facility-level risk-adjusted share of short-stay patients who gained independence in function between admission and discharge measure (CMS ID S023.02) is risk adjusted using patient-level covariates and is reported publicly on CMS's Care Compare site. The numerator includes short-stay SNF patients who have a change in function score between discharge and admission that is negative; the denominator includes all short-stay residents with a valid discharge and admission MDS. For each Part A short-stay patient who is included, function scores at admission and discharge are determined for multiple mobility items on the MDS related to transfer, locomotion, and walking, using a 6-point rating scale that ranges from 1 (dependent) to 6 (independent). Items are recoded to 1 (dependent) if they are skipped or missing. Total scores at admission and discharge can range from 15 to 90, with a higher score indicating greater independence. Patients who are independent on all items at admission are excluded. For additional exclusions and measure specifications, see Centers for Medicare & Medicaid Services (2023d), Centers for Medicare & Medicaid Services (2022c), Centers for Medicare & Medicaid Services (2019).
 - 15 A sale by a provider to a REIT that then leases the property back to the same provider is not considered arm's length. In contrast, a sale by a provider or owner to a REIT that then leases the property to an unrelated third party is considered an arm's length sale.
 - 16 In the Commission's comment letter on Medicare's FY 2022 SNF payment update, the Commission supported a delayed implementation of the recalibration of the parity adjustment because of the impact of the PHE on SNF providers (Medicare Payment Advisory Commission 2021a). However, the Commission noted that a phased-in implementation may not be warranted given high payments in the sector. The Commission also noted that CMS should keep an account of the overpayments until the parity adjustment is made.
 - 17 States are required to ensure that payment rates and methods are consistent with the statutory goals of efficiency, economy, quality, and access (Section 1902(a)(30)(A) of the Social Security Act).
 - 18 Because the sequestration is not applied to beneficiary copayments, the reduction to SNF payments is slightly lower than 2 percent. Suspension of the full sequester amount was in effect from May 1, 2020, through March 31, 2022. Between April 1, 2022, and June 30, 2022, half of the full sequester amount was suspended. The full reinstatement of the sequester began on July 1, 2022.
 - 19 Allocating a portion of the relief funds reported on 2022 cost reports to payments based on Medicare's share of total facility days, we estimate that the FFS Medicare margin for freestanding SNFs was 20 percent, assuming these funds did not affect providers' costs. General distribution of Provider Relief Fund payments, amounting to 2 percent of total revenues, aimed to help prevent, prepare for, and respond to the coronavirus outbreak and reimburse providers for lost revenues and health care-related expenses attributable to COVID-19. SNFs received these general-distribution funds and an additional \$10 billion in targeted funds. About half of the targeted funds were earmarked for infection control and for creating and maintaining a safe environment, and \$2.25 billion was slated for quality incentive payments (apart from the value-based purchasing program). The incentive funds were disbursed in multiple phases, which were captured on the 2020 to 2022 cost reports. Using Medicare's share of revenues allocates a larger share of the PHE funds to Medicare than using Medicare's share of total days because Medicare's payments are substantially higher than payments from other payers. In this case, the estimate of the FFS Medicare margin would be higher.
 - 20 States can elect to make supplemental payments to providers under their Medicaid programs. Supplemental payments can take several forms, including upper payment limit (UPL) payments, disproportionate share hospital payments, and uncompensated care pool payments. UPL payments are based on the difference between (1) base fee-for-service payments to a class of providers in the aggregate for a fixed period and (2) a UPL specified in regulation. For NFs, the UPL is defined as a reasonable estimate of the amount that would have been paid for the same service under Medicare.
 - 21 Our definition of low-income beneficiaries includes all those who receive full or partial Medicaid benefits (dual-eligible beneficiaries) and those who do not qualify for Medicaid benefits in their states but receive the Part D low-income subsidy (LIS) because they have limited assets and an income below 150 percent of the federal poverty level. Collectively, we refer to this population as "LIS beneficiaries"

because those who receive full or partial Medicaid benefits are automatically eligible to receive the LIS.

- 22 The Families First Coronavirus Response Act was enacted on March 18, 2020 (Pub. L. 116–127). Section 6008 provided a temporary 6.2 percentage point increase to each qualifying state’s or territory’s FMAP (“temporary FMAP increase”) under Section 1905(b) of the Social Security Act.

- 23 Under a provider tax, states tax all nursing facilities and use the collected amount to help finance the state’s share of Medicaid funds. The provider tax increases the state’s contribution, which in turn raises the federal matching funds. The augmented federal funds more than cover the cost of the provider tax revenue, which is returned to providers. The provider tax is limited to 6 percent of net patient revenues.

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C H A P T E R

7

Home health care services

R E C O M M E N D A T I O N S

- 7** For calendar year 2025, the Congress should reduce the 2024 Medicare base payment rates for home health agencies by 7 percent.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Home health care services

Chapter summary

Home health agencies (HHAs) provide services to beneficiaries who are homebound and need skilled nursing care or therapy. In 2022, about 2.8 million fee-for-service (FFS) Medicare beneficiaries received care, and the program spent \$16.1 billion on home health care services. In that year, 11,353 HHAs participated in FFS Medicare.

Assessment of payment adequacy

The indicators of FFS Medicare payment adequacy for home health care were positive in 2022.

Beneficiaries' access to care—Access to home health care was adequate in 2022: Over 98 percent of FFS Medicare beneficiaries lived in a ZIP code served by at least two HHAs, and 88 percent lived in a ZIP code served by five or more HHAs. The share of home health stays reported as being initiated in a timely manner (within 3 days of hospital discharge or a signed physician order) was 96 percent for the 12-month period ending September 30, 2022, a slight increase from prior years. The share of inpatient prospective payment systems hospital discharges that were followed by at least one 30-day home health period declined slightly to 18.7 percent in the first 10 months of 2022 relative to the prior year but remained higher than the rate in 2019.

In this chapter

- Are FFS Medicare payments adequate in 2024?
- How should FFS Medicare payments change in 2025?

- **Capacity and supply of providers**—Between 2021 and 2022, the number of HHAs declined by 1.1 percent.
- **Volume of services**—In 2022, the volume of 30-day periods declined by 7.5 percent, but this decline reflects two changes that may be curbing home health utilization in FFS Medicare. First, the number of beneficiaries enrolled in FFS Medicare has declined as more beneficiaries enroll in Medicare Advantage. Controlling for the number of FFS beneficiaries, home health volume declined by 4.3 percent in 2022. Second, the decline in FFS beneficiaries' use of inpatient hospital services likely accounts for some of the reduction in home health volume observed in 2022, because a hospital stay is a common precursor to home health stays. The rate of inpatient hospital stays per 1,000 FFS beneficiaries declined 2.6 percent in 2022. For FFS beneficiaries who use home health care, the average number of in-person visits per 30-day period fell by 15.6 percent between 2019 (the year before CMS implemented major congressionally mandated changes to the HHA prospective payment system) and 2022, but some of the decline might have been offset by greater use of virtual visits through telehealth, which we are unable to observe with available data.
- **FFS Medicare marginal profit**—The Commission also assesses access by examining a measure of HHAs' ability to cover their variable costs, excluding certain fixed costs, referred to as the FFS Medicare marginal profit. In 2022, freestanding HHAs' FFS Medicare marginal profit—that is, the rate at which FFS Medicare payments exceeded providers' marginal costs—was 23 percent, indicating a significant financial incentive for freestanding HHAs with excess capacity to serve additional FFS Medicare beneficiaries.

Quality of care—During the two-year period from January 1, 2021, to December 31, 2022, the median risk-adjusted rate of discharge to the community from HHAs was 79.2 percent, a decline of 3.3 percentage points relative to the median from the January 1, 2018, to December 31, 2019, period. Rates of successful discharge to the community varied by provider type, with lower rates and greater decline observed in for-profit and freestanding agencies. The median rate of potentially preventable readmissions after discharge was 3.88 percent from July 1, 2020, to December 31, 2022, and did not vary significantly across provider types. (Due to a change in the measure calculation, we cannot compare this to a prior period.) Most patient experience measures remained stable in 2022. The Commission continues to have concerns about the accuracy of provider-reported function data.

Providers' access to capital—Access to capital is a less important indicator of FFS Medicare payment adequacy for home health care because this sector is less capital intensive than other health care sectors. Recent years have seen substantial interest in HHAs by private equity and health insurance companies. According to industry reports, investor interest in home health care services slowed in 2023, but the slowdown came after a peak period for HHA mergers and acquisitions in 2021.

FFS Medicare payments and providers' costs—In 2022, there was an increase of 4.0 percent in the cost per 30-day period for freestanding HHAs, a reversal of the trend for 2021, when we observed cost per period decline by 2.9 percent. This increase in 2022 was due to higher cost per visit, but it was offset by a reduction in the number of in-person visits per 30-day period. However, even with this increase in cost, payments remained at high levels, with FFS Medicare margins for freestanding agencies averaging 22.2 percent in 2022. These margins indicate that FFS Medicare payments in 2022 far exceeded costs. In aggregate, FFS Medicare's payments have always been substantially more than costs: From 2001 to 2021, the FFS Medicare margin for freestanding HHAs averaged 16.8 percent. We project an aggregate FFS Medicare margin of 18 percent for 2024.

How should payments change in 2025?

The Commission's review indicates that FFS Medicare's payments for home health care are substantially in excess of costs. Home health care can be a high-value benefit when it is appropriately and efficiently delivered, but these excess payments diminish that value. The Commission recommends that, for calendar year 2025, the Congress reduce the 2024 base payment rate for home health agencies by 7 percent. ■

Background

Medicare home health care consists of skilled nursing, physical therapy, occupational therapy, speech therapy, aide services, and medical social work provided to beneficiaries in their homes. To be eligible for Medicare's home health benefit, beneficiaries must need part-time (fewer than eight hours per day) or intermittent skilled care to treat their illnesses or injuries and must be unable to leave their homes without considerable effort. In contrast to coverage for skilled nursing facility services, Medicare does not require a preceding hospital stay to qualify for home health care. Also, unlike for most services, Medicare does not require copayments or a deductible for home health services. In 2022, about 2.8 million FFS Medicare beneficiaries received home care, and the program spent \$16.1 billion on home health care services under the home health prospective payment system (PPS).

Medicare requires that a physician, nurse practitioner, clinical nurse specialist, or physician assistant certify a patient's eligibility for home health care.¹ Medicare also requires that a beneficiary have a face-to-face encounter with the practitioner ordering home health care. The encounter must take place in the 90 days preceding or 30 days following the initiation of home health care. An encounter through telehealth services may satisfy the requirement.

In 2020, CMS implemented major changes required by the Bipartisan Budget Act (BBA) of 2018: a new 30-day unit of payment and elimination of the number of in-person therapy visits as a factor in the payment system. CMS implemented the BBA of 2018 policies through a new case-mix system, the Patient-Driven Groupings Model (PDGM). Payments for a 30-day period are adjusted by the case-mix system to account for differences in patient severity. If beneficiaries need additional home health services at the end of the initial 30-day period, another period commences and Medicare makes an additional payment. Coverage for additional periods generally has the same requirements as the initial period (i.e., the beneficiary must be homebound and need skilled care). The PDGM applied to home health care services as of January 1, 2020.²

Home health payments historically have been high relative to costs

While the changes required by the BBA of 2018 substantially altered the home health PPS, they were not designed to reduce Medicare's payments for home health care services, which have substantially exceeded costs since the PPS was implemented in 2001. The Act required CMS to set the base rate for the PDGM at a level that was budget neutral relative to 2019, a year when the Commission reported high fee-for-service (FFS) Medicare margins (over 15 percent) for freestanding agencies. (FFS Medicare margins show the extent to which an agency's revenue from FFS Medicare patients covers, exceeds, or falls below the cost of providing care for these patients.)

The BBA of 2018 requires that payments based on the PDGM be budget neutral (neither raising nor lowering aggregate home health care spending) relative to spending that would have occurred without the new payment model's implementation. For 2020 through 2026, CMS must determine how actual aggregate home health spending under the PDGM differs from spending that would have occurred in the absence of the payment system changes and must adjust the PPS base rate as needed to achieve budget neutrality. CMS is required to make permanent adjustments when it determines that an observed deviation from expected behavior will continue in future years. The statute requires temporary (one-year) adjustments when CMS identifies overpayments or underpayments that occurred in a prior year.

In the 2024 final rule for the home health PPS, CMS determined that spending would be above the BBA of 2018 statutory target in that year and future years unless a permanent adjustment equal to 5.779 percent was made. However, CMS implemented a permanent reduction equal to 2.890 percent for 2024, only half of the reduction it identified as necessary. Assuming CMS's estimate of the budget-neutral level does not change, in future years CMS is required to recover the balance of the excess spending above the level required by the BBA of 2018 with another reduction. In addition, CMS examined spending prior to 2024 (for 2020 through 2022) and found it was \$3.4 billion above the budgetary targets. Under the BBA of 2018, CMS must implement temporary (one-time) reductions to cover

**TABLE
7-1**

Annual rate of decline for home health agencies participating in Medicare has been approximately 1 percent per year

					Average annual percent change	
	2019	2020	2021	2022	2019–2022	2021–2022
Active home health agencies	11,569	11,565	11,474	11,353	–0.6%	–1.1%
Number of home health agencies per 10,000 Medicare beneficiaries	1.88	1.83	1.79	1.75	–2.3	–2.7

Note: “Active home health agencies” includes all agencies operating during a year, including agencies that closed or opened at some point during the year. Average annual changes were calculated on unrounded data.

Source: MedPAC analysis of CMS’s Quality, Certification and Oversight file and the 2021 annual report of the Boards of Trustees of the Medicare trust funds.

this overage, but it has not yet indicated when or how it plans to recover these funds.

Are FFS Medicare payments adequate in 2024?

The Commission reviews several indicators to determine the level at which payments will be adequate to cover the costs of a provider in 2024. Specifically, we assess beneficiary access to care (by examining the supply of home health providers, annual changes in the volume of services, and marginal profit); quality of care; access to capital; and the relationship between FFS Medicare’s payments and providers’ costs. Overall, the payment adequacy indicators for home health care are positive.

Beneficiaries’ access to care: Good indicators of access in 2022

Supply and volume indicators show that almost all FFS beneficiaries have access to home health services. The share of inpatient prospective payment systems (IPPS) hospital discharges that were followed by at least one 30-day home health period declined slightly to 18.7 percent in the first 10 months of 2022 relative to the prior year but remained higher than the rate for 2019.

Agencies reported that 96 percent of home health stays were initiated in a timely manner, a slight increase from prior years.

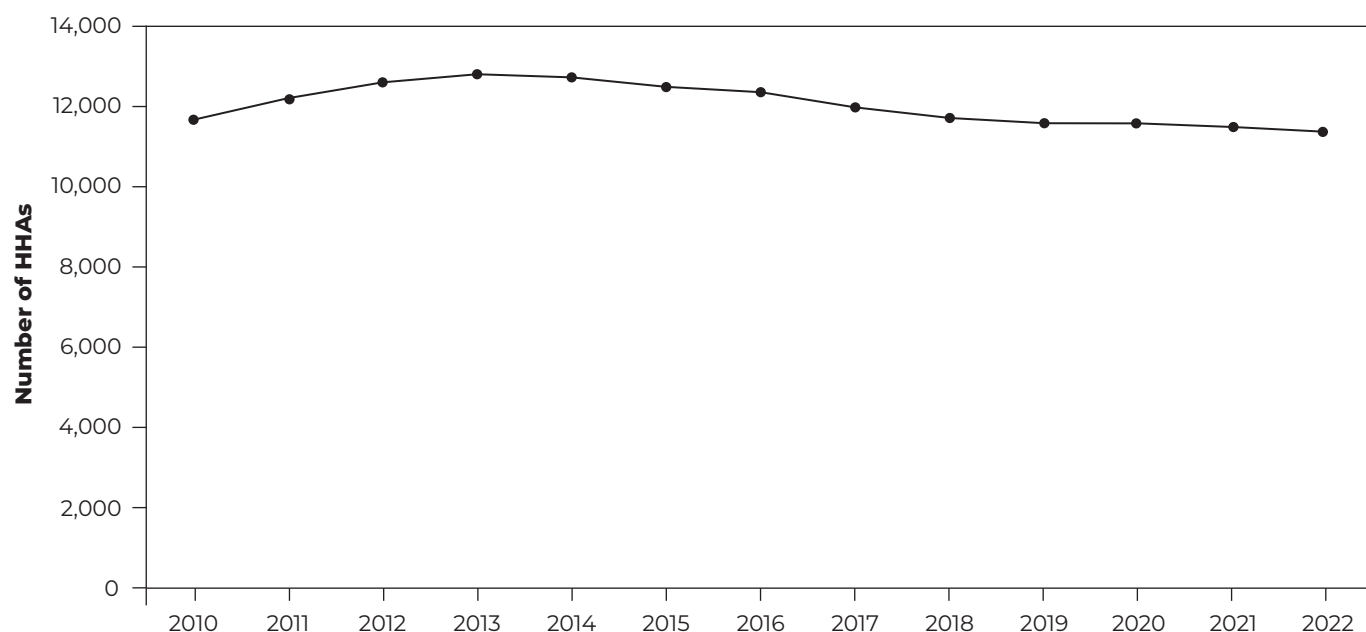
Though agency supply decreased slightly in 2022, almost all beneficiaries live in an area served by at least one home health agency

Home health agency (HHA) provider counts illustrate the overall size of the industry, but they are a limited measure of capacity. For example, HHAs can vary in size and the services they provide. Also, because home health care is not provided in a medical facility, HHAs can adjust their service areas as local conditions change. Even the number of employees may not be an effective metric to measure beneficiaries’ access to home health care because HHAs can use contract staff to meet their patients’ needs. However, even with these limitations, the number of HHAs is an important measure of industry capacity.

In 2022, 98 percent of FFS beneficiaries lived in a ZIP code served by two or more HHAs, and 88 percent lived in a ZIP code served by five or more agencies. The number of HHAs active in a ZIP code may not be a complete measure of access, but it does provide a baseline of how the supply of providers is distributed relative to the Medicare population. This definition may overestimate access because HHAs need not serve

**FIGURE
7-1**

Supply of HHAs has been in decline since 2013



Note: HHA (home health agency).

Source: Quality, Certification and Oversight Reports.

the entire ZIP code to be counted as serving it and because this measure does not assess the capacity of agencies relative to beneficiary demand (i.e., agencies may not have capacity to serve additional beneficiaries that require home health care). At the same time, the definition may understate access if HHAs are willing to serve a ZIP code but did not receive a request in the previous 12 months. The analysis excludes beneficiaries with unknown ZIP codes. These findings are consistent with our prior reviews of access.³

The supply of agencies peaked in 2013 and has slowly declined since then (Figure 7-1). Much of the decline has been concentrated in areas that experienced significant growth in agency supply in prior years. Prompted by concerns about fraud and abuse in home health care services, CMS implemented moratoriums in 2013 through 2019 prohibiting the entry of new HHAs in regions of Florida, Illinois, Michigan, and Texas.

The supply of agencies has remained relatively stable after the implementation of the PDGM in 2020, even through the coronavirus pandemic. In 2022, the supply of agencies declined by 1.1 percent (Table 7-1), slightly more than the decline observed from 2019 to 2022. The change in agency supply varied among states. For example, the supply in California increased by 186 agencies, or about 3.6 percent per year from 2019 to 2022. Florida, Texas, and Michigan, three states that had been a focus of fraud and abuse efforts, experienced a decline in agency supply of 2.3 percent per year from 2019 to 2022 (data not shown). Over the same period, all other areas experienced a decline in agency supply of 0.9 percent annually. On a per capita basis, the supply of agencies declined to 1.75 HHAs per 10,000 Medicare beneficiaries, including beneficiaries enrolled in both Medicare Advantage (MA) and FFS Medicare. Relative to the FFS Medicare population alone, the supply of agencies increased (to 2.3 HHAs per 10,000 FFS beneficiaries, data not shown) because

**TABLE
7-2****In 2022, the share of FFS Medicare beneficiaries receiving home health care declined**

FFS Medicare volume	2019	2020	2021	2022	Average annual percent change	
					2019–2022	2021–2022
Home health users (in millions)	3.3	3.1	3.0	2.8	–5.0%	–6.3%
Share of beneficiaries using home health care	8.5%	8.1%	8.3%	8.0%	–1.8	–3.0
30-day periods (in millions)	N/A	9.6	9.3	8.6	N/A	–7.5
30-day periods per 100 FFS Medicare beneficiaries	N/A	25.3	25.5	24.4	N/A	–4.3
30-day periods per FFS Medicare beneficiary who received home health care	N/A	3.13	3.08	3.04	N/A	–1.3

Note: FFS (fee-for-service), N/A (not available). Percentage changes were calculated on unrounded data. CMS implemented a 30-day period as the unit of payment in the home health prospective payment system in 2020; data for prior years in this unit of payment are not available.

Source: MedPAC analysis of home health standard analytic files from CMS and the 2023 annual report of the Boards of Trustees of the Medicare trust funds.

the 2022 decline in the number of FFS Medicare beneficiaries was greater than the decline in the number of agencies.

Decline in home health utilization in 2022 reflects several factors

The number of FFS Medicare beneficiaries using home health care and the volume of 30-day periods have decreased in recent years and continued to decline in 2022, falling 6.3 percent and 7.5 percent, respectively (Table 7-2). These declines have been driven by a reduction in the number of beneficiaries in FFS Medicare as a growing share of beneficiaries opt to enroll in Medicare Advantage. Controlling for the number of FFS beneficiaries, the volume of 30-day periods decreased by 4.3 percent in 2022, in part due to a 1.3 percent reduction in the number of 30-day periods delivered to FFS home health users.

But the share of FFS beneficiaries using home health care has been declining as well, falling 3.0 percent in 2022 (Table 7-2). Lower use of inpatient hospital care among FFS beneficiaries likely has contributed to this phenomenon because a hospital stay is a common

precursor to home health care. The number of IPPS discharges per 1,000 FFS beneficiaries declined by 2.6 percent relative to 2021 (data not shown).⁴ And even when FFS beneficiaries were hospitalized, they were somewhat less likely to be discharged to home health care in 2022 (18.7 percent of IPPS discharges) than in 2021 (19.6 percent of IPPS discharges), though the 2022 share remained higher than the share in 2019 (Table 7-3).

Some of the decline in home health care use in 2022 may also be attributable to a rebound in beneficiaries using skilled nursing facilities (SNFs). Before the pandemic, SNFs were the most frequent first post-acute care (PAC) destination among beneficiaries receiving formal PAC, with home health care services being the second most frequent PAC destination (Table 7-3). In 2020, the two services switched ranks in their share of use after an inpatient hospital stay. Home health care services became the most frequent first PAC service; the share receiving SNF services dropped to the second most frequent first PAC service. However, since 2020, the gap in shares between the two services has decreased. The annual frequency

**TABLE
7-3****FFS Medicare beneficiaries' first post-acute service
after an IPPS hospital stay, 2019–2022**

	2019	2020	2021	First 10 months of 2022
Share of discharges with:				
No PAC service after discharge	60.8%	59.0%	58.6%	58.4%
At least one PAC service (skilled nursing facility, home health care, inpatient rehabilitation facility, or long-term acute care hospital)	39.1	41.0	41.4	41.6
Subtotal of discharges with at least one PAC service:				
Skilled nursing facility	18.7	15.9	16.6	17.4
Home health agency	15.8	20.1	19.6	18.7
Inpatient rehabilitation facility	3.7	4.1	4.4	4.6
Long-term acute care hospital	0.9	1.0	0.8	0.8
Total	100	100	100	100

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), PAC (post-acute care). IPPS discharges that were followed by more than one PAC service after discharge were classified by the initial type of PAC.

Source: MedPAC analysis of Medicare Provider Analysis and Review data and home health standard analytic file.

of discharges to SNFs has increased slightly, while discharges to home health care have declined slightly, indicating a rebound in SNF utilization. The recent change suggests a return to prepandemic PAC referral patterns for Medicare beneficiaries, and the rise in SNF utilization could account for some of the decline in home health care utilization observed in 2022.

One important measure of access is the timely initiation of home health care. CMS tracks this measure

based on data reported by HHAs. The share of home health stays (including FFS Medicare and MA stays) that were reported as being initiated in a timely manner was 95.9 percent for the 12-month period ending June 30, 2022—a slight increase from prior years (Table 7-4). Though these data suggest that timely access to care remains strong, some caveats apply. For this measure, a home health stay is considered to have been initiated in a timely manner if the care begins within three days of hospital discharge or a signed physician

**TABLE
7-4****The share of agencies reporting that home health care
was initiated in a timely manner was steady in 2022**

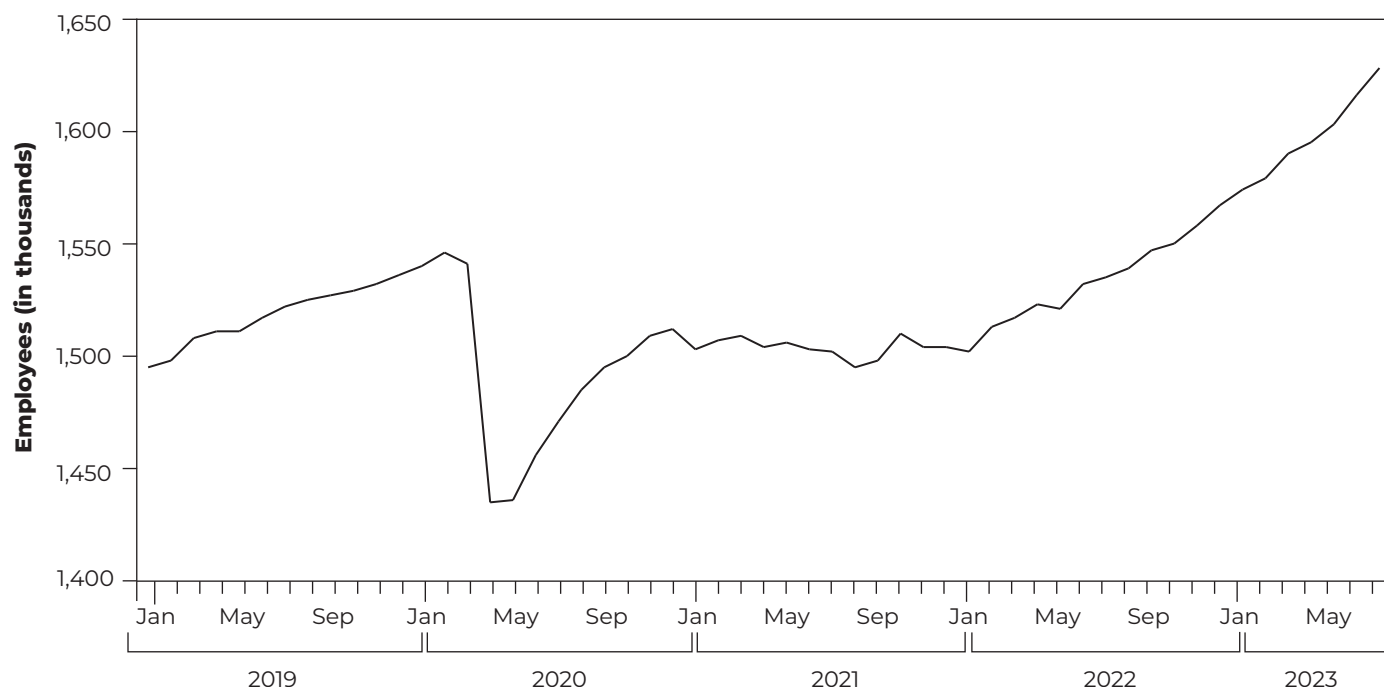
	July 1, 2017– June 30, 2018	July 1, 2018– June 30, 2019	July 1, 2020– June 30, 2021	July 1, 2021– June 30, 2022
Share of home health stays that were initiated in a timely manner	94.6%	95.5%	95.7%	95.9%

Note: Data include Medicaid, Medicare Advantage, and Medicare fee-for-service patients.

Source: Home Health Compare, 2023.

**FIGURE
7-2**

After a sharp decline in March 2020, employment rose above prepandemic levels for the sector of the economy that includes Medicare HHAs and other, non-Medicare home medical service providers



Note: HHA (home health agency). This figure includes employment for establishments classified by the North American Industry Classification System (NAICS) as home health care services (NAICS 6216). Under NAICS, home health care services comprise a broad array of home care establishments, including not only Medicare HHAs but also establishments that provide other in-home services such as personal care services, homemaker and companion services, medical equipment and supplies, counseling, 24-hour home care, dietary and nutritional services, audiology, and other specialized care, such as intravenous therapy.

Source: Bureau of Labor Statistics 2023.

order. The date of a physician order may reflect the administrative practices of specific physicians or home health agencies. If there are delays in the completion or receipt of physician orders, a delay of care may result that is not reflected in the data. In addition, a high rate might be expected under this measure as agencies would typically only begin care after an order is completed. However, a decline in the rate could still suggest an access issue and therefore should be examined in the context of other access indicators.

Employment in the broader home care sector in 2023 was higher than the prepandemic level

Since the pandemic, some HHAs have reported that staffing shortages limit the volume of services they

can provide, which in some areas may also contribute to declining use (Filbin 2023). Many of these reports may reflect local labor market conditions or other factors not observed in national labor force measures. However, the Department of Commerce's employment data on the broader medical home care sector (using a definition that includes Medicare HHAs, hospice, private duty, pediatric agencies, and other home care providers) indicate that total employment was about 5 percent higher in July 2023 than it was in February 2020, prior to the pandemic (Figure 7-2). While these data measure employment for a broader category of home care services than Medicare HHAs, the latter comprise a significant share of this sector. However, these data may not reflect labor conditions in local

**TABLE
7-5**

Since 2020, the average number of home health in-person visits per 30-day period has declined

Volume measure	2019	2020	2021	2022	Total change in number of visits		Percent change 2019–2022
					2019–2020	2020–2022	
Total visits per 30-day period	10.2	9.2	8.8	8.6	–1.0	–0.6	–15.6%
Visits per 30-day period by discipline:							
Physical therapy, occupational therapy, and speech–language pathology	4.9	3.9	3.9	4.0	–0.9	<0.1	–18.6
Skilled nursing	4.6	4.6	4.3	4.1	<0.1	–0.5	–10.5
Medical social services and home health aide	0.8	0.7	0.6	0.5	–0.1	–0.1	–32.3

Note: Home health services initiated in 2019 were paid under 60-day episodes. For this table, home health care services initiated in 2019 were recalculated as 30-day periods to provide comparable units of service in the later years. Thirty-day periods are included in the year that the period ended. Components may not sum to totals due to rounding. Visit counts have been rounded. “Total change in number of visits” column was calculated on unrounded data.

Source: MedPAC analysis of 2019 home health Limited Data Set file and standard analytic files from 2019 through 2022.

geographic areas. Despite the rebound in employment since the pandemic, there have been concerns from home health care stakeholders that staffing remains a challenge (National Association for Home Care and Hospice 2023).

In aggregate, use of home health care in rural areas is comparable with urban areas

In general, the Commission has found that, historically, per capita use of home health care services is comparable between urban and rural areas (Medicare Payment Advisory Commission 2021). In 2022, the number of 30-day periods per capita was slightly lower in rural than in urban areas, with beneficiaries in rural areas averaging 22.6 thirty-day periods per 100 FFS beneficiaries, while in urban areas the rate was 24.5 thirty-day periods per 100 FFS beneficiaries.

In-person visits during a 30-day period have declined since the PDGM was implemented, but data on telehealth services are necessary to assess services received by beneficiaries

In 2022, the number of in-person visits per 30-day period was 1.6 visits fewer,

or 15.6 percent lower, relative to 2019 (Table 7-5). The decline occurred in two phases: In 2020, the first year of the PDGM, the number of in-person therapy (physical, occupation, and speech-language pathology) visits per 30-day period declined by 0.9 visits (about 20 percent). A decline in therapy visits was expected following the implementation of the new PDGM, which eliminated the number of therapy visits as a factor in payment. Following this initial decline, the number of in-person therapy visits per 30-day period remained relatively steady through 2022. By contrast, there was little change in the number of skilled nursing visits per 30-day period in 2020, but the number of these visits per 30-day period decreased by 0.5 visits from 2020 to 2022. In total, therapy visits fell by 18.6 percent between 2019 and 2022, while skilled nursing visits fell by 10.5 percent. (As discussed below, the number of medical social services and home health aide services per 30-day period, which make up a small fraction of total visits, declined steadily between 2019 and 2022.)

Several factors may have contributed to the decline in visits per 30-day period since 2019. First, as noted above, changes to the incentives underlying the payment system likely resulted in changes in provider behavior. Second, fewer in-person visits could, in part, reflect trends related to the coronavirus pandemic, such as beneficiary reluctance to receive services in the home and provider staffing challenges. And growing use of telehealth services may have replaced some in-person visits. Shortly after the onset of the pandemic, CMS expanded the use of telehealth in home health care, permitting agencies to provide virtual visits and other telehealth services under the benefit. The coverage of telehealth was initially expanded for the duration of the public health emergency (PHE) but was later made permanent. A survey found that almost three-quarters of HHAs expanded their telehealth programs in 2020 (Shang et al. 2020). Several HHAs and industry experts we interviewed indicated that telehealth and virtual visits increased substantially during the coronavirus pandemic, surging at the beginning and receding in later months. Unfortunately, data were not available to assess the use of telehealth visits in 2020 through 2022. In 2023, CMS began requiring HHAs to report telehealth services, consistent with our recommendation in the March 2022 report to the Congress.⁵

Since the implementation of the home health PPS in 2000, the number of home health aide visits provided during a typical stay has declined (data not shown). In recent years, this decline continued, falling from 0.8 visits per 30-day period in 2019 to 0.5 visits per 30-day period in 2022. This decline has raised concerns that FFS Medicare beneficiaries are not receiving services they are entitled to under the Medicare home health benefit (Center for Medicare Advocacy 2019). In CMS's 2024 final rule, the agency highlighted industry and beneficiary stakeholder comments that discussed the reasons for the decline (Centers for Medicare & Medicaid Services 2023). Some commenters contended that FFS Medicare's payment policies do not adequately compensate HHAs for providing care to the patients with the highest need for aide services, and they cited challenges in hiring, training, and retaining aides. One comment to CMS noted that sometimes nurses or occupational therapists provide services typically furnished by a home health aide, raising the possibility that some of the decline in home health aide visits since 2000 represents a shift of these services to skilled nursing or therapist visits. In addition, commenters

raised concerns that, to maximize financial performance, agencies were avoiding patients who need extensive aide services.

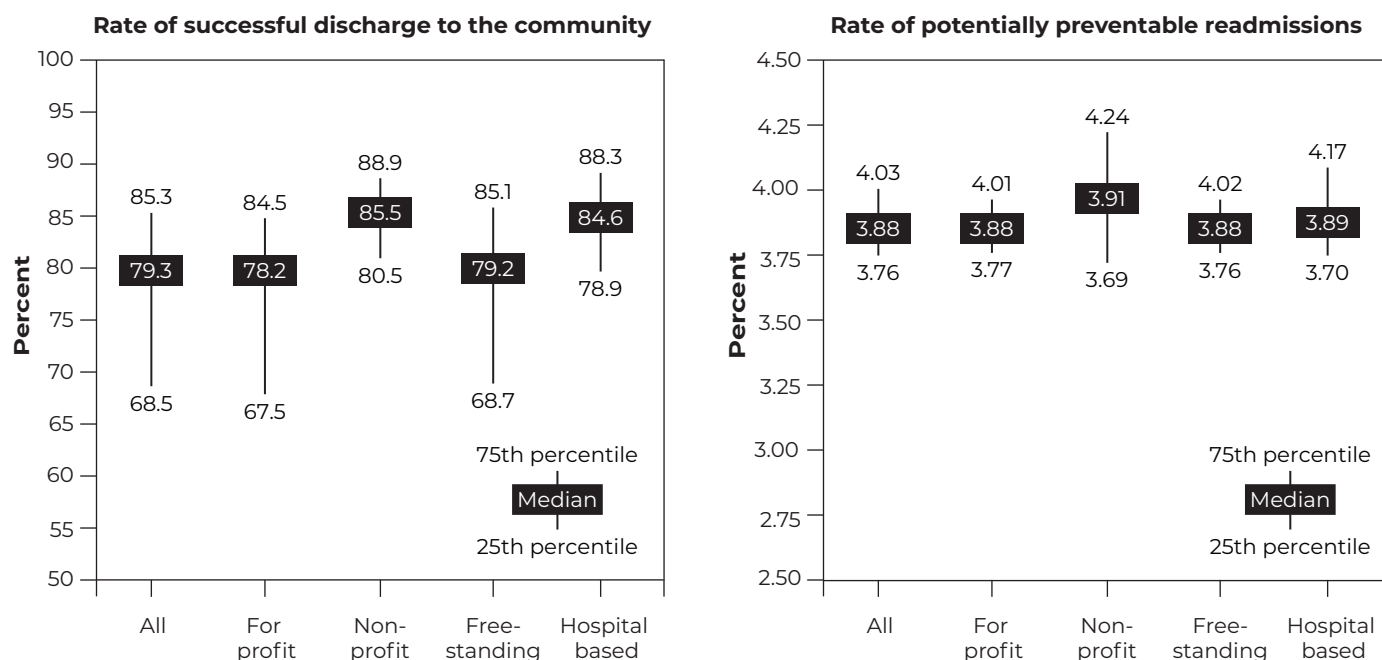
Like other Medicare PPSs, the home health PPS creates a financial incentive for agencies to limit the number of services they furnish per period. However, the average cost per visit of a home health aide is lower than the skilled nursing and therapy services provided during home health care. Like these other services, FFS Medicare's base payment rate includes the costs of home health aide services. Further, the average freestanding HHA has had a FFS Medicare margin in excess of 16 percent since 2001. The relatively low cost of home health aide services and high FFS Medicare margins for freestanding agencies indicate that FFS Medicare payment levels should be adequate to cover the costs of beneficiaries that need additional aide services.

Marginal profits

Another measure of access 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 (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If FFS Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider 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.⁶ In 2022, the average marginal FFS Medicare profit for freestanding HHAs was 23 percent, indicating that these HHAs have a strong incentive to serve FFS Medicare beneficiaries.

Quality of care: Discharge to the community and potentially preventable readmissions

The Commission prioritizes quality measures tied to clinical outcomes in our assessment of payment adequacy. This year, we report two outcome measures for HHAs: risk-adjusted potentially preventable hospital readmissions after discharge and risk-adjusted discharge to the community. We are replacing prototype cross-sector measures developed by the Commission, which we have previously used in our analysis of payment adequacy, with these similar

**FIGURE
7-3****Median and interquartile ranges of HHAs' risk-standardized rates of successful discharge to community and potentially preventable readmissions**

Note: HHA (home health agency). The measure of successful discharge to the community is an HHA's risk-standardized rate of fee-for-service (FFS) patients who were discharged to the community after a home health stay, did not have an unplanned admission to an acute care or long-term care hospital in the 31 days following discharge, and remained alive during those 31 days. All FFS Medicare patients, regardless of whether the home health stay was preceded by a hospitalization, are included in the calculation of the measure. Higher rates are better. The measure of potentially preventable readmission is calculated only for FFS home health patients who had an acute inpatient discharge within the five days before the start of their home health stay. For those patients, the measure is calculated as the risk-adjusted percentage who were readmitted to an acute care hospital during the 30 days following the start of the home health stay for a medical condition that might have been prevented. Lower rates are better. Rates are computed from Medicare claims for eligible Medicare Part A-covered home health stays. Data for successful discharge cover the two-year period from January 1, 2021, to December 31, 2022; data for potentially preventable readmissions cover the 30-month period from July 1, 2020, to December 31, 2022.

Source: MedPAC analysis of claims-based outcome measures from the Provider Data Catalog.

claims-based outcome measures developed by CMS. CMS outcome measures are the product of a transparent, expert-informed measure development process and have undergone public notice. They have and will be refined over time to incorporate improvements. CMS publicly reports facility-level measures after providers have the opportunity to review the data.

The return to the home or community quality measure shows the rate at which patients returned from the HHA and remained alive without any unplanned hospitalizations in the 31 days following discharge from the HHA (higher rates are better). This rate includes both community-admitted and posthospital home health beneficiaries. The median rate of discharge

to the community declined from 82.6 percent in the period from January 1, 2018, to December 31, 2019, to 79.3 percent in the period from January 1, 2021, to December 31, 2022. For-profit providers had the lowest median rates of discharge to community in both periods, while hospital-based providers had the highest rates. From January 1, 2021, to December 31, 2022, the HHAs at the 25th percentile and 75th percentile had rates of 68.5 percent and 85.3 percent, respectively (Figure 7-3).

Potentially preventable readmissions after discharge are calculated as the percentage of patients discharged from home health care services who were readmitted to a hospital within 30 days for a medical condition that might have been prevented (lower percentages

**TABLE
7-6**

Rate of hospitalization after the initiation of home health care declined slightly

	January 1, 2019– December 31, 2019	July 1, 2020– June 30, 2021	January 1, 2022– December 31, 2022
Share of FFS Medicare beneficiaries hospitalized within 60 days of initiating home health care	15.4%	14.2%	14.2%

Note: FFS (fee-for-service). CMS's all-cause hospitalization measure covers a 60-day period of home health care, includes hospitalizations and rehospitalizations for any cause (not only potentially preventable conditions), and includes both community-admitted and posthospital home health stays.

Source: Medicare Compare, 2019–2022.

are better; a home health stay had to be preceded by a hospital stay to be included in this measure). For the 30-month period from July 1, 2020, to December 31, 2022, the share of home health stays with a potentially preventable readmission was 3.88. The average rates of potentially preventable rehospitalization did not differ significantly across ownership categories or facility type. In the July 1, 2020, to December 31, 2022, period, the HHAs at the 25th percentile and 75th percentiles had potentially preventable rehospitalization rates of 3.76 percent and 4.03 percent, respectively (Figure 7-3, p. 213).

While the rate of potentially preventable hospitalizations was relatively low overall, an all-cause measure of hospitalization indicates that about 14.2 percent of FFS Medicare beneficiaries experienced a hospitalization in the first 60 days of home health care in 2022 (Table 7-6). Compared with the potentially preventable rehospitalization measure, the all-cause hospitalization measure captures the care experience for a broader range of home health care services: The measure covers a 60-day period of care, includes hospitalizations and rehospitalizations for any cause (not only potentially preventable conditions), and includes both community-admitted and posthospital home health stays.

Most patient experience measures remained stable in 2022

HHAs collect Home Health Care Consumer Assessment of Healthcare Providers and Systems® (HH-CAHPS®) surveys from a sample that includes FFS Medicare,

MA, and Medicaid patients served by HHAs.⁷ The HH-CAHPS measures key components of quality by assessing whether something that should happen during a stay (such as clear communication) actually happened. These data include beneficiaries admitted to home health care from the community or after a stay at an inpatient hospital or inpatient PAC provider.

HH-CAHPS ratings in 2022 were comparable with prior years on most measures; the same share of patients in 2021 and 2022 reported positive responses for three of the measures (Table 7-7). (Data for 2020 are unavailable because CMS waived the requirement to collect HH-CAHPS data for the first six months of 2020.) The share of beneficiaries reporting that (1) they would definitely recommend the HHA and (2) HHAs discussed medicines, pain, and home safety increased by 1 percentage point (Table 7-7).

Patient function is a key HHA outcome, but the Commission has questioned the accuracy of function information reported by post-acute care providers

Maintaining and improving patients' functional status is a key outcome of PAC. HHAs assess and record information on each beneficiary's level of function at admission and discharge from home health care using the Outcome and Assessment Information Set (OASIS). Provider-reported function data are used to assign patients to case-mix groups to adjust payments, and these data affect whether an HHA receives a penalty or a bonus under value-based purchasing (VBP). For these reasons, HHA-reported function data from OASIS

**TABLE
7-7**

Most patient experience measures did not change in 2022

HH-CAHPS® measure	2019	2021	2022	Percentage point change, 2021-2022
Share of patients rating the home health agency a 9 or 10 out of 10	84%	84%	84%	0
Share of patients who would definitely recommend the home health agency to friends or family	78	77	78	+1
Share of patients who reported that their home health provider:				
Gave care in a professional way	88	88	88	0
Communicated well with them	85	85	85	0
Discussed medicines, pain, and home safety with them*	83	81	82	+1

Note: HH-CAHPS® (Home Health Care Consumer Assessment of Healthcare Providers and Systems®). HH-CAHPS is a standardized survey of patients' evaluations of home health. The survey items are combined to calculate measures of patient experience for each HHA. Each year's results are based on a sample of surveys of HHAs' patients from January to December. CMS did not collect HH-CAHPS data for the first six months of 2020. Data include FFS Medicare, Medicare Advantage, and Medicaid beneficiaries.

*This measure averages seven HH-CAHPS® questionnaire items that ask whether HHAs discussed prescription medicines, pain, and home safety with beneficiaries.

Source: CMS summary of HH-CAHPS® public report of survey results tables.

should be interpreted carefully. For example, a 2017 assessment of a Medicare home health VBP program found that agencies refined their assessment practices, raising the possibility that some of the better functional outcomes observed in the program reflected agency assessment practices and not improved outcomes (Pozniak et al. 2018). This finding contributes to the Commission's ongoing concerns about the integrity of function information reported by HHAs and other PAC providers. As we noted in our June 2019 report to the Congress, providers' recording of functional assessment information, such as change in mobility, appear to be influenced by incentives in the applicable payment systems rather than objective assessments of patients' function (Medicare Payment Advisory Commission 2019).

Because functional outcomes are critically important to patients receiving PAC, the Commission has discussed strategies to improve the assessment data, the importance of monitoring the reporting of these data, and the use of alternative measures of function (such as

patient-reported surveys) that do not rely on provider-completed assessments (Medicare Payment Advisory Commission 2019). While current provider-reported patient function information is flawed, beneficiaries and policymakers have a strong interest in objective information about HHAs' effectiveness in improving or maintaining their patients' functional abilities. The ability to monitor patient function is especially important given the ongoing changes in delivery of care that have occurred since the implementation of the PDGM.

Providers' access to capital is adequate

In 2022, the all-payer margin for freestanding HHAs averaged 7.9 percent, indicating that many HHAs yield positive financial results that should appeal to capital markets. HHAs are not as capital intensive as other providers because they do not require extensive physical infrastructure, and many are too small to attract interest from capital markets. Few HHAs access capital through publicly traded shares or through public debt, such as issuance of bonds.

In past years, the Commission examined public financial statements to assess access to capital, but since 2021, three of the largest publicly traded companies were acquired by MA insurance companies and no longer report detailed results for Medicare home health services. One of the largest remaining publicly traded home health companies, Enhabit Incorporated, reported that it is assessing strategic options which may include a “potential sale, merger, or other strategic transaction” (Enhabit Home Health & Hospice 2023).

The acquisition trends suggest that the home health industry has been attractive to outsider investors. In 2021, Humana completed its purchase of Kindred at Home (Waddill 2021). In 2023, Optum Health Care, a subsidiary of UnitedHealth Group, purchased LHC Group and entered into an agreement to purchase Amedisys (Pifer 2023). According to industry analysts, these acquisitions reflect several trends, including efforts to expand population-based health care services, better manage spending on and utilization of home health care services, and capture revenues that are paid to providers for services to plan beneficiaries (Irving Levin Associates 2023, Pifer 2023).

Private equity firms own many home health agencies, but measuring private equity’s role in the sector is complicated by limitations in ownership data. As we noted in our June 2021 report to the Congress, Medicare providers can have complex ownership structures that make it challenging to identify the parent owner (Medicare Payment Advisory Commission 2021). As a result, efforts to identify private equity ownership may reflect analytic criteria unique to each analysis and may vary depending on the approach followed to resolve ambiguities in ownership structure. One recent analysis concluded that 5.7 percent of Medicare HHAs were owned by such firms in 2023 (Moss and Viera 2023). In recent years, private equity firms have accounted for a significant share of investment activity. An analysis by the Braff Group indicated that private equity’s share of annual reported home health care and hospice transactions (buying or selling of agencies) increased from about 20 percent in 2013 to about 50 percent in 2021, though it appears that private equity’s share of home health care transactions may have declined since 2021 (Braff Group 2022a, Braff Group 2022b). While the pace of private equity

investment in health care appears to have slowed in 2022, the home health care sector is still viewed as likely to attract interest from private equity investors in the future (Irving Levin Associates 2023).

About 6 percent of HHAs were owned by a hospital or other provider (such as a skilled nursing facility) in 2022. Among health systems, ownership of a PAC service is common, with one study finding that 80 percent of health systems operate an HHA or SNF. Studies suggest that integration of home health and other PAC services can lead to better quality and lower costs (Hogan et al. 2020, Kalata et al. 2023).

In the last 10 years, freestanding HHAs’ all-payer revenues have generally increased, but the share of revenues coming from FFS Medicare has declined. In 2013, the average freestanding HHA had total revenue of \$3.7 million; the average increased to \$4.8 million in 2022. FFS Medicare accounted for 58 percent of the average freestanding HHA’s revenues in 2013, but by 2022 that share had declined to 49 percent for the average freestanding agency. Some of the decline in FFS Medicare’s share of total revenue may reflect HHAs serving more Medicare beneficiaries through the MA program as enrollment in MA plans has increased. If the shift of beneficiaries from FFS Medicare to MA continues, freestanding agencies’ share of revenues from FFS Medicare will continue to decline. While the costs and payments for MA enrollees are included in the all-payer data that HHAs report to CMS, HHAs are not required to report these financial measures for the MA population separately. As a result, it is not possible to compute HHAs’ MA margins from the Medicare cost report. However, since HHAs’ all-payer margins are significantly lower than FFS Medicare margins, it is likely that other payers, including MA plans, pay less than FFS Medicare. HHAs have stated that payment rates from MA plans are lower than HHAs’ costs of providing home health care services (Dombi 2023).

Medicare payments and providers’ costs: FFS Medicare margins remain high

In 2022, the aggregate Medicare FFS margin for freestanding HHAs was 22.2 percent, down from 24.9 percent in 2021—the historic high. FFS Medicare margins varied across providers but were positive for most.

**TABLE
7-8****Total FFS Medicare expenditures for home health care services declined in 2022, but payments per in-person visit increased**

	2019	2020	2021	2022	Average annual percent change		Cumulative change
					2019-2022	2021-2022	
Total FFS payments (in billions)	\$17.9	\$17.1	\$16.9	\$16.1	-3.4%	-4.4%	-10.0%
Total in-person visits (in millions)	99.7	81.1	76.8	69.5	-11.3	-9.6	-30.3
FFS payment per in-person visit	\$180	\$211	\$220	\$232	8.9	5.8	28.9
Payment per FFS Medicare beneficiary who received home health care	\$5,437	\$5,591	\$5,588	\$5,703	1.6	2.1	4.9

Note: FFS (fee-for-service). Percentage changes were calculated on unrounded data.

Source: MedPAC analysis of home health standard analytic files from CMS and the 2023 annual report of the Boards of Trustees of the Medicare trust funds.

HHAs continue to curb per period costs by reducing visits

In 2022, total FFS Medicare spending for home health care declined by 4.4 percent to \$16.1 billion relative to the prior year (Table 7-8). The decline likely reflects several factors affecting utilization that were noted previously: decreased FFS Medicare enrollment, fewer hospitalizations leading to fewer post-acute admissions to home health, and increased SNF use by beneficiaries who have been hospitalized. Though total FFS Medicare payments for home health care declined between 2019 and 2022 by 10 percent, the average payment per FFS user of home health care has risen 4.9 percent over the period, while the average payment per in-person visit has climbed 28.9 percent, increasing from \$180 per visit to \$232.⁸

A decline in the number of in-person visits per 30-day period is a substantial factor in the higher payment per visit observed in 2020 and later years. When setting the PDGM base rate for 2020, CMS assumed, consistent with the requirements of the BBA of 2018, that the number of in-person visits in a 30-day period would remain stable; thus, the rate is based on a higher level of utilization than occurred in 2022.⁹ The base rate also does not reflect the shift to a less costly mix of services that occurred after

2019 due to the drop in therapy services. If telehealth visits had been counted, the 2022 per visit payment increase would likely have been somewhat lower, but HHAs were not required to report telehealth services until July 2023. The per visit payment increase also reflects other payment policies in 2020 through 2022, including annual payment updates, a percentage payment reduction that CMS implemented in 2020 in anticipation of coding changes under the PDGM, and the suspension of the sequester. Finally, a 4 percent increase in case-mix acuity also raised payments in 2020.

The decline in in-person visits under the PDGM was similar to the industry's behavioral response in 2000, when Medicare switched from a cost-based home health reimbursement system to a PPS that used 60-day episodes of care. In that year, the number of visits per 60-day episode fell below what CMS had assumed when it set the base payment for the newly established PPS. As a result, in 2001, the FFS Medicare margin for freestanding HHAs exceeded 20 percent. Though the number of in-person visits per period could rebound in future years as the effects of the coronavirus pandemic recede, the pattern of visits and payments observed after the implementation of the PDGM in 2020 is similar to the early experience

**TABLE
7-9****FFS Medicare margins for freestanding home health agencies declined in 2022 but remained high, 2021-2022**

	2021	2022	Share of home health agencies, 2022	Share of periods, 2022
All	24.9%	22.2%	100%	100%
Geography				
Majority urban	24.8	22.2	85.4	86.0
Majority rural	25.2	21.8	14.6	14.0
Type of ownership				
For profit	26.1	23.5	92.5	86.4
Nonprofit	20.2	15.8	7.5	13.6
Volume quintile				
First (smallest)	14.0	13.4	20	2.7
Second	15.9	14.4	20	6.3
Third	19.3	17.0	20	11.0
Fourth	22.8	20.9	20	19.5
Fifth (largest)	28.3	24.7	20	60.5

Note: FFS (fee-for service). Home health agencies (HHAs) were classified as majority urban if they provided more than 50 percent of episodes to beneficiaries in urban counties and were classified as majority rural if they provided more than 50 percent of episodes to beneficiaries in rural counties. These data do not include federal provider relief funds that HHAs received due to the coronavirus pandemic. Percentages reflect rounding and may not sum to 100 percent.

Source: MedPAC analysis of Medicare home health cost report files from CMS.

of the home health PPS that led to years of payments well in excess of costs.

In 2022, the average cost per 30-day period increased by 4.0 percent for freestanding HHAs, a reversal of the trend we observed in 2021, when cost per period declined by 2.9 percent. This increase in 2022 was due to higher costs per visit, but the increase was offset by a reduction in the number of in-person visits provided. Historically, the increase in average cost per unit of payment for HHAs has been less than the rate indicated by the home health market basket. For example, between 2017 and 2019, the annual increase in cost per 60-day episode averaged 1.4 percent, while the home health market basket averaged 2.6 percent over the same period.

The aggregate FFS Medicare margin for freestanding HHAs was over 20 percent in 2022

In 2022, the aggregate FFS Medicare margin for freestanding HHAs was 22.2 percent (Table 7-9). The margin ranged from 5.6 percent for those at the 25th percentile to 31.8 percent at the 75th percentile of the margin distribution (data not shown). For-profit HHAs had higher margins than nonprofit HHAs, and urban HHAs had slightly higher margins than rural HHAs. Agencies with higher volume had better financial results, likely reflecting the economies of scale possible for larger operations. For example, the margin for HHAs in the bottom quintile of volume averaged 13.4 percent, compared with a 24.7 percent margin for HHAs in the top quintile of volume. While there is variation in agency financial performance, FFS Medicare payments

**TABLE
7-10**

Home health PPS payment policy changes in 2023 and 2024

	2023	2024
Home health PPS policy changes:		
Home health market basket	4.0%	3.0%
Productivity	-0.1	-0.3
Budget-neutrality adjustment under BBA of 2018	-3.925	-2.890
Outlier threshold adjustment	0.2	0.2
Total	0.1	0.2

Note: PPS (prospective payment system), BBA (Bipartisan Budget Act). The effects of the home health PPS policy changes are multiplicative and do not sum to the total.
Source: MedPAC analysis of home health final rules for 2023 and 2024.

are well in excess of HHA costs. These overpayments have consequences for the Medicare program, as they increase the financial pressure on the Medicare trust funds and increase the Part B premium paid by Medicare beneficiaries.

The Commission includes hospital-based HHAs in its calculation of acute care hospitals’ FFS Medicare margins because these agencies operate in the financial context of hospital operations. In 2022, FFS Medicare margins for hospital-based HHAs were -17.0 percent (data not shown). The lower margins of hospital-based HHAs are attributable chiefly to their higher costs, some of which are a result of overhead costs allocated to the HHA from its parent hospital. Hospital-based HHAs help their parent institutions financially if they can shorten inpatient stays, lowering expenses in the more costly inpatient hospital setting.

FFS Medicare margin for 2024 projected to decline relative to 2022 but remain near 20 percent

In modeling 2024 FFS Medicare margins, we incorporate policy changes that will go into effect between the year of our most recent data, 2022, and the year for which we are making the margin projection, 2024. Table 7-10 shows the major payment policy changes in 2023 and 2024, including a permanent reduction to the base payment rate of 2.89 percent, as required to maintain budget neutrality following the implementation of the PDGM classification system and associated changes to the PPS. On the basis of these policies and assumptions,

the Commission projects a FFS Medicare margin of 18 percent in 2024.

The annual increase in cost per 30-day period has fluctuated significantly since the PDGM was implemented. In 2021, the cost per 30-day period declined by 2.9 percent, while in 2022, the cost per 30-day period increased 4.0 percent. The Commission’s projected margin assumes that the rate of cost inflation for 2023 will be 4.0 percent, equal to the increase observed in 2022. For 2024, the Commission assumes that costs will increase by 0.55 percent, the average of the increases in 2021 and 2022.

While our assumption of cost growth for 2024 is lower than the level of inflation projected by the home health market basket, it takes into consideration that, historically, annual cost increases in this industry have often been lower than anticipated. As noted earlier, cost per period in 2021 declined by 2.9 percent relative to 2020. In 2011 to 2019—the last 9 years that the 60-day payment episode was in effect—the average increase in cost per episode was about 0.5 percent per year.

How should FFS Medicare payments change in 2025?

In considering how payments should change, we note that current law is expected to increase home health payment rates by 2.7 percent in 2025 (an estimated

market basket increase of 2.9 percent minus a productivity adjustment of 0.2 percent). CMS will revise its estimates before the publication of the final rule. However, our payment adequacy indicators for FFS Medicare home health services are generally positive, and payments continue to substantially exceed costs, as they have for many years. These excess payments do not accrue to the advantage of beneficiaries or the Medicare program. Further, the high aggregate margin indicates that the home health PPS reduces the incentives for HHAs to furnish care efficiently.

As noted above, in 2023 CMS implemented a permanent reduction to the 30-day period base rate of 2.890 percent, half the amount required by law to maintain budget neutrality following the implementation of the PDGM classification system and associated changes to the PPS. Assuming this estimate does not change, in future years CMS will have to reduce the base rate for 30-day periods by an additional 2.890 percent to keep spending at the level required by law. We note that, even after such a reduction, payments to HHAs would remain far above costs.

RECOMMENDATION 7

For calendar year 2025, the Congress should reduce the 2024 Medicare base payment rates for home health agencies by 7 percent.

RATIONALE 7

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, FFS Medicare's payments for home health services are too high, and the excess payments diminish the service's value as a substitute for more costly services. Medicare has overpaid for home health care since the inception of prospective payment in 2000, and these overpayments create higher expenditures for the beneficiary and the Medicare program. The aggregate FFS Medicare margin was 22.2 percent in 2022, and we project that it will remain near 20 percent in 2024.

A 7 percent reduction to the FFS base payment in 2025 would significantly address the magnitude of excess payments embedded in FFS Medicare's home health payment rates. However, this reduction would likely be inadequate to align Medicare payments with providers' actual costs. Though the coronavirus public health emergency was a disruption for HHAs, it did not significantly change the industry's financial outlook; in fact, FFS Medicare margins in 2022 were much higher than in 2019.

IMPLICATIONS 7

Spending

- This recommendation would decrease federal program spending by \$750 million to \$2 billion in 2025 and by \$5 billion to \$10 billion over five years.

Beneficiary and provider

- We do not expect this recommendation to have adverse effects on beneficiaries' access to home health care. Given the current level of payments, we do not expect the recommendation to affect providers' willingness or ability to care for FFS beneficiaries. ■

Endnotes

- 1 The Medicare statute permits nurse practitioners, clinical nurse specialists, and physician assistants to order and supervise home health care services. State laws on medical scope of practice also govern the services these practitioners are permitted to deliver and may limit the ability of some nonphysician practitioners to order home health care.
- 2 An overview of the home health PPS is available at https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_HHA_FINAL_SEC.pdf.
- 3 As of November 2022, this measure of access is based on data collected and maintained as part of CMS's Home Health Compare database. The service areas listed are postal ZIP codes in which an HHA has provided services in the past 12 months.
- 4 On a per capita basis, the use of inpatient hospital services in FFS Medicare has declined by 20 percent since 2018.
- 5 HHAs could voluntarily report telehealth services beginning on January 1, 2023, with mandatory reporting beginning July 1, 2023.
- 6 If we approximate marginal cost as total Medicare costs minus fixed building and equipment costs, then marginal profit can be calculated as follows:

$$\text{Marginal profit} = (\text{payments for FFS Medicare services} - (\text{total FFS Medicare costs} - \text{fixed building and equipment costs})) / \text{FFS Medicare payments}.$$

This comparison is a lower bound on the marginal profit because we do not consider any potential labor costs that are fixed.
- 7 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.
- 8 These amounts of payment per visit were computed by dividing the total Medicare PPS payments in each year by the total number of visits (for 2021, only payments and in-person visits for 30-day periods paid under the PDGM were included).
- 9 The BBA of 2018 required CMS to set spending under the PDGM such that it would be equal to what Medicare would have spent under the predecessor payment system if the latter had been in effect in 2020.

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C H A P T E R

8

Inpatient rehabilitation facility services

R E C O M M E N D A T I O N

- 8** For fiscal year 2025, the Congress should reduce the 2024 Medicare base payment rate for inpatient rehabilitation facilities by 5 percent.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Inpatient rehabilitation facility services

Chapter summary

Inpatient rehabilitation facilities (IRFs) are hospitals and units of hospitals that 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 2022, fee-for-service (FFS) Medicare spent \$8.8 billion on 383,000 IRF stays in about 1,180 IRFs nationwide. The FFS Medicare program accounted for about 51 percent of IRF discharges.

Assessment of payment adequacy

In 2022, most IRF payment adequacy indicators were positive; however, FFS Medicare margins continued to vary across IRFs.

Beneficiaries’ access to care—Our analysis of IRF supply and volume of services provided and IRFs’ marginal profit under the IRF prospective payment system (PPS) suggests that access remains adequate.

- **Capacity and supply of providers**—Between 2021 and 2022, while the number of IRFs stayed the same, the number of IRF beds slightly

In this chapter

- Are FFS Medicare payments adequate in 2024?
- How should FFS Medicare payments change in 2025?
- Improving the accuracy of Medicare’s payments

increased. The aggregate IRF occupancy rate remained stable at 68 percent, indicating that capacity is more than adequate to meet demand.

- **Volume of services**—From 2021 to 2022, total FFS IRF users increased about 1 percent, and Medicare stays per 10,000 FFS beneficiaries increased by about 4 percent. The average length of stay was 12.8 days.
- **FFS Medicare marginal profit**—The FFS Medicare marginal profit, an indicator of whether IRFs with excess capacity have an incentive to treat more Medicare beneficiaries, was 18 percent for hospital-based IRFs and 39 percent for freestanding IRFs—a very strong indicator of access.

Quality of care—In 2021 and 2022, the median facility risk-adjusted rate of successful discharge to the community from IRFs was 67.3 percent, about 2 percentage points higher (better) than the rate for the period from 2018 to 2019. The median facility risk-adjusted rate of potentially preventable readmission was 8.6 percent and was higher (worse) for freestanding and for-profit providers than hospital-based and nonprofit providers. (Because of a change in the measure calculation, we cannot compare this rate to a prior period.) Lack of data on patient experience and concerns about the accuracy of provider-reported function data limit our set of IRF quality measures.

Providers' access to capital—Between 2021 and 2022, freestanding IRFs' all-payer total margin decreased from 13 percent to about 9 percent. The decrease reflects inflation in the greater macroeconomic environment. Despite this decline in the all-payer margin, the largest IRF chain (which accounted for almost a third of all FFS Medicare IRF discharges) continued to open new IRFs and enter joint ventures with other organizations, suggesting strong access to capital. The extent to which other freestanding IRFs can access capital is less clear. Hospital-based IRFs access capital through their parent hospitals.

FFS Medicare payments and providers' costs—IRFs' FFS Medicare margin decreased to 13.7 percent in 2022, driven by cost growth exceeding payment growth. We expect cost growth in 2024 to be lower, more in line with the historical trend, and thus project that the 2024 margin will increase to 14 percent.

How should payment rates change in 2025?

FFS Medicare's payments to IRFs must be reduced to more closely align aggregate payments with aggregate costs. The Commission recommends that, for fiscal year 2025, the 2024 base payment rate for IRFs be reduced by 5 percent. This reduction would continue to provide IRFs with sufficient revenues to maintain FFS Medicare beneficiaries' access to IRF care while

bringing IRF PPS payment rates closer to the cost of delivering high-quality care efficiently.

Improving the accuracy of payments

The Commission has previously reported on differences in profitability across IRF case-mix groups, noting that misalignment of payments and costs could create financial incentives to admit certain types of patients over others, which could reduce access to IRF services for some patients. Given the persistently large disparities in profit margins across IRFs and evidence of differential coding practices among some IRFs, we conducted additional analyses of the alignment of payments and costs under the IRF PPS. We found that the method for setting payment weights, the hospital-specific relative value (HSRV) method, combined with changes in the IRF landscape since the IRF PPS was implemented, has likely contributed to the disparities in profitability across case-mix groups. We simulated the effect of replacing the HSRV method with an “average-cost” method that is used in other Medicare payment systems to set weights and found that this method yielded more uniform profitability across case-mix groups. We describe how average-cost weights may help reduce providers’ incentives to admit certain patients (and avoid others) and incentives to code patients as more functionally impaired. ■

Background

After illness, injury, or surgery, some patients need intensive inpatient rehabilitative care, including but not limited to speech–language pathology, physical, and occupational therapy. Such services can be provided in inpatient rehabilitation facilities (IRFs).¹ IRFs must be focused primarily on treating conditions that typically require intensive rehabilitation, among other requirements. IRFs can be fully licensed freestanding hospitals or specialized units within acute care hospitals (ACHs). To qualify for a covered IRF stay, a beneficiary must, among other criteria, be able to tolerate and benefit from intensive therapy and must have a condition that requires frequent, face-to-face supervision by a rehabilitation physician. To reimburse IRFs for their facility’s costs of providing inpatient services, fee-for-service (FFS) Medicare sets per discharge payment rates under the IRF prospective payment system (PPS).² In 2022, the FFS Medicare program spent \$8.8 billion on 383,000 IRF stays paid under the IRF PPS in about 1,180 IRFs nationwide. FFS Medicare beneficiaries accounted for about 51 percent of IRF discharges.

Medicare facility requirements for IRFs

To qualify as an IRF for Medicare payment, a facility must meet the Medicare conditions of participation for ACHs.³ It must also:

- have a preadmission screening process to determine that each prospective patient is likely to benefit significantly from an intensive inpatient rehabilitation program;
- ensure that the patient receives close medical supervision and provide—through qualified personnel—rehabilitation nursing; physical therapy, occupational therapy, and, as needed, speech–language pathology and psychological (including neuropsychological) services; social services; and orthotic and prosthetic services;
- have a medical director of rehabilitation with training or experience in rehabilitation who provides services in the facility on a full-time basis for freestanding IRFs or at least 20 hours per week for hospital-based IRF units;

- use a coordinated interdisciplinary team led by a rehabilitation physician that includes a rehabilitation nurse, a social worker or case manager, and a licensed therapist from each therapy discipline involved in the patient’s treatment;
- have a treatment plan for each patient, which is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient; and
- meet the compliance threshold, which requires that no less than 60 percent of patients admitted to an IRF have as a primary diagnosis or comorbidity at least 1 of 13 conditions specified by CMS.⁴ The intent of the compliance threshold is to distinguish IRFs from ACHs. If an IRF does not meet the compliance threshold, Medicare pays for all its stays based on the inpatient hospital PPS rather than the IRF PPS.⁵

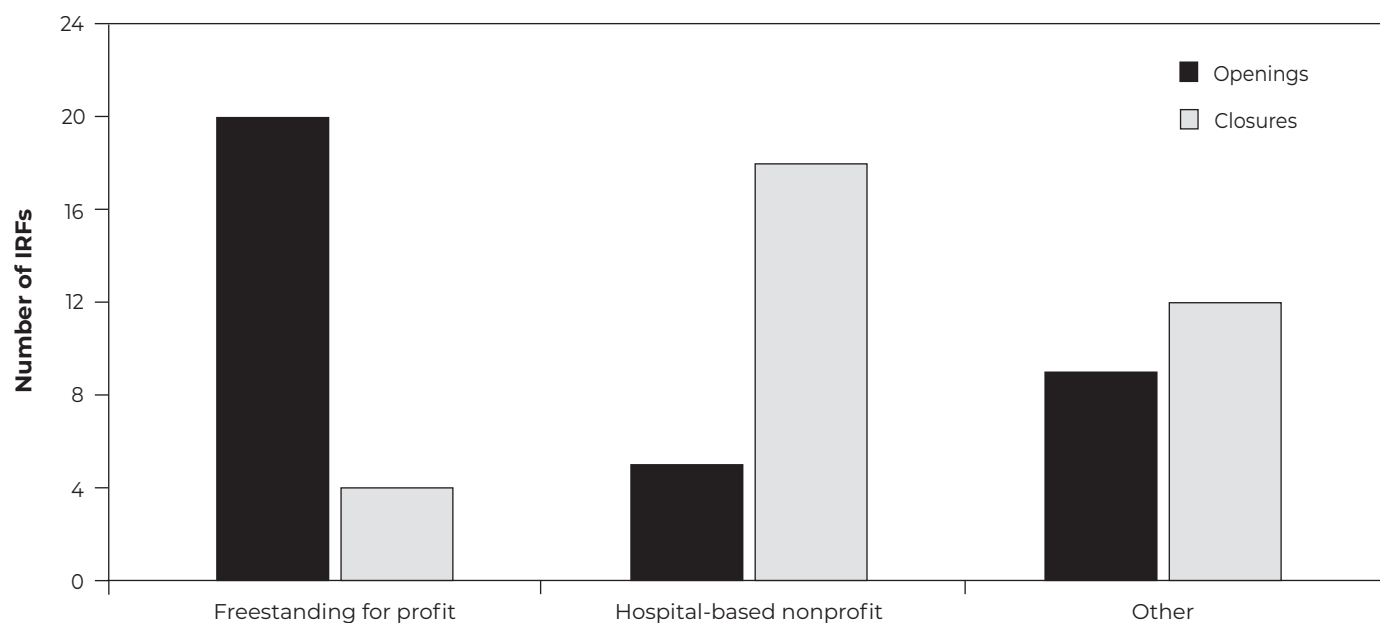
Medicare coverage criteria for beneficiaries

Medicare applies additional criteria that govern whether IRF services are covered for an individual Medicare beneficiary. For an IRF claim to be considered reasonable and necessary, the patient must be reasonably expected to meet the following requirements at admission:⁶

- The patient requires active and ongoing therapy in at least two modalities, one of which must be physical or occupational therapy.
- The patient can actively participate in and benefit from intensive therapy that most typically consists of three hours of therapy a day at least five days a week.
- The patient is sufficiently stable at the time of admission to actively participate in the intensive rehabilitation program.
- The patient requires supervision by a rehabilitation physician. This requirement is satisfied by face-to-face physician visits with a patient at least three days a week. Beginning with the second week of admission to the IRF, a nonphysician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation

**FIGURE
8-1**

In 2022, the majority of new IRFs were freestanding and for profit



Note: IRF (inpatient rehabilitation facility). "Other" includes government facilities, hospital-based for-profit facilities, and freestanding nonprofit facilities.

Source: MedPAC analysis of Provider of Services data.

may conduct one of the three required face-to-face visits with the patient per week, provided that such duties are within the nonphysician practitioner's scope of practice under applicable state law.

- The patient requires an intensive and coordinated interdisciplinary team approach to the delivery of rehabilitative care.

Are FFS Medicare payments adequate in 2024?

To assess whether FFS Medicare payments for fiscal year (FY) 2024 are adequate to cover the costs providers incur and how much providers' costs are expected to change in the coming year (2025), we examine several indicators of payment adequacy.

Specifically, we assess beneficiaries' access to care by examining the capacity and supply of IRFs and changes over time in the volume of services provided, quality of care, providers' access to capital, and the relationship between Medicare payments and providers' costs.

In general, our indicators of IRF payment adequacy are positive.

IRF supply and service volume suggest sufficient access

Although CMS has established admission criteria for IRFs, it is not always clear when IRF care is required for a given patient. Other, potentially lower-cost post-acute care (PAC) providers such as skilled nursing facilities (SNFs) can provide similar care for some types of patients. The absence of IRFs in some areas of the country implies that beneficiaries in these areas receive similar services in other settings.

**TABLE
8-1**

The number of IRFs remained stable in 2022

Type of IRF	Share of Medicare FFS discharges 2022	Number of IRFs					Average annual percent change	
		2018	2019	2020	2021	2022	2018–2020	2021–2022
All IRFs	100%	1,170	1,152	1,159	1,181	1,181	–0.5%	0.0%
Urban	94	1,014	1,000	1,004	1,021	1,021	–0.5	0.0
Rural	6	156	152	155	160	160	–0.3	0.0
Freestanding	60	290	299	310	329	345	3.4	4.9
Hospital based	40	880	853	849	852	836	–1.8	–1.9
Nonprofit	31	642	634	623	620	602	–1.5	–2.9
For profit	64	400	393	414	436	457	1.7	4.8
Government	5	121	116	113	115	111	–3.4	–3.5

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). Components may not sum to totals due to missing data.

Source: MedPAC analysis of Provider of Services data and Medicare Provider Analysis and Review data from CMS.

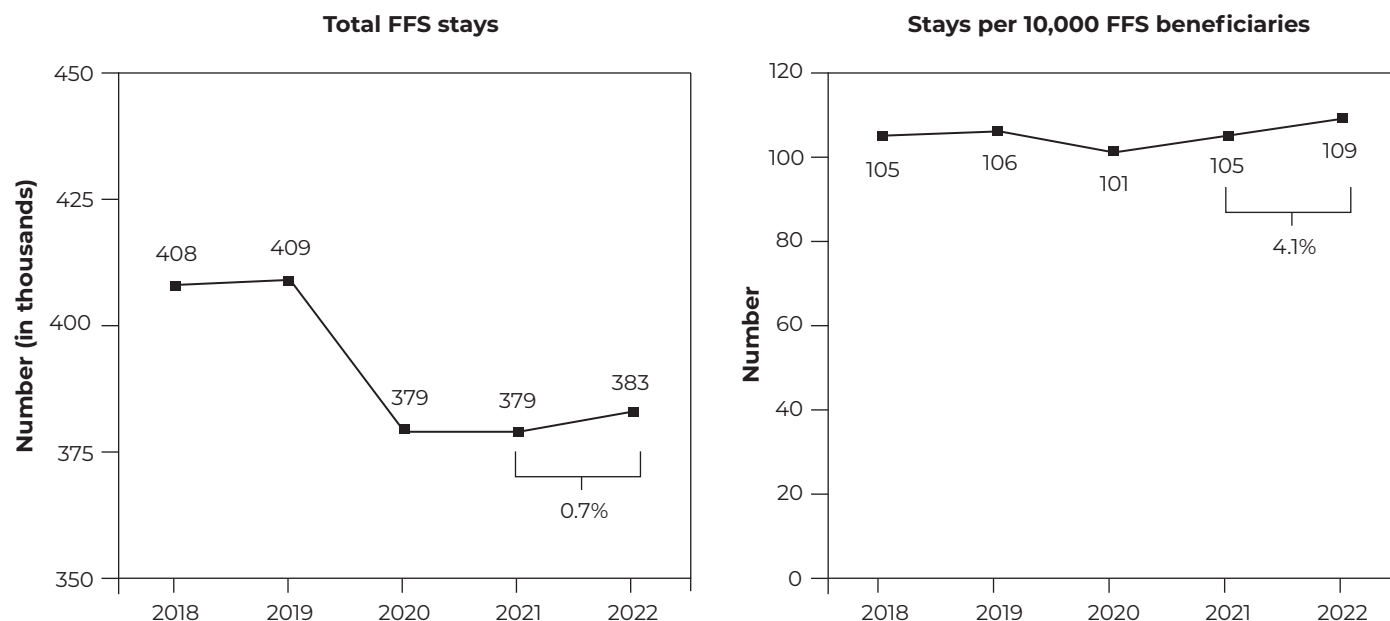
Nevertheless, our analysis of IRF supply and volume of services suggests that capacity remains adequate to meet demand. Moreover, FFS Medicare marginal profit, an indicator of whether IRFs with excess capacity have an incentive to treat more Medicare beneficiaries, was robust in 2022 for both freestanding and hospital-based IRFs, a very strong indicator of patient access.

Number of IRFs and occupancy rates suggest adequate capacity and supply

In 2022, the supply of IRFs was stable; there was an equal number of openings and closures (34 IRFs). The majority of IRFs that opened were freestanding and for profit, and most closures were hospital-based nonprofits (Figure 8-1). Less than 30 percent of the nation’s hospital service areas (HSAs) had one or more IRFs in 2022.⁷ (By comparison, 97 percent of HSAs contained at least one SNF). But because 70 percent of Medicare beneficiaries (including those in FFS and Medicare Advantage) lived in these HSAs, only about 30 percent of FFS beneficiaries lived in an HSA without an IRF. Beneficiaries who live in these HSAs may travel to other areas to receive IRF care or may receive rehabilitative care from other PAC providers.

After gradually declining from 2018 to 2020, the number of IRFs rose between 2020 and 2021 from 1,159 to 1,181 (Table 8-1). The overall number of IRFs remained stable at 1,181 in 2022. The majority of IRFs are located in urban areas, with about 14 percent located in rural areas (where about 19 percent of beneficiaries resided in 2022). About two-thirds of urban IRFs are units of ACHs, compared with 93 percent of rural IRFs (data not shown). From 2018 to 2020, freestanding and for-profit IRFs continued an upward trajectory, growing by 3.4 percent and 1.7 percent annually, respectively. In contrast, hospital-based and nonprofit IRFs have been on a steady decline for many years. Between 2018 and 2020, the number of hospital-based IRFs fell by 1.8 percent annually, and the number of nonprofit IRFs fell by 1.5 percent annually; those declines accelerated in 2022 (Table 8-1).

Though the number of freestanding IRFs has risen from year to year, the share of hospital-based IRFs is still greater than freestanding IRFs. In 2022, over 70 percent of IRFs were hospital based; the rest were freestanding facilities. However, because hospital-based units have, on average, fewer beds and a lower share of

**FIGURE
8-2****In 2022, IRF stays grew for the first time since the start of the pandemic**

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). The number of FFS stays and the number of beneficiaries are rounded.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

FFS Medicare discharges, they accounted for only 40 percent of FFS Medicare discharges. In contrast, freestanding facilities made up about 29 percent of the IRF supply but accounted for about 60 percent of FFS Medicare discharges. Similarly, for-profit IRFs made up about 39 percent of the total number of IRFs but accounted for about 64 percent of Medicare discharges (Table 8-1, p. 231). For-profit IRFs are disproportionately freestanding (data not shown).

In 2022, the aggregate IRF occupancy rate remained stable at 68 percent. From 2021 to 2022, the aggregate occupancy rate stayed the same among freestanding IRFs (71 percent) but decreased slightly from 65 percent to 64 percent among hospital-based IRFs. These rates suggest that capacity is more than adequate to meet demand for IRF services. Although IRFs provide a more intense level of therapy, IRFs are not the sole providers of rehabilitation services in communities. SNFs also

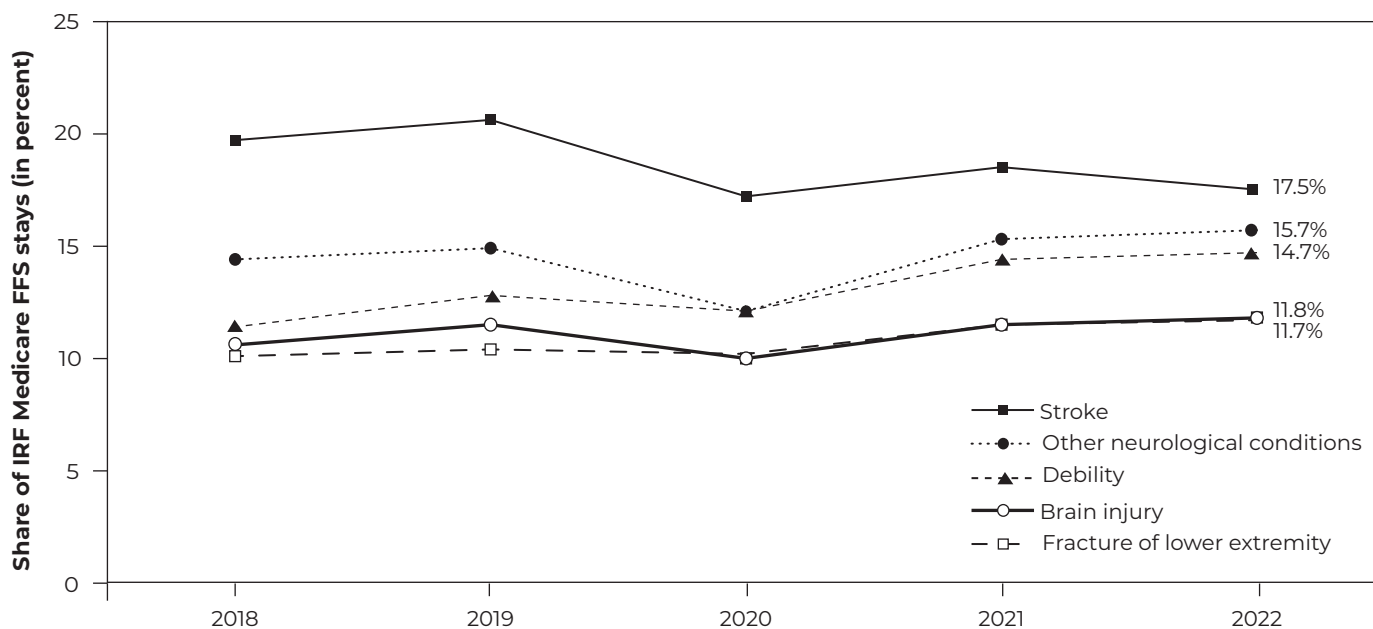
provide rehabilitation services in an institutional setting, and home health agencies, comprehensive outpatient rehabilitation facilities, and independent therapy providers furnish care at home or on an outpatient basis. Given the number and distribution of these other rehabilitation therapy providers, it is unlikely that IRFs are the only provider of rehabilitation therapy services available to Medicare beneficiaries in any given area.

In 2022, IRF stays per beneficiary exceeded prepandemic levels

From 2021 to 2022, the number of FFS stays rose by less than 1 percent to 383,000 (Figure 8-2). However, the number of stays per 10,000 FFS beneficiaries increased by 4.1 percent, from 105 to 109. The average length of stay remained relatively stable at 12.8 days in 2022, a 0.7 percent reduction from 12.9 days in 2021 (data not shown).

FIGURE
8-3

Stroke, other neurological conditions, and debility remain the most common conditions for FFS beneficiaries in IRFs



Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility). "Other neurological conditions" includes multiple sclerosis, Parkinson's disease, polyneuropathy, and neuromuscular disorders. "Fracture of lower extremity" includes hip, pelvis, and femur fractures. Patients with debility have generalized deconditioning not attributable to other conditions. "Brain injury" includes both traumatic and nontraumatic injuries. All FFS Medicare IRF stays with valid patient assessment information were included in this analysis. Yearly figures presented in the table are rounded.

Source: MedPAC analysis of Inpatient Rehabilitation Facility Patient Assessment Instrument data from CMS.

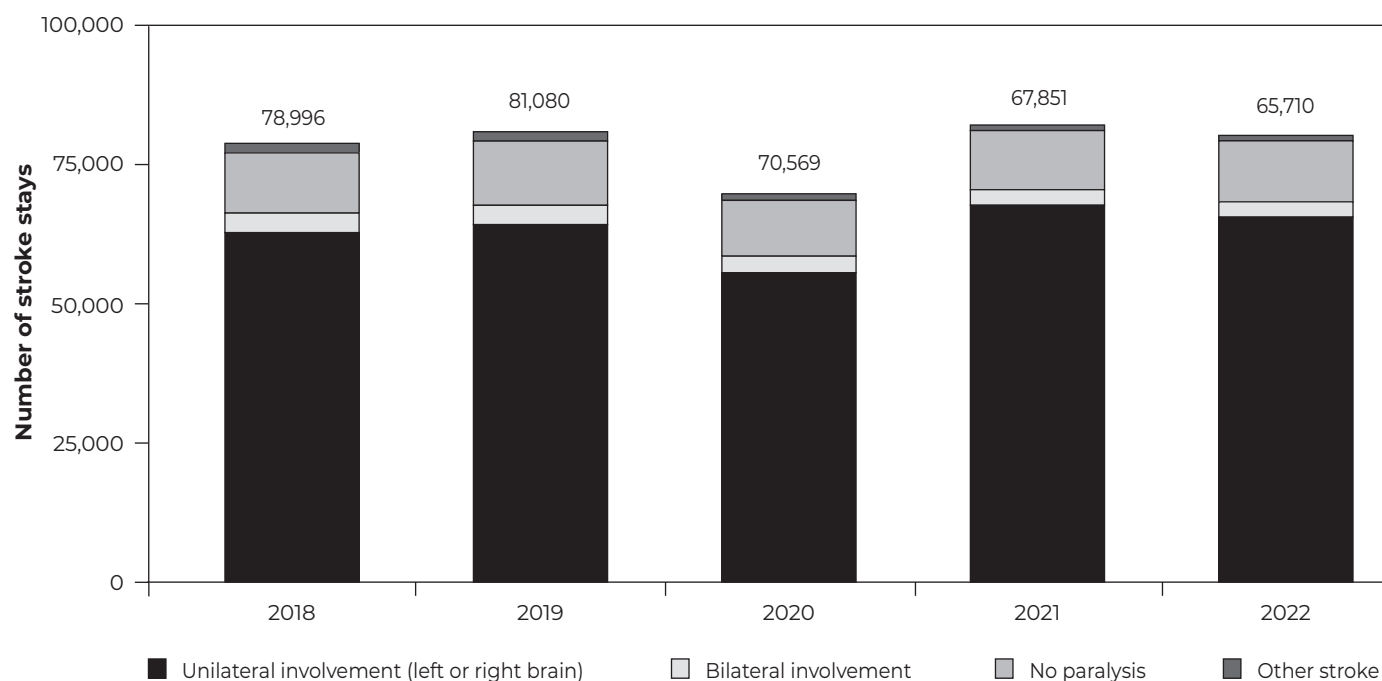
Patterns of use in IRFs

In 2022, the most common condition treated by IRFs was stroke—accounting for almost one-fifth of stays—followed by other neurological conditions and debility (Figure 8-3).

There are few evidence-based guidelines that would help direct beneficiaries seeking post-acute care to the most appropriate setting. For example, one study of patients treated for debility in IRFs concluded that more research was needed to identify the most appropriate setting (Kortebein et al. 2008). However, the American Heart Association/American Stroke Association established stroke guidelines that outline best practices in rehabilitation care for stroke patients (e.g., pain management, prevention of falls and skin

breakdown) and recommends placement in IRFs (Winstein et al. 2016). In 2022, the most common type of stroke treated in IRFs continued to be unilateral injuries of the right or left brain, though these cases represent a declining share of all stroke cases (Figure 8-4, p. 234).

The distribution of case types differs by type of IRF and ownership (Table 8-2, p. 235). For example, in 2022, only 14 percent of stays in freestanding for-profit IRFs were admitted for rehabilitation following a stroke, compared with 22 percent of stays in hospital-based nonprofit IRFs. By contrast, 21 percent of stays in freestanding for-profit IRFs were admitted with other neurological conditions, over twice the share admitted to hospital-based nonprofit IRFs. Stays with fracture of the lower extremity made up a higher share of stays

**FIGURE
8-4****Unilateral brain injuries have accounted for a declining share of FFS stroke stays in IRFs**

Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility). All FFS Medicare IRF stays with valid patient assessment information were included in this analysis. Yearly figures presented in the figure are rounded.

Source: MedPAC analysis of Inpatient Rehabilitation Facility Patient Assessment Instrument data from CMS.

in hospital-based for-profit facilities than in all other IRF types. The share of stays with brain injury and share of stays with other orthopedic conditions were generally similar across IRF types. The share of stays with debility was the same among all IRF types except hospital-based for-profit IRFs, which rose to 17 percent in 2022. The Commission has previously reported that some case types are more profitable than others under the IRF PPS (for more details, see the IRF chapter of our March 2023 report to the Congress).

FFS Medicare marginal profit provides incentive to treat more Medicare beneficiaries

Another measure of access is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e.,

the Medicare payment) with its marginal costs—that is, the cost of treating one more patient. If Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider has a financial incentive to care for Medicare beneficiaries.^{8,9} We found that Medicare payments in 2022 exceeded marginal costs by a substantial amount—18 percent for hospital-based IRFs and 39 percent for freestanding IRFs—suggesting that IRFs with available beds have a strong incentive to admit Medicare patients.

Quality of care: Successful discharge to the community and potentially preventable readmissions

The Commission prioritizes quality measures tied to clinical outcomes in our assessment of payment adequacy. This year, we report two outcome measures for IRFs: risk-adjusted potentially preventable hospital

**TABLE
8-2****Mix of FFS Medicare IRF stays differed by provider type and selected conditions, 2022**

Condition	Freestanding		Hospital based	
	For profit	Nonprofit	For profit	Nonprofit
Stroke	14%	21%	15%	22%
Other neurological conditions	21	7	9	8
Fracture of the lower extremity	10	10	15	13
Debility	14	14	17	14
Brain injury	11	12	13	11
Other orthopedic conditions	8	7	7	6

Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility). "Other neurological conditions" includes multiple sclerosis, Parkinson's disease, polyneuropathy, and neuromuscular disorders. "Fracture of the lower extremity" includes hip, pelvis, and femur fractures. Patients with debility have generalized deconditioning not attributable to other conditions. "Other orthopedic conditions" excludes fractures of the hip, pelvis, and femur, and hip and knee replacements (unless it is bilateral, the patient's body mass index is greater than or equal to 50, or the patient is age 85 or older).

Source: MedPAC analysis of Inpatient Rehabilitation Facility Patient Assessment Instrument data from CMS.

readmissions after discharge and risk-adjusted successful discharge to the community. We are replacing prototype cross-sector measures developed by the Commission, which we have previously used in our analysis of payment adequacy, with these claims-based outcome measures developed by CMS. CMS outcome measures are the product of a transparent, expert-informed measure development process and have undergone public notice. They have and will be refined over time to incorporate improvements. CMS publicly reports facility-level measures after providers have the opportunity to review the data. The measures are updated annually and cover a 24-month period. The most recent available data, released in October 2023, cover the period from the fourth quarter of 2020 through the third quarter of 2022 (FY 2021 to FY 2022).

Successful discharge to the community

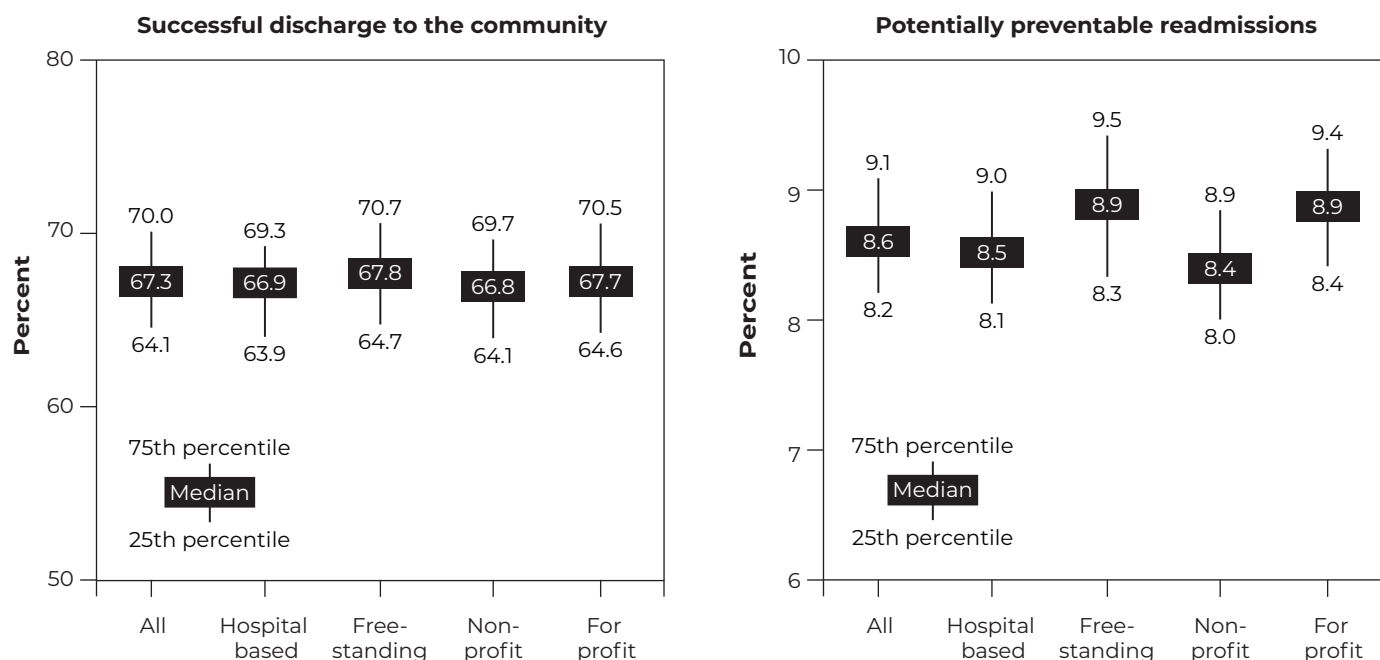
The measure of successful discharge to the community is the rate at which patients returned home or to the community from the IRF and remained alive without any unplanned hospitalizations in the 31 days following discharge from the IRF (higher rates are better) (Centers for Medicare & Medicaid Services 2023).¹⁰ IRFs can improve their rate of successful discharge to the community by providing rehabilitation strategies

to improve functional ability, discharge planning and care coordination, patient and family education, and solutions to barriers a patient may face in the community.

During FY 2021 and FY 2022, the median facility risk-standardized rate of successful discharge to the community was 67.3 percent, about 2 percentage points higher (better) than the rate for the period comprising 2018 and 2019 (not shown). About one-quarter of facilities had a risk-standardized rate below 64.1 percent, and one-quarter had a rate above 70 percent (Figure 8-5, p. 236).

Potentially preventable readmissions

Readmissions expose beneficiaries to hospital-acquired infections, increase the number of transitions between settings (which is disruptive to patient care), and can result in medical error. In addition, they unnecessarily increase Medicare spending (Centers for Medicare & Medicaid Services 2023). IRFs can reduce the number of potentially preventable hospital readmissions by preventing complications, providing clear discharge instructions to patients and families, and ensuring a safe discharge plan. Potentially preventable readmissions after discharge are calculated as the

**FIGURE
8-5****Median and interquartile range of IRFs' risk-standardized rates of successful discharge to the community and potentially preventable readmissions in FY 2021 and FY 2022**

Note: IRF (inpatient rehabilitation facility), FY (fiscal year). The potentially preventable 30-day postdischarge readmission measure captures all unplanned, potentially preventable readmissions for beneficiaries who receive services in an IRF. "Successful discharge to the community" includes beneficiaries discharged to the community who did not have an unplanned rehospitalization and/or die in the 31 days following discharge. Providers with at least 25 stays in the year were included in calculating the average facility rate. High rates of successful discharge to the community indicate better quality. High rates of potentially preventable 30-day postdischarge readmissions indicate worse quality.

Source: Medicare inpatient claims from CMS.

percentage of patients discharged from an IRF stay who were readmitted to a hospital within 30 days for a medical condition that might have been prevented (lower percentages are better). During the FY 2021 and FY 2022 period, the median facility-level risk-adjusted rate of potentially preventable readmissions was 8.6 percent. The rate was higher (worse) among freestanding and for-profit providers than hospital-based and nonprofit providers (Figure 8-5). This rate is not comparable with earlier periods because CMS updated the list of diagnosis codes that are considered potentially preventable readmissions. The measure is thus more comprehensive but incomparable with previous time periods.

Readmissions and successful discharge to the community measures assess key outcomes of IRF care, but they do not capture all aspects of quality in IRFs. Ideally, we could also measure other outcomes and the experience of IRF care for Medicare beneficiaries in a Part A stay. However, lack of data on patient experience and concerns about the validity of function data limit our set of quality measures, as discussed below.

Concerns about the validity of function data limit our set of IRF quality measures

Although functional outcomes are critically important to patients in need of rehabilitative care, we did not assess measures of provider-reported functional improvement.

While the Commission contends that maintaining and improving functional status is a key outcome of PAC, over time we have become so concerned about the integrity of this information that we do not believe it is a reliable indicator of provider quality (for a detailed discussion of functional assessment data, see our June 2019 report to the Congress). Because functional assessments are used in the case-mix system to establish payments, it is difficult to separate this information from payment incentives. Yet, improved function is an important outcome for patients, so reporting assessment data must be improved such that these outcomes can be accurately evaluated. In our June 2019 report to the Congress, the Commission discussed strategies to improve the assessment data, the importance of monitoring this data reporting, and alternative measures of function (such as patient-reported surveys) that do not rely on provider-completed assessments (Medicare Payment Advisory Commission 2019).

CMS developed an IRF experience-of-care survey. While CMS does not currently include this survey in the IRF Quality Reporting Program, the agency provides it and accompanying materials for public use (Centers for Medicare & Medicaid Services 2023).

IRFs' access to capital remained strong for freestanding IRFs in 2022

Almost three-quarters of IRFs are hospital-based units that access any necessary capital to maintain, modernize, or expand through their parent hospitals. Overall, as detailed in the hospital chapter of this report (Chapter 3), general ACHs' access to capital declined in 2022, despite strong access to bond markets. The all-payer operating margin for hospitals paid under the inpatient prospective payment systems fell to a relative low. Specifically, that margin declined from a record high of 8.8 percent in 2021 to 2.7 percent in 2022—the lowest level since 2008. In addition, hospitals' borrowing costs increased in both 2022 and 2023, but by less than the general market.

In 2022, the all-payer margin for freestanding IRFs decreased to about 9 percent, down from 13 percent in 2021.¹¹ However, the spread in all-payer margins across groups of freestanding IRFs varied by ownership: For-profit freestanding IRFs' all-payer total margin remained steady over the last few years, at about 14

percent, while nonprofit freestanding IRFs' all-payer total margin fluctuated from about 1 percent prior to the pandemic to 9.3 percent in 2021 (due to relief funds related to the coronavirus public health emergency (PHE)), then fell to -5.2 percent in 2022 as relief funds and other PHE-related payment policies ended and costs increased.

In 2022, the IRF industry's largest chain, Encompass Health—which at that time owned almost 45 percent of freestanding IRFs and accounted for about 31 percent of all Medicare IRF discharges—opened 9 IRFs and added 87 beds to their existing IRFs. Their all-payer total margin was about 14 percent in 2022. According to their latest investor report, the company has 20 IRFs underway, including 6 new IRFs already completed in 2023, and plans to open a total of 18 IRFs between 2024 and 2026. Though this company reported that premium labor costs—including contract labor, agency rates, sign-on bonuses, and shift bonuses—continue to be higher than prepandemic levels, there have been substantial year-over-year reductions in these costs. Specifically, Encompass Health reported a 19 percent decline in full-time contract labor employees and a 41 percent decline in the use of sign-on and shift bonuses from the third quarter of 2022 (Encompass Health 2023).

Most other freestanding IRFs are independent or local chains with a limited number of facilities. The extent to which these nonchain IRFs have access to capital is less clear.

Medicare payments and providers' costs: IRFs' FFS Medicare margin declined but remained strong in 2022

In 2022, IRFs' per case payments grew much more slowly than costs. As a result, the aggregate FFS Medicare margin declined in 2022 but remained strong at 13.7 percent.¹² Margins continued to vary widely across types of IRFs, with higher average margins seen in IRFs that were freestanding, for profit, urban, large, and had a greater share of FFS Medicare patients, and lower margins were found in IRFs that were hospital based, nonprofit, and small.

In 2022, IRFs' payments per case grew much more slowly than costs per case

From 2021 to 2022, IRFs' payments per case grew less than 1.0 percent, which was lower than

prepandemic growth but follows very high payment growth during the height of the pandemic (i.e., 6.4 percent in 2021 and 7.9 percent in 2020, mostly due to case-mix growth). In contrast, the growth in IRFs' costs outpaced payment growth at 4.5 percent (per case). While growth in payments per case was similar between hospital-based nonprofit IRFs and freestanding for-profit IRFs, there was an over 3 percentage point difference in cost growth per case (7.0 percent vs. 3.6 percent, respectively). This gap between growth in costs versus payments, relative to prior years, resulted from several factors:

- **Underestimated inflation:** In setting payment rates for 2022, CMS underestimated the growth in the market basket for IRFs by almost 3 percentage points (2.6 percent projected vs. 5.3 percent actual).
- **Decrease in outlier payments:** After increasing by 27 percent from 2020 to 2021, outlier payments decreased by about 5 percent from 2021 to 2022, as the number of stays qualifying as outliers fell by about 14 percent.¹³ Hospital-based IRF providers accounted for about 68 percent of high-cost outlier stays in 2022.
- **Reinstatement of Medicare sequestration:** The Congress suspended the 2 percent sequestration on Medicare payments from May 2020 through March 2022 and phased sequestration back in from April through June 2022. Therefore, sequestration was completely suspended for the first half of FY 2022 but slowly reinstated during the second half.
- **Flat case-mix growth:** After rising 11 percent in the first year of the pandemic, IRFs' overall case-mix index (CMI), which measures the severity of patients' health status, remained flat in 2022, decreasing from 1.41 to 1.40 (0.4 percent).

In 2022, IRFs' FFS Medicare margin declined to about 14 percent; margins across IRFs continued to vary significantly

The aggregate FFS Medicare margin declined among nearly all subgroups of IRFs we examined, though significant variation persisted (Table 8-3). For example, the hospital-based IRF FFS Medicare margin was 0.9 percent, compared with 23.3 percent for freestanding IRFs. While margins varied within each group of IRFs, in aggregate, the FFS Medicare margin continued to

be higher and positive—with or without federal relief funds—at IRFs that were freestanding, for profit, urban, and large. In contrast, the FFS Medicare margin continued to be lower among IRFs that were hospital based, nonprofit, and small. Notably, the FFS Medicare margin was higher for IRFs with a high share of FFS stays.

FFS Medicare margins also vary by IRFs' share of low-income patients (Table 8-3). Similar to the disproportionate share hospital adjustment for hospitals paid under the inpatient PPS, IRFs receive low-income percentage payments that are intended to offset costs incurred by treating a large or disproportionate number of low-income patients.¹⁴ Nevertheless, margins in IRFs that serve a higher share of beneficiaries with low incomes are lower than those of other IRFs: In 2022, the FFS Medicare margin for IRFs with a large share of low-income patients (constituting more than 25 percent of the facility's discharges) was 9.8 percent, compared with 16.5 percent for IRFs with a small share of low-income patients (less than 5 percent of a facility's discharges). The share of low-income patients in 2022 was similar across freestanding providers (about 17 percent) and hospital-based providers (about 15 percent) (data not shown).

Numerous factors contribute to lower margins in hospital-based IRFs

The Commission has long noted the disparity in margins between hospital-based and freestanding IRFs. Several factors account for this disparity, including size, stringency of cost control, patient mix, and share of high-cost outlier cases.

First, hospital-based IRFs tend to be smaller than freestanding IRFs. In 2022, about 65 percent of hospital-based IRFs had fewer than 25 beds (about 11 percent had fewer than 10 beds) compared with about 95 percent of freestanding IRFs that had more than 25 beds (about 32 percent had more than 65 beds). Because of their size, hospital-based IRFs are less likely to achieve economies of scale. In 2022, the median standardized cost for IRFs with fewer than 10 beds was about 39 percent higher than for IRFs with 65 or more beds (\$17,160 compared with \$12,360) (data not shown). Hospital-based IRFs also tend to have lower occupancy rates than freestanding IRFs (57 percent compared with 71 percent in 2022), which contributes to differences

**TABLE
8-3****IRFs' aggregate FFS Medicare margin decreased to just under 14 percent in 2022**

Type of IRF	Prepandemic		Coronavirus pandemic		
	2018	2019	2020	2021	2022
All IRFs	14.4%	14.1%	13.3%	16.9%	13.7%
Hospital based	2.0	1.7	1.4	5.7	0.9
Freestanding	25.3	24.6	23.4	25.9	23.3
Nonprofit	2.5	1.1	-0.3	5.3	-0.4
For profit	24.4	24.2	23.4	25.3	22.7
Government	N/A	N/A	N/A	N/A	N/A
Urban	14.7	14.5	13.6	17.3	14.1
Rural	9.1	7.6	9.0	11.7	7.8
Number of beds					
1 to 10	-9.1	-9.1	-7.3	-2.7	-6.3
11 to 24	1.4	1.6	2.2	5.7	1.2
25 to 64	16.8	15.8	14.8	18.6	15.0
65 or more	21.1	20.9	19.3	22.2	19.8
FFS Medicare day share					
<50%	9.2	9.2	8.0	11.8	7.4
50% to 75%	18.6	18.0	17.0	20.3	17.6
>75%	17.5	17.9	21.1	24.6	21.3
Low-income patient share					
0% to 5%	16.7	15.9	15.5	19.6	16.5
5% to 10%	17.9	18.0	16.9	19.4	16.8
10% to 15%	16.5	15.4	14.4	17.7	13.8
15% to 20%	12.4	13.9	14.1	15.4	13.5
20% to 25%	5.8	2.5	5.8	17.6	7.0
>25%	6.3	6.5	5.3	9.6	9.8

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service), N/A (not applicable). Government-owned facilities operate in a different financial context from other facilities, so their margins are not necessarily comparable. Their margins are not presented separately here, although they are included in the margins for other groups (e.g., "all IRFs"), where applicable.

Source: MedPAC analysis of cost report data from CMS.

in costs. Hospital-based IRFs also appear to have less control over cost growth. Between 2012 and 2022, costs per case for hospital-based IRFs grew over 10 percentage points higher than freestanding IRFs' costs.

There are also marked differences in hospital-based and freestanding IRFs' mix of cases. In 2022, compared with freestanding IRFs, hospital-based IRFs admitted a larger share of patients with stroke as the primary

reason for rehabilitation and smaller shares of cases with certain other neurological conditions (Table 8-2, p. 235). Differences in patient mix may contribute to profitability differences since profitability appears to vary by IRF rehabilitation impairment categories (RICs) (see the section on the accuracy of payments, p. 241).

Outlier cases—cases with extraordinarily high costs—also contribute to differences in margins. In general, hospital-based IRFs are much more likely than freestanding IRFs to have high-cost outlier cases. In fact, though hospital-based IRF providers accounted for about 40 percent of FFS discharges in 2022, they accounted for 68 percent of high-cost outlier stays. Although outlier payments diminish the financial loss per outlier case, by design these payments do not completely cover their costs. It is not clear whether the large number of outlier cases in hospital-based IRFs stems from differences in unit cost, unmeasured clinical complexity that is not fully captured by the case-mix system, or both.

Though differences in profitability across types of IRFs are driven in part by differences in underlying costs, size, patient mix, and share of outlier cases, coding practices may also contribute to IRF profitability. If providers differ in their assessment of patients' motor function, payments for some IRFs could be too high relative to the costs incurred in treating their patients while for other IRFs, payments could be too low (see the section on differential coding practices, p. 244).

IRFs' FFS Medicare margin in 2024 is projected to be higher than in 2022

We estimate that IRFs' FFS Medicare margin in 2024 will increase relative to 2022, driven by higher payment growth in 2024.

To estimate 2024 payments, costs, and margins with 2022 data, the Commission considers policy changes effective in 2023 and 2024. These changes include:

- an update of 3.9 percent in 2023 based on an IRF market basket increase of 4.2 percent and an offsetting total productivity adjustment of 0.3 percent;
- an update of 3.4 percent in 2024 based on an IRF market basket increase of 3.6 percent and an offsetting multifactor productivity adjustment of 0.2 percent;
- minimal changes to the high-cost outlier amount in 2023 and 2024; and
- the full reinstatement of the 2 percent sequestration on Medicare payments in 2023. Specifically, the suspension of the 2 percent Medicare sequestration (due to the coronavirus pandemic) continued through the end of March 2022 and was phased back in at 1 percent from April 2022 through the end of June 2022.

Historically, cost growth in this sector has been at or below market basket levels, though between 2019 and 2020, cost growth exceeded the market basket, increasing by 8.6 percent. Many factors related to the coronavirus pandemic drove cost growth in 2020, including faster growth in case mix, spreading fixed costs over fewer IRF stays, labor cost increases, increase in supplies, and longer average length of stay. After returning to a level below the market basket (2.0 percent) in 2021, cost growth increased again in 2022, jumping to almost 4.5 percent in 2022, which largely reflected the greater macroeconomic environment. In 2022, although the IRF industry reported decreasing operating expenses (such as staffing costs) year over year, their costs remained elevated. Some effects of the coronavirus pandemic, such as higher costs of labor (though decreasing year over year), could persist through 2024. For that reason, the Commission's margin projection assumes that costs will increase by the market basket estimate of 4.9 percent in 2023. Because the industry's costs have begun normalizing to prepandemic levels, we used a three-year historical average of prepandemic cost growth equal to about 2 percent for FY 2024. Considering these assumptions, we project an aggregate FFS Medicare margin of 14 percent for IRFs in 2024.

How should FFS Medicare payments change in 2025?

Under current law, Medicare's IRF PPS base payment rate is increased annually based on the projected increase in the IRF market basket, less an amount for productivity improvement. The final update for 2025 will not be set until summer 2024; however, using CMS's third-quarter 2023 projections of the market basket and productivity would increase IRF payment rates by 2.9 percent.

Our indicators of payment adequacy for IRFs—beneficiary access to care, quality of care, provider access to capital, and Medicare payments relative to providers’ costs—are generally positive. The Commission has concluded that current payment rates are sufficient to support the provision of high-quality care with a reduction to the base payment rates in 2025.

RECOMMENDATION 8

For fiscal year 2025, the Congress should reduce the 2024 Medicare base payment rate for inpatient rehabilitation facilities by 5 percent.

RATIONALE 8

Our indicators of access to care are positive, and the level of Medicare’s payment indicates that a reduction is needed to better align aggregate payments to aggregate costs. In 2022, the number of IRFs remained stable, but discharges per FFS beneficiary increased. FFS Medicare marginal profit remained robust in 2022, at 18 percent for hospital-based IRFs and 39 percent for freestanding IRFs. IRFs’ aggregate FFS Medicare margin of 13.7 percent in 2022 and our projected margin of 14 percent for 2024 indicate that Medicare payments continue to substantially exceed the costs of caring for beneficiaries.

IMPLICATIONS 8

Spending

- This recommendation would decrease Medicare spending relative to current law by \$750 million to \$2 billion in one year and by \$5 billion to \$10 billion over five years.

Beneficiary and provider

- We do not expect this recommendation to have an adverse effect on Medicare beneficiaries’ access to care or out-of-pocket spending. Given the current level of payments, we do not expect the recommendation to affect providers’ willingness or ability to care for Medicare beneficiaries, though financial pressure may increase for some providers.

Improving the accuracy of Medicare’s payments

Under the IRF PPS, each Medicare FFS stay is assigned to a RIC based on the principal diagnosis or impairment and is further classified to a case-mix group (CMG)

within each RIC based on the patient’s age and level of functional impairment.¹⁵ Within each CMG, patients are further classified into one of four tiers based on the presence of certain comorbidities that have been found to increase the cost of care. Each CMG and tier combination has a relative weight assigned to it that, when multiplied by the IRF payment base rate, establishes the payment for the case.¹⁶

The Commission has previously reported on differences in profitability (measured by the payment-to-cost ratios, or PCRs) across stays by IRF condition and by CMGs with a condition category (Medicare Payment Advisory Commission 2023, Medicare Payment Advisory Commission 2021). The substantial variation in PCRs across conditions and CMGs may create incentives for IRFs to admit patients with certain conditions over others. Because of the persistently large disparities in profit margins among IRFs with certain characteristics and evidence of differential coding practices among some IRFs, we further analyzed the variation in the relationship between payments and costs under the IRF PPS.

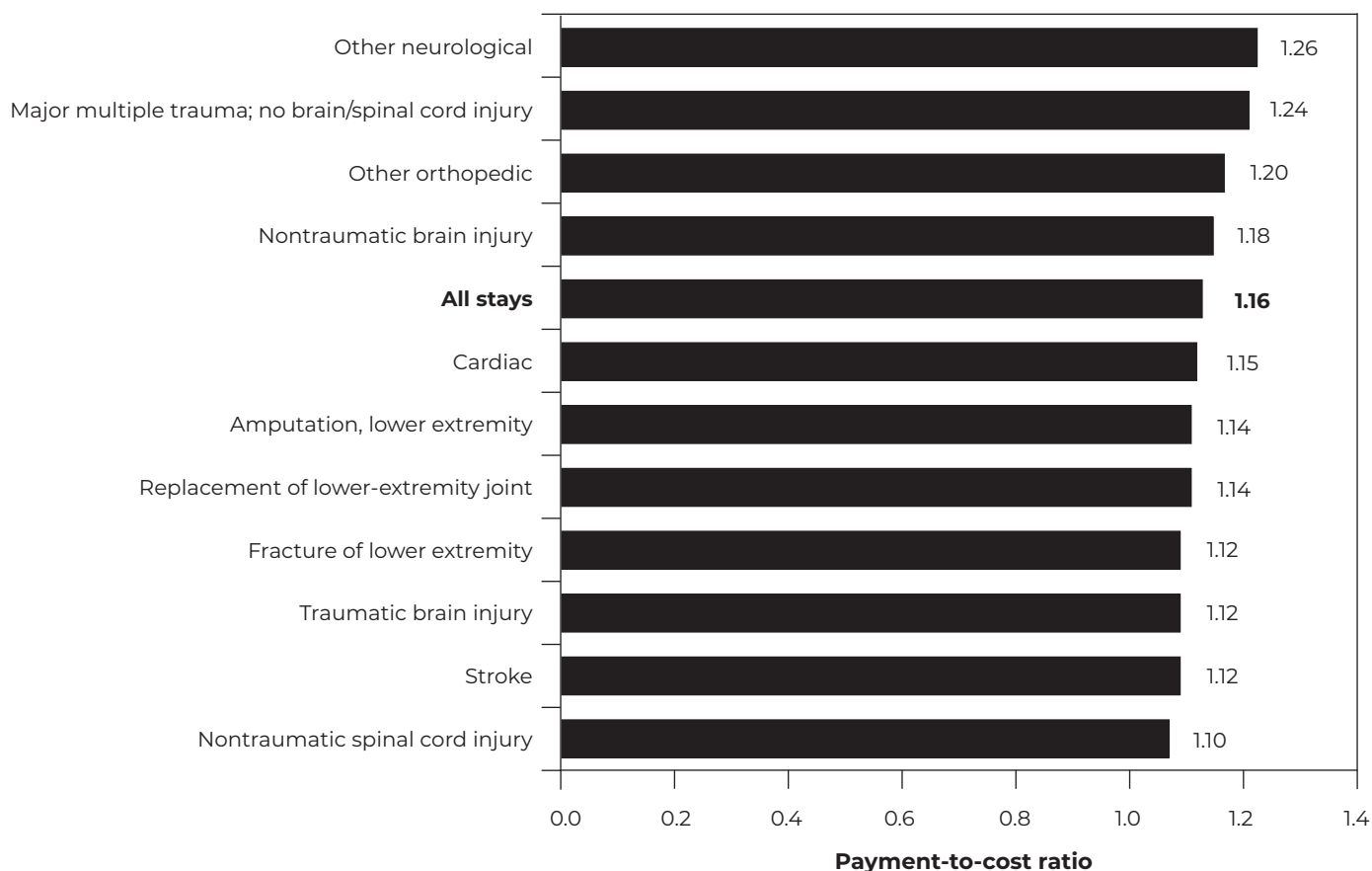
IRF payments do not track overall costs per stay

We found that profitability, measured by PCRs, varied substantially by RIC (see the text box, p. 243, for our data and methods). Stays grouped in the “other neurological” RIC were the most profitable, with a PCR of 1.26 (Figure 8-6, p. 242).¹⁷ That is, in aggregate, the payment for a stay in this RIC exceeded costs by 26 percent. In contrast, the profitability of stays grouped into the stroke RIC was 1.12 (payments were 12 percent more than costs) across all IRFs. Profitability differences across RICs may create financial incentives to select some patients over others.

PCRs also varied by a stay’s CMG within a RIC, with higher-severity CMGs within a RIC being more profitable than lower-severity CMGs. For example, among cases assigned to the stroke RIC, those in the least severe CMG (those with the highest motor function) had a PCR of 0.95, meaning that, on average, payments were 5 percent lower than costs (Figure 8-7, p. 244). Cases assigned to the most severe CMG (those with the lowest motor function) had a PCR of 1.17, meaning that, on average, payments exceeded costs by 17 percent. Generally, profitability steadily

**FIGURE
8-6**

Stays for other neurological conditions were the most profitable among FFS Medicare IRF stays, FY 2019



Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility), FY (fiscal year). "Other neurological" includes multiple sclerosis, Parkinson's disease, polyneuropathy, and neuromuscular disorders. "Fracture of lower extremity" includes hip, pelvis, and femur fractures; "other orthopedic" excludes hip, pelvis, and femur fractures. The figure includes rehabilitation impairment categories (RICs) with at least 10,000 stays in the year. Payment-to-cost ratios are calculated by dividing aggregate payments by aggregate costs for stays assigned to each RIC (see text box on the Urban Institute's calculations, p. 243).

Source: Urban Institute analysis of Medicare FFS claims and cost reports from CMS.

increased as severity worsened for all stroke CMGs. We found similar inverse relationships between PCRs and functional severity among the CMGs for other IRF conditions (data not shown). We also observed this pattern within CMGs when stratifying by each of the four comorbidity tiers (data not shown): Profitability increased as severity of comorbidities increased.

Higher-severity cases are expected to be more costly (all else equal), and the payment system assigns greater weights (and thus higher payments) to these

cases. However, Figure 8-7 (p. 244) demonstrates that severity (and payments) increases faster than costs rise, resulting in greater overall profitability for cases coded with the highest degrees of functional severity. The variation in profitability may reflect, in part, differences in the types of cases that IRFs treat. If lower-cost IRFs tend to treat patients whose conditions are of higher severity (or who are coded as being of higher severity), average costs for higher-severity cases will be lower relative to payments, resulting in higher profitability. While some variation in the types of cases treated

Calculating inpatient rehabilitation facilities' payments, costs, and profitability

Under contract with the Commission, the Urban Institute used fee-for-service (FFS) Medicare claims and Medicare cost reports to conduct the analyses presented in this chapter on payments, costs, and profitability (Garrett and Wissoker 2024). After excluding inpatient rehabilitation facility (IRF) stays missing payments or other data elements, the analytic file contained 366,800 IRF stays at 1,060 IRFs beginning and ending in fiscal year 2019.

Costs: Costs of treating FFS Medicare patients include routine and ancillary costs, overhead costs, and the additional costs associated with teaching programs and treating low-income patients. We estimated routine costs using the average routine cost per day from the cost report multiplied by the stay's covered length of stay from the claims data. We estimated both therapy and nontherapy ancillary costs by converting eligible charges on the

IRF claims to costs using facility- and department-specific cost-to-charge ratios from each provider's cost report. All costs were standardized using the labor share and the area wage index.¹⁸

Payments: FFS Medicare payments were calculated as the total amount of payments made directly to the facility, paid as coinsurance, copayments, and the deductible for blood products from the claims data. Total payments were standardized by each provider's labor share and area wage index.

Payment-to-cost ratios: To assess relative profitability by IRF rehabilitation impairment category and case-mix groups, we divided aggregate payments by aggregate costs for the group of interest. A payment-to-cost ratio of 1 indicates that payment equals cost; less than 1 indicates that payments are lower than costs; greater than 1 indicates that payments are higher than costs. ■

by IRFs is expected, the degree of differences in profitability and trends across different types of IRFs is concerning because it may create financial incentives to admit certain types of patients or code patients as more severely impaired than they are.

Declining relationship between IRFs' case-mix indexes and average costs per stay

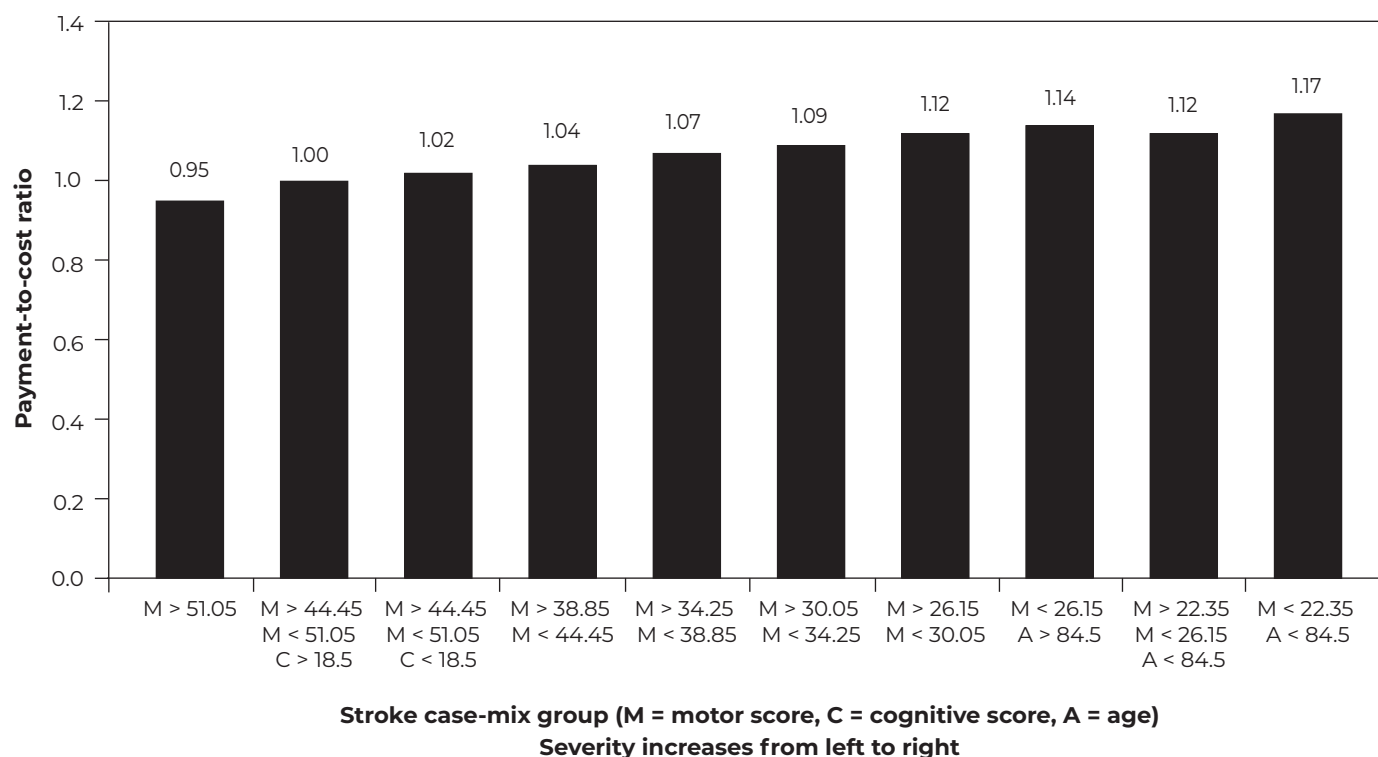
When the IRF PPS was first implemented in 2002, the developers demonstrated that IRF payment weights generally tracked IRFs' average costs per stay (Carter et al. 2002). We found that the relationship between average payment weight (or case-mix index (CMI)) and IRFs' average costs per stay continued to be nearly proportional in 2007; that is, a 1 percent increase in CMI was associated with an approximately 1 percent increase in average cost per stay (Figure 8-8, p. 245). However, this relationship deteriorated over time. By 2021, a 1 percent increase in CMI corresponded to only a 0.6 percent increase in costs. As a result, in recent years, IRFs with higher CMIs were not associated with

similarly high average costs per stay, as they were in prior years.

Generally, the payment system assumes that, compared with an IRF with a lower CMI, an IRF with a higher CMI serves patients requiring greater resource intensity and therefore has higher costs, on average. However, Figure 8-8 (p. 245) shows that in recent years, IRFs' CMIs and average costs per stay no longer track each other. This less-than-proportional relationship between IRFs' CMIs and average costs could be explained by lower-cost IRFs tending to treat patients in CMGs that have higher payment weights or by some IRFs tending to code patients as more functionally impaired, which would result in lower-cost cases being coded into higher-severity CMGs.

Growth of lower-cost IRFs

The decline in the relationship between CMI and average costs shown in Figure 8-8 (p. 245) corresponds with the growth of freestanding for-profit IRFs. From the late 1990s through the 2010s, hospital-based IRFs

**FIGURE
8-7****Medicare profitability of IRF stroke stays increased with CMG severity, FY 2019**

Note: IRF (inpatient rehabilitation facility), CMG (case-mix group), FY (fiscal year). There are 10 CMGs within the IRF stroke rehabilitation impairment group, which increase in severity, as shown, from left to right. The payment-to-cost ratios were calculated by dividing aggregate payments by aggregate costs for stays assigned to each stroke CMG (see text box on the Urban Institute's calculations, p. 243).

Source: Urban Institute analysis of Medicare fee-for-service claims and cost reports from CMS.

dominated the IRF market (Figure 8-9, p. 246). Around 2012, the number of freestanding for-profit IRFs began to grow rapidly. These IRFs tend to be large, so while hospital-based IRFs (which are usually nonprofit entities) are still the most numerous type of IRF, the largest share of IRF beds is now at freestanding IRFs (which tend to be for-profit entities). In 2022, the share of discharges at freestanding IRFs was 59 percent compared with 41 percent from hospital-based IRFs.

Freestanding for-profit IRFs tend to have lower costs than hospital-based IRFs, and the types of cases they treat may therefore be more profitable.¹⁹ Freestanding IRFs may have lower costs in part because they are larger and have more economy of scale. However, differential coding practices and the ability of IRFs to select certain types of patients may have also

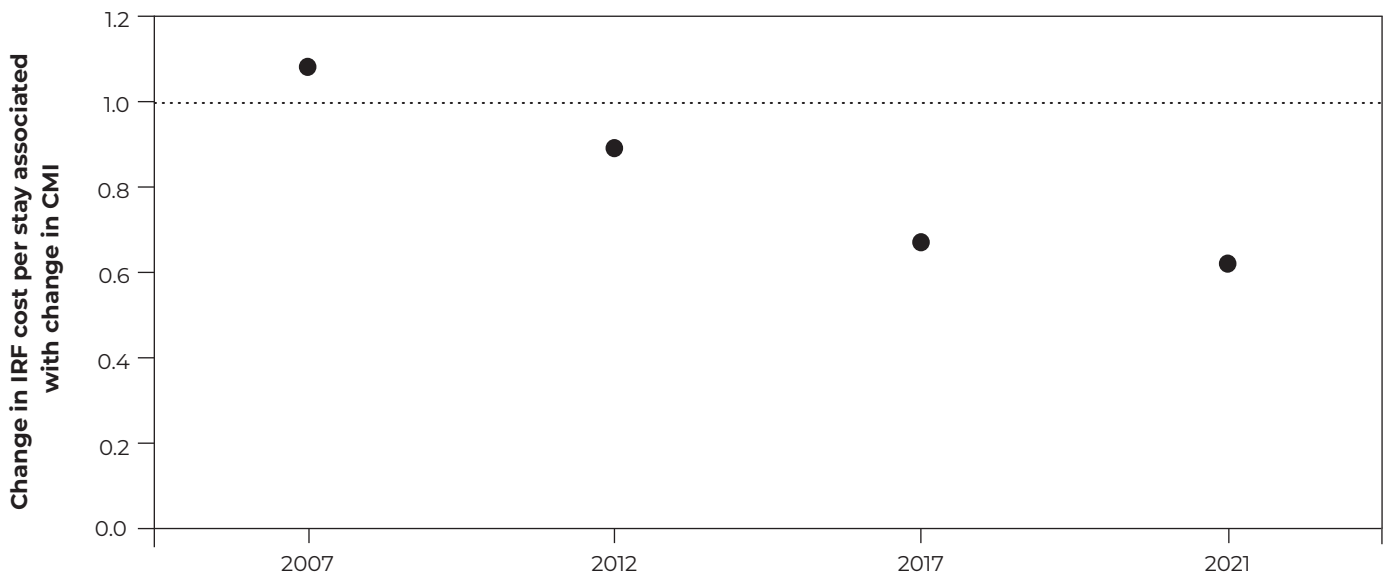
contributed to the substantial profitability differences we observed.

Differential coding practices

Payment for IRF services depends, in part, on how functionally impaired patients are at admission to the IRF. Patients who are coded as more functionally impaired generally are categorized in a higher-severity CMG, resulting in greater payment, even if they have lower (case-mix-adjusted) costs per stay. Compared with payments based on diagnosis codes reported on claims (as in ACH payment), functional assessment may involve a greater degree of clinician judgment (and can be more difficult to audit) and therefore poses a greater risk of differential coding. The Commission has previously reported findings that were suggestive

**FIGURE
8–8**

Decreasing relationship between IRFs' CMIs and average cost per stay, 2007–2021



Note: IRF (inpatient rehabilitation facility), CMI (case-mix index). Each point represents the coefficient estimated on a log-log regression of IRFs' average cost on CMI, controlling for IRF type (freestanding vs. hospital based), teaching status, and share of low-income patients. Each coefficient shown in the figure represents the percent difference in costs associated with a 1 percent increase in CMI. The CMI is the average payment weight for each IRF. For more detail on these calculations, please refer to Garrett and Wissoker (2024).

Source: Urban Institute analysis of the IRF prospective payment final rule rate-setting files for fiscal year 2009 through fiscal year 2023, found at <https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-rehabilitation/rules-related-files>.

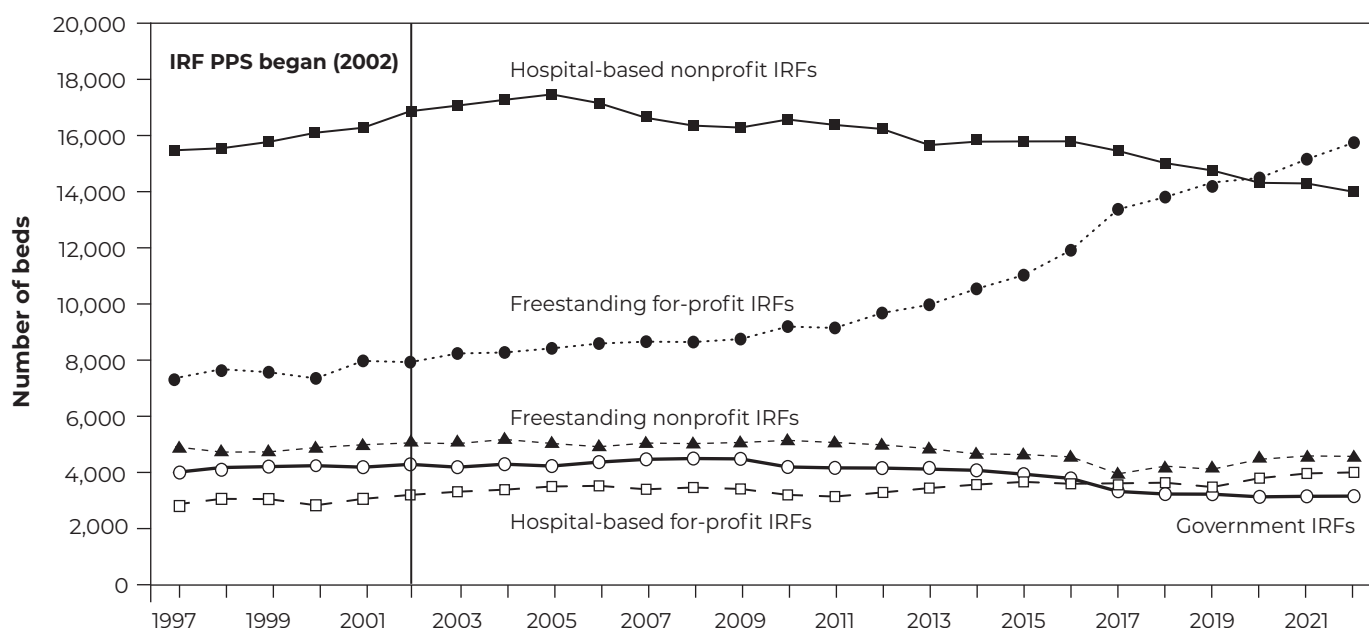
of such differential coding. In an analysis of data from 2013, we found that, within RICs, patients cared for by high-margin IRFs, compared with those in low-margin IRFs, were less severely ill during their preceding acute care hospitalization but appeared to be more functionally disabled upon assessment in the IRF (Medicare Payment Advisory Commission 2016). This pattern persisted across RICs and suggested that assessment and coding practices might contribute to greater profitability in some IRFs. Based on these findings, the Commission recommended that the Secretary conduct analyses of IRF coding and reassess the inter-rater reliability of the IRF Patient Assessment Instrument to help ensure payment accuracy and improve program integrity.

We have also discussed the use of nonresponse codes (or “activity not attempted” responses) that are recoded to the most dependent functional level and

result in greater payment, all else equal (Medicare Payment Advisory Commission 2023). In that report, we suggested alternative approaches to handle nonresponses that would not automatically increase payments.²⁰

Patient selection

IRFs must carefully screen patients before admission to ensure they meet Medicare’s coverage criteria: The patient must be stable, require therapy in two modalities, be able to participate in and benefit from intensive therapy, and must require an intensive and coordinated team approach to care under the supervision of a rehabilitation physician. Indeed, IRFs admit less than 40 percent of the patients who are referred to them because those patients do not meet Medicare coverage requirements, do not require intensive therapy, or do not have the potential to improve (American Medical Rehabilitation Providers

**FIGURE
8–9****Substantial growth in the number of beds in freestanding for-profit IRFs, 1997–2022**

Note: IRF (inpatient rehabilitation facility), PPS (prospective payment system).

Source: MedPAC analysis of Provider of Services data from CMS.

Association 2023). In interviews conducted with hospital discharge planners, we learned that some IRFs would not admit certain types of patients, such as those with a history of substance abuse or behavioral problems who are likely to be resource intensive (L&M Policy Research 2023).

In our analysis of 2019 data, we found variation in patient mix by IRF type. Notably, stays in the “other neurological” RIC (the most profitable RIC) were disproportionately admitted to freestanding for-profit IRFs (Figure 8-10). Among these IRFs, beneficiaries coded to this RIC composed 21 percent of stays compared with 8 percent of stays in nonprofit and government IRFs. Moreover, among stays in the “other neurological” RIC, over 30 percent admitted to freestanding for-profit IRFs indicated “other specified myopathies” as the condition for which the patient received rehabilitation compared with 6 percent of stays among hospital-based nonprofit hospitals (data not shown).²¹ The IRF admission of patients with

other specified myopathies by some IRFs has come under scrutiny by the Department of Justice and CMS (Centers for Medicare & Medicaid Services 2017, Department of Justice 2019).²²

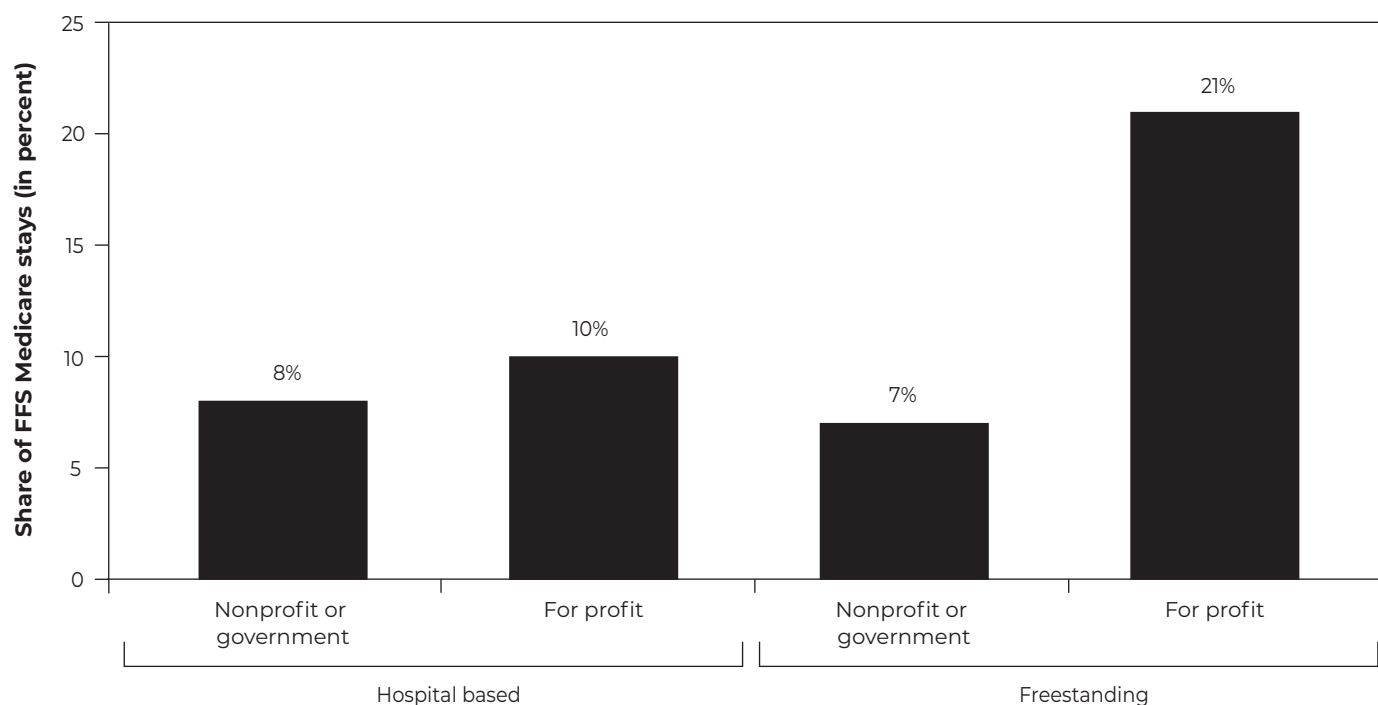
The profitability of neurological conditions is high in part because lower-cost IRFs tend to treat patients with these conditions. In the next section, we describe how a change in the method for calculating payment weights could address these profitability differences.

Changing the method used to calculate payment weights would improve payment accuracy

Payment weights assigned to each CMG should reflect differences in the costs of providing care to patients across CMGs. That is, a stay that is expected to cost twice as much to treat as another should have twice the payment weight. Having differences in payment per stay aligned with differences in cost per stay is intended to minimize incentives to admit one type of

**FIGURE
8-10**

**Shares of FFS Medicare stays for other neurological conditions
by IRF type and ownership, FY 2021**



Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility), FY (fiscal year). Using aggregate payment and cost data from 2019, we found that IRF stays for neurological conditions were the most profitable. “Other neurological conditions” includes multiple sclerosis, Parkinson’s disease, polyneuropathy, and neuromuscular disorders.

Source: MedPAC analysis of fee-for-service Medicare claims from CMS.

stay over another. A payment system that overpays for one type of stay and underpays for others could create incentives to selectively admit patients with certain conditions or code them to a more profitable CMG.

A standard method for setting payment weights involves averaging costs across all stays within each CMG and setting CMG weights proportional to how those costs vary with the average costs of all stays across all CMGs. For example, if the average costs of stays in case-mix group A are twice as much as the average costs of case-mix group B, the payment weight for stays grouped in A would be set to twice as much as for stays in group B. We refer to this method as the “average-cost” method, and it is used by the inpatient and skilled nursing facility PPSs to set payment weights.

The IRF PPS uses a hospital-specific relative value (HSRV) method to assign weights to CMGs. This method sets payment weights based on within-IRF relative cost variation in CMGs. That is, within an IRF, costs are averaged across stays in each CMG and divided by the IRF’s overall average cost per stay. For each CMG, the resulting relative cost ratios are then adjusted by each IRF’s average payment weight (or CMI) and averaged across IRFs to yield payment weights.²³ A simplified example is shown in the text box (pp. 248–249) to demonstrate how the HSRV and average-cost methods set payment weights.

The HSRV method was developed when hospital charges (not estimated costs) were used to set weights for diagnosis related groups (DRGs) under the inpatient hospital PPS. Different hospitals would have different

Illustrative example of payments under the average-cost and hospital-specific relative value methods

**TABLE
8-4**

Illustrative example of calculating average-cost weights

CMG	IRF cost per stay			Average cost per stay	Proportion of overall average cost per stay (average-cost payment weight)
	IRF A	IRF B	IRF C		
1	\$6,000	\$13,500	\$24,000	\$14,500	$\$14,500 / \$22,000 = 0.66$
2	\$20,000	\$22,500	\$46,000	\$29,500	$\$29,500 / \$22,000 = 1.34$
Average	\$13,000	\$18,000	\$35,000	\$22,000	

Note: IRF (inpatient rehabilitation facility), CMG (case-mix group). In this example, three IRFs (A, B, and C) each treat one patient in CMG 1 and one in CMG 2 (six total stays).

In this example, three inpatient rehabilitation facilities (IRFs) (A, B, and C) each treat one patient in case-mix group (CMG) 1 and 2 (six total stays). The cost per stay for each IRF is shown in Table 8-4. We calculate the average cost per stay across the three IRFs for each CMG. The overall cost per stay across all six stays is \$22,000. The average-cost weight for each CMG is then calculated as the ratio of each CMG's average cost per stay to the overall cost per stay.

The average costs for each IRF are shown in the bottom row of Table 8-4. We used these IRF-level averages to calculate relative costs within each

IRF for each stay, as shown in Table 8-5. We then average the relative costs across the row for each CMG to yield the hospital-specific relative value (HSRV) payment weights. The relative costs would be adjusted by the IRF's case-mix index (CMI) in combining the relative costs. In this simplified example, each IRF has a CMI of 1, but in reality, CMIs will differ across IRFs depending on the type and volume of patients they serve.

Assuming a base rate of \$22,000 (the overall average cost per stay as shown in Table 8-4), we multiply the average-cost and HSRV payments by the base rate to yield the payment assigned to each CMG,

**TABLE
8-5**

Illustrative example of calculating HSRV weights

CMG	Within-IRF relative cost per stay			Average across IRFs (HSRV payment weight)
	IRF A	IRF B	IRF C	
1	$\$6,000 / \$13,000 = 0.5$	$\$13,500 / \$18,000 = 0.8$	$\$24,000 / \$35,000 = 0.7$	0.63
2	$\$20,000 / \$13,000 = 1.5$	$\$22,500 / \$18,000 = 1.3$	$\$46,000 / \$35,000 = 1.3$	1.37

Note: HSRV (hospital-specific relative value), IRF (inpatient rehabilitation facility), CMG (case-mix group). In this example, three IRFs (A, B, and C) each treat one patient in CMG 1 and one in CMG 2 (six total stays). Within-IRF relative costs per stay are calculated using each IRF's costs shown in Table 8-4. "Average across IRFs" was calculated using unrounded figures.

(continued next page)

Illustrative example of payments under the average-cost and hospital-specific relative value methods (cont.)

as shown in Table 8-6. The payments are similar between the two methods, but not the same.

Payments differ under the two methods because the illustrative IRFs differed in their costs of treating

patients. The HSRV method seeks to set payments proportional to within-IRF relative costs per stay, while the average-cost method sets payments proportional to costs per stay across all IRFs. ■

TABLE 8-6
Illustrative example comparing average-cost and HSRV-weighted payment per stay

CMG payment per stay		
CMG	Average-cost weight	HSRV weight
1	$0.66 \times \$22,000 = \$14,500$	$0.63 \times \$22,000 = \$13,913$
2	$1.34 \times \$22,000 = \$29,500$	$1.37 \times \$22,000 = \$30,087$

Note: HSRV (hospital-specific relative value), CMG (case-mix group). The average-cost and HSRV payment weights in this example were derived in Table 8-4 and Table 8-5. The base rate is \$22,000, which is the overall average cost per stay, as shown in Table 8-4. Unrounded weights were used to calculate “CMG payment per stay.”

strategies (or markups) to establish charges based on costs. Comparing the relative charges of DRGs within each facility and then averaging was intended to provide a more accurate reflection of the differences in costs by DRGs. In contrast, if payment weights were set using a simple average of the charges across all stays in a DRG, stays in DRGs disproportionately served by hospitals with higher markups would result in inaccurately higher payment weights, all else equal.²⁴

When using costs to generate payment weights, as is done by the IRF PPS, HSRV and average-cost weights can also yield different results (as shown in the illustrative example in the text box) because IRFs differ in their costs of treating patients. The HSRV method seeks to set payments proportional to within-IRF relative costs, while the average-cost method sets payments proportional to costs per stay across all IRFs. Both methods are valid approaches to setting payment weights to reflect costs, but the average-cost method

would help to address the concerning patterns and trends observed across IRFs. If the average-cost method were used to set payment weights, when lower-cost providers treat cases in a CMG, the payment weights associated with that CMG would decrease relative to other CMGs (making cases in that CMG less profitable relative to cases in other CMGs). HSRV weights depend on the distribution of relative costs within an IRF. Growth in the number of a particular type of stay in lower-cost IRFs would increase the influence of these IRFs in calculating payment weights, but if the within-IRF relative costs do not change, neither will HSRV weights.

Replacing HSRV with average-cost payment weights resulted in more uniform profitability across case types

The Urban Institute, under contract with the Commission, simulated average-cost weights and compared them to HSRV weights using the same

Calculating inpatient rehabilitation facility payment weights

We contracted with the Urban Institute to calculate the inpatient rehabilitation facility (IRF) prospective payment system (PPS) hospital-specific relative values (HSRV) payment weights; simulate average-cost weights using the same data; and calculate the impacts of replacing HSRV with average-cost weights in fiscal year (FY) 2019 (Garrett and Wissoker 2024).

HSRV payment weights: Using FY 2019 data, the Urban Institute replicated methods described in reports published by RTI and RAND on the IRF PPS to calculate HSRV payment weights using the same method as CMS (Carter et al. 2002, Centers for Medicare & Medicaid Services 2019). This method consisted of calculating a hospital-specific relative cost of a stay as the ratio of cost per stay divided by the average cost of a stay at that IRF. The ratios were then averaged across the IRFs' stays in a case-mix group (CMG), adjusted by each IRF's case-mix index (CMI). The CMI is estimated simultaneously with the weights through an iterative process that ends when subsequent iterations yield very similar results. The objective of the HSRV method is to set weights such that the relative profitability of cases is equalized within each IRF. Short stays (where the patient was transferred to another inpatient setting before the average length of stay for the CMG)

received a proportionally lower weight based on the length of stay.

Average-cost payment weights: Using FY 2019 data, average-cost weights were calculated as the average standardized costs per stay for each CMG divided by the overall average cost per stay across all stays. That is, average-cost weights were set to be directly proportional to the average standardized costs across all stays within each CMG. With average-cost weights, the objective is to equalize profitability across all stays. Costs were standardized for the IRF adjustments in the PPS: teaching status, low-income share, and geographic location, including the wage index. Short stays received a proportionally lower weight based on the length of stay.

Impacts: The HSRV and average-cost payment weights were multiplied by the IRF PPS base rate to obtain HSRV and average-cost-based payments for each stay in FY 2019. The weights were also used to calculate separate HSRV- and average-cost-based CMIs for each IRF. Since we apply a budget-neutrality constraint, the overall difference between HSRV- and average-cost-based payments was zero; however, an individual IRF, depending on its mix of patients, could have a lower, same, or higher average-cost-based payment compared with HSRV-based total payment. ■

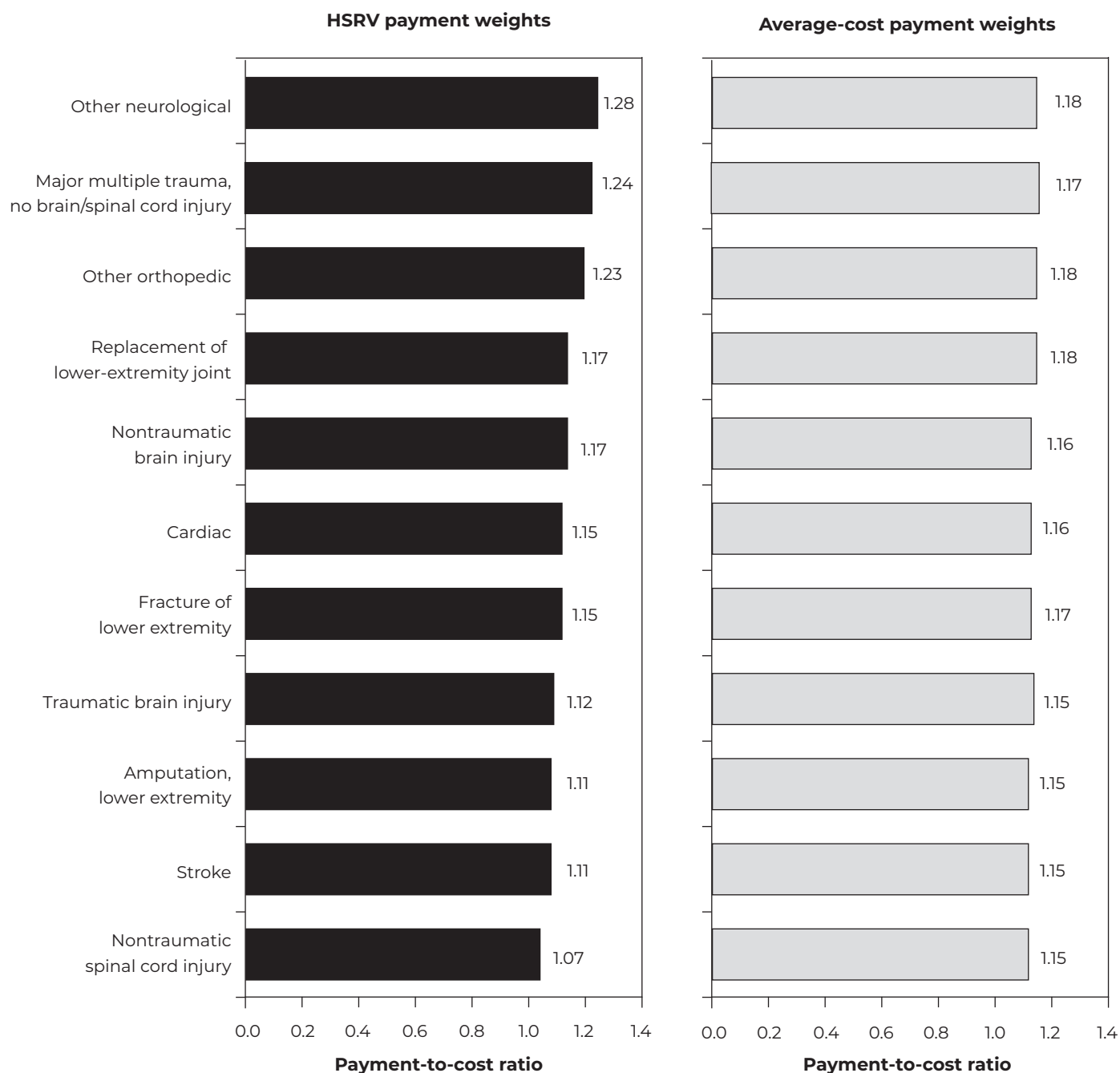
year of data (see the text box for the Urban Institute's methods of calculating IRF payment rates). It found substantive differences between HSRV and average-cost payment weights. Notably, average-cost weights improved the relationship between CMI and IRFs' costs—a 1 percent change in the average-cost-based CMI was associated with a nearly proportional (0.96 percent) increase in cost per stay.

The average-cost method, by definition, sets payment weights for any given CMG proportional to the average cost of all cases so that profitability (i.e., PCR) is more

uniform than under HSRV weights (Figure 8-11). Across the RICs, the PCRs based on average-cost weights ranged from 1.15 to 1.18 compared with 1.07 to 1.28 using the HSRV method (Figure 8-11).²⁵ Compared with HSRV weights, average-cost weights result in lower PCRs for some conditions and higher PCRs for other conditions. For example, the PCR for other neurological conditions would decrease from 1.28 using HSRV weights to 1.18 using average-cost weights. In contrast, for nontraumatic spinal cord injuries, the PCR increases from 1.07 with HSRV weights to 1.15 with average-cost weights.

**FIGURE
8-11**

Payment-to-cost ratios are more uniform across IRF conditions with average-cost payment weights compared with HSRV payment weights, FY 2019

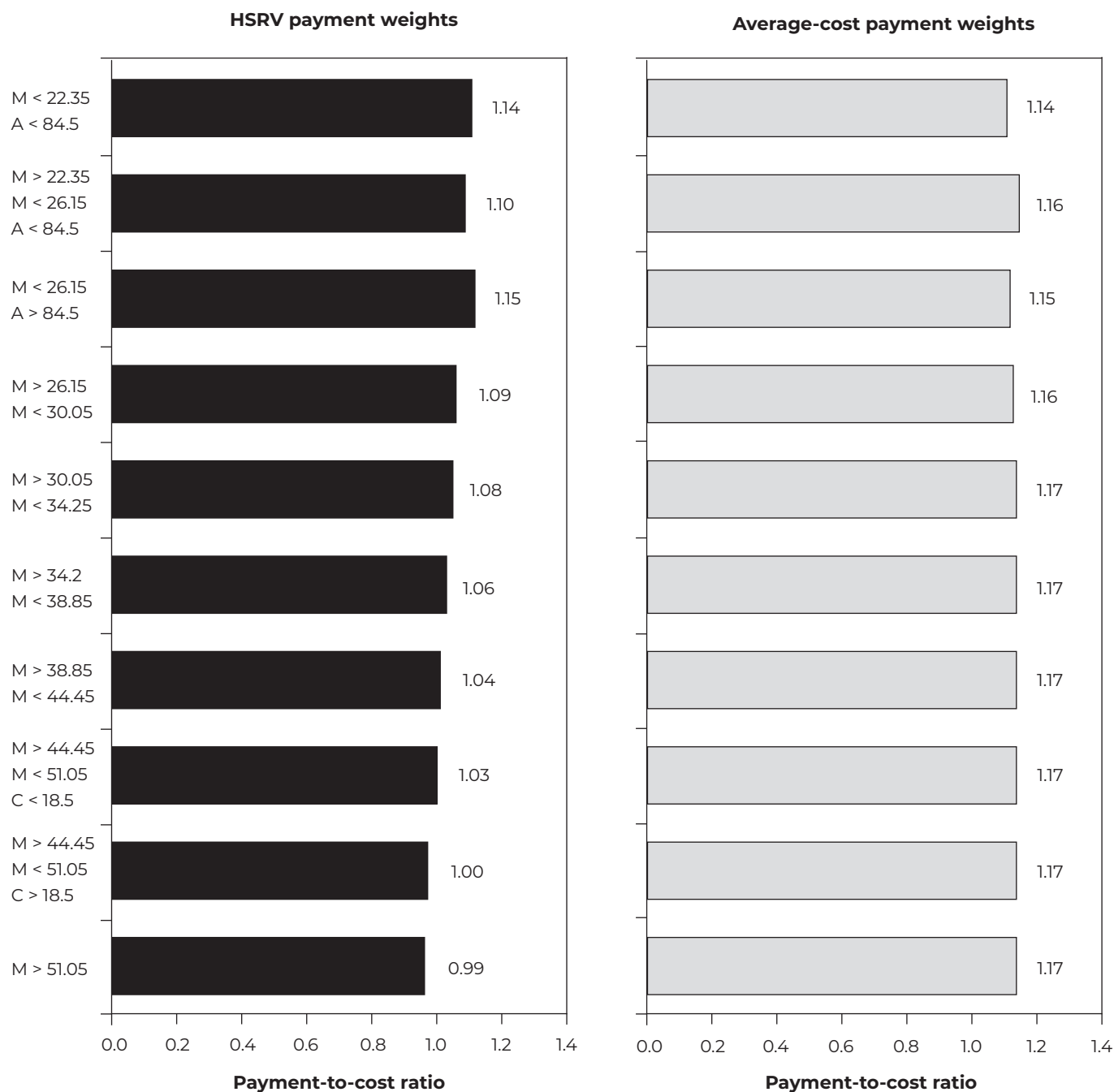


Note: IRF (inpatient rehabilitation facility), HSRV (hospital-specific relative value), FY (fiscal year). "Other neurological" includes multiple sclerosis, Parkinson's disease, polyneuropathy, and neuromuscular disorders. "Fracture of the lower extremity" includes hip, pelvis, and femur fractures; "other orthopedic" excludes hip, pelvis, and femur fractures. Payment-to-cost ratios are calculated by dividing aggregate payments by aggregate costs for stays assigned to each rehabilitation impairment category. Payments were calculated based on the Urban Institute's simulation of HSRV and average-cost weights (see text box on the Urban Institute's calculations, p. 250).

Source: Urban Institute analysis of Medicare fee-for-service claims from CMS.

**FIGURE
8-12**

Payment-to-cost ratios are more uniform across stroke CMGs with average-cost payment weights compared with HSRV payment weights, FY 2019



Note: CMG (case-mix group), HSRV (hospital-specific relative value), FY (fiscal year), M (motor score), C (cognitive score), A (age). There are 10 CMGs in the inpatient rehabilitation facility stroke rehabilitation impairment group, which increase in severity from bottom to top. CMGs are created from thresholds based on motor score, cognitive score, and age. Payment-to-cost ratios were calculated by dividing aggregate payments by aggregate costs for stays assigned to each stroke CMG. Payments were calculated based on the Urban Institute's simulation of HSRV and average-cost weights (see text box on the Urban Institute's calculations, p. 250).

Source: Urban Institute analysis of Medicare fee-for-service claims from CMS.

**TABLE
8-7**

The use of average-cost payment weights would have shifted dollars to hospital-based nonprofit and small IRFs, 2019

	Percent of stays	Estimated percent change in payment
All	100%	0.0%
Hospital-based	44	1.6
For profit	9	0.2
Nonprofit	29	2.0
Government	6	1.8
Freestanding	56	-1.2
For profit	50	-1.5
Nonprofit	5	0.7
Government	1	1.3
Rural	6	0.7
Urban	94	0.0
Small	6	2.5
Medium	34	1.3
Large	60	-1.0

Note: IRF (inpatient rehabilitation facility). "Estimated percent change in payment" was calculated by subtracting hospital-specific relative value (HSRV)-based payments from average-cost-based payments divided by HSRV-based payments. IRF size (small, medium, and large) was based on the number of FFS Medicare stays in the year (IRFs with less than the 25th percentile in stays were designated small, IRFs with greater than the 75th percentile in the number of stays were designated large, and all others were medium) (see Garrett and Wissoker (2024)).

Source: Urban Institute analysis of Medicare fee-for-service claims from CMS.

PCRs were also more uniform across CMGs within a condition. For example, PCRs for stroke CMGs ranged from 1.14 to 1.17 using average-cost weights, while they ranged from 0.99 to 1.15 using HSRV weights (Figure 8-12).

Under the average-cost method, payments are more uniformly aligned to costs across CMGs, but for any given IRF, payments may not be as well aligned to their own costs across groups. In contrast, the HSRV method yielded large distortions in profitability across CMGs (and in the relationship between CMI and IRFs' costs). This result is likely related to the relatively greater opportunity to select patients (compared with other settings of care) and differential coding practices across IRFs that may result in lower (case-mix-adjusted) costs at certain IRFs. Average-cost weights would be more sensitive to these shifts in the

IRF landscape, which may better ensure access to IRF services by reducing the financial incentives to avoid patients who would be assigned to lower payment-weighted CMGs and reducing incentives to code patients into higher-weighted CMGs.

Impacts of replacing HSRV with average-cost payment weights in the IRF PPS

We calculated the impacts of using average-cost weights in place of the current HSRV weights by IRF characteristics in 2019, assuming no change in admission pattern (Table 8-7). We assumed budget neutrality: The total payments remain the same. Under these assumptions, some IRFs would have received lower payments and some would have received higher payments, depending on the types of cases they served. Payments to nonprofit hospital-based IRFs would have increased by 2 percent. Small IRFs

(which tend to be hospital based) would have received a 2.5 percent increase in payments. Freestanding for-profit IRFs would have had a 1.5 percent reduction in payments. Rural IRFs would have seen a slight boost in payments of 0.7 percent. Large IRFs (which tend to be freestanding) would have had payments reduced by 1 percent. Across all IRFs with at least 50 stays in the year, the estimated change in payments would have ranged, at the 25th to 75th percentiles, from -2.0 percent to 2.8 percent (data not shown). The median IRF would have experienced a 1.2 percent increase in payment using average-cost weights (data not shown).

Next steps

CMS has the regulatory authority to replace the current HSRV payment weights used in the IRF PPS

with average-cost weights. Making such a change would pose no additional administrative burden on providers. Our simulations showed that the one-year impacts on any provider group would be relatively small and could be smaller or larger if IRFs altered their admitting and coding practices. With average-cost-based payment weights, IRFs would have less financial incentive to select higher-weighted cases over lower-weighted cases or to code patients into higher-weighted CMGs. However, this change would not eliminate financial incentives to select profitable patients, nor would it eliminate issues of inter-rater reliability in patient assessment. Therefore, continued monitoring and auditing of IRF service use and the accuracy of the provider-reported assessment data would be needed. ■

Endnotes

- 1 More frequently, some Medicare beneficiaries receive inpatient rehabilitation services in skilled nursing facilities (SNFs), in part because there are many more SNFs than IRFs nationwide.
- 2 More information about the prospective payment system for IRFs is available at https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_IRF_FINAL_SEC.pdf.
- 3 During the public health emergency (PHE), some exceptions were made to Medicare's facility requirements for IRFs to help health care providers in affected communities manage patient flow. For example, during the PHE, an IRF that agreed to admit a patient to help a nearby hospital free up an acute care bed could exclude that patient from its compliance threshold calculation as long as the patient's medical record properly indicated that the patient was admitted solely to respond to the pandemic (Centers for Medicare & Medicaid Services 2020). The compliance threshold (commonly referred to as the "60 percent rule") requires that no less than 60 percent of patients admitted to an IRF have as a primary diagnosis or comorbidity at least 1 of 13 conditions specified by CMS.
- 4 The 13 conditions are stroke; spinal cord injury; congenital deformity; amputation of a lower limb; major multiple trauma; hip fracture; brain injury; certain other neurological conditions (multiple sclerosis, Parkinson's disease, cerebral palsy, and neuromuscular disorders); burns; three arthritis conditions for which appropriate, aggressive, and sustained outpatient therapy has failed; and hip or knee replacement when it is bilateral, the patient's body mass index is greater than or equal to 50, or the patient is age 85 or older. In fiscal years 2014, 2015, and 2018, CMS updated its lists of ICD-10-CM codes, replacing certain general codes (such as the arthritis codes) with more specific ones for patients who would be likely to require intensive rehabilitation therapy.
- 5 More criteria are used to designate a case as compliant than the general 13 conditions. CMS applies an algorithm to determine compliant IRF stays. The algorithm is described here: <https://www.cms.gov/files/document/specifications-determining-irf-60-rule-compliance.pdf>.
- 6 During the PHE, some exceptions were made to IRF Medicare coverage criteria for beneficiaries to help health care providers contain the spread of COVID-19. For example, the Secretary waived Section 412.622(a)(3)(ii), commonly referred to as the "3-hour rule," the criterion that patients treated in IRFs generally receive at least 15 hours of therapy per week. IRFs were expected to provide typical IRF levels of care for beneficiaries admitted during the PHE who required and could benefit from such care (Centers for Medicare & Medicaid Services 2020).
- 7 HSAs are local health care markets for hospital care. An HSA is a collection of ZIP codes in which Medicare residents receive most of their hospitalizations from hospitals in that area. There are 3,435 HSAs. See <https://www.dartmouthatlas.org>.
- 8 In contrast, if payments do not cover the marginal costs, the provider could have a disincentive to care for Medicare beneficiaries.
- 9 If we approximate marginal cost as total Medicare cost minus fixed building and equipment cost, then:

$$\text{Marginal profit} = (\text{payments for Medicare services} - (\text{total Medicare costs} - \text{fixed building and equipment costs})) / \text{Medicare payments}.$$
- 10 Community, for this measure, is defined as home/self-care, with or without home health services, based on Patient Discharge Status Codes 01, 06, 81, and 86 on the Medicare FFS claim.
- 11 Hospital cost reports do not require hospitals to report an all-payer margin specifically for their IRFs or other hospital-based units.
- 12 We estimated the aggregate margin including reported relief funds based on FFS Medicare's share of 2019 all-payer operating revenue.
- 13 The number of stays qualifying as outliers fell in 2022 after CMS increased the fixed loss threshold required for outlier payments.
- 14 We use CMS's definition of the low-income patient adjustment. CMS defines an IRF's low-income patient share as the sum of two ratios: the share of all Medicare days devoted to patients on Supplemental Security Income (SSI) plus the share of Medicaid days over all inpatient days.
- 15 Clinical information used to classify IRF patients in CMGs is drawn from the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI), an assessment tool that providers complete when the patient is admitted and discharged. Diagnosis codes are used to categorize stays into RICs; functional impairment levels and age are used to classify stays into CMGs within a RIC.

- 16 The IRF PPS also has adjustments for teaching status, low-income share, geographic location, and outlier payments for patients who are extraordinarily costly.
- 17 Conditions in the “other neurological” RIC include multiple sclerosis, Parkinson’s disease, neuromuscular disorders, and polyneuropathy.
- 18 This method to calculate stay-level costs differs from the method used to calculate the margins shown in Table 8-3 (p. 239), which require only aggregate costs computed from the IRFs’ Medicare cost reports.
- 19 In 2021, the average cost per stay in for-profit freestanding IRFs was about 30 percent less than the average cost per stay in hospital-based IRFs, based on hospital cost reports.
- 20 In FY 2020, CMS transitioned from using Functional Independence Measure™ (FIM™) items on the IRF-PAI to Section GG functional ability items to calculate CMGs. Many analyses in this section use data from FY 2019, prior to the change to Section GG.
- 21 Among hospital-based nonprofit IRFs, critical illness myopathies (diagnosis code G72.81) and Parkinson’s disease (G20) were the most common diagnosis codes, accounting for about 45 percent of “other neurological” RIC stays. Among freestanding for-profit IRFs, other specified myopathies (G72.89) and critical illness myopathies (G72.81) together accounted for 60 percent of “other neurological” RIC stays.
- 22 The Department of Justice alleged that certain IRFs were inappropriately admitting these patients without supporting clinical evidence of their need for IRF services. The case was ultimately settled. At the time, CMS considered removing this condition (diagnosis code G72.89) from meeting the 60 percent compliance threshold. CMS stated that this condition was intended to represent confirmed (through, for example, medical testing) myopathies, but instead found that the diagnosis code was being used by certain IRFs as a nonspecific diagnosis for muscle weakness (Centers for Medicare & Medicaid Services 2017). Ultimately, CMS did not remove this code from the compliance list and stated that it would continue to monitor the appropriate use of this code.
- 23 The HSRV method is iterative: Once payment weights are calculated, a new CMI for each IRF is computed as the average payment weight. For each CMG, ratios of costs are adjusted by the new CMI and averaged across IRFs, yielding a new set of payment weights that are used to compute a new CMI for each IRF. When the CMI and payment weights do not differ in subsequent rounds, the weights are set. In the first round, the CMI for each IRF can be set to 1.
- 24 The inpatient PPS initially used an average-charge method to calculate payment weights. As costs and charges diverged and charge-based weights led to distortions, CMS considered the HSRV method but ultimately shifted to cost-based weights using the average-cost method in 2007 (Centers for Medicare & Medicaid Services 2007).
- 25 PCRs across RICs are not exactly the same when using average-cost payment weights because transfer stays receive an adjusted weight. The frequency of transfer stays varies by RIC and CMG.

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C H A P T E R

9

Hospice services

R E C O M M E N D A T I O N

- 9** For fiscal year 2025, the Congress should eliminate the update to the 2024 Medicare base payment rates for hospice.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Hospice services

Chapter summary

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. Fee-for-service (FFS) Medicare pays for hospice care for beneficiaries enrolled in both traditional FFS Medicare and Medicare Advantage (MA). In 2022, more than 1.7 million Medicare beneficiaries (including almost half of decedents) received hospice services from about 5,900 providers, and Medicare hospice expenditures totaled \$23.7 billion.

Assessment of payment adequacy

The indicators of FFS Medicare payment adequacy for hospices—beneficiaries' access to care, quality of care, provider access to capital, and Medicare payments relative to providers' costs—are positive.

Beneficiaries' access to care—In 2022, indicators of beneficiaries' access to care were positive. The number of hospice providers increased substantially, and measures of hospice utilization increased.

In this chapter

- Are FFS Medicare payments adequate in 2024?
- How should FFS Medicare payments change in 2025?
- Nonhospice spending for beneficiaries enrolled in hospice

- **Capacity and supply of providers**—In 2022, the number of hospice providers increased by about 10 percent as more for-profit hospices entered the market, a trend that has continued for more than a decade.
- **Volume of services**—The share of decedents using hospice increased to 49.1 percent in 2022, up from 47.3 percent in 2021. The number of hospice users and total days of hospice care also increased in 2022. For decedents, average lifetime length of stay increased by about 3 days in 2022 to 95.3 days. Between 2021 and 2022, median length of stay was stable, increasing slightly from 17 days to 18 days. On average, beneficiaries in hospice received 3.9 visits per week in 2022, up slightly from 3.8 visits per week in 2021.
- **FFS Medicare marginal profit**—In 2021, FFS Medicare payments to hospice providers exceeded marginal costs by 17 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—Scores on the Hospice Consumer Assessment of Healthcare Providers and Systems® were generally stable in the most recent period. Scores on a composite of seven processes of care at admission increased slightly but were topped out (i.e., 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 changed little between 2021 and 2022, but the number was lower than the prepandemic 2019 level.

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 at least 10 percent in 2022) 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.

FFS Medicare payments and providers' costs—Hospice FFS Medicare margins are presented through 2021 because of the data lag required to calculate cap overpayment amounts. Between 2020 and 2021, average costs per day increased 4.3 percent. The aggregate FFS Medicare margin for 2021 was 13.3 percent, down slightly from 14.2 percent in 2020. If Medicare's share of pandemic-related relief funds is included, the aggregate FFS Medicare margin

for 2021 was about 14.5 percent. Hospice average cost per day increased 3.7 percent in 2022. We project a FFS Medicare aggregate margin for hospices of about 9 percent in 2024.

How should FFS Medicare payments change in 2025?

Based on the positive indicators of payment adequacy and strong margins, the Commission concludes that current payment rates are sufficient to support the provision of high-quality care without an increase to the payment rates in 2025. The Commission recommends that the Congress eliminate the update to the hospice base payment rates for fiscal year 2025.

Findings from interviews about nonhospice spending for beneficiaries enrolled in hospice

Medicare's payments to hospices are intended to cover all services that are reasonable and necessary for palliation and management of the terminal condition and related conditions. Services that are unrelated to the terminal condition are covered separately outside of hospice by FFS Medicare for Part A and Part B services or by Part D plans for retail pharmacy drugs. Although CMS has stated that it considers "virtually all" services at the end of life to be related to the terminal condition, and thus would be the responsibility of the hospice provider, the Medicare program spent about \$1.5 billion in fiscal year 2022 on services outside of the hospice benefit for hospice enrollees. The issue of nonhospice service use and spending for beneficiaries enrolled in hospice is of interest for several reasons: It may represent duplicate payment by the Medicare program; it may result in increased out-of-pocket costs for beneficiaries; and the fragmented coverage of related and unrelated services may be confusing for beneficiaries, providers, pharmacies, and Part D plans.

In 2022 and 2023, the Commission interviewed hospice providers to better understand issues related to nonhospice spending for beneficiaries enrolled in hospice. The interviews suggest that several factors likely contribute to service use and spending on nonhospice services for hospice beneficiaries, including the following:

- Policy guidance on what services are "related" is broad, and providers vary in their interpretations of what is related.
- Hospices' efforts to educate beneficiaries and families about the hospice benefit can be unsuccessful.
- Hospices report challenges coordinating with other entities (other providers, pharmacies, and Part D plans) and gaps in information flow.

Given the variety of factors contributing to nonhospice service use and spending, a range of policies could be explored to address these issues, including administrative, payment, or penalty approaches. Each approach would raise complicated issues and require further exploration. ■

Background

The hospice benefit covers palliative and support services for Medicare beneficiaries who are terminally ill with a medical prognosis indicating that the individual's life expectancy is six months or less if the illness runs its normal course. In 2022, more than 1.7 million Medicare beneficiaries received hospice services, and Medicare hospice expenditures totaled about \$23.7 billion.

The hospice benefit covers a broad set of services for palliation of the terminal condition and related conditions (e.g., visits by nurses, aides, social workers, physicians, and therapists; drugs, durable medical equipment, and supplies; short-term inpatient care and respite care; bereavement services for the family; and other services for palliation of the terminal condition and related conditions). To receive hospice services, a beneficiary must elect the hospice benefit and agree to forgo Medicare coverage for conventional treatment of the terminal illness and related conditions. Medicare continues to cover items and services unrelated to the terminal illness and its related conditions outside of hospice. Most commonly, hospice care is provided in patients' homes, but hospice services may also be provided in nursing facilities, assisted living facilities, hospice facilities, and other inpatient settings.

Beneficiaries elect hospice for defined benefit periods. When a beneficiary first elects hospice, two physicians—a hospice physician and the beneficiary's attending physician—are required to certify that the beneficiary has a life expectancy of six months or less if the illness runs its normal course.¹ The first hospice benefit period spans up to 90 days. After the first benefit period, the hospice physician can recertify the patient for a second 90-day period and for an unlimited number of 60-day periods after that, as long as the patient's terminal condition continues to engender a life expectancy of 6 months or less. Beneficiaries can disenroll from hospice at any time (referred to as "revoking hospice") and can reelect hospice for a subsequent period as long as they meet the eligibility criteria.

Medicare payment for hospice services

The Medicare program pays a daily rate to hospice providers. The hospice provider assumes all financial

risk for costs and services associated with care for the patient's terminal illness and related conditions. The hospice provider receives payment for every day that a patient is enrolled, regardless of whether the hospice staff visits the patient or otherwise provides a service each day. This payment design is intended to encompass not only the cost of visits but also other costs that a hospice incurs for palliation and management of the terminal condition and related conditions (e.g., on-call services, care planning, and nonvisit services like drugs and medical equipment).

Payments are made according to a fee schedule that has four levels of care. Routine home care (RHC) is the most common level of care, accounting for 98.8 percent of Medicare-covered hospice days in 2022. There are three other specialized levels of care: continuous home care (CHC), which is provided in the home during periods of patient crisis; general inpatient care (GIP), which is provided when symptoms require management in an inpatient setting; and inpatient respite care (IRC), which is provided to enable a short respite for a patient's primary caregiver. In 2022, 90 percent of Medicare hospice patients received some (at least one day of) RHC, 16 percent received some GIP, 3 percent received some IRC, and 2 percent received some CHC (with some patients receiving more than one level of hospice care over the course of their hospice stay). The per diem payment for routine home care is higher during the first 60 days of a hospice episode and reduced for days 61 and beyond. For the other three levels of care, the daily payment rate is higher than for RHC. Medicare also makes additional payments for registered nurse and social worker visits that occur during the last seven days of life for patients receiving RHC.²

When the Congress established the hospice benefit, it included a "cap" limiting the aggregate Medicare payments that an individual hospice can receive.³ The cap is not applied individually to the payments received for each beneficiary, but rather to the total payments across all Medicare patients served by the hospice in the cap year. If a hospice's total Medicare payments exceed the total number of Medicare beneficiaries it served multiplied by the cap amount (\$33,494 in 2024), it must repay the excess to the program. Unlike the daily hospice payments, the cap is not adjusted for geographic differences in costs. In 2021, we estimate

that 18.9 percent of hospices (which provided care to about 5 percent of hospice patients) exceeded the cap and were required to return payments to the program. The Commission first recommended in March 2020 that the hospice cap be wage adjusted and reduced by 20 percent as a way to make the cap more equitable across providers and focus payment reductions on providers with long stays and high margins (Medicare Payment Advisory Commission 2023, Medicare Payment Advisory Commission 2020).

Fee-for-service (FFS) Medicare pays for hospice care for beneficiaries enrolled in either traditional FFS Medicare and Medicare Advantage (MA).⁴ Once a beneficiary in an MA plan elects hospice care, the beneficiary receives hospice services through a provider paid by FFS Medicare (while Medicare continues paying the MA plan for Part D services and extra benefits, but not Part A and Part B services).⁵ In March 2014, the Commission urged that this policy be changed, recommending that hospice be included in the MA benefit package (Medicare Payment Advisory Commission 2014). In January 2021, as part of its value-based insurance design (VBID) models in MA, CMS's Innovation Center launched a demonstration permitting MA organizations to provide hospice and palliative care services for their enrollees to test the effects of adding the hospice benefit to MA (Centers for Medicare & Medicaid Services 2020). According to a CMS contractor evaluation report, 19,065 MA beneficiaries in 2022 received hospice paid for by MA plans (Eibner et al. 2023). As of 2024, 13 MA organizations, comprising 78 plan benefit packages that cover 690 counties in 19 states and Puerto Rico, will furnish hospice benefits under the VBID model (Centers for Medicare & Medicaid Services 2023a, Centers for Medicare & Medicaid Services 2021). In March 2024, CMS announced the hospice component of the MA VBID model would sunset in December 2024. (Centers for Medicare & Medicaid Services 2023a).

The most important benefit of hospice is its effect on patient care. The Medicare hospice benefit was designed to provide beneficiaries with a choice in their end-of-life care, giving them the option to receive care focused on symptom management and to die at home or in another location consistent with their preferences. When the Congress expanded the Medicare benefit to include hospice care in 1983, it was thought that the new benefit would be a less

costly alternative to conventional end-of-life care (Government Accountability Office 2004, Hoyer 2007). The literature is mixed on whether hospice has saved the Medicare program money in the aggregate compared with conventional care, with findings varying in part depending on the methodology used. In 2015, a Commission contractor conducted research that examined the literature and carried out a market-level analysis. The contractor concluded that while hospice produces savings for some beneficiaries, such as those with cancer, overall, hospice has not reduced net Medicare program spending and may have even increased it because of very long stays among some hospice enrollees with noncancer diagnoses (Direct Research 2015). Since that research, several additional studies on this topic have had varied results, and there continues to be debate about hospices' effect on Medicare spending.⁶ The Commission has additional research underway in this area.

Are FFS Medicare payments adequate in 2024?

To address whether payments in 2024 are adequate to cover the costs of the efficient delivery of care and how much providers' payments should change in the coming year (2025), we examine several indicators of payment adequacy. Specifically, we assess beneficiaries' access to care by examining the capacity and supply of hospice providers, changes over time in the volume of services provided, quality of care, providers' access to capital, and the relationship between Medicare's payments and providers' costs.

Beneficiaries' access to care: Hospice supply grew substantially, and utilization increased

Our analysis of access indicators—including trends in the supply of providers, utilization of hospice services, and Medicare marginal profit—shows that beneficiaries' access to care in 2022 was favorable.

Capacity and supply of providers: Supply of hospices continued to grow in 2022, driven by an increase in for-profit providers

In 2022, 5,899 hospices provided care to Medicare beneficiaries, a 10 percent increase from the prior year

**TABLE
9-1****Increase in total number of hospices driven by for-profit providers**

Category	2018	2019	2020	2021	2022*	Average annual percent change 2018–2021	Percent change 2021–2022*
All hospices	4,639	4,840	5,058	5,358	5,899	4.9%	10.1%
For profit	3,234	3,436	3,691	4,008	4,414	7.4	10.1
Nonprofit	1,245	1,255	1,220	1,195	1,169	–1.4	–2.2
Government	159	148	146	143	141	–3.5	–1.4
Freestanding	3,701	3,936	4,189	4,511	4,919	6.8	9.0
Hospital based	453	429	413	396	383	–4.4	–3.3
Home health based	463	456	437	434	421	–2.1	–3.0
SNF based	22	19	19	17	17	–8.2	0.0
Urban	3,762	3,974	4,196	4,505	5,006	6.2	11.1
Rural	871	859	853	845	827	–1.0	–2.1

Note: SNF (skilled nursing facility). The providers included in this analysis submitted at least one paid hospice claim in a given year. Some categories do not sum to total because of missing data for some providers. The rural and urban definitions used in this chart are based on updated definitions of the core-based statistical areas (which rely on data from the 2010 census). Type of hospice reflects the type of cost report filed (a hospice files a freestanding hospice cost report or the hospice is included in the cost report of a hospital, home health agency, or skilled nursing facility).

*In 2022, data on ownership status, type of hospice, and rural and urban location are missing for more providers than usual due to a temporary pause in CMS's updating of the Provider of Services file data for hospices in 2022. While the total number of hospices providing care to Medicare beneficiaries in 2022 (5,899) is not affected by this issue, the table may understate the number of hospices in any ownership, hospice type, or urban/rural subgroup in 2022.

Source: MedPAC analysis of Medicare cost reports, Provider of Services file, and Medicare hospice claims data from CMS.

(Table 9-1). Market entry of for-profit, freestanding providers drove the growth in supply.

An issue of data availability affects our estimates of the number of providers by ownership status, type of hospice, and urban and rural location in 2022.⁷ Thus, we may be understating the number of hospices in any of these categories in 2022, although the total number of hospices providing care in 2022 (5,899) is unaffected by this issue.

In 2022, the number of for-profit hospices grew by at least 10 percent (Table 9-1). Between 2021 and 2022, the number of hospices with nonprofit ownership or government ownership appeared to decline, continuing the downward trend observed from 2018 to 2021. In 2022, among the hospices for which we have data, about 77 percent of providers were for profit; however, they furnished care to just over half of

Medicare hospice patients because, on average, for-profit providers were smaller than nonprofit providers (latter data not shown). The number of freestanding providers increased at least 9 percent in 2022. The number of home health–based and hospital–based hospices appeared to decline in 2022, while the number of SNF–based providers was unchanged.⁸ In 2022, based on available data, we found that about 86 percent of hospices were freestanding, and these hospices furnished care to 87 percent of Medicare hospice patients (latter data not shown).

The number of hospice providers is not necessarily an indicator of beneficiary access to hospice care because the number does not capture the size of providers, their capacity to serve patients, or the size of their service areas. Commission analyses in 2010 and 2019 found that hospice use rates across states appear unrelated to a state's number of hospice providers

per 10,000 beneficiaries (Medicare Payment Advisory Commission 2021).

The number of rural hospices has declined in recent years, falling about 1 percent per year between 2018 and 2021 and declining similarly in 2022 (Table 9-1, p. 267). As of 2022, we estimate 86 percent of hospices were located in urban areas and 14 percent were in rural areas; about 17 percent of Medicare beneficiaries (including beneficiaries in FFS and MA) lived in rural areas in 2022. As noted above, the number of hospices located in rural areas is not reflective of hospice access for rural beneficiaries because it does not capture the size of those hospice providers, their capacity to serve patients, or the size of their service area. Further, some urban hospices provide services in rural areas. Indeed, the share of rural decedents using hospice grew in 2022 (Table 9-2).

In 2022, much of the growth in the number of hospice providers was concentrated in California and Texas. Between 2021 and 2022, the growth in the number of providers in California and Texas combined (about 20 percent) exceeded the growth in the number of providers excluding these two states (about 4 percent). Between 2021 and 2022, California gained 342 hospices and Texas gained 75 hospices, continuing the trend in recent years of substantial market entry by hospice providers in these two states.⁹ In our March 2021 report to the Congress, an analysis of new hospices in California and Texas found that these providers tended to be small and had long average lengths of stay, high live-discharge rates, and high rates of exceeding the aggregate cap; nearly all were for profit (Medicare Payment Advisory Commission 2021). In 2022, other states also saw sizable net gains in the number of hospices: 24 in Nevada, 15 in Arizona, 12 in Michigan, 10 in Virginia, 8 in Indiana, 7 in Ohio, and 6 in both Oregon and Wisconsin. The number of hospice providers declined in some states, although these changes were generally modest. The three states with the biggest decline in the number of hospices were Minnesota (four hospices) and Mississippi and Idaho (two hospices each).

The rapid entry of providers in California has led to program integrity efforts by the state. California placed a moratorium on new hospice licenses in 2022 and bolstered its state laws governing hospice referral and patient enrollment practices (California Legislature

2021). In addition, the California state auditor issued a report on hospice care in Los Angeles County, stating that “growth in the number of hospice agencies in Los Angeles County has vastly outpaced the need for hospice services” and identifying “numerous indicators of fraud and abuse” (Tilden 2022).¹⁰

In summer 2023, CMS also announced a number of steps to increase program integrity efforts for hospice providers overall and specifically in four states (Centers for Medicare & Medicaid Services 2023b). For newly enrolled hospices in Arizona, California, Nevada, and Texas, CMS is implementing a provisional period of enhanced oversight that involves the agency conducting medical review before making payments on these providers’ claims. In addition, CMS has indicated it is undertaking a pilot project, not just in the four states mentioned, to review hospice claims following an individual’s first 90 days of hospice care.

Nationally, hospice use among Medicare decedents increased in 2022, after declining the prior two years due to the coronavirus pandemic. In 2022, 49.1 percent of Medicare decedents received hospice services, up from 47.3 percent in 2021 (Table 9-2). The hospice use rate, which had increased in the prior decade from 2010 to 2019, declined in 2020 and 2021 due to the pandemic. Between 2010 and 2019, hospice use grew from 43.8 percent to 51.6 percent. With the onset of the coronavirus pandemic, the increase in beneficiary deaths in 2020 outpaced growth in the number of hospice users; the share of decedents using hospice in 2020 declined to 47.8 percent (data not shown). In 2021, the hospice use rate declined slightly to 47.3 percent, as deaths remained elevated near 2020 levels and the number of decedents using hospice declined slightly (data not shown) (Medicare Payment Advisory Commission 2023). In 2022, the share of decedents using hospice grew, increasing nearly 2 percentage points to 49.1 percent, but remained below the prepandemic rate of 51.6 percent in 2019.

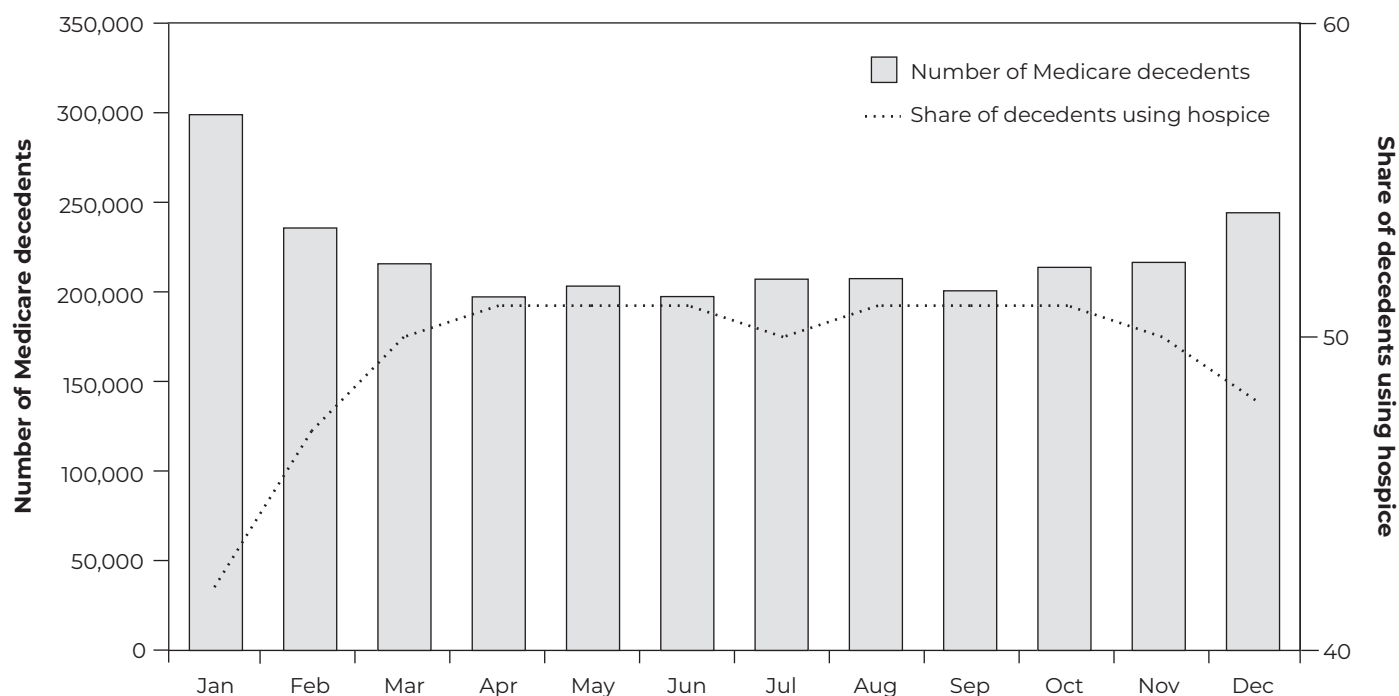
The share of decedents using hospice in 2022 continued to be affected by the coronavirus pandemic. We have observed that those months with the highest numbers of deaths during the pandemic had the lowest hospice use rates (Medicare Payment Advisory Commission 2023). This pattern has largely reflected the fact that elderly people who die of COVID-19, similar to those who die of pneumonia and influenza,

**TABLE
9-2****In 2022, share of decedents using hospice increased overall
and across all beneficiary subgroups****Share of Medicare decedents who used hospice**

	2010	2019	2021	2022	Average annual percentage point change 2010–2021	Percentage point change 2021–2022
All decedent beneficiaries	43.8%	51.6%	47.3%	49.1%	0.3	1.8
FFS beneficiaries	42.8	50.7	47.2	49.1	0.4	1.9
MA beneficiaries	47.2	53.2	47.4	49.2	0.0	1.8
Dually eligible for Medicaid	41.5	49.3	42.1	44.2	0.1	2.1
Not Medicaid eligible	44.5	52.4	49.2	50.9	0.4	1.7
Age						
<65	25.7	29.5	25.0	26.6	–0.1	1.6
65–74	38.0	41.0	35.8	37.7	–0.2	1.9
75–84	44.8	52.2	47.9	49.4	0.3	1.5
85+	50.2	62.7	60.8	61.8	1.0	1.0
Race/ethnicity						
White	45.5	53.8	50.0	51.6	0.4	1.6
Black	34.2	40.8	35.6	37.4	0.1	1.8
Hispanic	36.7	42.7	34.2	38.3	–0.2	4.1
Asian American	30.0	39.8	36.2	38.1	0.6	1.9
North American Native	31.0	38.5	33.8	37.1	0.3	3.3
Sex						
Male	40.1	46.7	42.1	43.8	0.2	1.7
Female	47.0	56.3	52.5	54.3	0.5	1.8
Beneficiary location						
Urban	45.6	52.8	48.5	50.2	0.3	1.7
Micropolitan	39.2	49.7	45.1	47.2	0.5	2.1
Rural, adjacent to urban	39.0	49.5	44.9	47.8	0.5	2.9
Rural, nonadjacent to urban	33.8	43.8	39.9	42.1	0.6	2.2
Frontier	29.2	36.2	33.0	35.2	0.3	2.2

Note: FFS (fee-for-service), MA (Medicare Advantage). For each demographic group, the share of decedents who used hospice is calculated as follows: The number of beneficiaries in the group who both died and received hospice in a given year is divided by the total number of beneficiaries in the group who died in that year. "Beneficiary location" refers to the beneficiary's county of residence in one of four categories (urban, micropolitan, rural adjacent to urban, or rural nonadjacent to urban) based on an aggregation of the Urban Influence Codes (UICs). This chart uses the 2013 UIC definition. The frontier category is defined as population density equal to or less than six people per square mile and overlaps the categories of residence. Yearly figures presented in the table are rounded, but figures in the columns for percentage point change were calculated using unrounded data. Analysis excludes beneficiaries without Medicare Part A because hospice is a Part A benefit.

Source: MedPAC analysis of data from the Common Medicare Enrollment file and hospice claims data from CMS.

**FIGURE
9-1****Monthly trends in Medicare decedents and hospice use, 2022**

Note: "Share of decedents using hospice" refers to decedents who used hospice in the last calendar year of life. Analysis excludes beneficiaries without Medicare Part A because hospice is a Part A benefit.

Source: MedPAC analysis of data from the Common Medicare Enrollment file and hospice claims data from CMS.

are much more likely to die in the hospital and less likely to die at home or in a nursing facility than elderly people who die of other illnesses. The number of deaths among Medicare beneficiaries was elevated in January 2022, corresponding to a surge in the pandemic, reaching about 300,000 decedents; the share who used hospice that month was 42 percent (Figure 9-1). As the number of deaths declined after January, oscillating from approximately 195,000 to 215,000 deaths per month from March through November 2022, hospice use rates were higher, approximately 50 percent to 51 percent each month in that period (Figure 9-1).

In 2022, the share of decedents using hospice increased across all subgroups examined (Table 9-2, p. 269). While hospice use rates rose for all groups, hospice

use remained more common among decedents who were older, female, White, residents of urban areas, and not dually eligible for Medicaid and Medicare. Hospice use among beneficiaries with end-stage renal disease, a group that has lower-than-average hospice use, increased slightly to 29 percent in 2022, up from 28 percent in 2021 (data not shown).

Between 2021 and 2022, hospice use rates increased among all racial or ethnic groups—White, Black, Hispanic, Asian American, and North American Native beneficiaries. Nevertheless, hospice use rates continued to be lower for non-White decedents (Table 9-2, p. 269). The reasons for these differences are not fully understood. Researchers have cited a number of possible factors, such as cultural or religious beliefs, preferences for end-of-life care, disparities in access to care or information about hospice, socioeconomic factors, and mistrust of the medical system (Barnato et

al. 2009, Cohen 2008, Crawley et al. 2000, LoPresti et al. 2016, Martin et al. 2011).

In 2022, hospice use rates increased in both rural and urban areas. Although a greater share of urban decedents than rural decedents have used hospice, that difference shrunk between 2010 and 2022 across counties with different degrees of rurality (Table 9-2, p. 269). Hospice use is lowest among beneficiaries in frontier counties, although hospice use in these areas has also grown.

In 2022, hospice use rates were similar for FFS and MA decedents, and use rates grew for both groups in 2022. Historically, a greater share of decedents in MA than in FFS have used hospice, although the difference has shrunk in recent years. Growth in the share of newly eligible, younger beneficiaries choosing to enroll in MA plans rather than traditional FFS Medicare has contributed to the shrinking difference in hospice use rates between FFS and MA decedents (because younger decedents are less likely to enroll in hospice than older decedents) (Table 9-2, p. 269).

Volume of services: Measures of hospice use increased in 2022

In 2022, measures of hospice use for all hospice enrollees (not just decedents) increased. That year, 1.72 million Medicare beneficiaries received hospice services, a slight increase (0.4 percent) from 2021. The number of hospice days furnished also increased 2 percent to about 130 million days (Table 9-3, p. 272).¹¹

Hospice length of stay increased in 2022 (Table 9-3, p. 272). Average lifetime length of stay among decedents was 95.3 days, up from 92.1 days in 2021. Median length of stay increased slightly to 18 days from 17 days in 2021. Most hospice decedents have short stays, but some have very long stays (Figure 9-2, p. 273). Between 2021 and 2022, length of stay among decedents with the shortest stays remained the same (2 days at the 10th percentile and 5 days at the 25th percentile), and it increased among those with longer stays (from 79 days to 84 days at the 75th percentile and from 264 days to 275 days at the 90th percentile) (Figure 9-2; 2021 data not shown). Hospice length of stay among hospice decedents in MA and FFS is generally similar, except the longest stays are slightly longer among beneficiaries in FFS than in MA.¹²

Length of stay has implications for our broader assessment of payment adequacy because patients' length of stay affects provider profitability. Hospices furnish more services at the beginning and end of a hospice episode and fewer services in the middle, making long stays more profitable for providers than short stays (Medicare Payment Advisory Commission 2013). Hospice lengths of stay vary by observable patient characteristics—such as patient diagnosis and location—so hospice providers can identify and enroll patients who are likely to have long (more profitable) stays if they so choose. For example, in 2022, average lifetime length of stay was longer among decedents with neurological conditions and chronic obstructive pulmonary disease (159 days and 135 days, respectively) than among decedents with cancer (52 days). Length of stay was also longer among patients in assisted living facilities (165 days) or nursing facilities (109 days) compared with patients at home (98 days).¹³

For-profit hospices have substantially longer average lengths of stay than nonprofit hospices (114 days compared with 72 days, respectively, in 2022). For-profit hospices have more patients with diagnoses that tend to have longer stays, but they also have patients with longer stays than nonprofit hospices for all types of diagnoses. For example, among hospice decedents with neurological conditions, average length of stay was 181 days for for-profit hospices and 128 days for nonprofit hospices.¹⁴ These differences in patient mix and length of stay contribute to the variation observed among providers' profit margins, discussed below.

Although most patients have short hospice stays, long stays account for the majority of Medicare spending on hospice. In 2022, Medicare spent just over \$14 billion, nearly 60 percent of hospice spending that year, on patients with stays exceeding 180 days (Table 9-4, p. 274). Over \$5 billion of that spending was on additional hospice care for patients who had already received at least one year of hospice services (which is already twice the presumptive eligibility period for the hospice benefit).

Among the hospices with very long stays are those that exceed the hospice aggregate cap. In 2021, we estimate that about 18.9 percent of hospices exceeded the aggregate payment cap, similar to the prior year (18.6 percent in 2020) (Table 9-5, p. 275).¹⁵ On average, above-cap hospices exceeded the cap by about

TABLE
9-3

Hospice use increased in 2022

					Average annual percent change	Percent change	
	2010	2019	2021	2022	2010–2019	2019–2021	2021–2022
Hospice use among Medicare decedents							
Number of Medicare decedents (in millions)	1.99	2.32	2.73	2.64	1.7%	8.4%	–3.5%
Number of Medicare decedents who used hospice (in millions)	0.87	1.20	1.29	1.30	3.6	3.9	0.2
Average lifetime length of stay among decedents (in days)	87.0	92.5	92.1	95.3	0.7	–0.2	3.5
Median lifetime length of stay among decedents (in days)	18	18	17	18	0 days	–0.5 days	1 day
Medicare use and spending for all hospice users (not limited to decedents)*							
Total spending (in billions)	\$12.9	\$20.9	\$23.1*	\$23.7*	5.5	5.1*	2.7*
Number of Medicare hospice users (in millions)	1.15	1.61	1.71*	1.72*	3.8	3.2*	0.4*
Number of hospice days for all hospice beneficiaries (in millions)	81.6	121.8	127.6*	130.2*	4.6	2.4*	2.0*

Note: Lifetime length of stay is calculated for decedents who were using hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during their lifetime. Total spending, number of hospice users, number of hospice days, and average length of stay displayed in the table are rounded; the percentage change columns for number of hospice users and total spending are calculated using unrounded data.

*These estimates are based on Medicare-paid hospice claims, which exclude hospice care paid for by Medicare Advantage (MA) plans participating in the Center for Medicare & Medicaid Innovation hospice MA value-based insurance design hospice model beginning 2021. According to CMS contractor evaluation reports, 9,630 MA beneficiaries in 2021 and 19,065 MA beneficiaries in 2022 received hospice paid for by MA plans (Eibner et al. 2023, Khodyakov 2022).

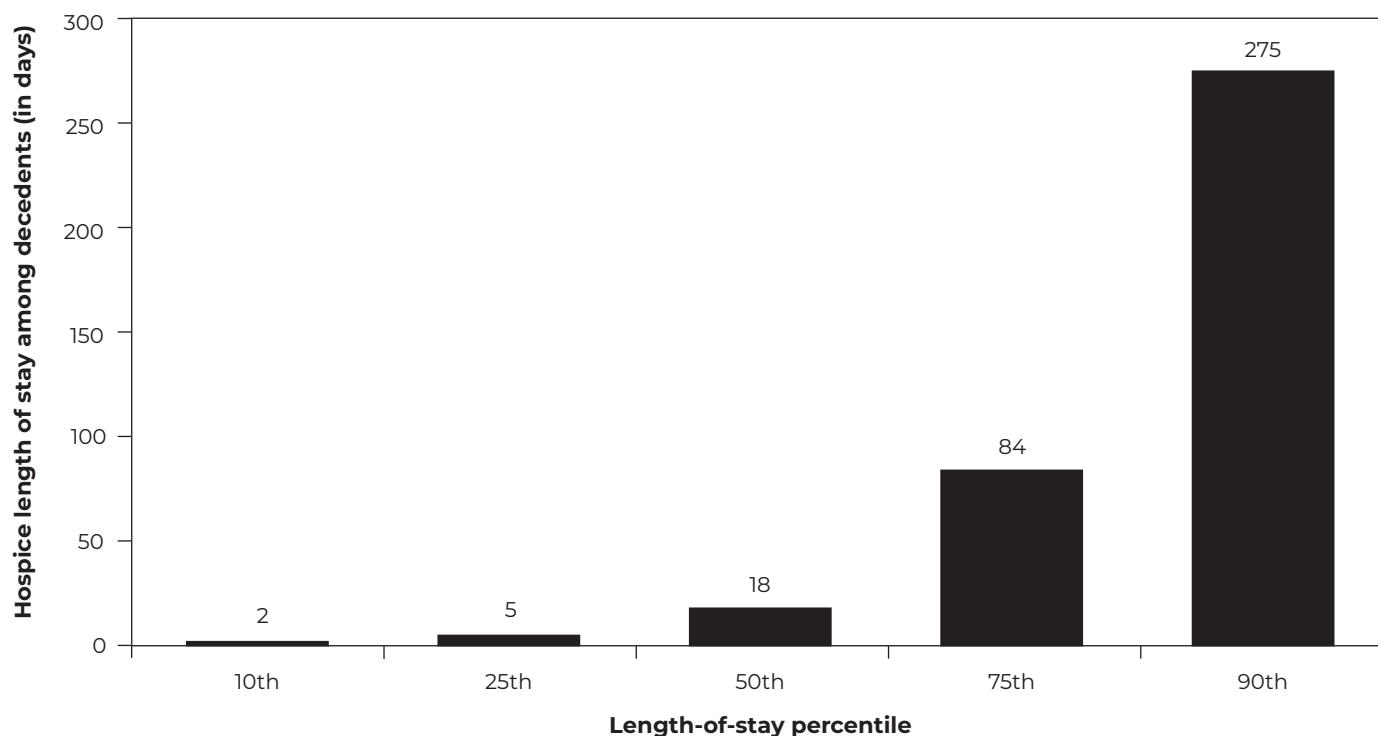
Source: MedPAC analysis of data from the Common Medicare Enrollment file and hospice claims data from CMS.

\$451,000 in 2021, up from \$422,000 in 2020. Above-cap hospices have fewer patients per year, on average, than below-cap hospices and are more likely to be for profit, freestanding, recent entrants to the Medicare program, and located in urban areas (Medicare Payment Advisory Commission 2022). Above-cap hospices have substantially longer stays than below-cap hospices, even for patients with similar diagnoses. Above-cap hospices also have substantially higher rates than

other hospices of discharging patients alive, even when we compare patients with similar diagnoses. As the Commission has noted in past reports, these length-of-stay and live-discharge patterns suggest that above-cap hospices are admitting patients who do not meet the hospice eligibility criteria, which merits further investigation by the Office of Inspector General and CMS.

**FIGURE
9-2**

Most hospice decedents had relatively short stays, but some had very long stays, 2022



Note: Lifetime length of stay is calculated for decedents who were using hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during their lifetime.

Source: MedPAC analysis of the Common Medicare Enrollment file and the Medicare Beneficiary Database from CMS.

In-person hospice visits increased slightly in 2022 but did not reach prepandemic levels

In 2022, in-person hospice visits increased slightly to 3.9 visits per week on average, up from an average of about 3.8 visits per week in 2021 (Table 9-6, p. 275). This increase resulted from a slight uptick in the average number of nurse, aide, and social worker visits per week.

However, the average number of in-person visits per week remained below prepandemic levels. Some of these visits may have been replaced by telehealth visits. Through the end of the public health emergency (May 11, 2023), hospices were given the flexibility to provide

RHC visits via telecommunications technology if it was feasible and appropriate to do so. We lack data on telehealth visits provided by hospices except for social worker phone calls, which has limited our ability to determine the extent to which telehealth visits were used to supplement in-person visits in 2022 (and in 2020 and 2021).

Another measure of access is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments are

**TABLE
9-4**

Nearly 60 percent of Medicare hospice spending was for patients with stays exceeding 180 days, 2022

	Medicare hospice spending, 2022 (in billions)
All hospice users in 2022	\$23.7
Beneficiaries with LOS > 180 days	14.1
Days 1–180	4.5
Days 181–365	4.3
Days 366+	5.3
Beneficiaries with LOS ≤ 180 days	9.6

Note: LOS (length of stay). “LOS” reflects the beneficiary’s lifetime days with hospice as of the end of 2022 (or at the time of discharge in 2022 if the beneficiary was not enrolled in hospice at the end of 2022). All spending reflected in the table occurred only in 2022. Breakout groups do not sum to totals because of rounding.

Source: MedPAC analysis of Medicare hospice claims data and an Acumen LLC data file on hospice lifetime length of stay (which is based on an analysis of historical claims data).

larger than the marginal costs of treating an additional beneficiary, a provider has a financial incentive to increase its volume of Medicare patients. In contrast, if payments do not cover the marginal costs, the provider could have a disincentive to care for Medicare beneficiaries.¹⁶ We found that the 2021 Medicare marginal profit for hospice providers was roughly 17 percent, suggesting that providers with the capacity to do so had a strong incentive to treat Medicare patients.

Quality of care is difficult to assess but appears generally stable

Scores on available quality metrics, based on the most recent available quality data, were generally stable. Scores on the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) survey were stable in the most recent period. Scores on a composite of seven processes of care at admission increased slightly in 2022 but are generally topped out. The provision of in-person visits at the end of life increased slightly in 2022 but remained below 2019 levels.¹⁷

Consumer Assessment of Healthcare Providers and Systems

The Hospice Quality Reporting Program requires hospice providers to participate in a CAHPS hospice survey. The survey gathers information from the patient’s informal caregiver (typically a family member) after the patient’s death. The survey addresses aspects of hospice care that are thought to be important to patients and for which informal caregivers are positioned to provide information. Areas of focus include how the hospice performed on the following measures: communicating, providing timely care, treating patients with respect, providing emotional support, providing help for symptom management, providing information on medication side effects, and training family or other informal caregivers in the home setting. Respondents are also asked to rate the hospice on a scale of 1 to 10 and to say whether they would recommend the hospice. In August 2022, CMS began reporting star ratings for hospices based on the CAHPS scores.

CAHPS scores—as measured by the share of caregivers who reported the “top box,” meaning the most positive, survey response in eight domains—were generally stable in the most recent period (January 2021 to December 2022) compared with the prior period (July 2019 to December 2021, excluding the first half of 2020). Similar to the prior period, 81 percent of caregivers in the most recent period rated the hospice a 9 or 10, and 84 percent would definitely recommend the hospice. Caregivers most frequently gave top ratings on measures of providing emotional support and treating patients with respect (90 percent of caregivers chose the most positive response in those areas). Roughly three-quarters of caregivers gave hospices top ratings for providing help for pain and symptoms, providing timely care, and training caregivers (with 74 percent to 77 percent of caregivers reporting the most positive responses in those areas) (Table 9-7, p. 276). The share of respondents giving a top rating declined slightly (1 percentage point) on four measures: treating patients with respect, help for pain and symptoms, providing timely help, and caregiver training in the most recent period. CMS has recently begun reporting star ratings for hospices as a way to summarize performance across the hospice CAHPS measures. In terms of star ratings, among providers with ratings, most providers scored 3 stars or 4 stars (36 percent and 39 percent, respectively), while some

**TABLE
9-5****Hospices that exceeded Medicare's annual payment cap, 2017-2021**

Year*	2017	2018	2019	2020	2021
Estimated share of hospices exceeding the cap	14.0%	16.3%	19.0%	18.6%	18.9%
Average payments over the cap per hospice exceeding it (in thousands)	\$273	\$334	\$384	\$422	\$451
Payments over the cap as share of overall Medicare hospice spending	1.0%	1.3%	1.7%	1.8%	2.0%

Note: The aggregate cap statistics reflect the Commission's estimates and may differ from CMS claims processing contractors' estimates. Our estimates assume all hospices use the proportional methodology and rely on claims data through 15 months after the end of each cap year. The claims processing contractors may reopen the hospice cap calculation for up to three years; the reopening process and timing vary across contractors.

*Spending in cap year 2017 reflects an 11-month period from November 1, 2016, to September 30, 2017. Beginning in 2018, the cap year is aligned with the federal fiscal year (October 1 to September 30 of the following year).

Source: MedPAC analysis of Medicare hospice claims data, Medicare hospice cost reports, and Medicare Provider of Services file from CMS.

providers scored higher (11 percent received 5 stars) or lower (12 percent received 2 stars, and 2 percent received 1 star). However, star ratings were available for less than half of providers (2,046 hospices).¹⁸

Another way to consider quality performance is to examine the frequency with which caregivers report poor experiences. Two fundamental purposes of hospice are to manage a patient's symptoms in accord with the patient's preferences and to provide timely help; thus, it could be informative to examine how frequently poor performance occurs in these areas.

For example, looking at the distribution of caregiver responses across providers on the CAHPS survey in the most recent period, the median hospice had 10 percent of patients' informal caregivers give the bottom rating on help for pain and symptoms (i.e., reported the patient sometimes or never got the help they needed for pain or symptoms) and the bottom rating on providing timely help (i.e., reported that the hospice team sometimes or never provided timely help). Across providers, the share of caregivers choosing the bottom rating on these two measures ranged from 6 percent at the 10th percentile to 15 percent at the 90th percentile.

**TABLE
9-6****Average number of in-person hospice visits per patient per week increased slightly in 2022 but did not reach prepandemic levels**

	Average number of visits per patient per week				Percent change 2021-2022
	2019	2020	2021	2022	
Total visits	4.3	3.6	3.8	3.9	1.8%
Nurse visits	1.8	1.6	1.7	1.7	1.4
Aide visits	2.2	1.7	1.8	1.8	1.6
Social worker visits	0.3	0.2	0.3	0.3	7.0

Note: "Visits" refers to in-person visits only. Nurse visits include both registered nurse and licensed practical nurse visits. Components of visits may not sum to total visits due to rounding.

Source: MedPAC analysis of Medicare hospice claims data from CMS.

**TABLE
9-7****Scores on hospice CAHPS® quality measures and hospice star ratings**

	National performance	
	Prior period (July 2019 – December 2019; July 2020 – December 2021)	Most recent period (January 2021 – December 2022)
Share of caregivers rating the hospice a 9 or 10	81%	81%
Share of caregivers who would definitely recommend the hospice	84	84
Share of caregivers who give top ratings on:		
Providing emotional support	90	90
Treating patients with respect	91	90
Help for pain and symptoms	75	74
Hospice team communication	81	81
Providing timely help	78	77
Caregiver training	76	75

Note: CAHPS® (Consumer Assessment of Healthcare Providers and Systems®). The CAHPS scores in the eight listed domains reflect the share of respondents who reported the “top box,” meaning the most positive, survey response across all providers. The “previous period” covers July 2019 to December 2021, excluding the first half of 2020, when hospices’ quality reporting requirement was suspended due to the coronavirus pandemic.

Source: CAHPS data from CMS.

In 2024, CMS will begin implementing the new Hospice Special Focus Program (mandated by the Consolidated Appropriations Act, 2021), which will identify providers with the poorest performance based on selected quality indicators (Centers for Medicare & Medicaid Services 2023e). Under this program, CMS will identify the poorest-performing hospices based on an algorithm that reflects the following quality indicators: condition-level deficiencies identified in surveys, substantiated complaint allegations, a claims-based measure of outlier patterns of care, and performance on the hospice CAHPS survey. The CAHPS scores incorporated into the algorithm include the share of caregivers who gave bottom ratings for pain and symptom management, getting timely help, and overall rating of the hospice, as well as the share who would not recommend the hospice. CMS will select from among the 10 percent of hospices with the poorest performance on the algorithm for inclusion in the Special Focus Program. Hospices selected for the Special Focus Program will be subject to more frequent surveys, every

6 months over an 18-month period. These providers could face termination from the Medicare program if they are found to have additional serious deficiencies or complaints that meet certain criteria while being surveyed during the Special Focus Program. CMS plans to publicly report the 10 percent of hospice providers that have the lowest performance on the algorithm and the subset of those providers selected for the Special Focus Program.

Process measures

Hospices are required to report data on seven processes of care that are important for patients newly admitted to hospice. These processes include pain screening, pain assessment, dyspnea screening, dyspnea treatment, documentation of treatment preferences, addressing beliefs and values if desired by the patient, and provision of a bowel regimen for patients treated with an opioid. CMS has a composite measure that reflects the share of admitted patients for whom the hospice performed all seven activities

appropriately (or appropriately performed all the activities relevant to the patient). Hospice providers' scores on the composite measure are very high and increased slightly in the most recent period. The provider-level median score was 96.2, up from 95.3 percent in the previous period. The consistently high scores on the composite measure suggest that it has topped out.

In August 2022, CMS added two new claims-based process measures to public reporting.¹⁹ One is the Hospice Care Index, which identifies providers with outlier patterns of care based on hospice providers' performance across 10 indicators. These indicators include four related to the provision of visits to hospice patients, four related to aspects of live discharge, one that reflects Medicare hospice spending per beneficiary, and one that gauges whether the provider furnished any high-intensity care (continuous home care or general inpatient care). In the most recent reporting period, from January 2021 to December 2022, 15 percent of providers with data were outliers on at least 3 of 10 measures, and 2 percent were outliers on at least half of the measures.

The second new claims-based process measure in the public reporting program focuses on visits by hospice nurses and social workers at the end of life. Measures of these visits are thought to be indicators of quality because patients' and caregivers' need for symptom management and support tends to increase in the last week of life. The measures calculate the share of hospice decedents who received in-person nurse or social worker visits on at least two of the last three days of life. Provider performance varied substantially on this measure. Among providers with at least 20 patients who died during the reporting period and met criteria for inclusion in the measure, scores ranged from 40 percent at the 25th percentile to 70 percent at the 75th percentile, similar to the prior reporting period.²⁰

The Commission has also used claims data to examine the aggregate trend from 2019 to 2022 in nurse and social worker in-person visits in the last seven days of life. After a modest decline in 2020 in the frequency and length of these visits in the last seven days of life, provision of these visits was generally stable in 2021 and 2022 but has not rebounded to the prepandemic level (Table 9-8, p. 278). The share of days with a visit was stable or increased slightly in 2021 and in 2022,

while the average length of visits declined slightly in these years, resulting in very small overall change in the average amount of visit time.

Future quality measures

The Commission consistently maintains that, with quality measurement in general, outcome measures are preferable to process measures. Although outcome measures for hospice are particularly challenging, the Commission believes that outcome measures such as patient-reported pain and other symptom management measures warrant further exploration. In the hospice final rule for fiscal year (FY) 2022, CMS indicated that, as part of the hospice patient assessment instrument currently under development (referred to as the Hospice Outcomes & Patient Evaluation (HOPE)), CMS has been working with a technical expert panel to explore three candidate outcome measures related to symptom management: timely reduction of pain impact, reduction in pain severity, and timely reduction of symptoms. In addition, CMS indicated in the FY 2024 hospice final rule that the agency intends to develop at least two process and outcome measures from the HOPE when it is implemented: timely reassessment of pain impact and timely reassessment of nonpain symptom impact (Abt Associates 2022). CMS is also working with a technical expert panel to develop health-equity structural composite measures for hospice and home health (Centers for Medicare & Medicaid Services 2022).

High rates of live discharge from hospice could signal problems

As the Commission has noted over the years, high rates of live discharge may signal poor quality or program integrity issues. Hospice providers are expected to have some live discharges because patients may change their mind about using the hospice benefit and disenroll from hospice or their condition may improve such that they no longer meet the hospice eligibility criteria. However, substantially higher rates of live discharge relative to other hospices could indicate a problem, such as a hospice provider not meeting the needs of patients and families or admitting patients who do not meet the eligibility criteria.

In 2022, the aggregate rate of live discharge (that is, live discharges as a share of all discharges) was 17.3 percent, close to the 2021 rate of 17.2 percent. As in prior years, hospice claims data show "beneficiary revocation" and

**TABLE
9-8****Measure of in-person nurse and social worker visits during the last seven days of life was generally stable in 2022, but down from 2019 levels**

	2019	2020	2021	2022
Nurse visits in last 7 days of life				
Share of days with visit	66%	62%	63%	63%
Average length of each visit (in 15-minute increments)	4.44	4.37	4.23	4.20
Average visit time per day (in 15-minute increments)	2.94	2.70	2.68	2.64
Social worker visits in last 7 days of life				
Share of days with visit	10%	7%	9%	9%
Average length of visits (in 15-minute increments) `	4.01	3.79	3.78	3.63
Average visit time per day (in 15-minute increments)	0.42	0.28	0.32	0.33

Note: "Nurse visits" includes both registered nurse and licensed practical nurse visits.

Source: MedPAC analysis of Medicare hospice claims data from CMS.

"beneficiary not terminally ill" as the most common reasons for live discharge (each accounting for 6.1 percent of hospice discharges in 2022).²¹ Among providers with more than 30 discharges, the median live-discharge rate was about 19 percent, but 10 percent of providers had live-discharge rates of 50 percent or more in 2022. Hospices with very high live-discharge rates were disproportionately for-profit and recent entrants to the Medicare program (entered in 2010 or after) and had an above-average rate of exceeding the aggregate payment cap. For example, our comparison of above- and below-cap hospices in 2021 found that the live-discharge rate among cancer patients was 10 percent for below-cap hospices and 26 percent for above-cap hospices; the live-discharge rate among heart failure patients was 19 percent for below-cap hospices and 57 percent for above-cap hospices.

Very short hospice stays signal opportunities for quality improvement

For many years, a significant share of hospice stays have been very short. More than one-quarter of hospice decedents enroll in hospice only in the last

week of life, a length of stay that is commonly thought to benefit patients less than enrolling earlier. Very short hospice stays occur across a wide range of diagnoses, often stemming from broader issues in the health care delivery system that precede the hospice referral (Medicare Payment Advisory Commission 2022). These short stays are generally unrelated to the adequacy of Medicare's hospice payment rates. For example, some physicians are reluctant to have conversations about hospice or tend to delay such discussions until death is imminent; some patients or families may prefer to exhaust all other treatment options before enrolling in hospice; and financial incentives in the FFS system may encourage increased volume of clinical services (compared with palliative care furnished by hospice providers) (Medicare Payment Advisory Commission 2009). The requirement that beneficiaries forgo intensive conventional care to enroll in hospice, some analysts point out, may also contribute to deferring hospice care, resulting in short hospice stays.

Initiatives are underway that seek to address concerns about potentially late hospice enrollment and to

improve the quality of end-of-life care more generally. Since 2016, under the physician fee schedule, Medicare has paid for advance care planning conversations between beneficiaries and their physicians, advanced practice registered nurses, or physician assistants. In 2016, CMS also launched a demonstration program (called the Medicare Care Choices Model (MCCM)) that permitted certain FFS beneficiaries who were eligible for hospice (but not enrolled in the Medicare hospice benefit) to enroll in the demonstration and receive palliative and supportive care from a hospice provider while continuing to receive “curative” care from other providers.²² An evaluation of the MCCM reported that participants were more likely to enroll in hospice before death and to do so earlier than the comparison group of decedents. The evaluation also reported that MCCM enrollees were more likely to receive better quality end-of-life care (i.e., they were less likely to receive aggressive procedures, surgeries, or diagnostic tests in the last 30 days of life and spent more days at home on average than the matched comparison group). The final evaluation found, based on the experience of 5,153 MCCM enrollees who enrolled between January 2016 and June 2021 and died before December 2021, that the MCCM was associated with a 13 percent net reduction in Medicare expenditures for these beneficiaries relative to a matched comparison group due to greater hospice use and lower acute care costs at the end of life (Kranker et al. 2023). The report cautioned against broadly extrapolating from these findings because the model involved a very small number of beneficiaries and hospice providers.²³

In March 2014, the Commission recommended that hospice be included in the MA benefit package, which would give plans greater incentive to develop and test new models aimed at improving end-of-life care and care for beneficiaries with advanced illnesses (Medicare Payment Advisory Commission 2014). As noted earlier, CMMI launched a VBID demonstration in January 2021 that tests the inclusion of hospice services in the MA benefit. Participating plans may also offer enrollees palliative care outside the hospice benefit, transitional concurrent hospice and curative care, and hospice supplemental benefits (e.g., waiver of hospice cost sharing for drugs and respite care or additional in-home caregiver support).

In the first two years of the VBID hospice model, MA plans were financially responsible for hospice

care for about 9,630 beneficiaries in 2021 and 19,065 beneficiaries in 2022 (Eibner et al. 2023, Khodyakov et al. 2022). A CMS contractor evaluation report using data from 2019 (two years prior to the model) and 2021 (the first year of the model) found that hospice use and patterns of hospice care did not appear to be significantly affected by the VBID model in its first year (Khodyakov et al. 2022). In the first two years of the model, the report indicated that the provision of transitional concurrent care, hospice supplemental benefits, and nonhospice palliative care was lower than expected. Of beneficiaries who elected hospice in VBID plans in 2022, less than 1 percent received transitional concurrent care, and 6.5 percent received hospice supplemental benefits. According to the report, MA plans and hospice providers indicated some implementation challenges (e.g., related to adapting information technology systems, data reporting burden, and communications). In March 2024, CMS announced the hospice component of the MA VBID model would sunset in December 2024.

In addition to MA plans, accountable care organizations (ACOs)—which are accountable for total spending for a defined Medicare population, including their end-of-life care and hospice—are entities that could provide hospice care and potentially reduce costs by implementing policies that would facilitate beneficiaries’ use of end-of-life care in a way that is consistent with their preferences. Research on the effect of ACOs on patterns of end-of-life care and hospice use are nascent, but several studies that examined experience through 2015 had mixed findings. Gilstrap et al. (2018) did not find evidence of differential growth in hospice use among decedents in ACOs compared with other decedents. Lam et al. (2022) found hospice use rates were higher among cancer patients who were not in ACOs than among those in ACOs. In contrast, Kaufman et al. (2019) found higher hospice enrollment rates among stroke patients who were in ACOs than stroke patients who were not in ACOs.

Several of CMS’s alternative payment models include an option for the participating entity to offer concurrent care to beneficiaries who enroll in hospice. Entities in these payment approaches generally take on financial risk for the total cost of care, which creates incentives for judicious use of services. Under CMS’s ACO REACH

(Realizing Equity, Access, and Community Health) model, one benefit enhancement that ACOs can offer is concurrent care for beneficiaries who elect hospice. Out of 132 ACOs in 2023, 46 chose to offer the concurrent care benefit enhancement.²⁴ Under the Kidney Care Choices Model, clinicians who take on financial risk for the total cost of care can also offer concurrent dialysis and hospice to a patient with end-stage renal disease (Vossel 2023b).

For beneficiaries with dementia, CMS's Innovation Center is launching an eight-year model beginning in mid-2024, referred to as the Guiding an Improved Dementia Experience (GUIDE) model, to test whether the provision of supportive services can improve quality of life for beneficiaries and their caregivers and delay preventable nursing home admissions (Centers for Medicare & Medicaid Services 2023c). Under GUIDE, an interdisciplinary team (consisting of a clinician and nurse navigator and other staff) will furnish care coordination and management services, caregiver education and support (including a 24/7 telephone help line), and (for beneficiaries meeting certain criteria) caregiver respite services. The GUIDE model excludes beneficiaries in hospice because it offers overlapping services; however, it may represent an option for beneficiaries earlier in the disease trajectory or for those who do not elect hospice.

Providers' access to capital: Hospices have good access to capital

Hospices in general require less capital than many other provider types because they do not need extensive physical infrastructure (although some hospices have built their own inpatient units, requiring significant capital). Overall, access to capital for hospices appears adequate, given the continued entry of for-profit providers in the Medicare program.

In 2022, the number of for-profit providers grew by at least 10 percent, indicating that these providers have been able to access capital. Although the coronavirus pandemic affected hospice providers' operations in a number of ways, large publicly traded hospice companies had strong financial performance through the third quarter of 2023 (Addus 2023, Amedisys 2023, Chemed 2023, Enhabit 2023). After the public health emergency ended in May 2023, companies have varied in the extent to which average daily census

and cost growth rates have returned to prepandemic levels, but, overall, companies report this process is underway. Changes in average daily census between 2022 and 2023 varied across companies, ranging from decreases to little change to large increases (Addus 2023, Amedisys 2023, Chemed 2023, Enhabit 2023). Among large publicly traded companies, staffing shortages and hiring challenges, which were reportedly pronounced in the first half of 2022, were reported to have resolved or eased in 2023. For example, two companies reported success in hiring new staff and no longer relying on contract personnel to fill vacancies (Chemed 2023, Enhabit 2023). Reports also suggest that growth in hospice cost per day may be moderating. Two publicly traded companies reported a decline in cost per day in the third quarter of 2023 compared with the same quarter of the prior year, and one company reported a substantial increase in cost per day in 2023 but no increase expected for 2024 (Amedisys 2023, Chemed 2023, Enhabit 2023). In 2023, publicly traded companies' aggregate hospice margins continued to be strong. Furthermore, the hospice sector continues to garner substantial investment interest from other health care companies and private equity firms and investors. For example, in 2023, an insurer, UnitedHealth Group, acquired LHC Group and announced a pending agreement to acquire Amedisys (two large home health and hospice companies) (Parker 2023). Private equity acquisitions of hospice providers slowed in 2023 following several years of increased activity, but the sector continues to be viewed favorably by investors (Vossel 2023a). Among nonprofit freestanding providers, less is known about access to capital, which may be limited. Hospital-based and home health-based nonprofit hospices have access to capital through their parent providers.

A provider's all-payer total margin—which reflects how its total revenues compare with its total costs for all lines of business and all payers—can influence a provider's ability to obtain capital. Irregularities in the way some hospices report their total revenue and total expense data on cost reports prevent us from calculating a reliable estimate of all-payer total margins for hospices. Among hospice payers, however, Medicare accounts for about 90 percent of hospice days, and hospices' Medicare margins are strong.

Medicare payments and costs: Aggregate payments exceed costs

Hospice costs per day increased 3.7 percent between 2021 and 2022. These costs vary substantially by providers' average length of stay: Hospices with longer stays have lower costs per day on average. Hospice margins are presented through 2021 because of the data lag required to calculate cap overpayment amounts. Average cost per day increased 4.3 percent between 2020 and 2021, which contributed to the small decline in the FFS Medicare aggregate margin to 13.3 percent, from 14.2 percent the prior year.

Medicare's payments to hospice providers

Between 2010 and 2022, Medicare's spending for hospice grew substantially, increasing 5.2 percent per year on average, from \$12.9 billion to \$23.7 billion. Between 2021 and 2022, Medicare hospice spending increased 2.7 percent (which was largely the result of a 2.0 percent update in the 2022 hospice base payment rates), a 2 percent increase in total days of care in 2022, which was partially offset by the reinstatement of the sequester (1 percent beginning April 2022 and 2 percent beginning July 2022). Not included in the payment totals are the coronavirus pandemic-related federal relief funds for some providers. According to the Medicare cost reports, in cost report years 2021 and 2022, these relief payments for freestanding hospice providers totaled about \$340 million and \$150 million, respectively. Although the intent of these funds was to provide relief broadly to support care for all patients regardless of payer, the vast majority of hospice patients are Medicare beneficiaries (accounting for more than 90 percent of all hospice patient days in 2021). On a per day basis, Medicare's average payment to hospice providers was about \$182 in 2022, up 0.7 percent from 2021.

Hospice costs

In 2022, hospice costs per day across all levels of care for hospice providers with cost report data averaged about \$162, rising 3.7 percent from 2021. Between 2020 and 2021 (the year of our margin estimate), hospice costs per day grew 4.3 percent.

Hospice costs per day vary substantially by type of provider (Table 9-9), which is one reason for differences in hospice margins across provider types. In 2022, freestanding hospices had lower average

TABLE 9-9 Total hospice costs per day varied by type of provider, 2022

Average total cost per day	
All hospices	\$162
Freestanding	155
Home health based	180
Hospital based	251
For profit	143
Nonprofit	195
Urban	163
Rural	149

Note: Data reflect aggregate costs per day for all types of hospice care combined (routine home care, continuous home care, general inpatient care, and inpatient respite care) for all payers. "Day" reflects the total number of days for which the hospice is responsible for care of its patients, regardless of whether the patient received a visit on a particular day. Data are not adjusted for differences in case mix or wages across hospices.

Source: MedPAC analysis of Medicare hospice cost reports and Medicare Provider of Services file from CMS.

costs per day than provider-based hospices (i.e., home health-based and hospital-based hospices). For-profit and rural hospices also had lower average costs per day than their respective counterparts. Many factors contribute to variation in hospice costs across providers. One factor is length of stay. Hospices with longer stays have lower costs per day on average. Freestanding and for-profit hospices have substantially longer stays than other hospices and thus have lower costs per day (Medicare Payment Advisory Commission 2022). Another factor is overhead costs. Included in the costs of provider-based hospices are overhead costs allocated from the parent provider, which contributes to provider-based hospices' higher costs compared with freestanding providers. The Commission maintains that payment policy should focus on the efficient delivery of services and that if freestanding hospices are able to provide high-quality care at a lower cost than provider-based hospices, payment rates should be set accordingly; the higher costs of

provider-based hospices should not be a reason for increasing Medicare payment rates.

Hospice margins

In 2021, the FFS Medicare aggregate margin for hospice providers was 13.3 percent, down slightly from 14.2 percent in 2020 (Table 9-10).²⁵ FFS Medicare aggregate margins varied widely across individual hospice providers: -5.7 percent at the 25th percentile, 12.6 percent at the 50th percentile, and 26.5 percent at the 75th percentile (data not shown). Our estimates of FFS Medicare aggregate margins exclude overpayments to above-cap hospices and are calculated based on Medicare-allowable, reimbursable costs, consistent with our approach used in other Medicare sectors.²⁶ In addition, these margin estimates do not include federal pandemic relief funds that were received by hospice providers in 2021. However, if a portion of these relief funds received by freestanding hospice providers in 2021 were included in our margin estimates, the FFS Medicare aggregate margin would have been about 14.5 percent (compared with our estimated 13.3 percent).²⁷

Hospice margins vary by provider characteristics, such as type of hospice (freestanding or provider based), type of ownership (for profit or nonprofit), patient volume, and urban or rural location (Table 9-10). In 2021, freestanding hospices had higher FFS Medicare aggregate margins (15.5 percent) than home health-based (10.9 percent) or hospital-based hospices (-15.6 percent) (Table 9-10). Provider-based hospices typically have lower FFS Medicare aggregate margins than freestanding hospices for several reasons, including their shorter stays and the allocation of overhead costs from the parent provider to the provider-based hospice. In 2021, the Medicare aggregate margin was considerably higher for for-profit hospices (19.2 percent) than for nonprofit hospices (5.2 percent). The FFS Medicare aggregate margin for freestanding nonprofit hospices was higher (8.5 percent; data not shown) than the margin for nonprofit hospices overall. Generally, hospices' FFS Medicare aggregate margins vary by the provider's volume: Hospices with more patients have higher margins on average. Hospices in urban areas had a slightly higher overall FFS Medicare aggregate margin (13.4 percent) than those in rural areas (12.3 percent).

In 2021, above-cap hospices had a high FFS aggregate margin before the return of overpayments but still had

a positive margin after the return of overpayments (Table 9-10). In 2021, the FFS Medicare aggregate margin for above-cap hospices was 21.8 percent before the return of overpayments and 2.5 percent after the return of overpayments. The FFS Medicare aggregate margin for below-cap hospices was 14.0 percent.

Hospice profitability is closely related to length of stay. Hospices with longer stays have higher margins. For example, in an analysis of hospice providers based on the share of their patients' stays exceeding 180 days, the FFS Medicare aggregate margin ranged from 0 percent for hospices in the lowest quintile to 22.2 percent for hospices in the second-highest quintile (Table 9-10). Hospices in the quintile with the greatest share of patients exceeding 180 days had a 9.7 percent FFS Medicare aggregate margin after the return of cap overpayments, but without the hospice aggregate cap, these providers' margins would have averaged 21.8 percent (latter figure not shown in table).

Hospices with a large share of patients in nursing facilities and assisted living facilities have higher FFS Medicare aggregate margins than other hospices (Table 9-10). For example, in 2021, the 50 percent of hospices with the highest share of patients residing in nursing facilities and assisted living facilities had a FFS Medicare aggregate margin that was more than double the margin for providers with fewer patients residing in facilities (17.6 percent versus 7.1 percent). The higher margin among hospices treating more facility-based patients is driven in part by the diagnosis profile and length of stay of patients residing in facilities. In addition, treating hospice patients in a centralized location may create efficiencies in terms of mileage costs and staff travel time, as well as facilities serving as referral sources for new patients. Nursing facilities can also be a lower-cost setting for hospices to provide care because of the overlap in responsibilities between the hospice and the nursing facility.

Projected 2024 FFS Medicare aggregate margin

To project the 2024 FFS Medicare aggregate margin, we model the policy changes that went into effect between 2021 (the year of our most recent margin estimates) and 2024. The policies include annual payment updates in 2022, 2023, and 2024 of 2.0 percent, 3.8 percent, and 3.1 percent, respectively. The updates for these years reflect the market basket update and a productivity adjustment. In addition, our margin projection reflects

**TABLE
9–10****Hospice providers' FFS Medicare aggregate margins
by selected characteristics, 2017–2021**

Category	Share of hospices 2021	2017	2018	2019	2020	2021
All	100%	12.5%	12.4%	13.4%	14.2%	13.3%
Freestanding	84	15.3	15.1	16.2	16.7	15.5
Home health based	7	8.1	8.4	9.7	11.2	10.9
Hospital based	8	–13.8	–16.5	–18.4	–18.2	–15.6
For profit	75	20.0	19.0	19.2	20.5	19.2
Nonprofit	22	2.5	3.8	6.1	5.8	5.2
Urban	84	12.9	12.6	13.6	14.3	13.4
Rural	16	8.9	10.3	11.5	13.5	12.3
Patient volume (quintile)						
Lowest	20	–1.1	–3.1	–4.5	–2.1	–4.4
Second	20	6.7	5.6	6.2	4.9	3.1
Third	20	13.8	13.8	13.5	14.2	13.3
Fourth	20	15.2	14.0	15.8	17.9	15.5
Highest	20	12.5	12.7	13.9	14.4	14.0
Below cap	81	12.6	12.6	13.8	14.8	14.0
Above cap (excluding cap overpayments)	19	12.1	10.3	10.0	7.7	2.5
Above cap (including cap overpayments)	19	21.9	21.8	22.5	22.8	21.8
Share of stays > 180 days						
Lowest quintile	20	–4.5	–3.0	–2.5	–0.4	0.0
Second quintile	20	7.0	8.5	10.3	11.8	11.1
Third quintile	20	17.1	16.8	19.9	20.0	20.5
Fourth quintile	20	22.1	20.8	22.8	24.1	22.2
Highest quintile	20	17.8	17.6	13.4	13.4	9.7
Share of patients in nursing facilities and assisted living facilities						
Lowest half	50	6.3	6.1	6.6	7.5	7.1
Highest half	50	18.1	17.3	18.7	18.9	17.6

Note: FFS (fee-for-service). Margins for all provider categories exclude overpayments to above-cap hospices, except where specifically indicated. Medicare aggregate margins are calculated based on Medicare-allowable, reimbursable costs. Margin by hospice ownership status is based on hospices' ownership designation from the Medicare cost report. The rural and urban definitions used in this chart are based on updated definitions of the core-based statistical areas (which rely on data from the 2010 census).

Source: MedPAC analysis of Medicare hospice cost reports, Medicare hospice claims data, and Medicare Provider of Services file from CMS.

reinstatement of the 2 percent sequester beginning in July 2022. (The sequester was suspended from May 2020 to March 2022 and was reinstated at 1 percent from April to June 2022.) It also reflects the penalty

providers face for not reporting quality data, which increases in 2024 to 4 percent. We assume a rate of cost growth equal to 3.7 percent in 2022 (the observed rate for that year). For 2023 and 2024, we assume cost

growth remains above historical trends, but to a lesser extent than for 2021 and 2022. Taking these factors into account, we project a FFS Medicare aggregate hospice margin of about 9 percent for 2024.

How should FFS Medicare payments change in 2025?

Under current law, Medicare's base payment rates for hospice care are increased annually based on the projected increase in the hospice market basket, less an amount for productivity improvement. The final update for 2025 will not be set until summer 2024; however, using CMS's third-quarter 2022 projections of the market basket (3.1 percent) and productivity adjustment (0.3 percent) would increase hospice payment rates by 2.8 percent.

Our indicators of payment adequacy for hospices—beneficiary access to care, quality of care, provider access to capital, and Medicare payments relative to providers' costs—are positive. The Commission has concluded that current payment rates are sufficient to support the provision of high-quality care without an increase to the base payment rates in 2025.

RECOMMENDATION 9

For fiscal year 2025, the Congress should eliminate the update to the 2024 Medicare base payment rates for hospice.

RATIONALE 9

Our indicators of access to care are positive, and there are signs that the aggregate level of payment for hospice care exceeds the level needed to furnish high-quality care to beneficiaries. In 2022, the number of providers increased by 10 percent. The share of Medicare decedents using hospice, the total number of beneficiaries receiving hospice care, and the total days of hospice care also increased. Among decedents, average length of stay and median length of stay increased. The 2021 FFS Medicare marginal profit was about 17 percent. Access to capital appears adequate: The number of for-profit providers increased by at least 10 percent, and financial reports suggest that the sector is viewed favorably by investors. The 2021 FFS Medicare aggregate margin was 13.3 percent (14.5 percent if pandemic relief funds are included). The

projected 2024 FFS Medicare aggregate margin is about 9 percent.

IMPLICATIONS 9

Spending

- This recommendation would decrease federal program spending relative to current law by \$250 million to \$750 million over one year and by \$1 billion to \$5 billion over 5 years.

Beneficiary and provider

- We do not expect this recommendation to have adverse effects on beneficiaries' access to hospice care. Given the current level of payments, we do not expect the recommendation to affect providers' willingness or ability to care for Medicare beneficiaries.

Nonhospice spending for beneficiaries enrolled in hospice

Coverage of the services hospice patients receive is fragmented. Medicare's payments to hospices are intended to cover all services that are reasonable and necessary for palliation and management of the terminal condition and related conditions. Services that are unrelated to the terminal condition are covered separately outside of hospice by Medicare FFS for Part A and Part B services or by Part D plans for retail pharmacy drugs.

Although CMS has stated that it considers "virtually all" services at the end of life to be related to the terminal condition and thus the responsibility of the hospice provider, significant spending occurs outside of the hospice benefit during hospice elections. CMS reported that Medicare spending on nonhospice services for hospice enrollees was about \$1.5 billion in FY 2022 (Centers for Medicare & Medicaid Services 2023g).²⁸ Medicare paid hospice providers approximately \$23 billion in FY 2022; thus, Medicare spent roughly an additional 6 percent on nonhospice service for beneficiaries enrolled in hospice. CMS estimates that:

- Medicare spending on Part A and Part B services outside of hospice was \$883 million in 2022, up nearly 29 percent from 2019. Nearly half of that amount was for physician services (\$472 million), and about a third was for outpatient services

(\$150 million) and hospital inpatient services (\$145 million) combined. In addition, hospice beneficiaries spent \$197 million on Part A and Part B cost sharing outside of hospice in 2022.

- Medicare Part D spending for beneficiaries in hospice totaled \$623 million in 2022, a 26 percent increase from 2019. Beneficiaries paid at least \$68 million in cost sharing for Part D drugs while in hospice in 2022. According to CMS, there has been an increase in Part D–paid prescriptions for maintenance drugs furnished to hospice enrollees. Examples of maintenance drugs include those for high blood pressure, heart disease, asthma, and diabetes.

The issue of nonhospice service use and spending for beneficiaries enrolled in hospice is of interest for several reasons. If some services intended to be covered under the hospice benefit are furnished outside of hospice, the Medicare program is paying twice for those services. Beneficiaries' out-of-pocket costs may also increase because nonhospice services generally involve cost sharing while hospice services do not. In addition, the fragmented coverage of related and unrelated services may be confusing to beneficiaries, their families, hospices, other providers, pharmacies, and Part D plans.

To better understand what factors contribute to service use and spending on nonhospice services for hospice enrollees, Commission staff and a contractor conducted interviews with clinical and administrative personnel from 12 hospice providers in 2022 and 2023. The providers we interviewed varied by ownership type, size, and location (including whether the provider served rural or urban areas or both).

Hospices' determinations of services that are related or unrelated

We asked hospice representatives about how they determined whether services are related to the beneficiary's terminal condition and related conditions (hereafter referred to as "related"). Most respondents described a similar general approach: considering any conditions that contribute to the terminal prognosis as related, rather than basing it on a single diagnosis. Some providers indicated that some determinations are more difficult to make (e.g., long-term stable chronic conditions or dialysis).

Providers varied in their interpretation of "related" when discussing certain specific services. For example, interviewees varied in how they classified diabetes medicines, ranging from a few providers reporting that they are usually unrelated to one provider indicating that they are almost always related.²⁹ Treatments for injuries from patients' falls are another example of varied interpretations. One hospice viewed treatments for falls as unrelated, though stated that it would depend on the circumstances. In contrast, another said that treatments for falls might be considered related because the fall occurred due to an underlying condition or medication or because such treatments helped alleviate patient discomfort.

We asked hospices if there were any services that were typically unrelated. Several hospices identified treatment for ocular issues (e.g., glaucoma, cataracts, and macular degeneration) and thyroid disease as generally unrelated. At least one interviewee mentioned a number of other conditions as typically unrelated (e.g., osteoporosis, gastroesophageal reflux disease, autoimmune disorders, allergies, vitamin deficiencies, longstanding depression and other mental illnesses, podiatry conditions, dental disease, high cholesterol, dermatology, and rheumatology).³⁰

Some interviewees reported that some hospice or nonhospice providers may inappropriately classify some services as unrelated. For example, some hospice providers indicated that they broadly categorize services as related and take financial responsibility for those services, but they expressed the view that not all hospice providers take this approach. A few respondents expressed concern about independent wound care companies that specifically market services as unrelated in situations where the hospice views the services as related. In such cases, wound care companies may seek to classify their services as unrelated so they can bill Medicare FFS, while Medicare would be double-paying for these services if they are actually related.

Hospices' efforts to educate patients and families

All respondents noted the importance of educating patients and families about the hospice benefit. That process begins at the initial meeting, where the hospice staff discuss the services included in the hospice plan

of care and explain that the hospice is responsible for furnishing the patient's care and the patient or family should call the hospice before calling 911 or seeking outside services. To facilitate this education, hospices reported using a variety of tools (e.g., handbooks, stickers, posters, or a large card to go on the refrigerator) to ensure that the hospice's phone number is immediately accessible to the patient or caregiver. Hospices also indicated that their nurses continue to educate patients, families, and caregivers (including training and supporting caregivers on what to do in an emergency) during in-person visits throughout the hospice episode. Hospices mentioned that these efforts were not always successful; they may sometimes find out that a patient went to the hospital or an outside doctor or filled a nonhospice prescription only after the fact—when hospice staff next visit the patient's home, or in some cases not at all.

When hospices are developing the patient's hospice plan of care, an issue that sometimes arises concerns services that are related to the terminal condition but not medically necessary. Hospices are required to cover all services that are reasonable and necessary for palliation of the terminal condition and related conditions. If the hospice determines a service is not reasonable and necessary, the beneficiary would be financially liable for the service if they choose to receive it (instead of the hospice, FFS Medicare, or a Part D plan being responsible). Hospices typically talk with the patient and family about any related medicines or treatments that they believe are no longer beneficial and should be discontinued.³¹ Hospices reported that patients and families are sometimes reluctant to discontinue treatments that are no longer beneficial. In such situations, some hospice respondents said they might include the treatment in the hospice care plan while others said that they would explain that the patient would be liable for the treatment's cost if they chose to receive it. One hospice provider noted that, even if families are informed that the patient would be liable for the cost of certain medicines, some of these prescriptions may wind up being filled under Part D.

Efforts to work with providers and pharmacies to facilitate correct billing

CMS has mechanisms to permit nonhospice providers and pharmacies to bill for unrelated services for

hospice enrollees. For Part A or Part B services, the nonhospice provider can bill FFS Medicare by placing a modifier on the claim to indicate that the service is unrelated and receive payment. If a Part D drug is unrelated, the pharmacy can bill Part D. There are four classes of medicines that CMS has said are usually related to hospice care (analgesics, antiemetics, anxiolytics, and laxatives) and for which CMS has encouraged Part D plans to implement prior authorization edits. CMS does not expect Part D plans to place special prior authorization edits on drugs for hospice patients outside of those four classes (Centers for Medicare & Medicaid Services 2023g). Hospices do not generally receive information from CMS on what services their individual patients receive outside of hospice that are paid for by Part D or FFS, unless there is an audit.

When services are related, the provider or pharmacy is expected to bill the hospice instead of FFS Medicare or Part D. Hospices reported various efforts to facilitate correct billing when patients receive services outside of hospice. Some reported putting a sleeve on patients' Medicare cards or giving patients a separate wallet card to be presented at the emergency department or other medical care locations to inform the health care provider that the patient is in hospice. Several respondents said their hospice sends information to relevant medical providers or pharmacies to inform them of patients who have been admitted to hospice and how to bill. However, some respondents reported that these efforts had mixed success because documents may get lost or may not reach the appropriate staff.

One issue that arises when a hospice patient seeks care at a hospital is whether the hospice has a contract with the hospital. A few hospices stated that if they do not have a contract with the hospital, they discharge the patient from hospice, in which case FFS Medicare pays the cost of the hospital care. At least one hospice indicated they did not contract with hospitals. In contrast, other hospices reported strong relationships with hospitals.

Interviewees indicated that billing issues can occur for hospice enrollees receiving pharmacy services. Sometimes a hospice identifies a billing error, for example, by finding a newly filled outside prescription

in a beneficiary's home. One respondent said that outreach by a nurse to the pharmacy makes it "fairly easy" to resolve the issue by asking the pharmacy to "unbill" the Part D plan and bill the hospice. However, another respondent noted that they have sometimes encountered issues getting a pharmacy to unbill Part D if the pharmacy has already been paid. Another hospice respondent noted that Part D plans conduct routine postpayment audits, which may lead to batch notices indicating patients for whom the hospice owes money. The hospice will review these cases to determine the appropriate actions. One challenge is that audits may lag one to two years after the drugs were dispensed (often long after the patient has died).

Current policy approaches aimed at addressing inappropriate billing

The Program for Evaluating Payment Patterns for Electronic Report (PEPPER) provides hospices with statistics on their performance in areas vulnerable to improper payments, including the number of Part D claims paid for their patients compared with national, state, and local benchmarks (Centers for Medicare & Medicaid Services 2023d).³² Respondents said that PEPPER statistics were helpful to gauge their performance relative to peers, but the data do not include information that might help identify the source of issues (such as the types of drugs paid by Part D).

Beginning in FY 2021, CMS requires that, upon request, hospices furnish patients and families with an addendum (referred to as the Patient Notification of Hospice Non-Covered Items, Services, and Drugs) that lists any items, drugs, or services that the hospice deems unrelated and consequently not covered by the hospice. CMS implemented this addendum to enhance coverage transparency in response to anecdotal reports that some hospices were inappropriately deeming services unrelated (Centers for Medicare & Medicaid Services 2019). Most interviewees viewed the addendum as having little impact, stating that patients or families rarely request it. Some interviewees also noted a gap in the addendum, pointing out that it does not include services that the hospice considers related but not medically necessary, information that might be of interest to patients and families since the beneficiary may bear financial liability for such services if they choose to receive them.

Policies to address nonhospice spending for beneficiaries in hospice

The interviews suggest that several factors likely contribute to service use and spending on nonhospice services for hospice beneficiaries. Policy on what services are related is not specific, and we heard differing interpretations across hospices for certain types of services. Hospices also indicated that their efforts to educate beneficiaries and families about the hospice benefit are not always successful. They also noted challenges in coordinating with other providers and gaps in information flow. For example, in some situations, a provider may not realize that a beneficiary is enrolled in hospice or a hospice may not know that a beneficiary sought care outside the benefit. Given the variety of factors contributing to nonhospice service use and spending, a range of policies could be explored to address these issues, including administrative, payment, or penalty approaches. Each approach would raise complicated issues and require further exploration.

Administrative approaches could be considered to clarify financial responsibility for services and promote information flow. For example, the definition of "related services" could be made more concrete. As noted previously, CMS has identified four categories of Part D drugs that are usually related. CMS could consider this approach for additional types of Part D drugs or other services. Administrative efforts could be considered to improve information flow across providers, pharmacies, and Part D plans. Hospice interviewees articulated a desire for real-time information to alert nonhospice providers of patients' hospice status and alert hospices when one of their patients receives care outside of the benefit. For example, CMS has a pilot project underway that seeks to more quickly inform a Part D plan that their enrollee has elected hospice (National Council for Prescription Drug Programs 2022).

A payment approach could be explored that would expand the bundle of services for which hospices are responsible to include services unrelated to the terminal condition, with an increase to the hospice base payment rates to account for the additional services. Hospices we interviewed had mixed reactions to this approach. Some were concerned about the

effect on small providers who might not have the patient volume to absorb high-cost hospital stays or other services. Another respondent expressed concern that some hospices might stint on care. Other respondents supported the idea of including unrelated services in the bundle and thought it would simplify things for providers and beneficiaries. Some respondents thought it would be simpler to include Part D drugs in the hospice bundle than unrelated Part A and Part B services, partly because hospices already provide many drugs to beneficiaries. Including unrelated Part A and Part B services raised complexities for some providers, particularly with respect to

hospital care that can be high cost and may require hospices to have more extensive relationships with hospitals than some currently do.

Another policy approach that could be considered is a payment penalty (Medicare Payment Advisory Commission 2022). Hospice providers with nonhospice spending above a specified threshold could be subject to a penalty that would reduce their hospice payments by a certain amount. A penalty policy would place some financial risk on providers, but less risk than a bundled policy. Nonetheless, a penalty might help counter financial incentives for some providers to shift services from hospice to FFS Medicare or a Part D plan. ■

Endnotes

- 1 When a beneficiary first elects hospice, if they do not have an attending physician, the certification can be done by the hospice physician alone. For subsequent benefit periods, only the hospice physician is required to certify the patient's eligibility (even if the patient has a separate attending physician).
- 2 For a more complete description of the hospice payment system, see https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_hospice_FINAL_SEC.pdf.
- 3 The Congress also established a second cap, which limits the share of inpatient care days that a hospice can provide to 20 percent of its total Medicare patient care days. This cap is rarely exceeded; any inpatient days provided in excess of the cap are paid at the routine hospice care payment rate.
- 4 Throughout this chapter, we use the term “FFS Medicare” or “traditional Medicare” as equivalents for the CMS term “Original Medicare.” Collectively, we distinguish the payment model represented by these terms from other models such as Medicare Advantage or advanced alternative payment models that may use FFS mechanisms but are designed to create different financial incentives.
- 5 When an MA enrollee elects hospice, the beneficiary remains in the MA plan for Part D drugs and extra benefits. If an MA beneficiary is discharged alive from hospice, any Part A or Part B services that the beneficiary receives following the live discharge through the end of that calendar month will be paid by FFS. At the beginning of the next month, responsibility for all Part A, Part B, and Part D services for the beneficiary reverts to the MA plan.
- 6 Several studies provide examples of the recent mixed findings in the literature on hospice's effect on Medicare spending. A recent working paper found that for-profit hospice enrollment led to large savings for some beneficiaries with dementia (Gruber et al. 2023). A recent industry-sponsored study reported that hospice saved 3 percent in the last year of life, with savings for long stays across all diagnoses (NORC at the University of Chicago 2023). However, several other studies that looked at spending in the last 6 or 12 months of life had more mixed results, finding that hospice was associated with higher Medicare spending or no difference in Medicare spending for beneficiaries with dementia (Aldridge et al. 2023, Zuckerman et al. 2016), lower Medicare spending for beneficiaries with cancer (Hung et al. 2020, Zuckerman et al. 2016), higher spending for beneficiaries with noncancer diagnoses and stays exceeding 30 days (Hung et al. 2020), and higher spending for beneficiaries residing in nursing facilities (Gozalo et al. 2015).
- 7 We determine provider ownership status, hospice type, and rural and urban location based on Medicare cost report data, and if those data are unavailable, we rely on the Provider of Services file. However, CMS paused updates to the Provider of Services file as of October 2022, due to the agency's migration of Provider of Services data for hospices to a cloud-based environment.
- 8 Type of hospice reflects the type of cost report filed (a hospice files a freestanding hospice cost report or the hospice is included in the cost report of a hospital, home health agency, or skilled nursing facility). The type of cost report does not necessarily reflect where patients receive care. For example, all hospice types may serve some nursing facility patients.
- 9 From 2018 to 2022, California on average gained about 185 hospices each year, and Texas gained 57 hospices on average each year.
- 10 The California auditor's report stated: “The fraud indicators we found particularly in Los Angeles County include the following: A rapid increase in the number of hospice agencies with no clear correlation to increased need. Excessive geographic clustering of hospices with sometimes dozens of separately licensed agencies located in the same building. Unusually long durations of hospice services provided to individual patients. Abnormally high rates of still-living patients discharged from hospice care. Hospice agencies using possibly stolen identities of medical personnel” (Tilden 2022).
- 11 This comparison of hospice use across years is based on paid Medicare claims. These data slightly understate hospice use in 2021 and 2022 because they exclude about 9,630 beneficiaries in 2021 and 19,065 beneficiaries in 2022 who received hospice care that was paid for by MA plans participating in the hospice VBID demonstration.
- 12 In 2022, hospice lifetime length of stay among Medicare decedents who received hospice services was 96.3 days for FFS beneficiaries and 94.1 days for MA beneficiaries. This difference in length of stay was driven by the longest stays. Length of stay at the 90th percentile was 279 days for FFS beneficiaries and 270 days for MA beneficiaries, while length of stay was similar for shorter stays (at the 10th, 25th 50th, and 75th percentiles) among these two populations.

- 13 In 2022, hospice patients in assisted living had markedly longer stays compared with those in other settings, even for the same diagnosis, which warrants further monitoring and investigation in CMS's medical review efforts.
- 14 The difference in length of stay for hospice decedents with neurological conditions treated by for-profit and nonprofit hospices is particularly pronounced for patients with the longest stays. In 2022, the 75th percentile length of stay for hospice decedents with dementia who were treated by for-profit hospices was 221 days compared with 137 days at nonprofit hospices; the 90th percentile length of stay was 536 days at for-profit hospices and 379 days at nonprofit hospices.
- 15 The share of hospices exceeding the cap is based on the Commission's estimates. While our estimates are intended to approximate CMS claims processing contractors' calculations, differences in available data, methodology, and the timing of the calculations can lead to different estimates. Our estimates assume all hospices use the proportional methodology and rely on claims data through 15 months after the end of each cap year. The claims processing contractors may reopen the hospice cap calculation for up to three years; the reopening process and timing may vary across contractors.
- 16 If we approximate marginal cost as total Medicare costs minus fixed building and equipment costs, then marginal profit can be calculated as follows: $\text{Marginal profit} = (\text{payments for Medicare services} - (\text{total Medicare costs} - \text{fixed building and equipment costs})) / \text{Medicare payments}$. This comparison is a lower bound on the marginal profit because we do not consider any potential labor costs that are fixed.
- 17 Recently enacted legislation has increased the penalty for hospices that do not report quality data. Beginning in fiscal year 2024, nonreporters face a 4 percent payment penalty, per the Consolidated Appropriations Act, 2021. In the fiscal year 2024 hospice final rule, CMS estimated that the increase in the penalty from 2 percent to 4 percent in 2024 would reduce hospice spending by about \$41 million (Centers for Medicare & Medicaid Services 2023f).
- 18 Hospices must have at least 75 CAHPS survey responses in a reporting period to have a published star rating.
- 19 For both of the new claims-based quality measures, the public reporting program uses an eight-quarter reference period, with the aim of increasing the sample size at the provider level to enable CMS to report data on as many providers as possible.
- 20 Estimates are based on providers that care for at least 20 patients who died during the reporting period and met criteria for inclusion in the measure. In the prior reporting period covering April 2019 through September 2021 (excluding the first half of 2020) and using these same inclusion criteria, scores ranged from 39 percent at the 25th percentile to 70 percent at the 75th percentile.
- 21 Our analysis focuses on the broadest measure of live discharge, including live discharges initiated by the hospice (because the beneficiary is no longer terminally ill or because the beneficiary is discharged for cause) and live discharges initiated by the beneficiary (because the beneficiary revokes hospice enrollment, transfers hospice providers, or moves out of the area). Some stakeholders argue that live discharges initiated by the beneficiary are outside the hospice's control and should not be included in a live-discharge measure. Because beneficiaries choose to revoke hospice for a variety of reasons, which in some cases are related to the hospice provider's business practices or quality of care, we include revocations in our analysis. A CMS contractor found that rates of live discharge—due to beneficiary revocations and to beneficiaries no longer being terminally ill—increase as hospice providers approach or surpass the aggregate cap (Plotzke et al. 2015). The contractor's report suggested that this pattern could reflect hospice-encouraged revocations or inappropriate live discharges and thus merit further investigation.
- 22 The term "curative care" is often used interchangeably with "conventional care" to describe treatments intended to be disease modifying.
- 23 Eligibility for the MCCM was limited to beneficiaries with a life expectancy of 6 months or less who had certain diagnoses, utilization history, and location of care (diagnoses of cancer, congestive heart failure, chronic obstructive pulmonary disease, or HIV/AIDS; at least 1 hospital encounter and at least 3 office visits in the last 12 months; no election of hospice in the last 30 days; lived in a traditional home continuously for the last 30 days). The report stated that "Although our evaluation results are promising, they might not generalize from MCCM to other hospice providers or beneficiaries. . . . A small percentage of all hospices nationwide volunteered to participate in MCCM, with only five hospices enrolling about half the beneficiaries. Further, the beneficiaries enrolled in MCCM represent a small percentage of the beneficiaries who, according to Medicare claims and enrollment data, lived near a participating hospice during model implementation and satisfied the model eligibility criteria but were neither referred to the model nor enrolled. The enrollees were also notably different from nonparticipating beneficiaries before matching, more often having cancer and high rates of Medicare expenditures

- and service use before enrollment. Voluntary selection into the model by hospices and beneficiaries limits the generalizability of the evaluation findings to a broader population of Medicare beneficiaries with less than six months to live” (Kranker et al. 2023).
- 24 Based on MedPAC analysis of CMS’s Accountable Care Organization Realizing Equality, Access, and Community Health (ACO REACH) Performance Year 2023 Participant Overview data (available at: <https://www.cms.gov/priorities/innovation/media/document/aco-reach-py23-participants>).
 - 25 The aggregate FFS Medicare margin is calculated as follows: $((\text{sum of total Medicare payments to all providers}) - (\text{sum of total Medicare costs of all providers}) / (\text{sum of total Medicare payments to all providers}))$. Estimates of total Medicare costs come from providers’ cost reports. Estimates of Medicare payments and cap overpayments are based on Medicare claims data. Although we refer to this margin as the FFS Medicare margin, it incorporates hospices’ payments and costs for MA beneficiaries whose hospice care is paid for by FFS Medicare. FFS Medicare pays for hospice care for most MA enrollees, with the exception of those who are in MA plans that are participating in the VBIID hospice component.
 - 26 Hospices that exceed the Medicare aggregate cap are required to repay the excess to Medicare. We do not consider the overpayments as part of hospice revenues in our margin calculation. We also exclude from our calculation the nonreimbursable bereavement and volunteer costs, which are reported in nonreimbursable cost centers on the Medicare cost report. Statute requires that hospices offer bereavement services to family members of deceased Medicare patients (Section 1861(dd)(2)(A)(i) of the Social Security Act); however, the statute prohibits Medicare payment for these services (Section 1814(i)(1)(A)). Including nonreimbursable bereavement and volunteer costs in our margin calculation would reduce the aggregate Medicare margin for 2021 by at most 1.3 percentage points and 0.3 percentage points, respectively.
 - 27 Because federal relief funds were intended to help cover lost revenue and payroll costs—including lost revenue from Medicare patients and the cost of staff who help treat these patients—this alternate margin estimate includes a portion of these relief funds (based on the amount of relief funds received by each provider in cost report year 2021 multiplied by the provider’s 2019 ratio of hospice days for Medicare patients to hospice days for all patients). Using this method, the alternate margin calculation allocates about 90 percent of federal relief funds that freestanding hospices reported on their 2021 cost reports toward hospices’ care of Medicare beneficiaries in 2020.
 - 28 Estimates of nonhospice spending during a hospice election exclude the first day of the hospice episode and the day of a live discharge (Centers for Medicare & Medicaid Services 2023g).
 - 29 A few other hospices said they viewed diabetes medicines as related, unless the patient’s terminal illness was completely unrelated (citing cancer or Parkinson’s disease as examples where it may be unrelated).
 - 30 Because interviewees were asked an open-ended question about what services they typically consider unrelated, it is uncertain whether interviewees who did not mention these items would find them typically related or unrelated.
 - 31 One hospice gave as an example a cholesterol medication (i.e., a statin) that a patient may have taken for many years but no longer benefits from due to the stage of their disease.
 - 32 Beginning fiscal year 2022, CMS added two measures of Part B claims per hospice enrollee, one for beneficiaries at home and one for beneficiaries residing in an assisted living facility, skilled nursing facility, or nursing facility. The interviews focused on the Part D PEPPER data.

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CHAPTER 10

Ambulatory surgical center services: Status report

R E C O M M E N D A T I O N

- 10** *The Commission reiterates its March 2022 recommendation that the Secretary require ambulatory surgical centers to report cost data.*

Ambulatory surgical center services: Status report

Chapter summary

Ambulatory surgical centers (ASCs) provide outpatient surgical procedures to patients who do not require an overnight stay. In 2022, about 6,100 ASCs treated 3.3 million fee-for-service (FFS) Medicare beneficiaries. FFS Medicare program spending and beneficiary cost sharing on ASC services was about \$6.1 billion. The volume of ASC surgical procedures per FFS beneficiary rose by 2.8 percent in 2022. Numerous factors 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. For patients, ASCs can offer more convenient locations, shorter waiting times, lower cost sharing, and easier scheduling relative to hospital outpatient departments. ASCs also offer physicians specialized staff and more control over their work environment.

The vast majority of ASCs are for profit and located in urban areas. The concentration of ASCs varies widely across states, ranging from 36 ASCs per 100,000 Part B beneficiaries in Maryland to 4 or fewer ASCs per 100,000 Part B beneficiaries in Kentucky, West Virginia, and Vermont. ASCs are more concentrated in areas with low social risk factors than in areas with high social risk factors. About 68 percent of ASCs that billed Medicare in 2022 specialized in a single clinical area, of which

In this chapter

- Supply of ASCs and volume of services continue to grow
- The ASC Quality Reporting Program does not have enough measures for meaningful analysis
- Aggregate FFS Medicare payments rose substantially in 2022, continuing a trend
- Ambulatory surgical centers should submit cost data

gastroenterology and ophthalmology were the most common. The remainder were multispecialty facilities, providing services in more than one clinical specialty (often pain management and orthopedic services or gastroenterology and ophthalmology). From 2017 to 2022, the specialties that grew most rapidly were pain management and cardiology.

The most common ASC procedure in 2022 was extracapsular cataract removal with intraocular lens insertion, accounting for almost 19 percent of volume and 20 percent of spending. The 20 most common surgical procedures made up about 69 percent of ASCs' FFS Medicare volume in 2022, though questions have been raised about the value of some of these procedures.

Medicare spending per FFS beneficiary on ASC services rose at an average annual rate of 8.2 percent from 2017 through 2021 and by 10.0 percent in 2022. Because FFS Medicare payment rates are lower in ASCs than in hospital outpatient departments (HOPDs) for all services that are covered in both settings, the cost to Medicare (and the taxpayers who fund the program) is lower if a surgical procedure is provided in an ASC rather than an HOPD. The beneficiary's cost-sharing obligation is lower as well. However, it is possible that the continuing shift of services from HOPDs to ASCs could increase the overall volume of surgical procedures, which would partially offset the reduction in Medicare spending and beneficiaries' cost sharing. Greater provision of services is especially likely if FFS Medicare's payments for ASC services are higher than the costs of providing them. But policymakers know little about the costs that 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. As a result, the Commission has determined that it is not possible to properly evaluate the level of Medicare's payments relative to costs for ASCs. In addition, available data do not permit a meaningful assessment of the quality of care provided in ASCs.

The Commission contends that ASCs could feasibly provide cost data, and we reiterate our long-standing recommendation that the Congress require ASCs to submit cost data. In addition, we encourage CMS to synchronize ASC Quality Reporting Program measures with measures included in the Hospital Outpatient Quality Reporting Program to facilitate comparisons between ASCs and HOPDs. ■

Background

An ambulatory surgical center (ASC) is a facility that primarily provides outpatient surgical procedures to patients who do not require an overnight stay. In addition to ASCs, providers perform outpatient surgical procedures in hospital outpatient departments (HOPDs) and, in some cases, physicians' offices.

For procedures performed in an ASC, Medicare makes two payments: one to the facility through the ASC payment system and the other to the physician for their professional services through the payment system for physicians and other health professionals, known as the physician fee schedule (PFS). For the facility portion, Medicare pays ASCs for a bundle of services and items—such as nursing, recovery care, anesthetics, and supplies—through a system that is linked primarily to the outpatient prospective payment system (OPPS), which Medicare uses to set payment rates for most services provided in HOPDs. The ASC payment system is also partly linked to the PFS. For services that were first covered under the ASC payment system in 2008 or later and for which volume is greater in freestanding physician offices than in ASCs, the ASC payment rate is set to the lesser of the standard ASC payment rate or the nonfacility practice expense from the Medicare PFS.

For most covered procedures, payment rates in the ASC payment system are the product of a relative weight and a conversion factor. The ASC relative weight for a procedure, which indicates the procedure's resource intensity relative to other procedures, is based on its relative weight under the OPPS. The conversion factor transforms the relative weight for a service into a payment rate. For 2024, CMS has set the ASC conversion factor at \$53.51. From 2010 through 2018, CMS updated the ASC conversion factor each year based on the consumer price index for all urban consumers. In a change of regulatory policy, from 2019 through 2025, CMS has instituted a policy of updating the ASC conversion factor using the hospital market basket index. Under this change, the annual updates to the ASC conversion factor have aligned with the updates to the OPPS conversion factor.¹

The ASC payment system in fee-for-service (FFS) Medicare covers over 3,600 surgical procedures, but in

2022 the provision of ASC services was concentrated in a relatively small number of procedures. Of the surgical procedures provided to Medicare FFS beneficiaries in ASCs, 75 percent of the volume was concentrated in 31 procedures. A potential factor limiting the breadth of services provided by ASCs is the inpatient-only (IPO) list maintained by CMS, which is a list of services (including surgical procedures) that cannot be provided to Medicare beneficiaries anywhere but the hospital inpatient setting. The extent to which eliminating the IPO list would expand the services that ASCs actually provide is not clear.² CMS has steadily removed surgical procedures from the IPO list, but ASCs generally have provided low quantities of these procedures. Important exceptions include knee arthroplasty and hip arthroplasty, which have increased in ASC volume since CMS removed them from the IPO list and made them covered services under the ASC payment system.

Another factor that may limit the breadth of ASC services is that over 350 surgical procedures that are not on the IPO list are covered under the OPPS but not the ASC payment system. Because these procedures are provided in another ambulatory setting (HOPDs), coverage of these procedures under the ASC system could result in nontrivial provision in ASCs. However, most of these services are low volume in HOPDs, so it is likely they would be low volume in ASCs.

Supply of ASCs and volume of services continue to grow

The number of ASC facilities increased in 2022, as did the volume of services provided to Medicare FFS beneficiaries in ASCs. Access to ASCs may be preferable to patients and physicians compared with HOPDs, the provider type most similar to ASCs. For patients, ASCs can offer more convenient locations, shorter waiting times, lower cost sharing, and easier scheduling relative to HOPDs. ASCs provide physicians with specialized staff and more control over their work environment. However, these same qualities could lead to overuse of some surgical procedures.

The number of ASCs is increasing

We usually use data from the last full calendar year reported in the Provider of Services (POS) file to estimate the number of ASCs that serve Medicare

**TABLE
10-1****Number of ASCs and operating rooms grew, 2017–2022**

				Average annual change
	2017	2021	1st quarter 2022	2017–2021
Total number of ASCs	5,581	6,075	6,088	2.1%
New	211	254	34	N/A
Closed or merged	126	95	21	N/A
Total number of ORs	17,137	18,689	18,739	2.2
New	492	755	104	N/A
Closed or merged	339	222	54	N/A

Note: ASC (ambulatory surgical center), N/A (not applicable), OR (operating room). We display the average annual percentage change for the “new” and “closed or merged” categories as “N/A” because they are outside the purpose of this table, which is to show the growth in the number of ASCs and ORs.

Source: MedPAC analysis of Provider of Services file from CMS, 2023.

beneficiaries. Ordinarily, our analysis for this report would have used a full year of data from 2022. However, CMS is in the process of changing the system of data processing for the POS, which has delayed updating the ASC data. Consequently, the most recent ASC data available on the POS are from the first quarter of 2022. We expect that the number of ASCs we report would be greater if a full year of ASC data for 2022 were included in the POS.

From 2021 through the first quarter of 2022, the number of Medicare-certified ASCs rose 0.2 percent to 6,088 ASCs, and from 2017 through 2021, the average annual growth rate was 2.1 percent (Table 10-1). Through the first quarter of 2022, 34 new ASCs opened while 21 ASCs closed or merged with other facilities, for a net increase of 13 facilities. Data from the ASC Association website indicates that there are currently 6,223 Medicare-certified ASCs (Ambulatory Surgery Center Association 2023a).³

Because the central purpose of ASCs is to provide surgical procedures, the number of operating rooms (ORs) is an indicator of supply in this sector. After the first quarter of 2022, there were 18,739 ORs in ASCs, or an average of 3.1 per facility. From 2017 to 2021, the total

number of ASC ORs increased 2.2 percent per year, a slightly higher rate than the increase in the number of ASCs over the same period (2.1 percent per year). From 2021 to the first quarter of 2022, the number of ORs in ASCs increased by 0.3 percent, a higher rate than the growth in the number of ASCs.

Numerous factors have likely influenced this long-term growth in the number of ASCs and ORs:

- Changes in clinical practice and health care technology have expanded the provision of surgical procedures in ambulatory settings. This trend could continue as momentum grows for performing knee and hip arthroplasty (knee and hip replacement) in ambulatory settings.⁴
- ASCs can offer patients greater convenience than HOPDs, such as patients having less “nonoperative” time (the total time a patient spends in an operating room, minus the procedure time) in ASCs (Imran et al. 2019).
- For most procedures covered under the ASC payment system, beneficiaries’ coinsurance is lower in ASCs than in HOPDs.⁵

- Physicians have greater autonomy in ASCs than in HOPDs, which enables them to design customized surgical environments and hire specialized staff. These features of ASCs allow physicians to perform more procedures in ASCs than in HOPDs in the same amount of time, earning more revenue from professional fees.
- Increased interest across the health care industry in value-based care and the provision of care in lower-cost settings has boosted interest in strategic investment of hospital systems, insurers, and private equity firms in ASCs (Barclays 2018, Japsen 2018).

Most ASCs are for profit, and geographic distribution is uneven

Consistent with previous years, the vast majority of ASCs in 2022 were for profit (95.3 percent) (Table 10-2). Because most ASCs are for-profit entities, they have an incentive to provide profitable services. As the number of ASCs grows, if ASCs act on this incentive, there is the potential for ASCs to account for an increasingly larger share of the profitable ambulatory procedures, leaving the less profitable ambulatory procedures to other settings, primarily HOPDs. However, because ASCs do not submit cost report data, we cannot identify which ambulatory procedures are profitable, so we cannot determine the share of the profitable services that are provided in ASCs versus HOPDs.

ASCs are also disproportionately located in urban areas (93.5 percent) (Table 10-2). Stakeholders contend that rural areas typically lack the surgical specialists needed for ASCs, and the lower population density in rural areas makes them less attractive locations for ASCs. In addition to low ASC penetration in rural areas, ASC penetration in 2022 was also low in areas with high social risk factors, which we measured using the area deprivation index (based on an area's income, unemployment, education level, and housing quality) (Table 10-3, p. 302). Even though some areas have low ASC penetration, beneficiaries who do not live near an ASC can usually obtain ambulatory surgical services in HOPDs and, in some cases, physicians' offices. Beneficiaries who live in rural areas may travel to urban areas to receive care at ASCs.

We found that rural beneficiaries—defined as those who live outside metropolitan statistical areas (MSAs)—

**TABLE
10-2**

Most ASCs are for profit and urban

Type of ASC	ASCs that were:		
	Open in 2017	Open in 2022	New in 2022
For profit	95.2%	95.3%	91.2%
Nonprofit	3.6	3.7	8.8
Government	1.2	1.0	0.0
Urban	93.2	93.5	100
Rural	6.8	6.5	0.0

Note: ASC (ambulatory surgical center). We defined "urban" as being in metropolitan statistical areas (MSAs) and "rural" as being outside MSAs. The results in the third column are from the first quarter of 2022.

Source: MedPAC analysis of CMS Provider of Services file, 2023.

are less likely to receive care in ASCs than are urban beneficiaries, defined as those living in an MSA. In 2022, 8.1 percent of rural beneficiaries received care in an ASC compared with 11.9 percent of urban beneficiaries (data not shown).

The concentration of ASCs varies widely across states. In the first quarter of 2022, Maryland had the most ASCs per Medicare beneficiary (36 ASCs per 100,000 Part B beneficiaries (both fee-for-service and Medicare Advantage)), followed by Georgia, Alaska, and Wyoming (respectively, 22, 18, and 18 ASCs per 100,000 Part B beneficiaries) (Figure 10-1, p. 303).⁶ Kentucky, the District of Columbia, West Virginia, and Vermont had the fewest ASCs per Part B beneficiary (4 or fewer ASCs per 100,000 Part B beneficiaries). Differences in certificate-of-need (CON) laws among states likely has a strong influence on the differences in ASC concentration between states. States that have CON laws tend to have fewer ASCs than states that do not.

According to surveys, most ASCs have partial or complete physician ownership (Ambulatory Surgery Center Association 2021, Ambulatory Surgery Center Association 2017, Leapfrog 2019). Physician owners of ASCs receive additional income through distributions of facility profits according to their ownership

**TABLE
10-3****Number of ASCs per Part B beneficiary decreased as ADI,
a measure of social risk, increased, 2021**

Range of ADI scores	Number of ASC ORs per 100,000 Part B beneficiaries	Number of ASCs per 100,000 Part B beneficiaries
1-10 (lowest)	42.7	15.5
11-20	39.5	13.3
21-30	39.9	12.5
31-40	36.0	11.4
41-50	32.5	10.1
51-60	27.1	9.1
61-70	26.8	8.8
71-80	18.0	5.5
81-90	12.7	4.1
91-100 (highest)	4.6	1.7

Note: ASC (ambulatory surgical center), ADI (Area Deprivation Index), OR (operating room).

Source: MedPAC analysis of Provider of Services file from CMS (2022), ADI measures from University of Wisconsin School of Medicine and Public Health.

interest. Other owners of ASCs include hospitals and corporate entities. One change that is occurring in the structure of ASC ownership is the extent of corporate involvement. In the ASC industry, six corporate entities are considered major holders of ASCs: United Surgical Partners International (USPI), AmSurg, Surgical Care Affiliates, SurgCenter Development, HCA Healthcare, and Surgery Partners Holdings. From 2017 to 2022, the number of ASCs in which these 6 entities have some degree of ownership increased by 20.6 percent from 1,041 to 1,255, and the share of ASCs in which these entities have an ownership stake increased from 18.6 percent to 20.8 percent (Hawkins et al. 2023).

For providers, ASCs offer several advantages over HOPDs because surgeons can customize their surgical environments and hire specialized staff, which allow them to perform more procedures in ASCs than in HOPDs in the same amount of time, earning more revenue from professional fees. ASCs also offer benefits over HOPDs for the Medicare program and beneficiaries. Medicare payment rates are lower in ASCs than in HOPDs for all services that are covered in both settings (for most services, the ASC payment rates

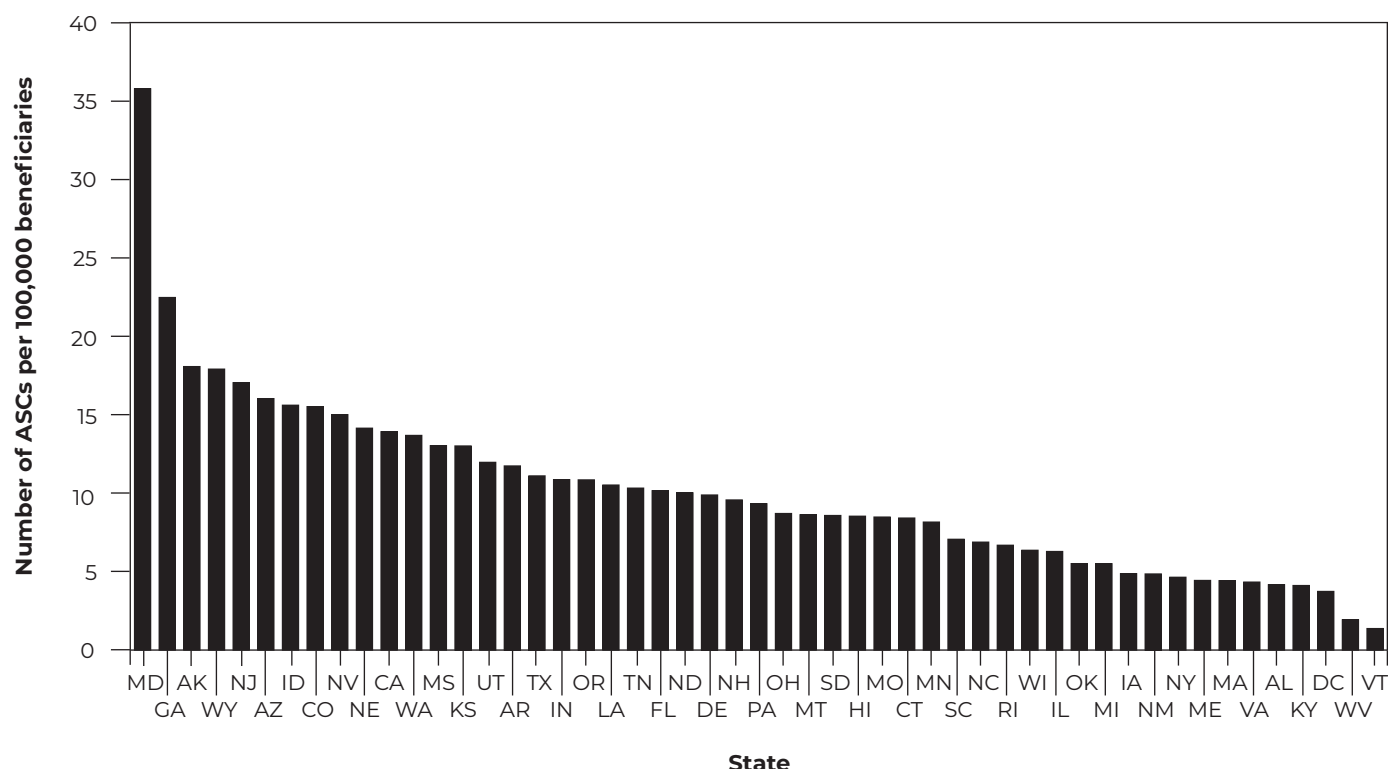
are 46 percent lower than the HOPD payment rates). Therefore, the cost to the Medicare program (as well as taxpayers) is lower if a surgical procedure is provided in an ASC rather than an HOPD, as is the beneficiary's cost-sharing obligation.⁷ However, it is possible that shifting services from HOPDs to ASCs could increase the volume of surgical procedures, which would partially offset the reduction in Medicare spending and beneficiaries' cost sharing. An additional advantage for beneficiaries is that, relative to HOPDs, patients have less nonoperative time in ASCs (Imran et al. 2019).

Because of these advantages of ASCs, it could be beneficial for surgical procedures to migrate from the HOPD setting to ASCs. However, the low concentration of ASCs in many states, in rural areas, and in areas with high social risk limits the extent to which beneficiaries can access care in ASCs.

Research indicates that when an ASC enters a market or a physician who performs surgical procedures in outpatient settings (HOPDs and ASCs) becomes an ASC owner, surgical procedures shift from HOPDs to ASCs and surgical volume in the outpatient settings

**FIGURE
10-1**

Number of ASCs per beneficiary varies widely by state, 2022



Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of CMS Provider of Services file for 2023 and Common Medicare Environment file.

may slightly increase. Courtemanche and Plotzke found that the addition of an ASC to a hospital's market reduces a hospital's outpatient surgical volume by 2 percent to 4 percent if the facilities are within four miles of each other, but they found that this impact on HOPD surgical volume is unlikely to have a serious impact on the financial viability of a typical hospital (Courtemanche and Plotzke 2010). Hollenbeck and colleagues found that the entry of an ASC into a market that previously did not have any ASCs reduced outpatient surgical procedures provided in HOPDs by 7 percent, while in other markets outpatient surgical procedures in HOPDs increased by 7 percent (Hollenbeck et al. 2015). Munnich and colleagues found that most physicians who provide surgical procedures in outpatient settings furnish those services in both

ASCs and HOPDs (Munnich et al. 2021). They also found that two years after physicians obtained an ownership stake in an ASC, the share of the surgical procedures that those physicians provided in ASCs had increased by 22 percent, while the share they provided in HOPDs had decreased by about the same percentage. At the same time, the total number of outpatient surgical procedures they provided to both Medicare and non-Medicare patients increased by 9 percent. However, the total number of outpatient surgical procedures provided to FFS Medicare patients increased by a small amount, though this change was not statistically significant. In summary, research indicates that increased presence of ASCs in a market causes a shift of outpatient procedures from HOPDs to ASCs, and it might or might not increase the total number of outpatient procedures by a small amount.

**TABLE
10-4****Specialization of ASCs billing Medicare in 2017 and 2022**

Type of ASC	2017		2022	
	Number of ASCs	Share of all ASCs	Number of ASCs	Share of all ASCs
Single specialty	2,890	61%	3,763	68%
Ophthalmology	1,022	21	1,134	21
Gastroenterology	1,019	21	1,197	22
Pain management	368	8	753	14
Dermatology	179	4	197	4
Urology	125	3	151	3
Podiatry	88	2	76	1
Orthopedics/musculoskeletal	29	1	71	1
Respiratory	24	1	30	1
Cardiology	18	0	126	2
OB/GYN	11	0	13	0
Neurology	6	0	4	0
Other	1	0	11	0
Multispecialty	1,878	39	1,767	32
More than 2 specialties	1,415	30	1,314	24
Pain management and orthopedics	288	6	240	4
Gastroenterology and ophthalmology	175	4	213	4
Total	4,768	100	5,530	100

Note: ASC (ambulatory surgical center), OB/GYN (obstetrics and gynecology). We define a single-specialty ASC as one with more than 67 percent of its Medicare claims in one clinical specialty. We define a multispecialty ASC as one with less than 67 percent of its Medicare claims in one clinical specialty. ASCs included in this analysis are limited to those in the 50 states and the District of Columbia that had a paid Medicare claim in 2022. Columns containing the shares of all ASCs do not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare carrier file claims, 2022.

Specialization of ASCs largely unchanged; some growth in pain management and cardiology

In 2022, the majority of ASCs that billed Medicare specialized in a single clinical area. Gastroenterology and ophthalmology were the most common, with each comprising about 20 percent of all ASCs that provided services to FFS Medicare beneficiaries. Overall, 68 percent of ASCs were single-specialty facilities and 32 percent were multispecialty facilities, providing services in more than one clinical specialty (Table 10-4).⁸ In 2022, multispecialty

ASCs most commonly focused on two specialties: pain management and orthopedic services or gastroenterology and ophthalmology (combined, 8 percent of all ASCs were multispecialty and focused on one of those two specialties). From 2017 to 2022, the number of ASCs specializing in pain management and cardiology services grew most rapidly.

Volume of services per beneficiary rose in 2022

From 2017 to 2022, the share of Part B FFS beneficiaries who received services in ASCs rose steadily from 10.7

**TABLE
10-5****Volume of ASC services per FFS beneficiary rose in 2022**

	2017	2021	2022	Average annual change	
				2017–2021	2021–2022
Volume of Medicare FFS services (in millions)	6.7	6.3	6.2	–1.7%	–1.2%
Part B FFS beneficiaries (in millions)	33.6	30.8	29.6	–2.1	–3.9
Volume per 1,000 FFS beneficiaries	200.9	204.5	210.2	0.4	2.8

Note: ASC (ambulatory surgical center), FFS (fee-for-service).

Source: MedPAC analysis of physician/supplier standard analytic claims files, 2017–2022.

percent to 11.3 percent (data not shown). Consequently, the volume of services per Part B FFS beneficiary rose on average by 0.4 percent per year from 2017 to 2021 and by 2.8 percent from 2021 to 2022 (Table 10-5).

However, from 2017 to 2022, the number of FFS beneficiaries with Part B coverage declined from 33.6 million to 29.6 million due to a substantial increase in the number of beneficiaries enrolled in Medicare Advantage plans. Because there were fewer Part B FFS beneficiaries, the aggregate number of ASC services provided to those beneficiaries declined by 1.7 percent per year from 2017 to 2021 and by 1.2 percent from 2021 to 2022 (Table 10-5).

Services that have historically contributed the most to overall ASC volume continued to be a large share of the total in 2022. For example, in both 2017 and 2022, extracapsular cataract removal with intraocular lens insertion had the highest volume, accounting for 18.6 percent of the total in 2017 and 18.7 percent in 2022 (Table 10-6, p. 306). Moreover, 18 of the 20 most frequently provided ASC services in 2017 were among the 20 most frequently provided in 2022. These services made up about 70 percent of ASC Medicare volume in 2017 and 69 percent in 2022.

A potential concern about the services most frequently provided in ASCs is the extent to which they are unnecessary or of low value. Seven of the 20 procedures listed in Table 10-6 (p. 306) were pain management services, such as spinal injections

and other pain management services, which some researchers have found to be of low value (Chant et al. 2023, Corp et al. 2021, Ganguli et al. 2021). Moreover, the volume for the procedure that accrued the second-highest Medicare revenue for ASCs in 2022—the insertion or replacement of spinal neurostimulators, which is a pain management procedure—grew by about 4 percent from 2021 to 2022 while being unchanged in HOPDs (data not shown). However, in situations in which these pain management procedures are efficacious, they could be a substitute for opioid use.

The ASC Quality Reporting Program does not have enough measures for meaningful analysis

CMS established the Ambulatory Surgical Center Quality Reporting (ASCQR) Program in 2012 (Centers for Medicare & Medicaid Services 2011). Under this system, ASCs that do not successfully submit quality measurement data have their payment update for that year reduced by 2 percentage points. Actual performance on these quality measures does not affect an ASC's payments; CMS requires ASCs only to submit the data to receive a full update. The Commission has recommended that CMS implement a value-based purchasing program for ASCs that would reward high-performing providers and penalize low-performing providers (Medicare Payment Advisory Commission 2012).

**TABLE
10-6**

For FFS beneficiaries, the 20 most frequently provided ASC services in 2017 were similar to those provided in 2022

Procedure name	2017		2022	
	Percent of volume	Rank	Percent of volume	Rank
Extracapsular cataract removal with IOL insert	18.6%	1	18.7%	1
Upper GI endoscopy, with biopsy: single or multiple	8.0	2	7.6	2
Colonoscopy and biopsy	6.9	3	7.0	4
Colonoscopy with lesion removal, snare technique	5.9	4	7.5	3
Inject transforaminal epidural: lumbar or sacral	4.8	5	4.1	5
After cataract laser surgery	4.2	6	3.8	6
Injection paravertebral facet joint: lumbar or sacral, single level	3.3	7	3.1	7
Injection interlaminar epidural: lumbar or sacral	2.9	8	2.0	9
Colorectal cancer screening, high-risk individual	2.0	9	2.4	8
Diagnostic colonoscopy	1.9	10	1.4	14
Colorectal cancer screening, not high-risk individual	1.8	11	1.5	11
Destroy lumbar/sacral facet joint, single	1.6	12	1.7	10
Injection procedure for sacroiliac joint, anesthesia	1.4	13	1.4	12
Extracapsular cataract removal complex without ECP	1.4	14	1.4	13
Cystourethroscopy	1.2	15	1.2	15
Inject paravertebral facet joint: cervical or thoracic, single level	1.1	16	1.0	16
Injection interlaminar epidural: cervical or thoracic	1.0	18	0.8	18
Upper GI endoscopy diagnostic brush wash	0.9	17	0.7	21
Blepharoplasty upper eyelid	0.9	19	1.0	17
Upper GI endoscopy, guide wire insertion	0.8	20	0.7	22
Total	70.4		69.1	

Note: FFS (fee-for-service), ASC (ambulatory surgical center), IOL (intraocular lens), GI (gastrointestinal), ECP (endoscopic cyclophotocoagulation). In both percentage columns, the numbers do not sum to the total because of rounding.

Source: MedPAC analysis of physician/supplier standard analytic files from 2017 and 2022.

Currently, the ASCQR Program has seven measures for which data are available to evaluate ASC quality, plus a voluntary measure for which too few ASCs report data for the measure to represent a reliable result (ASC-11, improvement in patient's visual function within 90 days following cataract surgery). The currently available quality measures include outcome measures for four important ASC specialties: gastrointestinal, ophthalmology, orthopedics, and urology. Hence, the measures provide some degree of representation of ASC quality. However, in recent years, CMS has

deleted several quality measures and added some new measures. As a result, data are available for only three quality measures in each year over the 2017 through 2022 period, so we cannot make a meaningful assessment of whether ASC quality has been improving. Therefore, we do not have a basis for evaluating the quality of care in ASCs.

CMS will add several measures for which ASCs will submit data from 2025 for ASC payment determination in 2027. However, we believe that CMS should

**TABLE
10-7**

FFS Medicare payments to ASCs rose rapidly, 2017–2022

	2017	2021	2022	Average annual change	
				2017–2021	2021–2022
Medicare payments (billions of dollars)	\$4.6	\$5.7	\$6.1	5.9%	5.8%
Medicare payments per FFS beneficiary	\$136	\$186	\$205	8.2	10.0

Note: FFS (fee-for-service), ASC (ambulatory surgical center). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Payments include spending for new-technology intraocular lenses. We calculated the percentage change columns using unrounded numbers.

Source: MedPAC analysis of data from the Office of the Actuary at CMS and data from physician/supplier standard analytic files.

implement additional quality measures to make the ASCQR Program more effective (see text box on CMS's new measures, pp. 308–309).

Aggregate FFS Medicare payments rose substantially in 2022, continuing a trend

In 2022, ASCs received \$6.1 billion in FFS Medicare payments and beneficiaries' cost sharing (Table 10-7). We estimate that spending by the FFS Medicare program was \$4.9 billion and beneficiary cost sharing was \$1.2 billion (data not shown).

Payments per FFS beneficiary rose at an average annual rate of 8.2 percent from 2017 through 2021 and by 10.0 percent in 2022 (Table 10-7). The increase in 2022 reflects a 1.9 percent increase in the ASC conversion factor, a 2.6 percent increase in per capita volume, a 6.2 percent increase in the average relative weight of ASC services, a 0.2 percent effect from an increase in spending from 2021 to 2022 on separately paid drugs provided to Medicare beneficiaries treated in ASCs, and a 1.0 percent reduction from the reinstatement of the sequester in 2022.

Although the ASC payment system covers over 3,600 surgical procedures, the revenue that ASCs receive for providing services to FFS Medicare beneficiaries is concentrated in a relatively small number of procedures. In 2022, 53 procedures accounted for

75 percent of the Medicare revenue from surgical procedures (data not shown).

Despite the strong growth in FFS Medicare revenue in 2022, there is evidence from one state that ASC operating margins declined, though they remained very high. The Pennsylvania Health Care Cost Containment Council collects total operating costs and total operating revenue from all ASCs in Pennsylvania, which allows for the calculation of operating margins for those ASCs. Historically, the operating margins for the Pennsylvania ASCs have been in the 23 percent to 25 percent range. In 2022, however, the operating costs for the Pennsylvania ASCs rose by a much higher percentage than did operating revenue (15.1 percent versus 10.3 percent, respectively). Consequently, the 2022 operating margins for Pennsylvania ASCs declined to 20.2 percent (Pennsylvania Health Care Cost Containment Council 2023).⁹

Ambulatory surgical centers should submit cost data

The Commission has frequently expressed concern that Medicare does not require ASCs to submit cost data, unlike other types of facilities. Every year from 2010 to 2022, the Commission recommended that the Congress require ASCs to submit cost data (Medicare Payment Advisory Commission 2010); the Commission reiterated this recommendation in 2023. Cost data

CMS will add measures to the ASC Quality Reporting Program, but further improvement is needed

The Ambulatory Surgical Center Quality Reporting (ASCQR) Program currently has data on seven quality measures, plus data on a voluntary measure. CMS will increase the number of quality measures in the ASCQR Program over the next few years so that the program will have 17 measures from which data from 2025 will be used to determine ASC payments in 2027 (Table 10-8).

The Commission asserts that CMS should continue to improve the ASCQR by moving toward outcome measures that apply to all ASCs. Although the ASCQR Program will eventually have four measures that are claims based and measure clinical outcomes (ASC-12, ASC-17, ASC-18, and ASC-19), these measures exclude many services provided at ASCs, such as eye procedures and pain management. To improve the ASCQR Program and to be consistent with MedPAC principles, it is important that the Secretary include more claims-based measures that assess clinical outcomes for the various specialties practiced at ASCs.

In addition, CMS should synchronize ASCQR measures with measures included in the Hospital Outpatient Quality Reporting (OQR) Program to facilitate comparisons between ASCs and hospital outpatient departments (HOPDs). Currently, the ASCQR and the OQR possess four common quality measures that pertain to cataract procedures, colonoscopy procedures, and patient assessments. CMS should consider expanding the overlap of the ASCQR and OQR, relying on either measures of general surgical procedures or measures of specific surgical procedures common to both settings. For example, CMS could consider including OQR measure OP-36 (the number of hospital visits after any outpatient surgery) in the ASCQR.

Because clinical outcomes can be effective measures of quality, CMS should also consider

developing new ASC quality measures covering these three categories:

- **Surgical site infections (SSIs) occurring at ASCs.** In the past, researchers have found that lapses in infection control were common among a sample of ASCs in three states (Schaefer et al. 2010). Although CMS has considered an SSI measure for ASCs in the past (Centers for Medicare & Medicaid Services 2011), it is not currently working to develop one (Centers for Medicare & Medicaid Services 2016). In general, an SSI measure could be used to track infection rates for ASCs and identify quality improvement opportunities for ambulatory surgeries conducted in ASCs. In addition, measuring SSI rates could encourage providers to collaborate and better coordinate care for ambulatory surgery patients.
- **Specialty-specific clinical guidelines to assess whether services provided in ASCs are appropriate.** While the ASCQR Program currently includes an ASC-reported colonoscopy measure that assesses appropriate follow-up care, CMS could consider claims-based measures that assess appropriateness. For example, current American Cancer Society guidelines state that patients over the age of 85 should no longer receive colorectal cancer screening (American Cancer Society 2018).¹⁰ Using these guidelines, a new measure could identify ASCs' share of colonoscopy cases for beneficiaries over age 85. CMS could consider similar measures for whether certain procedures that have become more common in ASCs in recent years are appropriate or for procedures that have drawn concern about appropriate use, such as spinal injections or certain orthopedic procedures (Chant et al. 2023, Ganguli et al. 2021).

(continued next page)

would enable policymakers to establish payment rates that accurately reflect ASC costs. Currently, ASC payment rates are not based on ASC cost data but

instead are largely derived from the OPPS payment rates, which are based on HOPD charges adjusted to cost. To the extent that there is a difference in the cost

CMS will add measures to the ASC Quality Reporting Program, but further improvement is needed (cont.)

**TABLE
10-8**

Quality measures used in the Medicare ASC Quality Reporting Program

Description of quality measure	Required in 2025
ASC-1: Patient burn	Yes
ASC-2: Patient fall	Yes
ASC-3: Wrong site, wrong side, wrong patient, wrong procedure, wrong implant	Yes
ASC-4: All-cause hospital transfer/admission	Yes
ASC-9: Endoscopy/polyp surveillance: Appropriate follow-up interval for normal colonoscopy in average-risk patients	Yes
ASC-11: Cataracts: Improvement in patient's visual function within 90 days following cataract surgery	Voluntary
ASC-12: Facility seven-day risk-standardized hospital visit rate after outpatient colonoscopy	Yes
ASC-13: Normothermia outcome: Percentage of patients under anesthesia who are normothermic within 15 minutes of arrival in the post-anesthesia care unit	Yes
ASC-14: Unplanned anterior vitrectomy: Percentage of cataract surgery patients who have an unplanned removal of the vitreous	Yes
ASC-15: Five patient experience measures from the Outpatient and Ambulatory Surgery Survey Consumer Assessment of Healthcare Providers and Systems (CAHPS®):	Yes
ASC-15a: About facilities and staff	
ASC-15b: Communication about procedure	
ASC-15c: Preparation for discharge and recovery	
ASC-15d: Overall rating of facility	
ASC-15e: Recommendation of facility	
ASC-17: Hospital visits after orthopedic ASC procedures	Yes
ASC-18: Hospital visits after urology ASC procedures	Yes
ASC-19: Hospital visits after general surgery ASC procedures	Yes
ASC-20: COVID-19 vaccination coverage among health care personnel	Yes
ASC-21: Risk-standardized patient-reported outcome-based performance measure following elective primary total hip arthroplasty and/or total knee arthroplasty*	No, required in 2028

Note: ASC (ambulatory surgical center), COVID-19 (coronavirus disease 2019).

*The measure ASC-21 will be voluntary for submission by facilities in 2025, 2026, and 2027. It will become mandatory in 2028.

Source: Final rule for outpatient prospective payment system and ambulatory surgical center payment system, 2023.

- **Claims-based outcome measure for cardiology services.** Stakeholders in the ASC industry expect cardiology to be a growth area for ASCs as providers become more comfortable performing angiograms and angioplasties in ASCs. One projection predicts that by 2025, 33 percent of

cardiology procedures will be provided in ASCs (Van Biesen and Johnson 2023). As cardiology procedures become more common in ASCs, it would be beneficial for CMS to add a claims-based measure to evaluate the quality of those procedures. ■

structures of HOPDs and ASCs, ASC payment rates do not accurately reflect the cost of ASCs. Though some evidence suggests that FFS Medicare's payments for ASC services are higher than ASC costs on average, it is plausible that ASC payment rates are higher than ASC costs for some services and lower than ASC costs for others. This disparity would create incentives for ASCs to focus on providing high-margin services, which would narrow their scope of services relative to what they might offer if the payment rate for each service accurately reflected ASC costs.

Cost data are also needed to determine whether an alternative input price index would be an appropriate proxy for ASC costs. The Commission has previously expressed concern that the price index that CMS used to update the ASC conversion factor from 2010 through 2018 (the consumer price index for all urban consumers) likely does not reflect ASCs' cost structure (Medicare Payment Advisory Commission 2010). Similarly, the price index that CMS has used to update the ASC conversion factor since 2019—the hospital market basket—likely does not reflect ASCs' cost structure.

CMS has shown some interest in collecting cost data to help determine ASC payment rates and has requested comments from stakeholders on whether the Secretary should collect cost data from ASCs. Most recently, the ASC industry has shown openness to submitting cost data, but the industry believes that the only credible reason for ASCs to submit cost data is to develop a market basket. Stakeholders have argued that a single market basket should be applicable to both the ASC and the HOPD settings to ensure that ASC and HOPD payment rates continue to be based on the same relative weights (Ambulatory Surgery Center Association 2023b).

However, it is likely that ASC payment rates and HOPD payment rates should be based on different relative weights. The Commission has asserted that the cost structure of ASCs and HOPDs are different. ASCs tend to be single specialty, for profit, and are not required to comply with the Emergency Medical Treatment and Labor Act (EMTALA), while HOPDs are multispecialty,

typically nonprofit, and many of them must comply with EMTALA. In addition, relative to hospitals, ASCs are more urban, serve a different mix of patients demographically and by payer type, have a much higher share of expenses related to medical supplies and drugs, and have a smaller share of employee compensation costs (Medicare Payment Advisory Commission 2018).

The Commission recognizes that ASCs are small facilities and requiring them to submit cost data would place a burden on them, but we have contended that it is feasible for ASCs to provide cost information. Small businesses like ASCs typically keep records of their costs for filing taxes and other purposes. In addition, all other facility providers submit cost data to CMS, including other small facilities such as rural health clinics, home health agencies, and hospices. Indeed, ASCs in Pennsylvania submit cost and revenue data annually to a state agency that uses the data to estimate margins for those ASCs (Pennsylvania Health Care Cost Containment Council 2023). The requirement that ASCs in Pennsylvania collect and submit cost data does not appear to have adversely affected the growth of ASCs in the state; from 2017 to 2021, the number of Medicare-certified ASCs rose by 10.3 percent in Pennsylvania versus 8.9 percent nationwide.

Until cost data are available, the Commission cannot properly assess the adequacy of Medicare's payments to ASCs. Therefore, we do not offer an update recommendation in this status report. However, we reiterate our 2022 recommendation pertaining to the collection of cost data from ASCs:

The Secretary should require ambulatory surgical centers to report cost data.

The Commission has coupled this recommendation with assertions that cost reporting for ASCs should be more streamlined and less burdensome relative to cost reporting for hospitals. As a template, CMS could use the cost reporting used in Pennsylvania, which provides the data needed to estimate margins for each ASC in the state. ■

Endnotes

- 1 The ASC payment system has several nuances that we have not discussed here. For a discussion of these nuances, see the Commission's *Payment Basics* for ambulatory surgical centers at https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_ASC_FINAL_SEC.pdf.
- 2 The IPO list consists of Healthcare Common Procedure Coding System codes that are typically provided in an inpatient setting and cannot be paid under the ASC payment system or the OPPS. Throughout its rulemaking for the ASC payment system and OPPS, CMS has received comments from stakeholders recommending that CMS eliminate the IPO list, while other stakeholders have recommended that CMS should maintain the list (Centers for Medicare & Medicaid Services 2020).
- 3 We chose not to use data from the ASC Association in Table 10-1 (p. 300) because it does not allow for estimates of historical trends.
- 4 Total knee arthroplasty (Current Procedural Terminology Code 27447) was first covered under the ASC payment system in 2020. About 10,800 of these procedures were provided to FFS Medicare beneficiaries in ASCs in 2020. The number of these procedures nearly tripled, to 29,000, in 2022.
- 5 By statute, coinsurance for a service paid under the OPPS cannot exceed the Medicare Part A inpatient hospital deductible (\$1,632 in 2024). The ASC payment system does not have the same limitation on coinsurance; for a small percentage of billing codes covered under the ASC payment system, beneficiary coinsurance exceeds the inpatient deductible. In these instances, coinsurance for an ASC-delivered procedure exceeds coinsurance for an HOPD-delivered procedure. Nearly all of these services are “device-intensive” procedures, which are procedures in which the cost of a device is at least 30 percent of the ASC payment rate for the procedure. Of these procedures, the most frequently provided in 2022 were insertion of a spinal neurostimulator generator or receiver and total knee arthroplasty.
- 6 The relatively high number of ASCs per Part B beneficiary in Maryland is due, at least in part, to a response to a Medicare waiver under which Maryland hospitals operate under global budgets. Under this system, hospital budgets are capped, and they receive no additional revenue if they exceed their budgets. However, medical care received in ASCs falls outside the budgets, so there is an incentive for hospitals to shift outpatient surgical care to ASCs.
- 7 For some services, the OPPS cost sharing is lower than the ASC cost sharing because under the OPPS the cost sharing for a service cannot exceed the Medicare Part A inpatient hospital deductible (\$1,632 in 2024), while the ASC system does not have a limit on beneficiary cost sharing. These services constituted 1.5 percent of the total ASC volume in 2022.
- 8 We define single-specialty ASCs as having more than 67 percent of their Medicare claims in one clinical specialty. We define multispecialty ASCs as having less than 67 percent of their Medicare claims in one clinical specialty.
- 9 The margins for the ASCs in Pennsylvania are different from the margins for other facilities because the margins for the ASCs do not include taxes or distributions to physician owners.
- 10 The American Cancer Society states that “people who are in good health and with a life expectancy of more than 10 years should continue regular colorectal cancer screening through the age of 75. For people ages 76 through 85, the decision to be screened should be based on a person's preferences, life expectancy, overall health, and prior screening history. People over 85 should no longer get colorectal cancer screening.”

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CHAPTER 11

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

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

Chapter summary

In 2023, Part D paid for outpatient prescription drug coverage on behalf of more than 51 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 nearly 14 million beneficiaries with low income and assets.

In 2022, Part D expenditures totaled \$117.3 billion. Of that amount, Medicare paid \$101.3 billion in subsidies for basic benefit costs and extra help for LIS enrollees and \$0.6 billion in retiree drug subsidies, and enrollees paid \$15.4 billion in premiums for basic benefits. Medicare spending for the LIS totaled \$39.7 billion: \$35.2 billion for cost sharing and \$4.5 billion for premiums. In addition, Part D plan enrollees paid \$18.5 billion in cost sharing and \$9.9 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 biological products (referred to as “biologics” hereafter) 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

In this chapter

- Enrollment and plan choices have continued to grow
- Plan sponsors, PBMs, and market concentration
- Although moderated by generic use, overall Part D prices have continued to rise
- Cost-based payments account for a growing share of program spending
- Most Part D enrollees were satisfied

Medicare's reinsurance and LIS. 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 Budget Reconciliation Act of 2022, 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 reforms to Part D's benefit structure have begun to be implemented, with more changes coming over the next several years.

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 when a sponsor positions a drug on its formulary in a way that increases the likelihood of gaining market share over competing drugs. Historically, most plan sponsors also used provisions in network contracts with pharmacies that required postsale recoupments or payments for meeting performance metrics. Beginning this year, however, sponsors may no longer recoup payments from pharmacies after the point of sale. Rebates and pharmacy fees have grown as a share of Part D spending, but these legislative and regulatory changes may affect their magnitude.

Enrollment in 2023 and benefit offerings for 2024—In 2023, 78 percent of Medicare beneficiaries were enrolled in Part D plans. An additional 1 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 comparable drug coverage from other sources and about 11 percent had no coverage or coverage less generous than Part D.

Enrollment in stand-alone prescription drug plans (PDPs) peaked in absolute terms in 2019 at 25.5 million (56 percent of total plan enrollment) but declined to 22.5 million by 2023 (44 percent). Enrollment in Medicare Advantage–Prescription Drug plans (MA–PDs) surpassed enrollment in PDPs for the first time in 2021 and reached 29.1 million in 2023. Since the start of Part D, the number of enrollees who received the LIS has grown more slowly than the

broader Part D population, but their share has stabilized. Since 2020, LIS enrollees have comprised 27 percent of total enrollment, and in 2022 they accounted for 46 percent of gross program spending.

For 2024, beneficiaries continue to have a broad choice of plans. Plan sponsors offered 3,507 general MA-PDs and 1,306 MA-PDs tailored to specific populations (special needs plans, or SNPs)—a slight decline in general MA-PDs and 4 percent more SNPs than in 2023. In 2024, plan sponsors are offering 709 PDPs, the fewest since the program began.

The base beneficiary premium (BBP) increased to \$34.70 in 2024. A recent legislative change capped the annual increase in the BBP at 6 percent, so the increase this year was less than the 20 percent increase that would have otherwise been incurred. While this cap is intended to protect beneficiaries from bearing the full cost of plan sponsors' increased liability under the new benefit design, cost increases beyond 6 percent will be borne by the Medicare program. Further, although the increase in the BBP was capped, individual plans' premiums still vary substantially, with PDPs typically having higher premiums than MA-PDs. In 2024, 126 PDPs, roughly one-sixth of all PDPs, are available premium free to enrollees who receive the LIS, compared with one-fourth of all PDPs last year. This drop in benchmark plans has left 8 regions out of 34 with just 2 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.

Part D program spending—In 2022, Medicare program spending on Part D (excluding the \$15.4 billion in premiums paid by enrollees) totaled \$101.9 billion, up from about \$95 billion in 2021. That amount includes the monthly capitated payment Medicare pays Part D plans for each Part D enrollee (the “direct subsidy”); the reinsurance amount that Medicare pays plans, which covers 80 percent of costs for those enrollees who reach the benefit's catastrophic phase; the LIS; and the retiree drug subsidy. Reinsurance continued to be the largest and fastest-growing component of program spending, totaling \$56.8 billion, or about 56 percent of the total. Medicare's monthly direct subsidy payments have fallen in recent years, as reinsurance payments soared, shifting the financial risk from Part D plans to the Medicare program. In 2023, direct subsidy payments averaged \$2 per member per month, while cost-based reinsurance payments averaged about \$94 per member per month. However, in 2024, as a result of legislative and regulatory changes, we see a reversal in the

trend toward higher reinsurance payments: Direct subsidy payments increased to an average of nearly \$30 per member per month, while average reinsurance payments are expected to decline to about \$90 per member per month.

In 2022, drug list prices continued to rise, approaching rates observed before the pandemic. Decreasing prices of generic drugs continued to 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 prices upward. Going forward, meaningful savings for biologics will depend largely on the successful launch and adoption of biosimilars by prescribers and beneficiaries. In 2022, about 482,000 enrollees filled a prescription that, by itself, was sufficiently expensive to reach the catastrophic phase of the benefit, up from just 33,000 enrollees in 2010.

Beneficiary access and quality in Part D—Surveys suggest high overall satisfaction with Medicare Part D. At the same time, focus groups show that both prescribers and beneficiaries are acutely aware of high drug costs. Among beneficiaries without the LIS, high cost sharing for expensive therapies can be a barrier to access. However, the redesigned benefit now places an annual limit on beneficiaries' cost sharing. As a result, going forward, beneficiaries are less likely to face cost-related access issues.

Medicare beneficiaries take an average of nearly five prescription drugs per month and are at higher risk for adverse drug events associated with polypharmacy. By law, Part D plans are required to carry out medication therapy management (MTM) programs and programs to manage opioid use. For years, the Commission has had concerns about the effectiveness of MTM programs, particularly among stand-alone PDPs, which do not bear financial risk for medical spending. A recent evaluation of a CMS demonstration testing an enhanced MTM model found that new payment incentives and regulatory flexibilities surrounding MTM failed to promote better health outcomes for beneficiaries. In addition, the demonstration yielded no significant reductions in Medicare spending for Part A and Part B services, with a net increase in Medicare spending after accounting for model payments. ■

Background

In 2023, 51.5 million Medicare beneficiaries enrolled in the Part D program for outpatient prescription drug coverage. Private Part D plans are available broadly: Dozens of stand-alone prescription drug plans (PDPs) and Medicare Advantage–Prescription Drug plans (MA–PDs) are offered in every region of the country.

For Part D plan enrollees, Medicare subsidizes about three-quarters of the cost of basic benefits, defined as Part D’s standard benefit or benefits with the same average value. Separately, Part D includes a low-income subsidy (LIS) that pays for much of the cost sharing and premiums on behalf of 13.8 million individuals with low income and assets. In 2022, Part D expenditures totaled \$117.3 billion on an incurred basis (Boards of Trustees 2023). Of that amount, Medicare paid \$101.3 billion in subsidies for basic benefit costs and extra help for LIS enrollees. Part D enrollees paid \$15.4 billion in premiums for basic benefits. Medicare spending for the LIS totaled \$39.7 billion: \$35.2 billion for cost sharing and \$4.5 billion for premiums. In addition, enrollees paid \$18.5 billion in cost sharing and \$9.9 billion in premiums for enhanced benefits.

Part D’s approach

Medicare’s payment system for Part D is different from payment systems under Part A and Part B. In Part D, Medicare pays competing private plans to deliver outpatient drug benefits to beneficiaries, whether they enroll in a PDP or MA–PD, rather than paying directly for prescription drugs. Instead of setting prices administratively, Medicare bases payments on bids submitted by plan sponsors. Plan sponsors establish networks of pharmacies and apply formularies—lists of drugs the plan will cover, typically on differential cost-sharing tiers—to manage enrollees’ use of and spending for prescription drugs. For drug classes that have competing therapies, plan sponsors negotiate with biopharmaceutical manufacturers to place brand-name drugs on the plan’s formulary, potentially on a preferred (lower) cost-sharing tier, in return for postsale rebates.

The costs of providing Part D benefits are shared by Medicare (taxpayers) and its enrollees. Medicare pays plan sponsors two subsidies on behalf of each enrollee in their plans:

- **Direct subsidy**—A monthly prospective amount set as a share of the national average bid for Part D basic benefits.
- **Reinsurance**—Reimbursement to plans for 80 percent of drug spending (net of all rebates and discounts) above an enrollee’s annual out-of-pocket (OOP) threshold (the catastrophic phase of the benefit).

Combined, the direct subsidy and expected reinsurance payments aim to cover 74.5 percent of the expected cost of basic benefits. Beneficiary premiums are designed to cover the remaining 25.5 percent of the expected cost of basic benefits. In addition to monthly premiums, Part D enrollees also pay any cost sharing required by plan sponsors or, in the case of LIS enrollees, nominal cost-sharing amounts set in law. Medicare pays all remaining cost sharing and premiums to the plans on behalf of enrollees who are eligible for the LIS.

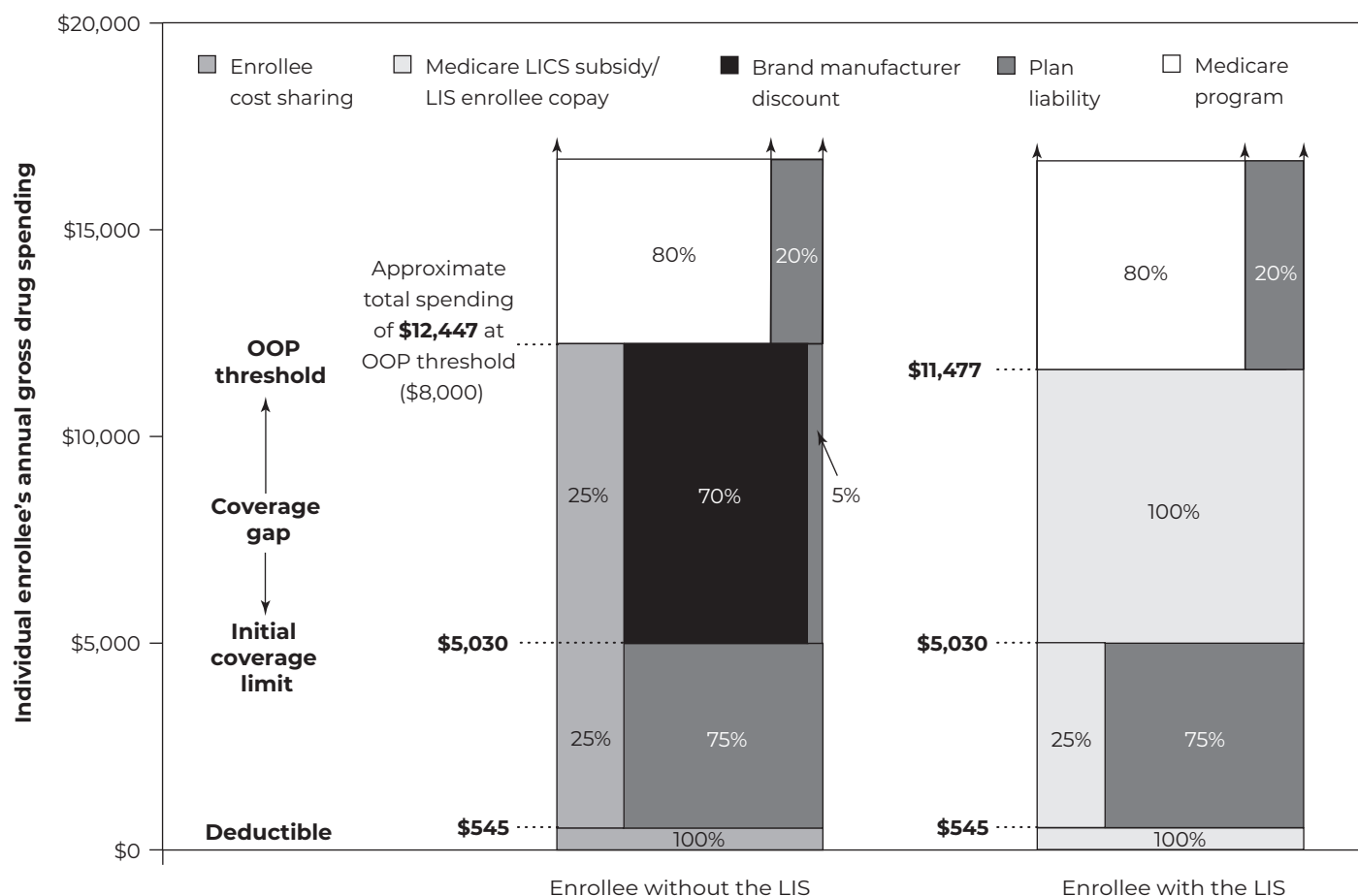
Benefit design

Medicare law defines a standard Part D basic benefit, but in practice, plan sponsors offer alternative benefit designs with equivalent or more generous coverage. Historical changes in law have altered the design of the standard benefit for most Part D enrollees, but those changes did not apply to beneficiaries who receive the LIS. As a result, there are currently two distinct standard Part D benefit designs. Recent changes in law will again alter Part D’s design (as described in a text box, pp. 324–326).

For Part D enrollees without the LIS (73 percent in 2023), Part D’s defined standard benefit includes a deductible where beneficiaries pay 100 percent of costs until it is met. Next, in the initial coverage phase, beneficiaries are responsible for 25 percent of drug spending until reaching the initial coverage limit. Finally, in the so-called coverage gap, beneficiaries continue to pay 25 percent cost sharing until reaching an OOP threshold (Figure 11-1, p. 322). Each year, the standard benefit’s parameters change at the same rate as the annual change in beneficiaries’ average drug expenses. For 2024, the deductible in Part D’s standard benefit is \$545, the initial coverage limit is \$5,030, and the OOP threshold is \$8,000 (Centers for Medicare & Medicaid Services 2023a). That threshold is based

FIGURE 11-1

Final year with two distinct benefit structures (without and with the LIS), 2024



Note: LIS (low-income subsidy), LICS (low-income cost sharing), OOP (out-of-pocket). This infographic depicts the defined standard benefit design, though most plans use an alternative benefit design that is actuarially equivalent to the defined standard benefit, such as using fixed-dollar copays instead of the 25 percent coinsurance. The coverage gap for enrollees without the LIS is depicted as it would apply to brand-name drugs, which are eligible for a 70 percent manufacturer discount in the coverage gap. There is no manufacturer discount for generic prescriptions, and thus cost sharing in the coverage gap is 25 percent and plans are responsible for 75 percent. Because of this difference, total covered drug spending at the OOP threshold depends on the mix of brand and generic prescriptions each individual fills while in the coverage gap. The dollar amount shown (\$12,447) was estimated by CMS for an individual with an average mix of drugs who does not receive Part D's LIS and has no other supplemental coverage.

Source: MedPAC depiction of Part D benefit structure for 2024.

on “true OOP” costs. True OOP spending excludes beneficiary cost sharing paid by most sources of supplemental coverage, such as employer-sponsored policies and more generous (enhanced) benefits from the beneficiary’s Part D plan, but it includes the 70 percent discount that manufacturers of brand-name drugs must pay in the phase of the benefit called the coverage gap, described in Figure 11-1.¹

The coverage gap, or donut hole, has effectively been closed and plans now provide some coverage after the initial coverage limit is reached. Plans continue to identify whether a prescription is filled in that phase because enrollees without the LIS are eligible for a 70 percent discount from manufacturers on brand-name prescriptions filled in the coverage gap.² No discount is

applied to prescriptions for generic drugs or for brand-name prescriptions filled by LIS enrollees. In 2024, brand discounts begin when an enrollee without the LIS has reached \$5,030 in cumulative drug spending, and the discounts continue until the individual reaches \$8,000 in combined OOP spending plus brand discounts (equivalent to \$12,447 in total gross drug spending, on average). Above this OOP threshold, enrollees no longer pay any cost sharing for the first time since the Part D program was created; as a result of changes made by the Budget Reconciliation Act of 2022 (BRA), plans are now responsible for the additional 5 percent of costs previously paid by enrollees.

For low-income beneficiaries, Medicare's LIS pays the difference between cost-sharing amounts set by each plan and nominal copayments set by law (Figure 11-1). In 2024, individuals receiving the LIS pay between \$0 and \$4.50 per prescription for generics and between \$0 and \$11.20 per prescription for brand-name drugs. (Previously, a small share of LIS enrollees with slightly higher levels of income or assets received a partial subsidy; beginning in 2024, all beneficiaries who previously would have been eligible for a full or partial LIS will receive full subsidy benefits.) If, for example, a plan normally charges a \$40 copayment to fill a brand prescription, an LIS enrollee would pay up to \$11.20 and Medicare's LIS would pay \$28.80. Because 100 percent of the costs in the coverage gap count toward the OOP threshold for LIS beneficiaries, they reach the catastrophic phase at a lower level of spending than other enrollees. (The coverage gap will be eliminated for LIS beneficiaries beginning in 2025, when a single benefit structure will apply to all enrollees. For more detail, see the text box, pp. 324–326, that gives an update on the implementation of recent Part D-related changes.) Above the OOP threshold, LIS enrollees have never paid cost sharing; Medicare's low-income cost-sharing (LICS) subsidy paid the 5 percent coinsurance they would owe if they did not receive the LIS. Beginning in 2024, no beneficiaries pay cost sharing above the OOP threshold. Since these costs had been covered for LIS enrollees by the low-income cost-sharing subsidy, this change has reduced Medicare's expense and increased plans' liability.

Plan sponsors typically use alternative benefit designs

In practice, the defined standard benefit is used primarily to set the average value of basic benefits that plan sponsors must offer under alternative benefit

designs. Most sponsors structure basic benefits in ways that differ from the defined standard benefit, such as setting the deductible lower than \$545 or using tiered copayments rather than coinsurance.³ Some plans encourage use of lower-cost medicines by not applying a deductible when a prescription is filled with certain preferred generics. However, sponsors must demonstrate that alternative designs have the same average value as the defined standard benefit for an enrollee of average health. CMS also sets maximum cost-sharing amounts for drug tiers to ensure that a sponsor's plan design is not discriminatory (Centers for Medicare & Medicaid Services 2023e).⁴ Once a sponsor offers a PDP with basic benefits in a region, it can also offer up to two "enhanced" PDPs that combine basic with supplemental coverage.

Some plan sponsors have taken the opportunity to offer enhanced plans to employ a strategy of segmenting the market such that they offer one basic plan geared toward LIS enrollees and two "enhanced" plans for non-LIS enrollees (Medicare Payment Advisory Commission 2022b). One of these enhanced plans may have a premium that is lower than the basic plan, intended to attract enrollees who expect to have limited drug costs. A second, higher-premium enhanced plan targets beneficiaries who expect to have higher drug costs.

Segmenting the market may make PDPs more profitable than would otherwise be the case. Sponsors want to maximize the revenues they receive for each LIS enrollee, which is easier to do when enrollees with and without the LIS are segmented into separate plans. For beneficiaries, the implications of a segmented market are mixed. Enrollees who do not receive the LIS may benefit from having access to low-premium plans. At the same time, segmentation may make it difficult for beneficiaries to understand the different plan options. For the Medicare program, segmentation likely increases Part D spending because it allows sponsors to charge higher premiums for plans that serve LIS beneficiaries (Medicare Payment Advisory Commission 2022b).

The Commission's Part D recommendations and the Budget Reconciliation Act of 2022

The Commission has long been concerned that changes to Part D's benefit design combined with trends in prescription drug pricing and spending have weakened

Update on implementation of the Part D-related provisions in the Budget Reconciliation Act of 2022

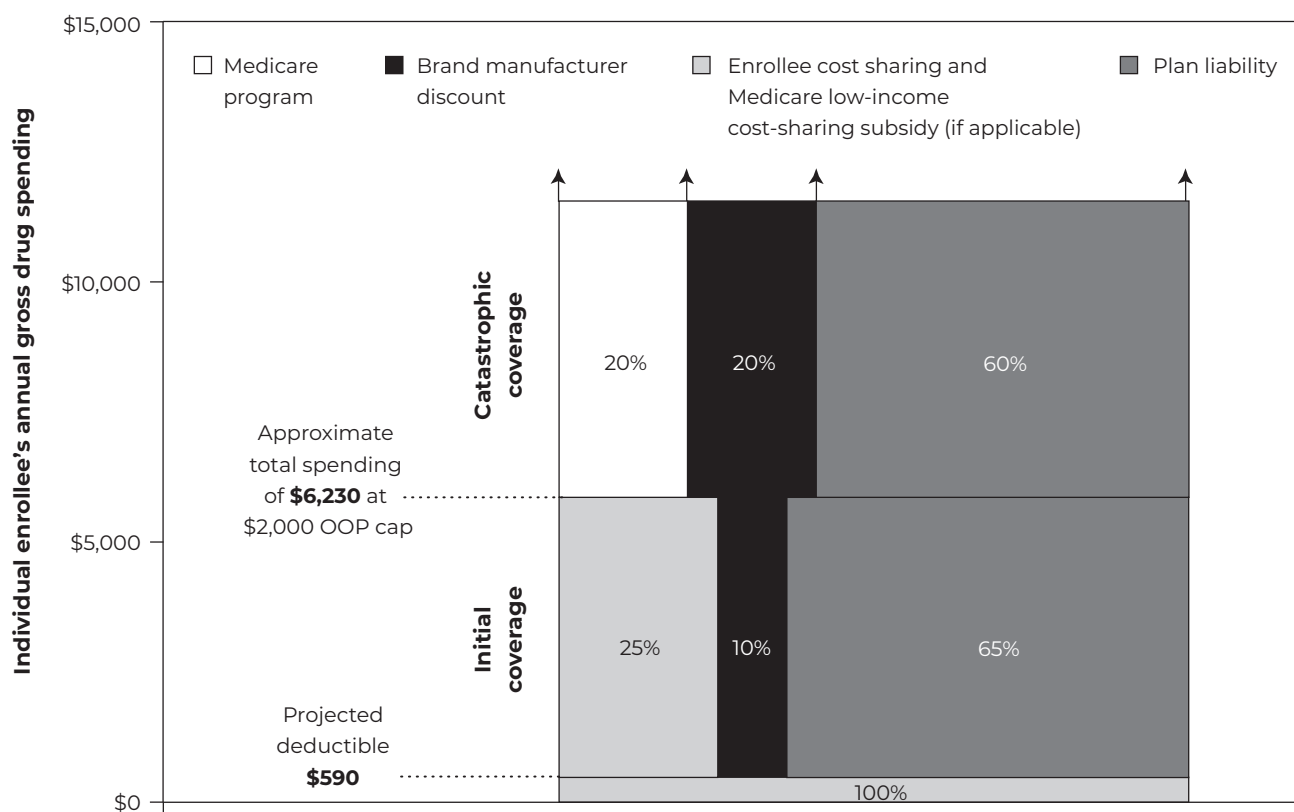
Numerous Part D-related provisions of the Budget Reconciliation Act of 2022 (BRA) are already taking effect. Since October 2022, manufacturers of drugs sold to Medicare beneficiaries face financial penalties if the price of their drug rises faster than inflation. Part D plans are now required to provide all Part D-covered vaccines that are recommended for adults at no cost and

insulin at no more than \$35 for each prescription of a month's supply of all insulin products included on a plan's formulary.⁵ Beneficiaries with income between 135 percent and 150 percent of the federal poverty level are now eligible for full low-income subsidies rather than a partial subsidy. For the first time this year, beneficiaries will have no out-of-pocket (OOP) obligations once they reach the

(continued next page)

FIGURE 11-2

Redesigned benefit structure for all Part D enrollees, effective in 2025



Note: OOP (out-of-pocket). Figure depicts the restructured defined standard benefit as it would apply to brand-name drugs and biologics. For generic drugs, plan sponsors must cover 75 percent of enrollee spending between the deductible and OOP cap, and Medicare's reinsurance will pay for 40 percent of spending in the catastrophic region.

Source: MedPAC depiction of redesigned Part D benefit structure resulting from changes made by the Budget Reconciliation Act of 2022.

Update on implementation of the Part D–related provisions in the Budget Reconciliation Act of 2022 (cont.)

catastrophic phase of the benefit. Last, the Secretary of Health and Human Services has begun to exercise its new authority to negotiate prices for select drugs under the Medicare Drug Negotiation Program.⁶ The 10 drugs that will first be subject to price negotiation were announced on September 1, 2023, though the resulting prices for these products will not be effective until 2026. If a manufacturer declines to participate in the Negotiation Program, it must either pay an excise tax of up to 1,900 percent on certain sales of the drug or withdraw entirely from the Medicare and Medicaid programs (Congressional Research Service 2023).⁷

The Budget Reconciliation Act of 2022 also changed Part D's benefit structure to fundamentally alter the incentives for plan sponsors. The redesigned structure has many similarities to the Commission's 2020 recommendations for the program (Medicare Payment Advisory Commission 2020a). Starting next year, a single benefit design will apply to all enrollees, whether or not they receive the low-income subsidy (LIS). The benefit will also be simplified with fewer benefit phases: After reaching their deductible, enrollees will pay 25 percent coinsurance until reaching \$2,000 in OOP spending (Figure 11-2). The redesigned benefit caps enrollee OOP spending thereafter. Additionally, plan sponsors will be required to offer their enrollees the option to smooth cost-sharing payments over the benefit year (Centers for Medicare & Medicaid Services 2023g).

The current coverage-gap discount will be replaced with a new program under which manufacturers of brand-name drugs and biologics must discount their prices by 10 percent below the OOP cap (for spending above the deductible) and by 20 percent above it.⁸ The manufacturer discount will no longer count toward the OOP threshold, which will slow beneficiaries' progression to the catastrophic phase. Medicare's reinsurance will be reduced from 80 percent to 20 percent of prescription spending

for brand-name drugs above the OOP cap. At the same time, Medicare's overall 74.5 percent subsidy of basic benefits will remain unchanged (unless required to increase to accommodate the 6 percent cap on annual premium increases), with much more of it taking the form of capitated rather than cost-based payments. In 2024, because this cap is binding, Medicare's subsidy is expected to exceed the statutorily set amount (see text box on p. 339 for more detail).

Plan sponsors will continue to be able to offer alternatives to this redesigned standard benefit so long as they demonstrate that the alternative plan has the same average benefit value.

The changes adopted in the BRA are likely to alter the program's incentives, as well as revenues of the pharmaceutical manufacturers directly or indirectly affected by those provisions. While some provisions (such as the \$2,000 cap on OOP spending) could increase revenues for some manufacturers by improving Part D enrollees' access to medications, much of the focus has been on the potential negative effects of the BRA changes on biopharmaceutical research and development (R&D). To the extent that the Negotiation Program results in manufacturer revenues that are lower than they otherwise would have been, there may be negative effects on biopharmaceutical innovation. However, estimates of possible effects have varied widely. For example, the Congressional Budget Office estimated that, as a result of the BRA, one less drug would be introduced to the U.S. market from 2023 to 2032 (Congressional Budget Office 2022). Other studies estimated significantly greater impact, with one estimating more than 100 fewer drugs coming to market in the next 10 years (Avalere 2022, Gassull et al. 2023, Philipson et al. 2023). As we discussed in our previous reports to the Congress, the price that Medicare and other entities pay for drugs is just one of many factors that influence investment in biopharmaceutical R&D (Medicare Payment Advisory

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Update on implementation of the Part D–related provisions in the Budget Reconciliation Act of 2022 (cont.)

Commission 2023b, Medicare Payment Advisory Commission 2022b).⁹ There are also uncertainties related to the implementation of the BRA, including certain aspects of the Negotiation Program.¹⁰ As a result, it may be challenging to measure with any certainty the effects on R&D specifically attributable to the Negotiation Program. In the near term, recent commentary suggests that the Negotiation Program’s impact on biopharmaceutical R&D so far has been more moderate than anticipated by some stakeholders. For instance, after the selection of the first 10 drugs, one analysis noted that “the overall financial impact of the price negotiations . . . will be modest for the pharmaceutical industry” (Moody’s Investors Service 2023). A report monitoring

earnings calls of pharmaceutical companies in the first half of 2023 stated that “few actions by large biopharma companies can be directly linked to the [BRA]” (ATI Advisory 2023).

The Commission has often stressed the importance of promoting price competition and balancing a drug’s net clinical benefit with an appropriate reward for innovation and affordability for beneficiaries and taxpayers (Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2022b, Medicare Payment Advisory Commission 2017b). The Commission will continue to monitor the many changes, keeping in mind both the need for beneficiary access to drug treatments and for program efficiency. ■

plan sponsors’ incentives for cost control (Medicare Payment Advisory Commission 2022c, Medicare Payment Advisory Commission 2021, Medicare Payment Advisory Commission 2020a, Medicare Payment Advisory Commission 2016). Between 2007 and 2022, plan sponsors’ overall financial risk for the basic benefit spending of their enrollees declined markedly, from 75 percent to 30 percent.

The Commission has also voiced concerns about enrollee cost sharing under Part D. Because beneficiaries historically have paid an unlimited amount of cost sharing in the catastrophic phase, a small but significant share of enrollees had high OOP spending that could pose a financial burden and hinder adherence to treatment. At the same time, limits on cost sharing for LIS enrollees have blunted their incentives to use lower-cost drugs and make it more difficult for plan sponsors to manage program spending.

In 2020, the Commission recommended major changes to the Part D program that would restructure its defined standard benefit and restore stronger financial incentives for plan sponsors and beneficiaries

to use lower-cost medicines (Medicare Payment Advisory Commission 2020a). The Commission has consistently held that when plan sponsors must bear more insurance risk, they should also be given tools to manage enrollee spending.¹¹ Subsequently, the BRA included a redesign of the Part D benefit that reflects many of the Commission’s recommendations (see text box for more details on this and other Part D–related provisions in the Budget Reconciliation Act, pp. 324–326).¹²

The upcoming changes to the Part D benefit design should provide stronger incentives for plan sponsors to manage prescription drug benefits in ways that are more consistent with the incentives present at the start of the program. The restructured benefit design will result in higher capitated payments from Medicare to plans, with payments for LIS beneficiaries being most affected. CMS will need to recalibrate the Part D risk-adjustment model to ensure that, on average, capitation rates are adequate for both LIS enrollees and other Part D beneficiaries.

Carrying out Part D’s benefit redesign and other changes mandated by the BRA will involve complex

decisions that will affect plan formularies, payments, incentives regarding drug development, and beneficiary access and costs. For example, plan sponsors may modify their formularies (within the constraints of CMS's guidance and formulary review) in response to bearing more risk for enrollee drug spending. Setting an OOP cap will increase the generosity of the Part D benefit, which may affect patients' decisions regarding which drugs to take: Patients may be more likely to fill their prescriptions, and they may be less incentivized to take generic or biosimilar medicines. Changes in patient and prescribing behavior, along with other recent legislative changes, may alter the types of drugs that manufacturers choose to develop. Changes to enrollees' access to drugs may also differ depending on how CMS carries out the policy of notifying enrollees that they have the option to smooth their cost-sharing expenses over the year.

Enrollment and plan choices have continued to grow

A growing proportion of Medicare beneficiaries have enrolled in MA-PDs while the number and share in stand-alone PDPs has declined. Over the program's first decade, a portion of enrollment shifted from retiree drug plans outside of Medicare to Part D plans set up for employer groups, but growth in those plans has slowed.

Share of Medicare beneficiaries enrolling in Part D continues to grow

In 2023, 51.5 million individuals—about 78 percent of Medicare's total enrollment—were enrolled in Part D plans (Table 11-1, p. 328). Another 1 percent of beneficiaries obtained drug coverage through non-Medicare employer-sponsored plans that received Medicare's retiree drug subsidy (RDS) for serving as the primary provider (data not shown). (The RDS is paid from the Part D program.) We estimate that among the remaining beneficiaries, just under 10 percent had creditable drug coverage from other sources. About 11 percent had no coverage or coverage less generous than Part D (data not shown).¹³

The distribution of Part D enrollment has moved gradually toward MA-PDs, both those that are open

to all enrollees and MA-PD special needs plans (SNPs), which are limited to enrollees who have a chronic condition, are dually eligible for Medicare and Medicaid, or are living in an institution. The number of enrollees in PDPs began to decline in 2020, and by 2023, about 22.5 million Part D enrollees (less than 44 percent) were in stand-alone PDPs (Table 11-1, p. 328). This shift toward MA-PDs is consistent generally with more rapid growth in MA enrollment compared with traditional fee-for-service (FFS) Medicare. Between 2019 and 2023, enrollment in MA-PDs grew an average of 10 percent annually compared with a 3 percent decline in PDPs.

Membership in employer group waiver plans (EGWPs)—Part D plans established for Medicare-eligible retirees of certain employers—totaled 7.6 million in 2023 (data not shown).¹⁴ EGWPs can take the form of PDPs or MA-PDs. Enrollment in EGWPs grew quickly over the Part D program's first decade but slowed subsequently. Similar to overall program trends, enrollment in MA-PD EGWPs has been growing, reaching 3.6 million in 2023, while enrollment in PDP EGWPs has declined modestly over the past two years. Still, at 4.0 million, enrollment in PDP EGWPs was higher than that of MA-PDs in 2023.

In 2023, 13.8 million beneficiaries (27 percent of Part D enrollees) received the full LIS. Of these individuals, 9.1 million were eligible for both Medicare and full Medicaid benefits (Boards of Trustees 2023).¹⁵ Compared with other enrollees, LIS enrollees are more likely to be female; nearly three times as likely to be either African American or Hispanic; and six times more likely to be under age 65 (Medicare Payment Advisory Commission 2023a).

Between 2019 and 2023, LIS enrollment grew at an average of just over 2 percent per year, slightly below the enrollment growth for other enrollees, but the share of Part D enrollees who received the LIS remained at 27 percent. In 2023, 63 percent of LIS enrollees were in MA-PDs; the rest were in PDPs. In past years, most individuals receiving the LIS were enrolled in traditional FFS Medicare rather than MA. However, LIS enrollment in MA-PDs has grown rapidly, climbing 12 percent per year, on average, between 2019 and 2023, while LIS enrollment in PDPs has declined. LIS enrollment in SNPs has grown particularly rapidly (data not shown).

**TABLE
11-1****Enrollment shift toward MA-PDs maintained momentum,
particularly among LIS beneficiaries**

	2019	2020	2021	2022	2023	Average annual change 2019–2023
Total Medicare enrollment (in millions)	61.5	62.9	63.8	65.0	66.3	1.9%
Total enrollment in Part D plans (in millions)	45.4	47.0	48.3	49.8	51.5	3.2
<i>As a share of total Medicare enrollment</i>	<i>74%</i>	<i>75%</i>	<i>76%</i>	<i>77%</i>	<i>78%</i>	<i>N/A</i>
Part D plan enrollment by plan type (in millions)						
PDP	25.5	25.1	24.0	23.3	22.5	–3.1
MA-PD	20.0	21.9	24.3	26.5	29.1	9.9
Full LIS enrollment (in millions)						
PDP	7.3	6.7	6.0	5.5	5.2	–8.3
MA-PD	5.4	6.1	6.8	7.7	8.6	12.4
Overall	12.7	12.8	12.8	13.3	13.8	2.1

Note: MA-PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy), PDP (prescription drug plan). Part D enrollment figures do not include beneficiaries in employer-sponsored plans that receive the retiree drug subsidy but do include enrollees in employer group waiver plans. In addition to beneficiaries who receive full LIS assistance, a small number receive partial assistance (0.2 million in 2023). Totals may not sum due to rounding.

Source: MedPAC analysis based on the 2023 Medicare Trustees' report and CMS Part D enrollment data as of April 1, 2023.

Majority of enrollees choose enhanced plans

Most enrollees are in plans that are actuarially equivalent to Part D's standard benefit or are enhanced in some way rather than in plans that follow the defined standard benefit. For example, an enhanced plan may wrap around a beneficiary's Part D plan benefit by lowering or eliminating the deductible or providing more generous coverage in the coverage gap.

Because MA-PD plan sponsors are permitted to use a portion of their MA payments to supplement their Part D benefits (e.g., by lowering deductibles) or to lower Part D premiums, enrollees in MA-PDs tend to have more generous benefits than enrollees in PDPs.¹⁶ Indeed, 99 percent of enrollees in regular (non-SNP) MA-PDs were in enhanced plans in 2023 (Table 11-2). By contrast, 58 percent of PDP enrollees chose enhanced plans in 2023, up from 54 percent in

2022 (2022 data not shown). Typically, enhanced plans reduce or eliminate the deductible used in the defined standard benefit. Among general MA-PDs, 76 percent of enrollees had no deductible in their plan's benefit design. By comparison, only 14 percent of PDP enrollees and 6 percent of SNP enrollees were in plans with no deductible. However, half of PDP enrollees were not required to meet a deductible for select drugs (usually certain generics), and most SNP enrollees are dual-eligible beneficiaries who automatically receive the LIS, which covers the deductible (data not shown).

Large cost-sharing differences between preferred generics and other drugs remain

Most Part D beneficiaries enroll in plans that have a five-tier structure: two generic tiers ("preferred" and "other" generics), one preferred brand-name tier, and one nonpreferred drug tier (which may include both brand-name and generic drugs), plus a specialty tier

**TABLE
11-2**

More enrollees chose conventional MA-PDs, which are much more likely than PDPs and SNPs to offer enhanced coverage, 2023

	PDP		General MA-PD		SNP	
	Number of enrollees (in millions)	Percent	Number of enrollees (in millions)	Percent	Number of enrollees (in millions)	Percent
Total	18.5	100%	18.9	100%	5.6	100%
Type of coverage						
Basic	7.9	42	0.1	<1	3.9	70
Enhanced	10.6	58	18.8	99	1.7	30
Type of deductible						
Zero	2.6	14	14.4	76	0.4	6
Reduced	2.0	11	4.2	22	0.2	4
Defined standard	13.9	75	0.3	2	5.0	90

Note: MA-PD (Medicare Advantage–Prescription Drug [plan]), PDP (prescription drug plan), SNP (special needs plan). Conventional MA-PD enrollment excludes employer-only plans, plans offered in U.S. territories, 1876 cost plans, demonstrations, and Part B-only plans. "Defined standard" deductible category includes plans that are actuarially equivalent. Totals may not sum due to rounding.

Source: MedPAC analysis of CMS landscape, plan report, and enrollment data.

(Medicare Payment Advisory Commission 2023a). The cost-sharing amounts for those tiers differ, but generally plans have kept generic copayments comparatively low. Among PDP enrollees, in 2023, median copayments were \$1 for preferred generics and \$5 for other generic drugs. Median cost sharing was \$44 for preferred brand-name drugs and 45 percent coinsurance for nonpreferred drugs. Among MA-PD enrollees, median copayments for the two generic tiers were \$0 and \$6, respectively, \$47 for preferred brand-name drugs, and \$100 for nonpreferred drugs. PDPs and MA-PDs typically charged a coinsurance of between 25 percent and 33 percent for specialty-tier drugs.

Average premiums remained stable in 2023

In 2023, monthly beneficiary premiums averaged about \$26 across all types of plans (basic and enhanced, stand-alone PDP and MA-PD)—effectively no change from the prior two years. However, premiums for individual plans vary widely around that average, from

\$0 for many MA-PDs to \$201 for the most expensive enhanced PDP. The \$26 average reflects plan sponsors' use of Part C quality bonus payments (or rebates) to offset premium costs that MA-PD enrollees would otherwise pay. In 2023, MA-PD enrollees paid an average of less than \$15 per month but received over \$54 of basic and supplemental drug benefits through Part C rebates (Medicare Payment Advisory Commission 2022a). PDP enrollees paid nearly \$42 per month, on average.

Two other factors, not accounted for in the averages described above, can affect the premium amounts that enrollees pay. First, higher-income individuals have a lower federal subsidy of their Part D benefits.¹⁷ In 2023, over 8 percent of enrollees were subject to the income-related premium, compared with less than 3 percent in 2011 (Liu and Centers for Medicare & Medicaid Services 2023). Second, individuals enrolling outside their initial enrollment period must have proof that they had drug coverage as generous as the standard

benefit to avoid the late enrollment penalty (LEP) that would be added to their premiums for the duration of their Part D enrollment.¹⁸ In 2023, about 5 percent paid the LEP, up from about 1 percent in 2007 (Liu and Centers for Medicare & Medicaid Services 2023). Some of the increase in enrollees subject to the LEP may be due to the lack of a notification process to ensure that individuals are aware of their eligibility for and need to enroll in Medicare, including Part D, as they turn 65 (Medicare Payment Advisory Commission 2019b).

Benefit offerings and premium changes for 2024

For 2024, plan sponsors are offering 3,507 general MA-PDs and 1,306 SNPs—a 1 percent drop in general MA-PD plans, but 4 percent more SNPs relative to 2023. Plan sponsors are offering 709 PDPs, nearly 12 percent fewer than the previous year.

Still, in each of the nation's 34 PDP regions, beneficiaries continue to have broad choice. The number of PDPs ranges from 15 in New York to 24 in Alabama and Tennessee, along with dozens of MA-PDs in most areas. The number of MA plans available to a beneficiary varies by the county of residence, with an average of 28 plans in each county. Because more beneficiaries live in areas with greater numbers of plans, the average beneficiary has 43 MA plans available.¹⁹

For 2024, CMS calculated that Part D's base beneficiary premium (BBP)—an enrollee's share of the monthly national average expected cost for basic benefits—is \$34.70, a 6 percent increase from 2023 (Centers for Medicare & Medicaid Services 2023f). Importantly, the cap on annual increases in the BBP from 2024 to 2029 at 6 percent per year prevented a 20 percent increase in the BBP (see text box on Part D premium stabilization on p. 339).

While the BBP has been limited to a 6 percent annual increase, individual plan premiums may increase by more (or less) than 6 percent. Premiums for individual Part D plans can vary substantially because they reflect any difference between the sponsor's bid and the national average bid, as well as any enhanced (supplemental) benefits the plan offers. In addition, in 2024, MA-PD sponsors are applying \$47 per month of Part C rebate dollars on average to lower their Part D premiums compared with over \$54 per month the

prior year (a decrease of nearly 13 percent) as plans, on average, allocated more rebate dollars toward Part C supplemental benefits instead.

In 2023, over 90 percent of all beneficiaries in PDPs (excluding employer-sponsored plans) were enrolled in plans marketed nationally or near nationally by eight large plan sponsors. If enrollees remained in those plans for 2024, most (but not all) saw an increase in their premiums averaging more than \$8 per month, or 22 percent. However, average monthly premiums for some nationally marketed PDPs fell by up to \$9, while others rose by roughly \$30. Most beneficiaries will have access to a plan with a premium of less than \$1 per month.

In 2024, the benchmarks that reflect the maximum amount Medicare will pay for monthly premiums on behalf of LIS beneficiaries range from \$28 in Texas to \$49 in New York. Compared with 2023, the number of zero-premium PDPs available to LIS enrollees in 2024 dropped by 34 percent to 126 plans, or about one-sixth of all PDPs. This drop significantly affects plan choice for LIS beneficiaries: Eight regions in 2024 have just two zero-premium PDPs available. Wisconsin has a high of seven premium-free PDPs. As a result, CMS expects to reassign roughly 1.4 million LIS enrollees in 2024, up from less than 0.5 million in 2023, so that they may continue to have coverage with no premium cost (Liu and Centers for Medicare & Medicaid Services 2023).

Plan sponsors, PBMs, and market concentration

About 300 organizations operate Part D plans. Most plan sponsors offer MA-PDs, but only about 50 operate stand-alone PDPs.²⁰ As plan sponsors merged throughout the earlier years of the program, Part D enrollment grew more concentrated (Medicare Payment Advisory Commission 2019c). However, over the past several years, enrollment concentration has stabilized. In 2022, the top five PDP sponsors ranked by enrollment accounted for 88 percent of covered lives, while the top five sponsors of MA-PDs accounted for 68 percent of enrollment.

Many of the largest plan sponsors have their own pharmacy benefit managers (PBMs) that negotiate

rebates with pharmaceutical manufacturers and achieve economies of scale in mail-order and specialty pharmacies. Other sponsors perform some PBM functions in house but contract with outside PBMs (that may be owned by a competitor) for services such as rebate negotiations.²¹ As a result, PBMs' market concentration is higher than that of plan sponsors. We estimate that in 2022, the top five PBMs (ranked either by Part D-covered lives or number of prescriptions) negotiated rebates on behalf of more than 90 percent of all Part D enrollees and prescriptions. Rebates can help reduce premiums for all enrollees, but the trade-off is that Medicare faces higher costs for its cost-based reinsurance and LICs subsidy, and patients who must pay a percentage coinsurance on a rebated drug pay disproportionately higher cost sharing.

The roles of plan sponsors and PBMs

In addition to their role as insurers, plan sponsors conduct marketing, enrollment, and customer support services. They also use PBMs (either a subsidiary firm or an unaffiliated firm under contract) to perform other administrative and clinical services such as developing formularies, processing claims, establishing networks of pharmacies, and negotiating with drug manufacturers and pharmacies for postsale rebates, discounts, and fees.

PBMs combine purchasing leverage across plans and plan sponsors to create stronger competition among therapies and counter drug manufacturers' pricing power. Our analysis has found that the differential between rebates obtained by large and smaller plan sponsors can be substantial (Medicare Payment Advisory Commission 2023b).

Formulary management and manufacturer rebates

Formularies remain plan sponsors' most important tool for managing drug spending. Sponsors and PBMs decide which drugs to include or exclude, which cost-sharing tier is appropriate for each drug, and whether a drug will be subject to utilization management—quantity limits, step therapy, and prior authorization. Those decisions require that plan sponsors strike a balance between providing access to medications and encouraging enrollees to use preferred therapies.

CMS reviews each plan's formulary as part of the process of deciding whether to approve a plan sponsor's bid. For most drug classes, plans must cover at least two distinct drugs that are not therapeutically equivalent or bioequivalent, as well as "all or substantially all drugs" in six protected classes—anticonvulsants, antidepressants, antipsychotics, immunosuppressants, antiretrovirals, and antineoplastics.

In drug classes that have competing therapies, PBMs negotiate with brand manufacturers for rebates that the manufacturers pay after each prescription has been filled. Generally, manufacturers pay larger rebates when a sponsor positions a drug on its formulary in a way that increases the likelihood of winning market share over competing drugs. In addition, rebates may vary based on the degree of therapeutic competition and Medicare's formulary coverage policies (Medicare Payment Advisory Commission 2023a, Medicare Payment Advisory Commission 2023b). Between 2010 and 2022, the magnitude of aggregate rebates grew from \$8.6 billion (11 percent of gross Part D spending) to \$57.3 billion (24 percent).²²

Pharmacy networks and postsale fees

Under Part D, plan sponsors must permit within their networks any pharmacy that is willing to accept the sponsors' terms and conditions; that is, plan sponsors cannot use exclusive pharmacy contracts. Sponsors must also demonstrate that their network meets pharmacy access standards.

However, sponsors can designate a subset of network pharmacies that offer preferred (lower) cost sharing. For 2024, if enrollees remained in the same plan as in the previous year, over 90 percent of PDP enrollees, 38 percent of general MA-PD enrollees, and less than 5 percent of SNP enrollees would be in plans that use preferred cost-sharing pharmacies.²³ The strategy of designating certain pharmacies as preferred has the potential to lower costs for Medicare and enrollees if it encourages enrollees to fill prescriptions at pharmacies that, for example, are more effective at encouraging generic drug use. Researchers found that over the period from 2011 to 2014, Part D enrollees without the LIS were highly sensitive to preferred cost sharing, and the approach reduced overall drug spending by about 2 percent (Starc and Swanson 2021a, Starc and

Recent regulatory change to the definition of “negotiated price”

In May 2022, CMS finalized a rule redefining the “negotiated price” of Part D–covered drugs to include all possible pharmacy price concessions, such that the price reflects the lowest possible reimbursement a network pharmacy may receive for a particular drug, effective January 1, 2024. (This policy does not apply to manufacturer rebates.) The negotiated price is the price paid at the point of sale (POS) to a network pharmacy or dispensing provider. When plans require a percentage coinsurance, beneficiary cost sharing is calculated based on this price.

Historically, negotiated prices have not included performance-based pharmacy price concessions because they cannot “reasonably be determined” at the POS and thus were excluded from the negotiated price. These price concessions were typically paid in lump sum at a later date (e.g., at the end of each quarter) and reported to CMS as direct and indirect remuneration (DIR).

Pharmacy DIR has grown from less than \$500 million in 2014 to \$17.1 billion in 2022.²⁴ CMS became concerned about the impact of these

fees and their retroactive application because the more the price concessions grow, the more disconnected beneficiaries’ cost sharing is from the actual price of the drug. Additionally, the large and growing magnitude of pharmacy DIR raises other concerns: In recent years, the amount of DIR that sponsors receive has consistently exceeded the amount projected in plan bids, which has primarily contributed to plan profits rather than lower premiums. Further, CMS noted that when sponsors “opt for higher negotiated prices in exchange for higher DIR . . . [it] shifts costs from the part D plan sponsor to beneficiaries who utilize drugs in the form of higher cost-sharing and to the government through higher reinsurance and low-income cost-sharing subsidies” (Centers for Medicare & Medicaid Services 2018). The lack of transparency and unpredictability of these price concessions has also caused cash-flow challenges for some pharmacies.

Requiring all possible pharmacy price concessions to be applied at the point of sale will affect all Part D stakeholders. (The cost estimates provided by CMS were calculated prior to passage of the Budget Reconciliation Act of 2022; the benefit redesign set

(continued next page)

Swanson 2021b). However, tiered pharmacy networks have been controversial because of concerns that some members have less access to preferred pharmacies or that tiering pharmacy networks could lead to higher low-income cost-sharing subsidies since LIS enrollees do not face any financial incentives to choose preferred pharmacies.²⁵

Over time, some major plan sponsors began requiring pharmacies in their networks to make postsale payments depending on their performance.²⁶ Because these payments rely on evaluations of performance metrics, they can flow from a plan sponsor and its PBM

to a pharmacy or vice versa. On the whole, however, pharmacies have paid increasing amounts to plan sponsors; in 2022, they totaled \$17.1 billion (7 percent of gross Part D spending), a 36 percent increase from \$12.6 billion in 2021.²⁷

For some medications, such as those placed on nonpreferred or specialty tiers, enrollee cost sharing is typically calculated based on the price negotiated between plan sponsors (or PBMs on their behalf) and pharmacies. But until this year, the “negotiated price” did not include performance-based pharmacy payments, similar to the exclusion applied to postsale

Recent regulatory change to the definition of “negotiated price” (cont.)

to go in effect in 2025, as well as other drug pricing-related provisions in the law, are likely to alter the expected impacts on costs.)

All beneficiaries would, on average, likely face higher premiums (relative to the prior status quo), but the out-of-pocket cost savings expected for a subset of beneficiaries are projected to more than offset the total increase in premiums, ultimately reducing total beneficiary spending, on net (Carver et al. 2022). CMS estimated beneficiary savings of \$26.5 billion from 2024 to 2032.

Federal spending is expected to increase as a result of higher premiums and thus higher costs for the direct subsidy, without sufficient reductions in low-income cost-sharing subsidies and Medicare’s reinsurance to fully offset those higher costs. CMS estimates the net cost to the federal government will be \$46.8 billion, or a 3 percent increase, from 2024 to 2032.

Manufacturers’ obligations through the coverage-gap discount program are expected to decrease (since their discounts are calculated as a percentage of the negotiated price and because fewer beneficiaries would reach the coverage gap) by approximately \$16.8 billion.

Plans will likely face higher liability (reflected in higher premiums, as mentioned above) and some transactional costs estimated at \$0.1 million (Avalere 2023).

Pharmacies should have more predictable revenues in the long term but may experience cash-flow challenges in the first quarter of 2024: Some pharmacies will simultaneously need to pay any price concession obligations from 2023 while also having their current reimbursements reduced to account for all possible pharmacy price concessions.

In responding to the proposed rule, some commenters suggested that this policy would reduce competition among pharmacies for preferred network placement. However, because no evidence was provided to support this claim, CMS rejected the argument and suggested that post-point-of-sale bonus payments can be just as effective as post-point-of-sale recoupments. Further, CMS expects that standardizing the application of price concessions will increase transparency and information symmetry between plan sponsors and enrollees choosing their Part D plan and deciding which pharmacy to use. Greater transparency, in turn, could improve competition among pharmacies and empower beneficiaries to make better plan comparisons. ■

manufacturer rebates. This arrangement has meant that enrollees who use highly rebated drugs may pay disproportionately high cost sharing relative to the net benefit cost of their medicines, and Medicare, in turn, spends relatively more on reinsurance subsidies and low-income cost-sharing subsidies.

Beginning in 2024, the definition of “negotiated price” must reflect all pharmacy price concessions, including performance-based ones that were previously assessed after the point of sale (see text box on recent regulatory

change to the definition of “negotiated price”). Plan sponsors’ negotiated price is the lowest possible reimbursement a network pharmacy could receive, and that amount will be the basis for assessing enrollee cost sharing when it takes the form of deductibles or coinsurance.

Concerns about vertical integration and high market concentration

Large PBMs have significant market power to negotiate rebates with pharmaceutical manufacturers and

achieve economies of scale in mail dispensing. As noted above, while rebates can benefit all enrollees in the form of lower premiums, PBMs' focus on rebates and the lack of price transparency can increase costs for payers and patients who need expensive medications (Loftus and Hopkins 2023). At the same time, a PBM may face conflicting interests as a PBM providing services to the payer and as an owner of a pharmacy facing financial incentives to dispense a greater volume of prescription drugs, particularly those with higher pharmacy spreads (Herman 2022).

A concern is that vertical integration combined with a highly concentrated market could be associated with anticompetitive behavior. For example, a health plan that also owns pharmacies and a PBM could attempt to restrict pharmacy network participation or raise the prices of PBM services for competing health plans that contract with that PBM (Greaney 2019).

The prices established between upstream and downstream entities of vertically integrated organizations are less transparent to CMS and commercial payers.²⁸ As a result, profits accruing to wholly owned downstream entities may be reflected as higher costs for Part D plans (Herman 2022). Similarly, when pharmacies are owned by insurers and/or PBMs, the use of these vertically integrated pharmacies may not necessarily result in lower costs (Medicare Payment Advisory Commission 2023b). In turn, the lack of information about prices established among vertically integrated plan sponsors, PBMs, and pharmacies makes it difficult to assess the profitability of Part D plans and their affiliated organizations (Office of Inspector General 2021).

Although moderated by generic use, overall Part D prices have continued to rise

Much attention has been focused on growth in prices at the pharmacy counter—referred to here as gross or point-of-sale (POS) prices. Most Part D enrollees primarily use generic drugs, and many (but not all) generic prices remain low. However, enrollees without the LIS who use brand-name drugs often feel the effects of rising POS prices when they pay a deductible or coinsurance. These effects especially involve the

relatively small share of enrollees who use high-priced specialty drugs. At the same time, drug prices net of postsale rebates and discounts affect the premiums paid by all Part D enrollees and are subsidized by the Medicare program.

All levels of the drug supply chain include incentives that drive POS prices higher, particularly when payments are based on a percentage of prices (Fein 2018, Feldman 2018, Garthwaite and Morton 2017, Sood et al. 2021). Meanwhile, manufacturers' focus on developing drugs and biologics for smaller patient populations means that many products are launched at high prices and may not have direct therapeutic competitors. Over time, these factors combined with the consolidation of supply-chain participants have pushed POS prices higher (Sood et al. 2020).

To examine growth in prices, the Commission contracted with Acumen LLC to construct a series of volume-weighted price indexes that reflect total amounts paid to pharmacies for Part D prescriptions, including ingredient costs and dispensing fees. The indexes reflect prices measured at the median of the distribution.²⁹

Prices paid at the pharmacy are an important indicator of Part D's costs because POS prices affect beneficiary cost sharing and the rate at which enrollees reach Part D's catastrophic phase. The indexes reported in this section reflect POS prices before postsale rebates and discounts.

In 2022, growth in overall Part D prices remained above prepandemic growth rates

Between 2006 and 2022, prices for all drugs and biologics, measured by individual national drug codes (NDCs), more than doubled on average (an index value of 2.17) (Table 11-3).³⁰ Overall, growth in drug prices slowed in 2022 to 3.8 percent, down from 4.1 percent in 2021; however, it still exceeded price growth observed prior to 2021 (price growth averaged 3.0 percent per year between 2018 and 2020).

Because generic drugs account for 90 percent of all prescriptions, decreases in generic prices help moderate overall price growth. Our price index for generic drugs has declined consistently in the past and continued to do so in 2022 (data not shown). However, the rate of decrease in generic prices has slowed in recent years, and as a result, our overall price index

**TABLE
11-3****Part D prices, after accounting for generic substitution, continued to rise in 2022**

	2018	2019	2020	2021	2022
Price index as of 4th quarter (1st quarter 2006 = 1.00)					
All drugs and biologics					
Before accounting for generic substitution	1.90	1.95	2.00	2.09	2.17
After accounting for generic substitution	1.14	1.11	1.13	1.17	1.20
Biologics (excluding insulin)	3.16	3.32	3.51	3.79	4.06
Annual percentage change*					
All drugs and biologics					
Before accounting for generic substitution	3.6%	2.9%	2.6%	4.1%	3.8%
After accounting for generic substitution	1.7	-2.1	1.3	3.4	2.6
Biologics (excluding insulin)	7.3	5.2	5.7	7.9	7.1
Share of gross Part D spending accounted for by biologics**	9	10	12	13	15

Note: Indexes are calculated using chain-weighted Fisher price indexes and are measured at the median of the distribution relative to prices as of the first quarter of 2006. Prices reflect total amounts paid to pharmacies before rebates or discounts from manufacturers and pharmacies. Indexes shown are rounded. Price indexes reflect changes in the prices of existing products. These indexes do not reflect the effect of launch prices of new products.

*Annual percentage changes reflect growth in the price index since the fourth quarter of the previous year, calculated using unrounded data.

**Gross spending for biologics excludes insulin. Biologics including insulin accounted for 18 percent of total gross Part D spending in 2018 and rose to 21 percent by 2022.

Source: Acumen LLC analysis for MedPAC.

that takes generic substitution into account rose in both 2021 and 2022 (by 3.4 percent and 2.6 percent, respectively), up from an average growth rate of less than 1 percent observed before 2020.³¹

Successful adoption of biosimilars will be key to lowering prices of biologics

Prices for generics are often a fraction of the prices for their brand-name counterparts (Association for Accessible Medicines 2021, Government Accountability Office 2016, Schondelmeyer and Purvis 2019). Part D enrollees have embraced their use, with generic dispensing growing in the decade between 2007 and 2017 from just over 60 percent of all prescriptions to nearly 90 percent (Medicare Payment Advisory Commission 2022c). Broad acceptance of generic medicines among prescribers and patients has

provided significant savings to beneficiaries and the Medicare program.

However, generics' share of prescriptions has plateaued since 2017, driven primarily by the shift in the drug development pipeline. Medicare now spends significant amounts on products for which generic versions are not available because they are biologics, which are given longer periods of market exclusivity when they are licensed. In 2022, biologics (not including insulin products) accounted for 15 percent of gross Part D spending, up from 9 percent in 2018 (Table 11-3). (Including insulin products, biologics accounted for 18 percent of gross Part D spending in 2018 and 21 percent by 2022.) Many biologics command high prices, often meeting the price threshold to be placed on a specialty tier (\$950 for a 30-day supply in 2024) (Assistant Secretary for Planning and Evaluation 2023). Prices of

Formulary coverage of Humira and its biosimilars

Humira (adalimumab) is a biological product manufactured by AbbVie and belongs to a class of medications known as tumor necrosis factor-alpha inhibitors. Humira is used to treat a wide range of autoimmune conditions, such as rheumatoid arthritis and ulcerative colitis. It is available in different doses and strengths, as well as in several injection devices, including autoinjector pens, prefilled syringes, and vials (Goodrich 2023).

Today, most of the Humira products sold in the U.S. are for the high-concentration (HC) formulation that requires less volume to be injected, which may be associated with less injection site-related pain (Goodroot 2023, Nash et al. 2016). Launched in July 2018, the HC products rapidly gained market share (Hagen 2021, Medicare Payment Advisory Commission 2022c). In 2022, over 80 percent of gross Part D spending for Humira products was for the HC formulation, up from less than 5 percent in 2018.

In 2023, nearly all Part D plans included all Humira products on their formularies. Annual therapy costs for Humira at list price can exceed \$80,000, and in 2022, gross Part D spending for Humira totaled \$5.4 billion (before postsale rebates and discounts), making it one of the products with the highest Part D spending.

Multiple Humira biosimilar products were launched in 2023

In 2023, nine adalimumab biosimilar products carrying mostly the same indications as Humira

entered the market (Goodrich 2023). Differences between Humira biosimilar products and the reference product are likely to have implications for formulary coverage as well as prescriber and patient willingness to switch to a biosimilar product. For example, many of the biosimilar products are available in the 40 mg dose but not in the 80 mg dose or in convenient package sizes for patients newly starting on adalimumab (Goodrich 2023). Other differences that could affect the uptake of Humira biosimilars include:

- **Formulation**—To date, only three biosimilar products (Hadlima, Hyrimoz, and Yuflyma) are available in the HC formulation. All other biosimilar products were approved in the original (low-concentration) formulation.
- **Interchangeability**—Currently, two products (Cyltezo and Abrilada) have the interchangeable designation, which allows pharmacists to substitute the biosimilar products for the reference product without obtaining a new prescription from the prescriber.³²
- **Pricing**—Some biosimilar manufacturers have launched their products with list prices that are 5 percent below Humira's list price, while others have priced their products at a steep discount (ranging from 55 percent to 86 percent relative to Humira's list price) (Fein 2023). Three manufacturers have launched products with both high and low list prices.

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biologics have grown by between 5.2 percent and 7.9 percent per year for the past five years, following years of double-digit growth (latter data not shown). Going forward, meaningful savings for biologics in Part D will largely depend on successful launch and adoption of biosimilars by prescribers and beneficiaries.

Several top-selling products for autoimmune conditions are now facing or are expected to face biosimilar competition in the next few years. In 2023, Humira, one of the top-selling products for the treatment of autoimmune conditions, began facing biosimilar competition (see text box on Humira

Formulary coverage of Humira and its biosimilars (cont.)

In 2024, most plans continue to cover Humira products

Humira biosimilars' success in gaining acceptance among patients and their prescribers crucially depends on their inclusion on plan formularies. To get a sense of how Part D plans are treating Humira biosimilars, we examined the formularies that Part D plans submitted for the 2024 benefit year.³³

While nearly all Part D plans will continue to provide broad coverage of Humira products, in 2024, nearly 60 percent of all Part D enrollees are in plans that include at least one Humira biosimilar product on their formularies.³⁴ About half of these enrollees are in plans that cover just one biosimilar product, while the other half are in plans that cover two or more. Roughly two-thirds of enrollees in plans that covered at least one biosimilar product are in Medicare Advantage–Prescription Drug plans (including special needs plans).

When a biosimilar product is on a plan's formulary, most plans place the biosimilar product on the same cost-sharing tier as Humira. (Note that when both Humira and its biosimilars are placed on the same tier (typically on a specialty tier with 25 percent or 33 percent coinsurance), the extent to which beneficiaries will use the biosimilar product depends, to some extent, on the size of the differences in list prices.) One exception is Kaiser Permanente plans: Amjevita is placed on a preferred brand tier (with a fixed-amount copayment), while

Humira products are placed on a specialty tier with 33 percent coinsurance.

Among the biosimilar products, Cyltezo, an interchangeable biosimilar available only in a low-concentration formulation, is most likely to be included on plan formularies. In 2024, Cyltezo is covered by about 50 percent of plans (accounting for just under 60 percent of Part D enrollees). While the vast majority of plans are covering both Cyltezo and Humira products (at parity), one sponsor is covering only Cyltezo in its nationwide prescription drug plan.

Hyrimoz, one of the two biosimilar products available in HC formulation, is covered by about a quarter of the plans (just under 30 percent of all enrollees). Because Hyrimoz is available in multiple dosage forms and package sizes, this product may offer more opportunities for patients and their prescribers to switch from Humira to a biosimilar product.

All other Humira biosimilar products are covered by less than 5 percent of plans. Having a low list price did not appear to give the biosimilar product an advantage in formulary placement over biosimilar products with higher list prices. Manufacturer rebates play an important role in plans' formulary coverage decisions. As a result, plans may opt to cover a biosimilar product (or a reference product) with a higher list price when the rebate makes such a decision more financially advantageous. ■

biosimilars). The experience of Humira and its biosimilar products could provide insights into the extent to which entries of biosimilar products help restrain Part D's prices of and spending for biologics. Part D plans' coverage of the biosimilar products will be critical to the success of biosimilar manufacturers that, in turn, will provide patients and Medicare with opportunities to benefit from the competitive pressure that lowers the prices of biologics.

Cost-based payments account for a growing share of program spending

The costs of providing Part D benefits are shared by Medicare (taxpayers) and its enrollees. Medicare pays plan sponsors two subsidies on behalf of each enrollee in their plans:

- **Direct subsidy**—A monthly (capitated) prospective amount set as a share of the national average bid

**TABLE
11-4****Medicare spending and enrollee premiums for Part D**

	Annual spending, in billions					Average annual change
	2018	2019	2020	2021	2022	2018–2022
Total Part D spending	\$83.3	\$88.3	\$93.0	\$94.8	\$101.9	5.2%
Capitated payments (direct subsidy)	13.5	11.8	10.9	7.1	4.8	–22.8
Cost-based reinsurance payments	<u>40.6</u>	<u>46.1</u>	<u>48.5</u>	<u>52.1</u>	<u>56.8</u>	8.8
Subtotal, basic benefits	54.1	57.9	59.4	59.2	61.6	3.3
Low-income cost-sharing and premium subsidy	28.5	29.7	33.0	35.0	39.7	8.6
Retiree drug subsidy*	0.7	0.7	0.6	0.6	0.6	–3.8
Enrollee premiums for basic benefits**	14.2	13.8	13.6	15.0	15.4	2.0

Note: Figures for capitated payments account for risk-sharing payments that plans make or receive under Part D's risk corridors. Figures for amounts that are paid prospectively (cost-based reinsurance and low-income subsidy) have been reconciled to actual spending amounts. Components may not sum to stated totals due to rounding.

*Subsidy for employers providing coverage that is comparable with or more generous than the basic Part D benefit.

**Excludes low-income premium subsidies. In addition, in 2022, enrollees paid \$9.9 billion in premiums for enhanced benefits.

Source: MedPAC analysis based on Table IV.B10 of the 2023 annual report of the Boards of Trustees of the Medicare trust funds.

for Part D basic benefits, adjusted for the risk of the individual enrollee.

- **Reinsurance**—Reimbursement to plans for 80 percent of drug spending above an enrollee's annual OOP threshold (the catastrophic phase of the benefit). Plans receive prospective payments for reinsurance that are reconciled with actual spending (net of postsale rebates and discounts) after the end of the benefit year for each enrollee who reached the OOP threshold.

Combined, the direct subsidy and expected reinsurance payments aim to cover 74.5 percent of the expected cost of basic benefits. Beneficiary premiums are designed to cover the remaining 25.5 percent of the expected cost of basic benefits. In addition to monthly premiums, Part D enrollees also pay any cost sharing required by plan sponsors or, in the case of LIS enrollees, cost-sharing amounts set in law. For enrollees who qualify for Part D's LIS, Medicare pays plans most or all of their cost sharing and premium liabilities on their behalf.

Medicare provides additional protection for the portion of the benefit for which plans are at risk (i.e., basic benefit costs, excluding cost-based reinsurance) by establishing symmetric “risk corridors” separately for each plan to limit its overall losses or profits. Under the risk corridors, Medicare finances a portion of the costs that are higher than expected or recoups a portion of profits that are higher than expected.

Between 2018 and 2022, program spending rose from \$83.3 billion to \$101.9 billion (Table 11-4), or an average of 5.2 percent per year. (Total Part D enrollment grew by about 3 percent per year on average during this period.) In 2022, Medicare paid \$4.8 billion for the monthly capitated direct subsidy, \$56.8 billion for reinsurance, \$39.7 billion for the LIS, and \$0.6 billion for the RDS. Part D enrollees paid \$15.4 billion in premiums for basic benefits in 2022 (not including the premiums paid by Medicare on behalf of LIS enrollees). In addition, enrollees paid \$9.9 billion in premiums for enhanced benefits.

Medicare's payments for the monthly capitated direct subsidy have declined sharply in recent years, falling

Effects of Part D premium stabilization provision on Medicare's overall subsidy rate

Each Part D plan submits a bid annually to CMS prior to the start of a benefit year. The bids reflect the plans' expected benefit costs (for a Part D enrollee of average health) plus administrative costs after deducting expected federal reinsurance subsidies. CMS calculates the national average bid for expected basic benefit costs (i.e., not including costs related to any supplemental benefits the plan may choose to include). The base beneficiary premium (BBP) is a share of the nationwide average bid.

Medicare provides plans with a subsidy that aims to average 74.5 percent of basic benefit costs. That subsidy takes the form of a direct subsidy—a capitated payment to plans calculated as a share of the national average of plan bids—and individual reinsurance, which currently covers 80 percent of spending above the out-of-pocket threshold. The remainder, 25.5 percent, is the base beneficiary premium.³⁵

Between 2023 and 2024, average basic benefit costs are expected to increase by about 20 percent. Under

prior law, the BBP, calculated as a share of that total, would have also increased by about 20 percent. However, beginning in 2024, a provision included in the Budget Reconciliation Act of 2022 limits the annual increase in the BBP to no more than 6 percent. Because of this 6 percent cap, the base beneficiary premium is \$34.70 per month in 2024. (Without the 6 percent cap, the base beneficiary premium amount would have been \$39.35 per month in 2024 (Centers for Medicare & Medicaid Services 2023c).) When the 6 percent cap is binding, Medicare's overall subsidy rate automatically increases to cover a larger share of basic benefit costs than the 74.5 percent originally set in law.³⁶ For 2030 and subsequent years, the BBP would be based on the lower of the 2029 BBP increased by 6 percent or the BBP calculated based on 2030 plan bids. However, the BBP in any given year may not be set at less than 20 percent of the average basic benefit costs (including expected average reinsurance) for that year (i.e., Medicare's subsidy rate can be no greater than 80 percent). ■

22.8 percent, on average, from 2018 to 2022. Multiple factors have contributed to this decline, including the increased use of generic drugs by Part D enrollees and the rapid growth in manufacturer rebates and pharmacy fees that disproportionately offsets basic benefit costs paid by plans. Meanwhile, Medicare's cost-based reinsurance payments continued to climb, rising 8.8 percent per year, on average, over the period, as the number of enrollees reaching the catastrophic phase of the benefit increased, as discussed below. As a result, by 2022 over 90 percent all of Medicare's basic benefit payments took the form of reinsurance (cost-based reimbursement) rather than monthly capitated direct subsidy payments. However, in 2024, average direct subsidy payments to plans will increase to nearly \$30 per member per month, up from an average of less than \$2 per member per month in 2023. At the same

time, average reinsurance payments will decrease to about \$90 per member per month, down from nearly \$94 per member per month in 2023.³⁷

A combination of legislative and regulatory changes likely contributed to the reversal of this trend toward higher reinsurance payments. In 2024, overall average basic benefit costs are expected to rise by 20 percent. That increase is due primarily to the increased generosity of Part D's basic benefits for specific products such as insulins and vaccines and to the elimination of cost sharing in the catastrophic phase of the benefit (see text box on implementation of the Part D-related provisions in the Budget Reconciliation Act of 2022, pp. 324–326).³⁸ An additional factor that is likely to increase benefit costs is the change in the

definition of negotiated prices. As discussed above, beginning in 2024, CMS now requires that enrollee cost sharing paid at the point of sale reflect all pharmacy price concessions; this regulatory change will, on average, reduce prices at the pharmacy and beneficiary cost sharing and thereby further increase benefit costs (Boards of Trustees 2023) (see text box on recent regulatory change to the definition of “negotiated price,” pp. 332–333). Lower beneficiary OOP costs, in turn, will slow the progression toward the OOP threshold. As a result, reinsurance costs are expected to decrease as some beneficiaries may no longer reach the catastrophic phase of the benefit. Finally, the annual increase in the base beneficiary premium is limited to no more than 6 percent. Consequently, most of the 20 percent increase in the average basic benefit costs (including expected average reinsurance) will be paid in the form of a higher direct subsidy (see text box on the effects of Part D premium stabilization provision, p. 339). Still, reinsurance continues to be a much larger share of the cost of the basic benefits.

In addition to reinsurance, Medicare shares financial risk with plan sponsors by risk adjusting direct subsidy payments to reflect the expected costliness of a plan’s enrollees and by limiting each plan’s overall losses or profits through risk corridors if actual benefit spending, excluding reinsurance, is much higher or lower than the plan sponsor anticipated in its bid.

In 2022, the number of beneficiaries reaching the catastrophic phase continued to rise after a drop in 2020

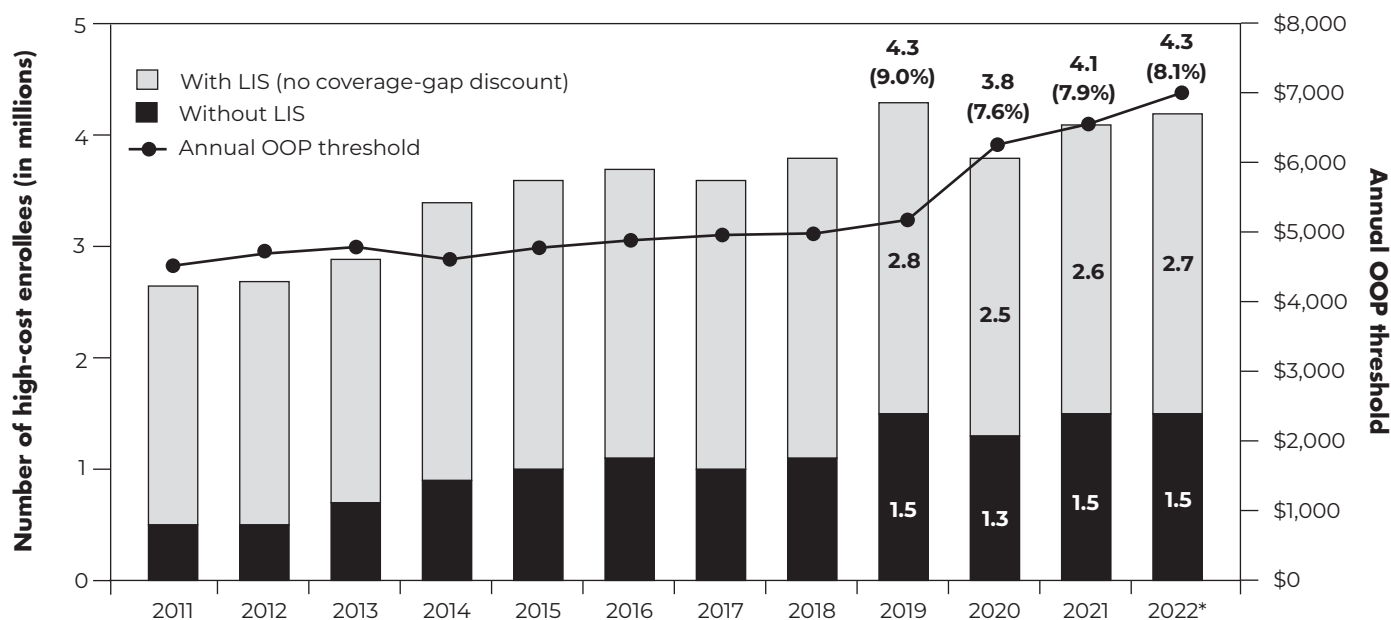
In 2022, the number of Part D high-cost enrollees—those with spending high enough to reach the catastrophic phase of the benefit—rose by about 5 percent to 4.3 million, following an increase of a similar magnitude in 2021 after a drop of 11 percent in 2020 (Figure 11-3). (Much of the decline in 2020 was likely driven by an unusually large, statutorily required 25 percent jump in the OOP threshold from its 2019 level.³⁹) In 2022, enrollees with the LIS continued to account for the majority (just over 64 percent) of all high-cost enrollees.⁴⁰ Beneficiaries with the LIS tend to use more medications and incur higher average spending compared with beneficiaries without the LIS (Medicare Payment Advisory Commission 2023a). While LIS enrollees accounted for less than 30 percent of all

Part D enrollees, in 2022, they accounted for about 46 percent of gross Part D spending.

Unlike in the previous years, the number of high-cost enrollees with the LIS grew more rapidly than the number of high-cost enrollees without the LIS. This faster growth in high-cost enrollees with the LIS may, in part, be due to more individuals retaining Medicaid eligibility (and therefore their LIS eligibility) during the COVID-19 public health emergency (Tolbert and Ammula 2023).

CMS adjusts the annual OOP threshold each year based on a formula set in law. Between 2021 and 2022, the annual OOP threshold increased from \$6,550 to \$7,050. Because LIS enrollees continued to make up most beneficiaries with high costs and Medicare’s LIS pays for nearly all costs in the coverage gap (above any nominal copayments required by law; see Figure 11-1, p. 322), the effects of the increase in the OOP threshold fell almost entirely on the program (and taxpayers) rather than beneficiaries themselves. For those enrollees without the LIS who did reach the coverage gap, the financial impact of a higher OOP threshold differed depending on whether the prescription was for a generic or a brand-name drug. For brand-name drugs, the manufacturer’s coverage-gap discount is treated as though it were the enrollee’s own OOP spending (see Figure 11-1). For example, an enrollee who filled only brand-name drugs in the coverage gap would be responsible for paying about a quarter of that increase. Meanwhile, beneficiaries who took only generic drugs would be responsible for the full increase. In 2022, coverage-gap discounts among high-cost enrollees without the LIS averaged more than \$4,800, accounting for 69 percent of the OOP threshold amount (\$7,050).

In 2022, the number of enrollees who used drugs with very high prices—where a single prescription was sufficiently expensive to meet the OOP threshold—rose by about 4 percent to over 482,000 enrollees—just over 11 percent of high-cost enrollees. That figure is lower than the corresponding figure for 2019 (483,000 enrollees) but still substantially higher than the 2010 figure (33,000 enrollees). High-cost enrollees without the LIS were more likely to have such claims compared with high-cost enrollees with the LIS (about 18 percent compared with just under 8 percent, respectively).

**FIGURE
11-3****Part D enrollees reaching the benefit's catastrophic phase, 2011–2022**

Note: LIS (low-income subsidy), OOP (out-of-pocket). Percentages shown are high-cost enrollees as a share of all Part D enrollees. Components may not sum to stated totals due to rounding.

*Amounts are based on preliminary Part D prescription drug event data.

Source: Enrollee counts for 2011 to 2022 are based on MedPAC analysis of Part D prescription drug event data.

Plans bear less risk for Part D spending than Medicare

Insurance risk provides an incentive for plan sponsors to offer attractive benefits while managing their enrollees' spending through formularies and other tools. The Commission has been concerned that the shift of risk from plan sponsors to Medicare has eroded plans' incentives to manage spending (Medicare Payment Advisory Commission 2022c). In 2022, plans were at risk for 25 percent of Part D spending net of all DIR and coverage-gap discounts (Table 11-5, p. 342). Medicare, on the other hand, was at risk for 62 percent of net Part D spending, consisting of 38 percent for reinsurance and 24 percent for the low-income cost-sharing subsidy.

The extent to which plans bear insurance risk varied by plan types. For example, MA-PDs' share of

insurance risk was more than double that of PDPs in 2022. The difference may reflect the fact that nearly all MA-PD enrollees are in enhanced plans that offer supplemental benefits for which plans are fully at risk. In comparison, about half of PDP enrollees in 2022 were in plans that offered basic coverage and did not include supplemental benefits. SNPs, which consist mostly of dual-eligible special needs plans that serve beneficiaries who receive both Medicare and Medicaid benefits, had a comparatively lower risk (9 percent) than other Part D plans. That difference may be due, in part, to the lack of plan liability in the coverage gap for beneficiaries with the LIS (see Figure 11-1, p. 322).

The distribution of insurance risk among stakeholders, however, is expected to change dramatically in 2025. The BRA restructured Part D benefits to replace much of what is now Medicare's cost-

**TABLE
11-5**

In 2022, plans' share of the insurance risk for Part D varied from 9 percent for SNPs to 34 percent for MA-PDs

	All Part D plans	By plan type*		
		PDPs	MA-PDs**	SNPs
As a share of spending net of all DIR and coverage-gap discounts:				
Plans at risk	25%	11%	34%	9%
Medicare at risk (reinsurance)	38	45	33	45
Low-income cost-sharing subsidy	24	27	17	44
Total, Medicare	62	72	50	89
Beneficiary cost sharing	12	17	16	1

Note: SNP (special needs plan), MA-PD (Medicare Advantage–Prescription Drug [plan]), PDP (prescription drug plan), DIR (direct and indirect remuneration). Plans are at risk for a portion of basic benefit costs and any supplemental benefits not subsidized by Medicare.

*Excludes employer group waiver plans.

**Excludes SNPs. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare Part D prescription drug event and direct and indirect remuneration data from CMS.

based payments—reinsurance and the low-income subsidy—with capitated payments (see text box update on implementation of the BRA's Part D-related provisions, pp. 324–326). As a result, plans will be at risk for a larger share of Part D spending. That change, in turn, is expected to restore incentives for plans to manage drug spending—incentives that have eroded over the years.

Most Part D enrollees were satisfied

Measuring the quality of the pharmacy benefit and enrollees' medication use is critical for assessing Part D's value, but it is a task that requires nuance. On the one hand, effective treatment for many conditions may hinge primarily on access and adherence to prescription drugs. On the other hand, Medicare beneficiaries are likely to have multiple chronic conditions and take an average of nearly five prescription drugs per month, putting them at higher risk for adverse drug events associated with polypharmacy. Thus, the degree to which Part D plans help to manage enrollees' medication therapies is important as well.

To ensure access, CMS reviews each plan's formulary to check that it includes medicines in a wide range of therapeutic classes used by the Medicare population and applies utilization management tools in appropriate ways. Further, Part D law requires sponsors to have a transition process to ensure that new enrollees, as well as current members whose drugs are no longer covered or are subject to new restrictions, have access to the medicines they have already been taking.⁴¹ CMS has also established network adequacy requirements to ensure that beneficiaries have a sufficient number of pharmacies in network within the plan's geographic area. In addition, Medicare requires plan sponsors to establish a process for coverage determination and appeals.⁴² If an enrollee is dissatisfied with a plan's final coverage decision, the enrollee may appeal the decision to an independent review entity and then to higher levels of appeal.

CMS collects quality and performance data to monitor plan sponsors' operations and evaluate access to medicines, enrollee experience, and patient safety. A subset of these data is used in the 5-star rating system made available through Medicare's Plan Finder at Medicare.gov to help beneficiaries evaluate their

plan options. The agency also uses star ratings that are based in part on prescription drug benefits to determine MA quality bonus payments. (Although both MA-PDs and stand-alone PDPs are evaluated with star ratings, only MA-PDs are eligible for quality bonus payments through the Part C payment system.) The agency displays other Part D quality measures on the CMS website, including some metrics that are either being removed from or evaluated for addition to the star rating system. In addition, by law, Part D plans are required to carry out medication therapy management (MTM) programs and programs to manage opioid use.

Plans offered in 2024 have lower average overall ratings for the second straight year, though the share of beneficiaries in a plan with 4 or more stars increased among MA-PD enrollees relative to 2023. Among PDPs, just 27 percent of plans being offered in 2024 received 4 or more stars, and these plans enrolled just 2 percent of PDP beneficiaries in 2023. MA-PDs, on the other hand, enrolled 73 percent of MA-PD beneficiaries in the 42 percent of such plans that earned 4 or more stars, reflecting a high concentration in high-performing plans. In total, 31 MA-PDs and 2 PDPs earned 5 stars. Nonprofit plans and plans with a longer history were more likely to score higher than for-profit and newer plans. One explanation for at least some of the decline in high-performing plans is a methodological change that created higher thresholds that were more difficult for plans to meet.⁴³

Dissatisfaction tied to costs is likely to be lessened by new OOP cap

Overall beneficiary satisfaction with Medicare Part D exceeds 90 percent, according to multiple surveys. More than 80 percent of Part D enrollees report that their Part D plans provide good value and that their costs are reasonable, though cost has been the most common reason for any dissatisfaction. Among respondents to the Medicare Current Beneficiary Survey (MCBS), 82 percent of Part D enrollees were satisfied with the amount they paid for prescriptions, which averaged \$608 annually (Centers for Medicare & Medicaid Services 2021b). In focus groups convened for the Commission, physicians and beneficiaries were acutely aware of high drug costs and reported having frequent discussions about ways to lower costs (NORC at the University of Chicago 2023). More specifically, findings show that the satisfaction rate pertaining

to the affordability of cost sharing for brand-name medicines is significantly lower (76 percent) than for generic medicines (89 percent) (*Medicare Today* 2023). Nevertheless, because the majority of prescriptions are for inexpensive generic drugs and a relatively small number of beneficiaries use brand-name or high-cost specialty drugs, overall satisfaction remains high.

For enrollees who do use expensive medications, high cost sharing can result in beneficiaries not initiating therapy or abandoning prescriptions at the pharmacy (Doshi et al. 2018, Dusetzina et al. 2020).⁴⁴ One recent study of fee-for-service Medicare beneficiaries who were newly prescribed a specialty drug found that LIS enrollees—who pay limited cost sharing—were twice as likely to fill their prescription within 90 days as enrollees without the LIS (Dusetzina et al. 2022).⁴⁵ Nearly one-fourth of enrollees responding to the MCBS reported an affordability issue, including 15 percent who did not take their medicine as prescribed because of cost (Table 11-6, p. 344) (Centers for Medicare & Medicaid Services 2021b).⁴⁶ These beneficiaries, on average, incurred higher OOP costs (\$703) than those who were satisfied (\$608).

Affordability issues were most prevalent among non-White beneficiaries (Centers for Medicare & Medicaid Services 2021b). There were no significant differences in rates of affordability challenges between PDP and MA-PD enrollees or LIS and non-LIS enrollees, although the amounts paid by these subgroups varied substantially (Table 11-6, p. 344).

The presence of chronic conditions may also affect enrollees' satisfaction with their costs and coverage. Only 61 percent of beneficiaries without a chronic condition were satisfied with their coverage compared with 81 percent of those with a chronic condition (data not shown) (Centers for Medicare & Medicaid Services 2021b). This distinction may be explained by the fact that most chronic conditions can be well managed with generic medicines that tend to be broadly covered and inexpensive (Centers for Medicare & Medicaid Services 2023b).

While premiums have long been viewed as the main factor that beneficiaries consider when choosing their plan, the MCBS found that only 28 percent considered plan premiums, while 32 percent considered the cost they would pay for drugs and 33 percent considered

**TABLE
11-6****Beneficiary satisfaction and affordability issues varied by subgroup, 2021**

	Overall satisfaction	Beneficiary experienced a cost-related access issue	Average OOP cost among beneficiaries with a cost-related access issue
Overall	80%	15%	\$621
Race/ethnicity			
White	81	14	717
Asian	69	9	184
Black	77	21	369
Hispanic	78	13	370
Multiple races	77	22	272
LIS status			
Not receiving LIS	82	14	858
Receiving LIS	73	16	140
Plan type			
PDP	76	15	704
MA-PD	84	15	543

Note: OOP (out-of-pocket), LIS (low-income subsidy), PDP (prescription drug plan), MA-PD (Medicare Advantage–Prescription Drug [plan]). Cost-related access issues include not filling a prescription or skipping or taking smaller doses than prescribed because of affordability challenges.

Source: Acumen analysis of Medicare Current Beneficiary Survey (2021).

the convenience of the pharmacy options available (data not shown) (Centers for Medicare & Medicaid Services 2021b). Average OOP costs among those who considered premiums most important were somewhat lower than for those who considered prescription costs most important. With the new OOP cap, however, premiums may once again become the primary factor to consider when choosing a plan.

Overall, White enrollees were more likely than enrollees of other races to be satisfied with the program (81 percent vs. 69 percent to 78 percent) (Table 11-6) (Centers for Medicare & Medicaid Services 2021b). Enrollees without the LIS were more likely to be satisfied with their Part D plan than LIS enrollees (82 percent vs. 73 percent). MA-PD enrollees were also more likely to be satisfied with the program than PDP enrollees (84 percent vs. 76 percent).

Recent medication therapy management demonstration yielded no significant impacts

Part D plan sponsors must operate MTM programs to improve therapeutic outcomes and reduce adverse drug events for certain high-risk beneficiaries: (1) those who have multiple chronic conditions, take multiple medications, and are likely to have drug spending that exceeds an annual cost threshold (\$5,330 for 2024, slightly above the initial coverage limit), and (2) those who are at risk for opioid misuse or abuse. Plan sponsors are required to enroll, with opt-out provisions, all eligible beneficiaries in their MTM programs and report certain measures annually to CMS to evaluate the outcomes of their interventions. These programs must offer interventions for both beneficiaries and prescribers. At a minimum, the programs must provide enrolled

beneficiaries with a comprehensive medication review (CMR) at least annually and a targeted medication review (TMR) at least quarterly for ongoing monitoring and follow-up of any medication-related issues.⁴⁷ MTM programs may also include services such as patient-directed medication counseling, immunization assessments and reminders, and care coordination.

For years, the Commission has had concerns about the effectiveness of MTM programs, particularly in stand-alone PDPs, which do not bear financial risk for medical spending like MA-PDs. In measures used for the 2024 star ratings (based on 2022 data), an average of just 55 percent of enrollees in PDP MTM programs received a comprehensive medication review, compared with an average of 84 percent in MA-PD MTM programs (Centers for Medicare & Medicaid Services 2023d).

Over the period from 2017 to 2021, CMS tested an enhanced MTM model to see if new payment incentives and regulatory flexibilities would spur stand-alone PDPs to improve their MTM programs and reduce Medicare spending. The demonstration's flexibilities allowed participating sponsors to set their own targeting criteria and better tailor their MTM interventions to their enrollees.⁴⁸ CMS made prospective payments per beneficiary per month to the sponsors to cover the estimated costs of more extensive interventions. Plans could also earn performance-based payments if they sufficiently reduced expenditures for Part A and Part B services, paid via reductions in beneficiary premium obligations in future years to reward their success through expected higher enrollment.

Six Part D sponsors operated 22 participating PDPs in 5 PDP regions over the 5-year period. In 2021, about 1.1 million enrollees in those plans were eligible for enhanced MTM services, and about 40 percent of those eligible received services, a rate that remained steady for model years two through five (Acumen LLC 2023).

The Part D Enhanced MTM Model, however, did not improve beneficiary health outcomes, as measured by reductions in drug-therapy problems and in downstream medical expenditures (Acumen LLC 2023).⁴⁹ A final evaluation of the entire five-year

demonstration found no statistically significant effects on Medicare spending for Part A and Part B services, while prospective payments for the enhanced MTM services under the model were larger than decreases in spending, resulting in net costs to Medicare of \$288.8 million (Acumen LLC 2023). The evaluation also found no significant improvements in medication adherence or measures of potentially unsafe medication use among beneficiaries receiving enhanced MTM services. For example, relative to nonparticipating enrollees, high statin adherence decreased, drug-drug interactions increased, and high-risk medication use decreased by less than that of comparators.

Plan sponsors expressed support for the program's flexibilities, noting that it allowed for innovative outreach and targeting of beneficiaries, but they reported that meaningfully engaging prescribers to play an active role in promoting the use of enhanced MTM by their patients was challenging (Acumen LLC 2023). Prescribers reported mixed views about plan sponsor involvement in their patients' care, and most reported that sponsors did not understand the goals of their prescribed medication therapy; still, three-fourths reported making changes to their patients' medications based on recommendations resulting from an MTM service.

Sponsors also reported that providing MTM services to LIS beneficiaries was challenging because of inaccurate contact information (Acumen LLC 2023). Thus, while they were more likely than non-LIS beneficiaries to be eligible for services, they were less likely to receive them.

The five-year demonstration did provide some valuable insights into ways in which Part D MTM programs could be improved. First, for an MTM to be effective, it is important to target and provide services at "clinically meaningful" times (Acumen LLC 2023). In particular, beneficiaries were most likely to receive MTM services when they experienced a transition of care (e.g., a hospital discharge) or changes to their medications. Beneficiaries and other stakeholders thought that MTM services that were too frequent or duplicative (such as CMRs offered at regular intervals) have limited value. Second, beneficiaries were more receptive to recommendations from community pharmacists with whom they have a longstanding

relationship but preferred conversations over the phone because of privacy concerns (Acumen LLC 2023). Finally, the report noted operational changes that could improve the efficiency of MTM services.

For example, for identifying beneficiaries with a recent transition of care, health information exchange data provided more timely information compared with Part A and Part B claims data. ■

Endnotes

- 1 Examples of other sources of payments that qualify as true OOP spending include AIDS Drug Assistance Programs, qualified State Pharmacy Assistance Programs, and certain charities.
- 2 Even today, when the defined standard benefit has 25 percent coinsurance in both the initial coverage phase and coverage-gap phase, many Part D plans structure their cost sharing differently across the two phases, charging copayments for generics and preferred drugs initially but charging 25 percent coinsurance in the coverage gap.
- 3 However, while a plan may set fixed-dollar copayments for certain tiers in the initial coverage phase, the way the coverage-gap discount is implemented requires cost sharing in the coverage gap to be calculated as a percentage of costs rather than fixed copayment amounts.
- 4 For example, in 2024, generic tiers cannot have copayments that exceed \$20 per prescription or charge coinsurance of more than 25 percent in the benefit phase between the deductible and the initial coverage limit. Plans may not use copayments of more than \$100 or coinsurance higher than 50 percent for drugs on nonpreferred tiers.
- 5 Insulin cost sharing must be capped at the lesser of 25 percent or \$35 for a month's supply.
- 6 Under the Medicare Drug Negotiation Program, the Secretary must select negotiation-eligible drugs from among the qualifying single-source drugs with the highest gross spending, for which at least 7 years (or 11 years for biologics) have elapsed between approval by the Food and Drug Administration (FDA) and the selected drug publication date (Centers for Medicare & Medicaid Services 2023h). By law, the "ceiling" for the maximum fair price (MFP) is the lower of (1) a weighted average of prices negotiated by Part D plans net of manufacturer rebates and discounts (not including the coverage-gap discount or any manufacturer discounts retained by pharmaceutical supply chain participants, such as specialty pharmacies); or (2) an amount calculated based on the nonfederal average manufacturer price and the number of years on the market since a drug was approved by the FDA. The Secretary may negotiate a lower MFP beyond the discounts required under law by taking into account factors such as the manufacturer's research and development costs, current unit costs of production and distribution, and prior federal financial support for novel therapeutic discovery and development, as well as evidence regarding alternative treatments (Centers for Medicare & Medicaid Services 2023h). The negotiated price could be higher or lower than the price that would have prevailed if the manufacturer's drug had not been selected, depending on the ultimate level of discount negotiated by the Secretary and other rebates and discounts the manufacturer would have paid, including any mandatory discounts (Berger et al. 2023).
- 7 If a manufacturer agrees to participate in the Negotiation Program but fails to honor the negotiated price, it will face civil monetary penalties.
- 8 Drugs selected for price negotiation will not be subject to the manufacturer discount. For LIS beneficiaries and for certain smaller manufacturers, the new manufacturer discount program will be phased in over time, reaching final levels by 2031.
- 9 Examples of other factors that affect investment in biopharmaceutical research and development include federal regulatory policies related to drug approval and patents and intellectual property; federal tax policy; payment policies of other payers in the U.S. and internationally; the cost of drug development, including capital availability and costs; and collaboration between pharmaceutical manufacturers and academic institutions (Congressional Budget Office 2021). In addition, the federal government contributes to innovation both directly and indirectly through its funding for basic science research and drug development research for some products (Galkina Cleary et al. 2018, Sampat and Lichtenberg 2011).
- 10 In addition, multiple lawsuits have been filed by pharmaceutical manufacturers and other stakeholders, including the National Infusion Center Association, which may affect the implementation of the Negotiation Program (O'Neill Institute 2023).
- 11 The Commission has also recommended establishing higher copayment amounts for nonpreferred and nonformulary drugs under the LIS benefit and giving plans greater flexibility regarding coverage of drugs in the protected classes, though these proposals have not yet been adopted (Medicare Payment Advisory Commission 2020a, Medicare Payment Advisory Commission 2019a, Medicare Payment Advisory Commission 2016).
- 12 The Budget Reconciliation Act of 2022 is often referred to as the Inflation Reduction Act.
- 13 Examples of creditable drug coverage from sources other than Part D include the Federal Employees Health Benefits Program, TRICARE, and coverage from the Department of Veterans Affairs.

- 14 EGWPs are sponsored by employers that contract directly with CMS or on a group basis with an insurer or pharmacy benefit manager to administer the Part D benefit. They differ from employer plans that receive the RDS in that Medicare Part D is the primary payer rather than the employer.
- 15 The remainder qualified either because they received benefits through the Medicare Savings Programs or Supplemental Security Income program or because they were eligible after they applied directly to the Social Security Administration.
- 16 A portion of the difference between an MA plan's payment benchmark and its bid for providing Part A and Part B services is referred to as "MA rebate dollars." Plan sponsors can use MA rebate dollars to supplement benefits or lower Part D or MA premiums. In 2023, MA-PD sponsors applied on average \$54 per month (26 percent) of their Part C rebate dollars to Part D benefits. Of that amount, 42 percent was used to lower Part D premiums for basic benefits and the rest was used for supplemental drug benefits.
- 17 As with the income-related premium for Part B, higher Part D premiums apply to individuals with an annual adjusted gross income greater than \$103,000 and to couples with an adjusted gross income greater than \$206,000. A beneficiary whose income exceeds these levels pays a monthly adjustment amount in addition to their Part D plan premium. For 2024, adjustments range from \$12.90 to \$81.00 per month, depending on income.
- 18 The LEP amount depends on the length of time an individual goes without coverage as generous as Part D and is calculated by multiplying 1 percent of the base beneficiary premium by the number of full uncovered months an individual was eligible but was not enrolled in a Part D plan and went without other creditable coverage.
- 19 Most MA plans are MA-PDs, offering combined medical and outpatient drug benefits. However, a small share of MA plans (including Medicare Savings Account plans) do not offer prescription drug coverage.
- 20 Most of the 50 organizations operate both PDPs and MA-PDs. About 20 of those 50 sponsors offer PDPs that are available only to employer groups.
- 21 Some PBMs that are vertically integrated with plan sponsors operate exclusively for the plan sponsor that owns them. Humana Pharmacy Solutions (Humana), IngenioRx (Anthem/Elevance), and Kaiser Pharmacy (Kaiser) are examples. Other PBMs serve the sponsor that owns them as well as other clients, e.g., CVS/Caremark (CVS Health), OptumRx (UnitedHealth Group), and Express Scripts (Cigna) (Guardado 2022).
- 22 The Commission's calculation is based on Part D prescription drug event and direct and indirect remuneration data from CMS.
- 23 Among plans that have them in 2024, preferred pharmacies make up an average of 40 percent, 48 percent, and 49 percent of all PDP, general MA-PD, and SNP network pharmacies, respectively.
- 24 The Commission's calculation is based on Part D prescription drug event and direct and indirect remuneration data from CMS.
- 25 Anecdotal evidence suggests that there may be situations in which cost-sharing amounts charged at a preferred pharmacy are higher than at other (nonpreferred) pharmacies. Such situations may be possible if, for example, the prices are higher at the preferred pharmacy (compared with other pharmacies) and the beneficiary pays a percentage coinsurance based on that higher price.
- 26 Examples include incentive bonuses (such as bonuses that encourage generic dispensing), fees that are assessed on other measures such as medication adherence that are set by the sponsor or its PBM, or other contingent amounts that cannot reasonably be determined at the point of sale. Pharmacies, however, contend that these fees "remain unpredictable, inconsistent, and based on unattainable standards" (National Association of Chain Drug Stores 2022).
- 27 The Commission's calculation is based on Part D prescription drug event and direct and indirect remuneration data from CMS.
- 28 CMS requires Part D plan sponsors to report PBM-negotiated rebates so that Medicare can appropriately pay the program's share of net-of-rebate drug spending rather than list-price spending. However, postsale rebates and discounts received by PBM subsidiaries such as mail-order and specialty pharmacies are not reported (Medicare Payment Advisory Commission 2017a). In interviews conducted for the Commission, PBM auditors and consultants voiced concerns that there is less visibility into the transfer prices that PBMs pay to their mail-order and specialty pharmacies, which affects what payers are subsequently charged (Hargrave 2017). PBMs noted that they have corporate firewalls to keep transactions between subsidiaries at arm's length. However, information firewalls are difficult to enforce.
- 29 The price index reflects changes in the prices of existing products. It does not reflect the effect of launch prices of new products.

- 30 An individual NDC uniquely identifies the drug, its labeler, dosage form, strength, and package size.
- 31 For this index, Acumen groups NDCs that are pharmaceutically identical, aggregating prices across drug trade names, manufacturers, and package sizes. As a result, brand-name drugs are grouped with their generics if they exist, and this price index more closely reflects the degree to which market share has moved between the two.
- 32 Abrilada is an interchangeable biosimilar product launched in the fall of 2023. The formulary files available at the time that the analysis was conducted did not include Abrilada.
- 33 The analysis was conducted in the fall of 2023 using the formulary files released in November. Consequently, the results do not reflect any formulary changes made after November 2023 files were released.
- 34 Enrollment for 2024 is estimated using 2023 enrollment, assuming beneficiaries remained in the same plan for 2024.
- 35 Monthly premiums paid by individual beneficiaries will vary as they pay the base premium plus any difference between their plan's bid and the nationwide average bid. Enrollees in costlier plans face higher-than-average premiums for standard Part D coverage; similarly, enrollees in less expensive plans pay lower-than-average premiums.
- 36 Based on the national average bid and the base beneficiary premium amounts for 2024, we calculate that, in 2024, Medicare's average subsidy rate (before reconciliation) will be about 77.5 percent.
- 37 Amounts are calculated from information in CMS's announcement of the 2024 Part D national average monthly bid amount and base beneficiary premium (Centers for Medicare & Medicaid Services 2022).
- 38 Although the legislative change to cap insulin cost sharing at \$35 for each prescription of a month's supply became effective January 1, 2023, because the change was made after plan bids for 2023 had already been submitted, bids for basic benefits in 2023 did not fully reflect the expected costs of the more generous insulin coverage. Note that, for 2023, about half of all plans had planned to participate in the Senior Savings Model that covered certain insulins at no more than \$35 for each prescription of a month's supply under their enhanced benefits.
- 39 The Affordable Care Act of 2010 required Medicare to temporarily apply slower growth rates to the OOP threshold between 2014 and 2019. However, for 2020 and thereafter, the OOP threshold reverted to the levels that would have been in place had the slower growth rates never applied.
- 40 However, going forward, the elimination of cost sharing in the catastrophic phase of the benefit beginning this year and the lowering of the OOP threshold in 2025 is expected to lessen cost-related access issues, particularly among enrollees without the LIS. As a result, in both 2024 and 2025, we may see an uptick in the number of high-cost enrollees without the LIS.
- 41 The transition fill is a temporary one-month supply provided within the first 90 days of coverage in a new plan or the new contract year for existing enrollees.
- 42 Plan sponsors must make coverage determination and exception decisions within 72 hours of a request or within 24 hours for expedited requests. If the initial request for an exception does not include the necessary supporting statement, the plan has up to 14 calendar days to obtain the information. See our March 2020 report to the Congress for more details (Medicare Payment Advisory Commission 2020b).
- 43 The Tukey outlier deletion methodology was employed for the first time this year to remove outliers from the data before determining threshold cut points for each of the measures. Because the outliers tended to be on the lower end of the spectrum, the cut points were higher than they would have been if those outliers were not deleted, and thus fewer plans were able to meet the higher thresholds.
- 44 The relationship between higher cost sharing and adherence, treatment initiation, and the rate of prescription abandonment is likely to vary widely across therapeutic classes. For example, patients may be less likely to abandon or not adhere to treatment plans for certain cancer regimens compared with therapies for chronic conditions such as rheumatoid arthritis (Medicare Payment Advisory Commission 2019b). This difference may reflect the varying availability of patient assistance programs for different disease types.
- 45 For drugs on specialty tiers, beneficiaries have little recourse because they may not request a tiering exception to obtain the specialty-tier drugs at lower (preferred) cost sharing.
- 46 We assessed the number of people who experienced affordability issues by examining the number who reported doing any of the following because of cost: delaying filling or not getting a prescription, skipping or taking smaller doses, using a credit card in order to pay over time, asking for their doctor's approval to stop taking a medicine, spending less to save for a prescription, or not using coverage because the cost was too high.

- 47 CMRs must include a person-to-person or telehealth consultation performed by a pharmacist or other qualified provider and a written summary of the review that includes a medication list and action plan, if any, provided to beneficiaries in CMS's standardized format. A TMR is distinct from a CMR because it is focused on specific medication-related problems, actual or potential. A TMR can be conducted person to person or be system generated, and details of interventions can be delivered by mail or faxed to the beneficiary or the prescriber, as appropriate (Centers for Medicare & Medicaid Services 2021a).
- 48 For example, a sponsor might choose to provide more counseling services on medication adherence and devote fewer resources to CMRs.
- 49 Assessments of whether beneficiary outcomes improved or expenditures declined were determined by comparing outcomes and expenditures of beneficiaries enrolled in plans participating in the demonstration with beneficiaries in plans not participating in the demonstration using a propensity score matching approach, and results are expressed relative to nonparticipants. Expenditure assessments included both Medicare Part A and Part B spending, as well as prospective and performance-based payments made as part of the demonstration, but not Part D (outpatient prescription drug) spending.

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CHAPTER 12

The Medicare Advantage program: Status report

The Medicare Advantage program: Status report

Chapter summary

Each year, the Commission provides a status report on the Medicare Advantage (MA) program. In 2023, the MA program included 5,635 plan options offered by 184 organizations, enrolled about 31.6 million beneficiaries (52 percent of Medicare beneficiaries with both Part A and Part B coverage), and paid MA plans an estimated \$455 billion (not including Part D drug plan payments). To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for beneficiaries enrolled in traditional fee-for-service (FFS) Medicare. We also provide updates on risk adjustment, risk coding practices, the structure of the MA market, and the current state of quality reporting in MA.

The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than from the FFS Medicare program. The Commission strongly supports the inclusion of private plans in the Medicare program. Beneficiaries should be able to choose among Medicare coverage options since 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 the additional benefits and alternative delivery systems that private plans provide. MA plans are required by statute to offer an out-of-pocket spending limit

In this chapter

- Robust MA enrollment, plan availability, and rebates
- Payments to MA plans far exceed FFS spending due to favorable selection into MA plans and higher MA coding intensity
- Industry concentration, integration, and financial condition
- Quality in MA
- Commission recommendations would address many problems with MA payment policies and the quality bonus program

that is not available in FFS Medicare, and plans can provide extra benefits not covered by Medicare, reduce cost-sharing liability, and offer integrated Part D benefits. Because Medicare pays private plans a partially predetermined rate that is risk adjusted for each enrollee rather than a per service rate, plans should have greater incentives than FFS providers to deliver more efficient care.

The MA program is quite robust, with growth in enrollment, increased plan offerings, and a near record-high level of extra benefits financed by payments to plans through Medicare rebates. From 2018 to 2023, the share of eligible Medicare beneficiaries enrolled in MA rose by 3 percentage points per year, from 37 percent to 52 percent. Thus, a majority of eligible Medicare beneficiaries are now enrolled in MA. In 2024, the average Medicare beneficiary has a choice of 43 plans (offered by an average of 8 organizations), and the average enrollee in a conventional MA plan has \$2,142 in extra benefits available from the plan for the year (plans project \$187 in administrative costs and profit for these services for an average plan rebate of \$2,329). These extra benefits are subsidized by Medicare payments to plans for MA enrollees; such benefits are not available to beneficiaries in FFS unless they purchase additional health insurance coverage or pay for the services out of pocket. Projected Medicare payments for MA extra benefits (including plan administrative fees and profit) have more than doubled since 2018 and account for a projected 17 percent of payments to all MA plans in 2024, yet currently there is no reliable information about the extent to which beneficiaries use these benefits.

Medicare spends an estimated 22 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates into a projected \$83 billion in 2024. The Commission acknowledges that a portion of these increased payments to MA plans are used to provide more generous supplemental benefits and better financial protection for MA enrollees. Table 12-3 (p. 371) includes a detailed breakdown of those benefits. Nevertheless, the Commission is concerned that the relatively higher payments to MA plans are subsidized by the taxpayers and beneficiaries who fund the program. Higher MA spending increases Part B premiums for all beneficiaries (including those in FFS who do not have access to the supplemental benefits offered by MA plans); the Commission estimates that those premiums will be about \$13 billion higher in 2024 because of higher MA spending. Further, the Commission is concerned that policies leading to higher MA payments also do not adequately address issues that distort the nature of plan competition in MA.

When risk-based payment for private plans was first added to Medicare in 1985, payments to private plans were 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 private plans in the aggregate have never been paid less than FFS Medicare because of policies that have increased payments to MA above FFS. As examples, MA benchmarks are set above FFS spending in many markets in part to encourage more uniform plan participation across the country, and payments under the quality bonus program further increase MA payments above FFS (without, the Commission has found, producing meaningful information on plan quality for Medicare beneficiaries or the Medicare program). Further, favorable selection of enrollees into MA plans leads to risk-standardized spending of MA enrollees that would be lower than the FFS average (this effect is independent of the effects of any plan utilization management). Moreover, MA plans' diagnostic coding practices increase payments and distort the goal of plans competing to improve quality and reduce health care costs. Currently, the Commission does not quantify the extent to which favorable selection stems from plan behavior, beneficiary preferences, or other reasons, nor the extent to which higher MA coding intensity reflects documenting diagnoses more comprehensively than providers in FFS Medicare, the fraudulent submission of diagnostic data, or other reasons. Regardless of the causes, favorable selection of enrollees in MA and higher MA coding intensity increases payments to plans. Finally, the Commission finds that plan-submitted data about beneficiaries' health care encounters are incomplete—or, in the case of many extra benefits, missing. Without adequate information, policymakers cannot fully understand enrollees' use of services, which limits policymakers' ability to oversee the program.

A major overhaul of MA policies is urgently needed for several reasons. First, beneficiaries lack meaningful quality information when choosing among MA plans. Second, Medicare is paying more for MA than for comparable beneficiaries in FFS Medicare. Third, the disparity between MA and FFS payment disadvantages beneficiaries who—for medical reasons or personal preferences—do not want to enroll in MA plans that use tools like provider networks or utilization management policies and instead want to remain in FFS (which includes care provided through alternative payment models). Fourth, the lack of information about the use and value of many MA supplemental benefits prevents meaningful oversight of the program such that we cannot ensure that enrollees are getting value from those benefits. Finally, the continued growth in MA will increasingly create challenges for benchmark

setting because beneficiaries remaining in FFS may be higher risk (and thus have higher spending) in ways that risk adjustment cannot adequately capture.

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. In addition, the growing subsidization of supplemental benefits remains a concern. Because of Medicare's fiscal situation, the subsidization of supplemental benefits, if desired by policymakers, should be considered with attention to their value. In the Commission's view, current policy does not meet that standard. If payments to MA plans were lowered, plans might reduce the supplemental benefits they offer. However, because plans use these benefits to attract enrollees, they might respond instead by modifying other aspects of their bids.

In this chapter, we examine:

Medicare payments to plans—As noted, Medicare payments to MA plans in 2024 (including rebates that finance extra benefits) are projected to total \$83 billion more than if MA enrollees were enrolled in FFS Medicare. Payments to MA plans average an estimated 122 percent of what Medicare would have expected to spend on MA enrollees if they were in FFS Medicare. This estimate reflects higher MA coding intensity, even after the annual CMS coding adjustment; favorable selection of beneficiaries in MA; setting benchmarks—the maximum amount Medicare will pay an MA plan to provide Part A and Part B benefits—above FFS spending in low-FFS-spending counties; and payments associated with benchmark increases under the quality bonus program, which the Commission contends does not effectively promote high-quality care.

Risk adjustment and coding intensity—Medicare payments to MA plans are specific to each enrollee, based on a plan's payment rate and an enrollee's risk score. Risk scores account for differences in expected medical expenditures and are based in part on diagnoses that providers code. In both MA and FFS Medicare, claims include both procedure and diagnosis codes; however, most FFS Medicare claims are paid using only procedure codes, which offers 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 adding new risk-adjustment-eligible diagnoses raises an enrollee's risk score and results in higher payments to the plan. And plans have several mechanisms that do

not exist in FFS Medicare to document diagnoses for their enrollees, including chart reviews (which document diagnoses not captured through the usual means of reporting diagnoses) and health risk assessments (which sometimes rely on unverified enrollee-reported data). Coding differences may reflect MA plans capturing more diagnoses than FFS providers, potentially because MA plans have an incentive to report every diagnosis for an enrollee and FFS providers may be more likely to focus on more significant diagnoses that are a primary reason for a visit. Research has shown that some FFS beneficiaries have chronic conditions that are reported inconsistently from year to year—including conditions like kidney failure or paraplegia—suggesting that not all diagnoses are reported in FFS Medicare. Furthermore, whistleblowers and the Department of Justice allege that some MA plans have submitted fraudulent diagnoses for risk adjustment. There are no data available to parse the share of higher MA coding intensity due to these or other reasons; however, because the risk-adjustment model is calibrated on FFS claims, relatively higher MA coding intensity—regardless of the reason—increases payments to MA plans above FFS spending.

We estimate that in 2022, MA risk scores were about 18 percent higher than scores for similar FFS beneficiaries due to higher coding intensity (the Commission has adopted a new method of estimating the effects of coding intensity; see Chapter 13). We project that in 2024, MA risk scores will be about 20 percent higher than scores for similar FFS beneficiaries (accounting for the phase-in of the V28 risk-adjustment model). By law, CMS reduces all MA risk scores by the same amount 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 2024, the adjustment will reduce MA risk scores by the minimum amount, 5.9 percent, resulting in MA risk scores that will remain about 13 percent higher than they would have been if MA enrollees had been enrolled in FFS Medicare. In 2024, higher scores will result in a projected \$50 billion in higher payments to MA plans. We continue to find that coding intensity varies significantly across MA plans, with some plans having coding intensity that falls below the 5.9 percent reduction (and even below FFS levels) and other plans coding far above that amount, including 10 MA organizations with average coding intensity that is more than 20 percent higher than FFS levels. Among the eight largest MA organizations, we estimate a 15 percentage point variation in average coding intensity. Higher coding intensity allows some plans to offer more extra benefits—and attract more enrollees—than other plans. That result distorts both the nature of plan competition in MA and 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, use two years of MA and FFS diagnostic data, and apply an adjustment to MA risk scores to eliminate any residual impact of coding intensity. We find that about half of higher MA coding intensity could result from use of diagnoses from chart reviews and health risk assessments and that these two mechanisms are primary factors driving coding differences among MA plans. Thus, the Commission expects that the recommendation, along with the exclusion of chart reviews from risk adjustment, would improve the heterogeneity in observed coding intensity across MA organizations.

Quality in MA—To make informed choices about enrolling in an MA plan, beneficiaries need good information about the quality and access to care provided by MA plans in their local market. However, the Commission has long been concerned about the ability of the current MA quality bonus program to help beneficiaries meaningfully differentiate across plans and between MA and FFS. Further, the Commission contends that the program does not effectively promote high-quality care and has several other flaws. For instance, it relies on too many measures that do not reflect salient enrollee outcomes or experiences; it distorts improvement incentives with performance thresholds that introduce “cliff effects”; and it evaluates quality for large and sometimes geographically disparate contracts, rather than for plans at the local market level.

In 2024, nearly three-quarters of MA enrollees (23.3 million beneficiaries) were in a plan that received a quality bonus increase to its benchmark, generating about \$15 billion in additional program spending. In its June 2020 report, the Commission recommended replacing the current quality bonus program, which does not achieve its intended purposes and is costly to Medicare, with a new value incentive program for MA. In this report, we focus on the spending implications and other concerns regarding the current quality bonus program. In a future report, we plan to include a more detailed chapter on MA quality and access to care, which will provide more information about the Commission’s approach to these topics, including some empirical analysis of MA plan performance. ■

Background

The Medicare Advantage (MA) program allows Medicare beneficiaries enrolled in both Part A and Part B to receive benefits from private plans rather than from the traditional fee-for-service (FFS) program. The Commission strongly supports including private plans in the Medicare program because they allow beneficiaries to choose between FFS Medicare and the alternative delivery systems that private plans can provide. Unlike traditional FFS Medicare, MA plans typically have flexibility to use alternative payment models, negotiate with individual providers, use care-management techniques that fill potential gaps in care delivery, and provide incentives for beneficiaries to seek care from more efficient providers. By contrast, traditional FFS Medicare has lower administrative costs, but it can lack incentives to coordinate care and is limited in its ability to make care delivery more efficient.¹

For beneficiaries, the primary trade-off in choosing between MA and FFS is access to the additional benefits that plans provide versus a broader choice of providers participating in FFS. MA plans are required by statute to offer an out-of-pocket spending limit that is not available in FFS Medicare. MA plans also can offer integrated Part D benefits, provide supplemental benefits not covered by Medicare, and reduce cost-sharing liability. For 2024, we estimate that conventional MA plans (those available to all MA enrollees) will receive an average rebate from CMS of \$2,329 per enrollee (or \$2,142 after subtracting plan projections for administrative costs and profit for these services) to provide supplemental benefits during the year and that more than half of that will be allocated to reducing beneficiaries' cost sharing or Part B and Part D premiums. In exchange for these benefits, MA plan enrollees accept differences in coverage such as higher cost sharing to access providers out of a plan's network. Because private plans and traditional FFS Medicare have structural aspects that appeal to different segments of the Medicare population, the Commission has supported payment policies that do not unduly favor MA or FFS.

Each year, the Commission provides a status report on the MA program. To monitor program performance, we examine MA enrollment trends, plan availability

for the coming year, and payments for MA enrollees relative to spending for FFS Medicare beneficiaries. We also provide updates on risk adjustment, risk coding practices, and the current state of quality in MA.

Types of MA plans

Our analysis of the MA program uses the most recent data available, and we report our results by plan type. The analysis does not include non-MA private plan options such as cost plans that may be available to some beneficiaries. The primary MA plan types are:²

- **HMOs and local preferred provider organizations (PPOs)**—These plans have provider networks and, if they choose, can use tools such as selective contracting and utilization management to coordinate and manage care and control service use.³ They can choose individual counties to serve and can vary their premiums and benefits across counties. These two plan types are classified as coordinated care plans (CCPs).
- **Regional PPOs**—These plans are required to offer a uniform benefit package and premium across CMS-designated regions made up of one or more states. Regional PPOs have more flexible provider network requirements than local PPOs. Regional PPOs are also classified as CCPs.

Two additional plan classifications cut across plan types: special needs plans (SNPs) and employer group plans. SNPs offer benefit packages tailored to specific populations (beneficiaries who are dually eligible for Medicare and Medicaid, are institutionalized, or have certain chronic conditions). Each SNP must be an HMO or PPO plan. Employer group plans are available only to Medicare beneficiaries who are members of employer or union groups that contract with those plans. SNPs are included in our plan data, with the exception of plan availability figures because these plans are not available to all beneficiaries. Employer plans do not submit bids, so they are not included in our access analyses. In contrast to prior years, we estimate payments for employer group plans and include them in our overall comparison of MA payments relative to FFS spending.⁴ (See the Commission's March 2015 report to the Congress for more detailed information on employer plans.)

How Medicare pays MA plans

In contrast to FFS Medicare's fixed rates per service paid to providers, Medicare pays MA plans a fixed rate for each enrolled beneficiary, which is the product of a base rate and a risk score. Risk scores adjust a plan's base rate to account for differences in expected beneficiary medical costs by increasing a plan's payment rate for beneficiaries who are likely to have higher medical expenses and vice versa.

A plan's base rate is determined by the MA plan's bid and the benchmark for the county in which the beneficiary resides. The bid is intended to represent the dollar amount that the plan estimates will cover the Part A and Part B benefit package for a beneficiary of average health. The benchmark is the maximum amount of Medicare payment set by law for an MA plan to provide Part A and Part B benefits.⁵ (Medicare also pays plans for providing the Part D drug benefit, but those payments are determined through the Part D bidding process, and not all MA plans include the Part D benefit.) Plans with higher quality ratings are rewarded with a higher benchmark (although the increase to the benchmark can be limited by the Affordable Care Act of 2010 (ACA) benchmark caps). If a plan's normalized bid is above the normalized benchmark (after both have been adjusted to reflect a person of average risk), the plan's MA base payment rate is set at the benchmark and enrollees have to pay a premium (in addition to the usual Part B premium) equal to the difference. For 2024, almost 100 percent of plans bid below their benchmarks. If a plan's normalized bid is below the benchmark, its payment rate is its bid plus a share of the difference between the plan's bid and the benchmark (as low as 50 percent but typically either 65 percent or 70 percent, depending on a plan's quality ratings). For this computation, the comparison is between an individual plan's actual bid for its expected enrolled population and a plan-specific risk-standardized average benchmark, weighted by the plan's projected enrollment from counties in its service area. The beneficiary pays no additional premium to the plan for Part A and Part B benefits (but continues to be responsible for paying the Medicare Part B premium and may pay premiums to the plan for additional benefits). The added payment to the plan, based on the difference between the bid and the benchmark, is

referred to as the rebate. The rebate must be used to provide additional benefits to enrollees in the form of lower cost sharing, lower premiums, or supplemental benefits. Plans also devote some of the rebate to their administrative costs and profit. Plans can choose to include additional supplemental benefits that are not financed by the rebate in their benefit packages and charge premiums to cover those additional benefits.⁶ (A more detailed description of the MA program payment system can be found in our *Payment Basics* series at <https://www.medpac.gov/document-type/payment-basic/>.)

How Medicare calculates MA benchmarks

Under the ACA, each county's benchmark, excluding quality bonuses, equals a certain share (ranging from 95 percent to 115 percent, subject to caps) of the projected average per capita FFS Medicare spending for the county's beneficiaries.⁷ Each county's benchmark is determined by organizing the counties into quartiles based on their FFS spending. Low-FFS-spending counties have benchmarks higher than their county's FFS spending level to help attract plans and enable enrollees to receive extra benefits, and high-FFS-spending counties have benchmarks lower than FFS spending to generate Medicare savings, given the history of very low bids in such counties that reflect high FFS service use. Counties are assigned to quartiles based on average FFS spending; the highest-spending quartile of counties has benchmarks set at 95 percent of local FFS spending. The next-highest-spending quartile of counties has benchmarks set at 100 percent of FFS spending, followed by the third-highest quartile set at 107.5 percent of FFS spending. The lowest-spending quartile has benchmarks set at 115 percent of local FFS spending. U.S. territories are treated like counties in this lowest-spending quartile. Counties that move among quartiles from year to year receive a blended quartile factor. For example, a county that moved from the 100 percent quartile in 2023 to the 107.5 percent quartile in 2024 would have had a blended rate of 103.75 percent in 2024.

By statute, plans awarded quality bonuses have benchmarks that are 5 percent higher than the standard county benchmarks (subject to benchmark growth caps); in certain counties, plans can receive a double bonus, and the benchmarks for plans

awarded quality bonuses are 10 percent higher than the standard benchmarks.⁸ Unlike nearly all of Medicare's FFS quality incentive programs, these quality bonuses are not budget neutral but are instead financed by added program dollars and beneficiary premiums. The Commission's original conception of a quality incentive program for MA plans was a system that would be budget neutral and financed with a small share of plan payments (Medicare Payment Advisory Commission 2012b, Medicare Payment Advisory Commission 2004). A budget-neutral system is consistent with the Commission's principle of providing a level playing field between private MA plans and FFS Medicare and reflects the Commission's recommendation to the Congress in June 2020 (Medicare Payment Advisory Commission 2020a, Medicare Payment Advisory Commission 2019).

How Medicare calculates risk scores

Risk scores are beneficiary-level index values that indicate the expected Medicare costs for an enrollee relative to the national average FFS beneficiary. How well Medicare's payments to MA plans match their enrollees' costliness depends in large part on how well the risk scores predict the expected costs for the plans' enrollees.

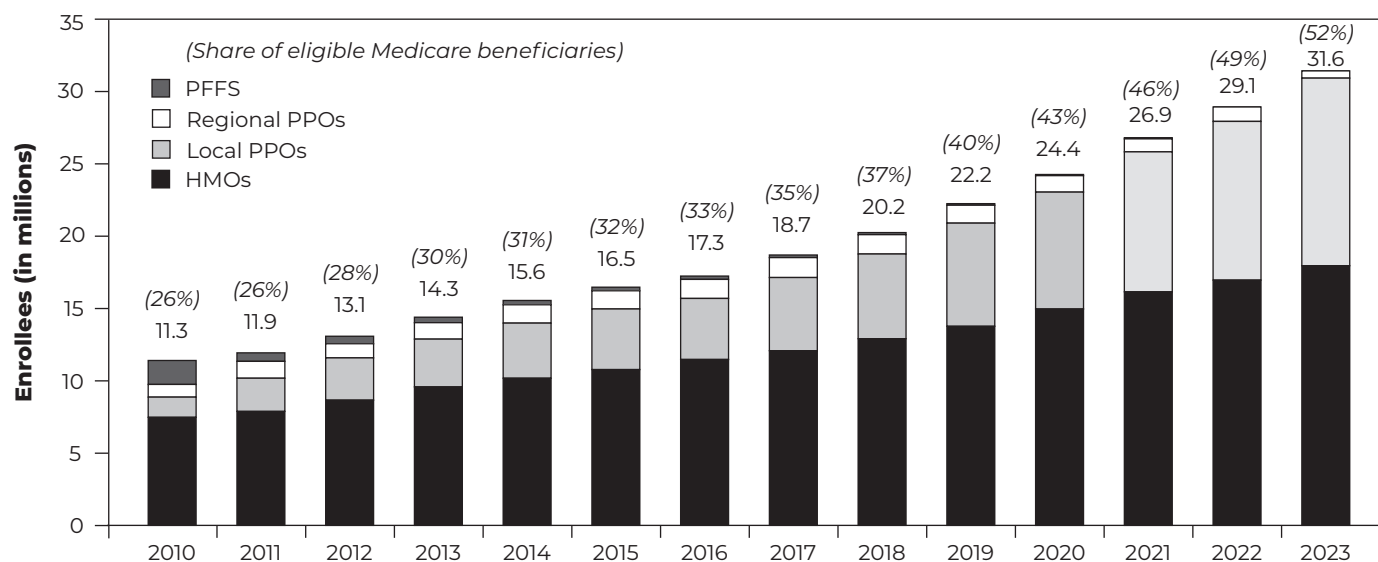
CMS calculates risk scores with the CMS hierarchical condition category (CMS-HCC) risk-adjustment model, which uses demographic information (e.g., age, sex, Medicaid enrollment, and disability status) and certain diagnoses grouped into HCCs to calculate a risk score for each enrollee. HCCs are medical conditions or groups of related conditions with similar treatment costs. Some conditions have more than one HCC, which differ by severity of the condition and are arrayed in a hierarchy. For example, the CMS-HCC model has three HCCs for diabetes: without complications, with chronic complications, and with acute complications. The "hierarchical" aspect of HCCs means that if a beneficiary's diagnoses map to more than one HCC in a condition hierarchy, CMS applies only the HCC that has the largest effect on the beneficiary's risk score—the highest-severity HCC.

CMS tracks beneficiary demographic information, but MA plans submit diagnostic information to CMS through encounter records, which contain basic

information about each Medicare-covered encounter an enrollee has with a health care provider and each Medicare-covered item provided to the enrollee.⁹ Diagnostic data collected from encounters in one calendar year are used to predict Medicare costs for the following calendar year.

CMS designed this risk-adjustment model to maximize its ability to predict annual medical expenditures for FFS Medicare beneficiaries while also ensuring that the model's diagnostic categories were clinically meaningful and specific enough to minimize opportunities for gaming or discretionary coding (Pope et al. 2004). CMS has two requirements to ensure the validity and reliability of the diagnostic data used in an enrollee's risk score: Diagnoses must (1) appear on a claim from a hospital inpatient stay, a hospital outpatient visit, or a face-to-face visit with a physician or other health care professional, and (2) be supported by evidence in the patient's medical record.¹⁰ Diagnoses resulting from telehealth services meet the face-to-face requirement when the services are provided using interactive audio and video telecommunication that enables real-time communication with the beneficiary. To ensure that diagnoses are supported by evidence in the patient's medical record, CMS conducts risk-adjustment data validation (RADV) audits. RADV audits have been limited so far, but the available results show significant issues with medical record support for risk-adjustment diagnoses (Schulte and Hacker 2022).^{11,12}

The CMS-HCC model is calibrated using FFS claims data so that each beneficiary's risk score reflects the expected spending that would occur for a beneficiary who represents national average spending in FFS Medicare. Therefore, risk scores do not reflect geographic spending variation, a beneficiary's propensity to seek care, differences between MA and FFS Medicare, including variation in plans' benefit design or initiatives to influence spending, or differences in diagnostic coding practices between MA and FFS Medicare and across MA plans. These factors drive differences between actual spending for MA enrollees and the expected spending based on MA risk scores, some of which are reflected in our estimates of the effects of favorable selection into MA and of higher MA diagnostic coding intensity.

**FIGURE
12-1****Enrollment in Medicare Advantage has more than doubled since 2014**

Note: PFFS (private fee-for-service), PPO (preferred provider organization), HMO (health maintenance organization). Beneficiaries must have both Part A and Part B coverage to enroll in a Medicare Advantage plan; therefore, beneficiaries who have Part A only or Part B only are not included in this figure.

Source: MedPAC analysis of CMS enrollment files, July 2010–2023.

Robust MA enrollment, plan availability, and rebates

Substantial growth in MA plan enrollment, availability, and rebates indicates a robust MA program. As of 2023, more than half of eligible Medicare beneficiaries were in MA plans. For 2024, the average beneficiary has access to 43 plans sponsored by 8 organizations, and rebates that finance extra benefits are at near record-high levels.

In 2023, 8 percent growth in MA plan enrollment; 52 percent of eligible Medicare beneficiaries enrolled in MA plans

Between July 2022 and July 2023, enrollment in MA plans grew by 8 percent—or 2.4 million enrollees—to 31.6 million enrollees, while the total MA-eligible population (beneficiaries with both Part A and Part B coverage) grew only 2 percent and FFS enrollment

declined about 4 percent. The change in MA enrollment of 2.4 million was the second-highest annual increase over the last five years. Between 2022 and 2023, MA enrollment rose from 49 percent to 52 percent of eligible Medicare beneficiaries (Figure 12-1). Enrollment in MA has more than doubled since 2014. MA has become increasingly attractive to beneficiaries because plans provide cost-sharing reductions and a cap on out-of-pocket expenses at little or no premium. Many beneficiaries with care needs that are met within plan networks will likely have lower financial liability (premiums and cost sharing) compared with beneficiaries who stay in FFS and purchase the most comprehensive supplemental coverage. Some MA enrollees with high care needs do experience greater cost liabilities compared with beneficiaries in FFS (e.g., greater cost sharing for in-network and out-of-network services compared with the premiums for Medigap supplemental coverage), but most of these

**TABLE
12-1****MA plan enrollment continued rapid growth in 2023**

	Enrollment (in millions)		Percent change in enrollment (2022–2023)
	July 2022	July 2023	
Total MA-eligible beneficiaries	59.2	60.4	2%
Total MA	29.1	31.6	8
Plan type			
HMO	17.1	18.1	6
Local PPO	11.2	12.9	15
Regional PPO	0.7	0.5	–32
PFFS	<0.05	<0.05	–22
Restricted-availability plans included in totals above			
SNPs*	4.9	6.1	25
Employer group*	5.2	5.5	6

Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). The total Medicare population used to calculate enrollment shares in this table excludes the approximately 8 percent of beneficiaries who are not eligible to enroll in an MA plan because they do not have both Part A and Part B coverage. Totals and calculated values may be affected by rounding.

*SNPs and employer group plans have restricted availability. Their enrollment is included in the statistics by plan type and location. We present them separately to provide a more complete picture of the MA program.

Source: MedPAC analysis of CMS enrollment files.

MA enrollees would likely have difficulty obtaining a Medigap policy if they switched to FFS.¹³

Among plan types, recent growth in MA enrollment has been disproportionately higher among local PPOs. Although HMOs continued to enroll the most beneficiaries (18 million) in 2023, enrollment in local PPOs grew faster (15 percent) than in HMOs (6 percent) (Table 12-1). In addition, between 2022 and 2023, enrollment in local PPOs grew by 1.7 million, accounting for more than two-thirds of the overall increase in MA enrollment. As MA rebates have risen, the resulting increase in extra benefits provided by local PPOs combined with less restrictive networks (relative to HMOs) has likely contributed to the recent enrollment increase among local PPOs.¹⁴ Much of the increase in HMO enrollment resulted from enrollment in SNPs: Increased SNP enrollment accounted for half of all MA enrollment growth between 2022 and 2023. In 2023,

SNP enrollment grew by 25 percent—an acceleration of the rapid growth (above 10 percent per year) observed over the last four years. HMOs accounted for nearly three-quarters of the SNP enrollment growth (data not shown). While enrollment in non-SNP HMOs was essentially unchanged, enrollment in SNP HMOs grew by 23 percent (data not shown). Local PPO SNPs have proliferated since 2018, rising from 4 percent of SNP enrollment to 18 percent in 2023. Altogether, in 2023, Medicare beneficiaries eligible to enroll in SNPs are predominantly enrolled in HMOs, and those without qualifying special needs are primarily enrolled in PPOs (data not shown), but local PPOs are increasingly popular among both groups.

Enrollment patterns differ in urban and rural areas. The majority (54 percent) of eligible urban beneficiaries are enrolled in MA compared with 44 percent of eligible beneficiaries residing in rural counties.¹⁵ However, the

**TABLE
12-2****Access to Medicare Advantage plans remains high**

Share of Medicare beneficiaries with access to at least one MA plan					
Type of plan	2020	2021	2022	2023	2024
Any MA plan	99%	99%	99%	>99.5%	>99.5%
Local CCP	98	98	99	99	>99.5
Regional PPO	73	72	74	74	74
PFFS	36	34	35	29	30
Special needs plans					
Dual eligible	90	92	94	94	95
Chronic condition	52	57	59	66	72
Institutional	67	72	74	77	78
Zero-premium plan with drug coverage	93	96	98	99	99
Average number of choices					
County weighted	15	18	22	26	28
Beneficiary weighted	27	32	36	41	43

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service). "Local CCP" includes HMO and local PPO plans. These figures exclude employer-only plans and Medicare medical savings account plans. Special needs plans are included in the three special needs plan rows but excluded from all other rows. For 2020 and 2021, "share of Medicare beneficiaries" includes beneficiaries who do not have both Part A and Part B coverage (i.e., includes all Medicare beneficiaries). For 2022 through 2024, the share of Medicare beneficiaries includes only beneficiaries with both Part A and Part B coverage (i.e., includes MA-eligible beneficiaries). A "zero-premium plan with drug coverage" includes Part D coverage with no Part D premium (but may include the Part B premium). "County weighted" means that each county is weighted the same and the measure is the average number of choices per county. "Beneficiary weighted" means that each county is weighted by the number of beneficiaries in the county.

Source: MedPAC analysis of CMS bid and enrollment data.

growth of MA plans in rural areas has been much faster in recent years. In 2023, MA enrollment in rural areas grew by 12 percent (compared with 8 percent growth in urban areas). The predominant plan type often differs between urban and rural areas. In 2023, 39 percent of rural MA enrollees were in HMO plans compared with about 61 percent of urban enrollees. By contrast, 57 percent of rural enrollees were in local PPOs compared with 38 percent of urban enrollees.

In many areas of the country, a majority of eligible Medicare beneficiaries are now enrolled in MA. In 28 states (including California, Florida, Michigan, New York, Pennsylvania, and Texas) and Puerto Rico, more than half of the eligible population was enrolled in an MA plan in 2023. In some metropolitan areas (e.g., El

Paso, TX; Grand Rapids, MI; Greensboro, NC; Miami, FL; Pittsburgh, PA; Rochester, NY), more than 70 percent of eligible Medicare beneficiaries were enrolled in MA plans. MA benchmarks are computed at the county level, and in an increasing number of counties, most Medicare beneficiaries are enrolled in MA plans. In all counties in Puerto Rico and an additional 1,170 counties across 39 states, more than half of eligible Medicare beneficiaries were enrolled in MA plans in 2023. The increasing share of MA enrollees in some geographic areas raises questions about whether the local FFS population should continue to be the basis for MA payment benchmarks. Benchmarks can become inaccurate if the FFS population is not representative of Medicare beneficiaries overall. Declining enrollment

in FFS can potentially diminish how well the CMS risk-adjustment model predicts costs for MA enrollees. For example, in some counties, a disproportionate number of FFS beneficiaries have comprehensive supplemental coverage, which is generally unavailable in MA and induces higher demand for health care services.

Access to MA plans remains high in 2024

Every year, we assess plan availability and projected enrollment for the coming year based on the bid data that plans submit to CMS. We find that access to MA plans remains high in 2024, with most Medicare beneficiaries having access to many plans. Some measures of availability have improved for 2024. While almost all beneficiaries have had access to some type of MA plan since 2006, local CCPs have become more widely available in recent years (Table 12-2). In 2024, nearly 100 percent of Medicare beneficiaries have an HMO or local PPO plan (both are considered local CCPs) operating in their county of residence, up from 99 percent in 2023.¹⁶

The availability of SNPs continues to be high across the types of special needs populations served (Table 12-2). In 2024, 95 percent of beneficiaries reside in areas where SNPs serve beneficiaries who are dually eligible for Medicare and Medicaid (up from 94 percent in 2023), 72 percent live where SNPs serve beneficiaries with chronic conditions (up from 66 percent in 2023), and 78 percent live where SNPs serve institutionalized beneficiaries (up from 77 percent in 2023).¹⁷ Overall, 99 percent of beneficiaries reside in counties served by at least one type of SNP (data not shown).

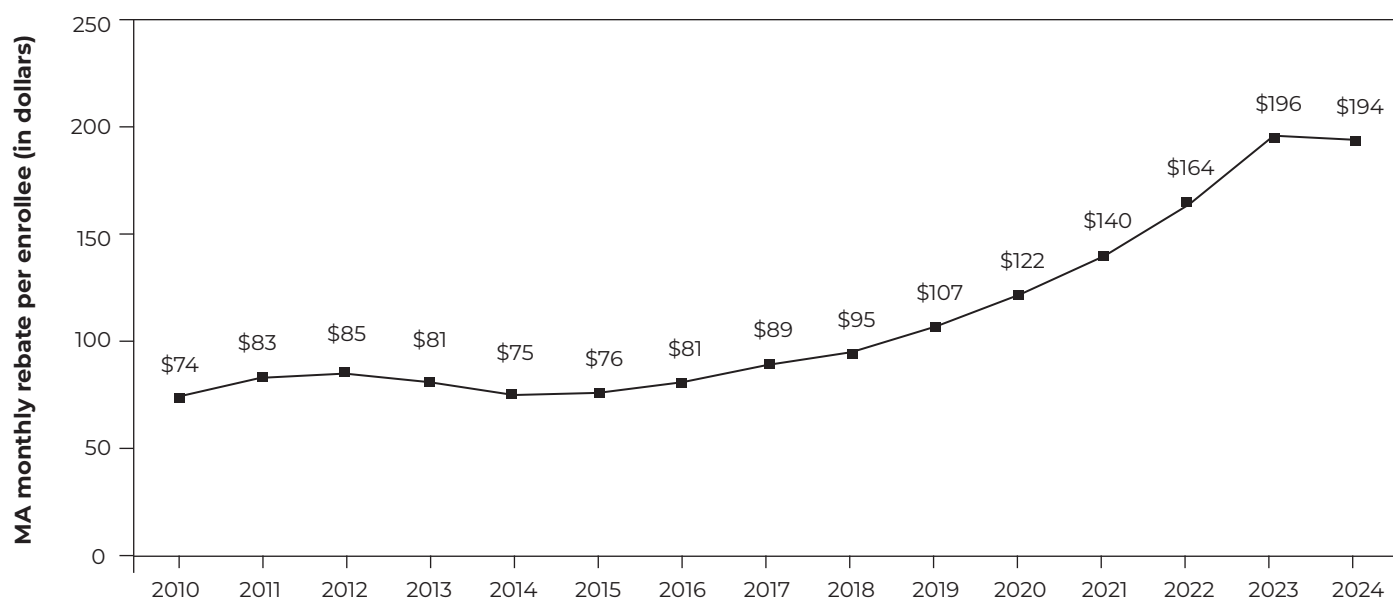
In 2024, nearly 100 percent of eligible Medicare beneficiaries (unchanged from 2023) have access to at least one conventional MA plan (i.e., excluding SNPs and employer group plans) that includes Part D drug coverage and charges no Part C or Part D premium (enrollees still pay the Medicare Part B premium) (Table 12-2).¹⁸ About 75 percent of MA enrollment is projected to be in these zero-premium plans (data not shown). Also in 2024, 99 percent of beneficiaries (unchanged from 2023) have access to plans that offer some reduction in the Part B premium, but only 12 percent of 2024 projected conventional MA enrollment was projected to be in these premium-reduction plans, and the average monthly premium reduction was \$7 (data not shown).

In most counties, beneficiaries have access to a large number of MA plans. In 2024, the average number of plans available in a county increased to 28 plans (from 26 plans in 2023) (Table 12-2). Plan availability can also be evaluated by the number of plan choices available to the average beneficiary. According to that calculation, the average beneficiary in 2024 has 43 available plans, an increase from 41 plans in 2023. An additional measure of plan access is the number of insurers offering products to the average beneficiary. In 2024, the average beneficiary can choose from plans sponsored by 8 organizations (organization data not shown); 98 percent of beneficiaries have access to MA plans sponsored by at least 3 organizations, 95 percent of beneficiaries can choose from plans sponsored by at least 4 organizations, and 91 percent of beneficiaries can choose from plans sponsored by at least 5 organizations. Given the large number of plan choices, beneficiaries may find it difficult to discern differences in plan benefit packages in order to make an optimal choice.

MA rebates in 2024 remain at nearly record levels

MA plans continue to receive nearly record levels of rebates in 2024. Plans must use the rebate to provide extra benefits—such as lower cost sharing, lower premiums, or supplemental benefits not covered by Part A or Part B (such as vision, hearing, dental, and fitness benefits) to attract more enrollees. Plans also use some of the rebate to cover their administrative costs and as profit. Although plans are required to submit encounter data for supplemental benefits, CMS does not have reliable information about enrollees' actual use of these benefits at this time.¹⁹

For 2024, rebates for conventional MA plans—excluding employer plans and SNPs—average \$194 per enrollee per month (\$2,329 annually per enrollee; \$2,142 after subtracting plan projections for administrative costs and profit), a slight decrease from the record high \$196 per enrollee per month in 2023 (Figure 12-2, p. 370). When including SNPs, rebates reached a record high of \$209 per enrollee per month in 2024—a slight increase from \$206 per enrollee per month in 2023 (data not shown). These rebates account for 17 percent of plan payments, unchanged from 2023 (data not shown). The average MA rebate among conventional plans has more than doubled since 2018.

**FIGURE
12-2****MA rebates for conventional plans have more than doubled since 2018**

Note: MA (Medicare Advantage). Employer group plans, special needs plans, and plans that do not offer Part D coverage are not included. The plan rebate is the per beneficiary per month amount that the plan offers as premium-free extra benefits. Rebate dollar amounts are based on the national average and reflect plan risk scores in plan bids but do not reflect payment adjustments for sequestration. We do not have reliable information about beneficiaries' use of these benefits.

Source: MedPAC analysis of data from CMS on plan bids.

We assess plan rebates based on projected rebate allocations included in plans' bids, but we do not have reliable information about enrollees' actual use of extra benefits. In 2024, the share of plan rebates allocated toward cost-sharing reductions is projected to remain about the same as 2023 levels (Table 12-3). Plans project that \$75 per enrollee per month in rebates (39 percent of rebate dollars, unchanged from 2023) will go toward reductions in cost sharing for Medicare services, 1 percent lower relative to 2023.^{20,21} However, plans reported allocating a slightly higher share of plan rebates to non-Medicare-covered supplemental benefits.

In 2024, plans project that 27 percent of rebates (averaging \$53 per enrollee per month) will be used for non-Medicare-covered supplemental benefits.²² The Commission previously reported that while these benefits often include coverage for vision, hearing, or dental services, the non-Medicare supplemental benefits are not necessarily tailored toward populations that have the greatest social or medical

needs (Medicare Payment Advisory Commission 2021a).²³ The lack of information about enrollees' use of supplemental benefits makes it difficult to determine whether the benefits improve beneficiaries' health (Government Accountability Office 2023).

Limited data suggest that use of non-Medicare-covered supplemental benefits is low. A small study by the actuarial firm Milliman analyzed 2018 MA claims for 1.9 million beneficiaries who were 65 or older and enrolled in plans that provided dental coverage (Wix and Fontana 2020). The study found that only 11 percent of enrollees had MA-covered claims for preventive dental care. In addition, multiple studies using survey data have found that beneficiaries with dental coverage in MA are not more likely to receive dental services than other Medicare beneficiaries (Centers for Medicare & Medicaid Services 2020, Simon et al. 2023, Willink et al. 2020). Moreover, one trade association examined data in 2020 for 30,000 MA enrollees in a regional plan who had access to the over-the-counter (OTC) benefit, which provides an allowance for beneficiaries

**TABLE
12-3****Conventional MA plans project that rebates will be used to reduce cost sharing, reduce Part B and Part D premiums, and offer non-Medicare benefits in 2024**

	Rebate (per member per month)		2024 percent change	Share of total rebate	
	2023	2024		2023	2024
Total	\$196	\$194	-1%	100%	100%
Extra benefit type					
Cost sharing	76	75	-1	39	39
Non-Medicare supplemental	50	53	6	26	27
Part D supplemental	38	34	-10	19	18
Part D premium	27	24	-8	14	13
Part B premium	5	7	40	3	4

Note: MA (Medicare Advantage). Employer group plans, special needs plans, and plans that do not offer Part D coverage are not included. Amounts for cost sharing and non-Medicare supplemental benefits include plan costs for administration and profit. Cost-sharing amounts include plan projections of their liability for the beneficiary out-of-pocket expenses cap. Rebate dollar amounts are based on the national average and reflect plan risk scores in plan bids but do not reflect payment adjustments for sequestration. We do not have reliable information about beneficiaries' use these benefits. Values may not sum due to rounding.

Source: MedPAC analysis of data from CMS on plan bids.

to receive specified nonprescription items from pharmacies (Consumer Healthcare Products Association 2021). This study found that only 33 percent of eligible beneficiaries used the OTC benefit during the year. Further, one plan sponsor released a limited summary of the use of their MA supplemental benefits for a sample of about 860,000 MA enrollees in 2022 (Elevance Health 2023). For 6 of the plan's 42 supplemental benefits, the plan did not have the available data to report utilization. For the remaining 36 benefits that the plan covered, most enrollees used 3 or fewer benefits. Although some benefits have restricted availability, the plan did not identify which share of eligible benefits were used. Among the plan's non-dual-eligible enrollees, 25 percent did not use any of the 36 supplemental benefits, the majority (52 percent) used 1 or fewer benefits during the year, and 86 percent used 3 or fewer benefits. Among the plan's dual-eligible enrollees, 17 percent did not use any of the 36 supplemental benefits, 36 percent used 1 or fewer benefits, and 76 percent used 3 or fewer benefits. The plan did not report what share of enrollees used any specific benefit, including benefits that are intended to address social determinants of health. Thus, to the extent that plans' supplemental benefits are intended

to address social determinants of health, it is not clear whether delivering those benefits through MA plans is more effective than other means of financial assistance would be.

Other uses of rebate dollars are for Part D supplemental benefits (18 percent of projected rebates), reductions in Part D premiums (13 percent of projected rebates), and reductions in Part B premiums (4 percent of projected rebates) (Table 12-3). MA plans cannot allocate administrative expenses or margin to Part B premium reductions. Administrative expenses and margin for Part D premium reductions and Part D supplemental benefits may be included in plans' Part D bids.²⁴

Payments to MA plans far exceed FFS spending due to favorable selection into MA plans and higher MA coding intensity

Payments to MA plans are determined using a plan's bid—which is intended to represent the dollar amount that the plan estimates it will need to cover the

**TABLE
12-4**

MA plan payments estimated to be substantially above FFS spending due to the effects of coding intensity and favorable selection

	Share of FFS spending in 2024		
	Benchmarks	Bids	Payments
Overall estimate	132%*	101%*	122%
Estimated before coding and selection	108*	82*	100
Estimated coding effect	+14	+11	+13
Estimated selection effect	+10	+7	+9

Note: MA (Medicare Advantage), FFS (fee-for-service). Benchmarks are the maximum Medicare program payments for MA plans and incorporate plan quality bonuses. Bids represent the dollar amount that plans estimate will cover the Part A and Part B benefit package for a beneficiary of average health. We estimate FFS spending by county using the 2024 MA rate book. Although MA enrollees must be enrolled in both Part A and Part B, the FFS spending denominator used in the MA rate book includes all Part A and Part B spending (including beneficiaries covered only by Part A). We retrospectively compared MA spending with actual FFS spending for beneficiaries enrolled in both Part A and Part B and found that the results were similar (within 1 percentage point) compared with our prospective analyses that start with CMS's rate book calculation (Medicare Payment Advisory Commission 2023b). We removed spending related to the remaining double payment for indirect medical education payments made to teaching hospitals. To account for our most recent coding estimate of 13 percent, we estimated overall benchmarks, bids, and payments if coding differences between MA and FFS were fully reflected (i.e., if the risk-adjusted differences between MA and FFS did not include coding differences). The coding effect accounts for CMS's 5.9 percent coding adjustment. We project coding intensity based on the annual trend from 2017 through 2021, an increase of 1.5 percentage points per year. For 2024, we reduced the annual trend by 0.67 percentage points to account for one-third of an estimated 2 percentage point reduction in coding intensity associated with the introduction of the V28 risk-adjustment model, which will be phased in over three years. Favorable selection accounts for the estimated lower risk-standardized spending that MA enrollees would have without any plan intervention. We assume that the 2024 effect of selection would be the same as our 2019 estimate of selection (before the coronavirus pandemic). More details on our coding and selection analyses are found in Chapter 13. Totals may not sum due to rounding.

*Estimates of benchmarks and bids relative to FFS spending do not include employer plans.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, FFS expenditures, and risk scores.

Medicare benefit package for a beneficiary—and the benchmark for the county in which the beneficiary resides. The benchmark is based on CMS's projection of risk-standardized local FFS spending and is the maximum Medicare payment amount set by law for an MA plan to provide Part A and Part B benefits for beneficiaries in that county.

In recent years, we have reported on payments to MA plans relative to what FFS spending would have been for comparable beneficiaries, highlighting that coding differences substantially contributed to MA payments above FFS spending. This year, in addition to coding differences, we include the effects of favorable selection, which the Commission discussed in prior reports (Medicare Payment Advisory Commission 2023a, Medicare Payment Advisory Commission 2012a).²⁵ Selection may reflect beneficiaries who are healthier than predicted or beneficiaries who use

less care than predicted for nonhealth reasons (e.g., preferences about seeking care).²⁶ More details on the coding and selection analyses that informed this chapter are provided in Chapter 13.

In 2024, we project that MA plan payments (including rebates that finance extra benefits) remain far above what Medicare would have paid for similar beneficiaries in FFS, continuing the trend of higher levels of payment throughout the history of Medicare managed care. We estimate that Medicare spends 22 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates into a projected \$83 billion in 2024.

Our estimate reflects the impact of higher MA coding intensity, even after the CMS coding adjustment; favorable selection of beneficiaries in MA; setting of benchmarks—the maximum amount Medicare will pay an MA plan to provide Part A and Part B benefits—

above FFS spending in low-FFS-spending counties; and payments associated with benchmark increases under the quality bonus program. The Commission acknowledges that a portion of these increased payments to MA plans are used to provide more generous supplemental benefits and better financial protection for MA enrollees.

Payments to MA plans are an estimated 22 percent higher than FFS spending for 2024

Because CMS's FFS projections do not fully account for coding differences (i.e., MA coding intensity in excess of what is expected when paying plans) and favorable selection (i.e., the extent to which risk-standardized spending of MA enrollees would be lower than the FFS average without any intervention from MA plans), the projections do not accurately reflect what an MA enrollee would have cost the Medicare program if instead enrolled in FFS.²⁷ We only show how MA benchmarks, bids, and payment compare with CMS's projected FFS spending because that spending is the amount that CMS assumes for purposes of creating benchmarks.²⁸ Benchmarks are based on CMS's projection of risk-standardized FFS spending, and the underlying MA payment rates assume that standardized spending is equal between MA and FFS enrollees. However, these benchmarks and the risk-adjustment model do not account for favorable selection and coding intensity, so payment rates to MA plans are inflated and CMS's FFS spending projections that are used for payment do not represent what FFS Medicare would have spent on MA enrollees.

We include uncorrected coding intensity and favorable selection in our analysis so that the MA and FFS populations are comparable. Because benchmarks do not account for these adjustments, it is also unlikely that plan bids assume the effects of uncorrected coding and favorable selection. With these adjustments, we project that benchmarks in 2024 are 132 percent of FFS spending (i.e., the amount that would have been spent on MA enrollees if they were in FFS). Overall, plan bids—14 percent of which are projected to be nonmedical expenses for administration and profit—in 2024 are an estimated 101 percent of FFS spending. Thus, though MA plans have lower medical costs than FFS, these projected efficiencies are offset by plans' projected administration costs and profits. In total, we project

that plans will offer the standard Medicare benefit at about the same cost as FFS in 2024, which implies that the majority of extra benefits for MA enrollees are not financed by plans offering the benefit at lower costs than FFS, but rather by the taxpayers and beneficiaries who fund the program. Overall, we estimate that coding and selection cause MA payments to be 22 percentage points above FFS spending in 2024.²⁹ That difference translates into MA payments that are a projected \$83 billion above FFS spending in 2024.

Before accounting for the effects of diagnostic coding practices (MA coding intensity in excess of the adjustment) and favorable selection (risk-standardized spending of MA enrollees would be lower than the FFS average without any intervention from MA plans) between MA and FFS, MA benchmarks in 2024 are estimated to average 108 percent of CMS's projected FFS spending (Table 12-4), down 1 percentage point from 2023.³⁰ Before accounting for coding intensity and favorable selection, in 2024, overall plan bids average an estimated 82 percent of CMS's projection of FFS spending, a record low relative to CMS's projected FFS amount (down from 83 percent in 2023). When a plan bids below the benchmark, its payment rate is its bid plus a share of the difference between its bid and the benchmark. Overall, we estimate that—without any adjustments for coding intensity or favorable selection—Medicare payments to MA plans in 2024 would average 100 percent of projected FFS spending. We estimate that quality bonuses accounted for 3.2 percent (an estimated \$15 billion) of MA payment in 2024. (Thus, the absence of these payments would have reduced payments relative to FFS spending by 3.2 percent.) However, because these estimates do not adjust for the effects of coding and selection, they only serve as a measure of how current policy directly pays MA plans relative to FFS spending.

Aggregate Medicare payments to MA plans have always been substantially higher than what estimated spending would have been in FFS Medicare

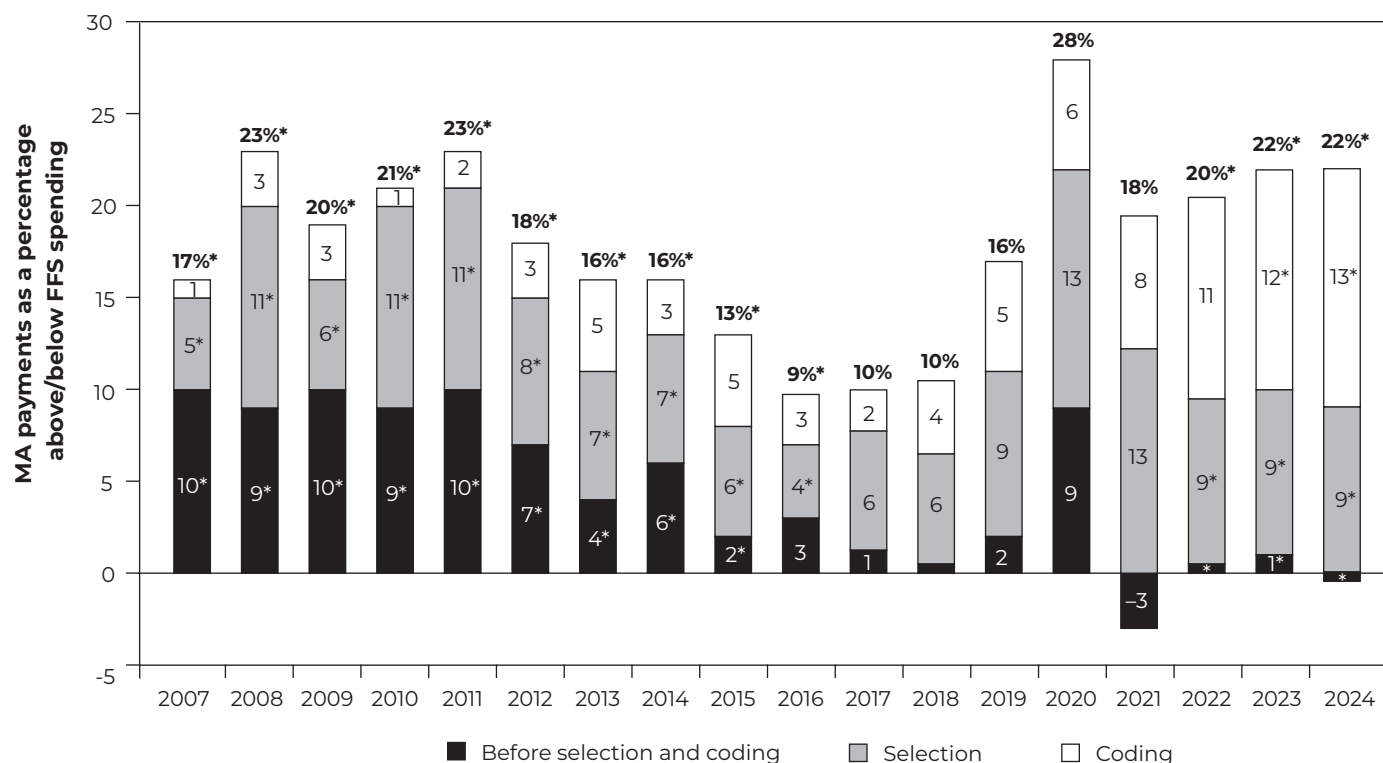
Our review of private plan payments suggests that over a 39-year history, the many iterations of full-risk contracting with private plans have never yielded aggregate savings for the Medicare program. Throughout the history of Medicare managed care, the program has paid more than it would have paid if

beneficiaries had been in FFS Medicare. Evaluations of private plan payment rates under Medicare demonstrations occurring before 1985 found that payment rates were 15 percent to 33 percent higher than FFS Medicare spending (Langwell and Hadley 1990). Between 1985 and 2004, risk adjustment was inadequate and researchers estimated that private plan payments were 5 percent to 7 percent higher than FFS Medicare spending in the late 1980s and through the mid-1990s (Brown et al. 1993, Medicare Payment Advisory Commission 1998, Newhouse 2002, Riley et al. 1996). Since the introduction of bids and benchmarks in MA payment policy, the Commission started using a prospective method to compare plan benchmarks, plan bids, and the resulting payments to MA plans relative to CMS’s projected FFS spending (standardizing differences in risk scores). From 2004 through 2006, the Commission found that payments to MA plans were 7 percent to 12 percent higher than FFS Medicare spending. However, these estimates used FFS projections that included beneficiaries who were not eligible for MA, did not account for differences in diagnostic coding, and did not account for the favorable selection that plans experience with beneficiaries who choose to enroll in MA (see Chapter 13, text box on “MA plan and beneficiary incentives may produce a favorable selection of enrollees,” for more detail on why plans may experience favorable selection). To account for these differences, the Commission now applies three adjustments on an ongoing basis:

- First, starting with 2016 data, the Commission retrospectively compares actual MA payments with actual FFS spending for beneficiaries who are eligible to enroll in an MA plan (i.e., beneficiaries with both Part A and Part B coverage). Our analysis from 2016 to 2019 showed that our prospective and retrospective comparisons consistently produced similar results. Thus, our prospective estimates prior to the coronavirus pandemic were reasonable (at least partially due to risk adjustment and adjustments for Medicare as a secondary payer that helped account for population differences). We have now updated our retrospective analysis to estimate MA payments as a percentage of FFS spending in 2020 and 2021 (the most recent year of available data). These years were directly affected by the coronavirus pandemic and produced a relatively larger difference between our prospective

and retrospective estimates, which were driven by large differences between projected and actual FFS risk-standardized spending. We will continue to update our retrospective analysis as data become available. Because of data availability, we continue to show our prospective analyses from 2007 through 2015 and 2022 through 2024. In addition, consistent with an adjustment the Commission made that assumed an override of the sustainable growth rate in 2010, we have now made a similar adjustment to our 2007 through 2009 prospective estimates of MA payments relative to FFS spending.

- Second, we have updated our method for estimating coding intensity and have retrospectively applied our estimate beginning in 2007. More details on our updated method are found in Chapter 13. From 2023 through 2024, we project coding intensity based on the annual trend from 2017 through 2021, an increase of 1.5 percentage points per year. For 2024, we reduced the annual trend by 0.67 percentage points to account for one-third of an estimated 2 percentage point reduction in coding intensity associated with the introduction of the V28 risk-adjustment model, which will be phased in over three years (from 2024 to 2026). There is uncertainty about the impact of moving to the V28 on MA coding intensity. We will continue to monitor those effects and will update our analysis as we are able.
- Third, we now account for favorable selection of beneficiaries into MA whereby the risk-standardized spending of MA enrollees would be lower than the local FFS average without any intervention from MA plans. We estimated the cumulative annual effect of selection, including the effects of attrition and regression to the mean from 2017 through 2021 (the most recent year of available data).³¹ For 2022 through 2024, we apply our 2019 estimate of selection (about 9 percent) to avoid any effect from the coronavirus pandemic on our projections. For 2007 to 2016, we apply the selection estimate for MA entrants in the subsequent year (i.e., beneficiaries who switched from FFS to MA in each year from 2008 to 2017). Our analysis from 2017 through 2021 showed that the overall selection effect was only slightly higher than the selection effect for entrants in the

**FIGURE
12-3****Higher MA payments relative to what estimated
spending would have been in FFS, 2007–2024**

Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates of MA payments before selection and coding relative to what spending would have been in FFS are less than 0.5 percent for 2018, 2022, and 2024. We exclude MA payments for beneficiaries with end-stage renal disease. Components may not sum to totals due to rounding. Our estimates before selection and coding reflect CMS's projection of FFS spending from 2007 through 2015 (including adjustments that assume an override of the sustainable growth rate during the applicable years) and 2022 through 2024. Estimates from 2016 through 2021 reflect our retrospective comparison of actual payments (including nonclaims spending) for beneficiaries who had both Part A and Part B coverage, had Medicare as their primary payer, did not have end-stage renal disease, and resided in the 50 states and the District of Columbia. Thus, estimates in 2020 and 2021 reflect the effects of the coronavirus pandemic. Estimates of actual MA payments in 2020 include remittances related to plan medical loss ratios. Favorable selection accounts for the estimated lower risk-standardized spending that MA enrollees would have incurred without any plan intervention. Estimates of the effect of selection from 2007 through 2016 are based on beneficiaries who switched from FFS to MA in the following year (2008 to 2017). These estimates do not account for attrition and regression to the mean, but our comprehensive estimates of selection annually from 2017 through 2021 suggest that these factors would, on net, increase the effect of selection. We assume that the 2022 through 2024 annual effect of selection would be the same as our 2019 estimate of selection (before the coronavirus pandemic). Coding estimates are net of CMS's adjustment to MA risk scores. From 2023 through 2024, we project coding intensity based on the annual trend from 2017 through 2021, an increase of 1.5 percentage points per year. For 2024, we reduced the annual trend by 0.67 percentage points to account for one-third of an estimated 2 percentage point reduction in coding intensity associated with the introduction of the V28 risk-adjustment model, which will be phased in over three years.

*Specified values used projected data.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files.

subsequent year (from 2018 to 2022). More details on our updated selection analysis are found in Chapter 13.

Figure 12-3 shows that since 2007, payments to MA plans have been substantially above the amount FFS

Medicare would have spent for the same beneficiaries. Throughout the 18-year period from 2007 through 2024, we estimate that MA payments were at least 9 percent more than FFS spending for comparable beneficiaries in each year. Between 2011 and 2017, relative MA payments decreased from 23 percent above

FFS spending to 10 percent above FFS spending. This change is largely explained by (1) declining benchmarks resulting from ACA policies and (2) declining favorable selection—coinciding with an increasing share of MA enrollees who were dually eligible for Medicaid and were found to have less favorable spending for plans in the risk-adjustment model that CMS applied prior to 2017. However, after changes to CMS’s risk-adjustment model were fully implemented in 2017 (including the segmentation of the model for dual-eligible beneficiaries, which makes them no longer unfavorable on a risk-standardized basis), MA payments increased relative to FFS spending through 2024—driven by the combined effects of coding intensity and selection. We estimate that MA payments are 22 percent above FFS spending in both 2023 and 2024. Given the increasing share of Medicare beneficiaries enrolled in an MA plan, these differences translate to a substantial amount of MA payments above FFS spending.

Figure 12-4 shows the higher payments to MA relative to what spending would have been in dollar terms if enrollees were in FFS. In estimating the payment amount above FFS spending, we removed MA payments for beneficiaries with end-stage renal disease, whom we exclude from all of our analyses and for whom there is no evidence of selection or coding intensity. Since 2007, we estimate that Medicare has paid \$507 billion and will pay \$83 billion more for MA enrollees in 2024 than if those beneficiaries had instead been in FFS—a total of \$591 billion. Over half (an estimated \$338 billion) of the MA payments above FFS spending will have occurred in the last five years—from 2020 through 2024. These higher payments are increasingly driven by coding intensity, which we estimate accounted for the largest share of payments above FFS spending from 2022 through 2024.

Coding differences increase payments to MA plans in 2024 by \$50 billion and continue to generate inequity across plans

Payments to MA plans are risk adjusted to account for differences in health status. Higher risk scores increase payments to plans for enrollees with higher expected Medicare spending. Risk scores are based on demographic information and diagnoses that plans submit to CMS. Documenting additional diagnosis codes raises plan enrollees’ risk scores, generating two distinct benefits for MA plans: (1) increasing the

monthly payments MA plans receive from Medicare and (2) increasing the rebates plans use to provide extra benefits to enrollees. Plans that document relatively more diagnosis codes have a competitive advantage over other plans.

Documenting more diagnosis codes increases payments to plans

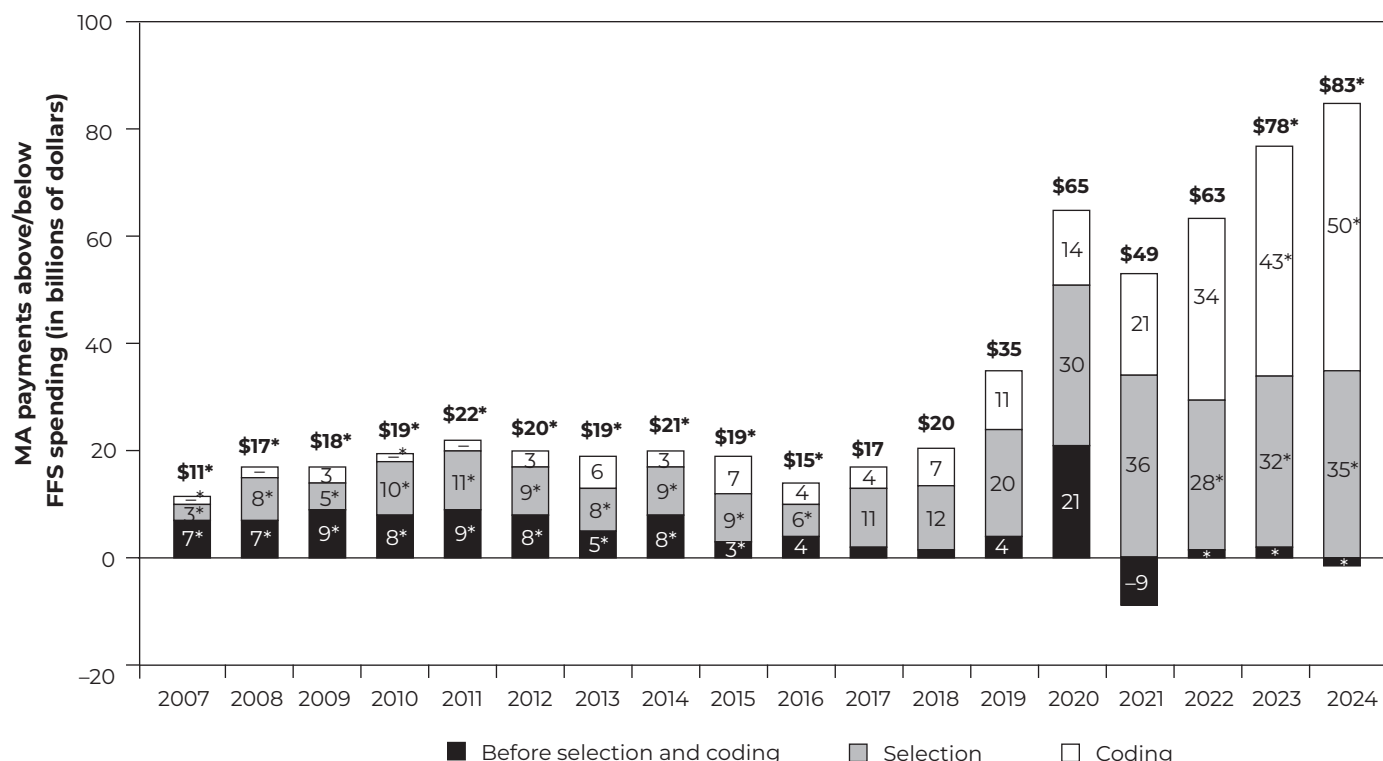
Among the 20 most common HCCs in MA—which have reimbursement amounts ranging from roughly \$1,000 to \$5,500—the average additional payment per HCC is about \$3,400 per year. Documenting each additional HCC for an enrollee can thus significantly increase Medicare payment to a plan. We can illustrate how coding additional HCCs increases payment to a plan using average FFS Medicare spending.³² For example, in 2022, the annual Medicare payment to an MA organization for a non-Medicaid-eligible 80-year-old male (where the demographic component of the risk score is valued at \$6,726) with diabetes without complication (HCC 19, valued at \$1,284) would have been \$8,010. If the same 80-year-old male with diabetes were also found to have vascular disease (HCC 108, valued at \$3,620), the Medicare annual payment to the MA organization would increase to \$11,630.

Because the CMS–HCC model uses FFS Medicare claims data to estimate the size of the model coefficients, the model calculates an expected spending amount based on FFS Medicare costs and diagnostic coding patterns. Most diagnoses are reported on physician and outpatient claims, which in FFS Medicare tend to be paid based on procedure codes, thus providing little financial incentive to document diagnoses for FFS beneficiaries. If certain diagnoses are not reported on FFS claims, the cost of treating those conditions is attributed to other components in the model, causing the coefficients overall to be inflated above the value they would have been if the diagnoses had been reported. For MA payments to be accurate, diagnoses must be coded with the same intensity in FFS Medicare and MA. When MA plans submit more diagnoses for a beneficiary than would have been documented in FFS Medicare, the program spends more for that beneficiary in MA than it would have if the beneficiary were in FFS.

Because of the increased financial incentives for MA plans to code more diagnoses and the additional tools

**FIGURE
12-4**

Estimated coding and selection have increased MA payments above what spending would have been in FFS



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates of MA payments before selection and coding relative to what spending would have been in FFS are less than \$3 billion for 2017, 2018, 2022, 2023, and 2024. We exclude MA payments for beneficiaries with end-stage renal disease. Components may not sum to totals due to rounding. Our estimates before selection and coding reflect CMS's projection of FFS spending from 2007 through 2015 (including adjustments that assume an override of the sustainable growth rate during the applicable years) and 2022 through 2024. Estimates from 2016 through 2021 reflect our retrospective comparison of actual payments (including nonclaims spending) for beneficiaries who had both Part A and Part B coverage, had Medicare as their primary payer, did not have end-stage renal disease, and resided in the 50 states and the District of Columbia. Thus, estimates in 2020 and 2021 reflect the effects of the coronavirus pandemic. Estimates of actual MA payments in 2020 include remittances related to plan medical loss ratios. Favorable selection accounts for the estimated lower risk-standardized spending that MA enrollees would have incurred without any plan intervention. Estimates of the effect of selection from 2007 through 2016 are based on beneficiaries who switched from FFS to MA in the following year (2008 to 2017). These estimates do not account for attrition and regression to the mean, but our comprehensive estimates of selection annually from 2017 through 2021 suggest that these factors would, on net, increase the effect of selection. We assume that the 2022 through 2024 annual effect of selection would be the same as our 2019 estimate of selection (before the coronavirus pandemic). Coding estimates are net of CMS's adjustment to MA risk scores. From 2023 through 2024, we project coding intensity based on the annual trend from 2017 through 2021, an increase of 1.5 percentage points per year. For 2024, we reduced the annual trend by 0.67 percentage points to account for one-third of an estimated 2 percentage point reduction in coding intensity associated with the introduction of the V28 risk-adjustment model, which will be phased in over three years.

*Specified values used projected data.

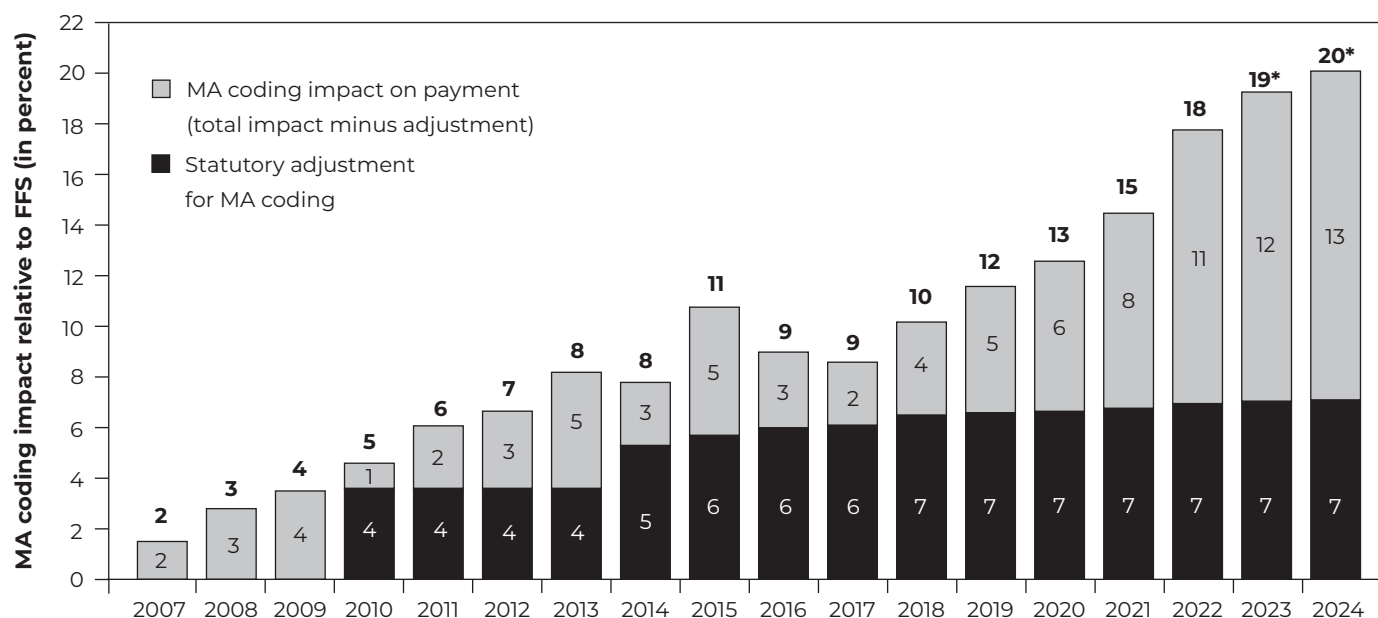
Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files.

that MA plans use to capture diagnoses—which are not features of FFS Medicare—coding intensity is higher in MA than in FFS and payments to MA plans are higher than intended. Although Medicare's accountable care organization (ACO) programs and some other

alternative payment models (APMs) offer incentives to increase diagnostic coding intensity in FFS Medicare, we continue to see higher coding intensity in MA, and that difference continues to increase. The tools that ACOs and APMs have available result in less coding

**FIGURE
12-5**

**Estimated impact of coding intensity on MA risk scores
was larger than coding adjustment, 2007–2024**



Note: MA (Medicare Advantage), FFS (fee-for-service). All estimates account for any differences in age, sex, Medicaid eligibility, and institutional status between MA and FFS populations. New enrollees are constrained to have no coding intensity as their risk scores are not based on diagnostic coding. The annual adjustment for MA coding began in 2010. MA coding intensity has increased MA risk scores annually, but increases were offset by new versions of the risk-adjustment model in 2014, 2016, and 2017 and by increased FFS coding in 2016 and 2017. The impact of the coding adjustment is calculated as the MA coding intensity estimate relative to FFS, multiplied by the coding adjustment. For 2024, we calculate $1.20 \times 5.9\% = 0.071$ or 7.1%. Components may not sum to totals due to rounding.

*For 2023 and 2024, we project coding intensity based on the annual trend from 2017 through 2021, an increase of 1.5 percentage points per year. For 2024, we reduced the annual trend by 0.67 percentage points to account for one-third of an estimated 2 percentage point reduction in coding intensity associated with the introduction of the V28 risk-adjustment model, which will be phased in over three years.

Source: MedPAC analysis of CMS enrollment and risk-score files.

intensity than those available to MA plans; notably, chart reviews, in-home health risk assessments, and subcapitation to medical groups are used only in MA. Furthermore, CMS limits annual risk-score growth for ACO enrollees when calculating shared savings or losses. Thus, we expect that FFS coding will continue to identify fewer diagnosis codes than MA coding does.

Coding differences may reflect MA plans capturing more diagnoses than FFS providers because plans have an incentive to report every diagnosis for an enrollee whereas FFS providers may be more likely to focus on more significant diagnoses that are primary reasons for a visit. Research has shown that some FFS

beneficiaries have chronic conditions that are reported inconsistently year to year—including conditions like kidney failure or paraplegia—suggesting that not all diagnoses are reported in FFS Medicare (Frognier et al. 2011, Medicare Payment Advisory Commission 2012a). Furthermore, whistleblowers and the Department of Justice allege that some MA plans have submitted fraudulent diagnoses for risk adjustment (Department of Justice 2022, United States of America ex rel. Benjamin Poehling v. UnitedHealth Group 2016, United States of America ex rel. James M. Swoben v. Secure Horizons 2017). There are no data available to parse the share of higher MA coding intensity due to these or other reasons; however, because the risk-adjustment

model is calibrated on FFS claims, relatively higher MA coding intensity—regardless of the reason—increases payments to MA plans above FFS spending.

Higher MA payments due to coding differences have been under scrutiny for more than a decade. Research has consistently found that the impact of coding differences on MA risk scores produces higher payments for MA plans (Congressional Budget Office 2017, Geruso and Layton 2015, Government Accountability Office 2013, Hayford and Burns 2018, Jacobs and Kronick 2018, Kronick and Chua 2021, Kronick and Welch 2014). One study found that when controlling for differences in health status using Part D prescription drug data, from 2008 to 2015, MA risk scores grew by about 1 percent more per year than FFS risk scores (Jacobs and Kronick 2018). A second study used a difference-in-difference approach on risk-adjustment data for 2008 to 2013 to estimate that risk scores for enrollees remaining in MA grew about 1.2 percent faster per year than for beneficiaries in FFS Medicare (Hayford and Burns 2018). A third study, using county-level data, found that the first year after MA enrollment, risk scores increased about 6 percent faster than FFS, and about 2 percent faster in the second year (Geruso and Layton 2020). Finally, the Government Accountability Office used a risk-score prediction model to estimate coding intensity for 2010 through 2012, and those estimates align very closely with the Commission's estimates over that same time period (Government Accountability Office 2013).

Starting in 2010, a series of congressional mandates required CMS to reduce MA risk scores to address the impact of MA and FFS coding differences on payments to MA plans. Because of these mandates, CMS reduced MA risk scores by 3.41 percent in each year from 2010 through 2013. Starting in 2014, legislation specified a minimum reduction of about 4.9 percent, which rose gradually to about 5.9 percent in 2018, where it will remain until the Secretary of Health and Human Services implements risk adjustment using MA diagnostic, cost, and use data. Although larger reductions are allowed under the legislation, CMS reduced MA risk scores by only the minimum amount required by law for 2014 through 2024.³³

This chapter reflects revisions to our method of estimating coding intensity. Chapter 13 describes those revisions, the research leading to them, and the impact

of estimating coding intensity using the revised method relative to the method used in prior MA status reports. Figure 12-5 shows the impact, for 2007 through 2022, of differences in coding intensity on MA risk scores relative to FFS and the size of the coding intensity adjustment (the amount by which CMS reduced MA risk scores to account for coding intensity).

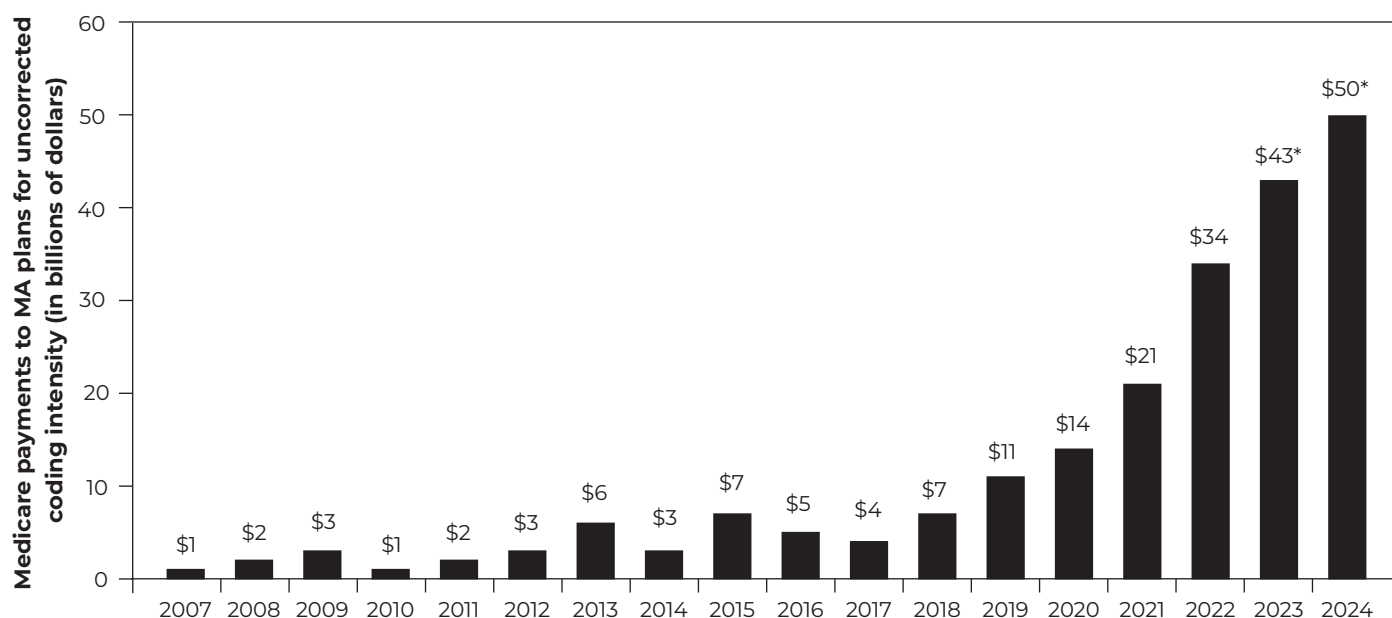
From 2007 through 2013, MA coding intensity increased MA risk scores by 1.15 percentage points per year more than the FFS risk-score trend, and by 1.5 percentage points more per year for 2017 through 2021. Deviations from the typical trend occurred in 2014, 2016, and 2017, which we attribute to two factors: (1) new versions of the risk-adjustment model that were introduced in 2014, 2016, and 2017 reduced the gap in MA and FFS diagnostic coding differences; and (2) FFS risk scores grew faster (matching or nearly matching MA risk-score growth rates) in 2016 and 2017 than in the previous or subsequent years, likely due to Medicare's transition from using International Classification of Diseases (ICD)-9 to ICD-10 diagnosis codes in October 2015. See our March 2021 report's MA chapter for a more detailed explanation of these factors (Medicare Payment Advisory Commission 2021b).

In 2021, overall MA risk scores (based on diagnoses on claims from services provided in 2020) decreased from 2020 (data not shown), which is associated with the reduction in service use in 2020 during the pandemic. However, the reduction in MA risk scores in 2021 was less than the reduction in risk scores for comparable FFS beneficiaries, so estimated MA coding intensity continued to increase in 2021. For 2022, we estimate a 3.3 percentage point increase from 2021, likely due to an increased effort to raise MA risk scores, in part through the use of health risk assessments and chart reviews as described below, after MA risk scores had fallen in the prior year.³⁴

For 2023 and 2024, we project coding intensity based on the annual trend from 2017 through 2021, an increase of 1.5 percentage points per year. For 2024, we reduced the annual trend by 0.67 percentage points to account for one-third of an estimated 2 percentage point reduction in coding intensity associated with the introduction of a new risk-adjustment model (V28), which will be phased in over three years.³⁵ There is uncertainty about the impact of moving to the V28 on

**FIGURE
12-6**

Uncorrected MA coding intensity has increased payments to plans by an estimated \$124 billion through 2022 and is projected to generate nearly \$94 billion more in 2023 and 2024



Note: MA (Medicare Advantage). Estimates for 2007 through 2022 are based on the Commission's estimate of uncorrected coding intensity. In all years, Medicare spending for MA plans is based on the Medicare Trustees' reports and excludes spending for end-stage renal disease beneficiaries.

*For 2023 and 2024, we project coding intensity based on the annual trend from 2017 through 2021, an increase of 1.5 percentage points per year. For 2024, we reduced the annual trend by 0.67 percentage points to account for one-third of an estimated 2 percentage point reduction in coding intensity associated with the introduction of the V28 risk-adjustment model, which will be phased in over three years.

Source: MedPAC analysis of CMS enrollment and risk-score files, and Medicare Trustees' reports.

MA coding intensity. We will continue to monitor those effects and will update our analysis as we are able.

For 2024, we project that MA risk scores will be about 20 percent above risk scores for comparable FFS beneficiaries. This difference is only partially offset by the coding intensity adjustment that reduced MA risk scores by 5.9 percent. The net effect is a 13 percent increase in MA risk scores due to coding intensity, leading to \$50 billion in higher payments to MA plans.

Between 2007 and 2024, we estimate that MA coding intensity will have generated \$217 billion in aggregate higher payments to MA plans (Figure 12-6). Between 2007 and 2022, MA coding intensity resulted in \$124 billion in increased payments to MA plans. Using our

projection of MA coding intensity, we estimate that uncorrected coding intensity in 2023 and 2024 will increase program spending by another \$43 billion and \$50 billion, respectively.

Documenting additional diagnosis codes increases plan rebates and can distort the nature of competition among plans

Documenting additional diagnostic codes increases the size of MA plans' rebates, which in turn allows plans to offer their enrollees more extra benefits than plans that document fewer additional diagnoses. For a plan submitting a bid below its benchmark (nearly all plans in 2024), the plan's rebate is based on the difference between the plan's bid for its expected enrollee population and the plan's risk-adjusted benchmark,

**TABLE
12-5****Illustrative example: A plan that codes diagnoses more aggressively can offer its enrollees more extra benefits**

Plan	Bid: Monthly cost of care for expected population	Risk score of expected population	Monthly MA benchmark for the county for an average-risk population (+5% for bonus plan)	Risk-adjusted monthly benchmark (benchmark multiplied by risk score)	Difference in risk-adjusted benchmark and plan bid	Monthly value of extra benefits (rebate amount)*
Nonbonus plans						
Plan A (3.5 stars)	\$900	0.97	\$952	\$923	\$23	\$15
Plan B (3.5 stars)	900	1.03	952	981	81	52
Bonus plan						
Plan Z (5 stars)	900	0.97	1,000	970	70	49

Note: MA (Medicare Advantage). An average-risk population has a risk score of 1.0. This example assumes that the actual cost of care for the expected population is \$900 monthly for each of the three plans and that the plans serve the same beneficiaries. Plan B's risk score of 1.03 is inflated due to greater diagnostic coding effort.

*Plans A and B at 3.5 stars have a rebate percentage of 65 percent. Plan Z at 5 stars has a rebate percentage of 70 percent.

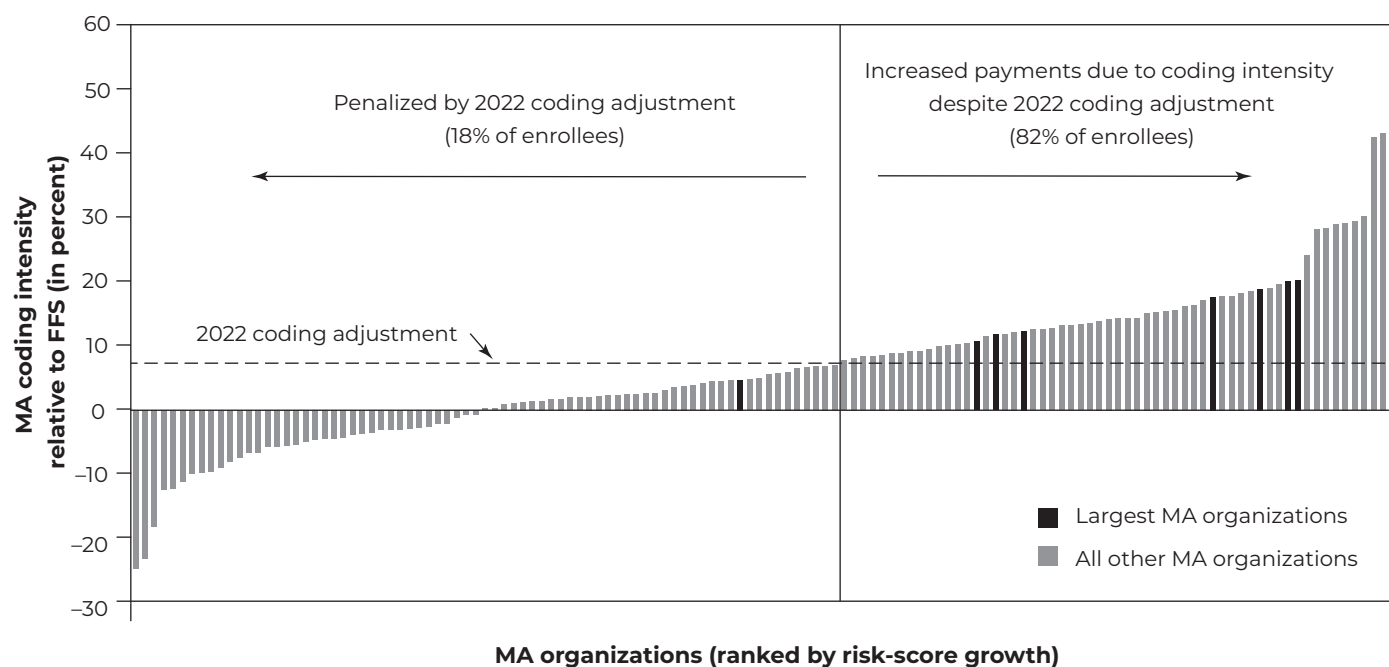
which is the standard benchmark (for a beneficiary of average risk, with a 1.0 risk score) multiplied by the plan's expected average risk score. Raising a plan's average risk score raises the plan's risk-adjusted benchmark and widens the difference between the plan's bid and the risk-adjusted benchmark, thereby increasing the plan's rebate amount and ability to offer more extra benefits. In sum, plans can translate greater coding effort into the ability to offer more extra benefits than their competitors and can gain a competitive advantage in attracting enrollees.

MA payment policies aim to give plans an incentive to lower spending and improve quality by allowing them to offer more extra benefits. By reducing health care costs, plans can reduce their bids, increasing their rebate and extra benefit value. By improving quality scores, plans can be rewarded with a 5 percent or 10 percent increase in their benchmark or with an increase in the rebate percentage (the percentage of the bid and benchmark difference that determines the rebate amount).³⁶ These policies are intended to benefit beneficiaries through improved quality, more extra benefits, and reduced premiums, as well as lower taxpayer funding for the Medicare program. Greater

MA coding intensity, however, distorts these incentives by allowing plans to offer more extra benefits regardless of whether they reduce costs or improve quality.

Table 12-5 illustrates the relationship between coding intensity and rebate amounts using a hypothetical example of three plans covering the same set of enrollees for whom the expected cost of care is the same, at \$900 per member per month. Plans A and Z have an expected risk score of 0.97, and Plan B has an expected risk score of 1.03 due to more aggressive diagnostic coding. All three plans have bids below the risk-adjusted benchmark and provide extra benefits funded by rebates. However, because Plan B has a higher risk score, its rebate is larger than Plan A's rebate (\$52 per month vs. \$15 per month), so it can offer enrollees more extra benefits. Plan B's aggressive diagnostic coding effort has therefore given it an unfair competitive advantage over Plan A.

In addition, aggressive coding can result in greater extra benefits than the effect of MA quality bonuses. The higher risk score of Plan B, which has only 3.5 stars, gives it an advantage over bonus-level Plan Z,

**FIGURE
12-7****Coding intensity varied across MA organizations relative to FFS, 2022**

Note: MA (Medicare Advantage), FFS (fee-for-service). Excludes special needs plans, contracts for the Program of All-Inclusive Care for the Elderly, and organizations with fewer than 2,500 enrollees in the analysis. All estimates account for any differences in age, sex, Medicaid eligibility, and institutional status between MA and FFS populations. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding.

Source: MedPAC analysis of CMS enrollment and risk-score files.

which has 5 stars: Plan B's rebate amount is higher than Plan Z's (\$52 per month vs. \$49 per month). Thus, by inflating its risk score from 0.97 to 1.03, Plan B can offer more extra benefits than are provided through quality bonuses.

The plans illustrated in Table 12-5 (p. 381) have a risk-score difference of 6 percentage points, reflecting different coding practices. We estimated coding intensity for MA organizations and found much greater variation in coding for 2022.³⁷ Figure 12-7 shows coding intensity relative to FFS coding by MA parent organization, excluding contracts in the Program of All-Inclusive Care for the Elderly, special needs plans, and organizations with fewer than 2,500 enrollees.

Consistent with prior years, coding intensity varies significantly across MA organizations. We find that

about half of organizations (covering 18 percent of MA enrollees) have coding intensity below the 2022 coding adjustment, and are thereby penalized by the adjustment, while the other half of organizations (covering 82 percent of MA enrollees) have coding intensity that increases their payment after accounting for the 2022 coding adjustment. These differences demonstrate that CMS's across-the-board adjustment for coding intensity, which reduces all MA risk scores by the same amount, generates inequity across contracts by reducing net revenue for plans with lower coding intensity and allowing other plans to retain a significant amount of revenue from higher coding intensity.

We also find significant variation in coding intensity across the largest eight MA organizations (covering 77 percent of MA enrollees), from 4.7 percent to 20.2

percent above FFS levels. Seven of the eight largest MA organizations had greater coding intensity than the 2022 coding adjustment and therefore received a net increase in payment due to aggressive coding practices. These differences are large enough to give MA organizations with higher coding intensity a significant competitive advantage by increasing the size of plan rebates and helping them to attract more enrollees. Our finding that coding intensity varies across MA organizations is consistent with other research assessing variation in coding intensity across or in the use of health risk assessments and chart review, which are key drivers of MA coding intensity (Geruso and Layton 2015, Kronick and Welch 2014, Office of Inspector General 2021).

MA plans have several tools that are unavailable in FFS to code more diagnoses

MA plans use several mechanisms that do not exist in FFS Medicare to document diagnoses for their enrollees. They can identify enrollees likely to have an HCC that has not yet been documented using data the plan already has: an enrollee's historical claims, risk-score data, and prescription drug data (e.g., a prescription for insulin likely indicates a diabetes diagnosis). Of all the mechanisms to document more diagnosis codes, evidence continues to highlight MA plans' use of health risk assessments and chart reviews as major sources of plan revenue from coding intensity.

Pay-for-coding programs and patient assessment forms

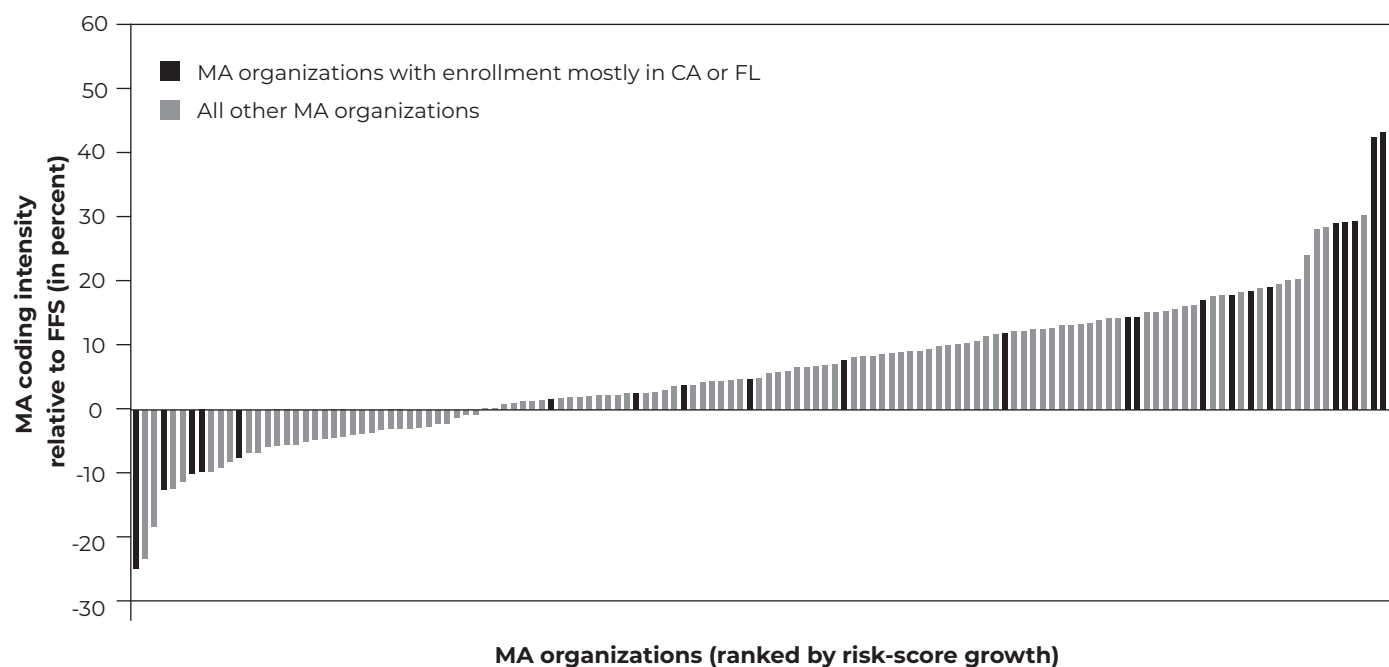
Some plans try to ensure that providers submit all possible diagnoses for their enrollees through pay-for-coding programs in which plans send physicians a patient assessment form that includes diagnosis codes that the plan has identified for a beneficiary. Plans ask physicians to confirm the existence of plan-identified diagnoses on the form and document those diagnoses on subsequent claims. Plans pay physicians based on completing the form or as a dollar amount per diagnosis code submitted, and some plans include a bonus payment for submitting every code that the plan identifies for a beneficiary.

Capitated arrangements in California and Florida may exacerbate coding intensity In the course of reviewing our coding intensity estimates by MA organization, we found that several organizations with the highest diagnostic coding relative to FFS are located in California and Florida. Of the 23 MA organizations

offering plans primarily in California and Florida (i.e., organizations with a majority of their enrollment in California or Florida, excluding the 8 largest MA organizations), 10 were among the 21 organizations with the highest coding intensity, including 6 of the top 7 highest coding organizations (Figure 12-8, p. 384). These six organizations had MA risk scores that ranged from 29 percent higher to 52 percent higher than scores for comparable FFS beneficiaries.

To address why these California- and Florida-focused organizations account for so many of the highest-coding organizations, we considered that health plans in California and (to a somewhat lesser extent) Florida have long participated in a form of capitated payment for providers known as the “delegated model.” Under the delegated model, the responsibility for health care delivery and associated financial risk are delegated by the plan to a medical group or independent physician association. Typically, a plan pays a medical group a risk-adjusted sum per enrollee, which is often calculated as a share of a plan's total Medicare revenue. Because a plan's revenue increases when more diagnoses are documented, the capitated payments to providers (determined as a percentage of the plan's revenue) increase proportionately. In these arrangements, the financial incentive to document more diagnoses is passed on to the medical group, which has direct access to an enrollee's medical records and diagnostic information.

Although we could not confirm that the plans offered by the highest-coding California and Florida organizations use the delegated model, we reviewed the share of 2021 provider payments that were capitated for 9 of the top 10 such organizations (one organization did not have 2021 data). Of these nine organizations, the share of provider payments that were capitated was above the national average (33 percent in 2021) for six organizations, including two organizations with provider payments that were almost entirely capitated. Two other organizations had some capitated provider payments but a lower share than the national average, and one organization reported no capitated provider payments. We note that the alignment of clinical and financial accountability under the delegated model may provide a number of beneficial incentives to constrain costs, avoid low-value care, and coordinate care. However, these potential benefits do not justify increased payments due to

**FIGURE
12-8****MA organizations offering plans primarily in California or Florida account for many of the organizations with the highest estimated coding intensity**

Note: MA (Medicare Advantage), FFS (fee-for-service). Excludes special needs plans, contracts for the Program of All-Inclusive Care for the Elderly, and parent organizations with fewer than 2,500 enrollees in the analysis. All estimates account for any differences in age, sex, Medicaid eligibility, and institutional status between MA and FFS populations. New enrollees are constrained to have no coding intensity since their risk scores are not based on diagnostic coding. The eight largest MA organizations were excluded from the highlighted organizations indicating enrollment mostly in CA or FL.

Source: MedPAC analysis of CMS enrollment and risk-score files.

coding intensity, and such payments are not necessary to sustain the model's incentives.

MA plans' use of health risk assessments to increase diagnosis coding Health risk assessments are provided to Medicare beneficiaries as part of an annual wellness visit, and, for MA enrollees, health risk assessments are often provided during a plan-initiated home visit.³⁸ Health risk assessments sometimes rely on patient self-reporting of medical conditions, which may result in HCCs based on inaccurate diagnoses, diagnoses that are no longer active (and therefore not eligible for risk adjustment), or diagnoses without sufficient evidence to conform to ICD coding guidelines (Department of Justice 2022). (More information about these concerns is in our March 2023 report chapter on Medicare Advantage.)

We analyzed 2021 encounter records to identify HCCs that were supported only by a health risk assessment, meaning that there was no physician or hospital service provided to treat a beneficiary for a specific health condition during the same calendar year.³⁹ In 2021, about 6.9 million MA enrollees had a health risk assessment that identified at least one HCC, and a total of 15.0 million unique HCCs were identified through health risk assessments. Of those, 3.2 million beneficiaries had a health risk assessment that was the only source for at least one of the HCCs identified, and a total of 5.0 million HCCs (one-third of all HCCs identified on health risk assessments) were identified only on a health risk assessment. Seven HCCs each generated more than \$500 million in payments from

these assessments, accounting for nearly 60 percent of all payments generated by health risk assessments.⁴⁰ We found that in 2022, diagnostic coding that was associated with only health risk assessments accounted for \$13 billion in payments to MA plans, or a little more than 3 percent of all payments to MA plans. About 60 percent of these payments were from health risk assessments conducted as part of an annual wellness visit or initial preventive physical examination, while the rest of these payments were from in-home health risk assessments.⁴¹

MA plans' use of chart reviews to increase diagnosis coding Some MA plans devote significant effort to conducting chart reviews to increase MA payments. Because chart reviews are not used in FFS Medicare, all diagnoses newly documented through chart reviews contribute to differences in FFS and MA diagnostic coding and contribute to increased payments to MA plans. Chart reviews allowable for risk adjustment document the diagnoses made during hospital and physician encounters in which medical services were provided. MA plans use chart reviews to identify diagnoses not captured through the usual means of reporting diagnoses (e.g., claims data and encounter data): diagnoses that are not reported on the provider's claim sent to the MA plan, diagnoses made during an encounter in which the MA plan does not submit a record of the encounter to CMS, or diagnoses made during an encounter in which the total number of diagnoses from that encounter exceeds the number of diagnosis fields on the encounter record. Because Medicare requires each HCC to be supported by diagnostic evidence in a patient's medical record (chart), chart reviews are one way for plans to identify diagnoses not captured through provider claims or on plan encounter data. However, chart review programs are used exclusively in MA (there is no incentive to undertake chart reviews in FFS Medicare) and thereby exacerbate Medicare's failure to sufficiently account for differences in MA and FFS diagnostic coding.

Like health risk assessments, some MA plans treat chart review programs as an independent revenue stream that yields a positive return on investment because the additional Medicare payments from newly documented diagnoses far exceed the costs of paying nurses and medical assistants to review medical charts.⁴² Several lawsuits allege that MA plans

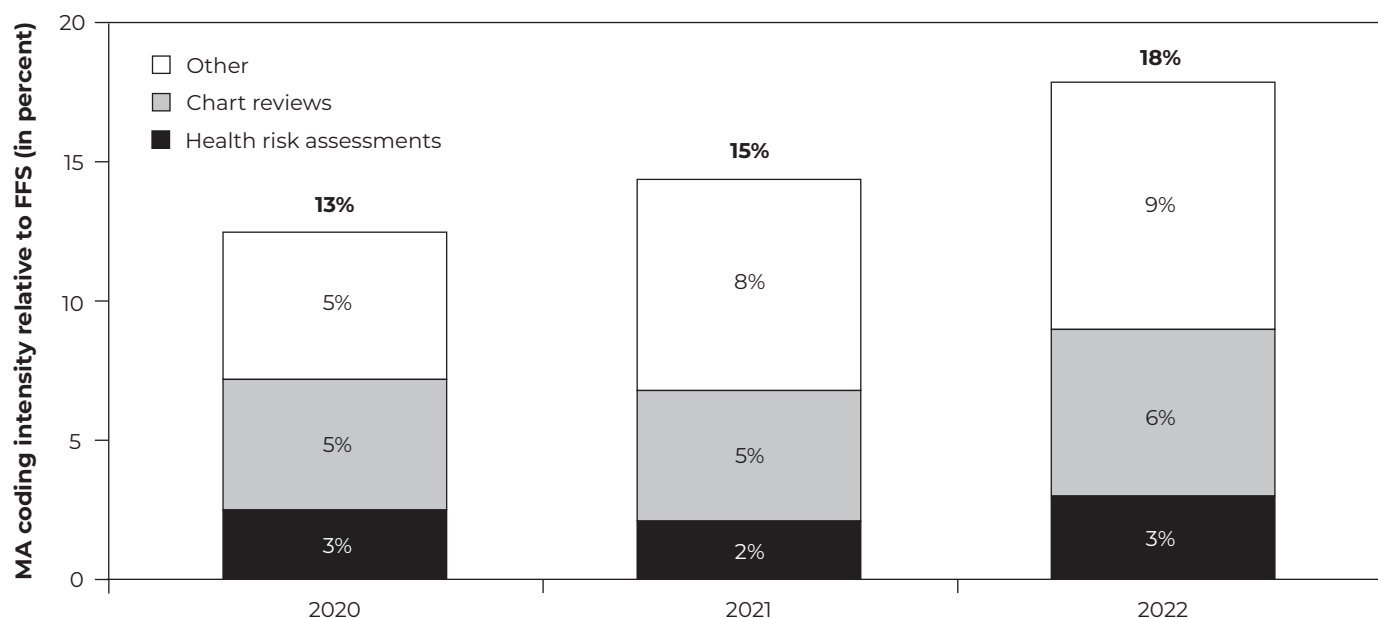
use chart reviews to identify new diagnosis codes, but not to verify the accuracy of already submitted codes. Some lawsuits allege that an MA organization is aware that diagnoses submitted to CMS are not supported by the medical chart and therefore violated Medicare's rules governing the reporting of diagnoses (United States of America ex rel. Benjamin Poehling v. UnitedHealth Group 2016, United States of America ex rel. James M. Swoben v. Secure Horizons 2017, United States of America v. Anthem 2020). Some plans and vendors appear to selectively review charts with a higher likelihood of increasing revenue and use artificial intelligence to more accurately identify likely revenue-producing charts (Blue Health Intelligence 2020, Optum 2020). While the financial return is worth plan sponsors' effort and financial investment, chart review programs increase the financial burden for the taxpayers and beneficiaries who fund the Medicare program.

We analyzed 2021 encounter records to identify HCCs that were supported by a chart review but not through any other record of a physician or hospital encounter during the same calendar year. In 2021, about 11.6 million MA enrollees had a chart review that identified at least one HCC, and a total of 32.7 million unique HCCs were identified on chart reviews. Of enrollees with a chart review, 5.9 million beneficiaries had a chart review that was the only source of an HCC, and a total of 9.6 million HCCs (about 30 percent of all HCCs identified on chart reviews) were identified only through a chart review. Eight HCCs each generated more than \$1 billion in Medicare payments from chart reviews, accounting for more than half of all chart review-based payments.⁴³ We found that in 2022, chart reviews alone accounted for about \$25 billion in payments to MA plans, or about 7 percent of all payments to MA plans.⁴⁴

We estimate that chart reviews and health risk assessments together accounted for about \$33 billion in payments to MA plans, or about 9 percent of all payments to MA plans in 2022.⁴⁵ Combined with our finding that all sources of coding intensity resulted in MA risk scores that were about 18 percent higher than risk scores for comparable FFS beneficiaries in 2022, we conclude that health risk assessments and chart reviews together accounted for about 50 percent of all MA coding intensity (Figure 12-9, p. 386).

**FIGURE
12-9**

Chart reviews and health risk assessments accounted for about half of overall MA coding intensity, 2020-2022



Note: MA (Medicare Advantage). FFS (fee-for-service). Figure shows the impact of coding intensity on payments to MA plans for the years 2020 through 2022. The underlying diagnoses were reported during health care encounters in the prior year, 2019 through 2021, respectively.

Source: MedPAC analysis of CMS enrollment and risk-score files, and Medicare Trustees' reports.

The Commission's prior recommendation on coding intensity

In our March 2016 report to the Congress, the Commission recommended a multipronged approach that would fully account for the impact of coding differences, improve the equity of the adjustment across MA contracts, and increase incentives to reduce costs and improve quality. The Commission's approach to reduce the impact of MA coding intensity has been to address the underlying causes first (e.g., remove health risk assessments and reduce year-to-year coding variations by using two years of diagnostic data) and then address remaining differences with either an across-the-board or tiered adjustment. The Commission's 2016 recommendation did not address the use of chart reviews because data were not available at that time, but eliminating chart reviews as

a source of diagnoses for risk adjustment is consistent with the Commission's approach.

The recommendation, which would replace the existing mandatory minimum coding intensity adjustment (which has reduced MA risk scores by 5.9 percent since 2018), has three parts:

- develop a risk-adjustment model that uses two years of FFS and MA diagnostic data,
- exclude diagnoses that are documented only on health risk assessments from either FFS or MA, and then
- apply a coding adjustment that fully accounts for the remaining differences in coding between FFS Medicare and MA plans.

Implementing the first two policies—using two years of diagnostic data and excluding diagnoses documented through health risk assessments alone—and excluding chart review data from risk adjustment (consistent with the Commission’s approach) would result in a more equitable, targeted adjustment to MA contracts than the current across-the-board adjustment. As noted earlier, health risk assessments and chart reviews alone account for roughly half of MA coding intensity. The Commission carefully considered options for addressing coding intensity and supports this approach because it balances implementation feasibility, administrative burden, and effectiveness.

Part of the cause of coding intensity is that providers do not report all possible diagnosis codes for the FFS beneficiaries. We note that using two years of diagnostic data would help address the under-reporting of chronic conditions for FFS beneficiaries by helping to capture conditions that are not reported consistently year to year. Theoretically, conducting chart reviews for FFS beneficiaries could also reduce differences in MA and FFS coding; however, such a strategy would need to carefully consider the number of chart reviews necessary to have a meaningful impact, the administrative effort involved in reviewing the charts to identify diagnoses allowable for risk adjustment, and the disruption to providers when assisting the collection of FFS beneficiary charts. Alternatively, chart reviews could be eliminated from risk adjustment altogether, thereby aligning the data sources used as sources of diagnoses for risk adjustment.

Adjusting for any remaining coding intensity differences could also improve equity across MA contracts. Under one approach, contracts would be grouped into tiers of high, medium, and low coding intensity, and a coding intensity adjustment would be applied based on each tier’s average level of coding intensity (Medicare Payment Advisory Commission 2016a). CMS has used a similar approach to select MA contracts for risk-adjustment data validation audits.⁴⁶ This policy would improve the overall equity of the coding intensity adjustment relative to the single, across-the-board adjustment used today. Finally, we note that in 2016, when the Commission voted on this recommendation, estimates of MA coding intensity net of CMS’s coding adjustment were much

smaller than they are for 2024. Given that the impact of the Commission’s recommendation, which would fully account for the effects of higher MA coding intensity, has grown substantially, policymakers could contemplate phasing in the Commission’s recommendation.

Industry concentration, integration, and financial condition

In 2023, the MA program included 5,635 plan options offered by 184 organizations. However, enrollment is highly concentrated at the local level and increasingly concentrated at the national level: The largest organization in a county typically enrolls between 40 percent and 50 percent of the market, and just three organizations enrolled more than half of all MA enrollees nationally in 2023. The continued growth in MA enrollment, the substantial number of plans offered by several organizations, and plans’ ability to provide generous extra benefits point to continued strong financial health in the MA sector. The Commission has historically analyzed the margins that MA plans report in their bids. However, we have become increasingly concerned about the appropriateness of focusing on plan margins (instead of other metrics of financial health) and about whether the margins reported in bids are sufficient for characterizing insurers’ financial condition.

MA market heavily concentrated, but slightly less concentrated in 2023

Enrollment in MA is highly concentrated at the local level and increasingly concentrated at the national level. High enrollment concentration—particularly at the local level—can be a cause for concern if it dampens the competitive pressures that might otherwise drive insurers to maintain or improve quality, make care delivery more efficient, lower premiums, or provide supplemental benefits. Researchers have studied MA market concentration by examining the results of legislated changes to MA payment policy that created natural experiments through which the effects of insurer market power were revealed. Two studies analyzing experience from the early 2000s investigated how insurers responded to payment cuts and increases (Cabral et al. 2018, Pizer and Frakt

**TABLE
12-6****Medicare Advantage enrollment share by top three parent organizations increased nationally and locally, July 2019–2023**

Top 3 parent organizations, by type of MA plan	Share of MA-eligible beneficiaries living in counties in which insurer offers an MA plan			Percentage point change in share	
	2019	2022	2023	2019–2023	2022–2023
Conventional plans					
UnitedHealth Group Inc.	80%	90%	94%	+14%	+4%
Humana Inc.	85	89	92	+7	+3
CVS Health Corporation	73	83	84	+11	+1
All MA plans					
Top 3 nationwide					
UnitedHealth Group Inc.	27	28	29	+2	+1
Humana Inc.	18	18	18	0	0
CVS Health Corporation	10	11	11	+1	0
Conventional plans					
Top 3 nationwide					
UnitedHealth Group Inc.	23	24	25	+2	+1
Humana Inc.	22	20	22	0	+2
CVS Health Corporation	9	10	9	0	–1
County level (weighted average)*					
Top organization	47	43	43	–4	0
Top 2 organizations	71	67	67	–4	0
Top 3 organizations	84	81	81	–3	0

Note: MA (Medicare Advantage). Includes only MA plans (coordinated care, private fee-for-service, and medical savings account plans). Excluded are cost-reimbursed plans and Medicare–Medicaid demonstration plans. Conventional plans exclude special needs plans and employer group plans, which have restricted availability. Totals, differences, and market shares may not sum due to rounding.

*County-level shares of MA enrollment reflect the beneficiary-weighted average of the top organizations in each county.

Source: MedPAC analysis of July 2018–2023 enrollment data and CMS Landscape files.

2002). In both, researchers found evidence that market power affects the generosity of plan offerings: Greater competition was associated with increases in benefit generosity and reductions in premiums, and higher payments to plans were passed through

to beneficiaries more completely in areas with higher competition in the wake of payment increases. In the late aughts and early 2010s, additional policy changes created a second opportunity to examine insurers' market power. Two studies, examining

two distinct policy changes, found further evidence that MA concentration affects whether competition works to the benefit of MA enrollees. One study again found that increases in MA payment in concentrated markets were incompletely passed through to beneficiaries, and the second found that insurer exit (decreased competition) was associated with declines in benefit generosity among plans that remained active, particularly in areas with higher concentration (Pelech 2018, Song et al. 2013).

In extreme cases, dominance by a single firm (or small set of firms) may make it difficult for competitors to enter or remain active in a market, particularly if economies of scale are a necessary feature of the business model. One study looking at the effect of competition on insurers' decisions to enter or exit a market demonstrated that insurers with higher market shares were less likely to exit a market following a regulatory shock, and that insurers with less market power relative to local providers were more likely to exit (Pelech 2017). Another study found that insurers were less likely to enter markets in which an incumbent had higher market power (Frakt et al. 2012).⁴⁷ While the studies described above all cover earlier periods in the history of the MA program (during which local markets were more highly concentrated than they are today), they illustrate the potential downsides of a highly concentrated market.

Over the last decade, enrollment has become increasingly concentrated at the national level in plans owned by a small set of large insurers that serve a majority of markets in the country. Between 2008 and 2023, the share of total MA enrollment in the three largest firms rose from 32 percent to 58 percent. Much of the growth of these firms has been driven by their expansion into new markets. For example, UnitedHealth Group expanded from offering plans in 48 percent of counties (a service area covering 70 percent of MA-eligible beneficiaries) in 2013, to 53 percent of counties (covering 80 percent of eligible enrollees) in 2019, to 82 percent of counties (covering 94 percent of eligible enrollees) in 2023. Humana and CVS Health Corporation have also expanded their service areas, and all three organizations now offer plans in counties that are home to more than 80 percent of MA-eligible beneficiaries (Table 12-6).

Between 2022 and 2023, the share of enrollees covered by these top three organizations rose by 1 percentage point to 58 percent (5 percentage points higher than in 2019) (Table 12-6).⁴⁸ Among conventional plans (plans available to all Medicare beneficiaries, i.e., excluding SNPs and employer plans), the top three organizations nationwide had 56 percent of enrollment in 2023—an increase from 54 percent in 2022.⁴⁹

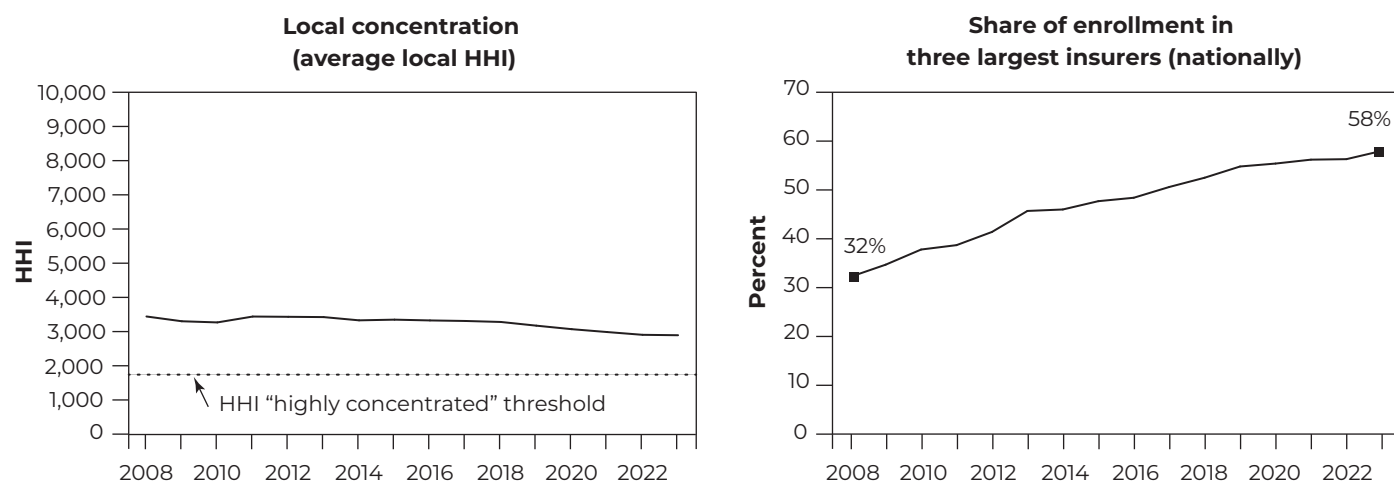
Given the relevance of local competition for MA enrollees, we place greater importance on examining competition at the county level (Table 12-6). Excluding employer plans and SNPs, in 2023, enrollment in the largest organization in each county accounted for 43 percent, on average, of all MA enrollment in the county (unchanged from 2022). Enrollment in the top three organizations in each county accounted for 81 percent, on average, of all MA enrollment (unchanged from 2022 but lower than the 84 percent observed in 2019). However, the share of MA enrollees living in counties with highly concentrated markets (as measured using the Herfindahl–Hirschman Index (HHI), a common measure of market concentration) increased from 89 percent in 2022 to 94 percent in 2023 (data not shown).⁵⁰

The geographic expansion of large national insurers has contributed to decreasing concentration in local markets. When measured using the HHI, average county-level enrollment concentration has fallen over the last decade, despite the rising share of enrollees covered by the three largest firms nationally (Figure 12-10, p. 390).

Although the local concentration of MA enrollment varies somewhat throughout the country, in the typical county, the top organization enrolls between 40 percent and 50 percent of MA enrollees in the county; the next largest enrolls roughly one-quarter of enrollees; the third largest enrolls 10 percent to 15 percent; and the remaining enrollment is shared among other organizations. This pattern is present in both urban and rural areas, though rural areas are slightly more concentrated than urban areas in 2023 (Figure 12-11, p. 391). Concentration—particularly the enrollment share of the largest organization in a county—is unusually high in areas with very low and very high MA penetration. However, a relatively small share of beneficiaries live in such counties. In 2023,

**FIGURE
12-10**

Local concentration has fallen as a small number of insurers enroll a growing share of total MA enrollees



Note: MA (Medicare Advantage), HHI (Herfindahl-Hirschman Index). Includes only Medicare Advantage plans (coordinated care, private fee-for-service, and medical savings account plans). Excluded are cost-reimbursed plans and Medicare-Medicaid demonstration plans. The threshold for highly concentrated markets is described in the Department of Justice and the 2023 Federal Trade Commission *Merger Guidelines*.

Source: MedPAC analysis of CMS July 2008–2023 enrollment data.

approximately 3 percent of MA-eligible beneficiaries live in counties with less than 20 percent or more than 80 percent penetration, while nearly half (48 percent) live in counties with penetration between 40 percent and 60 percent.

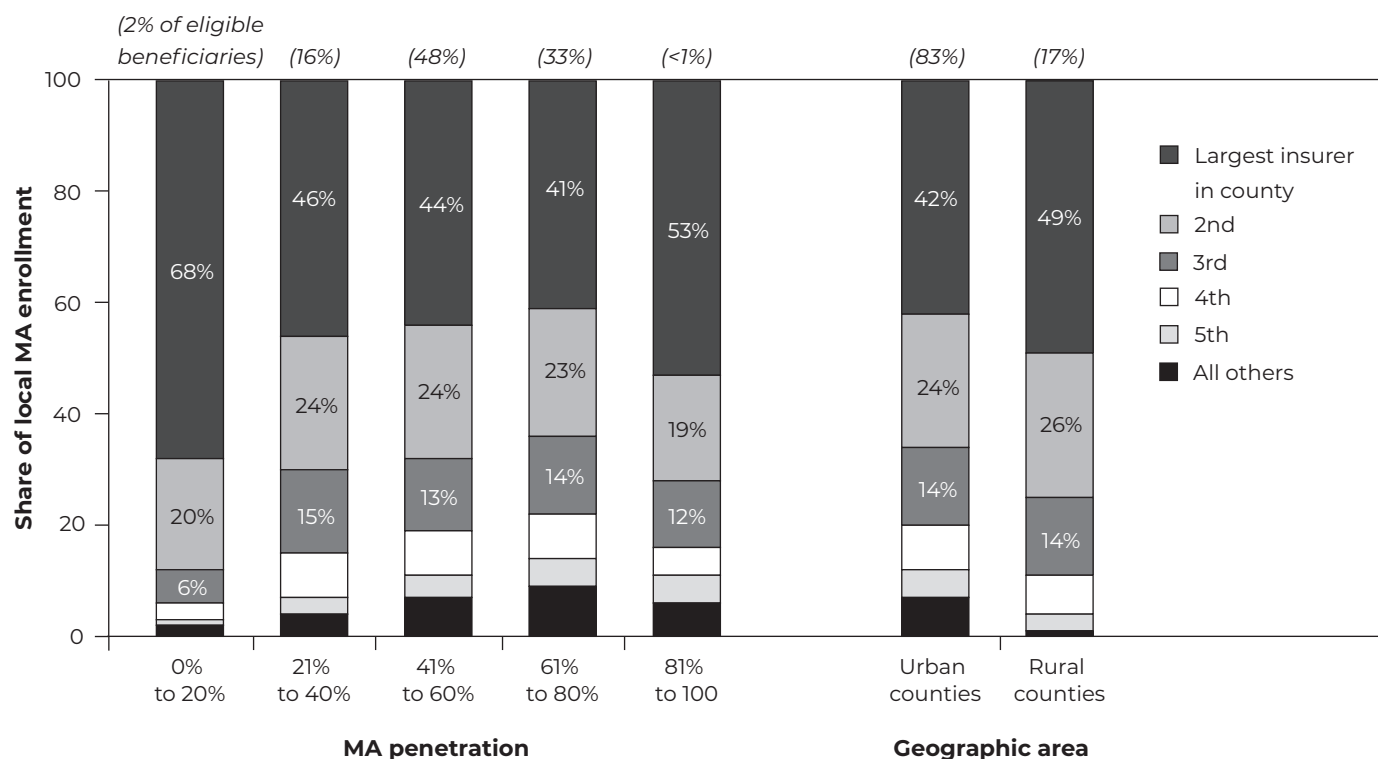
In addition to enrolling a dominant share of all MA enrollees nationally, large national insurers are also frequently the largest insurers in local markets. In 2023, 141 parent organizations offered an MA plan that was open to all enrollees (excluding SNPs and employer plans), and the typical enrollee had access to such plans offered by 8 insurers. Nevertheless, more than 60 percent of MA enrollees lived in a county in which the top insurer was one of the three largest insurers nationally. Large national insurers were similarly dominant in both urban and rural areas, enrolling the largest share of MA enrollees in 67 percent of the country's urban counties (home to 60 percent of urban-dwelling MA enrollees) and nearly three-quarters of rural counties (home to 65 percent

of enrollees in rural areas). Areas in which the largest insurer was one of the top three largest organizations nationally were typically more concentrated than other areas: The average HHI in counties led by a top-three national insurer was roughly 5 percent higher than in counties with a non-top-three leader. For the roughly 40 percent of MA enrollees living in a county in which the largest insurer was not among the national top three, the top insurer in their area was frequently a Blue Cross Blue Shield-affiliated plan (roughly 60 percent of counties with a non-top-three insurer as the largest insurer, home to 40 percent of MA enrollees in such counties), or a health plan for which the parent organization was a vertically integrated health system (25 percent of such counties, 50 percent of MA enrollees in such counties).⁵¹

Overall, local MA markets tend to be highly concentrated, although the level of concentration has trended downward in recent years. This trend coincides with insurers entering new markets and

**FIGURE
12-11**

Rural counties and those with unusually low or high MA penetration are more concentrated



Note: MA (Medicare Advantage). Excluded are cost-reimbursed plans and Medicare–Medicaid demonstration plans. Excludes special needs plans and employer group plans, which have restricted availability. U.S. territories are also excluded.

Source: MedPAC analysis of CMS enrollment data.

steadily gaining market share in areas that have historically been very concentrated. In addition, as illustrated earlier in this chapter, estimates for 2024 indicate that the average beneficiary will have access to many MA plans offered by a substantial number of organizations. However, large national insurers, and some regional or local insurers, frequently enroll a large fraction of MA enrollees in an area. Such concentration may dampen competition, a topic the Commission will continue to explore and monitor.

MA margins

The continued growth in MA enrollment, the substantial number of plans offered by several organizations, and plans' ability to provide generous

extra benefits point to continued strong financial health in the MA sector. We have historically analyzed the margins that MA plans report in their bids. We have consistently reported that the data do not include plans' expected costs and revenues for providing Part D (which nearly all MA plans offer) and do not include employer plans (17 percent of MA enrollment in 2022). However, we have become increasingly concerned about the appropriateness of focusing on plan margins (instead of other metrics financial health) and about whether the margins reported in bids are sufficient for characterizing insurers' financial condition.

One concern is that MA margins may not be comparable with the margins of other health insurance lines of business. For example, MA gross profits

(measured in total MA revenue dollars per enrollee after subtracting MA expenses) tend to be much higher than other lines of health insurance businesses (Ortaliza et al. 2023). While Medicare beneficiaries have higher costs, the remaining revenues after covering those costs tend to be higher per enrollee relative to individuals covered under other lines of business. Thus, an organization that has the same profit margin (measured as the share of remaining revenue after subtracting medical expenses) across its various insurance lines of business will likely have higher gross profits (measured in dollars per enrollee) in MA, particularly if the organization's fixed costs (e.g., rent, utilities, information technology infrastructure, and base salaries and benefits) are similar across lines of business. Thus, gross profits per MA enrollee may be a more salient indicator than margin because high gross profits would enable a plan to increase the amount of revenue allocated toward employee and broker compensation, investments, advertising, lobbying, and infrastructure.

A second concern with the margins reported in MA bids is whether the margin data collected through the bidding process appropriately characterize insurers' profits. This concern is particularly acute for vertically integrated firms—those in which plans and providers are owned by the same organization. For a vertically integrated organization, the margin for the insurance line of business might not reflect the margin for the parent organization. For example, payments from a plan to a provider owned by the same parent organization would count as medical expenses for the plan (putting downward pressure on plan margin) but contribute positively to the margin of the parent organization. Because plan bids include margin information only for the plan, they may understate insurers' financial health. The degree to which provider revenues are shared with plans under these arrangements is unclear, but limited financial data suggest a substantial shifting of revenues and expenses for at least one large health plan (Frank and Milhaupt 2022, Milhaupt 2023). In addition, we have observed some provider-sponsored plans that consistently report negative MA margins despite consistent growth in MA enrollment. These reported margins have become difficult for us to reconcile with CMS's requirement that MA plans with negative margins must submit a business plan to achieve profitability and

CMS's stated expectation that MA plans meet or exceed the year-by-year margin targets in the business plan. Because plan bid data do not necessarily reflect the expenses and margins of their affiliated providers, we have diminishing confidence in the margins reported in plan bids. This problem is likely to grow as vertical integration increases (see the text box on consolidation and vertical integration in MA, pp. 394–397, for more detail). Given our declining confidence in the salience and accuracy of plan-reported margins, we will consider omitting these data in future cycles and focus on more reliable indicators of the financial health of the MA program, such as plan availability and enrollment.

While analyses of MA margins are not indicative of the financial health of the MA sector (as discussed above), we analyzed plan-reported margins for 2022 to the limited extent that they can be used as a partial indicator of MA financial health. Using the most recent data available, in 2022, MA plans reported margins that averaged 3.6 percent, an increase from 2.2 percent in 2021.^{52,53} Plan-reported margins vary by a plan's tax status and whether a plan is a SNP. In the 2022 data, nonprofit plans reported a margin of 0.1 percent; for-profit entities reported a pretax margin of 4.3 percent, both increases relative to 2021. In 2022, all categories of SNPs reported overall positive margins. D-SNPs, for beneficiaries dually eligible for Medicare and Medicaid benefits, reported margins of 7.5 percent. SNPs for enrollees with certain chronic conditions (C-SNPs) reported margins of 7.4 percent. Institutional SNPs reported margins of 4.0 percent.

Quality in MA

The Commission has long held that MA presents opportunities for innovation to achieve higher-quality care at lower cost. To make informed choices about enrolling in an MA plan, beneficiaries need good information about the quality and access to care provided by MA plans in their local market. However, the Commission has determined that the current system for MA quality reporting and measurement is flawed and does not provide a reliable basis for evaluating quality across MA plans. Nonetheless, these measures are the basis for the MA quality bonus program (QBP), which uses trust fund and taxpayer dollars to increase MA payments by about \$15 billion

annually. It is unclear how responsive MA plan quality is to these incentives.

Here, we provide a brief overview of the current MA QBP and the Commission's standing recommendations to improve MA quality assessment. We continue to evaluate MA quality and access and are working to expand our assessment to include network adequacy, prior authorization, literature on MA quality, and some empirical analyses.

CMS assessment of MA quality

In 2006, CMS introduced the MA star rating system to give beneficiaries information about the clinical quality, administrative capability, and patient experience an enrollee can expect in an MA plan.⁵⁴ Medicare currently collects close to 100 MA quality measures, 40 of which are used to determine a star rating from 1 to 5 for each MA contract (Centers for Medicare & Medicaid Services 2022).^{55,56} These ratings are made available through the medicare.gov Plan Finder website to enable beneficiaries to compare across plans. As required by the ACA, since 2012 the star rating system has been the basis of the QBP, which increases benchmarks for MA contracts rated 4 stars or higher.⁵⁷ Contracts with a 5-star rating are able to enroll beneficiaries during every month of the year, rather than being limited to the annual election period from October to December. The star rating also contributes to the level of rebate payments. Plans with higher star ratings retain a higher share of the difference between a plan bid and the benchmark when bids are below the benchmark.

The share of MA contracts receiving quality bonuses is consistently high. Forty-two percent of all MA contracts are in bonus status for 2024, a decrease from recent years (Centers for Medicare & Medicaid Services 2023a). Under the coronavirus public health emergency (PHE), CMS relaxed quality reporting rules, boosting the average star rating from 4.04 in 2021 to 4.37 in 2022. The share of enrollees in plans achieving 5 stars was 27 percent in 2022 and 22 percent in 2023, compared with 5 percent in 2021 (before the PHE rule change) and 7 percent in 2024 (after the rules reverted back). The average star rating declined in 2024, but it remains above 4 stars. Roughly three-quarters of MA enrollees are enrolled in contracts with a 4-star rating or higher for 2024.

Unlike other Medicare quality programs, the QBP is financed with additional program dollars; it increases MA payments (and program spending) by about \$15 billion annually. Our prior work has indicated that plans have significant incentives to engage in activities that increase their star ratings, and our analyses raised questions about whether the extra dollars from quality bonus payments have been used to provide benefits to MA enrollees (Medicare Payment Advisory Commission 2020a, Medicare Payment Advisory Commission 2020b).

Previously, the Commission would monitor a subset of measures used in the QBP as part of the status report (Medicare Payment Advisory Commission 2017, Medicare Payment Advisory Commission 2016b). The Commission observed some variability but generally found it difficult to assess whether MA plan quality of care was changing over time. For the last several years, the Commission has concluded that the current state of quality reporting is such that we cannot provide an accurate description of the quality of care across MA plans with this information (Medicare Payment Advisory Commission 2019). Instead, the Commission has made recommendations to improve MA quality reporting and quality payment programs, including a recommendation to assess MA quality at the local market area (Medicare Payment Advisory Commission 2018). The next section details the Commission's recommendations to address these and other flaws in MA payment policies.

Commission recommendations would address many problems with MA payment policies and the quality bonus program

When risk-based payments for private plans were first incorporated in the Medicare program, policymakers expected that they would help to reduce Medicare spending. Indeed, under the original incorporation of private plans in Medicare in 1985, payments to private plans were set at 95 percent of FFS payments.⁵⁸ However, under current policy, Medicare pays rates higher than FFS in some areas, including quality bonuses that apply to the vast majority of payments to MA plans, and policy does not adjust for the full effect

Vertical integration of Medicare Advantage plans and providers

Medicare Advantage (MA) organizations are increasingly integrating vertically, with provider and insurer lines of business having common ownership (or other financially aligned arrangements). Vertical integration is highest in organizations in which a provider-based organization owns and operates a health plan, though insurer-led integration has accelerated in recent years, with the three largest MA organizations investing significantly in the acquisition of provider businesses. MA payment policy—though not the only factor influencing firms' decisions to integrate—likely promotes such arrangements.

MA organizations are increasingly vertically integrated

Recent acquisitions of provider businesses by insurers have been widely reported and suggest that insurers see significant advantages to owning a greater share of the health care supply chain. For example, UnitedHealth Group has pursued a strategy of acquiring physician groups and practices, and it reports having approximately 130,000 employed or affiliated physicians and advanced practice clinicians as of the end of 2023 (UnitedHealth Group 2023). Both Humana and CVS have followed suit, investing resources in acquiring clinics and primary care practices (CVS Health 2023, Humana 2022, Humana 2020). The three largest MA organizations (MAOs) have each also acquired their own home health businesses, purchasing several of the largest home health providers in the country. Humana bought Kindred at Home in 2021, UnitedHealth Group bought the LHC Group in 2022, and CVS Health Corporation acquired Signify Health in 2022 (Humana 2021, Signify Health 2023, UnitedHealth Group 2022).

In addition to insurer acquisition of providers, many MAOs are vertically integrated as a result of being owned and operated by a hospital system. We reviewed the websites of major

health systems and identified 56 MA parent organizations (of 184 offering plans in 2023) that had some degree of ownership by a health system. In addition to these, many health systems have partnered with an insurer to offer a co-branded insurance product. This review understates the extent of vertical integration in MA because it is limited to plans owned by health systems and is not a comprehensive review of all MA parent organizations and their financial arrangements with providers. There are no public data that provide a systematic accounting of ownership relationships between MA plans and health care providers—a significant barrier to studying the effects of vertical integration. Previous research on the prevalence of vertically integrated plans found that the share of MA enrollees in vertically integrated contracts (defined by the researchers as local coordinated care plans that are not special needs plans and are owned by a provider organization such as a hospital, physician group, or other integrated delivery system) fell from roughly 24 percent to 22 percent between 2011 and 2015 (Johnson et al. 2017). Earlier research found that vertical integration of MA plans was associated with higher premiums but could not establish that this relationship was causal (Frakt et al. 2013).

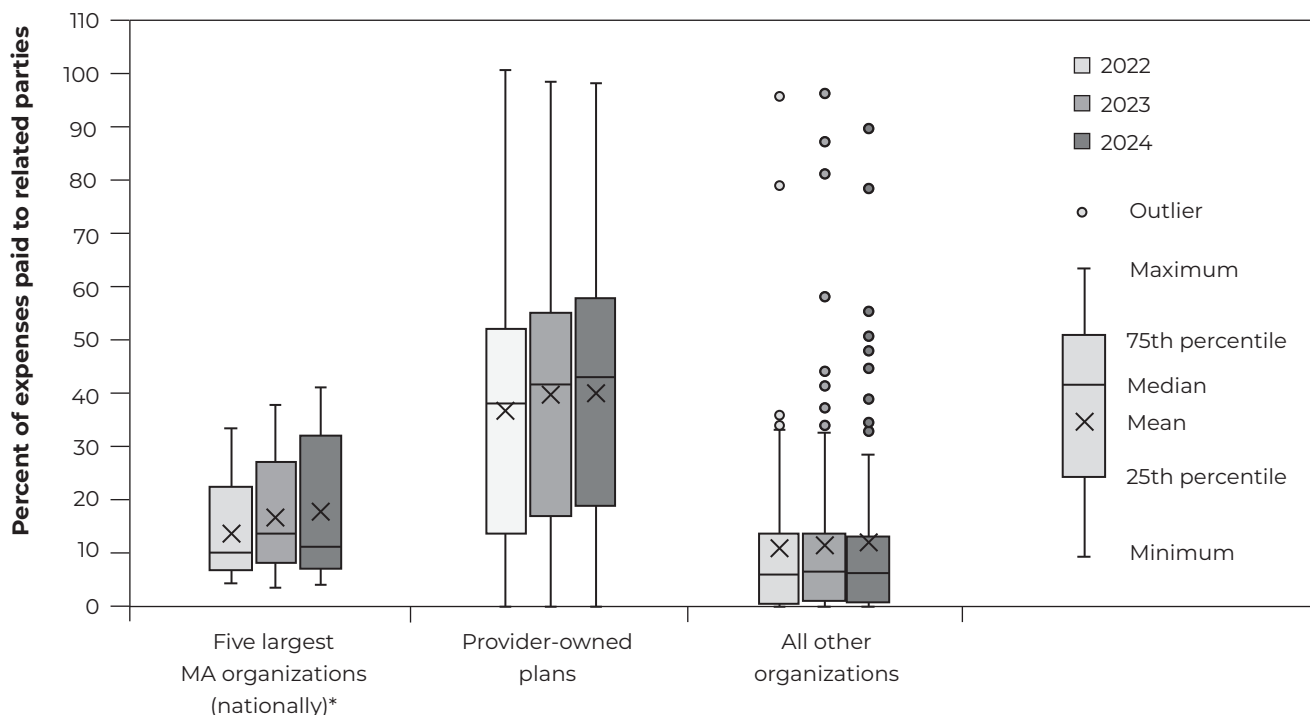
CMS requires MAOs to submit information about the extent of their financial relationships with providers and other entities as part of the bidding process. Specifically, plans submitting bids are required to report the amount (including medical costs and nonbenefit expenses) per member per month that they expect their members to receive from a related party, defined as any entity that “has a different tax identification number than that of the MAO but is associated with the MAO by any form of common, privately held ownership, control, or investment, including any arrangement in which the MAO does business with a related party through one or more unrelated parties” (Centers for Medicare & Medicaid Services 2023c). While the submitted data are projections and not a

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Vertical integration of Medicare Advantage plans and providers (cont.)

**FIGURE
12-12**

Vertical integration is increasing and is highest in plans owned by provider organizations



Note: MA (Medicare Advantage). Excluded are cost-reimbursed plans, Medicare–Medicaid demonstration plans, and employer group plans.

*The five largest non-provider-owned plans are UnitedHealth Group, Humana, CVS Health, Elevance Health, and Centene. Kaiser Foundation Health Plan enrolls more beneficiaries than Centene but is categorized as a provider-owned plan in the figure.

Source: MedPAC analysis of data from CMS on plan bids, MMIT Directory of Health Plans.

report of actual utilization in a completed year, they provide insight as to the MAO's own assessment of its integration with other entities. Figure 12-12 illustrates that the degree of vertical integration in MA varies widely across parent organizations and is highest in provider-owned plans. Among these, the share is highest in plans owned by health systems (data not shown).⁵⁹

Despite the attention paid to recent trends in insurer-led integration, the data show that large national insurers remain significantly less vertically

integrated than their provider-owned competitors. It is nevertheless important to consider that the large national organizations insure a significant share of MA enrollees nationwide, so trends in the organization of the businesses can affect millions of beneficiaries. The information presented here is reported at the parent organization level. However, health care markets operate primarily at a local level, and national statistics do not necessarily describe the markets in which most beneficiaries live.

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Vertical integration of Medicare Advantage plans and providers (cont.)

Interaction between MA payment policy and vertical integration of plans and providers

Several features of MA payment may reward firms that vertically integrate insurer and provider businesses. Incentives for integration are not confined to Medicare and are influenced by trends in other sectors of the health care system, as well as by the actions of regulatory agencies—particularly the Department of Justice and Federal Trade Commission.

Promoting efficient care delivery

Because Medicare pays private plans a predetermined rate that is risk adjusted for each enrollee rather than a per service rate, plans should have greater incentives than fee-for-service providers to deliver more efficient care. Some commentators have hypothesized that MA organizations may view vertical integration as a means of more directly promoting care that is more efficient, higher quality, and more clinically integrated. Evidence is limited regarding the effects of plan-provider integration on quality and efficiency in MA. Most studies that have analyzed these topics use data from plans owned by vertically integrated health systems or integrated provider groups (Frakt et al. 2013, Johnson et al. 2017, Meyers et al. 2020, Parikh et al. 2022, Park et al. 2023). As such, it is difficult to interpret whether the findings stem from the vertical integration of the plan with the provider or from other features of the organizations included in the studies. Additionally, results from studies of provider-owned health systems may not be generalizable to other forms of

plan-provider integration, such as insurer ownership of primary care businesses or home health organizations, and comparatively little research is available on these forms of integration. Regardless of whether the effects of plan-provider integration on quality and efficiency are yet evident to researchers, MAOs may view integration as a way to achieve the efficiencies incentivized under MA's capitated payment structure.

Risk adjustment

Payments to MA plans are risk adjusted to account for differences in health status. Risk scores are based on demographic information and diagnoses that plans submit to CMS (see section on how Medicare calculates risk scores, p. 365). Documenting additional diagnosis codes raises plan enrollees' risk scores, which increases plans' monthly payments from CMS, including the rebates used to offer extra benefits to enrollees. The higher payments garnered through more intensive risk coding may be easier to achieve in vertically integrated organizations that can increase the number of recorded diagnoses by (1) passing the same diagnosis-based incentives along to providers through risk-adjusted payment arrangements and (2) working directly with their employed or affiliated providers to code more thoroughly. Researchers have found that vertically integrated MA organizations tend to identify higher numbers of diagnoses and that coding intensity is higher for integrated plans (Geruso and Layton 2020, Meyers et al. 2020). Some researchers have suggested that the potential for additional revenue through higher risk coding is a key driver of such acquisitions (Gilfillan and Berwick 2021). If vertical

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of diagnostic coding intensity or account for favorable selection of enrollees into MA.

Overall, we estimate in 2024 that Medicare pays MA plans 22 percent, or \$83 billion, more than it would spend if those enrollees were covered under FFS Medicare, which increases financial burden on the

taxpayers and beneficiaries who fund the MA program (including those in FFS Medicare, who help finance MA through their Part B premiums). We estimate that aggregate Part B premiums will be about \$13 billion higher in 2024 because of payments above FFS spending.⁶⁰

Vertical integration of Medicare Advantage plans and providers (cont.)

integration enables MAOs to generate higher payments through greater coding intensity, it may also increase enrollment concentration as higher rebate payments allow plans to offer more generous extra benefits and attract more enrollees.

Quality bonus program

Medicare uses a quality bonus program (QBP) that rates MA plans based on a 5-star system and provides bonuses to plans rated 4 stars or higher (see the “Quality in MA” section, p. 392). The QBP rewards documentation of process measures, creating an incentive for MAOs to integrate with providers so the organization has more direct influence on providers’ performance on the measures that affect payment.

Medical loss ratio requirements

MA organizations are subject to a medical loss ratio (MLR) requirement of 85 percent—meaning that they are required to spend at least 85 percent of their revenue on care for their enrollees (42 CFR 422.2410).⁶¹ When a plan and provider are vertically integrated, a single organization determines contracted payment rates that the plan will pay the provider. Researchers have suggested that payments to related businesses offer an opportunity to avoid the constraints on profits posed by MLR regulations and asserted that insurers may pay higher rates to providers owned by the same parent organization in an effort to increase profits (Frank and Milhaupt 2023, Frank and Milhaupt 2022). To guard against such practices, CMS requires that MA organizations report related-party arrangements and provide documentation regarding the effect of the arrangement on the prices paid for the services

(e.g., by comparing to an estimate of what prices would have been in the absence of the arrangement, or to actual costs) (Centers for Medicare & Medicaid Services 2023c). Even at fair-market rates, however, payments to owned-providers may include a margin and enable a company to retain a higher share of profits within the parent organization while complying with MLR requirements.

Negotiations with providers

MA plans use networks and tiered cost sharing to influence where their members receive care. In designing networks, MA organizations must demonstrate that their network provides adequate access to a range of provider types. Networks are influenced by the outcome of negotiations between providers and insurers. Negotiated contract rates, which generally reflect the balance of market power between a provider and insurer, are heavily influenced by the level of consolidation in the market. Researchers have previously investigated the role of market power in the negotiations between MA plans and providers and found that an insurer’s market power was an important determinant of whether it continued to operate in a market—an effect that was particularly pronounced in more highly concentrated hospital markets (Pelech 2017).

Altogether, we find that the MA industry is increasingly vertically integrated and that such integration may enable MAOs to achieve higher profitability under current MA payment policy. The Commission plans to continue monitoring trends in integration in MA and evaluating their effects on enrollees and the function of the program. ■

In particular, the Commission has found that CMS’s coding intensity adjustment is inadequate to address the higher level of MA diagnostic coding we estimate for 2024 and the resulting higher payments to MA plans. At the same time, the quality bonus program boosts plan payments for 74 percent of MA enrollees

but does not effectively promote high-quality care. Further, we estimate that on average in 2024, after accounting for the effects of uncorrected coding intensity and favorable selection, MA plan bids exceed the costs of covering the Medicare benefit under FFS. Thus, a majority of the supplemental benefits

for MA enrollees are financed by increased program spending and not by MA plan efficiencies. For some enrollees, the extra benefits fill gaps in the Medicare benefit by adding coverage for services that are not included in traditional Medicare.⁶² The generosity of the additional benefits is appealing to beneficiaries, particularly for those who are unable to afford a Medigap policy that would reduce cost sharing in FFS. But these policies distort the goal of plans competing to improve quality and reduce health care costs; instead, the policies increase program spending and Part B beneficiaries' premiums. Moreover, the Commission has found that plan-submitted data about beneficiaries' health care encounters are incomplete. If these data were complete and accurate, they could be used to identify MA plan efficiencies, improve quality measurement, and provide more robust oversight of the MA program.

The Commission remains committed to including private plans in the Medicare program and allowing beneficiaries to choose among Medicare coverage options, including the alternative delivery systems that private plans can provide. But the rapid growth of MA enrollment and spending elevates the urgent need for a major overhaul of MA policies. As MA enrollment continues to grow, higher payments to plans will worsen Medicare's fiscal sustainability.

Paying MA plans more than FFS for beneficiary care also creates inequities among beneficiaries since in FFS Medicare, beneficiaries help finance the higher payments that MA plans use to provide extra benefits for their enrollees (benefits that FFS beneficiaries must pay for through supplemental insurance or out of pocket). Further, paying MA plans more than the program pays for FFS beneficiaries undermines incentives for efficient delivery of care. To encourage efficiency and promote value for taxpayers and beneficiaries, an overhaul of MA payment policy should include reducing the level of Medicare payments to MA plans. Past experience with reductions in MA payments under the ACA has demonstrated that plans can adjust their bidding behavior and lessen the effects on plan participation and beneficiary enrollment.

Over the past few years, the Commission has developed four recommendations (some that incorporate and update prior recommendations)

that would improve the MA program for both beneficiaries and taxpayers. Table 12-7 summarizes the Commission's standing recommendations to (1) account for continued coding differences between MA and FFS and address those differences in a complete and equitable way (Medicare Payment Advisory Commission 2016b); (2) ensure the completeness and accuracy of encounter data to improve the MA payment system, serve as a source of quality data, and facilitate comparisons with FFS Medicare (Medicare Payment Advisory Commission 2019); (3) replace the QBP with a market area-based, plan-financed reward program (Medicare Payment Advisory Commission 2020a); and (4) establish more equitable MA benchmarks for the Medicare program (Medicare Payment Advisory Commission 2021a). Through reforms to the MA payment system, the Commission aims to improve the program for the beneficiaries it serves and to harness plan efficiency to strengthen Medicare's long-term financial sustainability.

If payments to MA plans were lowered, plans might reduce the supplemental benefits they offer. However, because plans use these benefits to attract enrollees, they might respond instead by modifying other aspects of their bids (Cabral et al. 2018, Chernew et al. 2023, Congressional Budget Office 2022, Song et al. 2013).

The inability of the MA quality bonus program to meaningfully characterize the quality of care that MA enrollees receive makes it difficult for beneficiaries to make informed choices and for policymakers to assess the value that private plans bring to the Medicare program. In the June 2020 report to the Congress, the Commission recommended replacing the QBP with a value incentive program that addresses the flaws of the QBP. First, focusing on a small set of population-based outcome and patient/enrollee experience measures would facilitate comparisons across MA plans, enabling beneficiaries to choose based on factors that are most meaningful to their experience. A continuous scale of performance, rather than one with "cliff effects," would provide MA plans with the incentive to improve quality at every level. Performance evaluation at the local market level, rather than the contract level as is currently done, would similarly improve the information that beneficiaries can use for decision-making and would

Recommendation

Fully account for MA coding intensity—March 2016

The Congress should direct the Secretary to develop a risk-adjustment model that uses two years of FFS and MA diagnostic data and does not include diagnoses from health risk assessments from either FFS or MA, and then apply a coding adjustment that fully accounts for the remaining differences in coding between FFS Medicare and MA plans.

Improve encounter data accuracy and completeness—June 2019

The Congress should direct the Secretary to establish thresholds for the completeness and accuracy of MA encounter data and rigorously evaluate MA organizations' submitted data and provide robust feedback; concurrently apply a payment withhold and provide refunds to MA organizations that meet thresholds; and institute a mechanism for direct submission of provider claims to Medicare administrative contractors as a voluntary option for all MA organizations that prefer this method starting in 2024, for MA organizations that fail to meet thresholds, or for all MA organizations if program-wide thresholds are not achieved.

Replace the quality bonus program—June 2020*

The Congress should replace the current MA quality bonus program with a new MA value incentive program that scores a small set of population-based measures, evaluates quality at the local market level, uses a peer-grouping mechanism to account for differences in enrollees' social risk factors, establishes a system for distributing rewards with no "cliff" effects, and distributes plan-financed rewards and penalties at a local market level.

Establish more equitable benchmarks—June 2021**

The Congress should replace the current MA benchmark policy with a new MA benchmark policy that applies a relatively equal blend of per capita local area FFS spending with price-standardized per capita national FFS spending; a rebate of at least 75 percent; a discount rate of at least 2 percent; and the Commission's prior MA benchmark recommendations—using geographic markets as payment areas, using the FFS population with both Part A and Part B in benchmarks, and eliminating the current pre-Affordable Care Act cap on benchmarks.

Note: MA (Medicare Advantage), FFS (fee-for-service).
*The June 2020 quality recommendation incorporates the Commission's prior recommendations to eliminate the doubling of the quality increases in specified counties (recommended in March 2016) and to establish a geographic basis for MA quality reporting that reflects health care market areas (June 2005, March 2010, and March 2018).
**The June 2021 benchmark recommendation incorporates the Commission's prior recommendations to eliminate the cap on benchmark amounts implemented by the ACA (recommended in March 2016), base benchmarks on FFS spending data only for beneficiaries with both Part A and Part B (recommended in March 2017), and establish a geographic basis for MA payments that reflects health care market areas (recommended in June 2005, March 2010, and March 2018).

Source: Medicare Payment Advisory Commission (2021a), Medicare Payment Advisory Commission (2020a), Medicare Payment Advisory Commission (2019), Medicare Payment Advisory Commission (2016b).

correct MA plan incentives to improve quality in every geographic area.

The Commission also recommended that the value incentive program address the variation in the demographics of MA enrollees across plans. By accounting for differences in enrollees' social risk factors by stratifying plan enrollment into groups of

beneficiaries with similar social risk profiles, plans with higher shares of these enrollees would not be disadvantaged in their ability to receive quality-based payments, while actual differences in the quality of care would not be masked. Finally, the Commission believes strongly that MA quality bonus payments should not be financed with additional program dollars, especially given that Medicare pays MA plans

more than would have been spent on FFS for the same beneficiaries. Application of budget-neutral financing would ensure that the MA quality system is more consistent with Medicare's FFS quality payment

programs, which are either budget neutral (financed by reducing payments per unit of service) or produce program savings because they involve penalties (Medicare Payment Advisory Commission 2020a). ■

Endnotes

- 1 CMS includes FFS-claim administrative costs in MA benchmarks, which account for about 0.20 percent of FFS spending (Centers for Medicare & Medicaid Services 2023b, Centers for Medicare & Medicaid Services 2021). Expenses for FFS-claim administration are included in our comparison of FFS spending with MA payments and differ from the expenses found in Medicare's Trustees' report, which include the administration and oversight of the MA program and the enrollment of all Medicare providers (which is required for contracting with MA plans). The Medicare Trustees reported that administrative expenses (including those for MA enrollees) accounted for 1.04 percent of CMS's total Medicare benefit costs in 2020 (Boards of Trustees 2021).
- 2 Private FFS plans that operate without a network are limited to a small share of counties where fewer than 2 network-based plans offered; by the end of 2023, private FFS plans covered about 33,000 beneficiaries. Medical savings account plans combine a high deductible and a medical savings account, and by the end of 2023 they covered about 8,000 beneficiaries.
- 3 HMOs generally do not reimburse care provided by out-of-network (OON) providers. They often require that enrollees select a named primary care provider (PCP), who manages referrals to specialists. PPOs provide more flexibility for enrollees by not requiring a named PCP and by allowing enrollees to see both in- and out-of-network specialists without a referral. However, these plans generally have both higher premiums than HMOs and higher cost sharing for OON providers compared with in-network providers. HMO point-of-service (HMO-POS) is a subset of the HMO plan type that allows members to seek out-of-network care for certain types of services or in certain cases (such as travel). These plans offer less flexibility to seek care OON than PPOs but more than standard HMOs.
- 4 In 2017 and 2018, CMS began paying employer plans based on a blend of the 2016 bidding behavior of employer plans and the other MA plans. Starting in 2019, CMS began paying employer plans based on the prior year's bidding behavior of nonemployer plans by plan type and payment quartile. Because employer plans are mostly PPOs, their payment in 2024 largely reflects the average bidding behavior of nonemployer PPOs in 2023. We apply 2024 employer plan payment rates and recent employer plan enrollment and risk-score trends when estimating overall MA payments relative to FFS spending. Consistent with our prior analyses, we assumed employer plan enrollment growth of 3.5 percent from 2023 to 2024, which is lower than the enrollment growth of employer plans in most recent years. In addition, we calculated the overall risk-score ratio of employer plans to other MA plans in 2020 (reflecting diagnoses documented in 2019), and we applied this ratio to the average risk score in 2024 MA bids. Employer plans are also included in our estimates of coding intensity and favorable selection.
- 5 Payments described here do not apply to the relatively small number of enrollees with end-stage renal disease (ESRD). How Medicare pays MA plans for enrollees with ESRD is described in the Commission's March 2021 report under "Medicare payments to MA plans differ for ESRD and non-ESRD enrollees" (Medicare Payment Advisory Commission 2021b).
- 6 Plans' benefits may include a premium for mandatory supplemental benefits that cover all enrollees. Additionally, plans may offer optional supplemental benefits. Plans are not permitted to apply rebate dollars toward optional supplemental benefits. In addition, optional supplemental benefits cannot include reduced cost sharing for Medicare Part A and Part B services.
- 7 Benchmarks are calculated using FFS spending for all Medicare beneficiaries, including those with both Part A and Part B coverage and those with only Part A or Part B. In our March 2017 report to the Congress, we recommended that CMS change the calculation to include FFS spending for only those beneficiaries with both Part A and Part B coverage (that is, expenditures for only those beneficiaries eligible to enroll in MA plans) (Medicare Payment Advisory Commission 2017). This change would make the assumptions about FFS spending in the calculation of MA benchmarks and payments more reflective of the MA-eligible population.
- 8 The ACA caps any county's benchmark at the higher of (1) its pre-ACA level, projected into the future with a legislatively modified national growth factor, or (2) 100 percent of its estimated FFS spending in the current year. Our March 2016 report to the Congress provides more detail on double-bonus counties and benchmark growth caps. In that report, we recommended eliminating the double bonuses as well as the benchmark growth caps, which limited the benchmarks in many counties (Medicare Payment Advisory Commission 2016b).
- 9 Before 2022, MA plans also submitted diagnostic information through the Risk Adjustment Processing System (RAPS). The use of RAPS data was phased out from 2016 through 2021, except for contracts in the Program of All-Inclusive Care for the Elderly, which continue to use pooled RAPS and encounter data as the source of diagnostic data for risk scores.

- 10 Other possible sources of diagnostic information—such as encounters for home health services, skilled nursing, ambulatory surgery, durable medical equipment, lab and imaging tests, and hospice services—are not used to determine payment through the risk-adjustment model for several reasons: (1) adding diagnoses from these sources does not improve the model's ability to predict medical expenditures; (2) concerns exist about the reliability of diagnoses from providers with less clinical training (e.g., home health and durable medical equipment providers); and (3) a high proportion of reported diagnoses from certain settings (e.g., lab and imaging tests) are used to rule out having a diagnosis.
- 11 To date, RADV audits have been initiated for plan years 2016 and earlier and have been completed for only a few years. Information about payment recoveries based on RADV audits has only been made public for 2007. Given the limited nature of RADV audits, we do not yet know whether a “sentinel effect” will have a meaningful impact on higher MA coding intensity.
- 12 The Department of Health and Human Services Office of Inspector General has conducted RADV-like audits of high-risk diagnoses for at least 30 MA contracts and found that 70 percent of all diagnosis codes audited were not supported by medical records and that some diagnoses were not supported over 90 percent of the time (Office of Inspector General 2023).
- 13 Beneficiaries are guaranteed access to a Medigap supplemental insurance policy with no underwriting, even if they have a preexisting condition, if they purchase it during the 6-month Medigap open-enrollment period that begins on the first day a beneficiary is both 65 years old and enrolled in Medicare Part B. Beneficiaries have only one Medigap open enrollment period. Except for in limited circumstances (e.g., a beneficiary moves outside of their MA plan's service area), access to a Medigap policy is not guaranteed in most states after the Medigap open-enrollment period ends. Only four states require guaranteed-issue protections for aged (65 and over) beneficiaries in traditional Medicare, regardless of medical history. Under these protections, insurers cannot deny a Medigap policy to applicants based on preexisting conditions (Boccuti et al. 2018). In certain circumstances, beneficiaries who choose to enter MA and who subsequently disenroll to FFS within a 12 month trial period may also have guaranteed access Medigap coverage with no underwriting (42 USC 1395ss).
- 14 The availability of zero-premium local PPOs may have contributed to the increase in local PPO enrollment in 2023. For example, 96 percent of Medicare beneficiaries had a zero-premium local PPO available in 2023, up from 87 percent in 2022.
- 15 In 2023, 15 percent of MA enrollees and 20 percent of FFS enrollees resided in rural areas.
- 16 Our measurement of beneficiary access to plans uses 2024 plan bids and July 2023 county-level enrollment for the Medicare population with both Part A and Part B coverage. Plans are only included in a county if they project enrolling at least one beneficiary in the county.
- 17 Our measure of SNP availability reflects only the share of MA-eligible beneficiaries residing in a county served by a SNP. However, individuals must meet additional coverage criteria to be eligible to enroll in a SNP; for example, to enroll in an I-SNP, a beneficiary would typically reside in a skilled nursing facility that has a relationship with the plan.
- 18 All beneficiaries enrolling in Medicare Part B, regardless of their decision to receive benefits through FFS or MA, are required to pay the Medicare Part B premium. Some MA plans use rebate dollars to pay a portion of their members' Part B premium as a supplemental benefit. Beneficiaries enrolling in Part D may pay a separate Part D premium, although MA-PD plans may use rebate dollars to reduce the amount the beneficiary pays for drug coverage under the plan. Plans bidding above the local benchmark or offering more extra benefits than can be financed by the plan rebate charge enrollees an additional plan premium. We refer to plans that do not charge a separate plan premium (including any Part D premium) as “zero-premium” plans. The increasing availability of zero-premium plans in recent years has largely been driven by the availability of zero-premium local PPOs. Between 2019 and 2023, the availability of zero-premium local PPOs increased from 69 percent of Medicare beneficiaries to 96 percent, and the availability of zero-premium HMOs increased from 86 percent to 98 percent.
- 19 Federal regulations require MA plans to submit encounter records for all items and services provided to enrollees (42 CFR § 422.310(b)), including items and services provided through supplemental benefits; however, CMS's Encounter Data Submission and Processing guidance limits that requirement to supplemental services for which the plan has sufficient data to populate an encounter record. In addition, CMS systems are able to accept “professional” and “institutional” claim formats, which allow for the collection of some supplemental services, but CMS is not equipped to accept dental claims. Further, reimbursement for many supplemental benefits does not use any claim format (e.g., fitness, meals, transportation, pest control), meaning there is no standard way for plans to submit information about the use of such benefits. For 2024, CMS will require MA organizations to submit plan-level information (not through beneficiary-level encounter records) for a wide range of supplemental benefit categories, including data on the number of enrollees who are eligible for each benefit,

- number of enrollees who utilized each benefit, total and median instances of utilizations among eligible enrollees, the net amount incurred by the plan to offer each benefit, the type of payment arrangement, how the plan accounts for the cost of the benefit including administrative expenses, and the total out-of-pocket cost per utilization for enrollees (Centers for Medicare & Medicaid Services 2024).
- 20 In 2024, conventional plans project that 12 percent of the rebate dollars used for cost-sharing reductions will be allocated for plan administrative costs and profit. Among dual-eligible SNPs, 16 percent of the plan-projected rebate dollars used for cost-sharing reductions is projected to be allocated for plan administrative costs and profit.
 - 21 CMS generally expects MA plans to use their rebate dollars to cover the beneficiary cap on out-of-pocket (OOP) expenses. Thus, the plan liability for the OOP cap would be part of the cost-sharing reductions category. In 2024, plans project that their liability for the OOP cap will be \$14 per enrollee per month—equivalent to 7 percent of rebates and 1 percent of projected plan payments. The plan liability for the OOP cap is generally not comparable with FFS spending because most beneficiaries in FFS have supplemental insurance and are unlikely to have cost-sharing expenses that exceed the OOP cap for MA enrollees. In addition, MA enrollees are prohibited from purchasing Medigap coverage, and MA plans are expected to provide supplemental benefits in lieu of Medigap coverage.
 - 22 In 2023, conventional MA plans (excluding employer plans and SNPs) project that 13 percent of the rebate dollars used for non-Medicare-covered supplemental benefits will be allocated for plan administrative costs and profit. Among D-SNPs, 16 percent of the plan-projected rebate dollars used for non-Medicare-covered supplemental benefits is projected to be allocated for plan administrative costs and profit.
 - 23 Beginning in 2019, CMS relaxed one of the criteria for eligible supplemental benefits—that the benefit be primarily health related—to include items and services that are used to diagnose, compensate for physical impairments, ameliorate the functional and psychological impact of injuries or health conditions, and reduce avoidable emergency and health care utilization. A supplemental benefit is not primarily health related if it is an item or service that is solely or primarily used for cosmetic, comfort, or general-use purposes or to address social determinants of health. The amount of projected spending for new types of supplemental benefits is not available in plan bid data.
 - 24 MA plans do not allocate administrative expenses or margins for Part D premium buydowns or Part D supplemental benefits when submitting Part C bids.
 - 25 We note that our 2024 estimate of spending on MA relative to the amount Medicare would have spent for comparable FFS beneficiaries (122 percent) reflects several changes from the method used for the Commission's 2023 comparison (reported to be 106 percent in our March 2023 report) (Medicare Payment Advisory Commission 2023). First, in 2023 we did not account for the effects of favorable selection, which, for 2024, we estimate accounts for about 9 percentage points of the difference in spending. Second, we revised our method of estimating coding intensity, adding about 2 percentage points to the difference in spending. Also, we now project the effects of coding intensity from the most recent analytic year (2022) to the next payment year (2024) using a recent trend (1.5 percentage points per year from 2017 to 2021, and accounting for the phase-in of the V28 model in 2024), which adds a little more than 2 percentage points to the spending difference (we previously assumed coding intensity in 2023 was the same as it was in 2021). In addition, MA and FFS coding differences grew by about 3 percentage points between 2021 and 2022 (the largest one-year increase, which reflects the effects of the pandemic on MA risk scores and coding practices). Finally, all other factors (e.g., changes in the share of enrollees in plans receiving a quality bonus increase to their benchmark, changes in MA enrollment share across benchmark quartiles) reduced the difference in our MA and FFS spending comparison by about 1 percentage point. The net of these factors accounts for the 16 percentage point difference in our 2024 and 2023 estimates of MA spending relative to comparable FFS beneficiaries. See Chapter 13 for more information about our revised methods for estimating the effects of coding intensity and favorable selection.
 - 26 We measure selection into MA using risk-standardized spending (i.e., by comparing enrollees' actual spending with the amount predicted by their risk score). Because actual spending can differ from predicted spending at all levels of spending, the level of selection does not appear to be dependent on the share of Medicare beneficiaries enrolled in MA. More information is available in Chapter 13.
 - 27 In the Medicare program, the overall effect of coding intensity and favorable selection is not budget neutral because risk scores are calibrated on the non-MA population. Because the prediction of MA risk is based on the FFS population, unintended differences in risk-standardized spending can occur through coding intensity and favorable selection. In contrast, other insurance markets (e.g., Medicaid managed care markets) base risk on the managed care population rather than an external population. Thus, the effects of coding and selection are budget neutral in markets where the entire population is in managed care.

- 28 Prior to each payment year, CMS publishes plan benchmarks in April, and plans submit their bids in June. Benchmarks reflect projected FFS spending estimates using data available at the time the benchmarks were published (e.g., estimates of projected 2024 FFS spending use data available just prior to the release of benchmarks in April 2023). We use plans' projected enrollment, spending, and risk scores from their bids to estimate projected MA payments and compare those amounts with CMS's projected FFS spending for a like set of FFS beneficiaries (by applying the MA enrollment and risk profile to CMS's projected spending of FFS beneficiaries in each county).
- 29 Our estimate of 2024 MA payments relative to FFS spending does not account for other potential factors that are more difficult to measure with certainty, including how benchmark quartiles and plan bids and payments would have changed if calculating FFS spending using only beneficiaries with both Part A and Part B. In addition, our analysis does not include secondary effects that can be measured with far less certainty, such as the potential spillover of provider behavior that can occur from large increases in MA market share into FFS or potential spillover from FFS alternative payment models into MA, and any effect of MA and FFS improper payments found retrospectively.
- 30 The 1 percentage point decrease in benchmarks relative to FFS spending in 2024 is at least somewhat attributable to a decrease in the share of MA enrollees in a quality bonus plan, after a record high in 2023.
- 31 We estimate that including employer plans increased our estimate of favorable selection by less than 1 percentage point annually. For more information on the inclusion of employer plan enrollees in this analysis, see Chapter 13.
- 32 The actual dollar amount a plan will receive for coding a new HCC depends on several additional factors, including the version of the HCC model applied to a beneficiary and factors that affect a plan's base rate. Dollar-value coefficients are standardized relative to average FFS spending before being applied to each plan's base rate. CMS maintains separate HCC models for enrollees who lack a full calendar year of diagnostic data or have end-stage renal disease. A plan's base rate varies according to the plan's bid and the local area's benchmark.
- 33 CMS has modified the risk-adjustment model to better align FFS and MA risk scores. Between 2014 and 2016, CMS phased in a new risk-adjustment model that reduced the gap in coding intensity by about 2 percentage points to 2.5 percentage points relative to FFS by removing some diagnoses that were found to be coded more aggressively in MA. In 2017, CMS began accounting for Medicaid benefit eligibility more accurately (full, partial, or no benefits status by month), which reduced the gap in MA and FFS risk scores by about 1 percentage point, eliminating the amount that MA risk scores were unduly higher than FFS due to differing shares of beneficiaries by Medicaid eligibility status. Starting in 2024, CMS will phase-in a new risk model that, similar to the model introduced in 2014, is expected to reduce the gap in coding intensity relative to FFS by removing or constraining the coefficient of some diagnoses that were found to be coded more aggressively in MA.
- 34 We also found a large increase in coding intensity between 2021 and 2022 using our prior method of estimating coding intensity. The "revised MedPAC cohort method" (see Chapter 13 for a description of this method) found an increase of 3.9 percentage points between 2021 and 2022.
- 35 The new risk-adjustment model (V28) introduced in 2024 is expected to reduce MA risk scores relative to FFS because it removes HCCs or constrains the coefficients of HCCs that have much higher rates of MA coding relative to FFS. We believe a 2 percent reduction in risk scores under the V28 model relative to the previous V24 model is a reasonable expectation based on a combination of factors. In 2014, CMS implemented a model that similarly removed HCCs or constrained HCC coefficients with higher MA coding rates, which reduced MA risk scores by roughly 2.0 percentage points or 2.5 percentage points, depending on the year. Also, in the 2024 advance notice, CMS reported that the combined effect of changing from the V24 to the V28 model and of the normalization factor for 2024 would reduce payments to MA plans by -3.12 percentage points. We note that the average annual effect of the normalization factor over the past five years is -2.1 percentage points, with somewhat smaller effects in more recent years. There is uncertainty about the impact of moving to the V28 on MA coding intensity. We will continue to monitor those effects and will update our analysis as we are able.
- 36 In some counties, the full 5 or 10 percent quality bonus increase to a plan's benchmark is limited by the ACA benchmark caps.
- 37 This organization-level analysis, like our national estimate of coding differences, uses the same method of estimating coding intensity as described in Chapter 13, except that the MA risk scores are calculated separately for each MA organization.
- 38 Recent reporting shows that agents and brokers are often paid by plans to conduct health risk assessments of new enrollees, but such assessments are not allowable for risk adjustment because agents and brokers are not clinicians.
- 39 The general steps we followed were to identify physician and hospital encounter records allowable for risk adjustment;

identify each record as a health risk assessment (using procedure codes for annual wellness visit or initial preventive physical exam, or an evaluation and management visit provided in the home), chart review (using chart review indicator), or other service; map diagnoses from those records to HCCs; apply HCC hierarchies; compare the HCCs we identified from encounter records with the HCCs in CMS's risk-score file and exclude HCCs not identified in both sources; apply HCC coefficients for the appropriate risk model; and apply Part A and Part B payment rates specific to each plan. We then identified the number of HCCs and associated dollar amounts that were supported through a health risk assessment, chart review, or both.

- 40 The seven HCCs that each generated more than \$500 million in payments from health risk assessments and the percentage of the time that a health risk assessment was the only source of the HCC were vascular disease, 47 percent; major depressive, bipolar, and paranoid disorders, 46 percent; morbid obesity, 38 percent; chronic obstructive pulmonary disorder, 25 percent; diabetes with chronic complications, 15 percent; coagulation defects and other specified hematological disorders, 60 percent; and congestive heart failure, 23 percent. We note that diabetes with chronic complications and congestive heart failure are among the HCCs that have a constrained coefficient in the V28 risk model, meaning that differences in the level of severity (e.g., diabetes without complications, with chronic complications, or with acute complications) for these conditions are not reflected in the V28 risk-adjustment model coefficients, which may contribute to an expected reduction in overall MA and FFS coding differences.
- 41 The impact of health risk assessments on payments to MA plans has grown. For 2017, the Office of Inspector General (OIG) found that HCCs supported only by a health risk assessment accounted for \$2.6 billion, or about 1.3 percent of payments to MA plans in 2017 (Office of Inspector General 2020). OIG excluded beneficiaries with more than one health risk assessment during the year. Our analysis assessed all health risk assessments. For 2020, we found that HCCs supported only by a health risk assessment accounted for \$8.6 billion, or about 2.9 percent of all payments to MA plans.
- 42 The legal complaints cited in this section support this statement. One complaint includes exhibits of plan documents that detail the financial performance of the plan's chart review program (United States of America v. Anthem 2020).
- 43 The eight HCCs that each generated more than \$1 billion in payments from chart reviews and the percentage of the time that a chart review was the only source of the HCC were vascular disease, 36 percent; chronic obstructive pulmonary disorder, 29 percent; major depressive, bipolar, and paranoid disorders, 36 percent; diabetes with chronic complications, 19 percent; congestive heart failure, 26 percent; morbid obesity, 37 percent; disorders of immunity, 45 percent; and rheumatoid arthritis and inflammatory connective tissue disease, 32 percent. We note that diabetes with chronic complications and congestive heart failure are among the HCCs that have a constrained coefficient in the V28 risk model, meaning that differences in the level of severity (e.g., diabetes without complications, with chronic complications, or with acute complications) for these conditions are not reflected in the V28 risk-adjustment model coefficients, which may contribute to an expected reduction in overall MA and FFS coding differences.
- 44 The impact of chart reviews on payments to MA plans has grown substantially in recent years. OIG found that HCCs supported only by a chart review accounted for \$6.7 billion in payments to MA plans, or about 3.2 percent of payments to MA in 2017 (Office of Inspector General 2020). For 2020, we found that HCCs supported only by a chart review accounted for \$12.7 billion, or about 3.4 percent of all payments to MA plans.
- 45 About \$4.7 billion in payments to MA plans were from HCCs identified on a health risk assessment and a chart review but not during any record of a physician or hospital encounter during the same calendar year.
- 46 For risk-adjustment data validation audits in 2011, CMS grouped all contracts into high, medium, and low levels of coding intensity and selected 20 high-level, 5 medium-level, and 5 low-level contracts at random.
- 47 Other factors may also influence insurers' decisions to enter new markets. Examples include state and federal regulatory and financial requirements (including licensure requirements), the size of the market, the local MA penetration rate, the number of competitors, benchmark payment rates for the market relative to the health care needs of the population, availability and quality of providers, and the estimated likelihood of achieving a sustainable risk profile after accounting for CMS's coding intensity adjustment (Buzby et al. 2022, Killian and Swenson 2016).
- 48 The top three organizations nationally also had the highest share of enrollees in both urban and rural areas in 2023. In urban areas, the top three organizations covered 60 percent of MA enrollees (up from 55 percent in 2022). In rural areas, the top three organizations accounted for 65 percent of the MA enrollees (up from 64 percent in 2022).
- 49 In 2023, 17 percent of MA enrollees were eligible for Medicaid and enrolled in dual-eligible SNPs (D-SNPs). While national D-SNP enrollment is more concentrated than

- overall MA enrollment (the three largest D-SNPs had 64 percent of enrollment), only two of the three largest national MA organizations were also among the top three D-SNP organizations. Enrollment in D-SNPs has been getting more concentrated nationally: The largest three organizations nationally had 57 percent of total enrollment in D-SNPs in 2023, an increase from 54 percent in 2022.
- 50 The Herfindahl-Hirschman Index is calculated by squaring the market share of each entity competing in the market and summing the results. The index approaches zero when a market is occupied by a large number of firms of relatively equal size; the index reaches its maximum of 10,000 points when a market is controlled by a single firm. The index rises both as the number of firms in the market drops and as the disparity in size among those firms increases. Under Department of Justice and Federal Trade Commission guidelines, markets with an index above 1,800 are considered highly concentrated (Department of Justice and Federal Trade Commission 2023).
 - 51 We used the 2021 Compendium of U.S. Health Systems developed by the Agency for Healthcare Research and Quality to identify health systems (<https://www.ahrq.gov/chsp/data-resources/compendium-2021.html>). We reviewed the websites of systems that were indicated as offering an insurance product to identify whether the system is the parent organization for, or has any other ownership arrangement with, an MA plan. We excluded cases in which the health system offered a co-branded MA product but for which no ownership relationship could be identified. The compendium defines a health system as one that includes at least one hospital and at least one group of physicians who provide comprehensive care and are connected with each other and with the hospital through common ownership or joint management.
 - 52 Margins are calculated as the remainder of payments to the plan after accounting for all other costs, including all medical expenses, salaries, bonuses, beneficiary incentive payments, and all administrative costs. As in prior years, we removed contracts that reported medical expenses equal to or greater than their stated plan revenues for that year (i.e., contracts reporting insufficient revenue to cover benefits and any administrative expenses). We excluded plans at the contract level to account for plans that other MA plans could be subsidizing (i.e., product pairing) within the same service area.
 - 53 MA plans annually report their medical loss ratios (MLRs) to CMS and are subject to financial and other penalties for failure to meet the statutory requirement that they have an MLR of at least 85 percent. For contract year 2022, plans submitted MLRs to CMS in December 2023, and CMS will begin subtracting amounts from regular monthly plan payments in July 2024 to recoup any revenue difference between a plan's actual MLR and the 85 percent minimum MLR.
 - 54 Star rating is a framework that CMS uses across MA and FFS. On its Care Compare website, CMS publishes star ratings on different types of Medicare providers (like physicians, hospitals, nursing homes, and others) so that beneficiaries can see how providers perform for FFS beneficiaries in their local area. However, there is no single quality evaluation for Medicare FFS in its entirety; star ratings of providers in FFS reflect their individual performance. The performance of a set of providers in a local area is not directly comparable to an MA star rating, which reflects the joint performance of an MA organization and its network of contracted providers, at the contract level.
 - 55 This count includes measures for Medicare Advantage–Prescription Drug plan (MA–PD) contracts. MA-only contracts and PDPs are measured on subsets of measures.
 - 56 Measures are assigned unique weights, and the overall score is a weighted average. The other roughly 60 measures that Medicare collects are display measures that CMS publicly reports on the [medicare.gov](https://www.medicare.gov) website (not the Medicare Plan Finder website). Some display measures were previously incorporated into the star ratings but have been transitioned out. Others may be new measures being tested before inclusion in the star ratings or that are otherwise reported for informational purposes only.
 - 57 Currently, quality results for MA are reported on a contract-wide basis, and those results are used to determine the star rating for all plans under the contract's offerings.
 - 58 Although Medicare has contracted with private plans since 1966, prior to 1985 nearly all contracts used cost-based payment rates or used risk-based payment but were administered through a demonstration project. We identify 1985 as the year when the Tax Equity and Fiscal Responsibility Act of 1982 effectively initiated private plan contracting in Medicare with payment rates set on a full risk basis (Zarabozo 2000).
 - 59 Some parent organizations that are neither provider owned nor among the top five largest nationally report high rates of payments to related parties (shown under the “All other” category in Figure 12-4, p. 377). Most of these organizations are recent entrants to the MA market with venture capital financing. We did not find evidence that these companies were owners of health care provider organizations, and the high rates being reported may reflect the structure of the business venture rather than the degree of vertical integration with providers.

60 Part B spending represents about 60 percent of all Medicare FFS spending (which is assumed to be the same share of spending on Part B services by MA plans). Twenty-five percent of Part B spending is financed through premiums paid by all Medicare Part B enrollees. The estimate does not account for the reduction in Part B premiums that is offered by some MA plans as a supplemental benefit.

61 Medical loss ratio requirements are monitored at the contract level. The numerator of the MLR includes incurred claims for all enrollees, amounts used to buy down enrollees' Part B premiums, expenditures for activities that improve health care quality, and—for Medicare Savings Account contracts—the amount deposited into medical savings accounts. Incurred claims costs include, but are not limited to, amounts that the MA organization pays (including under capitation contracts) for covered services and the amount of incentive and bonus payments made to providers. Activities that improve health care quality may include those designed to improve health outcomes through quality reporting,

case management, care coordination, chronic disease management, and medication and care compliance initiatives; activities to prevent hospital readmissions; activities to improve patient safety and reduce medical errors; activities to promote health and wellness; activities to enhance the use of health care data to improve quality and support meaningful use of health information technology; medication therapy management programs (for MA-PDs); or activities to reduce fraud. The numerator excludes amounts paid to third-party vendors for network development, administrative fees, claims processing, and utilization management. The denominator of the MLR must equal the total revenue under the contract, which includes CMS's payments to the MA organization less licensing and regulatory fees, state and federal taxes, and certain community benefit expenditures.

62 One study found that additional benefits and limits on out-of-pocket spending were the two leading reasons that MA enrollees chose an MA plan (Leonard et al. 2022).

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CHAPTER 13

Estimating Medicare Advantage coding intensity and favorable selection

Estimating Medicare Advantage coding intensity and favorable selection

Chapter summary

In Chapter 12, we present the Commission’s current estimates of the effects of higher Medicare Advantage (MA) coding intensity and favorable selection of enrollees into MA on the amount Medicare pays to MA plans relative to what the program would have paid if the enrollees were covered under fee-for-service (FFS).

In this chapter, we describe the Commission’s methods for estimating the effects of higher MA coding intensity and of a favorable selection of enrollees into MA, including recent revisions to those methods. Estimating the effects of these two factors presents several challenging analytic issues, and we will continue to refine our methods based on the results of our continuing analytic work.

Estimating Medicare Advantage coding intensity

In prior years, the Commission has estimated the impact of higher coding intensity on MA risk scores by comparing changes in MA and FFS risk scores over time for cohorts of beneficiaries with similar age, sex, and MA or FFS enrollment length—the “MedPAC cohort method.” An alternative method of estimating the impact of MA coding intensity, the demographic estimate of coding intensity (DECI), has produced estimates of coding intensity that are double the estimates produced by the Commission’s

In this chapter

- Revising the Commission’s method for estimating MA coding intensity
- Revising the Commission’s method for estimating favorable selection into MA

cohort method. In the advance notice of payment rates for 2019, CMS requested comment on adopting an alternative method for calculating the MA coding adjustment factor, including the Commission's cohort method and the DECI method. We analyzed both methods to understand the reasons for the differing coding intensity estimates.

For our 2024 analysis of coding intensity in MA, we revised our cohort method to account for differences in Medicaid eligibility between MA and FFS beneficiaries (which has changed significantly since we first developed our method) and to remove a restriction requiring continuous enrollment in either MA or FFS. Removing the continuous enrollment restriction captures the full history of risk-score changes for all beneficiaries and results in a more accurate comparison of MA and FFS risk scores. These model improvements produced higher estimates of coding intensity compared with our original cohort method. For 2019, using the revised cohort method, we estimate that coding intensity increased MA risk scores by 12.4 percent compared with similar beneficiaries in FFS Medicare, whereas the result was 10.0 percent when using our original cohort method. (All coding intensity estimates in this chapter are before accounting for CMS's coding adjustment, which, since 2018, has reduced MA risk scores by 5.9 percent. Also, the Commission's original cohort method estimates presented in this chapter are reported as a percent of the average FFS risk score. This differs from our prior work, where we reported our cohort method estimates as a percent of the average MA risk score. Changing the denominator from average MA risk score to average FFS risk score allows for direct comparison with the DECI method; it does not reflect a change in the magnitude of our estimates.)

We also assessed the DECI method developed by Kronick and Chua. First, we successfully replicated Kronick and Chua's coding intensity estimate for 2019 of 20.0 percent. This estimate relies on publicly available MA and FFS CMS hierarchical condition category (HCC) risk-score figures that for MA are restricted to enrollees with both Part A and Part B, but that for FFS include beneficiaries with both Part A and Part B as well as those with Part A only. We then re-implemented the DECI method using complete enrollment, demographic, and risk-score data (beneficiary-level risk-score data are available to the Commission but not generally available to researchers) for MA and FFS beneficiaries with both Part A and Part B. Those revisions to the DECI method produced a coding intensity estimate of about 13.2 percent for 2019, decreasing the original 20.0 percent estimate due to these methodological improvements.

We further revised the DECI method to account for differences in Medicaid eligibility among MA and FFS beneficiaries, and to constrain new Medicare enrollees to have no coding intensity because their “new enrollee” risk scores are based only on demographic factors and are not influenced by diagnostic coding. After incorporating all improvements, the revised DECI method reduced the coding intensity estimate for 2019 to 11.6 percent, which is 8.4 percentage points lower than Kronick and Chua’s previously published estimates.

Despite differences in the two methods, the Commission’s improved cohort method and our revised DECI method yielded similar estimates of coding intensity (12.4 percent vs. 11.6 percent for 2019, and within 1.5 percentage points in all years from 2008 through 2021). However, the DECI method is able to incorporate a larger share of the MA and FFS populations, is not subject to the potential for small numbers in the sub-cohorts of MA and FFS beneficiaries used in our cohort method, and does not rely on any assumptions about when MA coding intensity surpassed FFS coding intensity. Given the similarity in coding intensity estimates from the two revised methods, the Commission has decided to adopt the revised DECI method to estimate the impact of coding intensity. Chapter 12 shows our current estimates of the effects of coding intensity using our revised DECI method.

Estimating Medicare Advantage favorable selection

Favorable selection into MA occurs when beneficiaries with lower actual spending relative to their risk score tend to enroll in MA; it is the extent to which risk-standardized spending of MA enrollees would be lower than the FFS average without any intervention from MA plans. Consistent with other research, the Commission’s June 2023 report to the Congress estimated that—prior to the effects of any utilization management or differential coding from MA plans—spending on MA enrollees in 2019 was about 11 percent lower than spending for FFS beneficiaries with the same risk scores, due to favorable selection. We have sought to further refine our estimate and incorporate our analysis of favorable selection in our estimate of MA payments that we present in Chapter 12. To that end, the analysis described in this chapter maintains the same analytic framework we used in our June 2023 report but makes four key technical improvements:

- We expanded our estimate of MA favorable selection to include overall estimates for each year from 2017 to 2021.

- We included employer plan enrollees and hospice enrollees more directly in our estimate of favorable selection. Previously, we assumed that MA employer plan enrollees had no favorable selection effect; now we measure the extent of their favorable selection with all other MA enrollees. In addition, while we previously excluded enrollees who had used any hospice services, we now include them in our estimates to better align our methodology with CMS's methodology for calculating the FFS spending amounts used for MA benchmarks. Although enrollment in employer plans and hospice only occurs in limited circumstances, these populations influence the overall effect of favorable selection that MA plans experience.
- We improved our method for estimating the expected “regression to the mean” effect during MA enrollment. This effect presumes that while a cohort of MA enrollees may have favorable risk-adjusted spending relative to the local FFS population in the year before they enroll in MA, the effect of favorable selection may become smaller in later years. While we previously assumed an MA entry cohort's selection percentage (i.e., their risk-standardized spending relative to the local FFS average) would trend forward with the same slope as future MA enrollees (our proxy group), we now match the distribution of the initial selection percentage of both groups before trending the selection percentage forward to the measurement year.
- We trended forward the spending on beneficiaries who enrolled in MA during the measurement year from the year before MA entry to the measurement year. This refinement affects only the cohort of MA beneficiaries that entered MA during the measurement year. Our previous assumption was that the selection percentage in 2018 would be sustained at the same level in 2019 for 2019 MA entrants. This methodological change more accurately estimates regression to the mean between 2018 and 2019 by trending forward the selection percentage in the base year (2018) to the first year of MA enrollment (2019).

Using this revised methodology, we estimate that the effects of favorable selection increased program spending (above what would have been spent if those same enrollees were in FFS Medicare) by 6 percent in 2017, rising to 9 percent in 2019 and 13 percent in 2021. Chapter 12 provides our current estimates of the effects of favorable selection on overall payments.

We continue to conduct sensitivity analyses of certain aspects of our method, particularly related to how our analysis deals with regression to the mean and

attrition of beneficiaries from MA cohorts. If these sensitivity analyses suggest that further refinements to our methods are needed, we will incorporate those refinements in future estimates. ■

Background

The Medicare Advantage (MA) program allows Medicare beneficiaries enrolled in both Part A and Part B to receive benefits from private plans rather than the traditional fee-for-service (FFS) program. The Commission has long supported including private plans in Medicare: The MA program gives beneficiaries more coverage options and has the potential to reduce overall Medicare spending. However, we estimate that in 2024 the Medicare program pays roughly 22 percent more for enrollees in MA relative to what the program would have paid if those beneficiaries were in FFS. Our estimate of higher payments to MA plans is primarily driven by two factors—higher coding intensity in MA and a favorable selection of enrollees in MA plans. This chapter describes the Commission’s methods for estimating the effects of MA coding intensity and favorable selection, including recent revisions. Chapter 12, assessing the status of the entire MA program, provides information about a wide range of MA topics, including:

- how Medicare pays MA plans, calculates benchmarks, and calculates risk scores;
- the mechanisms that MA plans use to document more diagnosis codes; and
- discussion of our current estimates of the effects of higher MA coding intensity and favorable selection of enrollees into MA on the amount Medicare pays to MA plans relative to the amount FFS Medicare would have spent to cover the same enrollees.

The remainder of this chapter provides detailed information about our methods for estimating coding intensity and favorable selection of enrollees into MA. Estimating these factors presents several challenging analytic issues, including accounting for regression to the mean and attrition of MA enrollees in our favorable selection analysis, and we will continue to refine our methods based on the results of our continuing analytic work.

Revising the Commission’s method for estimating MA coding intensity

In our March 2023 report to the Congress, we estimated the impact of higher coding intensity on MA risk scores in each year from 2007 to 2021 by comparing changes in MA and FFS risk scores over time for cohorts of beneficiaries with similar age, sex, and MA or FFS enrollment length (Medicare Payment Advisory Commission 2023c). (For more detail, see the text box on the Commission’s original cohort method for estimating coding intensity, pp. 422–423.) The Commission’s previously published analysis showed that since 2008, MA risk scores have been higher than risk scores for comparable FFS beneficiaries due to coding intensity, and that those differences in risk scores have increased by about 1 percentage point per year in most years since 2008 (Medicare Payment Advisory Commission 2023c).¹

All coding intensity estimates in this chapter are before accounting for CMS’s annual coding adjustment, which, since 2018, has reduced MA risk scores by 5.9 percent each year. Also, the Commission’s original cohort method estimates presented in this chapter are reported as a percent of the average FFS risk score and therefore are different from the original cohort method estimates we previously published, which were reported as a percent of the average MA risk score. Changing the denominator from average MA risk score to average FFS risk score allows for direct comparison with an alternative method described below and does not reflect a change in the magnitude of our estimates.

Several studies, using a variety of methods and data sources, have produced estimates of the impact of higher MA coding intensity that are generally consistent with the Commission’s estimates (Geruso and Layton 2020, Government Accountability Office 2013, Hayford and Burns 2018, Jacobs and Kronick 2018, Kronick and Welch 2014).

However, using an alternative method of estimating the impact of MA coding intensity—the demographic estimate of coding intensity (DECI)—authors Kronick and Chua produced estimates of coding intensity that are double the estimates produced by the Commission’s cohort method. For example, Kronick and Chua estimated that coding intensity in 2019 was

The Commission's original cohort method for estimating coding intensity

The Commission first reported estimates of the impact of coding intensity on Medicare Advantage (MA) risk scores in our March 2017 report to the Congress, and our method has remained the same since then. We compare changes in the “disease score” (the portion of the risk score generated by diagnosis codes, calculated by subtracting the demographic components of the risk score from the total risk score) for MA and fee-for-service (FFS) cohorts with equal lengths of enrollment.

The method implicitly assumes that, after controlling for differences in demographic characteristics, MA enrollees are no less healthy than FFS beneficiaries. The assumption is supported by several studies that use mortality rates, prescription drug-based risk scores, or health care spending to show that MA enrollees are healthier and have lower expected medical spending than FFS beneficiaries with the same risk score (Jacobs and Kronick 2018, Jacobson et al. 2019, Kronick and Welch 2014, Newhouse et al. 2019). The Commission's work on favorable selection in MA provides strong evidence to support that assumption (Medicare Payment Advisory Commission 2023b). Given this evidence, we can conclude that after controlling for demographic characteristics, faster rates of MA risk-score growth relative to FFS result from higher MA coding intensity rather than worsening health acuity or complexity among MA enrollees.

Here are the steps in the Commission's original cohort method of calculating coding intensity, using

2021 as an example (revisions to this method are described later):

1. We remove beneficiaries who have a 2021 risk score based on the new-enrollee, end-stage renal disease, or institutional model segments.² Note that we incorporate new enrollees later in the calculation under the constraint that new enrollees exhibit no coding intensity.
2. We identify the MA cohort as enrollees in a plan with both Part A and Part B for all 12 months of 2021. To determine the enrollment length for beneficiaries in the MA cohort, we include all consecutive prior years in which the 2021 MA enrollees have 12 months of MA enrollment with both Part A and Part B. For example, if a new Medicare beneficiary with both Part A and Part B enrolls in Medicare FFS in June 2012, then switches to MA in January 2014 and remains in MA through 2021, the beneficiary would be assigned to the MA cohort from 2014 to 2021. We use the same process to define the 2021 FFS cohorts.
3. We calculate the change in disease score for each beneficiary in the analysis by subtracting the disease score in the initial cohort year (2014 in the prior example) from the disease score in the final cohort year (2021 in the prior example). Beneficiaries who were assigned a new enrollee risk score in the initial cohort year were excluded because more beneficiaries initially enrolled and remained in FFS through 2021 than beneficiaries in MA. For each year, we use the risk-adjustment

(continued next page)

20.0 percent, whereas we previously estimated it at 10.0 percent (Kronick and Chua 2021b). Kronick and Chua's estimates have been published in two papers and were the subject of a Health Savers Initiative brief from the Committee for a Responsible Federal Budget (Committee for a Responsible Federal Budget 2021, Kronick and Chua 2021a, Kronick and Chua 2021b). In the advance notice of payment rates for 2019,

CMS requested comment on adopting an alternative method for calculating the MA coding adjustment factor, including the Commission's cohort method and the DECI method (Centers for Medicare & Medicaid Services 2018). Given the large difference in coding intensity estimates based on these two methods, we analyzed both methods to understand the reasons for the differing coding intensity estimates.

The Commission's original cohort method for estimating coding intensity (cont.)

model versions and associated diagnostic data sources that were used for payment in that year. For 2017 and subsequent years, there are different sets of risk-score coefficients (i.e., different model segments) based on aged or disabled status and on no, partial-, or full-benefit Medicaid eligibility. For those years, we calculate an annual disease score by assigning the appropriate model segment for each month and then taking the average of the 12 monthly disease scores.

4. We assign each beneficiary to an age × sex × enrollment cohort using the age and sex category used for each beneficiary's 2021 risk score and the enrollment cohort defined in step 2. There are 24 age and sex categories (mostly 5-year age categories) used in the CMS's hierarchical condition category risk model. For 2021, there are 14 enrollment cohorts with initial years 2007 through 2020. The cohort with initial cohort year of 2021 (those who were enrolled in both Part A and Part B for all of 2020 and 2021 but switched MA or FFS enrollment between 2020 and 2021) are constrained to exhibit no coding intensity because they have just one full calendar year of enrollment in the analysis.
5. For enrollment cohorts with initial years 2007 through 2020, we calculate the difference in the MA and FFS disease score change by subtracting the average disease score change for each FFS age × sex × enrollment cohort from the average disease score change for the same MA age × sex × enrollment cohort. For MA enrollees who have an initial cohort year of 2021 (those who switched from FFS in 2020) and those who have a new

enrollee risk score in 2021, we assign a disease score change of 0.

6. We calculate total MA coding intensity by:
 - (a) Calculating the MA enrollment-weighted average difference in MA and FFS disease score changes across all age × sex × enrollment cohorts, including MA enrollees with an initial cohort year of 2021 and 2021 MA enrollees with a new enrollee risk score. As noted earlier, the change in disease score for MA enrollees with initial cohort year of 2021 or with a new enrollee risk score in 2021 is constrained to have a disease score change of 0.
 - (b) Dividing the average in (a) by the average 2021 risk score for all MA enrollees included in the analysis (including new enrollees) to calculate the percentage of MA risk scores that is due to coding intensity.

For the Commission's original cohort estimates presented in this chapter, we modified step 6b to make those estimates—previously published as a percent of the average MA risk score—comparable to the demographic estimates of coding intensity (DECI), which are reported as a percent of the average FFS risk score. For example, in 2021, we previously reported that 10.8 percent of MA risk scores were attributable to coding differences. In this chapter, we report that MA risk scores in 2021 are 12.1 percent higher than risk scores for comparable FFS beneficiaries. The two numbers are the result of the same analysis and are related through the calculation $(1 / (1 - 0.108)) = 1.121$, or 12.1 percent. ■

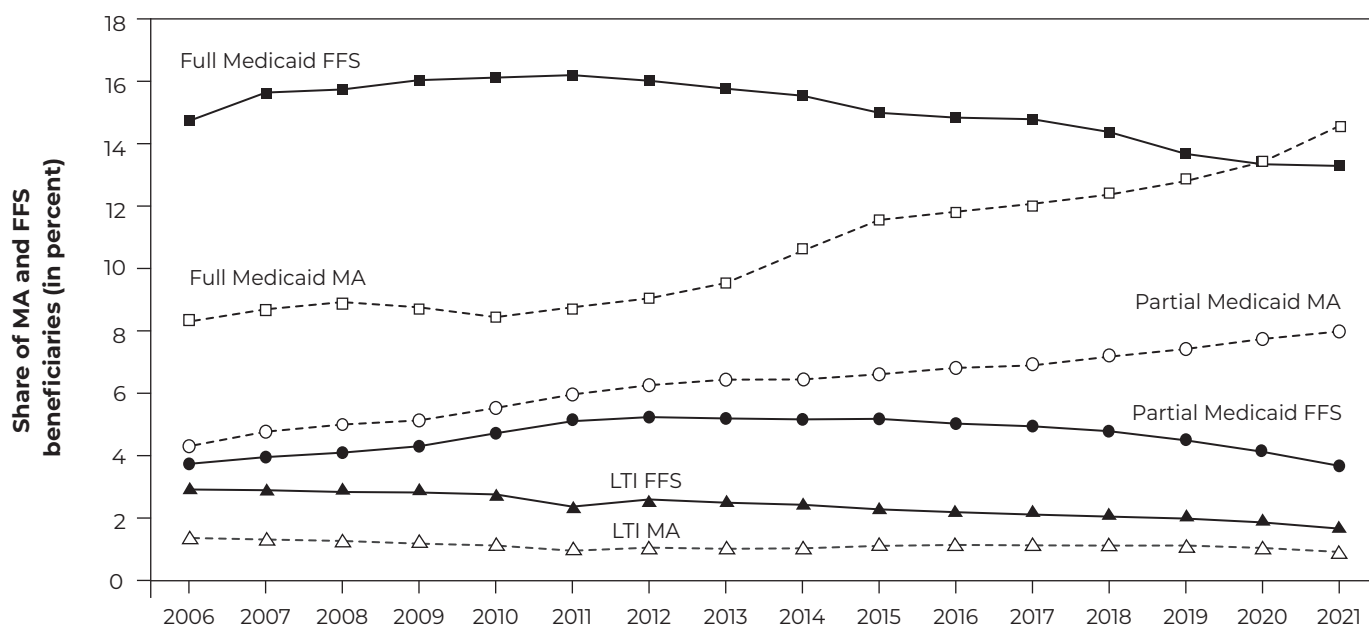
After assessing both methods and revising them to better account for differences between MA and FFS beneficiaries, we estimated using the revised cohort method that coding intensity increased MA risk scores by 12.4 percent in 2019 compared with similar beneficiaries in FFS Medicare; using the revised DECI

method, we estimated that MA coding intensity was 11.6 percent for 2019.

Overall, we find that after applying revisions to both methods, coding intensity estimates from the two methods closely align, and we are confident that both

**FIGURE
13-1**

The relative shares of MA and FFS beneficiaries with full and partial Medicaid benefits has changed over time; relative shares of beneficiaries with LTI status have been stable, 2006–2021



Note: MA (Medicare Advantage), FFS (fee-for-service), LTI (long-term institutional).

Source: MedPAC analysis of 2006 through 2021 Medicare enrollment and risk-score files.

methods can produce reasonable estimates. Given that the DECI method as revised by the Commission is more comprehensive than our original cohort method, the Commission has decided, for current and future analyses, to use the revised DECI method for estimating the effects of MA coding intensity.

Revising the Commission's cohort method for estimating coding intensity

We critically assessed our original cohort method to determine whether revisions were needed to make our estimates more accurate. The Commission developed the original cohort method of estimating the impact of coding intensity using data from 2013, 2014, and 2015 (Medicare Payment Advisory Commission 2017). Prior to 2013, more beneficiaries who were eligible for Medicaid were enrolled in FFS than in MA, but the relative shares of MA and FFS Medicaid-eligible beneficiaries were relatively stable (Figure 13-1). Since about 2014, the shares of MA and FFS beneficiaries eligible for partial or

full Medicaid benefits has changed rapidly. For the first time, in 2020, there were more beneficiaries eligible for full Medicaid benefits in MA than in FFS. By 2021, the share of beneficiaries eligible for partial Medicaid benefits in MA was more than twice as large as the share in FFS. By contrast, beneficiaries with long-term institutional (LTI) status have always made up a larger share of FFS beneficiaries than MA enrollees.

CMS noted that the risk-adjustment model used prior to 2017 produced scores that were too high (i.e., the risk scores overpredicted actual costs) for beneficiaries eligible for partial Medicaid benefits and risk scores that were too low for beneficiaries eligible for full Medicaid benefits (risk scores under predicted actual costs). In 2017, the agency introduced a risk-adjustment model that produced separate risk scores for beneficiaries eligible for no, partial, or full Medicaid benefits.³

The Commission's original cohort method for estimating coding intensity did not account for

differences in MA and FFS Medicaid eligibility. However, we have found that coding intensity differs by Medicaid eligibility such that MA enrollees who are eligible for partial or full Medicaid benefits have risk scores reflecting higher levels of coding intensity than MA enrollees not eligible for Medicaid (Medicare Payment Advisory Commission 2023a).

Some have critiqued the Commission's original cohort method because it does not capture all coding intensity for the MA population, specifically coding intensity that may accrue during early years of enrollment (Kronick and Chua 2021b). Because the original intention was to capture the coding intensity that accrued while the beneficiary was enrolled in an MA plan, our cohort method requires continuous enrollment in either MA or FFS Medicare. We now recognize that including the full risk-score history for all beneficiaries in our analysis allows us to compare MA and FFS beneficiaries whose total Medicare enrollment length is more similar, thereby creating a more accurate estimate of the impact of coding intensity in the payment year. Using the example from step 2 of the text box, if a new Medicare beneficiary enrolls in FFS in June 2012 and switches to MA in 2014, under our original method, the beneficiary would be assigned to the "MA 2014 through 2021" cohort, and we would compare the change in risk score over that period to the average change in risk score for a cohort of FFS beneficiaries who enrolled in FFS in 2014. We previously assumed that the restriction was reasonable because (1) each MA and FFS cohort is made up of new Medicare beneficiaries and "switchers" from the other program and (2) we match MA and FFS cohorts by enrollment length, age category, and sex. However, the restriction requiring continuous enrollment in either MA or FFS truncates the early years of enrollment more often for MA enrollees than for FFS beneficiaries, thereby reducing the accuracy of the comparison.

To address these two issues (continuing to use the 2021 example from the text box, pp. 422–423), we revised our cohort method to:

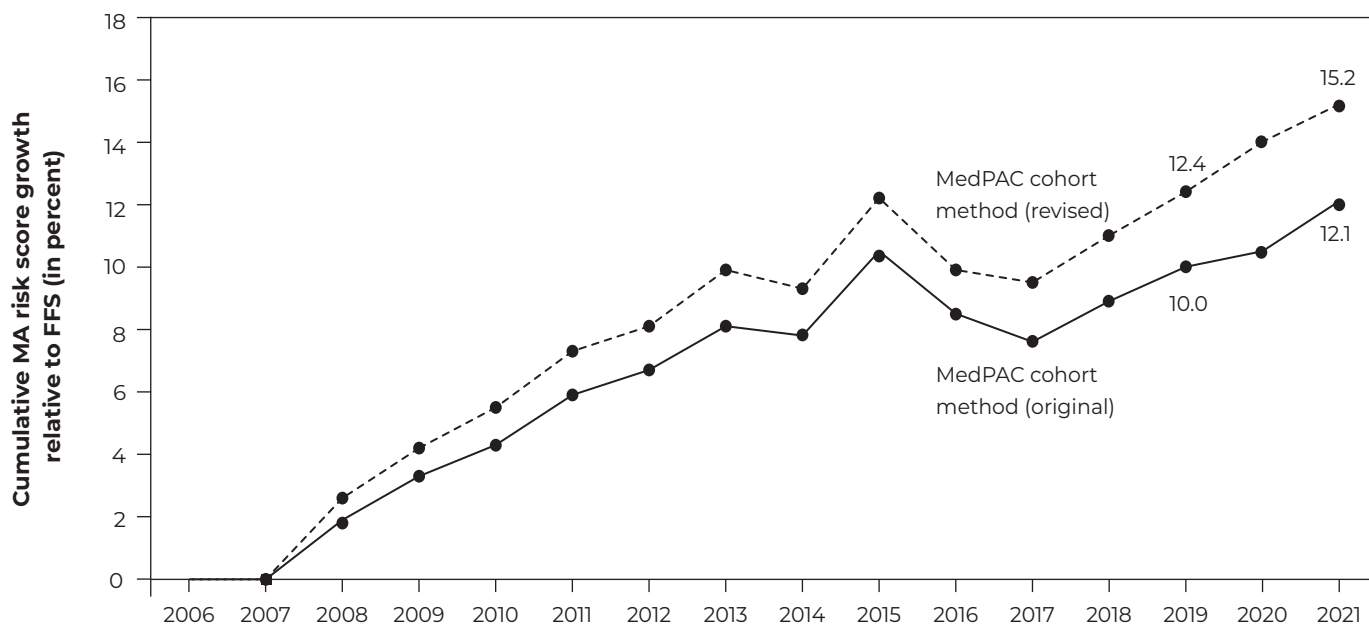
- Account for no, partial, and full Medicaid benefit eligibility (in addition to age and sex) based on each beneficiary's Medicaid eligibility as of July 2021. In this way, changes in risk scores for MA cohorts are compared with FFS cohorts with the same Medicaid eligibility.
- Remove the constraint that beneficiaries be continuously enrolled in either MA or FFS in the years prior to 2021. In our revised method, we identify the MA and FFS cohorts in the same way we did originally, requiring 12 months of Part A and Part B enrollment and either 12 months of MA enrollment or 12 months of FFS enrollment in 2021. However, we define the enrollment length differently by requiring only that beneficiaries have 12 months of Part A and Part B in the prior consecutive years of enrollment. Using the earlier example from the text box, and applying the updated method to define enrollment length, a beneficiary who initially enrolled in Medicare FFS in June 2012 and then switched to MA in January 2014 and remained in MA through 2021 would be assigned to the "MA 2013 to 2021" cohort (MA assignment based on 2021 enrollment only), rather than the "MA 2014 to 2021" cohort under our original method. At the same time, under our revised cohort method, we defined the disease score of new enrollees as zero (because the new enrollee risk scores are based entirely on demographic information), rather than excluding years where a new enrollee risk score would be applied from the analysis. This revision allowed us to capture the full change in risk scores for each beneficiary's entire enrollment.

Figure 13-2 (p. 426) shows coding intensity estimates using the Commission's original and revised cohort methods. The revised method produces larger estimates of coding intensity in each year, with smaller differences in the estimates for earlier years and larger differences in more recent years. The revised method produced an estimate of MA coding intensity of 12.4 percent for 2019, as opposed to 10.0 percent based on our original cohort method. For 2021, using our revised method, we estimate that MA coding intensity increased MA risk scores by 15.2 percent compared with what risk scores would have been if the same beneficiaries were enrolled in FFS Medicare.

Most of the change in our estimates results from removing the constraint that beneficiaries remain in the same program. Importantly, this change allows us to include all early years of enrollment, and many beneficiaries' initial year in the analysis starts with a disease score of zero (assigned because the beneficiary had a new enrollee risk score). However, because we

**FIGURE
13-2**

Coding intensity estimates based on the Commission's revised cohort method are slightly higher than estimates published in prior reports, 2006–2021



Note: MA (Medicare Advantage), FFS (fee-for-service).

Source: MedPAC analysis of 2007 through 2021 Medicare enrollment and risk-score files.

use 2007 as the initial year in the analysis, we still may not capture the full risk-score history for beneficiaries in the 2007 to 2021 cohorts.

Accounting for Medicaid eligibility had little effect on our estimates when implemented as an independent revision to our cohort method. However, when we account for Medicaid eligibility in conjunction with removing the restriction on beneficiaries remaining in the same program, we find a larger joint effect because beneficiaries eligible for Medicaid benefits are allowed to change Medicare enrollment (among MA plans or between MA and FFS) outside of the annual election period. As a result, under our original cohort method, Medicaid-eligible beneficiaries have their risk-score history truncated more than other beneficiaries. Although beneficiaries who are not eligible for Medicaid are also allowed to change their enrollment in limited circumstances, beneficiaries who are eligible for Medicaid switch between MA and FFS far more often than beneficiaries who are not (Medicare Payment Advisory Commission 2019).

Replicating the DECI method with complete data

Having improved the accuracy of the Commission's cohort model, we next assessed the DECI method. As noted earlier, the DECI method has produced estimates of coding intensity that are double the estimates produced by our original cohort method. We successfully replicated the coding intensity estimate of 20.0 percent for 2019 that was reported by Kronick and Chua. As described in this section, we found that this estimate relies on publicly available MA and FFS CMS-HCC risk-score data that for MA are restricted to enrollees with both Part A and Part B, but that for FFS include beneficiaries with both Part A and Part B as well as those with Part A only. We re-implemented the DECI method using complete enrollment and demographic data, as well as beneficiary-level risk-score data that are not generally available to researchers, for MA and FFS beneficiaries with both Part A and Part B. These methodological improvements reduced the coding intensity estimate for 2019 to 13.2 percent. Table 13-1

(p. 428) shows a step-by-step comparison of Kronick and Chua’s results and the Commission’s results using the improved method and complete data. (For more details about this analysis, see the text box on the Commission’s data sources, p. 429.)

As with the Commission’s cohort method, the DECI method implicitly assumes that MA enrollees are no less healthy than FFS beneficiaries with similar demographic characteristics. Therefore, after controlling for differences in demographic characteristics, the DECI method attributes faster rates of MA risk-score growth relative to FFS to higher MA coding intensity rather than worsening health acuity or complexity among MA enrollees.

The DECI method estimates coding intensity as the ratio of two ratios:

National average
MA CMS-HCC risk score

National average
FFS CMS-HCC risk score

Coding intensity =

National average
MA demographic-only risk score

National average
FFS demographic-only risk score

The CMS-HCC risk score is used to pay MA plans, and it incorporates both demographic and diagnostic information. The demographic-only risk score results from a separate risk model that is calculated using only demographic information for all Medicare enrollees.⁴

To calculate the national average MA CMS-HCC risk score, Kronick and Chua combined average plan-level risk scores and enrollment data published by CMS for an average risk score of 1.250.⁵ We replicated this number exactly when using the same publicly available information and found it to be similar to the 1.260 national average MA CMS-HCC risk score that we calculated using complete beneficiary-level risk-score data for MA enrollees with both Part A and Part B. (This analysis uses CMS-HCC “raw” risk scores that are not normalized and do not have the coding adjustment applied.)

Next, Kronick and Chua used a national average FFS CMS-HCC risk score of 1.069, which is published in CMS’s annual announcement of MA payment rates (Centers for Medicare & Medicaid Services 2020a).⁶ Using complete beneficiary-level data, we replicated this number almost exactly when we included about 5 million Part A-only beneficiaries who are assigned new enrollee risk scores. New enrollee scores are generally smaller than risk scores for enrollees who have a full calendar year of diagnostic data for Part B services. Because MA enrollees must have both Part A and Part B, we restricted the FFS population to beneficiaries with both Part A and Part B and calculated an average FFS CMS-HCC risk score of 1.117.

In Kronick and Chua’s analysis, the average FFS CMS-HCC risk score is lower by 0.049 because it includes all FFS beneficiaries, not just those with both Part A and Part B, and beneficiaries with Part A only have lower risk scores, on average. (We calculated an average CMS-HCC risk score for all FFS beneficiaries, including those with only Part A, of 1.069, and an average CMS-HCC risk score for FFS beneficiaries with both Part A and Part B of 1.117.) Kronick and Chua’s lower estimate of the average FFS CMS-HCC risk score thus results in an MA-to-FFS CMS-HCC risk-score ratio (1.179) that is overstated. We calculated an MA-to-FFS CMS-HCC risk-score ratio of 1.127 using complete data only for FFS beneficiaries with both Part A and Part B. The difference in the average FFS CMS-HCC risk score used accounts for about 80 percent of the difference between Kronick and Chua’s 20.0 percent estimate and the Commission’s 13.2 percent estimate using the original DECI method with more complete data.

For the national average demographic risk scores, Kronick and Chua calibrated annual risk-adjustment models based only on demographic characteristics for FFS beneficiaries with both Part A and Part B (excluding beneficiaries with end-stage renal disease (ESRD)) by including age category, sex, and Medicaid eligibility (yes or no). For Medicaid eligibility, Kronick and Chua used the “state buy-in” indicator, which does not differentiate between beneficiaries eligible for full or partial Medicaid benefits and is missing about 10 percent of Medicaid-eligible beneficiaries (most of whom are eligible for full Medicaid benefits) who pay their own premiums.⁷ Kronick and Chua did not include information about institutional status in the calibration of their risk models because the LTI indicator data were

**TABLE
13-1**

The DECI estimate of coding intensity in MA in 2019 is about one-third lower when using complete risk-score data and including only beneficiaries who are enrolled in both Part A and Part B

	Risk-score type	Average risk score	MA / FFS ratio before institutional adjustment	MA / FFS ratio	Estimated MA coding intensity
Kronick & Chua's DECI analysis (public data)	MA CMS-HCC	1.250	N/A	1.179	20.0%
	FFS CMS-HCC	1.069 ^a			
	MA demographic	b	1.005 ^b	0.975	
	FFS demographic	b			
MedPAC's DECI analysis (complete data)	MA CMS-HCC	1.260	N/A	1.127	13.2%
	FFS CMS-HCC	1.117			
	MA demographic	1.019	N/A	0.995	
	FFS demographic	1.024			

Note: DECI (demographic estimate of coding intensity), MA (Medicare Advantage), FFS (fee-for-service), N/A (not applicable). Average CMS-HCC risk scores are shown as "raw" risk scores, prior to applying the normalization factor and the coding intensity adjustment. Risk scores reflect the blend of risk model versions used for payment in 2019. The DECI estimate is the ratio of the CMS-HCC MA-to-FFS risk-score ratio and the demographic MA-to-FFS risk-score ratio. DECI estimates of 1.132 and 1.200 have been converted to 13.2 percent and 20.0 percent, respectively. Rounding affects some ratio values.

^aKronick and Chua's national average FFS CMS-HCC risk-score result is based on publicly available demographic data. Our analysis suggests that their result is calculated using data for all FFS beneficiaries, including those with Part A only, who are not eligible to enroll in MA. Because these beneficiaries, on average, have lower CMS-HCC risk scores than other beneficiaries, including them in this calculation lowers the estimate of the national average FFS risk score, resulting in a higher estimate of coding intensity in MA.

^bKronick and Chua's institutional adjustment reduces the MA-to-FFS ratio by 0.03 based on estimates from other data sources. The most recent DECI results (November 2021) report a demographic MA-to-FFS risk-score ratio of 1.005 but do not report the underlying MA and FFS average risk scores.

Source: Kronick and Chua (2021a), Kronick and Chua (2021b), MedPAC analysis of 2019 Medicare enrollment, risk-score, and Master Beneficiary Summary files.

not available to the researchers. To address this issue, they used a rough approximation based on Medicare Current Beneficiary Survey data and reduced the MA-to-FFS demographic risk-score ratio by 0.030 in each year. Kronick and Chua published the coefficients of the demographic risk model, and we were able to closely replicate their results using their coefficients and our demographic data; however, we chose to calibrate our own annual demographic risk-adjustment models with more complete Medicaid eligibility and LTI data (see the text box on the Commission's data sources).

For Medicaid eligibility and institutional status, we used the monthly indicators that CMS uses to apply the appropriate risk score for payment to MA plans and calibrated separate models for beneficiaries with institutional status and with full, partial, or no Medicaid benefits. Using our demographic models, we calculated an average demographic risk score of 1.019 for MA

enrollees, 1.024 for FFS beneficiaries, and an MA-to-FFS demographic risk-score ratio of 0.995. Kronick and Chua's average MA-to-FFS demographic risk-score ratio of 0.975 is 0.020 smaller primarily due to the specificity of the data used for Medicaid eligibility and institutional status. The combined effect of more accurate identification of Medicaid eligibility and institutional status accounts for roughly 20 percent of the difference in Kronick and Chua's 20.0 percent estimate and our DECI estimate of 13.2 percent.

Revising the DECI method to account for Medicaid eligibility and institutional status and constrain coding intensity for new enrollees

As with the Commission's original cohort analysis, the original DECI-method MA coding intensity estimates shown in Table 13-1 do not account for differing shares of MA and FFS beneficiaries who are eligible for full, partial, or no Medicaid benefits or have LTI status.

The Commission's data sources for analyzing the demographic estimate of coding intensity method

National average CMS hierarchical condition category risk scores

We identified monthly Medicare Advantage (MA) or fee-for-service (FFS) enrollment using the plan identification in the Medicare common enrollment file, and we required all MA and FFS beneficiaries to have both Part A and Part B using the “Medicare enrollment code” data field. Then we used monthly indicators in risk score data to exclude beneficiary months in which an end-stage renal disease (ESRD) risk score would be applied, and to assign new enrollee and institutional risk scores as appropriate. For all remaining months, we assigned the appropriate community model risk score using a Medicaid eligibility indicator from the enrollment file to adjust for full, partial, or no Medicaid benefits, and we used the beneficiary’s age from the risk-score file.⁸ In each year, we used the version of the risk model or blend of versions that was used for payment to MA plans.⁹ Finally, we aggregated the monthly risk scores to calculate national average MA and FFS CMS hierarchical condition category (HCC) scores. As a check on our method, we compared our estimate of the national average risk score for all FFS beneficiaries in 2019 (including those with Part A only) of 1.0682 to the national average published by CMS of 1.0685. Our estimate of the average risk score for all FFS beneficiaries was similarly close to CMS’s published results for 2017 and 2018.

National average demographic risk scores

We calibrated annual risk models based only on demographic characteristics for FFS beneficiaries with both Part A and Part B (excluding beneficiaries with ESRD) by including age category, sex, Medicaid eligibility (full benefits, partial benefits, or no benefits), and institutional status. We used the same enrollment and risk-score indicator variables as in the CMS–HCC risk-score analysis described above. We calculated monthly Medicare spending by summing the annual spending amounts in the Medicare beneficiary summary file (excluding beneficiaries with any hospice use) and dividing by the months of Part A and Part B enrollment in the year. We calculated risk models (with dollar-value age and sex coefficients) for beneficiaries with institutional status, full Medicaid benefits, partial Medicaid benefits, and no Medicaid benefits, and then divided each model’s coefficients by the average spending for that group to convert the dollar coefficients to risk scores with an average value of 1.0 for each model. Finally, we applied the risk-score coefficients to MA and FFS beneficiaries with both Part A and Part B and aggregated the demographic risk scores to national annual averages. ■

In a given year, the MA-to-FFS CMS–HCC risk-score ratio reflects the actual enrollment in each program, including differences in the MA and FFS shares of beneficiaries with Medicaid eligibility (see Figure 13-1, p. 424).

As we noted earlier, we estimated that coding intensity differs for beneficiaries eligible for full, partial, and no Medicaid benefits. Therefore, changes in the relative MA and FFS shares can affect the average CMS–HCC risk score for each population, particularly under the risk model introduced in 2017 that has separate sets

of model coefficients for full, partial, and no Medicaid benefit populations. Because the original DECI method does not account for such differences in the MA and FFS populations, the method attributes some population-related differences in average CMS–HCC risk scores to coding intensity.

In addition, the original DECI method estimates a coding intensity effect for beneficiaries who are new to Medicare and have risk scores based only on demographic factors. However, these new enrollee risk scores cannot be affected by higher

**TABLE
13-2**

The DECI estimate of MA coding intensity in 2019 is 11.6 percent when using complete risk-score data, including only beneficiaries who are enrolled in both Part A and Part B, and accounting for Medicaid eligibility, institutional status, and new enrollee status

Beneficiary group	CMS-HCC risk-score average		Demographic risk-score average		MA share of continuing enrollees
	MA	FFS	MA	FFS	
Continuing enrollees					
No Medicaid	1.078	0.966	1.017	1.022	79.4%
Partial Medicaid	1.360	1.145	1.006	1.004	7.5
Full Medicaid	1.664	1.438	1.050	1.010	11.8
Institutional	2.319	2.132	2.174	2.179	1.2
MA weighted average risk scores	1.183	1.049	1.034	1.033	

Beneficiary group	CMS-HCC MA/FFS ratio	Demographic MA/FFS ratio
Continuing enrollees	1.128	1.001

Beneficiary group	Estimated MA coding intensity	MA share of enrollees
Continuing enrollees	1.127 (12.7%)	91.2%
New enrollees	1.000 (0.0%)	8.8
All enrollees	1.116 (11.6%)	

Note: DECI (demographic estimate of coding intensity), MA (Medicare Advantage), FFS (fee-for-service), HCC (hierarchical condition category). Risk scores reflect the blend of risk model versions used for payment in 2019. The DECI estimate of coding intensity is the ratio of the MA-to-FFS CMS-HCC risk-score ratio and the MA-to-FFS demographic risk-score ratio. The 2019 DECI estimate of 1.116 has been converted to 11.6 percent. Rounding affects some ratio values.

Source: MedPAC analysis of 2019 Medicare enrollment, risk-score, and Master Beneficiary Summary files.

MA coding intensity because they are not based on diagnosis codes. Yet, we estimated that new enrollees accounted for roughly 1.1 percentage points of the 2019 DECI estimate (13.2 percent, as estimated by the Commission).¹⁰ (Our cohort method constrains new enrollees to have no coding intensity by assigning them a disease score change of zero, as described in steps 5 and 6a of the text box on the Commission's cohort method, pp. 422–423.)

To constrain the influence of new enrollees in the DECI method and to account for differing shares of MA and FFS beneficiaries who are eligible for Medicaid benefits or who have LTI status, we excluded beneficiaries

with new enrollee risk scores from our analysis and then calculated separate MA and FFS CMS-HCC and demographic risk-score averages for the other four groups of continuing enrollees: beneficiaries eligible for no, partial, or full Medicaid benefits and LTI (institutional) beneficiaries (Table 13-2). We then calculated the MA enrollment-weighted average MA and FFS CMS-HCC and demographic risk scores for MA and FFS continuing enrollees. Next, we calculated the MA-to-FFS CMS-HCC risk-score ratio (1.128) and the MA-to-FFS demographic risk-score ratio (1.001) for continuing enrollees. Finally, we combined the DECI estimate for continuing enrollees (12.7 percent) with the constrained DECI estimate for new enrollees

**TABLE
13-3**

Summary of differences between Kronick and Chua's DECI estimate and the Commission's revised DECI estimate, 2019

	Change in estimate	Estimated MA coding intensity
Kronick and Chua's DECI estimate for 2019		20.0%
Restricting national average FFS CMS–HCC risk score to include only beneficiaries with Part A and Part B	–5.6%	14.4
Calculating MA-to-FFS demographic risk-score ratio with complete Medicaid eligibility and LTI status data	–1.2%	13.2
Constraining new enrollees to have no coding intensity effect	–1.1%	12.1
Accounting for differing shares of MA and FFS beneficiaries eligible for Medicaid or with LTI status	–0.5%	11.6
The Commission's revised DECI coding intensity estimate for 2019		11.6

Note: DECI (demographic estimate of coding intensity), FFS (fee-for-service), HCC (hierarchical condition category), MA (Medicare Advantage), LTI (long-term institutional).

Source: Kronick and Chua (2021b) and MedPAC analysis of 2019 Medicare enrollment, risk-score, and Master Beneficiary Summary files.

(1.000) using the MA enrollment share of each group to calculate a revised DECI estimate of 11.6 percent for 2019, which is 8.4 percentage points lower than Kronick and Chua's original estimate shown in Table 13-1 (20.0 percent) (p. 428).

Table 13-3 summarizes the differences between Kronick and Chua's DECI estimates and the Commission's revised DECI estimate for 2019. Removing FFS beneficiaries with only Part A from the national average FFS CMS–HCC risk score accounts for 5.6 percentage points of the overall difference. Using complete Medicaid eligibility and LTI status to calculate demographic-only risk scores for MA and FFS beneficiaries accounts for an additional 1.2 percentage points.

We estimated that refinements to the DECI method—constraining new enrollees to have no coding intensity impact and accounting for differences in MA and FFS beneficiaries' Medicaid eligibility and LTI status—further accounts for 1.1 percentage points and 0.5 percentage points, respectively.

As noted earlier, revising the Commission's cohort method to account for differences in Medicaid

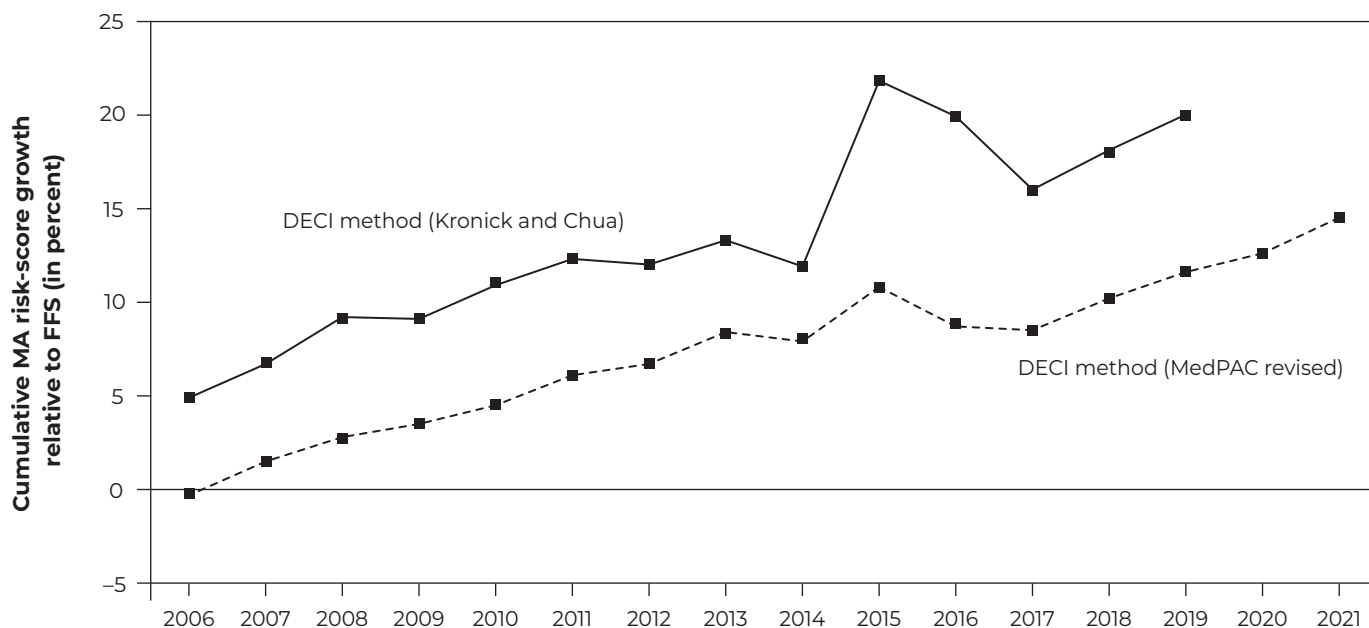
eligibility between MA and FFS and to remove a restriction requiring continuous enrollment in either MA or FFS produced a coding intensity estimate for 2019 that was 2.4 percentage points higher than when using our original cohort method (12.4 percent vs. 10.0 percent). Therefore, we find similar coding intensity estimates for 2019: 11.6 percent based on the revised DECI method and 12.4 percent based on our revised cohort method.

We repeated the calculation of our revised DECI estimates for the years 2006 through 2021 and plotted the results in Figure 13-3 (p. 432) alongside Kronick and Chua's DECI estimates (through 2019).

Compared with the Commission's revised DECI estimates, we find that Kronick and Chua's original DECI estimates of coding intensity were higher for all years 2006 through 2019. For most years (except 2014 through 2016, discussed below), the original DECI estimates were 5 percentage points to 8 percentage points higher than the Commission's revised method. Most of the difference in these years is attributable to including the Part A-only population in the FFS CMS–HCC average risk score. Prior to 2017, Kronick

**FIGURE
13-3**

Previous DECI estimates are consistently overstated when compared with the Commission's revised DECI estimates, 2006–2021



Note: DECI (demographic estimate of coding intensity), MA (Medicare Advantage), FFS (fee-for-service).

Source: Kronick and Chua (2021b) and MedPAC analysis of 2006 through 2021 Medicare enrollment, risk-score, and Master Beneficiary Summary files.

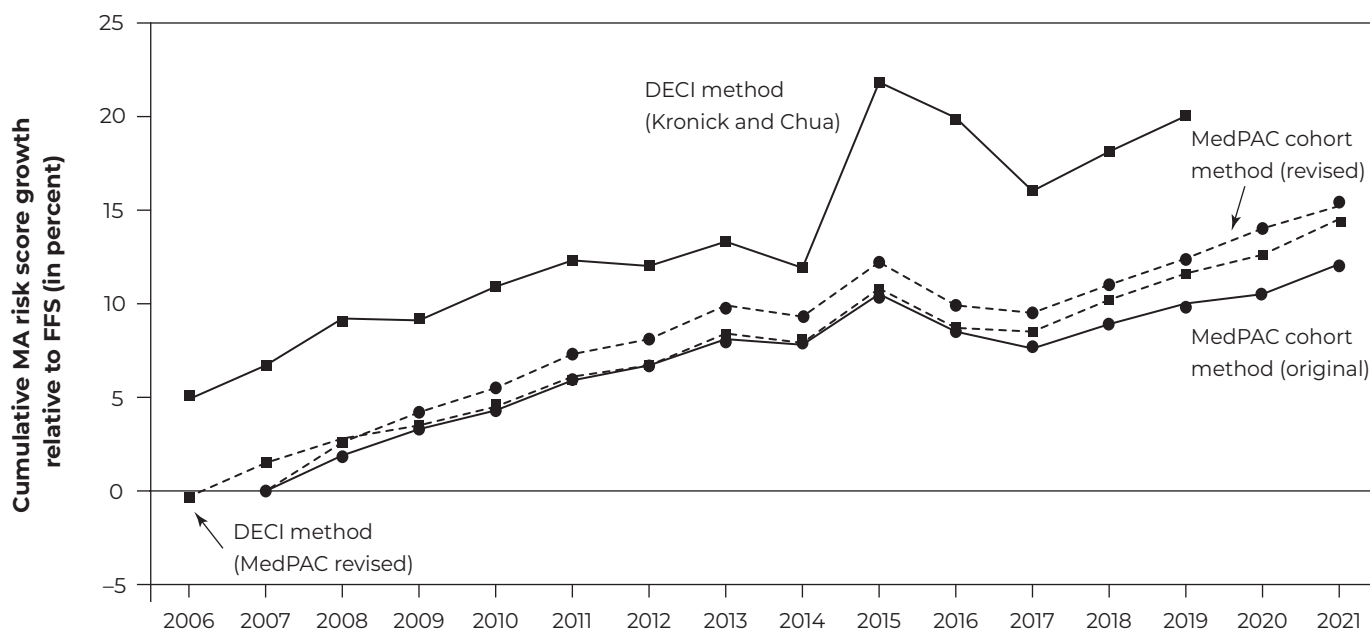
and Chua's DECI method used the FFS normalization factor as a proxy for the FFS CMS-HCC average risk score. The FFS normalization factor is a projection of what the average FFS risk score will be in each payment year based on the trend of five historic years of risk scores for all FFS beneficiaries (including those with Part A only), and therefore the factor may not match the actual average FFS risk score for a payment year. In 2014, the normalization factor overestimated the actual FFS CMS-HCC risk score for all beneficiaries, thereby partially offsetting the effect of including Part A-only beneficiaries and causing the original DECI estimate to be only 4 percentage points higher than our revised DECI estimate (Centers for Medicare & Medicaid Services 2017).¹¹ In 2015 and 2016, the normalization factor underestimated the average actual FFS risk score for all beneficiaries by about 2 percent, further inflating the original DECI estimate to about 11 percentage points higher than our revised DECI estimates (Centers for Medicare & Medicaid Services 2020b).¹²

Revised DECI estimates closely match the Commission's cohort method estimates of coding intensity

The Commission's revised DECI estimates are very similar to estimates produced by our original cohort method of estimating coding intensity prior to 2017, but estimates from the two methods diverge in subsequent years. The revised DECI estimates increased from 0.9 percentage points higher than our original estimates in 2017 to 2.4 percentage points higher in 2021. In Figure 13-4, we show that the Commission's revised DECI estimates closely align (within 1.5 percentage points for all years except 2007) with estimates from our revised cohort method, particularly for 2017 and subsequent years. We note that in 2017, the CMS-HCC risk-adjustment model incorporated different model segments (and coefficients) for beneficiaries based on having full, partial, or no Medicaid eligibility. Both the revised DECI and revised cohort methods account for

**FIGURE
13-4**

The Commission's revised DECI estimates closely align with our revised cohort method, 2006–2021



Note: DECI (demographic estimate of coding intensity), MA (Medicare Advantage), FFS (fee-for-service).

Source: Kronick and Chua (2021b) and MedPAC analysis of 2006 through 2021 Medicare enrollment, risk-score, and Master Beneficiary Summary files.

differences in the share of MA and FFS beneficiaries by Medicaid eligibility status, and since 2017, estimates from these two methods track more closely than the Commission's original cohort method, which does not account for differences in Medicaid eligibility. We conclude that the revised DECI method and our revised cohort method provide similar and accurate estimates of the impact of MA coding intensity.

The Commission adopts the revised DECI method

After making the methodological improvements described above to the DECI and the Commission's cohort methods, both approaches produce consistent results. That gives us confidence in our estimate of MA coding intensity. The Commission has decided to adopt the revised DECI method for estimating the effects of MA coding intensity in current and future analyses. The revised DECI method is able to incorporate a

larger share of the MA and FFS populations, is not subject to the potential for small numbers in the age and sex × Medicaid eligibility × enrollment categories used in our revised cohort method, and does not rely on any assumptions about when MA coding intensity surpassed FFS coding intensity:

- the revised DECI method incorporates a larger share of beneficiaries by including beneficiaries with LTI status and beneficiaries with partial years of enrollment;
- to account for age, sex, Medicaid eligibility, and enrollment length, the Commission's cohort method requires a large and increasing number of sub-cohorts (28 age and sex categories × 3 Medicaid eligibility categories × 17 enrollment categories for 2021) where small numbers may become an issue; and

- the revised DECI method can empirically show that MA coding intensity surpassed FFS coding intensity between 2006 and 2007. We draw this conclusion from the negative revised DECI estimate in 2006 and the positive estimate in 2007. (For our cohort method, we assumed that MA coding intensity began in 2007, which has turned out to be reasonable, but it was not based on an empirical assessment.)

Chapter 12 discusses the Commission's estimates of the effects of coding intensity using our revised DECI method for 2007 through 2024.

Revising the Commission's method for estimating favorable selection into MA

Because MA benchmarks are based on risk-standardized county-level FFS spending, CMS relies on enrollee risk scores to help ensure comparability between the MA and FFS populations. The risk score indicates a beneficiary's expected cost relative to the cost of the national average FFS beneficiary (e.g., a beneficiary with a risk score of 1.65 has expected costs that are 65 percent higher than the national average). The balance of Medicare's payments to MA plans relative to FFS (how well payments to MA plans match what FFS would have spent on MA enrollees) depends in large part on how well the risk scores predict the expected costs for the plans' enrollees, given their demographics and medical conditions. When setting MA benchmarks, CMS assumes that if MA enrollees were in FFS, their average Medicare spending would be equal to that of current FFS enrollees in the same local area after adjusting for differences in risk scores (prior to the effects of differences in coding practices between MA and FFS).

However, a substantial body of research suggests that risk scores do not fully account for spending differences between the FFS and MA populations because of favorable selection into MA (or adverse selection into FFS) (Brown et al. 2014, Curto et al. 2021, Curto et al. 2019, Goldberg et al. 2017, Government Accountability Office 2021, Jacobs and Kronick 2018, Jacobson et al. 2019, Lieberman et al. 2023, Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2012, Meyers et al.

2019, Newhouse et al. 2015, Rahman et al. 2015, Riley 2012, Ryan et al. 2023). The effect of favorable selection occurs before any plan intervention occurs; favorable selection is when the average beneficiary who chooses MA has lower actual spending compared with what their risk score predicts. Favorable selection can pertain to relative health status but can also pertain to other factors such as preferences in care. (See text box describing the plan and beneficiary factors that may lead to favorable MA selection, p. 436–437.)

The effect of favorable selection may increase or decrease in any given year, depending on the relative change of the MA and FFS populations. Beneficiaries with the same risk can have a wide distribution of actual spending (Lieberman et al. 2023). Because MA payments are risk standardized relative to the FFS population, higher-spending beneficiaries (including dual-eligible beneficiaries) are not necessarily unfavorable to MA plans. Favorable selection indicates that, on average, enrollees in MA have lower actual spending relative to what is predicted by their risk score (without any intervention from MA plans). Each year, a mix of beneficiaries who are favorable and unfavorable enroll in MA. As the share of beneficiaries in MA increases, it is not clear how favorable selection will change. It is possible that as MA grows, the favorability of the MA program will converge with the population remaining in FFS, and favorable selection will decrease. Alternatively, it is possible that as fewer beneficiaries remain in FFS, benchmarks will be set on an increasingly small group that is not representative of the Medicare population. For example, remaining beneficiaries in FFS may have a much higher rate of comprehensive supplemental coverage or life-threatening conditions such as cancer, which would tend to increase their preference for care and may increase favorable selection. One white paper found that selection was prevalent in counties with high MA penetration (Lieberman et al. 2023).

In prior work, the Commission estimated that if MA enrollees were in FFS, their 2019 spending would have been 11 percent lower than the spending of beneficiaries who actually enrolled in FFS and had the same risk scores (Medicare Payment Advisory Commission 2023b). Thus, risk-standardized spending on MA enrollees is lower than the FFS average prior to the effects of any utilization management or differential coding from MA plans. In this section, we

describe improvements in our method and update the analysis to estimate the cumulative favorable selection in each year from 2017 to 2021 (including potential effects from the coronavirus pandemic in 2020 and 2021). In this new analysis, we continue to estimate that—prior to any intervention from MA plans—average MA enrollees have substantially lower spending than FFS beneficiaries with the same risk scores, resulting in higher benchmarks and payment rates for MA plans. We estimate that:

- MA entrants as a group had lower risk-standardized spending in the year prior to joining an MA plan over the period from 2007 to 2021;
- beneficiaries who subsequently stayed in MA for longer periods of time tended to have lower pre-MA risk-standardized spending than enrollees who either died or disenrolled; and
- using our estimates of regression to the mean during MA enrollment (which remove any effects from the intervention of MA plans), for beneficiaries who remained in MA, the effects of favorable selection—lower risk-standardized spending—persisted for years after they entered MA.

After estimating the effects of enrollment attrition and regression to the mean during MA enrollment, we estimate that favorable selection resulted in MA spending in 2017 that was 5.6 percent lower than for FFS beneficiaries with the same risk score (equivalent to payments 5.9 percent above FFS spending). By 2021, we estimate that favorable selection increased MA payments by roughly 12.8 percent above what the program would have paid under FFS.

Thus, favorable selection into MA causes risk scores to systemically overpredict spending for MA enrollees; that is, spending on the average MA enrollee is lower relative to what their risk score, and MA plan payment, would suggest. This lower-than-predicted spending is evident in the years prior to a beneficiary enrolling in an MA plan, and thus the overprediction by a beneficiary's risk score cannot be attributed to any plan activity (such as utilization management). Because plan benchmarks rely on risk-standardized FFS Medicare spending estimates, they reflect the higher level of costs associated with the FFS-enrolled population rather than the costs associated with a plan's enrollees. For example, in a county with a benchmark set at 100 percent of FFS spending, favorable selection allows

plans to submit bids that are lower than FFS spending without producing any efficiencies in care delivery (that is, before accounting for the added effects of plan benefit design and cost-containment efforts). Note that the favorable selection that MA plans experience is separate from the effects of higher MA coding intensity, but the effects of the two phenomena are additive.

Revising the Commission's method of estimating a favorable selection percentage

The amount of favorable selection that MA plans experience in payment benchmarks can be estimated using a selection percentage, which represents the risk-standardized payments for MA enrollees as a percentage of the local FFS spending average. As discussed below, some prior research estimated the selection percentage in the year prior to MA entry for beneficiaries who switch from FFS to MA; this approach has some advantages because it eliminates the effects on spending of MA plan benefit design, utilization management, and coding differences (see text box, pp. 438–439, describing prior research measuring MA favorable selection). The Commission's June 2023 report to the Congress used this method for several FFS-to-MA switching cohorts who were still enrolled in MA in 2019 and used the FFS experience of 2020 MA entrants to account for expected changes in favorable selection during MA enrollment (Medicare Payment Advisory Commission 2023b). Seeking to further refine our estimate of favorable selection and incorporate our analysis of favorable selection into our estimate of MA payments reported in our annual March report to the Congress, the analysis described below maintains the same analytic framework we used in our June 2023 report but makes four key technical improvements:

- First, we expanded our estimate of MA favorable selection to include overall estimates in each year from 2017 through 2021. We continued to use beneficiary enrollment and spending data beginning with the cohort of 2008 MA entrants; expanding our estimate of overall selection (beyond 2019) allows us to better understand how favorable selection has changed over time.
- Second, we included employer plan enrollees and hospice enrollees more directly in our estimate of favorable selection. Previously, we assumed that MA employer plan enrollees had no favorable

Medicare Advantage plan and beneficiary factors that may produce a favorable selection of enrollees

Even after risk standardization, we estimate that the beneficiaries who choose to enroll in a Medicare Advantage (MA) plan systemically incur lower Part A and Part B spending than those who stay in the fee-for-service (FFS) program (or switch from MA to FFS), implying a correlation between a beneficiary choosing to join an MA plan and having lower risk-standardized spending. When the risk-adjustment model overpredicts what MA enrollees on net would have spent if they were in FFS, the result is higher payments for MA plans, and the overprediction distorts the comparison of risk-standardized spending on MA and FFS enrollees (Curto et al. 2021). This phenomenon may be driven by both non-plan and plan-level factors.

The MA program design gives plans a financial incentive to enroll beneficiaries with actual costs that are likely below what FFS Medicare's payment would have been for that beneficiary, as adjusted by the beneficiary's risk score. This incentive does not result in a preference for healthy enrollees but, rather, a preference to enroll beneficiaries who are likely to incur lower costs than others with a similar risk profile (Brown et al. 2014).¹³ Plans can develop offerings designed to attract such enrollees—and discourage the enrollment of beneficiaries with higher expected costs relative to their risk scores—using strategies such as utilization management, extra benefits, and cost-sharing arrangements.

Moreover, beneficiaries who have systematically lower spending than predicted may be more likely to enroll in MA plans. This choice could result in favorable selection independent of any plan efforts. For example, beneficiaries tend to enroll in a plan when the plan's benefit package matches their own self-assessed preferences and needs. These preferences may be guided by enrollment brokers who receive financial incentives for enrolling beneficiaries in certain MA, Part D, or Medigap plans. Because health needs, preferences for health care service use, and financial priorities vary across the Medicare population, plans that are attractive

to some beneficiaries will be unattractive to others. Risk scores account for some, but not all, of the variation in cost for MA beneficiaries (Brown et al. 2014, Jacobson et al. 2019). This additional variation in cost can include the overprediction of risk-standardized spending for Black and Hispanic beneficiaries (McWilliams et al. 2023). Thus, as MA plans enroll a higher share of Black and Hispanic beneficiaries, the average risk-standardized spending of their enrollees may become more favorable. While increased access to services once beneficiaries are enrolled in MA could dampen some of the effects of favorable selection, limited evidence suggests that MA plans are not providing greater access to services overall relative to FFS (Aggarwal et al. 2022, Commonwealth Fund 2021, Fuglesten Biniek et al. 2021).

Likewise, beneficiaries' health needs and financial situations change over time, and beneficiaries may find that a plan that worked well for them in the past no longer meets their needs.¹⁴ While many beneficiaries who switch from MA to FFS are not guaranteed a Medigap plan, a growing literature has found that a disproportionate share of the beneficiaries who leave MA for FFS are chronically ill, costly, or nearing the end of life (Goldberg et al. 2017, Government Accountability Office 2021, James et al. 2023, Meyers et al. 2019, Rahman et al. 2015, Riley 2012).

Plan networks and utilization management

MA plans can influence which beneficiaries enroll in their plan by maintaining either narrow or preferred provider networks. (An in-depth discussion of this type of plan influence will be undertaken in future work.) Plan networks can potentially lead to higher-quality care by ensuring that only high-quality providers are in network. However, a more limited network can also contribute to favorable selection by discouraging beneficiaries with preferences for certain health care services from enrolling in MA plans. For instance, MA plan networks may be

(continued next page)

Medicare Advantage plan and beneficiary factors that may produce a favorable selection of enrollees (cont.)

less likely than FFS to include cancer centers and geriatricians, endocrinologists, and psychiatrists (Jacobson et al. 2017, Jacobson et al. 2016b). A plan's network design can also contribute to favorable selection by including clinicians whose practice patterns and patient population tend to have lower overall medical spending (relative to what patient risk scores predict), or by dropping clinicians whose practice patterns and patient population have higher overall medical spending.

Plans also use other techniques—like prior authorization, claims denials, and sometimes coordination among specified providers—to encourage the use of high-value care and discourage the use of low-value services.¹⁵ However, beneficiaries with complex care needs may view these techniques as barriers to obtaining medically necessary care, which may lead some enrollees with complex care needs to disenroll (Meyers et al. 2019). In addition, these techniques—combined with potentially lower payment rates from MA plans—may influence some skilled nursing facilities to either encourage beneficiary MA disenrollment or even disenroll beneficiaries from MA plans without the beneficiaries' consent (Centers for Medicare & Medicaid Services 2021, Centers for Medicare & Medicaid Services 2015).

Cost sharing

MA plans may also attract some beneficiaries because they often have a different cost-sharing structure than FFS, including an overall limit on out-of-pocket spending and a variety of extra benefits. Although plans require cost sharing for most services, they can use different cost-sharing arrangements to encourage beneficiaries to use less costly sites of care. Beneficiaries who expect

to use more medical services than average may prefer more comprehensive coverage of their cost sharing and therefore remain in FFS and purchase supplemental Medigap insurance to cover their out-of-pocket spending. Comprehensive supplemental coverage (e.g., Medigap plans F and G) limits any out-of-pocket liability for beneficiaries and may induce additional service use (Direct Research 2014). This induced utilization may contribute to favorable selection for MA enrollees who would not have received comprehensive supplemental coverage while enrolled in FFS.

As described above, actual health care spending does not perfectly correlate with the spending predicted by risk scores. For a number of reasons (including personal attitudes toward health care use, provider treatment decisions, and interactions between health care conditions), beneficiaries with the same risk scores can have higher or lower actual costs. MA plans typically offer supplemental coverage for Medicare services (including an out-of-pocket maximum), which can include Part B and Part D premium reductions. However, these extra benefits are paired with in-network requirements and cost sharing for many services. While some beneficiaries may be attracted to an MA plan because of the out-of-pocket maximum, only a limited set of beneficiaries (e.g., ESRD beneficiaries with limited or no Medicaid coverage) would likely expect their out-of-pocket costs to exceed an MA-plan's out-of-pocket maximum.¹⁶ Thus, most prospective MA enrollees are unlikely to rely on an MA plan's out-of-pocket maximum, and plans are likely to attract many beneficiaries who are not inclined to use many health services while discouraging some beneficiaries who use more services from enrolling.¹⁷ ■

selection; now we estimate the extent of their favorable selection with all other MA enrollees. Even though the choice to enroll in an employer plan may be different from the choice to enroll in

a conventional MA plan, there is still potential for favorable selection. In addition, while we previously excluded enrollees who used any hospice services, we now include them in our estimates to better

An overview of prior research estimating favorable selection in Medicare Advantage

Medicare Advantage (MA) plans benefit from a favorable selection of enrollees if their spending on Part A and Part B benefits is, on average, consistently lower than the amount predicted by their enrollees' risk scores. (Conversely, plans would be adversely affected by unfavorable selection if their spending were, on average, consistently higher than the amount predicted by their enrollees' risk scores.) In measuring the effects of favorable selection, one must control for other important factors that can affect spending on MA enrollees, such as plan benefit designs, cost-containment efforts, and diagnostic coding practices.

Measuring the impact of favorable selection in MA is challenging because plans do not submit beneficiary-level spending data, and plans' diagnostic coding practices increase their risk scores relative to fee-for-service (FFS) Medicare, preventing an apples-to-apples comparison of actual and projected spending amounts for beneficiaries enrolled in MA plans. Studies vary widely in the way they measure selection, their sample populations, and the years of data used. Some studies have found evidence of favorable selection using indirect

measures, such as mortality (Curto et al. 2019, Newhouse et al. 2019) and Part D event data (Jacobs and Kronick 2018). One recent study found that MA enrollment was systemically and disproportionately higher in counties where CMS overpredicted risk-standardized FFS spending (relative to the national FFS average), resulting in an estimated \$9.3 billion per year in additional MA payments before even considering the risk-standardized differences between the MA and FFS populations (Ryan et al. 2023). Other studies have examined the risk scores and spending in the year before beneficiaries switch from FFS to MA (Jacobson et al. 2019, Lieberman et al. 2023, Newhouse et al. 2015). This approach is appealing given that an increasing share of MA enrollees were once in FFS Medicare (Xu et al. 2023). The prior-year spending and risk scores published in one study indicated that the risk-standardized spending of a sample of beneficiaries who switched from FFS to MA in 2010 was 13 percent lower than beneficiaries who remained in FFS (Newhouse et al. 2015). A 2019 study found that risk-standardized spending was 16 percent lower for a sample of beneficiaries in the year before switching to MA in 2016 compared with a sample of beneficiaries who stayed in FFS (Jacobson et al. 2019). A more recent

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align our methodology with CMS's methodology for calculating the FFS spending used for MA benchmarks. We estimate that including employer plan and hospice enrollees increased our estimate of favorable selection by less than 1 percentage point. We will consider the feasibility of segmenting employer plan enrollees in future estimates.

- Third, we improved how we trend forward the spending for MA enrollees from the year before MA entry to the measurement year in order to better estimate the expected "regression to the mean"

effect during MA enrollment. While we previously assumed that an MA entry cohort's selection percentage (i.e., their risk-standardized spending relative to the local FFS average) would trend forward with the same slope as future MA enrollees (our proxy group), we now match the distribution of the initial selection percentage of both groups before trending the selection percentage forward to the measurement year. We estimate that this change decreased our estimate of favorable selection by 2 percentage points to 3 percentage points.

An overview of prior research estimating favorable selection in Medicare Advantage (cont.)

study used spending data from 2015 through 2019 and estimated favorable selection equivalent to 14.4 percent of MA revenue, or \$59.3 billion in 2023 (Lieberman et al. 2023).

In 2012, the Commission also used the method of examining spending in the year before MA entry and found favorable selection both within CMS hierarchical condition categories (HCCs) and among one year of MA entrants overall (Medicare Payment Advisory Commission 2012). In the year before MA entry, the Commission found MA favorable selection within 68 of 70 CMS-HCCs and found that MA entrants had risk-standardized spending that was 15 percent lower overall than beneficiaries who remained in FFS. In addition, the Commission found that MA plans benefited from beneficiaries who switched from MA to FFS. The FFS spending for these beneficiaries was 16 percent higher than for beneficiaries who were continuously enrolled in FFS.

Despite results that suggest favorable selection for MA enrollees, examining spending in the year prior to MA entry has its limitations. In 2012, the Commission noted that using only one year of MA enrollee data to measure favorable selection

can estimate the effect of selection during the MA enrollment period—including when beneficiaries switch between FFS and MA—but it does not provide direct information about the persistence of the effects of favorable selection for the duration of MA enrollment. Researchers who used indirect measures of selection (e.g., mortality) have also acknowledged this limitation (Newhouse et al. 2019). One recent study indirectly addressed this limitation by assuming that the effect of favorable selection would be reduced by 15 percent relative to the prior year (Lieberman et al. 2023).

The Commission's June 2023 report to the Congress recently attempted to address this limitation by following cohorts of enrollees from the year before they switched to MA through 2019 and using the FFS experience of 2020 MA entrants to account for expected changes in favorable selection during MA enrollment (Medicare Payment Advisory Commission 2023b). We estimated that 2019 MA enrollees cumulatively had a selection effect that resulted in spending that was 11 percent lower than spending on the FFS population (prior to the effect of plan utilization management and coding). ■

- Fourth, we trended forward the spending of MA entrants in the measurement year from the year before MA entry to the measurement year—a modification that pertains to only the newest MA entrants. We previously assumed that the selection percentage in a given year (say, 2018) would have sustained the same level in the subsequent year for entrants in that year (say, 2019 for 2019 MA entrants). This change more accurately trends forward the selection percentage between the two years. We estimate that this change increased our estimate of favorable selection by less than 1 percentage point.

Estimating favorable selection when beneficiaries first enroll in MA

As our first step to better understand favorable selection, we built on our recent method of analyzing FFS spending in the year prior to MA enrollment by analyzing a longer period of spending in the year before MA entry (2007 through 2021). For each year, we compared the FFS spending for beneficiaries who switched into MA in the subsequent year with spending for the beneficiaries who stayed in FFS (Figure 13-5, p. 440). For example, we calculated the ratio of 2021 FFS spending for beneficiaries who switched to MA in 2022 to the 2021 FFS spending for beneficiaries who

**FIGURE
13-5****Illustrative example of estimating the favorable selection percentage for MA entrants in 2022**

Inclusion criteria		2021 FFS spending
Cohort	2021 FFS enrollment and 2022 MA entry	\$665 per member per month
Comparator	Continuous FFS enrollment in 2021 and 2022	\$736 per member per month

$$\text{Cohort selection percentage in 2021} = \frac{\$665}{\$736} = 90\%$$

Note: MA (Medicare Advantage), FFS (fee-for-service). Both the MA cohort and FFS comparator groups had FFS enrollment in 2020. The analysis excludes beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the year of MA entry as well as beneficiaries who joined a non-MA private plan (e.g., cost plan), had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico (due to the relatively small number of FFS beneficiaries in that territory). Spending for the FFS comparator group reflects the county-level average, adjusted by the geographic and risk-score distribution of the MA cohort. The selection percentage reflects the risk-standardized spending below the local FFS average prior to any MA efficiencies or coding differences. The selection percentage reflects 2021 spending and CMS–HCC risk scores. Because risk scores use prospective diagnoses from 2020, all beneficiaries in the analysis are required to have two full years of data.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2020–2022.

remained in FFS in 2022. We then converted the result to a percentage that we call the “selection percentage.” (When calculating benchmarks, CMS adjusts for geographic distribution (i.e., county-level enrollment) of beneficiaries and differences in risk scores. Similarly, we adjusted the spending of beneficiaries who remained in FFS to have the same geographic distribution and risk scores as the beneficiaries who switched to MA.) We calculated an initial selection percentage for each cohort that entered MA in 2008 through 2022.

Study and comparison populations

We included beneficiaries in our study population if they (1) enrolled in MA between 2008 and 2022 and (2) had been enrolled in FFS and had both Part A and Part B coverage for at least two full calendar years prior to enrolling in MA. We required beneficiaries to have at least two full calendar years of FFS enrollment because the CMS–HCC risk-adjustment model calculates risk

scores using diagnoses from the prior year’s claims, so we needed data on MA beneficiaries with two years of prior FFS enrollment to calculate risk scores for their last year of FFS enrollment. In 2021, about half of MA entrants (53 percent) met these criteria; for the remaining entrants, 8 percent had between one and two years of prior FFS enrollment, 12 percent had less than one year of prior FFS enrollment, and 26 percent had no prior FFS enrollment (meaning they enrolled directly in MA when they first became eligible for Medicare Advantage).^{18,19} Among all MA entrants from 2008 through 2021 who were enrolled in MA at any time in 2021, 38 percent had at least two years of prior FFS enrollment, 6 percent had between one and two years of prior FFS enrollment, 23 percent had less than one year of prior FFS enrollment, and 33 percent had no prior FFS enrollment.²⁰ We divided the study population into 15 annual cohorts based on the year they enrolled in MA (2008 through 2022).

Although enrollment in employer plans and hospice occurs only in limited circumstances, these populations influence the overall effect of favorable selection that MA plans experience. As an improvement to the Commission's June 2023 report, we included beneficiaries in our study population who were enrolled in employer-sponsored MA plans. Previously, while some employers offer beneficiaries both a Medigap and MA option, we assumed that because most beneficiaries in employer-sponsored plans often have limited control over their decision to join or leave MA, there were limited opportunities for favorable selection for those plans. We tested this assumption across multiple years of spending in the year before MA entry. From 2016 through 2021, we estimated that their average risk-standardized spending was above the spending for other MA entrants but also below the average spending for beneficiaries who stayed in FFS (i.e., there was consistent evidence of at least some favorable selection).²¹ The Commission previously reported that employer plan enrollees have favorable quality ratings, which may be due to higher average income, better health, and better access to health care (Medicare Payment Advisory Commission 2020a). These characteristics may also contribute to this group of beneficiaries having lower spending relative to their risk scores in their local areas.

In addition, to improve on the Commission's June 2023 report, we included beneficiaries who received hospice care during either the reference year (i.e., the year before MA entry) or the subsequent year. This technical revision improves our analysis because the nonhospice spending for beneficiaries who receive hospice care is included in MA benchmarks. In addition, hospice enrollees typically have high risk-standardized spending but receive their Medicare Part A and Part B coverage from FFS and not from MA plans. Thus, we estimate that FFS beneficiaries who elect hospice are typically unfavorable to MA plans and remain in FFS—resulting in an additional form of favorable selection. Further, the inclusion of hospice users is consistent with both our retrospective and prospective comparisons of MA payments relative to FFS spending (Medicare Payment Advisory Commission 2023c).

For the comparison population, we used FFS beneficiaries who did not switch to MA. We included any FFS beneficiaries who met our inclusion criteria for sufficient data and would have been part of CMS's

MA benchmark calculation. These beneficiaries had to have both Part A and Part B coverage for at least two full years by the end of the reference year (the study population's last year of FFS enrollment). For both our MA and FFS comparison populations, we required that beneficiaries live in the same county during the reference year because we used county-level figures in our spending calculations.

We excluded beneficiaries from either population if they had end-stage renal disease (ESRD) or if they had another source of health coverage for which Medicare acted as a secondary payer during the reference year. CMS excludes beneficiaries with ESRD from benchmark calculations, pays MA plans for ESRD beneficiaries based on state-based FFS rates, and adjusts benchmarks and payments for those with Medicare as a secondary payer to remove the secondary-payer effect.

Calculation of average FFS spending per capita

We calculated the average FFS spending per capita for the study and comparison populations using beneficiary-level spending data in each county. We then aggregated the county-level figures into an overall national average.

- We divided each beneficiary's actual FFS spending in the reference year by their CMS-HCC risk score for that year to generate their risk-standardized annual spending; we then divided that figure by 12 to produce the beneficiary's average risk-standardized monthly spending amount.
- We then calculated the average risk-standardized monthly spending in each county for the study and comparison populations. We multiplied the beneficiary-level figures by the number of months in the following year that beneficiaries were enrolled in MA (for the study population) or FFS (for the comparison population), and then we divided those amounts by the total number of MA or FFS enrollment months in the county. For beneficiaries who had some MA enrollment and some FFS enrollment during the year, we allocated their spending based on the number of months enrolled in each program. When a county's study or comparison population had fewer than 1,000 beneficiaries, we blended its average spending figure with the corresponding figures

for neighboring counties, similar to the “credibility adjustment” that CMS makes to MA benchmarks to ensure that they are reliable.

- Then we calculated a national figure for average risk-standardized monthly spending for the study and comparison populations. We summed the FFS and MA county-level spending figures weighted by the number of MA enrollment months and the average MA risk score (using the FFS experience of MA enrollees) for each county, and then we divided by the national total of MA enrollment months. This approach for standardizing ensured that the figure for the comparison population (FFS stayers) had the same geographic distribution and risk scores as the figure for the study population (new MA entrants).

We performed separate calculations for each annual cohort of MA entrants and its corresponding comparison population.

Estimating the effect of favorable selection on benchmarks

We estimated the effect of favorable selection for each cohort by dividing the national figure for average risk-standardized monthly spending for the study population (new MA entrants) by the corresponding figure for the comparison population (FFS stayers) and converting the result into a percentage, called the selection percentage (Figure 13-5, p. 440). There was favorable selection in MA if the selection percentage was less than 100 percent and unfavorable selection if the percentage was more than 100 percent. For example, an estimate of 95 percent means that the prior-year FFS spending for new MA entrants was 5 percent less than the prior-year spending for beneficiaries who remained in FFS, even after adjusting for differences in the risk scores and geographic distribution of the two groups.

Beneficiaries enrolling in MA showed evidence of favorable selection at the time of MA entry throughout the period from 2007 to 2021

We examined the prior-year spending of MA entrants nationally and found evidence of favorable selection among new MA enrollees throughout the period from 2007 to 2021 (Figure 13-6). We estimate that the selection percentage ranged from 90 percent to 96 percent during the period. Favorable selection at MA

enrollment was highest in 2011 (MA spending was 10.3 percent less than FFS spending for a beneficiary with the same risk score, a selection percentage of 89.7) and began to steadily decline through 2016, which had the lowest amount of favorable selection (MA spending was 4.2 percent less than FFS spending for a beneficiary with the same risk score, a selection percentage of 95.8). After 2016, favorable selection at MA enrollment began to steadily increase, reaching risk-standardized spending that was 10 percent below the local FFS average (a selection percentage of 90 percent) in 2021. The increase in favorable selection as of 2017 coincided with changes to the CMS-HCC risk-adjustment model, which segmented full and partial dual-eligible beneficiaries by disability status. Thus, as dual-eligible beneficiaries were no longer unfavorable in the risk-adjustment model, the effect of favorable selection among MA entrants began to increase—coinciding with a continued increase in the share of dual-eligible beneficiaries who enrolled in MA during the 2017 to 2021 period.

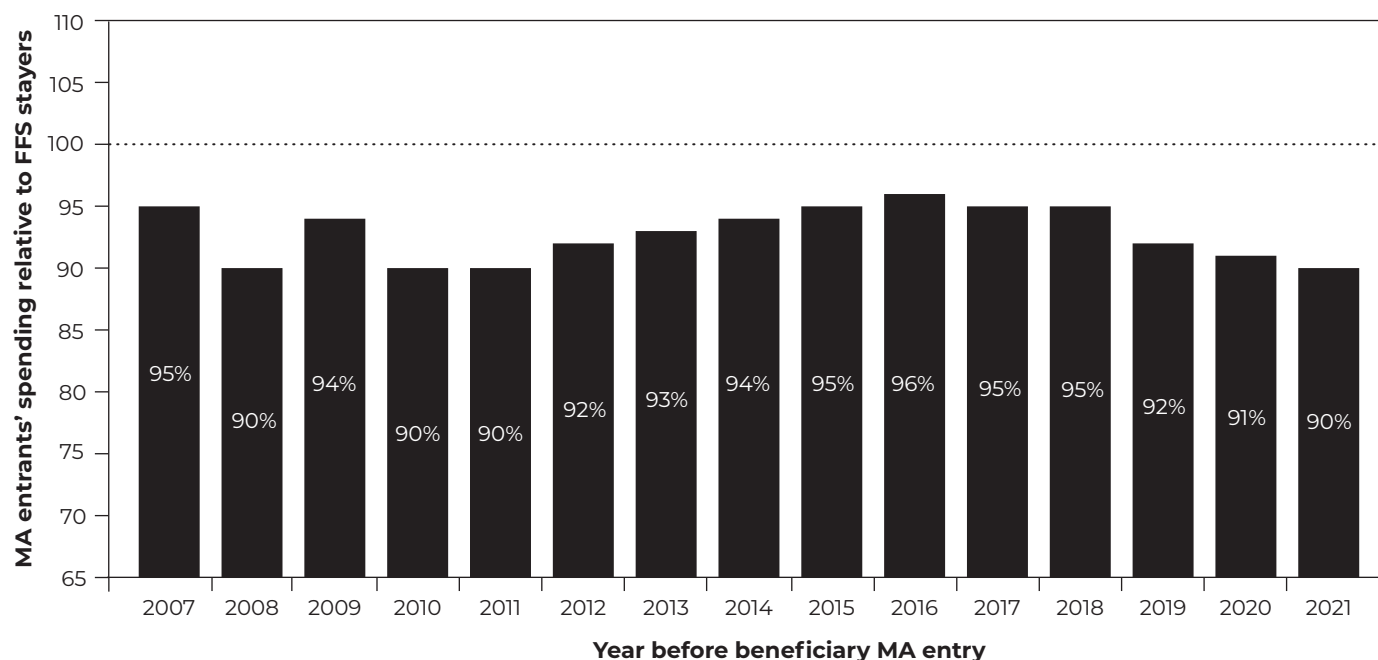
The effects of favorable selection among MA entrants were not explained by risk-score differences with the comparison population. For example, the prior-year average risk score of MA entrants from 2020 through 2022 was only 3 percent lower than the prior-year average risk score of FFS stayers during those years (data not shown), a period during which the effects of favorable selection far exceeded these risk-score differences. Consistent with prior MedPAC research (Medicare Payment Advisory Commission 2012), this suggests that MA enrollees have lower spending relative to FFS enrollees with the same set of chronic conditions.

Estimating the overall effect of favorable MA selection

While the conventional approach of examining FFS spending prior to MA entry suggests favorable selection when beneficiaries first enroll in MA, it does not provide an estimate of the overall impact of favorable selection on the FFS spending estimates used for MA benchmarks in any given year. The conventional approach can be limited because it does not account for subsequent changes that can either increase or reduce favorable selection. Figure 13-7 (p. 444) shows how the estimate of favorable selection for the 2017 cohort of MA entrants could change between 2017 and 2021.

**FIGURE
13-6**

Beneficiaries' FFS spending in the year before MA enrollment suggests favorable selection into MA from 2007 to 2021



Note: FFS (fee-for-service), MA (Medicare Advantage). MA entrants are beneficiaries who switched from FFS to MA. FFS stayers are beneficiaries who remained in FFS. Spending reflects the year prior to MA entry and is risk standardized. Lower MA entrant spending relative to FFS stayers reflects a greater effect of favorable selection. The analysis excludes beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the year of MA entry as well as those who joined a non-MA private plan (e.g., cost plan), had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico (due to the relatively small number of FFS beneficiaries in that territory).

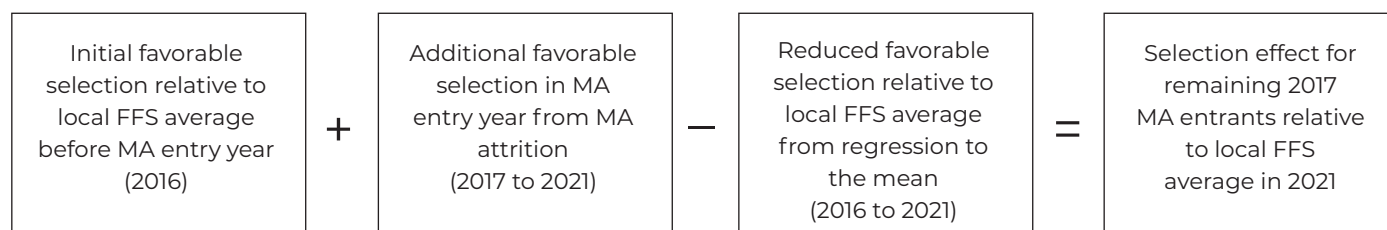
Source: MedPAC analysis of Medicare enrollment (2006–2022), Medicare claims spending (2007–2021), and risk-adjustment files (2007–2021).

The effect of favorable selection for a cohort of MA enrollees is potentially affected by both attrition out of MA over time and the convergence of risk-standardized spending for the beneficiaries who remain in the MA cohort toward the annual average risk-standardized spending. Estimates of the overall effects of favorable selection need to account for both factors.

- After the initial year of MA entry, some enrollees will either return to FFS or die. Because beneficiaries who leave MA or die are likely to have high utilization of services, the attrition in MA enrollment likely increases favorable selection for MA plans. Thus, the selection percentage that we calculated for the initial year of MA entry (shown in Figure 13-6) must be adjusted to reflect the population that is still enrolled in MA in later years.
- While a cohort of MA enrollees may have favorable risk-adjusted spending relative to the local FFS population when they first enter MA, the effect of favorable selection may become smaller in later years. This concept is often referred to as “regression to the mean,” but previous studies have largely assumed it occurs rather than measured it directly.²² Regression to the mean assumes that the effects of favorable selection will decline over a period of time because the growth in spending for MA enrollees will exceed their growth in risk scores during their enrollment (independent of the effects of coding differences and any plan interventions). To the extent that risk scores of MA entrants grow at the same rate as their spending, the effect of favorable selection of MA entrants will not decline (i.e., there will be no regression to the mean).

**FIGURE
13-7**

Illustration of the components that determine the net amount of favorable selection in 2021 for remaining MA entrants from 2017



Note: MA (Medicare Advantage), FFS (fee-for-service). Favorable selection is the percentage of risk-standardized spending below the local FFS average prior to any MA efficiencies or coding. Attrition of MA enrollment reflects the beneficiaries who were not continuously enrolled in MA from 2017 through at least the first month of 2021. The effects of attrition and regression to the mean can be either positive or negative.

Source: MedPAC.

These two factors work in opposite directions: Attrition due to beneficiaries leaving MA or dying tends to reinforce (or possibly increase) favorable selection, while regression to the mean tends to reduce favorable selection. On net, however, the effects of favorable selection may remain roughly constant, increase, or decrease over time for a given cohort of MA entrants.

In our June 2023 report to the Congress, we estimated the cumulative effect of favorable selection for all MA enrollees in 2019. In this chapter, we estimate the cumulative effect of favorable selection on MA benchmarks in each year from 2017 through 2021. To make this estimate, we largely aligned our approach to estimating favorable selection with CMS's method for calculating FFS spending in order to construct MA benchmarks, which are based on risk-standardized county-level averages of FFS spending.

Our approach for measuring overall favorable selection accounts for both the attrition of MA enrollees and the potential for spending on the remaining MA enrollees to converge toward the mean of the MA average (rather than the FFS average).

- First, we accounted for the subsequent attrition of beneficiaries who either died or switched back to FFS by estimating the selection percentages for the subset of each MA entry cohort who were continuously enrolled in MA through each

measurement year (2017, 2018, 2019, 2020, and 2021). For example, we compared the 2016 FFS spending of beneficiaries who switched to MA in 2017 and remained in MA through 2021 with the 2016 FFS spending of beneficiaries who remained in FFS in 2017.

- Second, we estimated the “regression to the mean” effect of MA enrollees by measuring the change in the selection percentage during MA enrollment from the base year (i.e., the year prior to MA entry) through the measurement year. To estimate regression to the mean, we used the spending history (going back to 2007) of proxy cohorts of FFS beneficiaries who entered MA in the year immediately after the measurement year (2018, 2019, 2020, 2021, or 2022).
- For example, we estimated the base-year selection percentage by comparing the 2016 FFS spending of beneficiaries who were in FFS from 2015 through 2021 and enrolled in MA in 2022 with the 2016 FFS spending of all other beneficiaries who were in FFS from 2015 through 2016 (and did not enter MA in 2016).
- For the same set of beneficiaries who were in FFS from 2015 through 2021 and enrolled in MA in 2022, we estimated their measurement-year selection percentage by comparing their

FFS spending in 2021 with beneficiaries who were in FFS from 2020 through 2022 (and did not enter MA in 2022). The change in relative FFS spending from 2016 to 2021 was used to estimate the change in the selection percentage during the 2016 to 2021 period.

- We add this change in selection percentage to the initial selection percentage estimated for 2017 MA entrants who were continuously in MA through 2021. This step effectively trends forward the initial selection percentage of the 2017 MA entrants to 2021 (i.e., the years of MA enrollment).
- As a technical improvement to our method in the June 2023 report to the Congress, we aligned the initial selection percentage levels of the MA entrants and proxy cohorts before trending the selection percentage forward. We grouped the initial selection percentage of the MA entrants and the proxy cohort into 45 sub-cohorts based on their initial selection percentage.²³ For example, the 2017 MA cohort with an initial selection percentage between 0 percent and 5 percent (in 2016) had their selection percentage trended forward by the overall change in selection percentage from the proxy cohort with an initial selection percentage between 0 percent and 5 percent (in 2016).

Favorable selection in MA tends to increase when lower-spending enrollees remain in MA longer and higher-spending enrollees leave MA

An estimate of favorable selection solely among MA entrants is limited because it does not account for differences between the beneficiaries who subsequently leave MA (either through FFS enrollment or death) and those who remain enrolled. The starting selection percentage for any cohort of MA entrants will change based on who is still enrolled in MA (i.e., the population of MA entrants will always change over time). In addition to calculating any effect of regression to the mean, selection estimates must account for the effect of MA attrition. The initial selection percentage of a cohort of MA entrants in Figure 13-6 (p. 443) may not represent the amount of favorable selection in a future year. For example, the MA entry cohort in 2017 may have changed substantially by 2021. Thus,

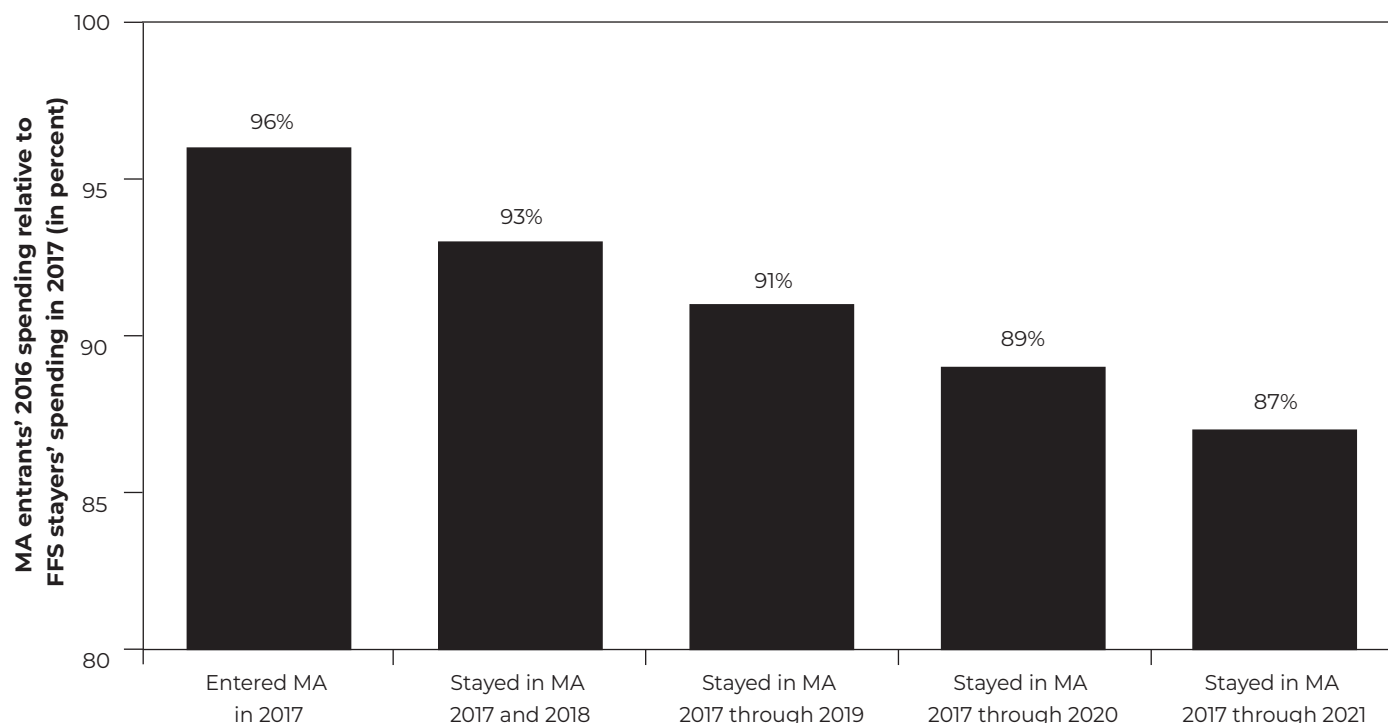
the initial favorable selection for 2017 MA entrants in the 2016 reference year (i.e., the selection percentage “starting point”) would have to be recalculated using only the MA entrants who were continuously in MA through 2021.

Prior research on disenrollment from MA to FFS While some MA enrollees die while being continuously enrolled in MA, a notable share disenroll from MA and enroll (or reenroll) in FFS. Studies following the same cohort of beneficiaries over several years show that over time, a larger share of beneficiaries switch from MA to FFS than would be apparent from a one-year snapshot of switching across all cohorts (Dong et al. 2022, Meyers and Trivedi 2022, Newhouse et al. 2019). One study examined the rate of switching for beneficiaries who were newly eligible for Medicare in 2008 and elected MA in that year; after 5 years, 19 percent of enrollees had switched to FFS at some point during the period, and the switching rate was somewhat higher (23 percent) among enrollees who initially switched from FFS to MA (Newhouse et al. 2019). Another study followed all MA entrants who had switched from FFS during the 2011 through 2019 period; this study similarly found that 23 percent of these beneficiaries switched back to FFS at some point within five years of MA enrollment (Meyers and Trivedi 2022). We identified all beneficiaries who entered MA in 2010 and followed their enrollment for a nine-year period. By 2019, 51 percent of MA entrants in 2010 remained continuously enrolled in MA, 31 percent switched to FFS at some point between 2011 and 2019, and an additional 18 percent died while enrolled in MA (data not shown).²⁴

While beneficiaries with full Medicaid benefits are increasingly likely to join an MA plan (Figure 13-1, p. 424), studies have shown that beneficiaries who are chronically ill, or beneficiaries who have nursing home use or high costs in their final year of life, are disproportionately likely to leave MA (Goldberg et al. 2017, Government Accountability Office 2021, James et al. 2023, Meyers et al. 2019, Rahman et al. 2015, Xu et al. 2023). Because these beneficiaries may be more likely to use more services relative to what their risk scores predict, we should expect the effects of favorable selection to increase at least somewhat when beneficiaries either leave MA for FFS or die (and thus are no longer compared with the local FFS average for benchmark purposes). If the beneficiaries who leave

**FIGURE
13-8**

2017 MA entrants who remained in MA through 2021 had lower pre-enrollment spending than the original cohort of 2017 MA entrants



Note: MA (Medicare Advantage), FFS (fee-for-service). MA entrants are beneficiaries who switched from FFS to MA. FFS stayers are beneficiaries who remained in FFS. MA entrants who stayed in MA through 2021 are those with at least one month of MA enrollment in 2021. Spending reflects the year prior to MA entry and is risk standardized. Lower MA entrant spending relative to FFS stayers reflects a greater effect of favorable selection. The figure excludes beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the year of MA entry as well as those who joined an employer plan or non-MA private plan (e.g., cost plan), elected hospice, had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico (due to the relatively small number of FFS beneficiaries in that territory). Because CMS-HCC risk scores prospectively rely on risk scores from the prior calendar year, we require two full years of FFS enrollment to help ensure comparability between beneficiaries who switched from FFS to MA and beneficiaries who stayed in FFS.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2015–2021.

an MA cohort have higher risk-standardized spending, over time, it could reinforce the effects of favorable selection and may even exacerbate those effects for several years after the cohort initially joined an MA plan.

Estimating the effect of MA attrition As we did with our previous analysis of cohorts of MA entrants, we estimated the effects of attrition by identifying the subset of beneficiaries in each cohort who remained in MA until the measurement year. For example, when measuring the 2021 selection effect in the 2017 cohort

of MA entrants, we identified the beneficiaries who were still enrolled in MA through the beginning of 2021. Thus, a beneficiary in that cohort who switched to FFS or died before 2021 would be excluded from the subset that was still enrolled in MA in 2021. We then recalculated the initial selection percentage for each subset of beneficiaries who remained in MA until the measurement year. Because favorable selection in MA benchmarks would always be relative to the local FFS average, the local FFS average continues to be our comparison group.

Consistent with our previous analysis, we found that beneficiaries who remained in MA for longer periods of time had lower risk-standardized FFS spending prior to their enrollment in MA than the beneficiaries who left MA (Figure 13-8). We analyzed sub-cohorts of the 2017 MA entry cohort based on the duration of their MA enrollment. While the full cohort of 2017 MA entrants had prior-year FFS spending that equaled 96 percent of the 2016 FFS average, the sub-cohort of 2017 MA entrants who remained in MA through 2021 had prior-year FFS spending that equaled 87 percent of the 2016 FFS average, while beneficiaries who left MA between 2016 and 2021 (and either returned to FFS or died) were substantially unfavorable to MA plans in 2016. These MA “leavers” had prior-year FFS spending that equaled 117 percent of the 2016 FFS average (data not shown). These analyses suggest that favorable selection for MA plans may increase over time, as favorable (lower-spending) beneficiaries tend to remain in MA while relatively unfavorable (higher-spending) beneficiaries tend to leave MA. This phenomenon effectively redefines the selection percentage “starting point” for an MA entrant cohort in future years as MA attrition increases. Thus, any estimate of favorable selection should account for the effect of MA attrition.

Across all cohorts, estimates of MA attrition suggest that more favorable MA enrollees remained in MA longer

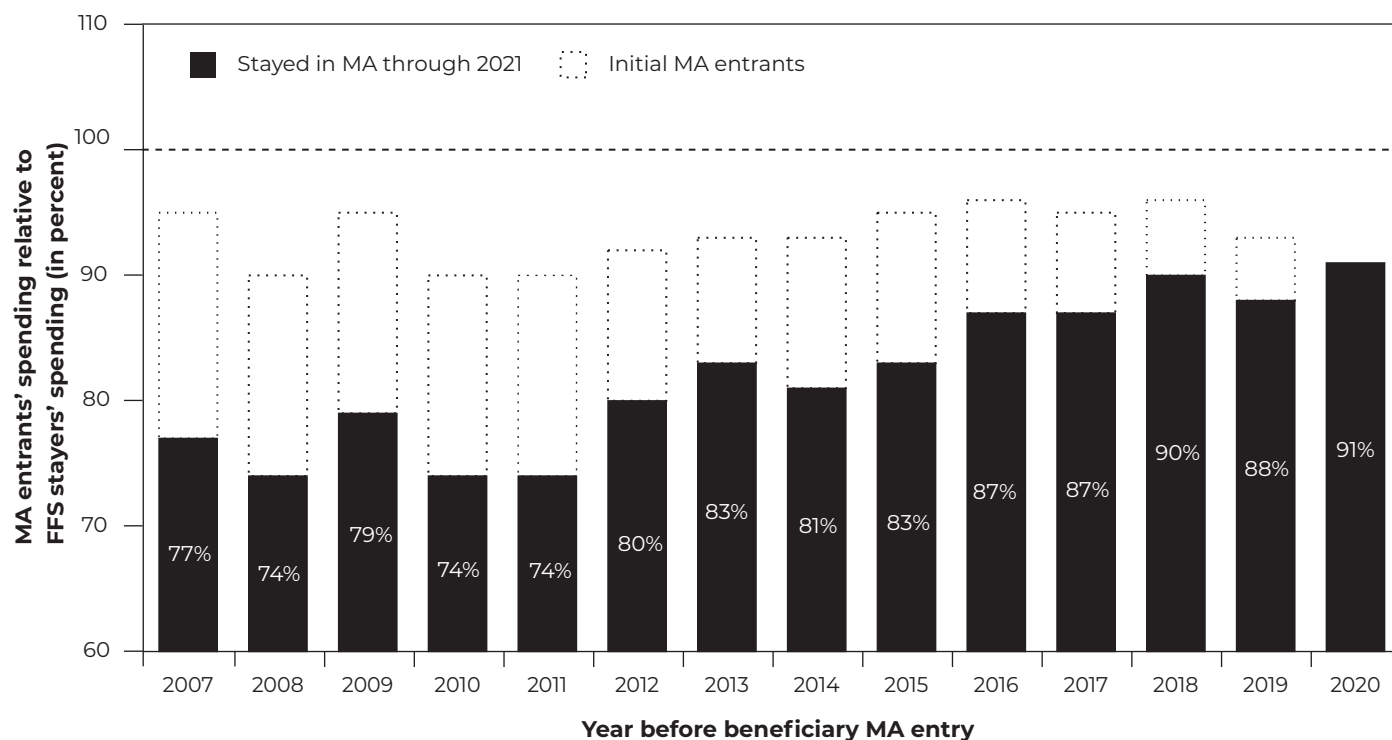
We recalculated the base-year selection percentage for each cohort of MA entrants in each measurement year to incorporate our estimates of attrition. Similar to the analysis shown in Figure 13-8 (which analyzed the effects of favorable selection for sub-cohorts of 2017 MA entrants), we examined the effects of favorable selection within each cohort of MA entrants from 2008 to 2020 by examining the pre-enrollment spending of the subset of enrollees who were still in MA in 2021 (and repeated this analysis for MA enrollees in 2017 to 2020). We estimate that, across all cohorts, MA entrants who remained enrolled in MA for longer periods had lower risk-standardized average spending in the year prior to joining MA (Figure 13-9, p. 448), well below the levels observed for all MA entrants (as shown in Figure 13-6, p. 443). By contrast, we estimate that MA enrollees who disenrolled or died prior to 2021 had average spending either near or above the FFS local average in the year prior to joining an MA plan (data not shown). The differences in the favorable selection starting point (i.e., at the time of MA entry) appear greater for

beneficiaries in earlier years because we estimate that the effects of attrition increase over time.

Estimating changes in favorable selection from regression to the mean for beneficiaries who remain enrolled in MA

One limitation of the conventional approach to measuring favorable selection based on prior FFS spending is that it focuses on selection at the time of MA entry. Favorable selection may change while beneficiaries are enrolled in MA, but we cannot directly measure those changes due to the lack of beneficiary-level spending data for MA enrollees. Even if that data were available, the analysis would be limited because MA enrollee risk scores would be affected by plans’ benefit design, utilization management, and diagnostic coding practices. Prior research implies that the effects of favorable selection will “regress to the mean” such that favorable selection essentially fades away; however, the regression to the mean assumption had never been tested until the Commission’s June 2023 report estimated the historical change in FFS spending for cohorts of 2020 MA entrants. We created non-mutually exclusive cohorts that were conditioned on continuous FFS enrollment through 2019. We found that all cohorts—irrespective of how long they had been in FFS prior to enrolling in MA—regressed to nearly the same selection percentage (94 percent to 95 percent) in 2019. For example, even beneficiaries with at least 13 consecutive years in FFS had a selection percentage of 95 percent in 2019. Thus, historical trends of MA entrants suggest that we would expect MA entrants—after attrition—to regress to the MA mean over time. We would not expect MA entrants to regress to the mean of the FFS population, which consistently shows patterns of higher risk-standardized spending.

We calculated the net selection effect for each MA entry cohort (going back to MA entrants in 2008) that was still enrolled in MA in a given measurement year. (See Figure 13-7, p. 444, for an illustration of the net selection-effect calculation of one cohort that accounts for attrition and regression to the mean.) The cumulative selection effect for all cohorts in one measurement year is equal to the enrollment-weighted sum of each cohort’s net selection effect. Therefore, to estimate the cumulative selection effect for each measurement year (2017, 2018, 2019, 2020, and 2021), we approximated the net change in favorable selection

**FIGURE
13-9****Beneficiary spending in the year before MA suggests greater favorable selection for enrollees who stayed in MA through 2021**

Note: MA (Medicare Advantage), FFS (fee-for-service). MA entrants are beneficiaries who switched from FFS to MA. MA entrants who stayed in MA through 2021 are those with at least one month of MA enrollment in 2021. Beneficiaries who left MA after the entry year either returned to FFS or died during the period. Spending reflects the year prior to MA entry and is risk adjusted. Lower MA entrant spending relative to FFS stayers reflects a greater effect of favorable selection. The analysis excludes beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the year of MA entry as well as those who joined an employer plan or non-MA private plan (e.g., cost plan), had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico (due to the relatively small number of FFS beneficiaries in that territory).

Source: MedPAC analysis of Medicare enrollment (2006–2022), Medicare claims spending (2007–2021), and risk-adjustment files (2007–2021).

for the applicable cohorts of MA entrants from 2008 to 2021 while they were enrolled in MA by looking at the past experience of a proxy group of beneficiaries who entered MA in the year immediately after the measurement year (2018, 2019, 2020, 2021, or 2022) but had FFS coverage for many years before that. We calculated the change in the selection percentage for those beneficiaries during those prior years of FFS enrollment and assumed that the selection percentage for beneficiaries who were in MA during the same period changed by the same amount (after adjusting for differences in the distribution of the initial selection

percentage, as described earlier). This approach estimates the degree of regression to the mean for enrollees in MA by using a proxy population that likely had coverage preferences that were similar to MA cohorts' preferences in terms of coverage (i.e., they had historically favorable risk-standardized spending and eventually chose to enroll in MA) and for which we have complete spending data. Although we cannot directly measure the effects of favorable selection during MA enrollment, using this proxy population has several advantages:

- It estimates favorable selection independent of the effects of MA plan efficiencies and coding.
 - It reflects the observation that MA entrants have favorable risk-adjusted spending in the years prior to joining an MA plan, as estimated in Table 13-4 (p. 452).
 - It estimates the change in favorable selection for the proxy group of future MA entrants who had favorable risk-standardized spending prior to MA entry.
 - It measures the relative change in selection percentage over the same period of time that the cohort of earlier MA entrants remained in MA.
 - It reflects the same FFS spending, risk score, and MA entrant eligibility criteria for both the proxy group of future MA entrants and the actual cohort of earlier MA entrants; these criteria are applied to both the MA entry year and the measurement year.
 - Similar to the method used to calculate MA benchmarks, it accounts for the geographic differences between MA and FFS, which also account for the geographic variation in risk-score prediction of the CMS-HCC model.
 - As a technical revision to our June 2023 report, using the proxy population aligns the initial estimated selection percentage levels of the MA entrants and proxy cohorts so that they have similar starting points.
 - Because the change in favorable selection is indexed to a change in selection percentage and because risk scores account for differences in demographic characteristics (e.g., age, sex, Medicaid eligibility), our proxy population serves as a reasonable estimate for the change in favorable selection for each additional year of MA enrollment.
 - Our proxy population are future MA entrants who, when faced with similar incentives for choosing to enroll in MA or FFS, ultimately selected an MA plan—indicating that they likely had preferences that were similar to the beneficiaries' preferences in the earlier MA entry cohorts. (See text box describing the plan and beneficiary incentives that may lead to favorable MA selection, pp. 436–437.)
 - Our proxy population reflects the propensity of MA enrollees to regress to the mean of the MA population rather than to a FFS population that includes beneficiaries who may never enroll in MA. This decision was informed by the differences that persist between the MA and FFS decedent populations, which suggest that the MA population would not likely regress to the mean of the FFS population.²⁵ (See text box describing our sensitivity analyses to address unobservable data, pp. 455–457.)
- Figure 13-10 (p. 450) illustrates how we approximated the change in selection percentage for the 2017 cohort of MA entrants who were continuously enrolled in MA through the beginning of 2021:
- We identified a proxy group of beneficiaries in the 2022 cohort of MA entrants who had both Part A and Part B and were enrolled in FFS from 2015 through 2021. As a result, this subset met the same criteria as the 2017 cohort of MA entrants, except they remained in FFS through 2021 (step 2).
 - We estimated the selection percentage (i.e., spending relative to the risk-adjusted local FFS average) for this subset of 2022 MA entrants in 2016 (the spending reference year for the 2017 cohort of MA entrants) and 2021 (step 2).
 - We grouped the initial selection percentage of each beneficiary in the 2017 MA cohort and each beneficiary in the proxy group into 45 sub-cohorts based on their initial selection percentage (step 3).
 - Within each sub-cohort of initial selection percentage, we calculated the overall change in selection percentage for the subset of 2022 MA entrants over the period from 2016 through 2021. This calculation measures the change in the effect of favorable selection over time (i.e., regression to the mean) for a group of beneficiaries that is comparable with the 2017 MA entry cohort (step 4).
 - If the selection percentage increased, the effect of favorable selection decreased during the period; if the selection percentage decreased, the reverse was true (step 4).

**FIGURE
13-10****Illustrative example estimating net favorable selection
in 2021 for the 2017 cohort of MA entrants**

Step 1: For each beneficiary in the 2017 cohort who was continuously enrolled in MA through 2021, estimate the initial selection percentage in the pre-entry MA year. The requirement for continuous MA enrollment accounts for the attrition shown in Figure 13-9.

$$\text{Selection percentage in 2016} = \frac{\text{MA pre-entry spending}}{\text{Local area FFS average: Risk-standardized FFS spending (adjusted by MA months and risk score)}} = 87\% \text{ (overall)}$$

Step 2: Using the historical FFS spending of 2022 MA entrants as a proxy (for changes in favorable selection during MA enrollment), estimate the relative spending for each proxy beneficiary in the base year (2016) and the measurement year (2021).

	Inclusion criteria	Spending year(s)
MA cohort	2015–2016 FFS enrollment & 2017–2021 MA enrollment	2016
T ₁ comparator	2015–2016 FFS enrollment & no MA entry in 2017	2016
Proxy cohort	2015–2021 FFS enrollment & 2022 MA entry	2016; 2021
T ₁ proxy comparator	2015–2016 FFS enrollment & no MA entry in 2017 & 2022	2016
T ₂ proxy comparator	2020–2022 FFS enrollment & no MA entry in 2017 & 2022	2021

Step 3: Assign the initial selection percentage of each beneficiary in the 2017 MA cohort and each beneficiary in the proxy group into 45 sub-cohorts based on their initial selection percentage in 2016.

Step 4: Estimate the overall change in selection percentage within each proxy group sub-cohort and apply the selection percentage change to the MA cohort beneficiaries in each initial selection percentage sub-cohort.

$$\text{Proxy selection percentage in } T_1 = \frac{\text{Proxy } T_1}{\text{Comparator } T_1} \quad \text{Proxy selection percentage in } T_2 = \frac{\text{Proxy } T_2}{\text{Comparator } T_2}$$

$$\triangle = T_2 \text{ selection percentage} - T_1 \text{ selection percentage} = +2\% \text{ (adjusted for the initial selection percentage of the MA cohort)}$$

Step 5: Estimate net favorable selection in 2021 for the 2017 MA cohort.

$$\begin{array}{|c|} \hline \text{Step 1 result} \\ \hline \text{2016 initial} \\ \text{selection percentage} \\ \hline (87\%) \\ \hline \end{array} + \begin{array}{|c|} \hline \text{Step 4 result} \\ \hline \text{2016–2021 expected change} \\ \text{in selection percentage} \\ \hline (+2\%) \\ \hline \end{array} = \begin{array}{|c|} \hline \text{Estimated 2021} \\ \text{selection percentage} \\ \text{for 2021 MA cohort} \\ \hline (89\%) \\ \hline \end{array}$$

Note: MA (Medicare Advantage), FFS (fee-for-service), T₁ (time period 1 = 2016), T₂ (time period 2 = 2021). Analyses exclude beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the years of MA entry (2017 and 2022) as well as those who joined a non-MA private plan (e.g., cost plan), had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico (due to the relatively small number of FFS beneficiaries in that territory). The 2022 MA entrants (proxy cohort) are mutually exclusive of the comparator groups of FFS enrollees. Comparator spending reflects the county-level average, adjusted by the geographic and risk-score distribution of the MA cohort in step 1 and the proxy cohort in step 2. The selection percentage reflects the risk-standardized spending below the local FFS average prior to any MA efficiencies or coding differences. Lower MA entrant spending relative to FFS stayers reflects a greater effect of favorable selection. Totals and differences may not sum due to rounding in step 5.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2015–2022.

- We then estimated the effect of favorable selection in 2021 for the 2017 cohort of MA entrants who remained in MA through 2021 by adding the initial selection percentage for each beneficiary in the cohort to the change in the selection percentage from 2016 to 2021 that we calculated for the subset (i.e., proxy group) of 2020 MA entrants with the same initial selection percentage (i.e., within the same sub-cohort of initial selection percentage) (step 5).

For measurement year 2021, we repeated the steps above for each of the 2008–2021 cohorts of MA entrants. The subsets of beneficiaries from the 2022 cohort of MA entrants that we used to calculate the change in the selection percentage were not mutually exclusive. For example, a beneficiary in the 2022 cohort of MA entrants who was in FFS from 2017 through 2021 would be in the subsets of beneficiaries that we used to estimate the change in favorable selection for the 2018, 2019, 2020, and 2021 cohorts of MA entrants.

After we estimated the initial selection percentages for the 2008 to 2021 cohorts of MA entrants, we trended those figures forward to 2021 using the methodology illustrated in Figure 13-10. These trends include a technical improvement from our June 2023 report in which we also trend forward the 2020 selection percentage of 2021 MA entrants to 2021 (rather than assuming their selection percentage would be unchanged in 2021). We then estimated the overall effect of favorable selection in MA in 2021 by calculating the enrollment-weighted average of the trended selection percentages for each cohort. In our calculation, we assumed that the effect of favorable selection for MA enrollees who joined prior to 2008 (which we did not estimate) was the same as the amount for the 2008 cohort. When we calculated the enrollment weights for each cohort, we excluded any beneficiaries who had at least one month during which they had end-stage renal disease or Medicare acted as a secondary payer.

The pre-MA enrollment spending history of MA entrants suggests favorable selection persists throughout the duration of MA enrollment

The extent to which favorable selection for 2021 MA enrollees persisted depends largely on how much the selection percentage changed after initially enrolling in MA.²⁶ For MA entrants from 2018 through 2022, we retrospectively examined several prior years of

their FFS spending to assess whether lower risk-standardized spending is persistent over time. If lower risk-standardized spending persists, then favorable selection among MA enrollees is likely to be found across all years of their MA enrollment.

We analyzed cohorts of MA entrants from 2018 through 2022 based on the number of consecutive years of FFS enrollment prior to joining MA and compared them with the remaining beneficiaries in FFS. We retrospectively calculated the selection percentage for each MA entrant cohort while they were in FFS. Across all years and cohorts, MA entrants systemically exhibited favorable risk-standardized spending in multiple years prior to joining MA (Table 13-4, p. 452). For example, among beneficiaries who entered MA in 2018, their risk-standardized spending was 95 percent of the local FFS average one year before MA entry, 91 percent of the local FFS average two years before MA entry, 91 percent of the local FFS average five years before MA entry, and 87 percent of the local FFS average 10 years before MA entry. In fact, all MA entrants from 2018 to 2022 had a selection percentage between 86 percent and 89 percent 10 years before they enrolled in an MA plan. In all instances, the average beneficiary with at least 10 consecutive years of FFS enrollment was also favorable in the year before MA entry (data not shown). These results suggest that MA entrants not only show evidence of favorable selection in the year prior to joining MA, they have a history of lower risk-standardized spending several years before entering MA. These analyses suggest that the effects of favorable selection persist in the absence of any intervention from MA plans.

Results suggest that MA payments were overestimated by 13 percent in 2021 due to favorable selection

To estimate the cumulative annual impact of favorable selection on spending for MA enrollees from 2017 to 2021, we combined our estimates of favorable selection in the year prior to joining MA (accounting for MA enrollment attrition in the measurement year) with estimates of the change in the level of favorable selection over time (accounting for regression to the mean). Figure 13-9 (p. 448) shows the estimates of risk-standardized spending relative to risk-standardized spending for FFS stayers in the year prior to joining MA for the 14 MA entry cohorts (2008 through 2021) for our 2021 estimate. These cohorts were continuously

**TABLE
13-4**

For 2018–2022 MA entrants, the estimated effects of favorable selection were persistent across all prior years of FFS enrollment

Selection percentage, by years prior to MA entry

MA entry year	1 year	2 years	5 years	10 years
2018	95%	91%	91%	87%
2019	95	92	92	89
2020	92	91	90	88
2021	91	90	88	86
2022	90	89	88	89

Note: MA (Medicare Advantage), FFS (fee-for-service). MA entrants are beneficiaries who switched from FFS to MA. The selection percentage is derived by taking the spending of MA entrants divided by the local area average spending of FFS stayers (i.e., beneficiaries who remained in FFS). Spending is risk standardized. Lower MA entrant spending relative to FFS stayers reflects a greater effect of favorable selection. The analysis excludes beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the year of MA entry as well as those who joined a non-MA private plan (e.g., cost plan), had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico (due to the relatively small number of FFS beneficiaries in that territory).

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2006–2022.

enrolled in MA through 2021 and therefore accounted for the effects of attrition. To account for regression to the mean, we trended these estimates of favorable selection using the cohorts of 2022 MA entrants' change in risk-standardized spending relative to FFS stayers in Table 13-5.²⁷ We matched the initial favorable selection estimates by MA entry-year cohort with the cohort of 2022 MA entrants based on years of consecutive FFS enrollment (Table 13-5). This matching uses the change in risk-adjusted FFS spending for 2022 MA entrants relative to FFS stayers as a proxy for the change in favorable selection for MA enrollees that would have occurred during their MA enrollment. After matching each MA entry cohort to its expected change in selection percentage, we found that the estimate for all cohorts converged closely toward the 2021 selection percentage of 2022 MA entrants (90.3 percent) (data not shown).

By taking the enrollment-weighted sum across all cohorts, we estimate that beneficiaries in MA plans in 2021 had spending that was approximately 11.4 percent lower than the spending of beneficiaries in FFS with the same risk scores (i.e., their risk-standardized spending was 88.6 percent of the FFS-stayer comparison population). In addition, our sensitivity analyses of the

population that did not meet our inclusion criteria (i.e., two prior years of FFS spending) indicate that including this population would not decrease our estimate of favorable selection. (See text box on our sensitivity analyses of unobservable data, pp. 455–457.) Thus, because beneficiary risk scores do not fully account for the local area spending differences between the FFS and MA populations (prior to the effects of differences in coding practices between MA and FFS), we estimate that MA payments were increased by approximately 12.8 percent (100 percent divided by 88.6 percent) due to favorable selection alone.

We estimated the trend in the annual impact of favorable selection from 2017 to 2021. To make this estimate, we repeated the analytic steps that generated Table 13-5 to estimate the cumulative selection in each year from 2017 to 2021 (using cohorts of MA entrants and proxy groups that tracked spending relative to the local FFS average beginning in 2007). We estimate that the cumulative annual effect of favorable selection increased from spending 6 percent below FFS in 2017 to spending 11 percent below FFS in 2021 (Figure 13-11, p. 454). We estimate that about one-fifth of this increase was due to the effects of attrition. These estimates equate to payments that were 6 percent above FFS

**TABLE
13-5****Estimated favorable selection implied substantially lower risk-standardized spending for MA enrollees in 2021**

MA entrant	(Consecutive years in MA) MA entrant year													
	(14) 2008	(13) 2009	(12) 2010	(11) 2011	(10) 2012	(9) 2013	(8) 2014	(7) 2015	(6) 2016	(5) 2017	(4) 2018	(3) 2019	(2) 2020	(1) 2021
Spending relative to FFS stayers	77%	74%	79%	74%	74%	80%	83%	81%	83%	87%	87%	90%	88%	91%
Approximate change in selection percentage while in MA	10%	13%	9%	14%	14%	8%	6%	8%	6%	2%	3%	0%	2%	-2%
Selection percentage trended forward to 2021	87%	87%	88%	88%	88%	88%	89%	89%	89%	89%	89%	90%	89%	88%
Overall plan spending relative to 2021 average across 14 cohorts (enrollment weighted)														88.6%
Overall impact on MA payments relative to FFS spending (100% divided by 88.6%)														12.8%

Note: MA (Medicare Advantage), FFS (fee-for-service). MA entrants are beneficiaries who switched from FFS to MA. FFS stayers are beneficiaries who remained in FFS. MA entrants who stayed in MA through 2021 are those with at least one month of MA enrollment in 2021. Spending reflects the year prior to MA entry and is risk adjusted. Lower MA entrant spending relative to FFS stayers reflects a greater effect of favorable selection. The analysis excludes beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the year of MA entry as well as those who joined a non-MA private plan (e.g., cost plan), had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico (due to the relatively small number of FFS beneficiaries in that territory). The approximate change in relative risk-standardized spending is based on the historical experience of beneficiaries with continuous years of FFS enrollment before entering MA in 2022. This historical experience is used to trend forward the selection percentage of each MA entry cohort. Estimates for 2008 are used for enrollees who entered MA prior to 2008. Totals may not sum due to rounding.

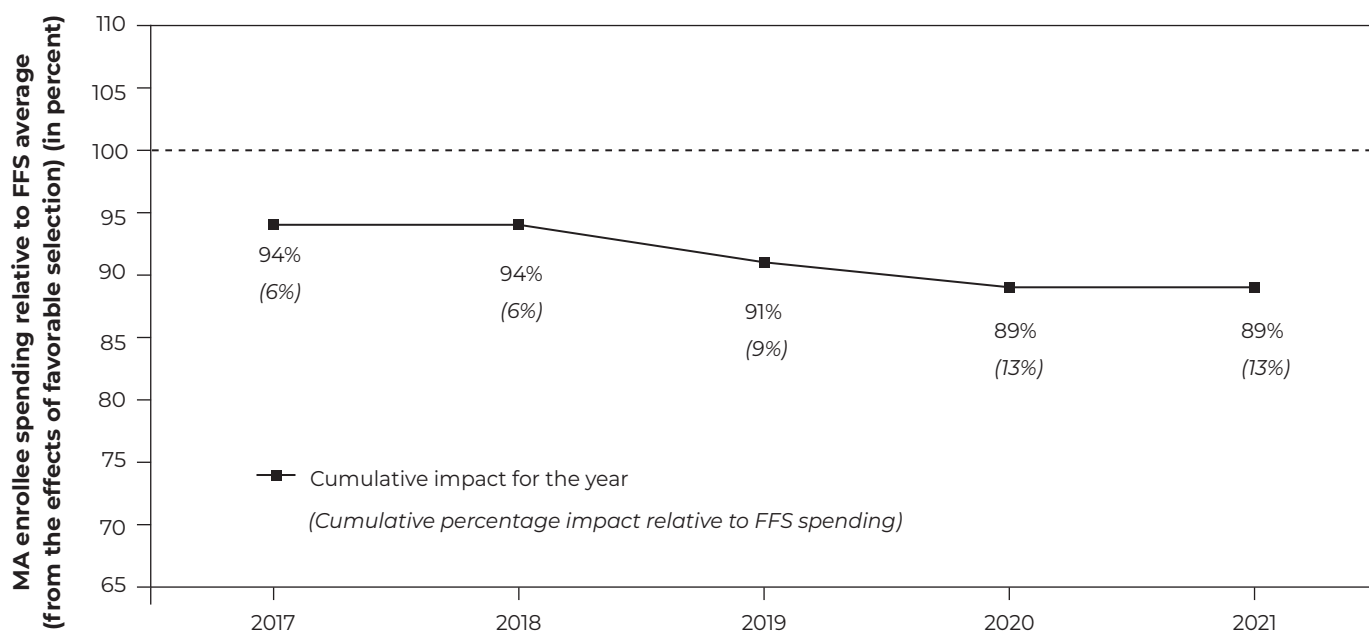
Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2006–2022.

spending in 2017 and 13 percent above FFS spending in 2021. In addition, the technical improvements to our June 2023 report (described earlier) decreased our overall 2019 selection estimate by 2 percentage points (a selection percentage that changed from 89.5 percent to 91.5 percent). Further, the overall selection percentage in each year during the 2017 to 2021 period was similar to the reference-year selection percentage of MA entrants from 2018 to 2022 (reflecting spending from 2017 to 2021). For example, the overall selection percentage in 2020 was 88.8 percent compared with the 2020 reference-year selection percentage of 90.6 percent for 2021 MA entrants. Thus, the selection

percentage of prior MA entrants regressed to the mean of the most recent MA entrant population rather than the mean of the most recent FFS population. This finding suggests that favorable selection will likely persist in future years rather than converge toward the FFS average.

The Commission's revised method of estimating favorable selection appears reasonably robust

Prior research has shown evidence of favorable selection in MA. Despite differences in analytic method and years evaluated, we estimate a generally similar

**FIGURE
13-11****Estimate of cumulative favorable selection increased from 2017 to 2021**

Note: MA (Medicare Advantage), FFS (fee-for-service). Spending is risk standardized and reflects differences due to favorable selection alone (prior to any intervention from MA plans). Lower MA entrant spending relative to FFS stayers reflects a greater effect of favorable selection. The analysis excludes beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the measurement year as well as those who joined a non-MA private plan (e.g., cost plan), had end-stage renal disease, had Medicare as a secondary payer, or resided in Puerto Rico (due to the relatively small number of FFS beneficiaries in that territory). Estimates incorporate the historical experience of beneficiaries with continuous years of FFS enrollment before entering MA. Estimates are rounded to the nearest percent.

Source: MedPAC analysis of Medicare enrollment (2006–2022), Medicare claims spending (2007–2021), and risk-adjustment files (2007–2021).

magnitude of impact as in prior studies. Further, our estimate has been reasonably robust as we have continued refining our approach. Like our June 2023 report, our analysis suggests that favorable selection in MA is likely to persist rather than regress to the mean of the FFS population, as has been posited by other researchers. First, enrollees who have more unfavorable (or less favorable) spending at the time of MA entry are more likely to either die or leave MA sooner, thereby reinforcing the effects of favorable selection among remaining MA enrollees. Second, our analysis suggests that lower risk-standardized spending is persistent over time in the years prior to MA entry. Although the effects of favorable selection (after accounting for attrition) can subside, the rate of decline is slow and generally converges toward the mean of the average MA entrant, such that at the time of joining MA, beneficiaries still have lower risk-

standardized spending than beneficiaries remaining in FFS. Third, our analysis studied spending patterns over a much longer time period than other studies and found consistent evidence of favorable selection among MA entrants and consistent evidence that this effect persists over time. Chapter 12 provides our current estimates of the effects of favorable selection and its impact on payments to MA plans, as well as discussion of the Commission's past recommendations to improve the program.

We continue to conduct sensitivity analyses of certain aspects of our method, particularly related to how our analysis deals with regression to the mean and attrition of beneficiaries from MA cohorts. To the extent that these sensitivity analyses suggest that our methods require further refinements, we will incorporate those refinements in future analyses. ■

Sensitivity analyses to address unobservable data in our favorable selection estimates

Our approach of estimating favorable selection by using FFS spending prior to enrolling in MA assumed that the effect of favorable selection for the Medicare Advantage (MA) entrants who were not in our study population was the same as for the MA entrants who were in our study population. Primarily, we did not estimate the effect of favorable selection for MA enrollees with less than two full calendar years of prior fee-for-service (FFS) coverage. As a secondary issue, we were not able to include an estimate of favorable selection during the year of death for any MA enrollees. These two assumptions may tend to underestimate the extent of favorable selection because of the design of our analysis, the consistent evidence of favorable selection prior to beneficiaries enrolling in MA (see Table 13-4, p. 452, and Table 13-5, p. 453), and the results from sensitivity analyses that we conducted.

Beneficiaries with less than two years of prior FFS coverage

Based on available evidence, we expect that MA enrollees with less than two years of prior FFS coverage would have a larger effect of favorable selection than MA enrollees with at least two years of prior FFS coverage. As a sensitivity analysis, we examined the effect of favorable selection for beneficiaries who had only one full year of prior FFS enrollment (and thus had a full year of FFS spending). These beneficiaries did not have risk scores that included diagnostic information in the reference year (i.e., the year prior to MA entry), so we instead calculated their risk-standardized spending in the reference year using risk scores during the MA entry year. This relatively “concurrent” risk score reflects diagnoses from the reference year and demographic information from the MA entry year. We found that the effect of favorable selection was consistently greater for these beneficiaries than those who had at least two years of FFS enrollment before joining MA (Figure 13-12, p. 456). This finding is consistent with a study that used mortality as a rough proxy for

MA favorable selection (i.e., to the extent that the prevalence of conditions that affect mortality are correlated with selection) and found substantially lower mortality rates among enrollees that elected MA during their first year of Medicare eligibility (Newhouse et al. 2019).²⁸ The study found mortality differences that somewhat diminished but persisted after five years. However, the study did not consider whether these differences diminished because of beneficiaries who switched from MA to FFS (19 percent to 22 percent of beneficiaries in the study’s cohorts) and switched from FFS to MA (9 percent to 12 percent of beneficiaries in the study’s cohorts) during the study period. In addition, one recent study found that a small sample of beneficiaries who elected MA at age 65 had substantially favorable pre-Medicare risk-standardized spending relative to the pre-Medicare spending of beneficiaries who elected FFS at age 65 (Teigland et al. 2023a).²⁹ Our analysis combined with the results of other research suggests that the effect of favorable selection for MA entrants who had less than two years of prior FFS coverage, or none at all, may also be larger than what we observed in our study population.

In addition, our estimate of favorable selection does not include beneficiaries with one full year of FFS who were previously enrolled in MA. We examined one year of spending data for these beneficiaries and applied risk-adjusted spending using risk scores in the year after FFS entry (avoiding any effect from MA coding intensity). We found that beneficiaries who were in FFS in 2018 but had been in MA in 2017 had average spending per capita that was 19 percent higher than our FFS comparison population. Thus, if we had included these MA-to-FFS switchers in our comparison population, our estimate of favorable selection may have been larger.

Favorable selection during the year of death

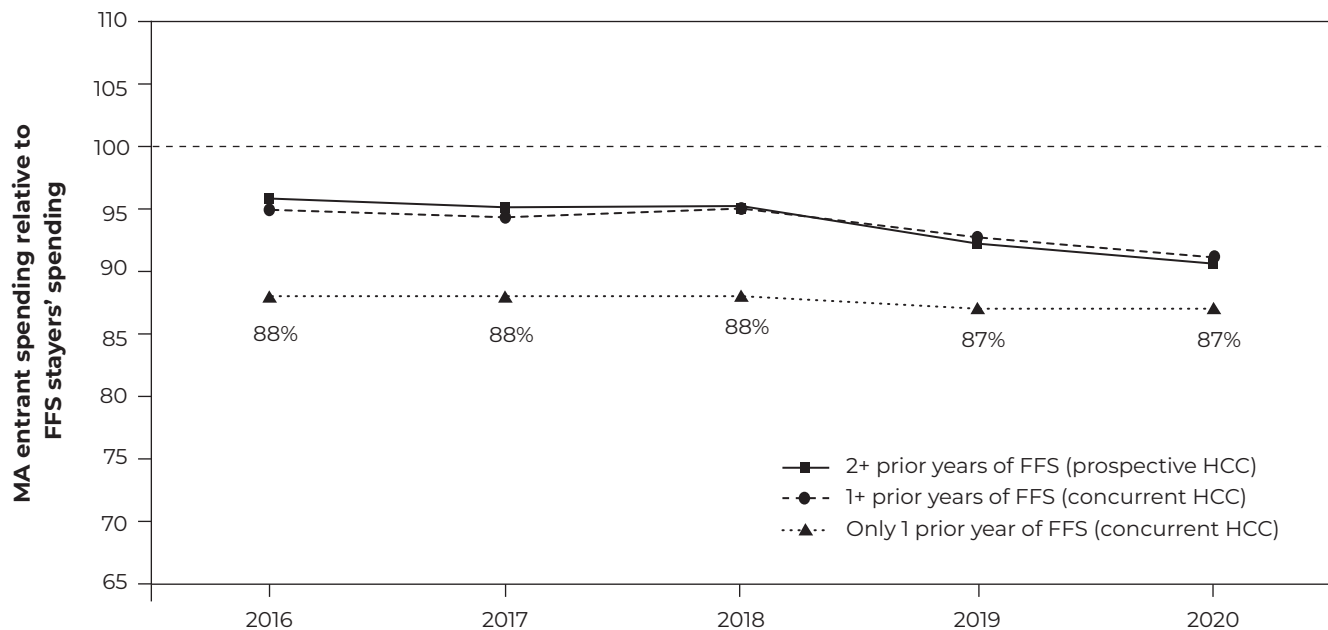
Based on available evidence, we expect that including a favorable selection effect during the

(continued next page)

Sensitivity analyses to address unobservable data in our favorable selection estimates (cont.)

**FIGURE
13-12**

Beneficiaries with only one year of prior FFS spending likely had a large favorable selection effect



Note: FFS (fee-for-service), MA (Medicare Advantage), HCC (hierarchical condition category). MA entrants are beneficiaries who switched from FFS to MA. Beneficiaries who left MA after the entry year either returned to FFS or died during the period. Spending reflects the year prior to MA entry and is risk adjusted. Lower MA entrant spending relative to FFS stayers' spending reflects a greater effect of favorable selection. All analyses exclude beneficiaries without at least one full year of enrollment in FFS Part A and Part B prior to the year of MA entry as well as those who joined a non-MA private plan (e.g., cost plan), had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico (due to the relatively small number of FFS beneficiaries in that territory). Analyses that require only one full year of enrollment in FFS Part A and Part B were risk adjusted using CMS-HCC risk scores in the year of MA entry (reflecting diagnoses in the year before MA entry).

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2006–2021.

year in which beneficiaries died (i.e., decedents) would not significantly change our overall results and may increase the effect of favorable selection. As a sensitivity analysis, we compared the share of enrollment months for beneficiaries who died in FFS or in MA in each year from 2017 to 2022, and we adjusted the FFS population to match the geographic distribution (i.e., county-level enrollment) of the MA population.³⁰ Overall, we find that the share of MA enrollment months among decedents is small

(less than 2 percent in each year) and that the share of MA decedent months is consistently smaller than the share of FFS decedent enrollment months. Because risk-standardized spending is somewhat higher among decedents relative to the overall Medicare population, the higher share of decedents in FFS would mitigate the potential for selective attrition in our estimates. In our sensitivity analyses, we did not observe any unfavorable selection among MA decedents (relative to FFS decedents) that would

(continued next page)

Sensitivity analyses to address unobservable data in our favorable selection estimates (cont.)

negate this potential additional favorable selection. Because the favorable selection implications are different for beneficiaries in hospice, we separately analyzed decedents who used hospice and decedents who did not.³¹

Hospice users

In each year, about half of the decedent enrollment months in each program are for beneficiaries in hospice. Because MA plans do not generally provide coverage for Part A and Part B benefits during the months an MA enrollee elects hospice, we would expect decedents who use hospice to contribute to greater favorable selection for MA plans during the months of hospice election.^{32,33} Our estimates of regression to the mean during MA enrollment cannot account for this type of favorable selection. In addition, although MA enrollees who elect hospice are not considered FFS enrollees during the months of their hospice use, we found consistently higher shares of decedents who used hospice in FFS compared with MA. For example, in 2022, there were 20 percent more hospice-user decedent months in FFS than MA (after adjusting for the number of MA enrollees in each county). Thus, to the extent that beneficiaries who used hospice and died had higher risk-standardized spending, including spending during the year of death would have potentially increased the effect of favorable selection in MA.

Nonhospice users

Among decedents who did not use hospice, we also consistently found higher shares of enrollment

months in FFS than MA. From 2017 to 2022, this difference in decedent months steadily narrowed. However, in 2022, there were 11 percent more nonhospice decedent months in FFS than MA (after adjusting for the number of MA enrollees in each county). Thus, unless MA nonhospice decedents had far more unfavorable spending relative to FFS nonhospice decedents, including the spending for these populations would have likely increased the effect of favorable selection. As a sensitivity analysis, we compared the pre-entry spending of MA nonhospice decedents with the spending of FFS nonhospice decedents. To capture spending that closely reflects the spending of decedents, we limited our analysis to beneficiaries who died within the first six months of the MA entry year. This choice limited our analysis to a small group of 2,000 to 3,000 MA decedents (measured in person-years during the year of death) in each year from 2017 to 2021. We found that risk-standardized decedent spending was larger than that of the general population, and these beneficiaries were consistently favorable for MA plans (relative to decedents in FFS). In addition, the MA selection percentage among these decedents was similar to the selection percentage for the general MA and FFS population. For example, the MA selection percentage among nonhospice decedents was 90 percent (the same as nondecedents) in 2021. The cumulative evidence therefore suggests that including these beneficiaries in our analysis would not have had a marked impact on our overall results, and would have likely marginally increased our estimate of favorable selection in MA. ■

Endnotes

- 1 The difference in MA and FFS risk scores was reduced relative to the prior year in 2014, 2016, and 2017 due to new versions of the risk-adjustment model that reduced the gap in MA and FFS diagnostic coding differences. In 2016 and 2017, there was less difference because FFS risk scores grew faster (matching or nearly matching MA risk score growth rates), likely due to Medicare's transition from using International Classification of Diseases (ICD)-9 to ICD-10 diagnosis codes in October 2015 (Medicare Payment Advisory Commission 2023c).
- 2 The coding intensity adjustment factor is applied to new enrollee, community, long-term institutional (LTI), and postgraft ESRD risk scores, but not ESRD risk scores for beneficiaries in dialysis or transplant status because those risk-score models use a different denominator. Excluding beneficiaries with LTI and postgraft ESRD risk scores is a minor limitation of this analysis.
- 3 Long-term institutional status is defined monthly for beneficiaries who have had a 90-day Minimum Data Set assessment and continue to reside in a facility at the start of the month. These beneficiaries have always had a risk score based on an "institutional" model rather than the "community" model.
- 4 The demographic risk model used in the DECI method is not used for payments to MA plans. It is calibrated on all FFS beneficiaries with Part A and Part B and is used to calculate demographic risk scores for all MA and FFS beneficiaries in the analysis. The demographic risk model differs from the new enrollee CMS-HCC risk-score model, which also uses only demographic information, because the new enrollee model is calibrated on beneficiaries with less than one calendar year of Part B enrollment and is used only to pay MA plans for such enrollees.
- 5 The plan-level risk-score data for 2019 include risk scores for the roughly 97 percent of MA enrollees who are in HMO, preferred provider organization, private FFS, and Medical Savings Account plans with sufficient enrollment to be publicly reported (11 or more enrollees). Generally, these risk scores are for MA enrollees with both Part A and Part B, except for enrollees in a small number of plans covering Part B services only (representing less than 0.1 percent of enrollment in the plan-level risk-score data).
- 6 CMS publishes the average FFS risk scores because they are the basis for estimating the FFS normalization factor. In the advance notice for 2021, part II, CMS stated that "The normalization factors for the CMS-HCC risk adjustment models are applied to the community non-dual aged, community non-dual disabled, community full benefit dual aged, community full benefit dual disabled, community partial benefit dual aged, community partial benefit dual disabled, institutional, *new enrollee*, and *C-SNP new enrollee* risk scores" (Centers for Medicare & Medicaid Services 2020a). Because the normalization factor is applied to both new enrollee and continuing (not new) enrollee risk models, we conclude that the average FFS risk scores used as the basis for the normalization factors are estimated using all FFS beneficiaries, including those with Part A only (but without ESRD). It would not be appropriate for CMS to apply the same normalization factor to new and continuing enrollee risk models if that normalization factor were calculated using only continuing enrollee risk scores.
- 7 In 2019, the share of full-benefit Medicaid beneficiaries was almost equal in MA and FFS at about 11 percent, but the share of partial-benefit Medicaid beneficiaries in FFS was about 3 percentage points lower than in MA (4.4 percent vs. 7.3 percent). Furthermore, the "state buy-in" indicator identifies only the beneficiaries for whom the state Medicaid agency paid their Medicare Part B premium. Therefore, the indicator excludes about 10 percent of Medicaid-eligible beneficiaries (most of whom are eligible for full Medicaid benefits) who pay their own Medicaid premiums, which often occurs because of "spend-down" requirements by some state Medicaid agencies.
- 8 Medicaid eligibility is defined based on the monthly Medicare-Medicaid dual status code (Research Data Assistance Center 2023).
- 9 The 2019 average risk score is based on a blend of V22 and V23 risk models that was used for payment.
- 10 The exact effect of constraining new enrollees to have no coding intensity depends on the order in which the effects are calculated. To estimate the -1.1 percentage point effect of constraining new enrollees to have no coding intensity in 2019, we first produced a DECI estimate of coding intensity with new enrollees included. Second, we produced a DECI estimate with new enrollees excluded and then weighted that estimate by the share of continuing (not new) enrollees in the analysis, effectively applying a 1.0 DECI estimate to the share of new enrollees in the analysis. For 2019, we produced a DECI estimate including new enrollees of 13.2 percent, and a DECI estimate excluding new enrollees of 13.3 percent, which after weighting by the share of not-new enrollees (91.2 percent) produces a DECI estimate that is applicable to all MA enrollees (new and continuing) of 12.1 percent. We concluded that the effect of constraining new enrollees to have no coding intensity is -1.1 percentage points, the difference between 13.2 percent and 12.1 percent. This approach to

constraining the influence of new enrollees is similar to the approach CMS took (called the “stayer percentage”) in its original coding adjustment of 3.41 percent (Centers for Medicare & Medicaid Services 2010).

- 11 See Figure 1 on p. 30 of the advance notice for 2018.
- 12 See Figure II-1 on p. 44 of Part II of the advance notice for 2022.
- 13 Because plans are paid based on the risk profile of their individual enrollees, plans still have the incentive to enroll beneficiaries who have above-average spending, such as beneficiaries who are dually eligible for Medicaid and Medicare. In fact, plans that exclusively enroll dual-eligible beneficiaries (i.e., dual-eligible special needs plans) consistently report higher profit margins relative to conventional MA plans (Medicare Payment Advisory Commission 2023c, Medicare Payment Advisory Commission 2022, Medicare Payment Advisory Commission 2021, Medicare Payment Advisory Commission 2020b).
- 14 While the most common supplemental benefits offered by MA plans (e.g., gym benefits and worldwide travel coverage) may initially be most attractive to relatively healthy beneficiaries, the preference for these benefits may not persist.
- 15 MA plans can also encourage enrollment by offering extra benefits beyond the standard Medicare benefit package. Popular benefits include integrated Part D coverage for no additional premium, gym memberships, and worldwide emergency and urgent care coverage. However, some supplemental benefits (e.g., worldwide emergency and urgent care coverage) are only or disproportionately attractive to relatively healthy beneficiaries, which may contribute to favorable selection in MA plans. These benefits can serve as a signaling mechanism to indicate the type of beneficiary the plan is trying to attract.
- 16 We do not include beneficiaries with ESRD, including those who do not have Medicaid supplemental coverage, in our comparisons of MA payments relative to what FFS spending would have been for MA enrollees. As a greater share of beneficiaries with ESRD enroll in MA, we will continue to monitor the potential effects of these enrollees on MA payments.
- 17 One study found that more generous out-of-pocket maximums did not result in enrollment gains in 2022 (Cates et al. 2022). Instead, the study found that lower premiums and a higher prevalence of supplemental benefits were associated with plans that experienced enrollment growth. This finding is consistent with prior research that found premiums were a driving factor in beneficiary plan selection (Jacobson et al. 2016a, Jacobson et al. 2014, Medicare Payment Advisory Commission 2015, Meyers et al. 2019, Skopec et al. 2019).
- 18 MA entrants do not include beneficiaries who have ESRD or have Medicare as a secondary payer. We also excluded beneficiaries who enrolled in Medicare plans that are not part of the MA program, such as cost plans.
- 19 From 2017 through 2021, at least 51 percent of MA entrants had at least two years of FFS enrollment prior to joining an MA plan.
- 20 Among all MA entrants from 2008 through 2021 who were enrolled in MA at any time in 2021, 10 percent had between 3 and 11 months of prior FFS enrollment.
- 21 From 2016 through 2021, the selection percentage (i.e., risk-standardized spending relative to the local FFS average in the year before MA entry) of employer plan enrollees in each year was 99 percent, 95 percent, 98 percent, 97 percent, 92 percent, and 92 percent, respectively.
- 22 One study approximated regression to the mean of mortality rates after the initial year in MA, but the authors noted that this method could not account for the effect of continuous enrollment in MA (Newhouse et al. 2019).
- 23 Our 45 sub-cohorts based on initial selection percentage had 20 sub-cohorts with a selection percentage under 100 percent (separated by intervals of 5 percentage points), 10 sub-cohorts with a selection percentage between 100 percent and 200 percent (separated by intervals of 10 percentage points), and 15 sub-cohorts with a selection percentage above 200 percent (separated by intervals that gradually widened). To have a sufficient number of beneficiaries assigned to each sub-cohort, the intervals of the sub-cohorts were informed by the distribution of the initial selection percentage for the MA entrant cohorts in 2008 and 2021.
- 24 We examined the 2018 risk-standardized spending of FFS beneficiaries who were in MA at any time between 2006 and 2016. These beneficiaries had spending that was 107 percent of their local FFS average—indicating that they would have been unfavorable to MA plans. These beneficiaries were included in our FFS comparator when estimating favorable selection.
- 25 Nevertheless, we conducted a sensitivity analysis to estimate the effects of favorable selection using the assumption that the initial favorable selection of the MA cohorts regresses to the mean of the FFS population. To implement this assumption, we used alternative proxy groups made up of FFS beneficiaries who did not enter MA and found that the results are similar to the results of our original analysis. For

2019, we estimated regression to the mean using a proxy group made up of the 2020 FFS population that did not enter MA and found that our 2019 favorable selection estimate decreased from 9.3 percent (for the FFS proxy group entering MA) to 7.9 percent (for the FFS proxy group not entering MA). We also considered a slightly different sensitivity analysis using the assumption that the initial favorable selection of the MA cohorts regresses to the weighted average mean of the MA and FFS populations. To implement that assumption, we weighted the two FFS proxy groups—those that entered and did not enter MA—to reflect a regression to the mean of the entire Medicare population and found that our 2019 favorable selection estimate decreased from 9.3 percent (for the FFS proxy group entering MA) to 8.4 percent.

26 If the FFS population used for county benchmarks changes only incrementally from year to year (e.g., some beneficiaries die while other individuals become newly eligible), the cohort of MA entrants in a particular year would get older and develop more chronic conditions over time (i.e., the constant MA entry cohort in a particular year would not gain new entrants).

27 Beginning our analyses with FFS spending in 2008, we used the FFS historical change in selection percentage of MA entrants from 2018 to 2022 as our proxy groups to trend forward the selection percentages of MA enrollees in the prior year (2017 to 2021). As described in Figure 13-10 (p. 450), each proxy cohort was further grouped into sub-cohorts based on their initial selection percentage. We found that beneficiaries with the lowest initial selection percentage tended to have larger convergence toward the FFS mean, but these beneficiaries still had the lowest selection percentage in the year before MA entry (data not shown). In addition, beneficiaries who were initially unfavorable tended to converge toward being favorable in the year before MA entry. These patterns were exhibited by 2022 MA entrants who were continuously enrolled in FFS from 2006 through 2021. All 20 sub-cohorts with an initial selection percentage below 100 percent remained favorable between 2008 and 2021; 13 of the remaining 25 sub-cohorts that were initially unfavorable in 2008 were favorable in 2021. Thus, regression to the mean occurred in both directions and did not dissolve the favorability of beneficiaries who were already favorable 14 years prior to joining an MA plan.

28 The number of conditions that significantly affect mortality are generally far smaller than the number of conditions that affect spending (<https://www.cms.gov/files/document/hybrid-hospital-wide-all-condition-all-procedure-risk-standardized-mortality-measure-electronic.pdf>).

29 One group of researchers examined pre-Medicare spending for a small sample of about 11,000 beneficiaries who enrolled in MA at age 65 between 2015 and 2019. When comparing

the risk-standardized pre-Medicare spending of these MA enrollees with the risk-standardized pre-Medicare spending of a small sample of beneficiaries who elected FFS at age 65, these researchers found favorable risk-standardized spending of about 13 percent relative to the sample of FFS beneficiaries (Teigland et al. 2023a). Using a somewhat larger but limited sample of 25,000 beneficiaries who enrolled in MA at age 65, the researchers found that these MA enrollees had pre-Medicare risk scores and comorbidity scores that were 10 percent lower than a small sample of beneficiaries who enrolled in FFS at age 65. In addition, this comparison found that beneficiaries who enrolled in FFS were more likely to have cancer, joint issues (rheumatoid arthritis, osteoarthritis, and osteoporosis), and heart issues (ischemic heart disease and prior experience with heart failure) (Teigland et al. 2023b).

30 Our sensitivity analysis of beneficiaries who died applied similar exclusions to our main analysis of favorable selection (i.e., beneficiaries with end-stage renal disease, Medicare as a secondary payer, or enrollment in non-MA private plans). The results of our sensitivity analyses were similar even after adjusting for the geographic distribution of MA enrollees.

31 We tested the extent to which beneficiaries who died in the baseline year had an effect on our overall estimate of favorable selection in 2019. To conduct this sensitivity analysis, in the year before MA entry, we compared the risk-standardized spending of cohorts of MA entrants who remained in MA through the measurement year with those who remained in FFS through the measurement year. Because our new FFS comparator was no longer the local FFS mean in the baseline year, we changed our regression to the mean method to reflect that our new proxy FFS comparator was the set of beneficiaries who were in FFS from the baseline year through the year after the measurement year. We found that this method reduced our overall estimate of favorable selection in 2019 by 2 percentage points.

32 During the time that the hospice election is in effect, CMS reduces the monthly capitation payment to an MA plan. CMS does not make payments to an MA plan on behalf of a Medicare enrollee who has elected hospice care, except for the portion of the payment attributable to plan rebate and the applicable amount of the monthly prescription drug payment.

33 In March 2014, the Commission recommended including hospice in the MA benefit package (Medicare Payment Advisory Commission 2014).

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CHAPTER 14

Mandated report: Dual-eligible special needs plans

Mandated report: Dual-eligible special needs plans

Chapter summary

Individuals who qualify for both Medicare and Medicaid—known as dual-eligible beneficiaries, or “dual eligibles”—may receive care that is fragmented or poorly coordinated because of the challenges of navigating two distinct and complex programs. The Bipartisan Budget Act (BBA) of 2018 directs the Commission to periodically compare the performance of several types of Medicare managed care plans that serve dual eligibles but vary in their level of integration with Medicaid. Many of the plan types are particular variations of the dual-eligible special needs plan (D-SNP), which is a specialized Medicare Advantage (MA) plan. This report is our second under the BBA of 2018 mandate.

As required by the mandate, we compared plans’ performance using quality measures that plans report as part of the Healthcare Effectiveness Data and Information Set® (HEDIS®) and patient experience data that plans collect using the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) beneficiary survey. (We used HEDIS data in our first mandated report, while our analysis of CAHPS data is new.) We find that these data sources provide limited insight into the relative performance of D-SNPs because most HEDIS measures are not tied to clinical outcomes and because HEDIS and CAHPS scores on many measures are fairly similar across plan types. MA plans perform better on some measures

In this chapter

- Introduction
- Background
- Comparing the performance of D-SNPs and other plans that serve dual-eligible beneficiaries
- Most MMPs will likely convert into D-SNPs
- Conclusion

than Medicare–Medicaid Plans (MMPs), which are demonstration plans that operate outside the MA program, but those differences could reflect structural differences between the two types of plans. These findings are consistent with our first mandated report and with other Commission analyses that have examined the difficulties of assessing the quality and performance of MA plans.

The landscape of health plans that serve dual eligibles will change in 2025, when the MMP demonstration is scheduled to end. Most evaluations have found that MMPs increase Medicare spending and have had mixed effects on service use. After the demonstration ends, we expect most MMPs to convert into D–SNPs. ■

Introduction

Individuals who qualify for both Medicare and Medicaid—known as dual-eligible beneficiaries, or “dual eligibles”—may receive care that is fragmented or poorly coordinated because of the challenges of navigating two distinct and complex programs. Many observers argue that managed care plans that provide both Medicare and Medicaid services would improve quality and potentially reduce spending for this population because integrated plans would have stronger incentives to coordinate care than either program has when acting on its own.

The Bipartisan Budget Act (BBA) of 2018 directs the Commission to periodically compare the performance of several types of Medicare managed care plans that serve dual eligibles but vary in their level of integration with Medicaid. Many of the plan types are particular variations of the dual-eligible special needs plan (D-SNP), which is a specialized Medicare Advantage (MA) plan that limits its enrollment to dual eligibles.

The BBA of 2018 requires the Commission to provide a report every two years, starting in 2022 and continuing through 2032. After that, the schedule changes, with another report due in 2033 and updates required every five years. This chapter is our second report under the mandate, which we are required to submit to the Congress by March 15, 2024.

Background

Individuals must separately qualify for both Medicare and Medicaid coverage to become dual-eligible beneficiaries. For these individuals, the federal Medicare program covers medical services such as hospital care, post-acute care, physician services, durable medical equipment, and prescription drugs. The federal-state Medicaid program covers a variety of long-term services and supports (LTSS), such as custodial nursing home care and community-based care, and wraparound services, such as dental benefits and transportation. Medicare is the primary payer for any services that are covered by both programs, such as inpatient care and physician services.

Roughly half of dual-eligible beneficiaries first qualify for Medicare based on disability (compared with 15 percent of beneficiaries who are not dual eligibles) and roughly half qualify when they turn 65. Medicaid's eligibility rules vary somewhat across states, but most dual eligibles qualify because they receive Supplemental Security Income benefits, need nursing home care or have other high medical expenses, or meet the eligibility criteria for the Medicare Savings Programs, in which Medicaid provides assistance with Medicare premiums and cost sharing (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2024). Not all individuals who are eligible for Medicaid participate in the program. In July 2022, about 12.2 million Medicare beneficiaries (19 percent of all Medicare beneficiaries) were dual eligibles.

Dual-eligible beneficiaries belong to one of two broad groups—“full benefit” and “partial benefit”—based on the Medicaid benefits they receive. Full-benefit dual eligibles qualify for the full range of Medicaid services covered in their state, while partial-benefit dual eligibles receive assistance only with Medicare premiums and, in some cases, with cost sharing.¹ In July 2022, there were 8.9 million full-benefit dual eligibles and 3.4 million partial-benefit dual eligibles.

Given the role that factors such as disability and functional impairment play in becoming a dual-eligible beneficiary, it is not surprising that dual eligibles are more likely than other Medicare beneficiaries to report that they are in poor health (11 percent vs. 4 percent) or need help performing three or more activities of daily living (ADLs) (24 percent vs. 6 percent) (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2024).² The poorer health of this population leads in turn to higher program costs (Table 14-1, p. 470). Measured on a per capita basis, the average annual Medicare cost for dual eligibles in 2021 was over \$24,000, more than two times higher than the corresponding figure for other Medicare beneficiaries. Within the dual-eligible population, those eligible for full Medicaid benefits had higher Medicare costs and much higher Medicaid costs than those eligible for partial Medicaid benefits only. In 2021, Medicare and Medicaid together spent more than \$44,000 per capita, on average, on full-benefit

**TABLE
14-1****Dual eligibles had much higher per capita annual spending in 2021 than other Medicare beneficiaries**

	Medicare	Medicaid	Total
Dual-eligible beneficiaries			
All dual eligibles	\$24,370	\$14,175	\$38,545
Full-benefit dual eligibles	25,582	19,119	44,701
Partial-benefit dual eligibles	21,094	813	21,908
All other Medicare beneficiaries	11,172	N/A	11,172

Note: N/A (not applicable). Figures include all Medicare (Part A, Part B, and Part D) and Medicaid spending except Medicare or Medicaid spending on Part A, Part B, or Part D premiums. The Medicaid spending for partial-benefit dual eligibles is for coverage of Medicare cost sharing. Components may not sum to totals due to rounding.

Source: MedPAC analysis of linked Medicare-Medicaid enrollment and spending data.

dual eligibles; Medicare accounted for about 57 percent of the combined spending and Medicaid the other 43 percent.

The high Medicare costs for dual eligibles are driven by a combination of higher utilization of all major types of services and higher per user spending for those who receive care. For example, in 2021, full-benefit dual eligibles were more likely than other Medicare beneficiaries to use inpatient care (22 percent vs. 13 percent), and those who were hospitalized had higher inpatient costs (\$27,207 vs. \$22,092, respectively). The Medicaid costs for full-benefit dual eligibles were largely for LTSS, such as nursing home care and home- and community-based waiver programs. Less than half of full-benefit dual eligibles (43 percent) used LTSS in 2021, but spending on those services accounted for about 75 percent of this population's total Medicaid costs (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2024).

The share of dual-eligible beneficiaries enrolled in MA has grown rapidly

As with other beneficiaries, the share of dual eligibles enrolled in MA plans has grown rapidly in recent years. The left half of Figure 14-1 shows the share of dual-eligible and non-dual-eligible beneficiaries enrolled in

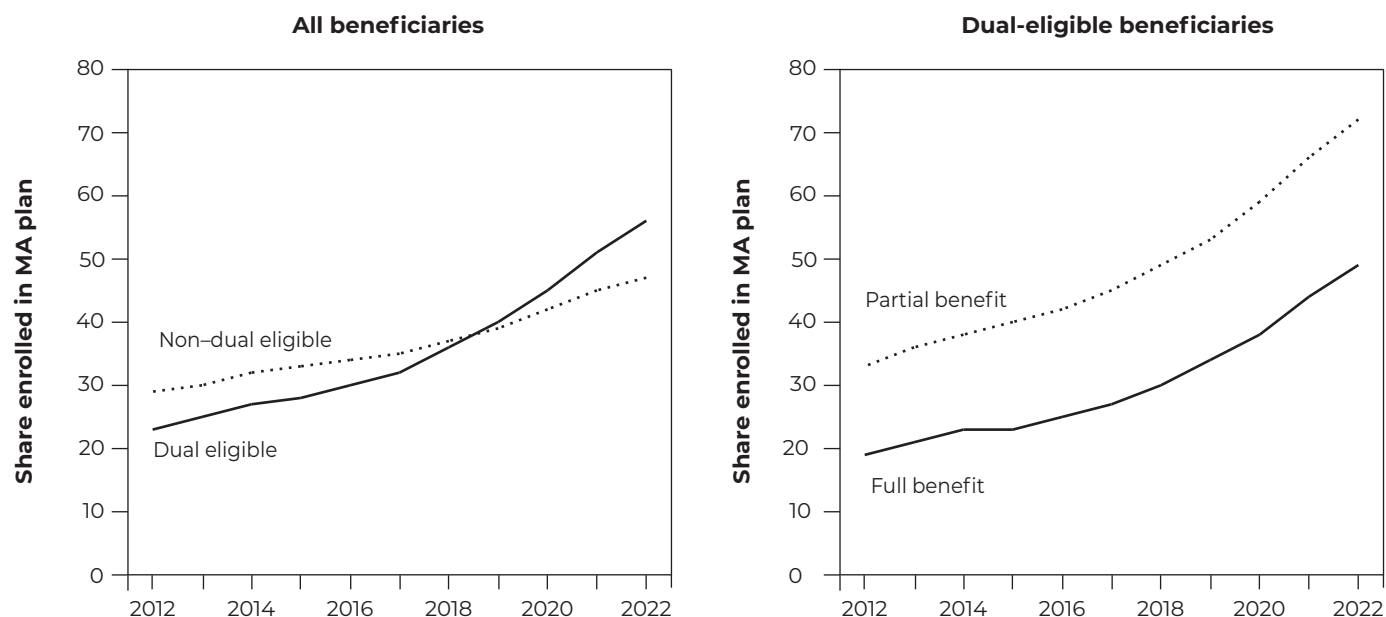
MA from 2012 to 2022. Dual eligibles were historically less likely than other beneficiaries to enroll in managed care plans, but that pattern reversed during this period, and the share of dual eligibles enrolled in MA is now higher than that of non-dual-eligible beneficiaries (56 percent vs. 47 percent in 2022). Within the dual-eligible population, as shown on the right half of Figure 14-1, partial-benefit dual eligibles have consistently been more likely than full-benefit dual eligibles to enroll in MA plans. Between 2012 and 2022, the MA participation rates for both groups more than doubled, but the growth for partial-benefit dual eligibles was particularly rapid, and more than 70 percent are now enrolled in MA plans.

It is worth noting that Figure 14-1 does not include enrollment in plans that are not part of the MA program, such as cost plans, Medicare-Medicaid Plans (MMPs), and the Program of All-Inclusive Care for the Elderly (PACE). In 2022, about 6 percent of full-benefit dual eligibles were enrolled in those plans (largely in MMPs), compared with 1 percent of non-dual-eligible beneficiaries. Very few partial-benefit dual eligibles were enrolled in non-MA plans.

Dual-eligible beneficiaries also tend to enroll in different types of MA plans than other beneficiaries (Table 14-2, p. 472). In 2022, among beneficiaries

FIGURE
14-1

The share of dual-eligible beneficiaries enrolled in MA plans rose substantially between 2012 and 2022



Note: MA (Medicare Advantage). Figures are based on enrollment in July of each year. Full-benefit dual eligibles qualify for the full range of Medicaid services covered in their state, while partial-benefit dual eligibles receive assistance only with Medicare premiums and, in some cases, with Medicare cost sharing. Figures do not include beneficiaries who did not have both Part A and Part B coverage or lived in the U.S. territories. Figures do not include beneficiaries who were enrolled in health plans that are not part of the MA program (stand-alone Part D plans, cost plans, Medicare-Medicaid Plans, and the Program of All-Inclusive Care for the Elderly).

Source: MedPAC analysis of Medicare enrollment and eligibility data.

who were not dually eligible, 75 percent were in conventional plans, which are available to all beneficiaries who have Part A and Part B and live in a plan's service area, and another 23 percent were in employer-sponsored plans, which are available only to beneficiaries who worked for specific companies. In contrast, among dual eligibles, 62 percent were enrolled in D-SNPs, while 34 percent were in conventional plans and only 1 percent of dual eligibles were in employer plans.

Full-benefit dual eligibles were particularly likely to enroll in D-SNPs instead of conventional plans (71 percent vs. 25 percent), while partial-benefit dual eligibles were split about evenly between the two plan types. For partial-benefit dual eligibles, plan choice appears to depend heavily on the extent of

their Medicaid coverage. About half of partial-benefit dual eligibles—those with income below the federal poverty level—receive assistance with both Medicare premiums and cost sharing. These beneficiaries were more likely to enroll in D-SNPs instead of conventional plans (71 percent vs. 28 percent, about the same as full-benefit dual eligibles), probably because they prefer the more generous supplemental benefits that D-SNPs typically offer. In contrast, the other partial-benefit dual eligibles—with income between 100 percent and 135 percent of the poverty level—receive assistance with the Part B premium only. These beneficiaries were more likely to enroll in conventional plans than D-SNPs (74 percent vs. 22 percent) and appeared to prefer the lower cost sharing and out-of-pocket limits that conventional plans typically offer.

**TABLE
14-2****Distribution of MA enrollment by dual-eligibility status and type of plan, 2022**

	Conventional plan	Employer plan	D-SNP	Other MA plan
All Medicare beneficiaries	66%	18%	14%	2%
Non-dual-eligible beneficiaries	75	23	<1	1
Dual-eligible beneficiaries	34	1	62	3
Type of dual-eligible beneficiary				
Full-benefit dual eligibles	25	1	71	3
Partial-benefit dual eligibles	51	1	47	2
Medicaid covers Part A/B cost sharing	28	<1	71	1
Medicaid does not cover Part A/B cost sharing	74	1	22	3

Note: MA (Medicare Advantage), D-SNP (dual-eligible special needs plan). Figures are based on July enrollment. Full-benefit dual eligibles qualify for the full range of Medicaid services covered in their state, while partial-benefit dual eligibles receive assistance only with Medicare premiums, and, in some cases, with Medicare cost sharing. Figures do not include beneficiaries who did not have both Part A and Part B coverage or lived in the U.S. territories. Figures do not include beneficiaries who were enrolled in health plans that are not part of the MA program (stand-alone Part D plans, cost plans, Medicare-Medicaid Plans, and the Program of All-Inclusive Care for the Elderly). Components may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare enrollment and eligibility data.

Integration requirements for D-SNPs

D-SNPs are based on the rationale that dual-eligible beneficiaries will receive better care from a specialized MA plan that is tailored to meet their distinct care needs than they would from a conventional MA plan. The extent to which D-SNPs must integrate the delivery of Medicare and Medicaid services has evolved over time. When D-SNPs were first authorized in 2003, they did not have to meet any specific requirements for integration. The Congress enacted the first requirements in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Since 2010, MIPPA has required D-SNPs to have Medicaid contracts that meet certain minimum requirements, such as specifying the plan's service area, the Medicaid services the plan provides (if any), and the plan's responsibility to coordinate the delivery of Medicaid services for its enrollees.

Later, with the Affordable Care Act of 2010, the Congress added requirements for plans that wanted to qualify as a *fully integrated dual-eligible SNP* (FIDE-SNP). These plans must be offered by an entity that

has a capitated Medicaid contract to provide both institutional and community-based LTSS, and they can receive higher Medicare payments if their enrollees have high levels of functional impairment.

The BBA of 2018 built on the MIPPA standards by requiring D-SNPs, starting in 2021, to meet one of three additional criteria for integration:

- The plan meets a minimum set of requirements, determined by the Secretary, to coordinate the delivery of LTSS, behavioral health, or both for plan enrollees. CMS specified through regulation that these plans must notify the state about admissions to inpatient hospitals and skilled nursing facilities for at least one group of "high-risk" full-benefit dual eligibles, which is defined by the state. CMS refers to these plans as *coordination-only D-SNPs*; they have the lowest level of integration because they do not have to provide any Medicaid services (plan enrollees instead receive those services through a Medicaid fee-for-service (FFS) program or a separate Medicaid managed care plan).

- The plan qualifies as either (1) a *highly integrated dual-eligible SNP* (HIDE-SNP) by having a capitated Medicaid contract to provide LTSS, behavioral health, or both; or (2) a FIDE-SNP. HIDE-SNPs fall somewhere in the middle in terms of their integration with Medicaid: They are more integrated than coordination-only plans because they provide some Medicaid services, but less integrated than FIDE-SNPs because their Medicaid contracts may not be as extensive and they can use a wider variety of contracting arrangements with states. FIDE-SNPs have the highest level of integration because they provide a broad range of Medicaid services, including substantial LTSS coverage.
- The plan assumes “clinical and financial responsibility” for both Medicare and Medicaid benefits provided to its enrollees. CMS has defined these plans as HIDE-SNPs or FIDE-SNPs that have exclusively aligned enrollment, which means that enrollment in the D-SNP is limited to dual eligibles who receive their Medicare and Medicaid benefits from the same parent company. Based on a separate BBA of 2018 provision, these plans must have a unified process for handling appeals and grievances (instead of separate processes for Medicare-covered and Medicaid-covered services).³ The use of exclusively aligned enrollment also allows plans to integrate other aspects of the enrollee experience, such as member materials.

In addition to the requirements for Medicaid integration, D-SNPs must complete annual health risk assessments for their enrollees, have an approved evidence-based model of care, and report certain additional quality measures. Otherwise, they are largely subject to the same rules as conventional MA plans. For example, they can require enrollees to receive care from in-network providers, employ utilization management tools like prior authorization, and offer supplemental benefits that traditional Medicare does not cover.

This year, D-SNPs are available in 45 states and the District of Columbia; the only states without them are Alaska, Illinois, New Hampshire, North Dakota, and Vermont. As shown in Table 14-3 (p. 474), enrollment in D-SNPs has surged in recent years, jumping from 3.3 million in 2021 to 5.2 million in 2023. More

than half of those beneficiaries (57 percent) were in coordination-only D-SNPs, which have the lowest level of integration. Another 35 percent were enrolled in HIDE-SNPs, and 8 percent were enrolled in FIDE-SNPs. Those percentages have changed relatively little since the new integration standards took effect in 2021.

The D-SNP categories that we use in our mandated report differ from the coordination-only, HIDE-SNP, and FIDE-SNP categories because they also account for whether HIDE-SNPs and FIDE-SNPs have exclusively aligned enrollment. However, as shown in the bottom half of Table 14-3 (p. 474), the differences between the two methods for categorizing D-SNPs are relatively modest. Nearly all HIDE-SNP enrollees are in plans that do not have exclusively aligned enrollment, while about 80 percent of FIDE-SNP enrollees are in plans that do have exclusively aligned enrollment.⁴

Comparing the performance of D-SNPs and other plans that serve dual-eligible beneficiaries

The BBA of 2018 directs the Commission to periodically examine how D-SNPs “perform among each other” using Healthcare Effectiveness Data and Information Set[®] (HEDIS[®]) quality measures or other data sources, such as the Consumer Assessment of Healthcare Providers and Systems[®] (CAHPS[®]) beneficiary survey or plan encounter data, as appropriate (see text box for the legislative language of the mandate, p. 475).⁵ We are also required to consult with the Medicaid and CHIP Payment and Access Commission in preparing these reports.

To the extent feasible, these reports must compare five types of plans that serve dual-eligible beneficiaries:

- three types of D-SNPs (divided according to the BBA of 2018’s integration criteria);
- MMPs, which are demonstration plans that CMS and certain states have been testing as part of an effort to develop new models of care for dual eligibles; and
- other MA plans (but looking only at the dual-eligible beneficiaries enrolled in those plans).

**TABLE
14-3****Most D-SNP enrollees have been in plans with a low level of integration, 2021–2023**

Plan type	Enrollment (thousands)			Share of D-SNP total		
	2021	2022	2023	2021	2022	2023
Coordination-only D-SNP	1,904	2,186	2,971	57%	53%	57%
HIDE-SNP	1,128	1,559	1,815	34	38	35
FIDE-SNP	<u>282</u>	<u>351</u>	<u>417</u>	<u>8</u>	<u>9</u>	<u>8</u>
Total, all D-SNPs	3,313	4,096	5,204	100	100	100
Plan groupings specified in BBA of 2018 mandate:						
Coordination-only D-SNP	1,904	2,186	2,971	57	53	57
HIDE-SNP or FIDE-SNP without exclusively aligned enrollment	1,150	1,578	1,886	35	39	36
HIDE-SNP or FIDE-SNP with exclusively aligned enrollment	260	332	347	8	8	7

Note: D-SNP (dual-eligible special needs plan), HIDE-SNP (highly integrated dual-eligible special needs plan), FIDE-SNP (fully integrated dual-eligible special needs plan), BBA (Bipartisan Budget Act). Figures are based on July enrollment for each year and do not include plans in the U.S. territories. The terms “with exclusively aligned enrollment” and “without exclusively aligned enrollment” indicate whether the plan does or does not require all enrollees to have aligned enrollment. Components may not sum to totals because of rounding.

Source: MedPAC analysis of CMS enrollment and D-SNP integration data.

Another logical group to include in this comparison would be dual-eligible beneficiaries who are enrolled in FFS Medicare, although the mandate does not call for this. However, the Commission has previously noted that efforts to compare FFS and MA performance are hindered by several data limitations (such as a lack of clinical data for FFS enrollees and discrepancies between plans’ HEDIS data and encounter data) and the challenges of adjusting for differences between the FFS and MA populations (Medicare Payment Advisory Commission 2023, Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2019). Given these challenges, we determined in our March 2023 report to the Congress that rigorous comparisons of quality and outcomes between MA and FFS could not be made (Medicare Payment Advisory Commission 2023).

In July 2022, about 42 percent of all dual eligibles were enrolled in Medicare’s FFS program, 33 percent were enrolled in a D-SNP, 20 percent were enrolled in some

other type of MA plan, and 3 percent were enrolled in an MMP.

Dual-eligible beneficiaries also account for a disproportionate share of the enrollment in two other, smaller plan types that target beneficiaries who need LTSS: MA institutional special needs plans and the Program of All-Inclusive Care for the Elderly (see text box on Medicare plans that target beneficiaries who need LTSS, p. 476).

HEDIS clinical quality measures

For this report, we analyzed person-level HEDIS data for measurement year 2021, the most recent year of available data at the time we performed our analysis. HEDIS is a set of quality measures that has been developed by the National Committee for Quality Assurance (NCQA) to evaluate health plans. CMS requires both MA plans and MMPs to collect and report data annually for a subset of HEDIS measures. We also used HEDIS data in our first mandated report.

Legislative language for mandated report

Section 50311(b)(1)(E) of the Bipartisan Budget Act of 2018 reads:

(E) STUDY AND REPORT TO CONGRESS.—

(i) IN GENERAL.—Not later than March 15, 2022, and, subject to clause (iii), biennially thereafter through 2032, the Medicare Payment Advisory Commission established under section 1805, in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900, shall conduct (and submit to the Secretary and the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on) a study to determine how specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) perform among each other based on data from Healthcare Effectiveness Data and Information Set (HEDIS) quality measures, reported on the plan level, as required under section 1852(e)(3) (or such other measures or data sources that are available and appropriate, such as encounter data and Consumer Assessment of Healthcare Providers and Systems data, as specified by such Commissions as enabling an accurate evaluation under this subparagraph). Such study shall include, as feasible, the following comparison groups of specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii):

(I) A comparison group of such plans that are described in subparagraph (D)(i)(I).

(II) A comparison group of such plans that are described in subparagraph (D)(i)(II).

(III) A comparison group of such plans operating within the Financial Alignment Initiative demonstration for the period for which such plan is so operating and the demonstration is in effect, and, in the case that an integration option that is not with respect to specialized MA plans for special needs individuals is established after the conclusion of the demonstration involved.

(IV) A comparison group of such plans that are described in subparagraph (D)(i)(III).

(V) A comparison group of MA plans, as feasible, not described in a previous subclause of this clause, with respect to the performance of such plans for enrollees who are special needs individuals described in subsection (b)(6)(B)(ii).

(ii) ADDITIONAL REPORTS.—Beginning with 2033 and every five years thereafter, the Medicare Payment Advisory Commission, in consultation with the Medicaid and CHIP Payment and Access Commission, shall conduct a study described in clause (i). ■

The person-level HEDIS data have both beneficiary and plan identifiers, which we used to identify beneficiaries enrolled in D-SNPs, MMPs, and other MA plans and to determine which beneficiaries in other MA plans were dual-eligible beneficiaries. We divided the D-SNP enrollees into three groups based on the BBA integration criteria that each plan met in 2021.

CMS typically requires plan sponsors to collect and report HEDIS data at the contract level, but the BBA

of 2018 mandate directs the Commission to use data reported at the plan level. The distinction between contract-level and plan-level data is important for certain measures. Plan sponsors rely exclusively on administrative data (such as encounter data) as the source for many measures, but there are some “hybrid” measures for which sponsors can or must use both administrative data and data collected from a sample of enrollee medical records. When sponsors rely entirely

Medicare plans that target beneficiaries who need long-term services and supports primarily serve dual-eligible beneficiaries

Four of the plan types that we are directed to compare by the mandate in the Bipartisan Budget Act of 2018—the three types of dual-eligible special needs plans and Medicare-Medicaid Plans—are specifically designed to serve dual eligibles. However, two other plan types—MA institutional special needs plans (I-SNPs) and the Program of All-Inclusive Care for the Elderly (PACE)—also deserve mention because they target beneficiaries who need long-term services and supports (LTSS). Since Medicaid is the largest payer for LTSS, dual eligibles represent a disproportionate share of the enrollment in both types of plans.

I-SNPs are specialized MA plans for beneficiaries who need the level of care provided in a nursing home. These plans have the option of serving beneficiaries who already live in nursing homes, beneficiaries who are frail but still live in the community, or both. Most I-SNPs appear to focus on beneficiaries in nursing homes, although there is relatively little data available. I-SNPs are available only to beneficiaries who live in certain nursing

homes in the plan's service area and typically rely on nurse practitioners to make regular visits to those facilities to deliver care on-site and avoid inpatient stays. In 2023, about 110,000 beneficiaries were enrolled in I-SNPs, and full-benefit dual eligibles have historically accounted for about 90 percent of I-SNP enrollees.

PACE plans serve beneficiaries who are age 55 or older and need the level of care provided in a nursing home. The program aims to keep people living in the community instead of going into nursing homes, and it uses a distinctive model of care based on adult day-care centers that are staffed by interdisciplinary teams that provide therapy and medical services. PACE plans provide all Medicare- and Medicaid-covered services. PACE is the oldest type of integrated plan; it started as a demonstration in the early 1980s and was permanently authorized in 1997. In 2023, about 60,000 beneficiaries were enrolled in PACE plans, and full-benefit dual eligibles have usually accounted for almost all of their enrollment. ■

on administrative data for a measure, they report HEDIS data for every enrollee under a given contract, which makes it feasible to calculate scores for either the entire contract or any individual plan offered under that contract.

In contrast, when sponsors report data for hybrid measures, they collect data for a random sample of 411 enrollees, which is chosen at the contract level. (These sampling requirements are specified by the NCQA.) Since most contracts have multiple plans and may have both D-SNPs and other types of MA plans, this sample is too small to generate reliable plan-level estimates. CMS requires MA plan sponsors to report plan-level data for a subset of HEDIS measures for all types of special needs plans, including D-SNPs. That subset includes some hybrid measures, but sponsors are not

required to collect any additional data for them, so the plan-level scores for them are not reliable. As a result, our analysis excludes four hybrid measures—colorectal cancer screening, controlling high blood pressure, comprehensive diabetes care, and transitions of care. CMS may want to consider requiring plan sponsors that collect data from medical records to use large enough samples (411 enrollees at the plan level, instead of at the contract level) to generate reliable estimates for SNPs. Such a change would help provide more meaningful information to dual-eligible beneficiaries when evaluating the D-SNPs offered in their area.

For each comparison group, we calculated scores for 23 HEDIS measures that had a total of 45 associated rates (Table 14-4, pp. 478–479). Some measures have more than one associated rate: For example, the

measure on follow-up after an emergency department visit for substance abuse has two rates, one for 7-day follow-up and one for 30-day follow-up. The number of observations that were used to calculate each rate varied depending on the enrollment in each plan type and the demographic and clinical specifications for each measure.

The results from our analysis are mixed—each plan type performed relatively well on some measures and relatively poorly on others—and do not clearly favor one plan type. (These findings are consistent with our first mandated report.) In many cases, the differences between the scores on a given measure are relatively small and may not be very meaningful to beneficiaries, even if they are statistically significant. CMS has addressed this challenge in some analyses by requiring scores to differ by at least 3 percentage points to have “practical significance” (Centers for Medicare & Medicaid Services 2023b, Centers for Medicare & Medicaid Services 2023c).

We applied the concept of practical significance to our analysis by looking for cases where the highest or lowest score on a measure differed from every other score by at least 3 percentage points. Our goal was to identify instances in which one plan type clearly performed better or worse than the others. Using this approach, we found the following:

- Coordination-only D-SNPs did not perform noticeably better or worse on any rates.
- HIDE-SNPs and FIDE-SNPs without exclusively aligned enrollment performed better on three rates (both rates for kidney health evaluation for patients with diabetes and osteoporosis management in women who had a fracture) and worse on three rates (one of the rates for potentially harmful drug-disease interactions in older adults, initiation of substance use disorder treatment, and nonrecommended prostate screening in older men).
- HIDE-SNPs and FIDE-SNPs with exclusively aligned enrollment performed better on four rates (two rates for follow-up after emergency department visit for mental illness, adherence to antipsychotic medications for individuals with schizophrenia, adherence to statin therapy

for patients with diabetes) and did not perform noticeably worse on any measure.

- MMPs had the greatest variation in performance in the five comparison groups. They performed better on three rates (one of the rates for potentially harmful drug-disease interactions in older adults and two rates for follow-up after hospitalization for mental illness), but they performed noticeably worse on six rates (both rates for adults’ access to preventive/ambulatory health services, breast cancer screening, osteoporosis management in women who had a fracture, osteoporosis screening in older women, and use of spirometry testing in the assessment and diagnosis of chronic obstructive pulmonary disease).
- Other MA plans did not perform noticeably better on any measure and performed worse on two behavioral health rates (follow-up after hospitalization for mental illness and follow-up after emergency department visit for mental illness).

Drawing broader conclusions about plan performance from this analysis is challenging because other factors may contribute to the variation in scores. For example, in 2021, 99 percent of beneficiaries lived in counties where at least one MA plan was available and 92 percent lived in counties where at least one D-SNP was available, but some plan types were not widely available. The more highly integrated plans, in particular, had limited availability: MMPs and FIDE-SNPs were available in only 9 and 12 states, respectively, and about 85 percent of the enrollment in each plan type was in just 5 states. Thus, differences in HEDIS scores across the five comparison groups could be influenced by factors such as regional differences in state Medicaid eligibility requirements, disease prevalence, access to care, and physician practice patterns.⁶

Another factor could be structural differences between MMPs and MA plans. MMPs are part of a demonstration and operate outside of the MA program. The two plan types differ in many ways, and differences in their enrollment models and quality incentives could affect their relative performance on HEDIS measures. In MA, almost all beneficiaries enroll voluntarily, while in MMPs, many beneficiaries

**TABLE
14-4****HEDIS® scores for measurement year 2021, by plan type**

Measure	Coordination- only D-SNPs	HIDE-SNPs and FIDE-SNPs		MMPs	Other MA plans
		Unaligned	Aligned		
Access/availability of care					
Adults' access to preventive/ambulatory health services					
Ages 20–64	96.0%	95.6%	95.0%	91.5%	95.4%
Ages 65+	96.6	96.3	97.4	90.5	95.8
Initiation and engagement of substance use disorder treatment					
Initiation	37.8	26.7	33.7	40.7	33.7
Engagement	7.0	4.3	6.1	7.6	5.0
Effectiveness of care: Behavioral health					
Antidepressant medication management					
Effective acute phase treatment	76.0	77.2	79.7	76.9	79.9
Effective continuation phase treatment	59.3	60.3	66.3	63.9	64.7
Follow-up after emergency department visit for substance abuse					
7-day follow-up	12.8	11.2	14.5	14.3	12.4
30-day follow-up	18.1	16.5	18.5	21.4	17.7
Follow-up after hospitalization for mental illness					
7-day follow-up, ages 18–64	28.0	32.1	31.7	41.8	26.3
7-day follow-up, ages 65+	22.1	24.4	32.3	30.1	20.0
30-day follow-up, ages 18–64	49.1	52.4	51.9	63.0	46.2
30-day follow-up, ages 65+	40.8	42.5	55.8	54.4	36.8
Follow-up after emergency department visit for mental illness					
7-day follow-up, ages 18–64	34.4	34.2	53.3	54.5	31.3
7-day follow-up, ages 65+	28.7	28.0	45.3	35.7	29.9
30-day follow-up, ages 18–64	51.8	52.1	66.5	68.7	47.4
30-day follow-up, ages 65+	42.8	42.0	57.8	49.6	42.4
Adherence to antipsychotic medications for individuals with schizophrenia	74.2	75.8	81.1	78.0	75.5
Effectiveness of care: Cardiovascular conditions					
Cardiac rehabilitation					
Attended 2+ sessions within 30 days	2.6	2.2	3.5	2.1	2.7
Attended 12+ sessions within 90 days	2.7	2.4	3.0	3.1	3.1
Attended 24+ sessions within 180 days	2.5	2.3	2.6	3.3	2.8
Attended 36+ sessions within 180 days	1.1	1.2	0.7	2.2	1.3
Persistence of beta-blocker treatment after a heart attack	89.3	89.0	87.9	91.1	87.6
Statin therapy for patients with cardiovascular disease					
Received statin therapy	85.1	85.5	87.0	83.8	85.5
Statin adherence 80%	82.1	83.3	85.7	84.3	82.9

**TABLE
14-4**

HEDIS® scores for measurement year 2021, by plan type (cont.)

Measure	Coordination- only D-SNPs	HIDE-SNPs and FIDE-SNPs		MMPs	Other MA plans
		Unaligned	Aligned		
Effectiveness of care: Diabetes					
Kidney health evaluation for patients with diabetes					
Ages 18–64	36.9	47.2	35.9	38.6	40.6
Ages 65–85	45.8	56.4	46.5	47.6	50.6
Statin therapy for patients with diabetes					
Received statin therapy	79.8	81.2	83.3	78.4	80.4
Statin adherence 80%	81.2	81.8	85.3	82.3	81.6
Effectiveness of care: Care coordination					
Follow-up after emergency department visit for people with multiple high-risk chronic conditions					
Ages 18–64	56.4	57.5	60.6	60.7	57.0
Ages 65+	57.1	58.3	59.3	54.6	56.2
Effectiveness of care: Musculoskeletal conditions					
Osteoporosis screening in older women	45.6	49.1	46.1	34.9	48.5
Osteoporosis management in women who had a fracture	42.6	47.8	38.5	22.2	42.4
Effectiveness of care: Overuse/appropriateness (lower scores indicate better performance)					
Use of high-risk medications in older adults	22.4	22.7	23.6	17.7	20.6
Potentially harmful drug-disease interactions in older adults					
History of falls	41.5	40.5	40.4	35.7	39.8
Dementia	43.3	46.3	42.4	40.4	41.7
Chronic kidney disease	12.6	14.7	12.2	13.2	10.3
Use of opioids at high dosage	5.8	8.4	7.5	7.5	6.4
Nonrecommended PSA-based screening in older men	28.6	33.2	25.4	25.2	28.2
Use of opioids from multiple providers					
Multiple pharmacies	2.0	1.7	1.4	2.2	1.6
Multiple prescribers	15.6	13.2	15.1	16.0	13.8
Multiple prescribers and pharmacies	1.0	0.9	0.8	1.4	0.8
Effectiveness of care: Prevention and screening					
Breast cancer screening	69.6	71.3	67.8	58.5	68.3
Effectiveness of care: Respiratory conditions					
Pharmacotherapy management of COPD exacerbation					
Systemic corticosteroid	74.0	72.7	72.2	73.6	73.5
Bronchodilator	86.3	86.7	89.3	88.3	85.5
Use of spirometry testing in the assessment and diagnosis of COPD	26.8	26.3	26.3	20.0	23.9

Note: HEDIS® (Healthcare Effectiveness Data and Information Set®), D-SNP (dual-eligible special needs plan), HIDE-SNP (highly integrated dual-eligible special needs plan), FIDE-SNP (fully integrated dual-eligible special needs plan), MMP (Medicare-Medicaid Plan), MA (Medicare Advantage), PSA (prostate-specific antigen), COPD (chronic obstructive pulmonary disease). Figures do not include plans in the U.S. territories.

Source: MedPAC analysis of HEDIS person-level data for measurement year 2021 and D-SNP integration data for 2021.

have been passively enrolled by states. MMPs might have more difficulty engaging with passive enrollees, which could contribute to their poor performance on some measures. Both types of plans have quality incentives, but the incentive for MA plans is structured as a bonus (higher payments for plans with a rating of 4 stars or better), while the incentive for MMPs is structured as a quality withhold (lower payments for plans that do not meet performance thresholds), and they are not evaluated on the same HEDIS measures. Three measures in Table 14-4 (pp. 478–479) (breast cancer screening, osteoporosis management in women who had a fracture, and statin therapy for patients with cardiovascular disease) are used in the MA star ratings but not the MMP quality withhold, and MA plans performed better than MMPs on three of the four rates associated with those measures, particularly breast cancer screening and osteoporosis management. Conversely, one measure (follow-up after hospitalization for mental illness) is used in the MMP quality withhold but not the MA star ratings, and MMPs generally performed better than MA plans on the four rates associated with that measure, particularly the rates for beneficiaries under age 65. Some of the differences in HEDIS scores may thus reflect differences in plans' financial incentives to focus on certain measures over others.

The challenges of using HEDIS measures to assess performance also reflect larger difficulties in assessing the quality and performance of MA plans (both in terms of how well individual plans perform compared with each other and how well MA plans perform compared with the FFS program). Most HEDIS measures are process measures that are not tied to clinical outcomes, but the Commission holds that measures tied to clinical outcomes and patient experience are more suitable for quality payment programs (Medicare Payment Advisory Commission 2018). CMS includes some process measures in the calculation of the MA star ratings, accounting for about 15 percent of a plan's overall star rating for 2024, but it gives more weight to outcomes and patient experience measures (Centers for Medicare & Medicaid Services 2023d).

In 2020, the Commission recommended replacing the MA quality bonus program with a new MA value incentive program that uses a small set of measures tied to clinical outcomes and patient experience to evaluate plan performance (Medicare Payment Advisory Commission 2020).

CAHPS patient experience measures

For this report, we also analyzed results from the CAHPS beneficiary survey, which was developed by the Agency for Healthcare Research and Quality (AHRQ) to assess patient experience with the health care system. This analysis is new and did not appear in our first mandated report.

Each year CMS requires MA plans and MMPs to administer a version of the survey to a sample of enrollees. The agency selects the sample and requires plans to hire an approved outside vendor to conduct the surveys. The surveys are usually conducted in the spring of each year and ask enrollees about their experience during the previous six months. For this report, we analyzed results from the surveys conducted in 2022, the most recent available. The responses to the survey thus refer to care that enrollees received in late 2021 and early 2022. Across all MA plans, about 35 percent of the enrollees who were selected for the 2022 survey responded (Centers for Medicare & Medicaid Services 2023a).

The MA version of the CAHPS survey has more than 60 questions, which makes it impractical to report the results for each question. We instead focused on scores for six composite measures, which combine the scores on groups of closely related individual measures, and on scores for five measures for which enrollees give an overall rating (from 0 to 10) of a key feature of their health care experience. For example, the composite measure for “how well doctors communicate” is based on four individual questions that ask if the enrollee's personal doctor explained things in a way that was easy to understand, listened carefully to the enrollee, showed respect for what the enrollee had to say, and spent enough time with the enrollee. We also present scores for one individual measure—the share of enrollees who received a flu shot—that is part of both the MA and MMP quality incentives. Our focus on a limited number of measures is consistent with AHRQ guidance and similar to the approach CMS uses to incorporate CAHPS scores in the MA star ratings (Agency for Healthcare Research and Quality 2015, Centers for Medicare & Medicaid Services 2022).⁷

We used beneficiary and plan identifiers, as we did with the HEDIS data, to determine which CAHPS respondents were dual-eligible beneficiaries and to

**TABLE
14-5**

CAHPS® scores from 2022 surveys, by plan type

	Overall average for all plan types	Coordination- only D-SNPs	HIDE-SNPs and FIDE-SNPs			
			Unaligned	Aligned	MMPs	Other MA plans
Composite measures						
Getting care quickly	74	76 (+)	73 (-)	74	74	75
Getting needed care	78	80 (+)	78	78	77 (-)	79
How well doctors communicate	89	90 (+)	89	90	89 (-)	89
Customer service	83	84 (+)	83	83	83	82
Care coordination	84	86 (+)	84	84	83	84
Getting needed prescription drugs	90	91 (+)	90	90	89 (-)	90
Enrollee ratings						
All health care	84	85	85	84	83 (-)	84
Personal doctor	91	91	90	91	89 (-)	91
Specialist	88	89	88	89	88	88
Health plan	89	91 (+)	90 (+)	89	87 (-)	87 (-)
Drug plan	90	91 (+)	91 (+)	91	89 (-)	89 (-)
Individual measure						
Received annual flu shot	68	65 (-)	66 (-)	73 (+)	69	70

Note: CAHPS® (Consumer Assessment of Healthcare Providers and Systems®), D-SNP (dual-eligible special needs plan), HIDE-SNP (highly integrated dual-eligible special needs plan), FIDE-SNP (fully integrated dual-eligible special needs plan), MMP (Medicare-Medicaid Plan), MA (Medicare Advantage). All scores have been converted to a 0 to 100 scale (from low to high) for ease of interpretation and, except for the flu shot measure, have been case-mix adjusted for response bias. Figures do not include plans in the U.S. territories.
(+) Score is better than overall average and difference is statistically significant ($p < 0.05$).
(-) Score is worse than overall average and difference is statistically significant ($p < 0.05$).

Source: MedPAC analysis of CAHPS person-level data and D-SNP integration data for 2022.

assign them to the five comparison groups specified in the BBA mandate. We divided the D-SNP enrollees based on the integration criteria that each plan met in 2022. We also adjusted survey responses to account for differences in case mix, using the same factors that CMS applies when it adjusts CAHPS responses to calculate the MA star ratings. Finally, we converted the scores on each measure to a scale of 0 to 100 (from low to high) for ease of interpretation.

The CAHPS scores for each comparison group are shown in Table 14-5. Instances in which the difference between the score for a given plan type and the average score for all plan types were statistically significant using a t-test are marked with a plus sign

(+) when the plan type performed better and a minus sign (-) when the plan type performed worse.⁸ We found that the coordination-only D-SNPs, as a group, had higher scores on many measures, including all of the composite measures, and that the MMPs tended to have lower scores on many measures. This finding is somewhat counterintuitive since the level of integration is relatively low in coordination-only D-SNPs and high in MMPs. As with the HEDIS measures, structural differences between MA plans and MMPs may contribute to the somewhat lower scores for MMPs on CAHPS measures.

However, the differences between the highest- and lowest-performing plan types are relatively small in

absolute terms—only a few percentage points for most measures—and may not be very meaningful for beneficiaries. CMS has used a difference of 3 percentage points, as it has with HEDIS scores, as a threshold for “practical significance” in some analyses (Centers for Medicare & Medicaid Services 2023c). Using this threshold, the only measures with meaningful differences in scores were the overall health plan rating (for which coordination-only D-SNPs performed better than MMPs and other MA plans) and the share of enrollees who received a flu shot (for which FIDE-SNPs and HIDE-SNPs with exclusively aligned enrollment performed better than the other plan types).

Other analyses have also found that CAHPS scores for many measures tend to cluster within a narrow range. For example, the Commission identified clustering as one weakness of the MA star rating system and noted that the minimal differences in scores may not provide a reasonable basis for deciding which plans should receive a quality bonus (Medicare Payment Advisory Commission 2019). Similarly, a study that used CAHPS data from 2015 to 2019 found relatively small differences in the scores for dual-eligible beneficiaries enrolled in D-SNPs versus other MA plans (Haviland et al. 2021). Most recently, a study that used CAHPS data from 2015 to 2018 to compare the experience of dual-eligible beneficiaries in FIDE-SNPs, other D-SNPs, and other MA plans found relatively small differences in the scores for those plan groupings (Meyers et al. 2023).

The lower scores for MMPs, as with the HEDIS scores, may also be partly due to differences in the MA and MMP quality incentives. The MA star ratings use 9 of the 12 measures shown in Table 14-5 (p. 481), while the MMP quality withhold uses only 1 measure. On the only measure used in both systems, the flu shot measure, MMP performance was in the middle compared with the other plan types.

Most MMPs will likely convert into D-SNPs

MMPs are part of a broader effort known as the financial alignment demonstration in which CMS and states have tested new models of care for dual-

eligible beneficiaries. Participating states have tested one of three models: (1) a capitated model that uses managed care plans (the MMPs) to provide both Medicare and Medicaid services, (2) a managed FFS model that provides greater care coordination to dual eligibles who are enrolled in both FFS Medicare and FFS Medicaid, and (3) an alternate model that tested new ways to integrate Medicare and Medicaid administrative functions within D-SNPs. CMS is conducting the demonstration using the authority of its Center for Medicare & Medicaid Innovation.

Most participating states (10 of 13) have tested the capitated model. There have been a total of 11 separate demonstrations using MMPs (New York had 2 demonstrations) that started between 2013 and 2016. The MMPs are distinctive because they provide all Medicare-covered and all or most Medicaid-covered services to their enrollees and are more highly integrated than even FIDE-SNPs. The MMPs are also noteworthy because states are allowed to passively enroll beneficiaries (who can opt out if they wish) and plans are paid using a blended Medicare-Medicaid payment rate that is reduced to reflect expected savings. We examined the financial alignment demonstration in depth in our June 2018 and June 2016 reports (Medicare Payment Advisory Commission 2018, Medicare Payment Advisory Commission 2016).

At their peak, MMPs had between 400,000 and 450,000 enrollees, making the demonstration one of the largest specifically aimed at dual-eligible beneficiaries. Eight of the 11 demonstrations (in Illinois, Massachusetts, Michigan, New York (1 of 2 demonstrations in New York), Ohio, Rhode Island, South Carolina, and Texas) are still in operation, while 3 (in California, New York (the other of 2 demonstrations in New York), and Virginia) have ended. About 300,000 beneficiaries are currently enrolled in MMPs, with the majority in Illinois and Ohio.

CMS has contracted with RTI International (RTI) to evaluate the effects of each demonstration on areas such as program costs and service use. The evaluations that have been released so far typically cover the first four to five years of a demonstration (Feng and Greene 2023a, Feng and Greene 2023b, Feng and Greene 2023c, Feng and Greene 2023d, Feng and Greene 2023e, Feng and Greene 2023f, Feng and Greene 2023g, Feng and Greene 2022a, Feng and Greene 2022b, Feng

and Greene 2021a, Feng and Greene 2021b). Those evaluations have found:

- *Higher Medicare spending.* Eight MMP demonstrations have resulted in statistically significant increases in Medicare spending, with estimates ranging from 3.1 percent to 9.8 percent. These estimates were based on a comparison of Medicare spending under the demonstration and an estimate of what Medicare would have spent without the demonstration. Two MMP demonstrations also led to higher spending, but the differences were not statistically significant; RTI did not estimate the effects of one MMP demonstration due to data limitations.
- *Challenges in estimating effects on Medicaid spending.* RTI has not been able to estimate the Medicaid spending effects of 7 of the 11 MMP demonstrations due to a variety of data limitations. Among the four MMP demonstrations where RTI was able to calculate an estimate, two demonstrations have seen statistically significant increases in Medicaid spending, ranging from 6.6 percent to 32.0 percent. These estimates were based on a comparison of Medicaid spending under the demonstration and an estimate of what Medicaid would have spent without the demonstration. The other two demonstrations had effects on Medicaid spending (higher in one case and lower in the other) that were not statistically significant.
- *Mixed effects on service use.* One key question about the MMP demonstrations had been whether MMPs could achieve more desirable patterns of service use—for example, reducing the use of inpatient hospital services, emergency rooms, and nursing homes, and expanding the use of primary care, ambulatory care, and home- and community-based forms of LTSS. RTI produced estimates for 7 of the 11 MMP demonstrations. It found that the use of physician evaluation and management services had increased in four demonstrations, with statistically insignificant changes in the other three demonstrations. RTI also found that beneficiaries in three demonstrations were more likely to have an emergency room visit, with statistically insignificant changes in the other four demonstrations. However, the effects on other

services—such as inpatient admissions and long nursing home stays—were mixed, with increases in some demonstrations and decreases in others.

The findings from the evaluations are somewhat challenging to interpret given the analytic approach that was used. RTI measured the effects of the demonstrations by comparing dual-eligible beneficiaries who are eligible for the demonstrations (whether or not they actually participate) with similar groups of dual eligibles in other states. The participation rates for many demonstrations have been lower than expected, often between 20 percent and 40 percent, making it less clear that any differences between the demonstration-eligible and comparison populations are due to the demonstration rather than other factors. However, higher Medicare spending has been a reasonably consistent finding, even in demonstrations with relatively high participation rates. The evaluations also do not explain exactly *why* the demonstrations have increased spending.

CMS has announced that it plans to end the MMP demonstrations in 2025. When that happens, we expect most MMPs to convert into D-SNPs. In most cases, these successor plans will likely have some meaningful level of integration with Medicaid and qualify as either HIDE-SNPs or FIDE-SNPs. At that point, unless policymakers develop an entirely new plan type, any future efforts to improve Medicare-Medicaid integration will likely use the D-SNP model as a starting point.

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Conclusion

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Dual-eligible beneficiaries tend to be in poorer health than other Medicare beneficiaries and may face challenges obtaining care from two separate programs. Managed care plans that provide both Medicare and Medicaid services, such as D-SNPs, have the potential to improve care for this population, but their level of integration with Medicaid varies. Unfortunately, HEDIS and CAHPS quality data provide limited insight into the relative performance of D-SNPs because most HEDIS measures are not tied to clinical outcomes and because HEDIS and CAHPS scores on many measures are fairly similar across plan types. These challenges are not

unique to D-SNPs and reflect larger difficulties in assessing the quality and performance of MA plans. For our next mandated report, we plan to add ambulatory care-sensitive hospitalization rates (calculated using

a combination of MA encounter data and hospital discharge data) to provide another way of assessing plan performance. ■

Endnotes

- 1 When dual eligibles receive assistance with Medicare cost sharing, Medicaid law lets states limit their payment to the lesser of the Medicare cost-sharing amount or the difference, if any, between the Medicare and Medicaid payment rates for the service. Most states have these “lesser of” policies; since Medicaid rates are typically lower than Medicare rates, states may pay only a portion of the cost sharing or none at all. When states do not pay the entire cost-sharing amount, providers cannot bill beneficiaries for the difference.
- 2 ADLs include eating, using the toilet, personal hygiene, and transferring (being able to move from one setting to another, such as getting in and out of a chair). Most states require Medicaid beneficiaries to need help with two or three ADLs to qualify for nursing home care or community-based forms of long-term care.
- 3 CMS also requires coordination-only D-SNPs to have a unified process for handling appeals and grievances if they have exclusively aligned enrollment and provide a minimum set of Medicaid-covered services. The various types of D-SNPs that are required to have a unified process for handling appeals and grievances are collectively referred to as applicable integrated plans.
- 4 Starting in 2025, CMS will require FIDE-SNPs to use exclusively aligned enrollment. Among FIDE-SNPs that do not currently use exclusively aligned enrollment, some plans may modify their enrollment rules to comply with the new requirement (thus keeping their FIDE-SNP status), while some plans may decide instead to become HIDE-SNPs, which are not required to use exclusively aligned enrollment.
- 5 HEDIS® is a registered trademark of the National Committee for Quality Assurance; CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.
- 6 One type of variation that we investigated was the share of enrollees who qualify for full or partial Medicaid benefits. In 2021, partial-benefit dual eligibles accounted for 53 percent of the dual eligibles enrolled in other MA plans and 30 percent of HIDE-SNP and coordination-only D-SNP enrollees, but less than 1 percent of FIDE-SNP and MMP enrollees. When we calculated HEDIS scores using data for full-benefit dual eligibles only, the effects on our findings were relatively modest.
- 7 As part of the MA star ratings, CMS uses five of the six composite measures, three of the five measures in which enrollees rate their health care experience, and the flu shot measure.
- 8 We measured statistical significance by comparing the score for each plan type with the unweighted average of the scores for all plan types. As a sensitivity test, we also measured statistical significance using the enrollment-weighted average of the scores for all plan types. Using this alternate method had very little effect on our findings.

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CHAPTER 15

Mandated report: Rural emergency hospitals

Mandated report: Rural emergency hospitals

Chapter summary

Since 1983, when Medicare moved from paying hospitals on the basis of their costs to prospectively determined rates, policymakers have sought ways to financially support rural hospitals, which may be the sole provider of hospital care in their communities. Historically, Medicare's support for rural hospitals has focused on making inpatient services more profitable. However, inpatient volume has declined dramatically over the past 40 years, especially at rural hospitals. Such declines diminish the impact of Medicare's inpatient-centric support of hospitals and, in the 2010s, contributed to an increase in rural hospital closures.

This situation led the Congress to create the new rural emergency hospital (REH) designation in the Consolidated Appropriations Act, 2021 (CAA). As an REH, a hospital will:

- not furnish inpatient care;
- have an emergency department that is staffed 24/7;
- be paid fixed monthly payments from Medicare of approximately \$270,000 in 2023 (which amounts to \$3.2 million per year);
- be paid 105 percent of standard outpatient prospective payment system rates for emergency and outpatient services; and

In this chapter

- Evolution of Medicare's support for rural hospitals
- Adjusting payment policy to acknowledge the dramatic shift away from inpatient care in rural areas
- Medicare's support for rural hospitals has reduced closures
- Rural emergency hospitals: Which hospitals are converting?

- meet other criteria (e.g., have a transfer agreement with a Level I or II trauma center).

The CAA requires the Commission to report annually on payments to REHs, beginning in March 2024. Because this program began in 2023, complete REH claims data are not yet available. Therefore, this chapter provides context on the evolution of Medicare’s support for rural hospitals, gives background on the REH designation and the hospitals that have converted to REHs, and describes our 2023 site visits to (prospective) REHs to understand their experiences and decision-making processes.

In 2023, 21 hospitals converted to REHs, 6 of which were critical access hospitals and 15 of which were paid based on prospective payment systems. Before converting, these hospitals often furnished a low (and declining) volume of inpatient care, received enhanced payments from Medicare (through cost-based payments or other special payments), were located relatively close to other hospitals, and had financial difficulties. The REH designation has been seen as a way for many communities that cannot support a full-service hospital to overcome financial difficulties and retain local access to emergency and outpatient services.

Rural communities have to balance issues of travel time, quality of care, and cost of care when determining whether their local hospital should become an REH. Because of the difficult decision such a choice presents to communities, the newness of the program, and other issues, the Commission contends that the modest number of hospitals that have transitioned to date does not indicate an immediate need to revise the fundamental parameters of the REH designation. Instead, the Commission will continue to monitor the new REH designation, including analyzing REH claims data when they become available, and consider possible modifications in the future. ■

Mandate to review payments to rural emergency hospitals

MEDPAC REVIEW OF PAYMENTS TO RURAL EMERGENCY HOSPITALS.—Each report submitted by the Medicare Payment Advisory Commission under section 1805(b)(1)(C) of the Social Security

Act (42 U.S.C. 1395b–6(b)(1)(C)) (beginning with 2024), shall include a review of payments to rural emergency hospitals under section 1834(x), as added by subsection (a). ■

Evolution of Medicare's support for rural hospitals

From the beginning of the program until 1983, Medicare paid hospitals based on their costs. Cost-based payments encouraged long hospital stays, and Medicare hospital spending grew rapidly. From 1967 to 1983, Medicare hospital spending increased more than 10-fold, from \$3 billion to \$37 billion (Office of Inspector General 2001). To constrain costs, the Congress passed the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). TEFRA contained some limits on how fast hospitals' cost-based payments could grow and required the Secretary of the Department of Health and Human Services to develop a plan for an inpatient prospective payment system (IPPS) for hospitals. The hospital industry objected to the TEFRA limits on cost growth, and the Congress continued to be concerned about cost-based payments fueling the growth in Medicare spending (Quinn 2014). As a result, the Congress enacted an IPPS in 1983. The IPPS set prospective payment rates for acute care hospital services to encourage hospitals to reduce the costs of inpatient stays. Hospitals could profit under the new IPPS by reducing their costs per admission, such as by shortening patients' length of stay. As hospitals' cost growth per admission declined (and hospital profits increased), the Medicare program was able to slow growth in payment rates per admission and generate savings for the taxpayer (Prospective Payment Assessment Commission 1995b).

However, some rural advocates and policymakers were concerned that the IPPS might put undue financial

pressure on small rural hospitals, so they sought ways to financially support these hospitals. Historically, most rural hospital revenues were generated from inpatient services, with inpatient care revenue being seven times that of hospital outpatient care revenue in 1980 (Prospective Payment Assessment Commission 1995a). Because hospitals' financial viability was dependent on inpatient revenue, much of the financial support targeted at rural hospitals in the 1980s focused on ways to increase Medicare inpatient payments above standard IPPS rates.

The Congress enacted a series of inpatient-centric Medicare programs to support rural hospitals, including sole community hospitals (SCHs) in 1983, Medicare-dependent hospitals (MDHs) in 1989, critical access hospitals (CAHs) in 1997, and low-volume hospitals (LVHs) in 2005.¹ By 2018, over 95 percent of rural hospitals were CAHs, MDHs, or SCHs, or they qualified as LVHs and received above-standard Medicare inpatient rates (Medicare Payment Advisory Commission 2021b).² Some rural hospitals qualify for more than one of these programs, receiving an LVH adjustment while also receiving special payment rates through their designation as an SCH or MDH.

The Commission has recommended financial support for necessary providers that have high costs due to factors outside of their control, such as supporting isolated providers with low patient volume (Medicare Payment Advisory Commission 2018, Medicare Payment Advisory Commission 2001). Special payments to provide this financial support should be empirically determined, narrowly targeted, and not duplicative of other payment adjustments (Medicare Payment Advisory Commission 2012).

Declining inpatient volume at rural hospitals diminishes impact of Medicare's inpatient-centric supports

Inpatient volume has declined dramatically over the past 40 years, reducing the effectiveness of Medicare's inpatient-centric supports. Between 1983 and 2021, national Medicare inpatient fee-for-service (FFS) days per capita declined by 70 percent (Medicare Payment Advisory Commission 2023b, Prospective Payment Assessment Commission 1995a). Not only has the aggregate volume of all hospital admissions declined dramatically, but rural hospitals' share of those admissions has also declined relative to urban hospitals. For example, even over the relatively short period from 2016 to 2022, rural hospitals' share of acute inpatient FFS admissions fell from 12.5 percent to 11.3 percent, whereas urban hospitals' share increased by a commensurate amount.

Occupancy is particularly low in the smallest rural hospitals (e.g., CAHs). By 2022, CAHs had an average daily census of seven occupied beds. Among the smallest 300 CAHs, the average daily census (combining acute inpatient, post-acute swing bed care, and observation patients) was fewer than 3 patients. Despite the small number of patients, hospitals were historically required to maintain an inpatient department to participate in the Medicare program as a hospital.

Reasons for the declining share of admissions in rural hospitals relative to urban hospitals

Rural hospitals' share of all inpatient admissions is declining while urban hospitals' share is increasing for multiple reasons. First, a portion of the decline reflects changes in technology. Forty years ago, rural heart attack and stroke patients may have been treated locally at a rural hospital. Today, heart attack patients are commonly transported to facilities that offer angioplasty and cardiac surgery. Even the smallest rural hospitals frequently have a helicopter pad outside of their hospital to facilitate these transfers. Similarly, a stroke patient who might have been treated locally 40 years ago may now be transported to a larger hospital that has a stroke center. Admissions that bypass local hospitals due to technological change are seen as contributing to an "unavoidable" increase in bypass rates because it is impractical to expect small

rural hospitals to maintain high-cost technologies or specialized staff (e.g., a cardiac catheterization lab) to treat very few cases. However, bypassing the local hospital is not always unavoidable. In 2018, rural FFS Medicare beneficiaries bypassed their local hospital for about one-third of inpatient admissions even when services were available locally (Knudson et al. 2020). Declining inpatient care nationally, technological changes, and beneficiaries increasingly choosing to bypass their local hospital have all reduced rural inpatient volumes.

Effect of declining inpatient volumes

Declining volume may raise concerns about the quality of services, especially in the smallest hospitals. Researchers have long found a relationship between volume and outcomes for some types of surgeries (Birkmeyer et al. 2002, Finks et al. 2011, Halm et al. 2002, Luft et al. 1979, Vogel et al. 2010).³ Even for the types of admissions common in small rural hospitals (e.g., pneumonia, congestive heart failure), some research indicates that low-volume rural hospitals tend to have worse outcomes than higher-volume rural and urban hospitals (Joynt et al. 2015, Joynt et al. 2013, Medicare Payment Advisory Commission 2012, Moscovice and Casey 2011, Silber et al. 2010). This literature suggests that there may be quality benefits to merging the inpatient services of two small hospitals that are close to each other when both are struggling because of very low volumes (e.g., 2 hospitals 15 miles from each other that each have an average daily census of 4). However, combining inpatient services into one hospital would be politically difficult, and communities would need to balance concerns about quality of care, reduced competition, increased travel times, and the costs to taxpayers of maintaining excess capacity.⁴

Declining inpatient volumes can also materially affect hospitals' financial stability and can ultimately lead to hospitals closing. For example, we examined changes in inpatient volume at the 40 rural hospitals that closed between 2015 and 2019. In the decade prior to closure (2005 to 2014), total (all-payer) inpatient admissions at these 40 hospitals fell by an average of 54 percent. In comparison, over the same period, hospitals that remained open saw total (all-payer) inpatient admissions decline by 3 percent (among

urban hospitals), 19 percent (among rural micropolitan hospitals), and 32 percent (among other rural hospitals). Among the closed hospitals, we found that inpatient admissions declined across a broad range of service lines, and the decline was not attributable to overall population change: Over the same period, the population of the counties in which these hospitals were located declined by an average of only 1 percent (Medicare Payment Advisory Commission 2021b).⁵

Even relatively high payment rates from FFS Medicare are often insufficient to offset the financial effects of declining inpatient volumes. For example, the chief executive officer of a hospital that received special payments under Medicare (as an SCH and LVH) chose to convert to a rural emergency hospital (REH) because the number of inpatients to which that special rate applied reached a point that was too low to remain profitable financially (Medsphere 2023).

The continuing decline in inpatient volume among rural hospitals and an increase in rural hospital closures in the latter half of the 2010s—even though nearly all rural hospitals received enhanced Medicare payment rates—led some stakeholders (including the Commission) to suggest the need for a new model of supporting rural hospitals. Rather than focusing on increasing the profitability of the (dwindling) volume of inpatient care, the new model would focus on making emergency care financially viable and resilient to declining inpatient volumes.

Adjusting payment policy to acknowledge the dramatic shift away from inpatient care in rural areas

In 2018, the Commission recommended that Medicare create a new category of hospital: an outpatient-only facility with a 24/7 emergency department (ED). Rather than being paid on a purely FFS basis, the new outpatient-only hospitals would receive a fixed monthly payment to help support the hospitals' standby costs of maintaining an ED plus PPS rates for each outpatient service. Medicare's total spending per hospital—including the fixed payment—was expected to be similar to the cost of providing cost-based payments to a CAH. By having Medicare cover a large

share of hospitals' ED standby costs, isolated rural communities could preserve emergency access, even if the area's low population density resulted in limited patient volumes. In return for receiving a fixed monthly payment from the Medicare program, the hospital would guarantee 24/7 access to emergency services for Medicare beneficiaries.

Consistent with the Commission's recommendation, the Congress created the REH designation in the Consolidated Appropriations Act, 2021 (CAA). As an REH, a hospital will:

- not furnish inpatient care;
- have an ED that is staffed 24/7;
- be paid fixed monthly payments from Medicare of about \$270,000 in 2023 (which amounts to approximately \$3.2 million per year);⁶
- be paid 105 percent of standard outpatient prospective payment system (OPPS) rates for emergency and outpatient services provided to Medicare FFS beneficiaries and standard rates for other services; and
- meet other criteria (e.g., have a transfer agreement with a Level I or II trauma center).

Becoming an REH is voluntary, meaning hospitals can choose whether or not they want to transition to an REH. Hospitals eligible to transition to an REH are those that, as of December 27, 2020, were a CAH or a PPS hospital with 50 or fewer beds in a rural county.⁷

Hospitals that choose to convert to REHs are allowed to convert back to full-service hospitals, although REHs that want to convert back to CAHs will need to be located a specified distance from the next-nearest hospital—more than 35 miles from the next-nearest hospital or more than 15 miles away in mountainous areas or areas where only secondary roads are available. In 2013, the Office of Inspector General found that nearly two-thirds of all CAHs would not meet this distance requirement (Office of Inspector General 2013). Most of the CAHs that would not have met the distance requirement were “necessary provider” CAHs, which did not have to meet the distance requirement when they were initially certified.⁸

REHs are required to offer ED and observation care.⁹ REHs must maintain an annual average per patient length of stay of 24 hours or less. Thus, any particular beneficiary is able to stay in observation care at an REH for more than 24 hours, but the REH's average must be 24 hours or less across all their patients. For example, if an REH had 1,000 ED visits that averaged 3 hours a visit and 200 observation stays that averaged 2 days a stay, the hospital would have an average length of stay of 10.5 hours and meet the REH length-of-stay requirement.¹⁰

REHs can also choose to offer a broad range of outpatient services. All services that are paid under the OPPS when furnished in an OPPS hospital can, with the exception of acute inpatient services, be provided by REHs. REHs can also furnish other services that are not paid through the OPPS, such as ambulance services.

REHs are also exempt from certain site-neutral payment policies. The Bipartisan Budget Act of 2015 lowered the payment rate for certain off-campus outpatient departments in order to make Medicare's total payment (physician fee schedule plus OPPS payments) for services rendered in these settings similar to the total if the service had been performed in a clinician's office. However, these lower payment rates do not apply to REHs, so they receive 105 percent of the full OPPS rates. In addition, REHs' provider-based rural health clinics are able to retain their grandfathered status, which results in substantially higher payment rates than if the rural health clinics were subject to the national statutory payment limit for rural health clinics.

The monthly fixed payments that REHs receive are updated annually by the increase in the hospital market basket. This predictable increase in revenue stands in contrast to the declining volume that many rural hospitals have experienced and makes transitioning to an REH more attractive to hospitals to the extent that their inpatient volumes (and associated revenues) continue to decline. The fixed payments also benefit hospitals in areas with increasing Medicare Advantage (MA) penetration because the fixed payments are made directly from the federal government to hospitals. REHs are therefore not reliant on MA plans matching high FFS rates, which anecdotal reports suggest sometimes does not occur.

(See the text box for more information about how REH payments affect the MA program, p. 498.)

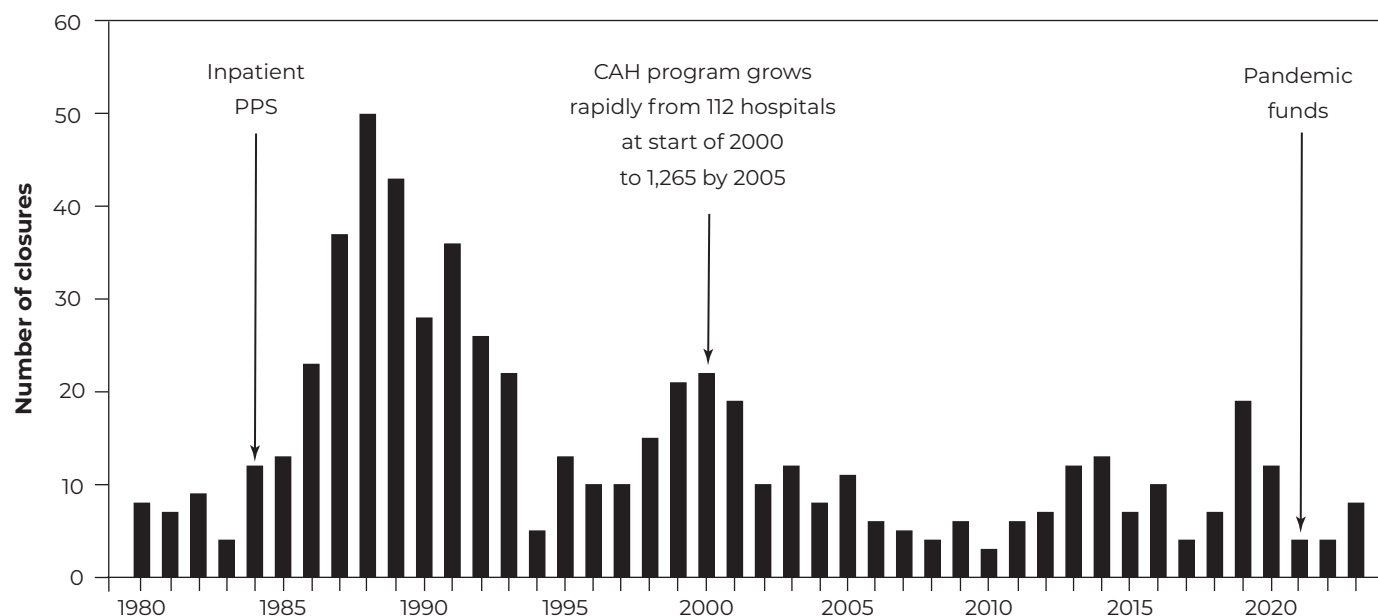
The fixed payments that REHs receive are also allowed to be used flexibly. For example, some hospitals may choose to spend the funding on expanding telehealth services, while others might spend it on supporting an ambulance service. This flexibility promotes local control over the funding and accounts for the heterogeneity of needs across rural communities.

Beneficiary cost sharing for services furnished by REHs will be lower than or similar to their cost sharing before hospitals converted. Cost sharing for REH services is based on standard OPPS rates. If an REH was previously a PPS hospital, beneficiary cost sharing will be similar to the amount that beneficiaries paid before the conversion.¹¹ However, if an REH was previously a CAH, beneficiary cost sharing will decrease substantially because beneficiary cost sharing at CAHs is based on 20 percent of charges (not costs) and can far exceed cost sharing under the OPPS. For example, the Office of Inspector General has found that for 10 outpatient services that were frequently provided at CAHs, beneficiaries paid between 2 and 6 times the amount in coinsurance that they would have for the same services at hospitals paid under the OPPS (Office of Inspector General 2014).

Medicare's support for rural hospitals has reduced closures

Rural hospitals are not homogeneous. They range from tertiary care hospitals with revenue of \$1 billion to small facilities with \$5 million total annual revenue. Large rural facilities often have pricing power and economies of scale that allow them to generate all-payer profit margins that are comparable with those of urban hospitals (Maxwell et al. 2020, Pink et al. 2013, Thomas et al. 2015). In contrast, the smallest hospitals lack economies of scale, and if their patient volumes fall far enough, they may close.¹²

Though not all closures are negative and other metrics may also be important markers of financial health, the rate of closures often drives interest in changing or enhancing support for rural hospitals. Thus, we track

**FIGURE
15-1****Number of rural hospital closures by year, 1980–2023**

Note: PPS (prospective payment system), CAH (critical access hospital). All counties that are not part of a metropolitan statistical area are considered rural, including micropolitan areas. A micropolitan area contains an urban core of at least 10,000 individuals (but less than 50,000). Other rural areas do not contain a city of at least 10,000. The Commission measures closures in each fiscal year starting in October in order to align closures with changes in payment rates. Earlier work by the Office of Inspector General and the Government Accountability Office measured closures using calendar years.

Source: MedPAC analysis of hospitals participating in Medicare and past reports by the Office of Inspector General and the Government Accountability Office (Government Accountability Office 2018, Government Accountability Office 1991, Medicare Payment Advisory Commission 2023a, Medicare Payment Advisory Commission 2021a, Medicare Payment Advisory Commission 2020a, Medicare Payment Advisory Commission 2020b, Medicare Payment Advisory Commission 2019, Medicare Payment Advisory Commission 2006, Office of Inspector General 2003, Office of Inspector General 1991, Office of Inspector General 1990).

the history of closures from the few years immediately preceding the implementation of the IPPS in 1983 to show that Medicare's special payments to rural hospitals have reduced closures. We also discuss why some rural closures continue to occur despite substantial federal support.

After the IPPS was implemented in October 1983, the number of rural hospital closures increased. Special rural payment policies enacted in the 1980s and 1990s increased payments to rural hospitals and reduced closures. For example, the CAH program (which provides cost-based payments for inpatient, outpatient, and post-acute swing bed services) was enacted in 1997 and grew rapidly from 2000 to 2005, when the

program expanded from 112 hospitals (5 percent of rural hospitals) to 1,265 hospitals (over 50 percent of rural hospitals). In the years after this rapid growth, rural hospital closures declined (Figure 15-1).

However, some rural hospitals continued to close because substantial declines in volume resulted in unsustainably high costs per service. For example, by 2021, CAHs' average costs for post-acute care had increased to \$2,400 per day, more than five times the cost that competing skilled nursing facilities incurred to furnish the same service (i.e., \$440 per day). Even with FFS Medicare paying the high cost of caring for its patients, some CAHs closed because they had difficulty

Rural emergency hospital payments and Medicare Advantage benchmarks

CMS bases payments to Medicare Advantage (MA) plans partially on county-level fee-for-service (FFS) spending per beneficiary. Like nearly all other FFS payments, rural emergency hospitals' (REHs') enhanced FFS outpatient prospective payment rates will be incorporated into county-level benchmarks. While the data are not yet available, we expect that MA plans will pay rates similar to FFS rates for outpatient hospital services at REHs.

REHs also received fixed monthly payments equal to an annual total of \$3.2 million per REH in 2023. However, unlike the payments for furnishing services, we do not expect MA plans to match the fixed payments coming directly from Medicare for multiple reasons. First, especially for MA plans with few enrollees who use REHs, the extra payments that MA plans would need to make to match Medicare's fixed payments would be very high per service, and coordinating extra payments across

multiple MA plans whose enrollees use REHs would be administratively complex. Second, MA plans have an incentive to reduce their spending in order to bid lower so that they can offer extra benefits to beneficiaries and attract more beneficiaries to enroll. Third, we are unaware of any requirements mandating that MA plans match Medicare's fixed payments. And, fourth, in conversations with the first group of hospitals that have converted to REHs, we have not heard of any MA plans paying REHs fixed payments similar to those being paid by the Medicare program.

Excluding REH fixed payments from MA benchmarks would also promote equity between FFS and MA because plans would not be paid (through higher benchmarks) for doing something they are not expected to do (i.e., match the fixed payments to REHs). Therefore, policymakers may want to consider clarifying that REHs' fixed payments should be excluded from MA benchmarks in the future. ■

obtaining large enough payments from commercial insurers, Medicaid, and MA plans to cover the costs of care for those patients and for patients without insurance (Medicare Payment Advisory Commission 2021b). These other payers may not be willing to pay CAHs at rates that are equal to or above Medicare's cost-based rates when alternative providers are willing to provide care for far lower rates.

As a result of these shifting dynamics, the slowdown in rural hospital closures that occurred after the expansion of the CAH program was temporary. Around 2013, the number of closures began to increase again and continued at elevated levels through 2020 (Figure 15-1, p. 497). From 2013 to 2020, an average of 10.5 rural hospitals closed per year.

In 2021 and 2022, rural hospital closures slowed to four per year as hospitals received pandemic relief funds that were greater than the additional costs associated

with the pandemic. After those funds stopped flowing in 2023, the rate of rural closures increased to eight. Those 8 closures are still below the long-run annual average of 14 from 1980 to 2023.

Rural emergency hospitals: Which hospitals are converting?

Because the main goal of the new REH designation was to maintain access to emergency care, we analyzed why the eight rural hospitals that closed in 2023 did so instead of converting to REHs. We identified several reasons:

- Two hospitals are considering reopening as REHs, but they did not have time to convert prior to closure.

- One hospital became an outpatient facility of another hospital with a 24/7 ED but cannot convert to an REH because the state has not yet put REH regulations in place.¹³
- One hospital converted to an outpatient department of a neighboring hospital owned by the same hospital system.
- One hospital is less than two miles from another CAH.
- Three hospitals have more than 50 beds (making them ineligible to convert to REHs); 2 of these hospitals are in the process of reopening as full-service hospitals.

These findings suggest that the new REH designation will not prevent all rural hospital closures, and that might not always be undesirable. For example, subsidizing an REH that is two miles from a CAH is likely not an efficient use of taxpayer funding. It may make sense to consolidate inpatient volume in one facility when two nearby hospitals are both struggling with low volumes, given that low volumes can raise quality and cost concerns. Nevertheless, some stakeholders have highlighted potential issues that could be addressed in the future to allow a larger number of hospitals to convert to REHs, including state-level issues (e.g., state licensing and Medicaid payments) and federal-level issues (e.g., allowing all CAHs to revert back to CAH status and allowing REHs to participate in the 340B program) (Walters et al. 2023).

While the new REH designation did not prevent all closures, we expect that the program will keep the number of rural hospital closures below the annual average of 14 closures per year from 1980 to 2023. In 2023, the program likely prevented several closures, as is indicated by the historical volume trends and other characteristics of the 21 hospitals that have already converted to REHs.

Characteristics of rural emergency hospitals

In 2023, 21 hospitals converted to REHs.¹⁴ Six of these hospitals had been CAHs, and the remaining 15 had been paid based on PPS rates (Table 15-1, p. 500). Prior to converting, all but one of the hospitals received cost-based payments as CAHs or qualified as LVHs (and received an average add-on of 24 percent to IPPS

rates in 2022).¹⁵ Seven hospitals also qualified as SCHs and three qualified as MDHs. (SCHs and MDHs receive inpatient payments based partially on their historical costs in addition to any applicable LVH adjustment.)

The 21 REHs tended to be located relatively close to other general acute care hospitals—on average, 15 to 35 miles away (Table 15-1, p. 500). Of the 21 REHs, 5 were located less than 15 miles from the next-nearest hospital, 14 were located between 15 miles and 35 miles from the next-nearest hospital, and 2 were more than 35 miles from the next-nearest hospital.

In the decade prior to converting to REHs, the volume of inpatient care furnished at these 21 hospitals declined substantially. On average, from 2011 to 2021, total (all-payer) inpatient admissions declined by 55 percent (Table 15-1, p. 500).¹⁶ Overall population declines appear to explain a small share of the decline in admissions. From 2011 to 2021, the median population decline in the counties in which REHs were located was 4 percent (data not shown). This finding is consistent with our previous research on rural hospital closures that found that the secular declines in inpatient hospital use and rural beneficiaries bypassing their local hospitals were more important factors in explaining declining inpatient admissions among rural hospitals that subsequently closed (Medicare Payment Advisory Commission 2021b).

By 2021, these hospitals averaged 377 total (all-payer) inpatient admissions during the year—about 1 admission per day. Commenting on the decline in inpatient admissions, one local leader of a rural hospital that converted to an REH said that “critical access hospitals across the country have been finding it hard to survive . . . you end up having a hospital that you have to staff for inpatient services, and you literally don’t have inpatient services” (KY3 2023).

Choosing to no longer offer inpatient services is undoubtedly a difficult decision for many rural hospitals and communities. However, our analyses suggest that the hospitals that chose to convert to REHs were furnishing only a modest amount of inpatient care before converting, and many were located within a reasonable distance of another hospital.

Before converting to REHs, the volume of outpatient care furnished at these 21 hospitals was also declining,

**TABLE
15-1****Most hospitals had special FFS Medicare rates, were near other hospitals, and had low inpatient volume before converting to rural emergency hospitals**

Count of REHs	Hospital type (before REH conversion)	Special Medicare FFS payments (before REH conversion)	Miles to nearest general acute care hospital	Total (all-payer) inpatient admissions		
				2011	2021	Percent change
1	CAH	CAH	15–35	77	0	–100%
2	CAH	CAH	>35	259	7	–97
3	CAH	CAH	<15	85	11	–87
4	PPS	LVH	15–35	399	70	–82
5	PPS	LVH, MDH	15–35	327	96	–71
6	CAH	CAH	15–35	216	103	–52
7	CAH	CAH	15–35	366	107	–71
8	PPS	LVH, SCH	>35	210	118	–44
9	CAH	CAH	<15	286	130	–55
10	PPS	LVH, SCH	15–35	639	139	–78
11	PPS	LVH, SCH	15–35	390	216	–45
12	PPS	LVH, MDH	15–35	630	335	–47
13	PPS	LVH, SCH	15–35	612	342	–44
14	PPS	LVH, SCH	<15	908	458	–50
15	PPS	LVH	<15	1,630	492	–70
16	PPS	LVH, SCH	15–35	1,624	551	–66
17	PPS	None	<15	1,865	676	–64
18	PPS	LVH, MDH	15–35	1,853	786	–58
19	PPS	LVH, SCH	15–35	815	820	1
20	PPS	LVH	15–35	1,687	887	–47
21	PPS	LVH	15–35	2,679	1,581	–41
Average			15–35	836	377	–55

Note: REH (rural emergency hospital), FFS (fee-for-service), CAH (critical access hospital), PPS (prospective payment system), LVH (low-volume hospital), MDH (Medicare-dependent hospital), SCH (sole community hospital).

Source: MedPAC analysis of cost reports; Provider Enrollment, Chain, and Ownership System data; provider-specific files; and Quality, Certification and Oversight Reports data.

but at a slower rate than inpatient care. We do not have total (all-payer) data for outpatient visits, so we relied on Medicare FFS data to measure changes in outpatient volume. From 2012 to 2022, the volume of FFS outpatient visits declined at about half the rate of FFS inpatient volume. The change over time in outpatient volume was also less consistent. Six hospitals had flat or increasing FFS outpatient volume before conversion, but the rest experienced declines, some of which were substantial.

Outpatient visits can include a variety of services, such as clinic visits, outpatient surgeries, and ED visits.¹⁷ In 2022, these 21 hospitals averaged about 4,200 outpatient visits for Medicare FFS beneficiaries, or about 11 outpatient visits per day. In the same year, these 21 hospitals furnished an average of about 720 Medicare FFS emergency department visits, or about 2 visits a day. These figures do not include beneficiaries enrolled in MA, individuals with other types of insurance (e.g., commercial, Medicaid), or those without insurance.

Hospitals were generally unprofitable before converting to REHs. In 2022, the median total (all-payer) margin of the 21 hospitals that transitioned to REHs was -11 percent. However, not all hospitals were under equal financial strain before converting. Of the 21 hospitals, 17 hospitals had negative total profit margins, 2 hospitals had a small profit margin, and 2 hospitals had substantial profit margins. The two hospitals with substantial margins were CAHs, furnished virtually no inpatient care, and were part of larger hospital chains. Their margins were higher in 2021 and 2022 than in preceding years, suggesting that the coronavirus pandemic and the associated relief funds could have contributed to their relatively high total margins.

REHs were disproportionately located in the South. Of the 21 REHs, 19 were located in the Southeast or Southwest, with Texas having the highest number of REHs in one state. REHs also varied in terms of their ownership structure and whether they were part of a system. Ten REHs were owned by a governmental entity (e.g., a local hospital district), while 6 were nonprofits and 5 were for profit. Twelve REHs were part of a system, while 9 were not.

Our examination of hospitals that closed or converted to REHs makes it clear that rural hospitals often have unique circumstances and localized patterns of health care delivery. While almost all hospitals that converted to REHs experienced large declines in inpatient admissions prior to converting, their changes in outpatient volume varied substantially. Some REHs are relatively isolated providers that are likely essential for emergency access, but others are closer to alternative sources of care. Most REHs appeared to have converted because of significant financial stress, but a few may have done so because it is a more financially advantageous model for them. Nevertheless, the ability to convert to an REH serves as an option for most rural communities to maintain emergency services even if they cannot support a full-service hospital. Given the hospitals that have chosen to convert, the REH designation appears to be a more efficient and effective method for preserving emergency access than trying to subsidize largely empty inpatient departments in these communities.

Site visits with hospitals transitioning to rural emergency hospitals

Because only a limited number of hospitals have converted to date and claims data are not yet available,

we spoke with a range of REH stakeholders (including researchers, hospital administrators, and rural hospital advocates) and conducted site visits to hospitals that were in the process of transitioning to REHs in order to gain additional qualitative context about hospitals that are considering converting.

In the summer of 2023, Commission staff conducted telephone and on-site interviews with three hospitals that had converted to REHs or were in the process of converting. For the site visits, we toured the facilities and spoke with representatives of those facilities, representatives of a nearby hospital (who might be impacted by a conversion), a local emergency medical services provider, and community leaders. We aimed to better understand why the hospitals chose to convert to REHs, how they planned to operate as REHs, and how their communities reacted to the proposed transition.

Representatives from all the hospitals that converted or were in the process of converting to REHs said their facilities would have closed without the new REH designation. The hospitals had been consistently losing money over several years, except for the years when the hospitals received substantial federal funding during the coronavirus pandemic. The financial losses persisted despite hospitals limiting expenses, reducing unprofitable service lines (e.g., obstetrics and behavioral health), adding financially profitable service lines (e.g., imaging), receiving financial support from state and local organizations (e.g., dedicated local sales tax revenues and charitable donations), and receiving enhanced FFS Medicare payment rates (e.g., LVH and MDH payments).

Hospital representatives cited several factors that drove their financial difficulties, including increasing staff wages, local residents increasingly bypassing their hospitals for more distant hospitals, and the negative financial impacts of expanding MA penetration (e.g., increased denials and reduced payment rates).

The hospitals we visited all had a full-service hospital within 35 miles of their facility. Nonetheless, the loss of inpatient beds was the most prominent concern among the local residents and clinicians, even for a hospital that had an average daily inpatient census of less than two patients (from all payers). Because of the low volume of inpatient care furnished at these hospitals, nearby full-service hospitals will be able

to successfully absorb those cases. The concerns about losing inpatient services focused on patient convenience (as some patients will be required to travel farther to receive inpatient care), additional burden on local emergency medical service providers (as longer ambulance transports might be needed), disruptions of long-established care patterns of local clinicians (who are used to admitting and rounding on their patients locally), and a generalized concern about regional bed capacity for high-acuity patients. While the hospitals that are transitioning to REHs treated relatively few high-acuity inpatients, representatives noted that securing transfers to tertiary hospitals that are often 30 miles to 60 miles away has become increasingly difficult, and some believed that rural hospitals could alleviate the limited capacity of these hospitals by caring for less-acute patients at their hospitals.

When the hospitals convert to REHs, representatives said they would reduce costs in some areas but expand service offerings in others. Multiple representatives said they would be able to reduce nursing costs by reducing reliance on contract nursing or by not filling open positions. Reducing nursing costs is possible because these hospitals had to maintain a certain level of nurse staffing to support their low-volume inpatient departments. After they transition, they will no longer need to maintain nursing staff for that purpose, and representatives said that furnishing outpatient care is less nurse intensive. In contrast, some representatives said they were planning on using some of the additional fixed payments from Medicare to expand outpatient services, make capital improvements to

their facilities, enhance emergency room staffing, and offer other services that they thought the community needed but that were currently unavailable (e.g., transportation services). The variety of ways in which hospital representatives planned on using the monthly payments from Medicare highlights one of the key differences between the REH model and traditional FFS payments: Local hospitals and communities have substantial discretion to decide which services are most needed.

Ongoing monitoring of REHs

The new REH designation's focus on maintaining access to emergency and outpatient care represents a substantial departure from Medicare's historical approach to supporting rural hospitals. Rural communities will have to balance issues of travel time, quality of care, and cost of care when determining whether to close their inpatient departments. Because of the difficult decision that such a choice presents to communities, the newness of the program, and other issues (e.g., lack of state regulations), the modest number of hospitals that have transitioned to date does not imply a need to substantially revise the fundamental parameters of the REH designation. Instead, the Commission will continue to monitor the volume of hospitals that transition to REHs, speak with representatives of rural hospitals that are considering converting, and analyze data to inform any future policy considerations. As part of that ongoing monitoring, the Commission will consider possible modifications to the REH designation in the future. ■

Endnotes

- 1 These models are “inpatient centric” in that they all require hospitals to maintain inpatient services. In addition, most of the supplemental payments to CAHs, MDHs, and SCHs go to increasing acute inpatient and post-acute swing bed payments. CAHs receive cost-based outpatient payments, and SCHs receive a 7.1 percent increase to outpatient prospective payment system rates; however, a large share of supplemental federal payments for these providers are for inpatients. LVH adjustments apply only to inpatient payments.
- 2 For a full description of these special payments, see the Commission’s June 2021 report to the Congress.
- 3 One exception to the volume-outcomes relationship is a study that found 30-day mortality rates were similar for CAHs and larger hospitals for appendectomy, cholecystectomy, colectomy, and hernia repair. CAHs had slightly higher readmission rates but lower reported complications. The combination of fewer complications and higher readmission rates may reflect less complete coding in CAHs (Ibrahim et al. 2016).
- 4 Communities’ desires to maintain their local hospital can make merger negotiations difficult. For example, we talked with an administrator of a hospital in a small community. He and the administrator of the neighboring town’s hospital agreed to merge their two hospitals. Both hospitals were struggling with aging facilities and low patient volumes. But the merger never materialized. The boards of the two hospitals could not agree on which community would gain the new merged hospital, so the communities continued to operate two separate hospitals.
- 5 We used FFS claims to examine whether the decline was due to specific service lines or occurred across multiple service lines. For each of the seven most common diagnosis related groups at the closed hospitals (pneumonia, heart failure, chronic obstructive pulmonary disease, nutritional and metabolic disorders, esophagitis and digestive disorders, kidney and urinary tract infections, and septicemia), we found that volume declined by between 40 percent and 84 percent from 2005 to 2014.
- 6 In 2023, REHs received \$272,866 per month less a 2 percent sequestration adjustment, which nets out to \$267,409 per month or approximately \$3.2 million per year.
- 7 For the purpose of REH eligibility, a rural county is one that is not in a metropolitan statistical area as delineated by the Office of Management and Budget. Hospitals are also eligible if they had 50 or fewer beds and were treated as rural pursuant to 1886(d)(8)(E) (which allows hospitals in metropolitan statistical areas to reclassify as rural if they meet specified criteria that include location in areas that states have declared rural).
- 8 Prior to 2006, states could exempt a CAH from this distance requirement by designating it as a “necessary provider.” Effective January 1, 2006, the Medicare Prescription Drug, Improvement, and Modernization Act prohibited the creation of new necessary-provider CAHs but allowed existing ones to retain their necessary-provider designations permanently. Because states can no longer create new necessary-provider CAHs, REHs that try to revert back to CAHs might be unable to do so.
- 9 Observation care includes ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients require further treatment as hospital inpatients or can be discharged from the hospital. Observation services are commonly ordered for patients who present to the ED and require a significant period of treatment or monitoring for a clinician to make a decision about a patient’s admission or discharge. In most cases, the decision about whether to discharge or admit the patient after resolving the reason for observation care can be made in less than 48 hours, and usually in less than 24 hours. Only in rare cases do reasonable and necessary outpatient observation services span more than 48 hours (Centers for Medicare & Medicaid Services 2020).
- 10 This average length of stay is calculated as $((1,000 \text{ visits} \times 3 \text{ hours per visit}) + (200 \text{ visits} \times 48 \text{ hours per visit})) / (1,000 \text{ visits} + 200 \text{ visits})$.
- 11 Beneficiary cost sharing for REH services is based on standard OPPS rates—i.e., cost sharing is based on 100 percent of OPPS rates, not the 105 percent rate that REHs are paid.
- 12 Some larger rural hospitals may also close due to volume declines or other reasons.
- 13 According to the National Conference of State Legislatures, only 15 states have currently enacted laws enabling REH licensure (National Conference of State Legislatures 2023). Other states have different licensure pathways for REHs. For example, Georgia has not passed a law specifically pertaining to REH licensure but has a preexisting licensure process for freestanding EDs.

- 14 The count of REHs is based on the most recent Provider Enrollment, Chain, and Ownership System data and Quality, Certification and Oversight Reports data as of December 30, 2023. One hospital included in the count of REHs closed after converting to an REH. Hospital leaders cited their inability to pay a \$13 million mortgage debt, which was incurred prior to converting to an REH, as a key reason for closing (Kayser 2023).
- 15 The hospital that was not a CAH and did not qualify as an LVH was located within 15 miles of another PPS hospital. In 2022, one criterion to qualify as an LVH was to be located more than 15 road miles from the nearest Subsection (d) hospital.
- 16 We observed similar declines in inpatient admissions when looking only at Medicare patients (data not shown).
- 17 The data do not include visits at rural health clinics owned by the hospitals.

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A P P E N D I X

A

**Commissioners' voting
on recommendations**



Commissioners' voting on recommendations

In the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Congress required MedPAC to call for individual Commissioner votes on each recommendation and to document the voting record in its reports. The information below satisfies that mandate.

Chapter 1: Context for Medicare payment policy

No recommendations

Chapter 2: Assessing payment adequacy and updating payments in fee-for-service Medicare

No recommendations

Chapter 3: Hospital inpatient and outpatient services

- 3** For fiscal year 2025, the Congress should update the 2024 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1.5 percent.

In addition, the Congress should:

- begin a transition to redistribute disproportionate share hospital and uncompensated care payments through the Medicare Safety-Net Index (MSNI);
- add \$4 billion to the MSNI pool;
- scale fee-for-service MSNI payments in proportion to each hospital's MSNI and distribute the funds through a percentage add-on to payments under the inpatient and outpatient prospective payment systems; and
- pay commensurate MSNI amounts for services furnished to Medicare Advantage (MA) enrollees directly to hospitals and exclude them from MA benchmarks.

Yes: Barr, Casalino, Chernew, Cherry, Damberg, Dusetzina, Jaffery, Konetzka, Navathe, Poulsen, Rambur, Riley, Ryu, Sarran, Upchurch

Abstain: Kan, Miller

Chapter 4: Physician and other health professional services

4 The Congress should:

- for calendar year 2025, update the 2024 Medicare base payment rate for physician and other health professional services by the amount specified in current law plus 50 percent of the projected increase in the Medicare Economic Index; and
- enact the Commission's March 2023 recommendation to establish safety-net add-on payments under the physician fee schedule for services delivered to low-income Medicare beneficiaries.

Yes: Barr, Casalino, Chernew, Cherry, Damberg, Dusetzina, Jaffery, Kan, Konetzka, Miller, Navathe, Poulsen, Rambur, Riley, Ryu, Sarran, Upchurch

Chapter 5: Outpatient dialysis services

For calendar year 2025, the Congress should update the 2024 Medicare end-stage renal disease prospective payment system base rate by the amount determined under current law.

Yes: Barr, Casalino, Chernew, Cherry, Damberg, Dusetzina, Jaffery, Kan, Konetzka, Miller, Navathe, Poulsen, Rambur, Riley, Ryu, Sarran, Upchurch

Chapter 6: Skilled nursing facility services

For fiscal year 2025, the Congress should reduce the 2024 Medicare base payment rates for skilled nursing facilities by 3 percent.

Yes: Barr, Casalino, Chernew, Cherry, Damberg, Dusetzina, Jaffery, Kan, Konetzka, Navathe, Poulsen, Rambur, Riley, Ryu, Sarran, Upchurch

Abstain: Miller

Chapter 7: Home health care services

For calendar year 2025, the Congress should reduce the 2024 Medicare base payment rates for home health agencies by 7 percent.

Yes: Barr, Casalino, Chernew, Cherry, Damberg, Dusetzina, Jaffery, Kan, Konetzka, Miller, Navathe, Poulsen, Rambur, Riley, Ryu, Sarran, Upchurch

Chapter 8: Inpatient rehabilitation facility services

For fiscal year 2025, the Congress should reduce the 2024 Medicare base payment rate for inpatient rehabilitation facilities by 5 percent.

Yes: Barr, Casalino, Chernew, Cherry, Damberg, Dusetzina, Jaffery, Kan, Konetzka, Miller, Navathe, Poulsen, Rambur, Riley, Ryu, Sarran, Upchurch

Chapter 9: Hospice services

For fiscal year 2025, the Congress should eliminate the update to the 2024 Medicare base payment rates for hospice.

Yes: Barr, Casalino, Chernew, Cherry, Damberg, Dusetzina, Jaffery, Kan, Konetzka, Miller, Navathe, Poulsen, Rambur, Riley, Ryu, Sarran, Upchurch

Chapter 10: Ambulatory surgical center services: Status report

The Commission reiterates its March 2022 recommendation that the Secretary require ambulatory surgical centers to report cost data.

Chapter 11: The Medicare prescription drug program (Part D): Status report

No recommendations

Chapter 12: The Medicare Advantage program: Status report

No recommendations

Chapter 13: Estimating Medicare Advantage coding intensity and favorable selection

No recommendations

Chapter 14: Mandated report: Dual-eligible special needs plans

No recommendations

Chapter 15: Mandated report: Rural emergency hospitals

No recommendations

Acronyms

Acronyms

A-APM	advanced alternative payment model	CON	certificate of need
ABLE	Achieving a Better Life Experience Act of 2014	COPD	chronic obstructive pulmonary disease
AC	average cost	COVID-19	coronavirus disease 2019
ACA	Affordable Care Act of 2010	CPI-U	consumer price index for all urban consumers
ACH	acute care hospital	CPT	Current Procedural Terminology
ACHaH	acute care hospital at home	C-SNP	chronic condition special needs plan
ACO	accountable care organization	CT	computed tomography
ACS	ambulatory care sensitive	DECI	demographic estimate of coding intensity
ADI	Area Deprivation Index	DIR	direct and indirect remuneration
ADL	activity of daily living	DMEPOS	durable medical equipment, prosthetics, orthotics, and supplies
AHRQ	Agency for Healthcare Research and Quality	DOJ	Department of Justice
AKI	acute kidney injury	DRG	diagnosis related group
AMA	American Medical Association	D-SNP	dual-eligible special needs plan
APM	alternative payment model	E&M	evaluation and management
APRN	advanced practice registered nurse	ECP	endoscopic cyclophotocoagulation
ASC	ambulatory surgical center	ED	emergency department
ASCQR	ASC Quality Reporting	eGFR	estimated glomerular filtration rate
ASP	average sales price	EGWP	employer group waiver plan
BBA	Bipartisan Budget Act	EMTALA	Emergency Medical Treatment and Labor Act
BBP	base beneficiary premium	ESA	erythropoiesis-stimulating agent
BLS	Bureau of Labor Statistics	ESRD	end-stage renal disease
BRA	Budget Reconciliation Act of 2022	ETC	ESRD Treatment Choices
CAA	Consolidated Appropriations Act, 2021	FFCRA	Families First Coronavirus Response Act
CAH	critical access hospital	FDA	Food and Drug Administration
CAHPS®	Consumer Assessment of Healthcare Providers and Systems®	FFS	fee-for-service
CARES	Coronavirus Aid, Relief, and Economic Security	FIDE-SNP	fully integrated dual-eligible special needs plan
CASPER	Certification and Surveyor Provider Enhanced Reporting	FIM™	Functional Independence Measure™
CBO	Congressional Budget Office	FMAP	Federal Medical Assistance Percentage
CC	complication or comorbidity	FPL	federal poverty level
CCP	coordinated care plan	FQHC	federally qualified health center
CEC	Comprehensive ESRD Care	FY	fiscal year
CHC	continuous home care	g/dL	grams per deciliter
CHIP	Children's Health Insurance Program	GDP	gross domestic product
CKD	chronic kidney disease	GI	gastrointestinal
CMG	case-mix group	GIP	general inpatient care
CMI	case-mix index	GUIDE	Guiding an Improved Dementia Experience
CMMI	Center for Medicare & Medicaid Innovation	HC	high concentration
CMR	comprehensive medication review	H-CAHPS®	Hospital Consumer Assessment of Healthcare Providers and Systems®
CMS	Centers for Medicare & Medicaid Services	HCBS	home- and community-based services
CMS-HCC	CMS hierarchical condition category	HCC	hierarchical condition category

HCPCS	Healthcare Common Procedure Coding System	MACRA	Medicare Access and CHIP Reauthorization Act of 2015
HEDIS®	Healthcare Effectiveness Data and Information Set®	MAO	Medicare Advantage organization
HHA	home health agency	MA-PD	Medicare Advantage–Prescription Drug [plan]
HH-CAHPS®	Home Health Care Consumer Assessment of Healthcare Providers and Systems®	MA-VIP	Medicare Advantage value incentive program
HHI	Herfindahl–Hirschman Index	MCBS	Medicare Current Beneficiary Survey
HHS	Department of Health and Human Services	MCC	major complication or comorbidity
HI	Hospital Insurance (Medicare Part A)	MCCM	Medicare Care Choices Model
HIDE-SNP	highly integrated dual-eligible special needs plan	MDH	Medicare-dependent hospital
HMO	health maintenance organization	MDS	Minimum Data Set
HMO-POS	HMO point-of-service	MedPAC	Medicare Payment Advisory Commission
HOPD	hospital outpatient department	MedPAR	Medicare Provider Analysis and Review
HOPE	Hospice Outcomes & Patient Evaluation	MEI	Medicare Economic Index
HPRD	hours per resident day	MFP	maximum fair price
HSA	hospital service area	MIPPA	Medicare Improvements for Patients and Providers Act of 2008
HSRV	hospital-specific relative value	MIPS	Merit-based Incentive Payment System
HUD	Department of Housing and Urban Development	MLR	medical loss ratio
HVIP	hospital value incentive program	MMP	Medicare–Medicaid Plan
ICD	International Classification of Diseases	MOOP	maximum out-of-pocket
IGC	impairment group code	MSA	metropolitan statistical area
IOL	intraocular lens	MSA	Medicare Savings Account
IPO	inpatient only	MS-DRG	Medicare severity–diagnosis related group
IPPS	inpatient prospective payment systems	MSN	Medicare safety net
IRA	Inflation Reduction Act of 2022	MSNI	Medicare Safety-Net Index
IRC	inpatient respite care	MTM	medication therapy management
IRF	inpatient rehabilitation facility	N/A	not applicable
IRF-PAI	Inpatient Rehabilitation Facility Patient Assessment Instrument	N/A	not available
I-SNP	institutional special needs plan	NAICS	North American Industry Classification System
KFF	Kaiser Family Foundation	NCQA	National Committee for Quality Assurance
LDO	large dialysis organization	NDA	new drug application
LEP	late enrollment penalty	NDC	national drug code
LICS	low-income cost-sharing	NHSN	National Healthcare Safety Network
LIS	low-income [drug] subsidy	NIC	National Investment Center [for Seniors Housing & Care]
LOS	length of stay	NP	nurse practitioner
LTCH	long-term care hospital	NPI	national provider identifier
LTI	long-term institutional	NPP	nonphysician practitioner
LTSS	long-term services and supports	NTA	nontherapy ancillary
LVH	low-volume hospital	OACT	Office of the Actuary
LVI	low-volume and isolated	OASIS	Outcome and Assessment Information Set
MA	Medicare Advantage	OB/GYN	obstetrics and gynecology
MACPAC	Medicaid and CHIP Payment and Access Commission	OIG	Office of Inspector General
		OON	out of network

OOP	out of pocket	QIP	Quality Incentive Program
OPPS	outpatient prospective payment system	R&D	research and development
OQR	Outpatient Quality Reporting	RADV	risk-adjustment data validation
OR	operating room	RAPS	Risk Adjustment Processing System
OT	occupational therapy	RDS	retiree drug subsidy
OTC	over the counter	REACH	Realizing Equity, Access, and Community Health
PA	physician assistant	REH	rural emergency hospital
PAC	post-acute care	REIT	real estate investment trust
PACE	Program of All-Inclusive Care for the Elderly	RHC	routine home care
PAMA	Protecting Access to Medicare Act of 2014	RIC	rehabilitation impairment category
PBM	pharmacy benefit manager	RN	registered nurse
PCP	primary care provider	RTI	Research Triangle Institute
PCR	payment-to-cost ratio	RUC	Relative Value Scale Update Committee
PD	peritoneal dialysis	RVU	relative value unit
PDGM	Patient-Driven Groupings Model	SCH	sole community hospital
PDP	prescription drug plan	SLP	speech-language pathology
PDPM	Patient-Driven Payment Model	SMI	Supplementary Medical Insurance
PE	private equity	SNF	skilled nursing facility
PEPPER	Program for Evaluating Payment Patterns for Electronic Report	SNP	special needs plan
PFFS	private fee-for-service	SSI	Supplemental Security Income
PFS	physician fee schedule	SSI	surgical site infection
PHC4	Pennsylvania Health Care Cost Containment Council	TBD	to be determined
PHE	public health emergency	TDAPA	transitional drug add-on payment adjustment
POS	point of sale	TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
POS	Provider of Services	TMR	targeted medication review
PPO	preferred provider organization	TPNIES	transitional payment adjustment for new and innovative equipment and supplies
PPS	prospective payment system	UIC	Urban Influence Code
PSA	prostate-specific antigen	UPL	upper payment limit
PY	patient year	USPI	United Surgical Partners International
PT	physical therapy	USRDS	United States Renal Data System
Q	quarter	VBID	value-based insurance design
QBP	quality bonus program	VBP	value-based purchasing
QCOR	Quality, Certification and Oversight Reports	VIP	value incentive program

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Lynn Barr, M.P.H., is recognized as an influential leader in the movement to transform and improve our nation's rural and safety-net health care systems. As founder of Caravan Health, Ms. Barr led the development and implementation of nationwide programs that resulted in better patient care and helped health care providers achieve sustainable financial success. Caravan Health, now CVS ACO, was established to support safety-net providers interested in value-based payment models under population health programs such as accountable care organizations (ACOs). With a background as a chief information officer for a rural hospital, she recruited and organized small rural hospitals across three states to form the first National Rural ACO to help rural providers succeed in value-based payment. Ms. Barr formed Caravan Health to manage the ACO's services and was awarded a \$30 million Transformation of Clinical Practice Initiative grant from CMS to provide similar services to rural providers and small practices who were not yet ready to participate in value-based payments. In March 2022, Ms. Barr sold Caravan to Signify, a division of CVS Health, and created the Barr-Campbell Family Foundation, which focuses on rural health, the underserved, education, and the environment. Prior to forming Caravan Health, Ms. Barr shepherded 4 start-up companies and 12 medical inventions through the Food and Drug Administration and worldwide markets. While earning her master's degree in public health from the University of California, Berkeley, she led the group purchasing of Electronic Medical Records for California's rural hospitals, including individual needs assessments, vendor selection, negotiations, contracting assistance, and financing.

Lawrence Casalino, M.D., Ph.D., is emeritus professor of public health at Weill Cornell Medical College, where he served as the Livingston Farrand Professor of Public Health and chief of the Division of Health Policy and Economics in the Department of Population Health Sciences. His research focuses on the intended and unintended effects of public and private policies on the types of provider organizations that exist, on the processes they use to provide care, on the quality and cost of care, and on the impact of policies and organizational processes on socioeconomic and

racial/ethnic disparities. Dr. Casalino has served as senior advisor to the director of the U.S. Agency for Healthcare Research and Quality, as chair of the Academy Health Annual Research Meeting, as a member of the Panel of Health Advisors for the Congressional Budget Office, on the FAIR Health board of directors, and on many other national committees, technical advisory panels, and nonprofit boards. Prior to academia, Dr. Casalino worked full time as a primary care physician for 20 years and, prior to that, as a community organizer.

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Gregory P. Poulsen, M.B.A., is senior vice president at Intermountain Healthcare, an integrated health system based in Salt Lake City, UT. He has vast

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Scott Sarran, M.D., M.B.A., is the founding chief medical officer of Harmonic Health, a start-up company focused solely on revolutionizing the dementia care journey for patients, caregivers, and providers.

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Gina Upchurch, R.Ph., M.P.H., is the founder and executive director of Senior PharmAssist, a nonprofit organization that helps older adults obtain and manage medication and provides Medicare benefits counseling and tailored community referrals in Durham, NC. Ms. Upchurch is a registered pharmacist and has participated in various committees at the state and national levels, such as the American Geriatrics Society Public Policy Committee and several working groups for the North Carolina Institute of Medicine. She received her bachelor of science degree in pharmacy and her master of public health degree from the University of North Carolina at Chapel Hill, where she also completed her geriatric pharmacy practice residency and still holds adjunct positions. In 2001, she was named a Robert Wood Johnson Community Health Leader for her patient advocacy and health literacy efforts. Ms. Upchurch began her career as a science teacher with the U.S. Peace Corps in Botswana.

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