MEDPAC

Advising the Congress on Medicare issues

Improving Medicare's payment approaches

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Presentation roadmap

1. Introduction
2. Drivers of Medicare spending trends
3. Incentives in fee-for-service Medicare, alternative payment models, and Medicare Advantage
4. Improving incentives in Medicare's payment approaches
5. Discussion

Introduction

Introduction

- Medicare uses three different approaches to pay for care:
  - Traditional Medicare
    - Stand-alone fee-for-service (FFS)
    - Alternative payment models (APMs)
  - Medicare Advantage (MA)
- Each has advantages and disadvantages
  - Some may be addressed with policy changes
  - Others may be more challenging
- CMS's annual survey generally finds that beneficiaries are equally satisfied in FFS and MA

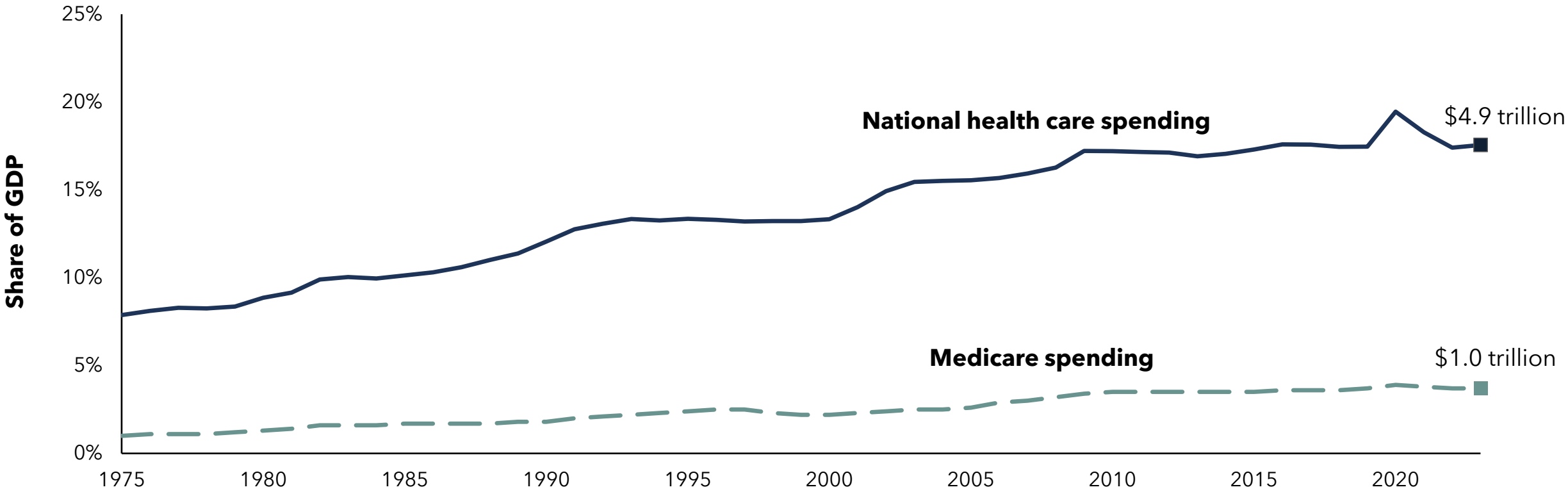
MedPAC's guiding principles

- MedPAC regularly assesses Medicare's payment policies and recommends improvements
- Three principles guide our work:

1. Payments should be sufficient to support beneficiary access to high-quality health care in an appropriate clinical setting
2. Providers should have incentives to supply appropriate and equitable care in an efficient manner
3. Medicare payments should reflect efficient care delivery, thereby ensuring that the program's fiscal burden on beneficiaries and taxpayers is not greater than necessary

Drivers of Medicare spending trends

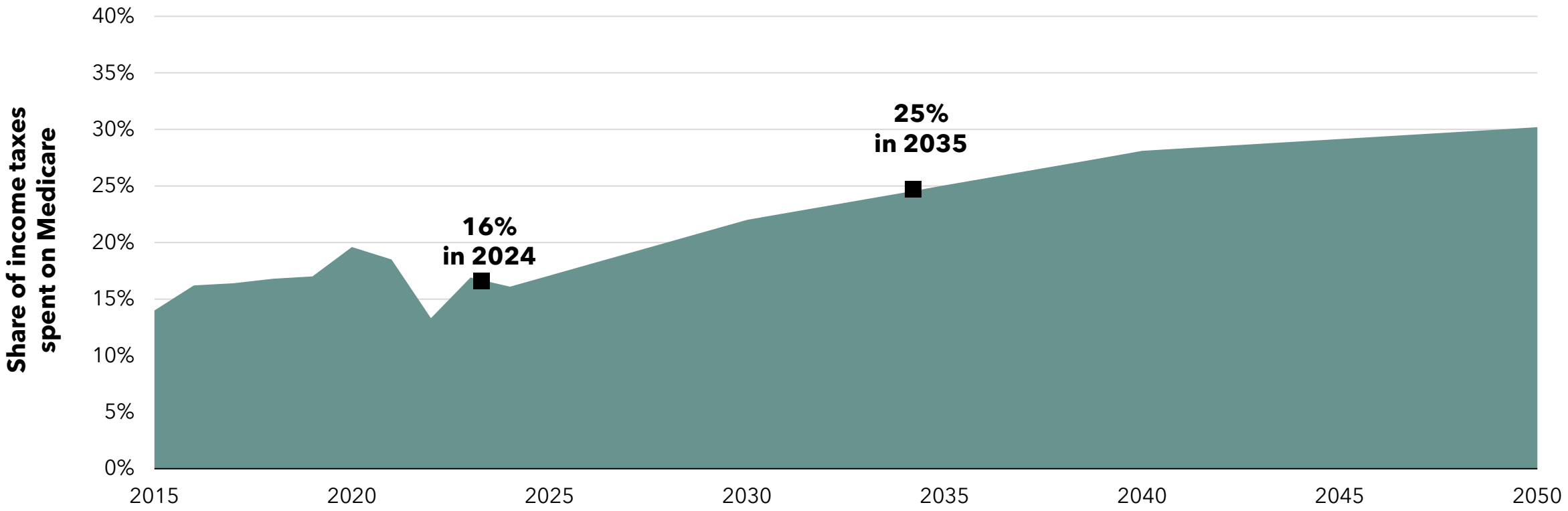
Medicare constitutes a growing share of GDP



Note: GDP (gross domestic product). Pandemic relief funds are counted as national health care spending rather than Medicare spending because they were meant to offset pandemic-related revenue losses from all payers, not just Medicare. Medicare spending excludes COVID-19 Accelerated and Advance payments (short-term loans paid to providers in 2020 that were subsequently repaid) since this graph shows expenditures on an incurred basis rather than a cash basis.

Source: MedPAC analysis of CMS's national health expenditure data (projected data released in June 2025 and historical data released in December 2024),

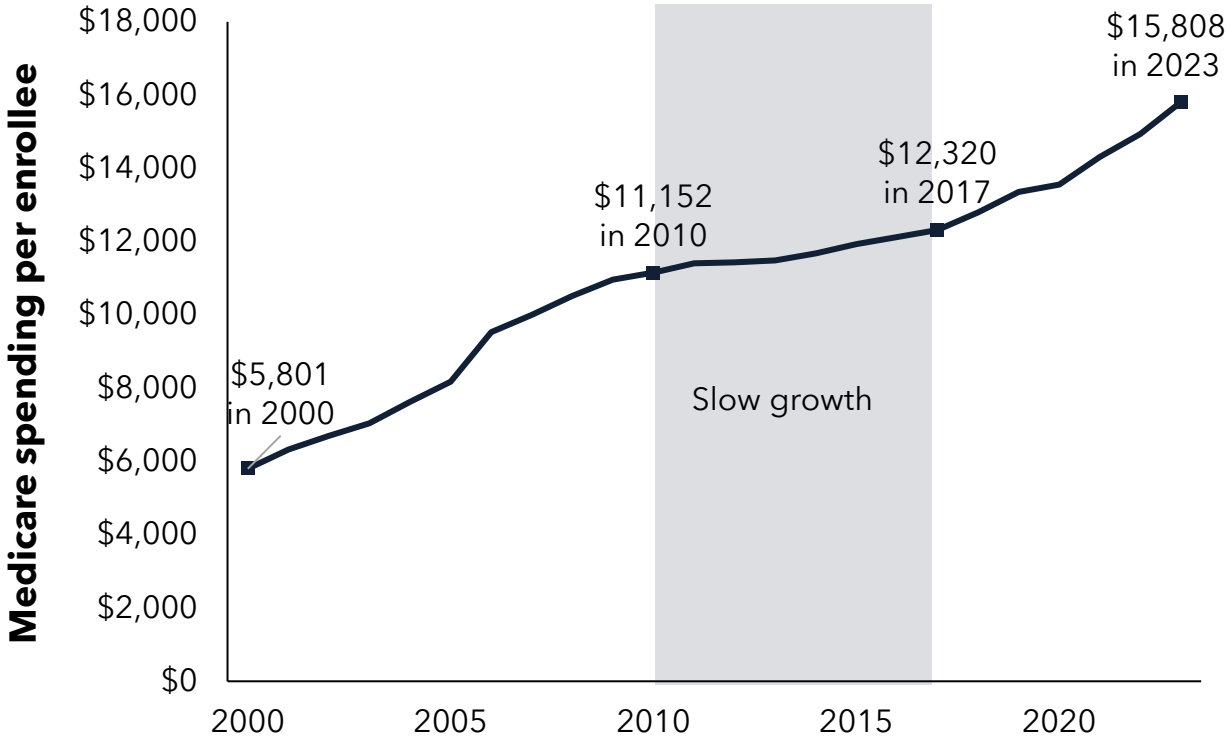
Medicare is projected to consume an increasing share of federal income taxes



Note: Includes both personal and corporate income tax revenues, which are the main source of general revenues. General revenues also include customs duties, leases of government-owned land and buildings, the sale of natural resources, usage and licensing fees, and payments to agencies. First projected year is 2025.

Source: 2025 annual report of the Boards of Trustees of the Medicare trust funds, Table II.F3.

Slowdown in Medicare spending growth per beneficiary, 2010-2017



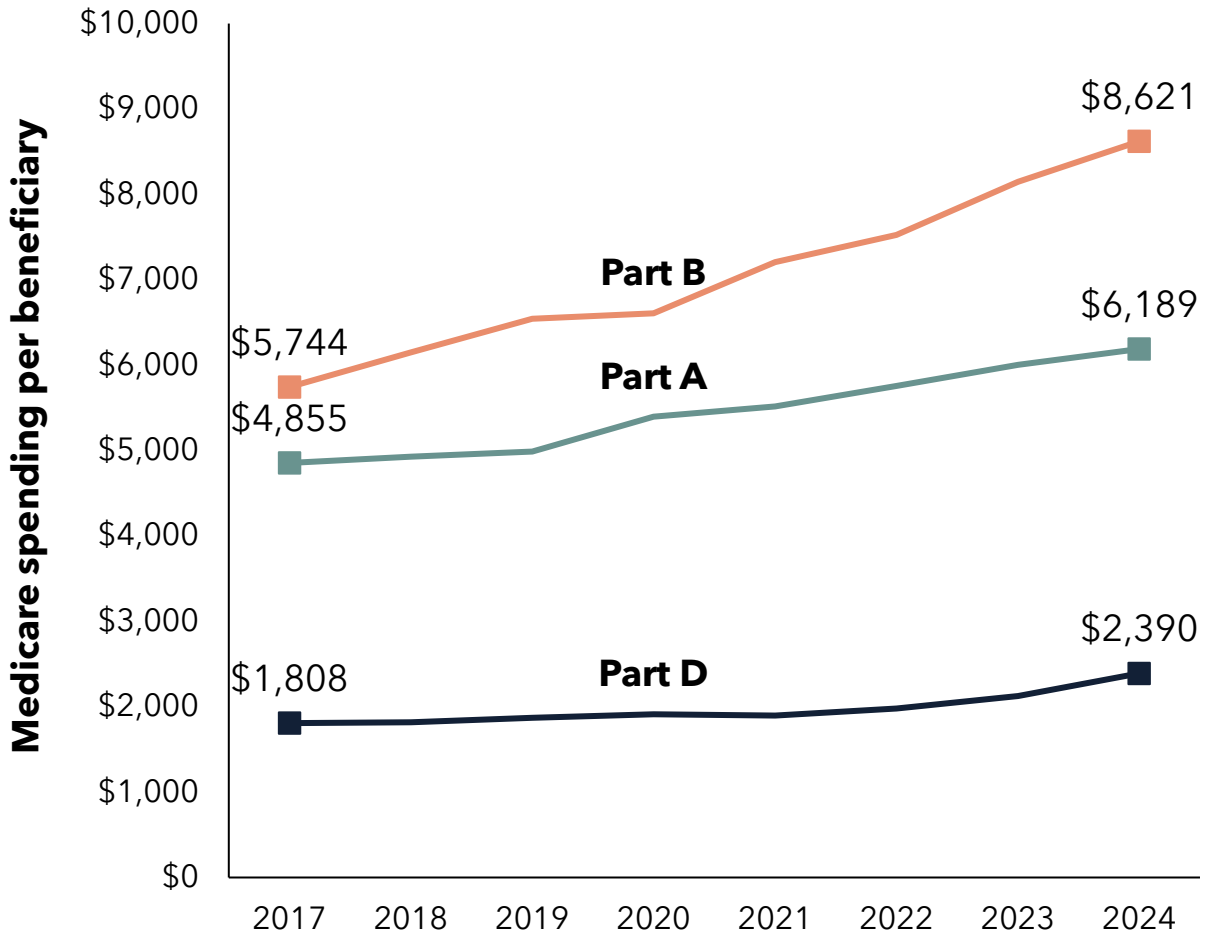
Note: Shown in nominal dollars (the actual, face-value amount of money at a given point in time.

Source: MedPAC analysis of CMS national health expenditure data (historical data released in December 2024).

- General slowdown in national health care spending (e.g., due to low inflation)
- Legislative changes to Medicare (e.g., lower payment updates, changes to MA benchmarks)
- Baby boomers reduced the average age of the senior Medicare population
- Lower use of some Medicare services (e.g., inpatient admissions, home health (partly due to fraud enforcement), DME (due to competitive bidding))

Note: MA (Medicare Advantage), DME (durable medical equipment).

Since 2017, Part B spending has grown quickly



Part B spending includes payments for:

- Clinician services
- Hospital outpatient departments
- Physician-administered drugs
- Other ambulatory services/items

Note: Includes enrollees in Medicare Advantage and fee-for-service Medicare. Calculated as nominal spending (not adjusted for inflation) for each respective Medicare part divided by the number of beneficiaries enrolled in that part.

Source: MedPAC analysis of data from the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

Part B spending is driven by clinicians providing an increasing volume & intensity of services/items

PROJECTIONS

	Average annual percent change (from 2025-2034) in:				
	Medicare prices (minus inflation)	Number of beneficiaries	Beneficiary demographic mix	Other (e.g., volume & intensity of services/items used)	**Medicare spending (minus inflation)**
Part A	-0.3%	1.8%	0.4%	1.8%	**3.6%**
Part B	-1.0	1.9	0.1	4.5	**5.5**

Note: Includes fee-for-service and 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. "Beneficiary demographic mix" adjusts for age, sex, and time to death. "Other (e.g., volume and intensity of services used)" refers to the residual after the other three factors shown in the table (Medicare prices, number of beneficiaries, and beneficiary demographic mix) are removed. "Medicare spending" is the product of the other columns in the table.

Source: MedPAC analysis of data provided by CMS's Office of the Actuary (OACT).

Incentives in FFS Medicare, APMs, and MA

FFS Medicare, APMs, and MA have incentives that can influence volume & intensity growth

- Medicare's three payment approaches can influence incentives through:
  - Their **basic design**
    - Paying for each service/item delivered in FFS Medicare encourages volume growth
    - Capitated payments encourage efficiency, but their payment formulas encourage intensively coding diagnoses and favor providers/plans in some geographic areas
  - Their **overall payment rates**
    - If payments are too high, can lead to overprovision of care or unintended subsidies
    - If payments are too low, risk of some plans/providers not participating
  - Their **relative payment rates**
    - If payments are too high for some services/items and too low for others, can affect which services/items are delivered and where they are provided

Incentives in stand-alone FFS Medicare

Basic design

- Medicare sets prices and pays separately for each item/service/stay, which gives providers an incentive to increase volume
- In some FFS payment systems (e.g., IPPS), bundling helps mitigate incentives to increase volume and intensity
- Beneficiaries have wide access to FFS Medicare providers, but face cost-sharing that can be a barrier

Note: MIPS (Merit-based Incentive Payment System, a pay-for-performance program that some clinicians are subject to).

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Overall payment levels

- Hard to get Medicare's FFS prices "right" (e.g., should payments cover providers' average cost or marginal cost?)
- MedPAC's payment adequacy analyses find payments too high in some settings and too low in others
- If not high enough, providers might not participate in Medicare and beneficiary access could suffer
- If payments are too high, encourages overuse of services

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Relative payments

- Within some payment systems, payment rates for some services are too high while others are too low—which incentivizes the provision of some services over others
- Prices for the same service vary depending on what setting it is provided in—incentivizes delivering care in higher-paid settings
- Accurate cost and time data are not always available to help set prices
- Payment rates tend to be "sticky upward" (don't decline even when efficiencies develop) so services that can be delivered more quickly over time can become overvalued

Incentives in alternative payment models (APMs)

Basic design

- Offers providers an incentive to deliver a more efficient mix of services
- APMs have some tools to limit spending growth (e.g., referrals to preferred providers, additional care management services to keep patients healthy)
- Requires providers to bear more-than-nominal financial risk if their patients' spending exceeds a spending target, use MIPS-like quality measures, and use EHRs
- Providers have flexibility in how they spend APM payments

Note: MIPS (Merit-based Incentive Payment System), EHRs (electronic health records).

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- Hard to get APM payment levels right
- If APM payments too high, no savings generated for Medicare
- If APM payments too low, providers won't voluntarily participate (but mandatory models can get around this issue)
- Voluntary models induce self-selection by providers likely to earn bonuses
- Clinician-level compensation arrangements tend to continue to reward maximizing volume and intensity, which dulls APMs' clinician-level incentives

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Relative payments

- CMS pays ACOs differently for different patients
- Providers in APMs have higher (easier) spending targets if they code patient diagnoses more intensively, or curate their participating provider list
- Providers in certain geographic areas have higher (easier) spending targets based on how MSSP formula is constructed

Incentives in Medicare Advantage

Basic design

- Pays capitated payments to MA plans, providing powerful incentives to manage enrollee spending
- When plans use FFS rates to pay providers, same issues as FFS Medicare (see earlier slide)
- Plans have powerful tools to manage utilization (e.g., prior authorization, provider networks)
- Plans have an incentive to keep spending on Part A and B benefits low, to enable them to offer extra benefits or lower cost sharing and attract enrollees

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Overall payment levels

- Hard to get MA payment levels "right" (e.g., risk-adjustment)
- Issues with MA payment design have made it difficult for Medicare to realize savings from MA (Medicare payments to plans tend to exceed FFS spending per enrollee)
- High payments to plans have prompted many insurers to offer plans
- High payments have enabled plans to offer low cost-sharing and extra benefits, which has attracted many beneficiaries

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Relative payments

- CMS pays plans differently for different patients
- Plans have an incentive to:
  - code patients' diagnoses more intensively
  - curate their provider network to maximize their quality score
  - attract beneficiaries likely to use less care than expected
- Plans in certain geographic areas have higher benchmarks based on how formula is currently constructed

Fee-for-service Medicare, APMs, and MA would all benefit from policy changes MedPAC has suggested

- Medicare spending makes up a larger share of national health care spending than it did when the program was created
- CMS actuaries project that growth in the volume and intensity of Part B items and services will be a primary driver of spending growth in the next ten years
- Opportunities to improve the incentives created by stand-alone FFS, APMs, and MA differ:
  - Stand-alone FFS tends to promote volume and intensity growth
  - APMs and MA plans have incentives and tools to manage spending but designing systems by which Medicare can realize savings is challenging
- The Commission has recommended improvements to each payment approach and has ongoing work to identify additional ways to improve their incentives, guided by our principles

Improving incentives

Improving stand-alone FFS Medicare

Basic design

- FFS Medicare benefit design should be overhauled (e.g., let CMS vary cost sharing for low- vs. high-value care; add an out-of-pocket max.)

Source: "Reforming Medicare's benefit design," in MedPAC's June 2012 report to the Congress.

Improving stand-alone FFS Medicare

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Overall payment levels

- FFS payment rates should be increased for hospital and clinician services but decreased for post-acute care
- Payments for physician-administered drugs under Part B should be reduced

Source: Various chapters in MedPAC's March 2025 report to the Congress; "Addressing high prices of drugs covered under Medicare Part B" in MedPAC's June 2023 report to the Congress.

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Relative payments

- Prices for clinician services should be set using empirical data and a new advisory committee
- Payments should be site-neutral
- Payments for Part B drugs under the hospital outpatient prospective payment system (OPPS) should be reformed

Source: "Reviewing the work relative values of physician fee schedule services," in MedPAC's March 2006 report to the Congress; MedPAC's 2011 letter to chairmen and ranking members re: moving forward from the sustainable growth rate (SGR) system; "Aligning fee-for-service payment rates across ambulatory settings," in MedPAC's June 2023 report to the Congress; "Improving Medicare's policies for separately payable drugs in the hospital outpatient prospective payment system," in MedPAC's June 2021 report to the Congress.

Improving alternative payment models

Basic design

- CMS should operate a smaller number of APMs designed to work together
- CMS could operate one ACO model with different tracks for different-sized providers, and a mandatory episode-based payment model for proven episodes

Source: "Streamlining CMS's portfolio of alternative payment models," in MedPAC's June 2021 report to the Congress; "An approach to streamline and harmonize Medicare's portfolio of alternative payment models" in MedPAC's June 2022 report to the Congress.

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Basic design

- CMS should operate a smaller number of APMs designed to work together
- CMS could operate one ACO model with different tracks for different-sized providers, and a mandatory episode-based payment model for proven episodes

Overall payment levels

- In the Medicare Shared Savings Program (MSSP), ACOs' spending targets should not be "ratcheted down" periodically

Source: MedPAC's 2022 comment letter on CMS's proposed rule for the CY 2023 physician fee schedule.

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Overall payment levels

- In the Medicare Shared Savings Program (MSSP), ACOs' spending targets should not be "ratcheted down" periodically

Relative payments

- MSSP ACOs' spending targets should be calculated differently, to reduce coding incentives and reduce favorable selection of beneficiaries likely to generate lower-than-expected spending

Source: MedPAC's 2023 comment letter on CMS's proposed rule for the CY 2024 physician fee schedule.

Improving Medicare Advantage

Basic design

- Hospice should be added to the MA benefits package
- Larger geographic markets should be used for MA plan payment areas

Source: "The Medicare Advantage program: Status report," in MedPAC's March 2014 report to the Congress; "Medicare Advantage payment areas and risk adjustment," in MedPAC's June 2005 report to the Congress.

Improving Medicare Advantage

Basic design

- Hospice should be added to the MA benefits package
- Larger geographic markets should be used for MA plan payment areas

Overall payment levels

- Calculation of the benchmarks that MA plans bid against should be changed

Source: "Rebalancing Medicare Advantage benchmark policy," in MedPAC's June 2021 report to the Congress.

Improving Medicare Advantage

Basic design

- Hospice should be added to the MA benefits package
- Larger geographic markets should be used for MA plan payment areas

Overall payment levels

- Calculation of the benchmarks that MA plans bid against should be changed

Relative payments

- The MA quality bonus program should be overhauled
- Risk adjustment should be improved to reduce disparities in plan-level coding intensity

Source: "Replacing the Medicare Advantage quality bonus program" in MedPAC's June 2020 report to the Congress; "The Medicare Advantage program: Status report," in MedPAC's March 2016 report to the Congress.

Future work

- FFS, APMs, and MA each have a role to play—but they all have room for improvement
- MedPAC will continue to study Medicare payment approaches and identify ways to improve their incentives, guided by our principles
- Examples of possible future work:
  - Further analyze Medicare spending trends to better understand sources of spending growth and identify opportunities to address volume and intensity of service delivery
  - Continue harmonizing Medicare payments across settings and service types, where clinically appropriate
  - Improve the design and methods used for setting payments for APMs
  - Explore alternative methods for calculating Medicare's payments to MA plans, and assess plans' incentives to balance efficiency with access to care

Discussion

Discussion

- Questions about material?
- Feedback?
- Future direction?

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