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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

Medicare Payment Policy



*Medicare Payment
Advisory Commission*

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March 13, 2025

The Honorable JD Vance
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 Mister President and Mister Speaker:

I am pleased to submit the Medicare Payment Advisory Commission's March 2025 *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. This report also satisfies additional legislative mandates to report on payments to rural emergency hospitals and on Medicaid use and spending in nursing homes.

The report contains 13 chapters:

- a chapter that provides a broad context for the report, including Medicare's overall financial situation and factors contributing to Medicare spending growth;
- a chapter that describes the Commission's analytic framework for assessing fee-for-service (FFS) Medicare payment adequacy;
- seven chapters that describe the Commission's recommendations on 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 describes the Medicare Advantage program, including recent trends in enrollment, plan offerings, and Medicare's payments to plans, and discusses related issues such as coding intensity, favorable selection, and market concentration;
- a chapter about Medicare's pharmacy benefit, Part D, that updates trends in enrollment and plan offerings and includes information about the effects of significant changes happening in 2025, as implementation of the Inflation Reduction Act of 2022 continues; and

- a chapter that describes the Commission's recommendation to improve beneficiaries' access to inpatient psychiatric care by eliminating both the 190-day lifetime limit on covered days in freestanding inpatient psychiatric facilities (IPFs) and the reduction of the number of covered inpatient psychiatric days available to some beneficiaries during their initial benefit period.

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. For 2026, we recommend FFS payment updates above current law for acute care hospitals and for physician and other health professional services; the payment update specified in current law for outpatient dialysis providers; no payment update for hospice providers; and payment reductions for skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities. We also recommend targeting 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.

In addition, we recommend eliminating two long-standing coverage limits on days in freestanding IPFs. If enacted, this recommendation would improve access to inpatient behavioral health care for some of the most vulnerable Medicare beneficiaries.

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 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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Executive summary

Executive summary

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.

By law, the Medicare Payment Advisory Commission reports to the Congress each March on the Medicare fee-for-service (FFS) payment systems. We evaluate the adequacy of FFS Medicare's payments and make recommendations for how those payments should be updated for the policy year in question (in this report, 2026). 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 this report, we make recommendations for the following 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.

The Commission is also required by law to report to the Congress each March on the Medicare Advantage (MA) program (Medicare Part C) and the Part D prescription drug program. In this report, we provide a status report on MA, including recent trends in enrollment, plan offerings, and Medicare's payment to plans, and we

discuss issues such as MA coding intensity, favorable selection, and market concentration. We also provide a status report on Part D that, in addition to providing information on recent trends in enrollment and plan offerings, describes the expected effects of significant changes happening in 2025, as implementation of the Inflation Reduction Act of 2022 continues.

In this year's report, we also include a status report on ambulatory surgical centers and a chapter that describes our recommendation to improve beneficiaries' access to inpatient psychiatric care by eliminating both the 190-day lifetime limit on covered days in freestanding inpatient psychiatric facilities and the reduction in the number of covered inpatient psychiatric days available to some beneficiaries during their initial benefit period.

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/.

Context for Medicare payment policy

Chapter 1 provides context for this report, and MedPAC's work more broadly, by describing Medicare's overall financial situation and highlighting factors that contribute to growth in Medicare spending.

Both national health care spending and Medicare spending tend to grow more quickly than the U.S. gross domestic product (GDP)—causing spending in both sectors to consume growing shares of GDP over time. In 2023, \$4.9 trillion was spent on health care in the U.S. (equivalent to 17.6 percent of GDP); Medicare spending made up about \$1.0 trillion of this spending (equivalent to 3.7 percent of GDP).

Total Medicare spending grew at a slower-than-usual pace during the first year of the coronavirus pandemic in 2020. 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. Since then, Medicare beneficiaries' health care spending has generally returned to more typical levels.

Looking ahead, CMS expects Medicare spending to grow by about 4 percent per year between now and the early 2030s, after accounting for economy-wide price inflation. This increased spending is driven by Medicare enrollment growth and growth in the volume and intensity of services that clinicians deliver per beneficiary. FFS Medicare prices are not a significant driver of spending growth since they are projected to grow more slowly than inflation. The shift in beneficiary enrollment from traditional FFS Medicare to MA also contributes to Medicare spending growth since the program pays an estimated 20 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare.

Despite this projected spending growth, the Medicare program finds itself in a better position financially than it was a few years ago. After an initial economic slowdown at the start of the pandemic, the U.S. economy subsequently experienced strong growth, yielding higher-than-expected Medicare payroll tax revenues. At the same time, Medicare beneficiaries used a lower volume of Part A services than expected during the pandemic, and future Part A spending (on hospital inpatient and skilled nursing facility care) is now projected to be lower than previously estimated. As a result, the balance in Medicare's Hospital Insurance Trust Fund is now projected to be able to pay for its share of Part A services for a decade longer than was projected before the pandemic—until 2036 according to the Medicare Board of Trustees, or until 2035 according to the Congressional Budget Office.

Yet pressure to restrain the growth in Medicare's overall spending remains. 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, the share of personal and corporate income taxes collected by the federal government that was transferred to the SMI Trust Fund to pay for Part B and Part D was 17 percent in 2023 and is projected to increase to 22 percent by 2030, according to the Medicare Trustees. Further, Medicare's current rate of spending growth causes beneficiaries to face higher premiums and cost sharing over time. The Medicare Trustees estimate that spending by FFS beneficiaries on Medicare Part B and Part D premiums and cost sharing consumed 26 percent of the average Social Security benefit in

2024—up from 17 percent 20 years earlier, in 2004. It is important for policymakers to consider the effect of raising Medicare's payments to providers and plans on beneficiaries' premiums and cost-sharing liabilities. Restraining the annual growth in Medicare payments to providers and plans can help beneficiaries afford their health care.

One way the Medicare program has kept spending growth relatively low is by setting payment rates in certain sectors. Our annual March report recommends updates to FFS Medicare payment rates for various types of providers, which can be greater than, less than, or equivalent to current law, 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 (2025), by considering beneficiaries' access to care, the quality of care, providers' access to capital, and how Medicare payments compare with providers' costs. As we detail in Chapter 2, we consider several different types of provider margins, in combination with other metrics, when assessing these domains. 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. Finally, we make a recommendation about what, if any, update is needed for the policy year in question (in this report, 2026).

This year, we consider recommendations in the following sectors: 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. The Commission's goal is to use consistent criteria

across settings, but because data availability, conditions at baseline, differences in the external pressures on each sector, and anticipated changes between baseline and the policy year may vary, we do not have a standard formula for producing recommendations based on these criteria, 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 2026 accurately reflect current conditions. Because of standard data lags, the most recent complete data we have are generally from 2023. We use preliminary data from 2024 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 relatively more profitable, or otherwise result in differences that could undermine access to care for some beneficiaries. We may also recommend changes to improve program integrity.

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 medical and surgical care to patients needing an overnight stay, as well as outpatient services, including procedures, tests, evaluation and management services, and emergency care. To pay hospitals for the facility share of providing these services, FFS Medicare generally sets prospective payment rates under the inpatient prospective payment systems (IPPS) and the outpatient prospective payment system (OPPS). In 2023, the FFS Medicare program and its beneficiaries spent nearly \$180 billion on IPPS and OPPS services, including \$6.7 billion in uncompensated-care payments made under the IPPS.

As described in Chapter 3, indicators of hospital payment adequacy were mixed. Beneficiary access to care remained good overall, and hospitals' all-payer margin was positive and improved. However, quality indicators were mixed, and aggregate FFS Medicare payments remained well below hospitals' costs.

Beneficiaries' access to care—Indicators of beneficiaries' access to hospital inpatient and outpatient services suggest that FFS Medicare beneficiaries maintained good access to care. From fiscal year (FY) 2022 to FY 2023, hospital employment and the number of inpatient beds increased. The aggregate hospital occupancy rate of ACH beds remained at 69 percent, and the median percentage of emergency department patients who left without being seen remained near 2 percent. The supply of hospitals was relatively steady, though about 10 more hospitals closed than opened in both 2023 and 2024, and others converted to rural emergency hospitals. The volume of both inpatient and outpatient services per FFS Medicare beneficiary increased from 2022 to 2023 (by 1 percent and 2 percent, respectively). We estimate that hospitals' FFS Medicare marginal profit on IPPS and OPPS services—an indicator of whether hospitals with excess capacity have an incentive to treat more Medicare beneficiaries—remained positive in FY 2023.

Quality of care—Hospital quality indicators were mixed. In FY 2023, FFS beneficiaries' risk-adjusted hospital mortality rate was 7.6 percent, an improvement relative to the 2019 and 2022 level of 7.9 percent. FFS Medicare beneficiaries' risk-adjusted readmission rate was 15.0 percent, worse than the previous year (14.6 percent), but improved relative to the rate in 2019 (15.5 percent). Most patient-experience measures improved in 2023 but remained below prepandemic levels by at least 1 percentage point.

Providers' access to capital—From FY 2022 to FY 2023, hospitals' all-payer operating margin (the percentage of revenue from all payers and sources exclusive of investments and donations that is left as profit after accounting for all costs) increased from 2.7 percent to 5.1 percent. However, within this aggregate, there continued to be substantial variation: A quarter of hospitals had an all-payer operating margin greater than 10 percent, and a quarter had an all-payer operating margin less than -4 percent. In addition,

the all-payer operating margin continued to be lower among hospitals with higher values of the Commission-developed Medicare Safety-Net Index (MSNI). Other measures of hospitals' access to capital were positive in 2023: Hospitals' all-payer total margin (the percentage of revenue from all payers, sources, and lines of business that is left as profit after accounting for all costs) increased over 4 percentage points, hospitals' borrowing costs increased by less than the general market, and mergers and acquisitions continued. Preliminary data suggest further improvement in hospitals' access to capital in FY 2024.

FFS Medicare payments and providers' costs—FFS Medicare payments for inpatient and outpatient services continued to be below hospitals' costs in FY 2023. From 2022 to 2023, exclusive of coronavirus relief funds, hospitals' FFS Medicare margin (the percentage of revenue from FFS Medicare that is left as profit after accounting for the allowable costs of providing services to FFS Medicare patients) was stable (from -13.1 percent to -13.0 percent). Nonetheless, some hospitals—which we refer to as “relatively efficient”—consistently achieved much lower costs while still performing relatively well on a specified set of quality metrics. The 2023 median FFS Medicare margin among these relatively efficient hospitals was -2 percent, exclusive of coronavirus relief funds. For 2025, we project that hospitals' FFS Medicare margin will remain stable at about -13 percent. Similarly, we project that the median FFS Medicare margin among relatively efficient hospitals will remain stable at about -2 percent.

Recommendation—The current-law updates to payment rates for 2026 will not be finalized until summer 2025, but CMS's current 2024 forecasts and other required updates are projected to increase the IPPS and OPPS base rates by over 2 percent.

The Commission recommends that the Congress should (1) for 2026, update the 2025 Medicare base payment rates for general ACHs by the amount reflected in current law plus 1 percent and (2) redistribute existing disproportionate-share-hospital and uncompensated-care payments to hospitals through the Commission's 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.

Rural emergency hospitals—The Consolidated Appropriations Act (CAA), 2021, requires the Commission to report annually on payments to rural emergency hospital (REHs). In 2023, 21 hospitals converted to REHs. FFS Medicare paid about \$10 million for outpatient hospital services at these REHs and about \$30 million in fixed monthly payments to cover standby costs. FFS Medicare's monthly fixed payments are three times as high as claims-based payments, which underscores the importance of fixed payments for the viability of REHs.

Physician and other health professional services

Medicare's physician fee schedule pays for about 9,000 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, advanced practice registered nurses (APRNs), and physician assistants (PAs) but also chiropractors, podiatrists, physical therapists, psychologists, and other types of health professionals. In 2023, the Medicare program and its beneficiaries paid \$92.4 billion for services billed by about 1.4 million clinicians and delivered to 28.2 million FFS beneficiaries, accounting for just under 17 percent of FFS spending. As described in Chapter 4, most physician payment-adequacy indicators have remained stable or improved in 2023 and 2024, but clinicians' input costs are estimated to have grown faster than the historical trend.

Beneficiaries' access to care—In the Commission's 2024 survey, Medicare beneficiaries continued to report access to clinician services that was comparable with or, in most cases, better than that of privately insured people. In response to a request from the House Committee on Appropriations, our survey began asking respondents to quantify wait times this year. We found that the number of weeks Medicare beneficiaries reported waiting for appointments with new clinicians was comparable with or better than the wait times reported by privately insured people. Our findings are consistent with those of other national surveys, which have found that people ages 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 clinicians who bill Medicare accept physician fee schedule amounts as payment in full and do not seek higher payments from patients for fee schedule services. The supply of most types of clinicians billing FFS Medicare has been growing in recent years, although the composition of the clinician workforce continues to change, with a rapid increase in the number of APRNs and PAs, a steady increase in the number of specialists, and a slow decline in the number of primary care physicians. For each year between 2016 and 2021, the number of clinicians who began billing the fee schedule for the first time was larger than the number who stopped billing the physician fee schedule.

The number of clinician encounters per beneficiary has increased over time, with faster growth from 2022 to 2023 (4.3 percent) compared with the average annual growth rate from 2018 to 2022 (0.5 percent). Growth rates varied by clinician specialty and type of service. From 2022 to 2023, the number of encounters per beneficiary with primary care physicians declined by 0.1 percent while encounters per beneficiary with specialist physicians increased by 2.7 percent and encounters with APRNs and PAs increased by 10.1 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 2023, risk-adjusted rates of ACS hospitalizations and ED visits remained below (that is, better than) prepandemic levels and continued to vary across health care markets. Between 2022 and 2023, 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 Medicare payments compare with the costs of providing services.

In 2023, payment rates paid by private preferred provider organization (PPO) health plans for clinician services were 140 percent of FFS Medicare's payment rates, up from 136 percent in 2022. 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).

Physician fee schedule spending per FFS beneficiary grew for most types of services in 2023, despite declines in payment rates for many types of services from 2022 to 2023. Among broad service categories, growth rates were 4.2 percent for evaluation and management services, 4.2 percent for imaging, 3.7 percent for other (i.e., nonmajor) procedures, 7.2 percent for treatments, and 4.9 percent for tests. Spending per FFS beneficiary declined by 0.1 percent for major procedures. Growth in clinicians' input costs as measured by the Medicare Economic Index (MEI) has moderated from recent highs reached during the coronavirus pandemic and is expected to moderate further in the coming years. MEI growth is projected to be 3.3 percent in 2024 and 2.8 percent in 2025.

Recommendation—Under current law, in 2026, payment rates are expected to increase by 0.75 percent for clinicians in advanced alternative payment models (e.g., accountable care organization models that involve some financial risk) and 0.25 percent for all other clinicians. Given recent high inflation, cost increases in 2026—which are currently projected to be 2.3 percent—could be difficult for clinicians to absorb. Yet current payments to clinicians appear to be adequate, based on many of our indicators.

Given these mixed findings, for calendar year 2026, the Commission recommends that the Congress replace the current-law updates to Medicare payment rates for physician and other health professional services with a single update equal to the projected increase in the MEI minus 1 percentage point. Based on CMS's MEI projections at the time of this publication, the update recommendation would be equivalent to 1.3 percent. Our recommendation 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 reiterates its March 2023 recommendation that the Congress also should establish new, permanent safety-net add-on payments for clinician services furnished to FFS Medicare beneficiaries with low incomes. The amount of the add-on payments would differ by clinician specialty. We estimate that the recommended safety-net add-on policy would increase the average clinicians' fee schedule revenue by 1.7 percent.

We estimate that the combination of the recommended update and safety-net policies would increase fee schedule revenue for the average clinician by 3.0 percent above current law, but the effects would differ by provider specialty and share of services furnished to low-income beneficiaries. We estimate that 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 2023, about 262,000 beneficiaries with ESRD and on dialysis were covered under FFS Medicare and received dialysis from more than 7,700 dialysis facilities. In 2023, the FFS Medicare program and its beneficiaries spent \$8.1 billion for outpatient dialysis services. 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 Medicare payments are adequate.

Beneficiaries' access to care—The capacity of dialysis facilities appears to exceed demand. Between 2022 and 2023, the number of in-center treatment stations was steady, while the number of FFS and MA dialysis beneficiaries declined (due to several factors, including the excess mortality among ESRD patients during the public health emergency, the decline in the adjusted rate of new ESRD cases during the last decade, and the increase in treatments furnished in-home). The 11 percent decline in FFS treatments in 2023 was largely due to ending the statutory provision that prevented most dialysis beneficiaries from enrolling in MA plans. The share of beneficiaries on dialysis enrolled in FFS Medicare fell by 18 percent in 2021—the first year of the

statutory change—and by about 12 percent annually between 2021 and 2023. An estimated 17 percent FFS marginal profit in 2023 suggests that dialysis providers with excess capacity have a financial incentive to continue to serve Medicare beneficiaries.

Quality of care—FFS dialysis beneficiaries' rates of all-cause hospitalization, ED use, and mortality held relatively steady between 2022 and 2023, as did measures of their experience receiving in-center hemodialysis. 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 prospective payment system (PPS), the two largest dialysis organizations have grown through acquisitions of and mergers with midsize dialysis organizations. In 2023 and 2024, facility closures and consolidations by each of the two largest dialysis organizations aimed to reduce overcapacity related to the increasing use of home dialysis and the decline in patient census in some markets.

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 3 percent, while cost per treatment rose by 2 percent between 2022 and 2023. In 2023, a decline in cost growth was observed across most cost categories, including capital, ESRD drugs, and labor. Consequently, the FFS Medicare margin (the percentage of revenue from FFS Medicare that is left as profit after accounting for the allowable costs of providing services to FFS Medicare patients) rose from -1.1 percent in 2022 to -0.2 percent in 2023. We project a 2025 aggregate Medicare margin of 0 percent. This projection does not account for the add-on payments for new ESRD drugs and phosphate binders in 2024 and 2025, which may increase FFS Medicare payments relative to facilities' costs and thus increase the margin.

Recommendation—Under current law, the Medicare FFS base payment rate for dialysis services is projected to increase by 1.7 percent in 2026. Though the FFS Medicare margin is low, other indicators of payment adequacy are generally positive. Thus, the Commission recommends that, for calendar year 2026, the Congress

update the 2025 base payment rate for outpatient dialysis services 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 a recent inpatient hospital stay. Most SNFs also furnish long-term care services not covered by Medicare. In 2023, about 14,500 freestanding SNFs furnished about 1.6 million Medicare-covered stays to 1.2 million FFS beneficiaries. In that year, the FFS Medicare program and its beneficiaries spent \$30 billion on SNF services. As described in Chapter 6, the indicators of Medicare payment adequacy for SNF care are mostly positive, indicating sufficient beneficiary access to SNF care.

Beneficiaries' access to care—Changes in the indicators of access to SNFs were mostly positive. The number of SNFs declined by about 1 percent in 2024, but given that Medicare is a small share of most nursing homes' business and that its payment rates are high relative to costs, it is unlikely that the closures reflect the adequacy of Medicare's payments. In 2023, 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), and this share has remained the same since 2018. Between 2022 and 2023, Medicare-covered SNF admissions per 1,000 FFS beneficiaries decreased by 12 percent, and Medicare-covered SNF days per 1,000 FFS beneficiaries decreased by 8 percent. In 2023, FFS Medicare marginal profit (an indicator of whether SNFs have an incentive to treat more Medicare beneficiaries) averaged 31 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 fiscal years 2022 and 2023, the mean facility risk-adjusted rate of successful discharge to the community from SNFs was 50.9 percent, similar to the rate for the 2021 and 2022 two-year period (50.7 percent). The mean facility risk-adjusted rate of hospitalizations was 10.4 percent, similar to the rate in the 2021 and 2022 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—The sector continues to be attractive to investors. In the first six months of 2024, there were 144 publicly announced merger and acquisition transactions, on pace for record transaction volume. In 2023, the all-payer total margin—the percentage of revenue from all payers, sources, and lines of business that is left as profit after accounting for all costs—improved from –1.3 percent in 2022 to 0.4 percent in 2023. Total margins may be understated, given the complex arrangements many nursing homes have with third parties.

FFS Medicare payments and providers' costs—From 2022 through 2023, FFS Medicare payments per day to freestanding SNFs increased 2.4 percent, while growth in costs per day increased 3.8 percent. The FFS Medicare margin for freestanding SNFs (the percentage of revenue from FFS Medicare that is left as profit after accounting for the allowable costs of providing services to FFS Medicare patients) was 22 percent in 2023. 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 23 percent for 2024.

Recommendation—Based on our assessment of the payment-adequacy indicators above, Medicare's FFS payment rates need to be reduced to align aggregate payments more closely with aggregate costs. However, some uncertainty remains about the impact of new nurse staffing requirements on SNF costs in 2026. The Commission therefore proposes a modest reduction to the payment rates and recommends that, for fiscal year 2026, the Congress reduce the 2025 Medicare base payment rates for SNFs 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 in nursing homes. Almost all SNFs are also long-term care nursing facilities, and Medicaid finances most long-term care services provided in SNFs. Between December 2023 and October 2024, the number of Medicaid-certified facilities declined 1.1 percent, to about 14,300 facilities. In 2023, FFS Medicaid spending (federal and state) was \$42.5 billion, 5.6 percent more than in 2022. The average non-FFS Medicare margin (the percentage of

revenue from all payers, sources, and lines of business except FFS Medicare SNF services that is left as profit after accounting for costs) was -4.1 percent, an improvement from 2022. The improvement reflects the increases in Medicaid base payment rates made by many states.

Home health care services

Home health agencies (HHAs) provide services to beneficiaries who are homebound and need skilled nursing care or therapy. In 2023, about 2.7 million Medicare FFS beneficiaries received care, and the program spent \$15.7 billion on home health care services. In that year, over 12,000 HHAs were certified to participate in Medicare. As described in Chapter 7, the indicators of Medicare payment adequacy for home health care are generally positive.

Beneficiaries' access to care—Supply and volume indicators show that FFS beneficiaries have good access to home health care. The number of HHAs participating in the Medicare program increased by 3.4 percent in 2023. However, this increase was due almost entirely to growth in the number of HHAs in Los Angeles County, California. Excluding this county, the number of participating HHAs declined by 2.8 percent. Still, in 2023, 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. The number of 30-day periods per FFS Medicare beneficiary declined by 1.8 percent in 2023. This decline was driven by a decrease in the use of home health care after acute care hospital discharge, which increased in 2020 and then began to decline, although it remained higher in 2023 than in prepandemic years. The number of full 30-day periods per FFS user of home health was stable at 3.1. The average number of in-person visits per 30-day period has declined since 2020, but the decline slowed in 2023. (Due to anomalies related to cost allocation on the home health cost report, we were unable to compute the FFS Medicare marginal profit for 2023.)

Quality of care—During the two-year period from January 1, 2022, to December 31, 2023, the median risk-adjusted rate of discharge to the community from HHAs was 80.6 percent, an increase (improvement) of 1.3 percentage points relative to the median from January 1, 2021, to December 31, 2022. The median rate of

potentially preventable readmissions after discharge was 3.8 percent from January 1, 2021, to December 31, 2023.

Providers' access to capital—Access to capital is a less important indicator of Medicare payment adequacy for home health care because this sector is less capital intensive than other health care sectors; still, with an all-payer margin for freestanding HHAs of 8.2 percent in 2023, many HHAs yield positive financial results that could appeal to capital markets. 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 has slowed since 2023, but the slowdown comes after a peak period for HHA mergers and acquisitions in prior years.

FFS Medicare payments and providers' costs—HHAs' cost growth exceeded payment growth in 2023, but FFS Medicare margins for freestanding agencies (the percentage of revenue from FFS Medicare that is left as profit after accounting for the allowable costs of providing services to FFS Medicare patients) remained high, averaging 20.2 percent. In aggregate, FFS Medicare's payments have always been substantially more than costs under prospective payment: From 2001 to 2022, the FFS Medicare margin for freestanding HHAs averaged 17.1 percent. The projected FFS Medicare margin for 2025 is 19 percent.

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 far exceed the cost of delivery, and that cost is largely borne by taxpayers and beneficiaries paying Part B premiums. On this basis, the Commission recommends that, for calendar year 2026, the Congress should reduce the 2025 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. Inpatient, interdisciplinary care provided in IRFs is supervised by rehabilitation physicians and includes services such as physical and occupational therapy, rehabilitation nursing, and

speech–language pathology. In 2023, the FFS Medicare program and its beneficiaries spent \$9.6 billion on 404,000 IRF stays in about 1,200 IRFs nationwide. The FFS Medicare program accounted for about 51 percent of all IRF discharges. As described in Chapter 8, IRF payment-adequacy indicators were positive in 2023.

Beneficiaries’ access to care—Between 2022 and 2023, the number of IRF beds increased by 3 percent. Similar to the previous year, the aggregate IRF occupancy rate was 69 percent in 2023, indicating that, in markets with IRFs, capacity is more than adequate to meet demand. From 2022 to 2023, the number of FFS Medicare stays in IRFs increased by about 7 percent, and stays per FFS beneficiary increased by about 10 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 40 percent for freestanding IRFs—a very strong indicator of access.

Quality of care—For the two-year period of 2022 through 2023, the median facility risk-adjusted rate of successful discharge to the community from IRFs was 67.2 percent, essentially stable from the prior period of 2021 through 2022. The median facility risk-adjusted rate of potentially preventable readmissions was also relatively stable at 8.8 percent and was higher (worse) for freestanding and for-profit providers than hospital-based and nonprofit providers.

Providers’ access to capital—Between 2022 and 2023, freestanding IRFs’ all-payer total margin (the percentage of revenue from all payers, sources, and lines of business that is left as profit after accounting for all costs) rose from 8 percent to about 10 percent. For-profit corporations continued to open new IRFs and enter joint ventures with other organizations, suggesting strong access to capital. Hospital-based IRFs access capital through their parent hospitals.

FFS Medicare payments and providers’ costs—In 2023, IRFs’ average payment per stay increased by less than 1 percent, while average cost per stay declined slightly after several years of higher growth. As a result, IRFs’ FFS Medicare margin (the percentage of revenue from FFS Medicare that is left as profit after accounting for the allowable costs of providing services to FFS Medicare patients) rose to 14.8 percent, up from 13.7 percent in 2022.

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 2026, the 2025 base payment rate for IRFs be reduced by 7 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 either traditional FFS Medicare or MA. In 2023, more than 1.7 million Medicare beneficiaries (including more than half of decedents) received hospice services from about 6,500 providers, and Medicare hospice expenditures totaled \$25.7 billion. As described in Chapter 9, the indicators of Medicare payment adequacy for hospice services are positive.

Beneficiaries’ access to care—In 2023, indicators of beneficiaries’ access to hospice were positive. In 2023, the number of hospice providers increased by more than 10 percent as more for-profit hospices entered the market, a trend that has extended for more than a decade. The overall share of Medicare decedents using hospice services increased from 49.1 percent in 2022 to 51.7 percent in 2023, similar to the prepandemic high of 51.6 in 2019. The number of hospice users and total days of hospice care also increased. For decedents, average lifetime length of stay increased by about 1 day in 2023 to 96.2 days. Between 2022 and 2023, median length of stay was stable at 18 days. In 2023, Medicare payments to hospice providers exceeded marginal costs by 14 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 very high and topped out for most providers (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 or increased slightly between 2022 and 2023, but the frequency of nurse visits remained lower than the prepandemic level.

Providers' access to capital—Hospices are generally not as capital intensive as many other provider types because they do not require extensive physical infrastructure. Continued growth in the number of for-profit providers (an increase of more than 10 percent in 2023) 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 margins are presented through 2022 because of the data lag required to calculate cap overpayment amounts. Between 2021 and 2022, average cost per day increased by 3.8 percent. The FFS Medicare margin (the percentage of revenue from FFS Medicare that is left as profit after accounting for the allowable costs of providing services to FFS Medicare patients) for 2022 was 9.8 percent, down from 13.3 percent in 2021. If Medicare's share of pandemic-related relief funds is included, the aggregate FFS Medicare margin was about 10.4 percent. Cost growth slowed in 2023, with hospices' average cost per day increasing by 3.0 percent. We project a FFS Medicare margin for hospices of about 8 percent in 2025.

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 2026. The Commission recommends that the Congress eliminate the update to hospice base payment rates for fiscal year 2026.

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 2023, about 6,300 ASCs treated 3.4 million FFS Medicare beneficiaries. FFS Medicare program

spending and beneficiary cost sharing on ASC services was about \$6.8 billion.

The supply of ASCs and volume of services continued to grow in 2023: The number of ASCs rose 2.5 percent, and the number of ASC surgical procedures per FFS beneficiary grew by about 5.7 percent. Numerous factors have contributed to this sector's growth over the past few decades, including changes in clinical practice and health care technology that have expanded the provision of surgical procedures in ambulatory settings. The most common service in ASCs, which accounted for almost 19 percent of volume and 19 percent of spending in 2023, 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 2023 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, of which pain management and orthopedics were the most common. From 2018 to 2023, the ASC specialties that grew most rapidly were pain management and cardiology. Relative to hospital outpatient departments (HOPDs), ASCs are less likely to provide surgical procedures to FFS Medicare beneficiaries who are disabled, have Medicaid coverage, or are age 85 or older.

Medicare spending per FFS beneficiary on ASC services rose at an average annual rate of 7.8 percent from 2018 through 2022 and by 15.4 percent in 2023. 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, as other small providers such as home health agencies and hospices do. Beginning in 2010 through 2022, the Commission recommended that the Congress require ASCs to submit cost data and reiterated this recommendation in 2023 and 2024. The Commission also encourages CMS to synchronize measures in the ASC Quality Reporting Program with measures included in the Hospital Outpatient Quality Reporting Program to facilitate comparisons between ASCs and HOPDs.

The Medicare Advantage program: Status report

The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than from the traditional FFS Medicare program. As described in Chapter 11, in 2024, the MA program included 5,678 plan options offered by 175 organizations; enrolled about 33.6 million beneficiaries (54 percent of Medicare beneficiaries with both Part A and Part B coverage); and paid MA plans an estimated \$494 billion (not including payments for drug coverage offered by MA plans). To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, plan generosity (including enhanced financial protections and supplemental benefits), and payments for MA plan enrollees relative to spending for beneficiaries enrolled in FFS Medicare. We also provide updates on risk adjustment, risk-coding practices, favorable selection of enrollees into MA, 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 FFS Medicare, while others may prefer features of MA, like reduced premiums and cost-sharing liability. As evidenced by rapid growth in enrollment, these additional benefits 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.

The MA program is quite robust, with growth in enrollment, increased plan offerings, and a near record-high level of supplemental benefits. From 2018 to 2024, the share of eligible Medicare beneficiaries enrolled in MA rose from 37 percent to 54 percent. In 2025, the average Medicare beneficiary has a choice of 42 plans offered by an average of eight organizations.

In 2025, we estimate that Medicare will spend about 20 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates into a projected \$84 billion. These higher payments vary significantly across MA

parent organizations and are not an estimate of plan profits and administrative expenses. However, they are the primary source of funding for supplemental benefits, which include coverage of non-Medicare services (services not covered by Part A and Part B) and better financial protection for MA enrollees relative to beneficiaries in FFS Medicare without supplemental coverage. The rebates that plans use to finance these benefits have nearly doubled since 2018 and account for a projected 17 percent of payments to all MA plans in 2025, equaling \$2,255 annually per enrollee in conventional plans (including \$180 per enrollee for plan administrative expenses and profit). However, CMS lacks information about beneficiaries' use of many of these benefits.

The relatively higher payments to MA plans are financed by the taxpayers and beneficiaries who fund the Medicare program. Higher MA spending increases Part B premiums for all beneficiaries, including those in FFS Medicare; the Commission estimates that Part B premium payments will be about \$13 billion higher in 2025 because of higher Medicare payments to MA plans (equivalent to roughly \$198 per beneficiary per year).

The two largest factors responsible for higher payments to plans in recent years are favorable selection and coding intensity. “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. “Coding intensity” refers to the tendency for more diagnosis codes to be recorded for MA enrollees, which causes risk scores—and payments—for the same beneficiaries to be higher when they are enrolled in MA than they would be if they were in FFS Medicare. Both favorable selection and coding intensity lead to pricing errors that cause CMS's risk-adjustment system to set the payment rate too high for a given MA enrollee.

Favorable selection may stem from a variety of factors, including differences in enrollees' propensities for using care for reasons unrelated to their health, differences in enrollees' health status that are not accounted for by risk scores, and differences in provider practice styles, among other reasons. Similarly, MA coding intensity is driven by several factors, including MA plans documenting diagnoses

more comprehensively than providers in FFS Medicare and, in some cases, submitting fraudulent diagnostic data. Separately identifying all of these factors is challenging and in many cases is not possible given available data. However, regardless of the causes, higher MA coding intensity and favorable selection of enrollees in MA increase Medicare's payments to plans. Higher payments to MA plans fund more generous benefits, but those higher payments increase Medicare spending and create an imbalance between the MA and FFS programs such that policymakers must weigh the added cost with the unmeasured value of the added benefits. Past experience with reductions in MA payments has demonstrated that plans can adjust their bidding behavior and lessen effects on plan participation and beneficiary enrollment while achieving program savings.

The Commission contends that important reforms are needed to improve Medicare's policies of paying and overseeing MA plans. First, reforms are needed to reduce the level of Medicare payments to MA plans. Relatively higher levels of payment stem largely from coding intensity and favorable selection. Second, the program that is used to reward plans for better quality is administratively burdensome, adds significantly to program costs, and does not meaningfully improve quality, nor does it provide meaningful quality information for beneficiaries choosing among MA plans. Third, MA benchmarks generate a number of inequities, including "cliff" effects from dividing counties into quartiles, caps on benchmarks, and benchmarks that are skewed by the inclusion of FFS-spending data for beneficiaries with only Part A coverage. Fourth, Medicare must address the challenges, burdens, and care disruptions for beneficiaries that stem from the process of choosing between plans and from changes to provider networks. Finally, the Commission finds that plan-submitted data about enrollees' health care encounters are incomplete, and we lack information about the use of many MA supplemental benefits. Without these data, policymakers cannot fully understand enrollees' use of services, which limits policymakers' ability to oversee the program and assess the value that enrollees get from supplemental benefits.

Medicare payments to plans—In 2025, Medicare's payments to MA plans will total a projected \$538 billion (about \$507 billion excluding projected payments for

enrollees with ESRD). As noted above, we project that Medicare's payments to MA plans in 2025 (including rebates that finance supplemental benefits) will be \$84 billion more, or about 20 percent higher, than if MA enrollees were enrolled 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.

Favorable selection—We estimate that favorable selection increased MA payments in 2022 by roughly 10 percent above what the program would have paid under FFS Medicare. We project that in 2025, favorable selection will increase MA payments by roughly 11 percent above what the program would have paid under FFS Medicare, or \$44 billion of the \$84 billion in higher total payments to MA plans. We found relatively little variation in favorable selection by MA market penetration; that is, we estimate that favorable selection persists as the share of MA enrollees in a market increases. In addition, there were larger favorable-selection effects in MA enrollees with higher risk scores, implying that selection persists even as beneficiaries with more expensive health conditions enroll in MA. In fact, beneficiaries with higher risk scores can exhibit greater selection because there is more potential for overprediction. The Commission's estimates of favorable selection are reasonably robust and in line with a growing body of research that also estimates substantial effects from favorable selection on Medicare payments to MA plans.

Risk adjustment and coding intensity—We estimate that in 2023, MA risk scores were about 17 percent higher than scores for similar FFS beneficiaries due to higher coding intensity. We project that in 2025, MA risk scores will be about 16 percent higher than scores for similar FFS beneficiaries after accounting for the phase-in of the V28 risk-adjustment model. 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 2025, the adjustment will reduce MA risk scores by

the minimum amount, 5.9 percent, resulting in MA risk scores that will remain about 10 percent higher than they would have been if MA enrollees were in FFS Medicare. In 2025, higher scores due to coding intensity will result in a projected \$40 billion of the \$84 billion in higher total payments to MA plans.

Coding intensity for MA and FFS beneficiaries can arise for several reasons. We previously identified mechanisms that contribute to coding differences, such as health risk assessments and chart reviews, and we continue to examine why coding practices differ. In response to a congressional request, we examined the differing incentives in MA and FFS Medicare to document diagnoses, and we estimated rates of documenting chronic conditions in subsequent years in MA and FFS Medicare. 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.

In addition, we continue to find that coding intensity varies significantly across MA plans; 15 percent of MA enrollees are in plans that have coding intensity that falls below the 5.9 percent reduction (and even below FFS levels), and others are in plans that code far above that amount, including 16 MA organizations with average coding intensity that is more than 20 percent higher than FFS levels. Higher coding intensity allows some plans to offer more supplemental 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 address any residual impact of coding intensity. The Commission expects that our recommendation, along with the exclusion of chart reviews from risk adjustment, would reduce the heterogeneity in estimated coding intensity across MA organizations.

Quality in MA—The MA quality-bonus program increases MA payments by about \$15 billion annually. In 2025, 69 percent of MA enrollees are in a plan that received a quality-bonus increase to its benchmark. At the same time, beneficiaries in MA and FFS report similar satisfaction with their coverage. Enrollees

in both MA and FFS tend to rate their coverage and access to care highly—a trend that has held over time. For example, scores for all MA and FFS Consumer Assessment of Healthcare Providers and Systems survey measures, except annual flu vaccine, were above 80 percent from 2018 to 2023.

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

As described in Chapter 12, in 2024, Part D paid for outpatient drug coverage on behalf of more than 54 million Medicare beneficiaries. In 2023, Medicare and beneficiaries enrolled in Part D made payments to stand-alone Part D plans (known as PDPs) and Medicare Advantage-Prescription Drug plans (MA-PDs) totaling \$128.2 billion (about 12 percent of total Medicare expenditures). Of that amount, Medicare paid \$68.2 billion in subsidies for basic benefit costs and \$43.9 billion in extra financial support for enrollees who received the low-income subsidy (LIS), while Part D enrollees paid \$16.1 billion in premiums for basic benefits. Not included in this total is an additional \$18.8 billion in cost sharing paid by enrollees and \$0.5 billion in retiree drug subsidies paid by Medicare to employers who provide drug coverage to their retirees. Surveys and focus-group findings suggest high overall satisfaction with Medicare Part D.

Significant changes happening in 2025—The passage of the Inflation Reduction Act of 2022 (IRA) brought many changes to the Part D program. One of the most important changes, the redesign of the Part D benefit structure, occurs in 2025. The redesign includes key elements of the Commission's 2020 recommendations intended to restore the plan incentives to manage drug spending that were in place at the start of the program. Notably, the redesign reduces the role of Medicare's reinsurance payments—the cost-based reimbursement that had paid for most of the costs incurred by enrollees with high spending—while increasing the role of capitated direct-subsidy payments.

By adding cost-sharing protections such as the \$2,000 annual limit on out-of-pocket costs, the redesign also substantially shifts liability for drug spending from cost sharing paid by beneficiaries at the point of sale (POS) to plans (which increases both enrollee premiums and the premium subsidies paid by Medicare). By lowering POS costs and increasing premiums, the redesign spreads the cost of the prescription drug benefit more

broadly among enrollees. Because the IRA also places a limit on the annual increase in average premiums paid by enrollees, Medicare's share of program spending has automatically increased to just over 83 percent (from the original 74.5 percent) in 2025.

Changes taking place in 2025 and subsequent years are expected to have wide-ranging impacts on Part D plan sponsors and their enrollees as well as participants in the pharmaceutical supply chain. For 2025, the national average plan bid rose by nearly 180 percent. The redesign's increase in plan liability was expected to raise premiums and Medicare's upfront payments for capitated direct subsidies while decreasing the share of spending paid by Medicare's reinsurance and beneficiaries' costs at the POS. However, greater variation in bids submitted by Part D plans for 2025 compared with previous years was likely driven by plans' uncertainty regarding the effects of the IRA on benefit costs, for which plans now bear a substantial portion of the insurance risk.

The Premium Stabilization Demonstration that CMS implemented for 2025 reduced some of the largest premium increases observed among the PDPs but will increase program spending by an estimated \$5 billion in 2025; large variations in premiums remain. Over the coming years, we expect plan sponsors to adjust to the redesigned benefit as they gain claims experience while adapting to the new market dynamics.

Historical trends and concerns about the long-term stability of the PDP market—Historical data has continued to show Part D enrollment shifting from PDPs to MA-PDs. In 2024, PDPs accounted for less than 43 percent of all Part D enrollees, down from 53 percent in 2020. Trends through 2024 also showed stable average premiums but significant differences between PDPs and MA-PDs, in part due to MA-PDs' ability to use Part C rebates to lower Part D premiums: The average PDP premium in 2025, weighted by 2024 enrollment, is estimated at \$44, while the average MA-PD premium (including both special-needs plans and conventional plans) is \$14. In 2023, Medicare's spending on cost-based reinsurance and the LIS continued to grow.

Some of the recent trends have raised concerns about the long-term stability of the PDP market, which provides drug coverage for FFS beneficiaries and,

critically, ensures that premium-free plan options are available for individuals with low income and assets. The shift in Part D's enrollment from PDPs to MA-PDs is consistent with the shift in enrollment from FFS to MA in the broader Medicare program. At the same time, however, MA-PDs' ability to offer more generous prescription drug coverage at lower premiums using Part C rebate dollars may affect insurers' willingness to participate in the PDP market. Misalignment between Medicare's payments to Part D plans and their enrollees' drug costs could also create disincentives for insurers to participate in the PDP market. Part D's risk adjustment has historically paid MA-PDs relatively more compared with their actual average costs while paying relatively less to PDPs compared with their actual average costs. Those inaccuracies may result from differences in management of drug spending, differences in coding behavior, or some combination of the two. To try to address the inaccuracy in Part D's risk-adjustment model, CMS is using a separate normalization factor for MA-PDs and PDPs in 2025. Despite a significant drop in PDP offerings across the country, in 2025 each beneficiary continues to have at least 12 PDPs from which to choose and roughly 30 MA-PDs.

Eliminating Medicare's coverage limits on stays in freestanding inpatient psychiatric facilities

In Medicare, coverage of treatment in freestanding inpatient psychiatric facilities (IPFs) is subject to limitations—a 190-day lifetime limit on days in IPFs and a reduction of inpatient psychiatric benefit days available in the initial benefit period for beneficiaries who are in freestanding IPFs on their first day of Medicare entitlement. (Under Part A, a beneficiary's initial Medicare benefit period can span 150 days: 60 full-benefit days, 30 days with Part A coinsurance, and 60 lifetime reserve days.) These provisions were established in 1965 (with the implementation of Medicare), when most inpatient psychiatric care took place in state- and locally run freestanding facilities. However, the landscape has changed substantially in the last 60 years, and the provision of inpatient psychiatric services has shifted away from longer-term custodial-type care in government-run facilities to acute psychiatric care in privately owned facilities. In 2023, only 4 percent of Medicare-covered IPF days were in government-run freestanding IPFs, while 35

percent were in privately owned freestanding IPFs. The remaining 60 percent of Medicare inpatient psychiatric days took place in hospital-based IPFs, which are not subject to these limitations.

A small but highly vulnerable group of beneficiaries is affected by Medicare's coverage limits on freestanding IPFs. As of January 2024, since their initial enrollment in Medicare, about 40,000 Medicare beneficiaries had exhausted their coverage in freestanding IPFs. An additional 10,000 Medicare beneficiaries were within 15 days of the 190-day limit. In 2023, among the Medicare beneficiaries who were near or at the 190-day limit, over 70 percent were under 65 (disabled) and 84 percent had low incomes. Eighty percent of FFS Medicare beneficiaries near or at the limit had a diagnosis of schizophrenia in the prior year; these beneficiaries also were more likely than other IPF users to have "dual" diagnoses of schizophrenia or depressive order with substance abuse disorder.

Medicare beneficiaries reaching the limit may still obtain psychiatric care from hospital-based IPFs or general acute care hospitals, but an alternative setting may be difficult to find, be disruptive to care, and potentially be a less appropriate setting for the beneficiary. We compared beneficiaries who were near or at the 190-day limit with a group of beneficiaries who were further away from the limit but had a similar history of previous freestanding IPF use. We found that beneficiaries affected by the limit had an average of 2.4 covered days in a freestanding IPF compared with 7.6 covered days for the comparison group, suggesting

that freestanding IPF days could increase by about 5 days on average if the limit were removed. However, beneficiaries affected by the limit had 5.0 covered days in a hospital-based IPF compared with 2.8 days for those in the comparison group, indicating that some substitution away from hospital-based IPFs would occur in the absence of the limit. Beneficiaries affected by the limit had an average of 2.2 fewer days of covered inpatient psychiatric care than beneficiaries in the comparison group, indicating that overall covered days for inpatient psychiatric services would likely increase if the limit were removed.

The Commission recommends that the Congress eliminate the 190-day lifetime limit on covered days in freestanding IPFs and the reduction of the number of covered inpatient psychiatric days available during the initial benefit period for new Medicare beneficiaries who received care from a freestanding IPF on and in the 150 days prior to their date of Medicare entitlement. Eliminating the limits on psychiatric services in freestanding IPFs would improve access to inpatient psychiatric care for some of the most vulnerable Medicare beneficiaries and would better align Medicare's coverage of inpatient psychiatric services with coverage for other types of medical care. Continued work to ensure that Medicare beneficiaries are receiving high-quality inpatient psychiatric care and are transitioned appropriately to the community upon discharge is critically important. The Commission will continue to monitor access and quality of care for beneficiaries who use IPF services. ■

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 Medicare's various fee-for-service (FFS) payment systems, the Medicare Advantage (MA) program, and the Medicare Part D prescription drug program. To provide context for the information presented in this report, this chapter describes Medicare's overall financial situation and highlights factors contributing to growth in Medicare spending.

Trends in national health care and Medicare spending

Both national health care spending and Medicare spending tend to grow more quickly than the U.S. gross domestic product (GDP)—causing spending in both sectors to consume growing shares of GDP over time. In 2023, \$4.9 trillion was spent on health care in the U.S. (equivalent to 17.6 percent of GDP); Medicare spending made up about \$1.0 trillion of this spending (equivalent to 3.7 percent of GDP).

During the first year of the recent coronavirus pandemic, Medicare spending grew more slowly than usual (if short-term loans paid by CMS to providers are not included). 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-19

In this chapter

- National health care spending usually grows 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 do beneficiaries' costs
- Differences in beneficiaries' access to care and health outcomes
- The Commission's recommendations to slow the growth in Medicare spending and improve beneficiary access to care

care. Since then, Medicare beneficiaries' health care spending has generally returned to more typical levels. Looking ahead, CMS expects Medicare spending to grow by about 4 percent per year between now and the early 2030s, after accounting for economy-wide price inflation. This increased spending is driven by Medicare enrollment growth and growth in the volume and intensity of services clinicians deliver per beneficiary. Medicare prices are not a significant driver of spending growth since they are projected to grow more slowly than inflation.

A longer-term trend contributing to increased Medicare spending is the growing enrollment in MA plans. MA plans may be attractive to beneficiaries because they can offer reduced cost sharing for many services, a cap on enrollees' annual out-of-pocket spending for covered services, and coverage of some items and services that are not covered by FFS Medicare—often at no additional premium beyond beneficiaries' Part B premiums. But the Commission estimates that in 2025 Medicare will spend an estimated 20 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare. The features of MA payment policy that drive those relatively higher payments may contribute to increased Medicare spending in the future.

Medicare's financial outlook has recently improved despite challenges

Although Medicare spending is projected to grow in the coming years, 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, yielding higher-than-expected Medicare payroll-tax revenues. At the same time, Medicare beneficiaries used a lower-than-expected volume of Part A services during the pandemic, and future Part A spending (on hospital inpatient and skilled nursing facility care) is now projected to be lower than previously estimated. As a result, the Part A trust fund is now projected to be able to pay for its share of Part A services for a decade longer than was projected before the pandemic—until 2036, according to the Medicare Board of Trustees, or 2035, according to the Congressional Budget Office.

Yet pressure to restrain the growth in Medicare's overall spending remains. A growing share of federal revenues must be transferred to Medicare's Supplementary Medical Insurance (SMI) Trust Fund to help pay for spending on Part B (clinician services and outpatient fees) and Part D (prescription drug

coverage). For example, the share of personal and corporate income taxes collected by the federal government that was transferred to the SMI Trust Fund to pay for Part B and Part D was 17 percent in 2023 and is projected to increase to 22 percent by 2030, according to Medicare's Trustees.

Increasing Medicare spending puts pressure on beneficiaries

In 2023, Medicare spent an average of \$16,710 per beneficiary on Part A, Part B, and Part D benefits—almost \$3,000 more than in 2019 according to the Medicare Trustees. As Medicare spending grows, it affects beneficiaries' ability to afford health care by raising their premiums and cost sharing. The Medicare Trustees estimate that spending by FFS beneficiaries on Medicare Part B and Part D premiums and cost sharing consumed 26 percent of the average Social Security benefit in 2024—up from 17 percent 20 years earlier, in 2004. Although only 6 percent of Medicare beneficiaries reported having problems paying a medical bill according to CMS's 2022 Medicare Current Beneficiary Survey (which includes enrollees in both FFS Medicare and MA), some subpopulations experience affordability issues at higher rates. For example, among beneficiaries under the age of 65 (most of whom are disabled), 18 percent reported problems paying a medical bill. Among partial-benefit dually eligible beneficiaries (who do not qualify for the same Medicaid benefits that full-benefit dually eligible beneficiaries receive), 28 percent reported this problem. And among beneficiaries enrolled in FFS Medicare with no supplemental coverage, 12 percent reported this difficulty. Since a notable share of beneficiaries already report having a hard time affording health care, it is important for policymakers to consider the effect of raising Medicare's payments to providers and plans on beneficiaries' premiums and cost-sharing liabilities. Restraining the annual growth in Medicare payments to providers and plans can help beneficiaries better afford their health care.

The Commission's recommendations aim to obtain good value for the program's expenditures

One way the Medicare program has kept spending growth relatively low is by setting payment rates in certain sectors. The Commission's annual March report recommends updates to Medicare payment rates for various types of providers for a given year. These recommended updates can be positive, neutral, or negative, depending on our assessment of the adequacy of Medicare payments in a given 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 clinical setting. A list of the Commission's recommendations, with links to relevant report chapters, is available at www.medpac.gov/recommendation. The Commission's recommendations are based on our 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 Medicare's various fee-for-service (FFS) payment systems, the Medicare Advantage (MA) program, and the Medicare Part D prescription drug program. To provide context for the information presented in this report, this chapter describes Medicare's overall financial situation and highlights factors contributing to Medicare's spending growth.

National health care spending usually grows faster than GDP

In 2023, the U.S. spent \$4.9 trillion on health care (Martin et al. 2025). Since national health care spending usually grows faster than the U.S. gross domestic product (GDP), it has made up an increasing share of GDP over time (Figure 1-1, p. 8).

National health care spending temporarily diverged from this historical trend during the recent coronavirus pandemic—sharply increasing as a share of GDP in 2020 before falling just as sharply in 2021 and 2022 (reflected in the spike in Figure 1-1, p. 8). The sharp increase in 2020 occurred because national health care spending increased by 10.4 percent that year—largely due to one-time federal spending for vaccine development and health facility preparedness and to provide additional support for health care providers—while the country's GDP shrank (Hartman et al. 2024, Martin et al. 2025). In 2021 and 2022, national health care spending as a share of GDP then fell as GDP grew rapidly and pandemic-related funding tapered off (Martin et al. 2025).

In 2023, spending trends began to return to historical norms, with national health care spending growing faster (7.5 percent) than GDP (6.6 percent)—causing health care spending to rise from 17.4 to 17.6 percent of GDP (Martin et al. 2025). Health care spending growth accelerated in 2023 in part because the share of the population with health insurance reached an all-time high of 92.5 percent (Martin et al. 2025). Coverage gains were driven by a substantial increase (5.8 million people) in the number of people with direct-purchase Marketplace plans from 2020 to 2023, which was

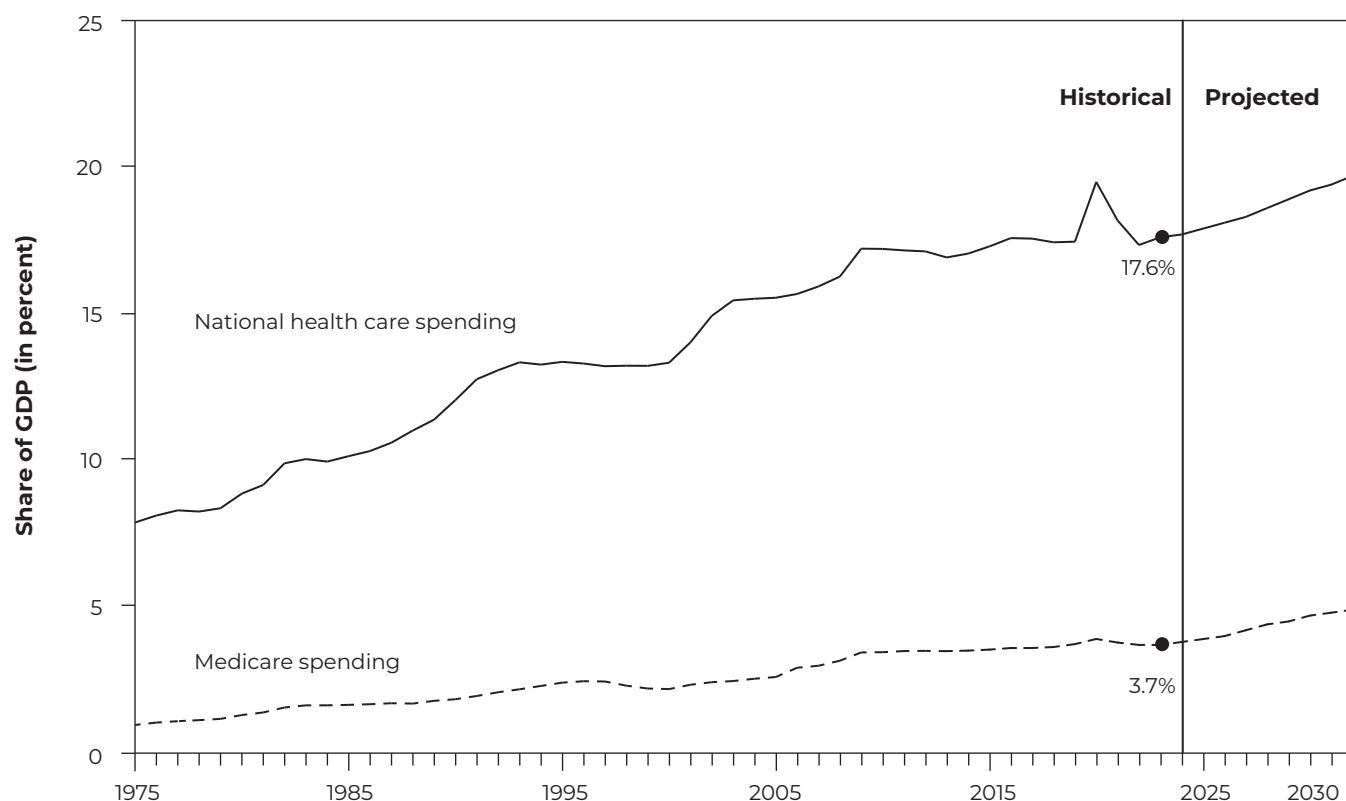
facilitated by the availability of enhanced subsidies beginning partway through this period. An even larger number of people (15.5 million people) gained coverage through Medicaid from 2020 to 2023 due to a change in law that allowed states to keep people continuously enrolled in Medicaid during the pandemic.¹ The overall share of the U.S. population with health insurance is expected to decline by 1 percentage point to 2 percentage points in coming years as this Medicaid policy expires and as subsidies for direct-purchase Marketplace plans are scaled back (Centers for Medicare & Medicaid Services 2024i, Fiore et al. 2024).²

Another driver of growth in national health care spending in 2023 was the increasing volume and intensity of health care services used per patient that year (particularly hospital care and clinician services) among both Medicare beneficiaries and the privately insured (Martin et al. 2025). Consumers also used a more expensive mix of retail prescription drugs in 2023, with more higher-cost and newer brand-name drugs, and drug prices increased faster in 2023 than in 2022, in general (Martin et al. 2025). Consistent with most years in the prior decade and a half, in 2023 spending per person grew faster for privately insured people (9.7 percent) than for Medicare beneficiaries (5.9 percent) (Centers for Medicare & Medicaid Services 2024h).

Looking ahead, national health care spending is projected to continue to outpace growth in GDP during the next decade, in part because medical prices are expected to grow faster than economy-wide prices over the period (Fiore et al. 2024). (For a discussion of the role played by provider consolidation in increasing health care prices, see the text box (pp. 9–11).) Other drivers of growth in health care spending in the coming decade are the aging of the U.S. population and demand for health care that is expected to outpace income growth (Fiore et al. 2024).

Medicare spending is projected to double in the next 10 years

During the first year of the coronavirus pandemic, Medicare spending grew more slowly than usual (by 3.7 percent) (Martin et al. 2025). Although spending increased on COVID-19 testing and treatment and on services that were made more widely available through

**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 2024. 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 2024 and historical data released in December 2024), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html>.

waivers of Medicare's usual payment rules, the increase was more than offset by decreased spending on non-COVID-19 care (Boards of Trustees 2024, Hartman et al. 2022). Medicare spending then grew at higher rates in subsequent years (by 7.3 percent in 2021, 6.4 percent in 2022, and 8.1 percent in 2023), as Medicare beneficiaries' use of most types of health care services rebounded (Martin et al. 2025). In 2023, growth in Medicare spending was also driven by provisions in the Inflation Reduction Act of 2022 (IRA) that increased the generosity of the Part D benefit by limiting beneficiary cost sharing for insulins and requiring coverage of vaccines with no cost sharing (Martin et al. 2025). (We say more about the expected

effects of this law's changes to Part D later in this chapter.) Other factors that contributed to Medicare spending growth in 2023 were increasing use of outpatient hospital services, increases in Medicare's payment rates for inpatient and outpatient hospital services, and a rapid increase in the use of brand-name antidiabetic drugs (Martin et al. 2025).

In recent years, FFS Medicare enrollment has declined and enrollment in MA plans (which cost the Medicare program more per beneficiary than FFS coverage) has rapidly increased. As a result of this shift, by 2023 MA plans covered 48 percent of Medicare beneficiaries and constituted 52 percent of Medicare spending (up from

Health care providers continue to consolidate and obtain higher prices

Over the last several decades, health care providers have pursued horizontal mergers and vertical acquisitions—in part to obtain higher payment rates both from Medicare and private payers.

Consolidation can lead to higher payment rates from Medicare because when a hospital acquires a clinician practice, the hospital can sometimes bill a “facility” fee (in addition to the physician’s fee) each time a Medicare beneficiary is seen in the hospital-owned practice located on the hospital campus. The combination of the facility fee and the physician’s fee results in hospitals’ on-campus physician practices receiving higher Medicare rates than independent physician practices. The Commission has recommended eliminating this payment differential by applying “site-neutral” payment rates for certain services provided in hospitals’ on-campus practices, which would reduce incentives to shift the billing of Medicare services from low-cost settings to high-cost settings and would result in lower Medicare program spending and lower beneficiary cost sharing. Hospitals and physician practices could still vertically integrate if they believed integration would create true efficiencies that improve quality or lower provider costs.

Consolidation can also lead to higher payment rates from private payers, by increasing a provider’s market power. Consolidated providers are often in a stronger bargaining position when negotiating rates with private insurers (Baker et al. 2014, Beaulieu et al. 2023, Beaulieu et al. 2020, Cooper et al. 2015, Gaynor and Town 2012, Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2017, Whaley et al. 2022). When hospitals acquire physician practices and create a vertically integrated entity, it can also make it more difficult for competing hospitals to enter the market since the new hospital does not have a built-in network of practices referring patients to them. Some have also argued that tying physician and hospital services together can create shared market power and thus increase commercial payment

rates (Curto et al. 2022). While market power and commercial-insurer payment rates vary widely from market to market and even from hospital to hospital within a market, commercial hospital prices average more than twice Medicare rates, and commercial physician rates are in the range of 20 percent to 60 percent above Medicare rates (Chernew et al. 2020, Congressional Budget Office 2022, KFF 2020, Medicare Payment Advisory Commission 2017, Whaley et al. 2024, Whaley et al. 2022).

Obtaining higher payment rates is not the only reason providers consolidate. According to a 2022 survey by the American Medical Association (AMA), physicians also sell practices to hospitals or health systems to gain access to costly resources and to get help meeting regulatory and administrative requirements (Kane 2023).

While market forces have resulted in commercial insurers’ prices being significantly above Medicare rates, physicians nevertheless accept Medicare and commercial patients at comparable rates (American Medical Association 2023b, Schappert and Santo 2023). Clinicians may accept fee-for-service (FFS) Medicare despite lower payment rates because FFS Medicare patients make up a large share of physicians’ patients and clinicians often face fewer administrative burdens from FFS Medicare than from private payers. A recent AMA survey found that physicians complete an average of 45 prior authorization requests per week, requiring 14 hours per week of staff time, 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. Another factor that may boost Medicare’s acceptance rates is that almost all hospitals accept

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Health care providers continue to consolidate and obtain higher prices (cont.)

Medicare patients, and hospitals may expect their employed physicians to take Medicare patients given the important role these patients play in hospitals' missions and revenue streams.

An increasing array of entities are acquiring provider organizations

In previous decades, provider consolidation mainly involved like-types of provider organizations (e.g., hospitals merging with other hospitals) or different types of provider organizations that had referral relationships between them (e.g., hospitals acquiring physician practices in their area). As we noted in our March 2020 report to the Congress, the share of hospital markets that were “super” concentrated—with a single dominant health system that accounted for a majority of hospital discharges—rose from 47 percent in 2003 to 57 percent in 2017 (Medicare Payment Advisory Commission 2020).³ And by 2021, 52 percent of all physicians were affiliated with a health system (Contreary et al. 2023). Hospitals have also been consolidating across markets, which could also increase market power with common customers across markets (Fulton et al. 2022).

In recent years, nonprovider organizations have also acquired provider organizations. Private insurers have 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). By employing physicians, insurers may be able to better coordinate care and gain physician cooperation in cost-control efforts such as prescribing generic drugs. They also may be able to generate more extensive diagnosis coding, which can yield higher payments to both insurers and physicians in some capitated payment models. In addition, buying physician practices could allow insurers to shift profits to owned physician practices as a way to avoid being constrained by medical-loss-ratio regulations that limit the share of premiums that insurers are allowed to keep as profit (Frank and Milhaupt 2023).

Companies that have not traditionally participated in health care, such as Amazon, have also begun acquiring primary care practices and providing telehealth visits (Landi 2022). It remains to be seen whether these types of nontraditional players will remain in the health care industry long term. Walmart recently closed all of its primary care clinics, stating that it did not “see a path to achieving an acceptable level of profitability” (McMillon 2024).

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covering 37 percent of enrollees and constituting 39 percent of Medicare's spending in 2019 (Martin et al. 2025, Martin et al. 2021)).⁴

Looking ahead, Medicare spending is projected to grow faster than spending by all other types of payers over the next decade: Between now and the early 2030s, CMS expects Medicare spending to grow by 7 percent to 8 percent per year (Fiore et al. 2024). This increase will cause Medicare spending to nearly double over a

10-year period—growing from \$1.0 trillion in 2023 to \$1.9 trillion in 2032 (Figure 1-2, p. 12). (These amounts include Medicare program spending and beneficiaries' premiums but not beneficiaries' cost sharing.)

A number of factors are expected to affect Medicare spending in the coming years. For one, Medicare enrollment in Part A and Part B will increase by about 2 percent per year as the baby-boom generation continues to age into the Medicare program

Health care providers continue to consolidate and obtain higher prices (cont.)

Private-equity funds have been investing in provider organizations as well, targeting certain specialties in certain geographic markets. One report suggests a dramatic increase in private-equity deals, from 75 practice acquisitions in 2012 to 484 deals in 2021 (Scheffler et al. 2023). That study found that in 108 markets, a private-equity company's physician practices had a 30 percent or larger market share. It is possible that the so-called “roll-up” of small practices in specific specialties (combining independent practices into a larger group) could result in greater market power and profits. However, past efforts of private equity to employ emergency department physicians have not always been financially successful (Knauth 2023).

Effect of provider consolidation on quality is unclear

There is limited information on the effects of horizontal consolidation and vertical integration on quality. Most of the older literature suggests that consolidation increases prices without improving quality. Some literature suggests a lack of competition may hurt quality (Gaynor et al. 2017). However, the effect of horizontal consolidation and vertical integration on quality

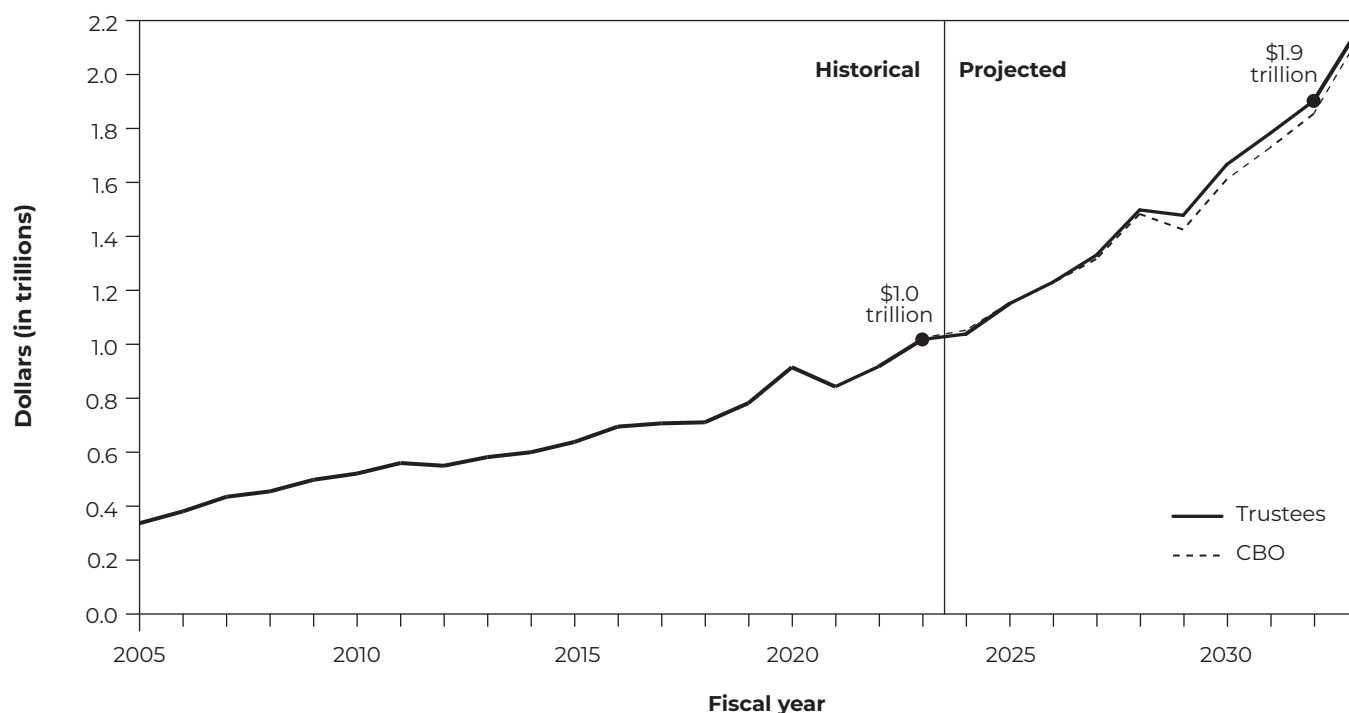
is less clear than the effect of consolidation on price. A study that examined the longitudinal effects of hospital mergers on quality found that “hospital acquisition by another hospital or hospital system was associated with modestly worse patient experiences and no significant changes in readmission 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. ■

(Table 1-1, p. 13). During this same period, the number of people with private health insurance is expected to decline and Medicaid enrollment is expected to grow slightly (Fiore et al. 2024)).

Medicare spending is also expected to grow due to an increase in the volume and intensity of services delivered per beneficiary, which is projected to rise by an average of 2.8 percent per year in the coming years (Table 1-1, p. 13). An example of increasing volume and intensity of service delivery is when newer, higher-resolution computed tomography (CT) scans identify potential issues that might not have been identified

by lower-resolution CT scans, and those issues are then pursued through additional clinical workup. Intensity can also increase when providers furnish more complex, higher-priced services in place of less complex, lower-priced services. For example, analyses of claims data show an increase in recent years in the share of visits billed as involving a “moderate” level of medical decision-making rather than a “low” level of medical decision-making, shown in Figure 1-3 (p. 13).⁵

The demographic mix of beneficiaries in the program is not expected to cause a significant increase in spending over the next 10 years (shown in Table 1-1, p. 13). To the

**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 2024. The sharp increase in spending in 2020 includes \$104 billion in Medicare Accelerated and Advance Payments paid to providers that were then recouped by the Medicare program in 2021, 2022, and 2023. The decline in spending in 2029 is due to a timing issue: When October 1 (the first day of the federal fiscal year) falls on a weekend, certain payments that would have ordinarily been made on that day are instead made at the end of September and thus are shifted into the previous fiscal year.

Source: 2024 annual report of the Boards of Trustees of the Medicare trust funds, Table V.H4; CBO's June 2024 baseline projections for the Medicare program.

contrary, the average Medicare beneficiary has been getting younger and healthier in recent years, as the baby-boom generation ages into Medicare (Boards of Trustees 2024). And the Medicare beneficiaries who survived the recent coronavirus pandemic are now healthier, on average, than beneficiaries before the pandemic began—which has lowered actuaries' projections of Medicare's per capita spending through 2029 (Boards of Trustees 2024).

But in the 2030s, as the baby-boom generation begins to reach older ages, this demographic shift will contribute to increased spending per beneficiary since spending generally increases with age (Medicare Payment Advisory Commission 2024a). The aging of the baby-boom generation will contribute to

increased spending per beneficiary through about 2045 (Boards of Trustees 2024).

Medicare spending projections are also influenced by the IRA's prescription drug provisions—some of which are expected to increase Medicare spending and some of which are expected to decrease it.⁶ In 2025, the redesigned Part D benefit is expected to lower beneficiaries' out-of-pocket costs, on average—which is expected to put upward pressure on Medicare spending and premiums. Other changes in this law increase plan sponsors' share of insurance risk, which, in turn, could result in stronger incentives for plans to manage drug spending. (For a detailed status report on the Part D program, see Chapter 12.) In addition, beginning in 2026, the point-of-sale prices paid by

**TABLE
1-1****Factors contributing to Medicare's projected spending growth, 2024–2033 (after subtracting economy-wide inflation)**

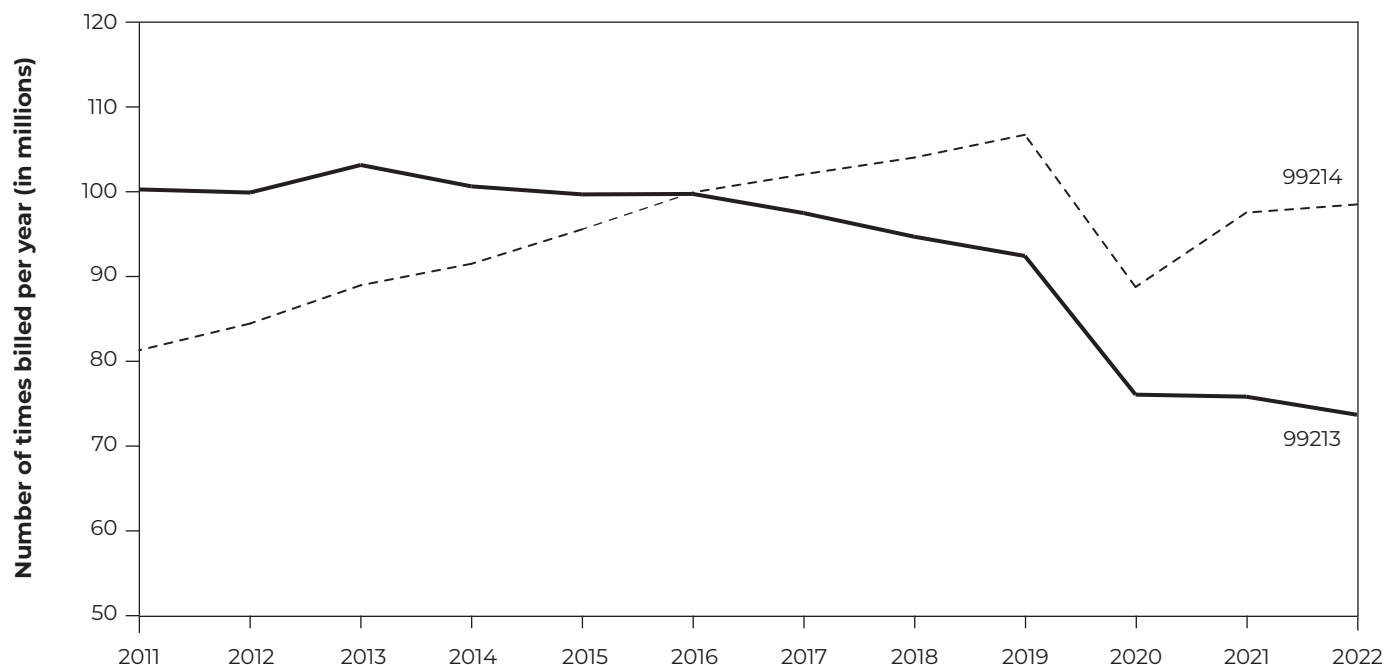
Average annual percent change in:

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	0.1%	1.9%	–0.2%	1.6%	3.4%
Part B	–0.9	2.0	0.1	3.7	4.8
Part D	–0.4	2.7	–0.2	2.8	3.1
Total	–0.4	N/A*	–0.1	2.8	4.1

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. "Beneficiary demographic mix" adjusts for age, sex, and time to death. "Volume and intensity" refers to 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 Medicare spending in 2023.

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

Source: MedPAC analysis of data from the 2024 annual report of the Boards of Trustees of the Medicare trust funds.

**FIGURE
1-3****Clinicians increasingly use billing code 99214 instead of 99213**

Note: Current Procedural Terminology (CPT) codes 99213 and 99214 pertain to office/outpatient visits with established patients that involve a medically appropriate history and/or examination; CPT code 99213 refers to visits involving a "low" level of medical decision-making and/or 20–29 minutes of practitioner time, while CPT code 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: Part B National Summary Data Files, 2011–2022, from CMS.

Expanded coverage of GLP-1 drugs is expected to increase Part D spending

A class of drugs called glucagon-like peptide-1 receptor agonists (GLP-1s) is garnering increased attention from the public and policymakers, with several products in the class recently approved by the Food and Drug Administration (FDA) to support weight loss and reduce the risk of adverse cardiovascular events (NovoMedLink 2024c). The first GLP-1 prescription medication was initially approved in 2005 to assist with glycemic control in individuals with Type 2 diabetes. Over time, several more GLP-1s were approved, and developers realized that at higher doses, these products could assist with weight loss. Currently, there are three drugs that have both a low-dose version for glycemic control in patients with Type 2 diabetes and a second, higher-dose version (typically with a different name) approved for weight loss.⁷

In clinical trials, patients on newer versions of these medications have achieved an average weight loss of between 17 percent and 21 percent compared with 7 percent for the first GLP-1 drug (Lilly Medicine 2024, NovoMedLink 2024a, NovoMedLink 2024b,

Rodriguez et al. 2024). Early evidence, however, suggests that some patients may stop use of such products before achieving clinically meaningful results.⁸

By statute, Medicare Part D is prohibited from covering drugs for weight loss, so GLP-1s have been available only for the treatment of Type 2 diabetes so far (P.L. 108-173).⁹ However, recent approvals of new indications by the FDA are expected to increase access to GLP-1s for Part D enrollees. The new indications would allow Medicare to cover GLP-1s when used to reduce the risk of cardiovascular death, heart attack, and stroke and to treat moderate to severe obstructive sleep apnea in adults with obesity or overweight (Cubanski et al. 2024, Food and Drug Administration 2024a, Food and Drug Administration 2024b, Frieden 2024). Medicare coverage of GLP-1s could be expanded to other indications in the coming years: A recent clinical trial showed significant risk reduction for major kidney disease (American Diabetes Association 2024), and another study has shown a reduction in the risk of developing various obesity-related cancers in

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Part D plans and coinsurance paid by beneficiaries for drugs selected under the Medicare Drug Price Negotiation Program will reflect discounts negotiated by the Secretary of Health and Human Services (see text box, pp. 437–439, in Chapter 12). Medicare's Trustees expect the net effect of the various provisions in this law to lower Part D spending from 2031 onward. Beginning in 2028, spending on drugs administered by clinicians (covered under Part B) is also expected to decline (Boards of Trustees 2024).

Future growth in Part D spending will also be affected by new developments in coverage policies or therapies that treat conditions that affect Medicare beneficiaries. One such case is a class of drugs called glucagon-like peptide-1 receptor agonists (GLP-1s) (Centers for

Medicare & Medicaid Services 2024e, Congressional Budget Office 2024b). For years, GLP-1s have been used to treat patients with Type 2 diabetes, although they have recently gained attention for their weight-loss effectiveness. Recent approval of new indications for some GLP-1 drugs, including to reduce the risk of adverse cardiovascular events, is expected to increase these drugs' uptake among Part D enrollees, even if the statutory exclusion of weight-loss drugs from coverage under Part D remains in place (see text box on coverage of GLP-1 drugs). Clinical guidelines and coverage policies concerning GLP-1s are changing rapidly, and we will continue to monitor and update in future work.

A longer-term trend contributing to increased Medicare spending is the growing enrollment in MA

Expanded coverage of GLP-1 drugs is expected to increase Part D spending (cont.)

adults with obesity or overweight (Lin et al. 2024). Given that tens of millions of Medicare beneficiaries have been diagnosed with diabetes, heart disease, obesity, or kidney disease, the number of potential users of such medicines is sizable (Centers for Disease Control and Prevention 2024b).^{10,11} Changes in Medicare's policy to allow Part D plans to cover GLP-1s for weight loss would further expand access to these drugs (Assistant Secretary for Planning and Evaluation 2024, Centers for Medicare & Medicaid Services 2024e).

Part D enrollees' increased use of GLP-1s (with list prices of roughly \$1,000 per month) is expected to put upward pressure on Part D spending (Amin et al. 2023, Congressional Budget Office 2024b). In fact, the Medicare Trustees noted in their 2024 report that overall drug expenditures in 2023 were 4.4 percent higher than anticipated because of the unexpected and rapid increase in the use of antidiabetic drugs, which includes GLP-1s (Boards of Trustees 2024). Further, true demand may have been dampened by the shortages of many of these products (Food and Drug Administration 2024c).

Spending on these drugs could be partially offset by savings if patients who take these drugs lose weight and consequently do not need more expensive medical care, though these drugs are relatively new and respective spending data are limited. Last year, CBO raised its projection of Medicare Part D outlays for the 2025 to 2034 period by \$36 billion, in part because of a newly approved indication that expanded coverage of GLP-1s under Part D (Congressional Budget Office 2024d).

At the same time, spending on GLP-1s will also be affected by rebates and discounts negotiated by Part D plans as well as discounts negotiated by the Secretary of Health and Human Services under the Medicare Drug Negotiation Program (see text box on the program in Chapter 12, pp. 437–439).

Part D plans may apply utilization management such as prior authorization to ensure that the drug is covered only for FDA-approved indications. Beyond price, length of treatment and adherence will also be major factors in overall spending on GLP-1 drugs (Congressional Budget Office 2024a). ■

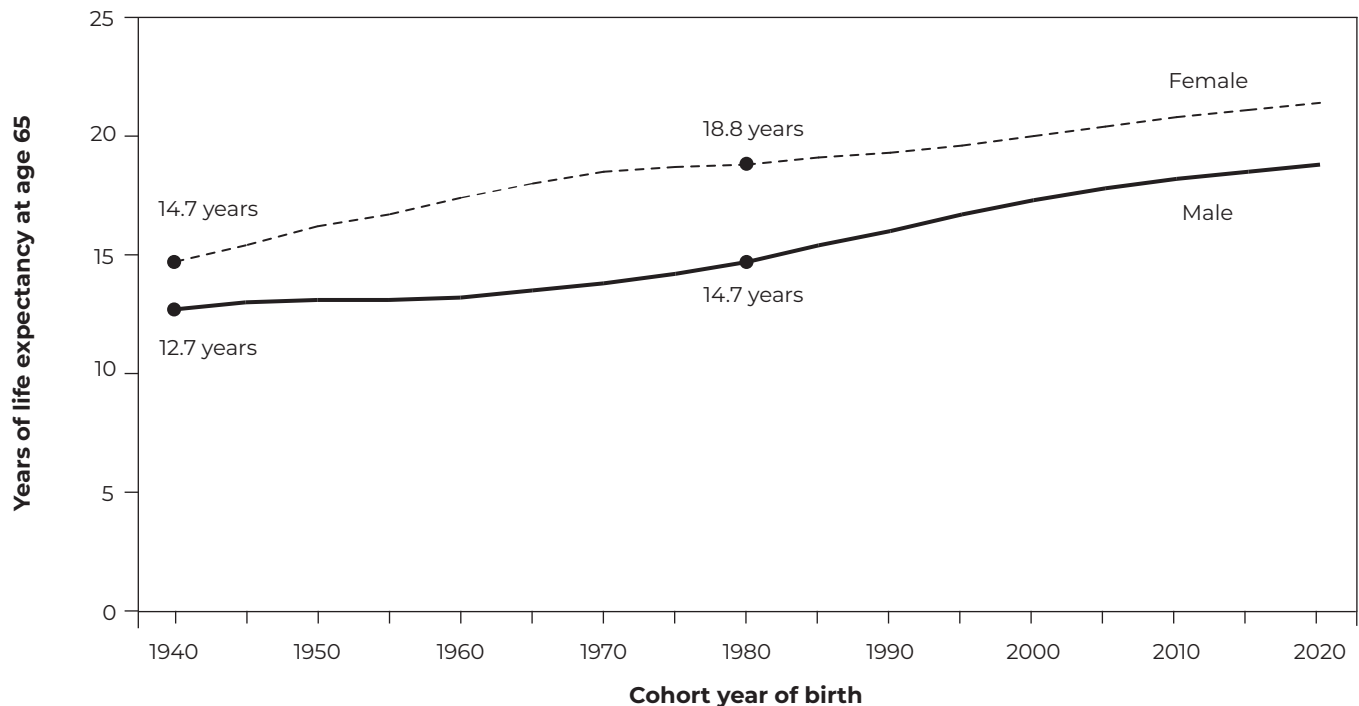
plans, noted earlier (Martin et al. 2025). MA plans may be attractive to beneficiaries because they can offer reduced cost sharing for many services, a cap on enrollees' annual out-of-pocket spending for covered services, and coverage for some items and services that are not covered by FFS Medicare—often at no additional premium beyond beneficiaries' Part B premiums. (For information on MA plan benefits, see text box on p. 24.) But Medicare spends an estimated 20 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare—a difference that translates into a projected \$84 billion in additional spending in 2025 alone. (For more on MA, see Chapter 11.) That extra spending is financed by

taxpayers and by beneficiaries enrolled in FFS Medicare and MA in the form of higher Part B premiums.

Two main factors contribute to the Commission's estimate of higher spending on MA: (1) the increased number of diagnoses recorded by MA plans (which increases payments to the respective MA plan) and (2) the favorable selection that MA plans experience because MA payments are based on beneficiary predicted costs and beneficiaries with lower-than-predicted spending are more likely to enroll in these plans—potentially because such beneficiaries are less averse to plans' limited networks and utilization management efforts. The Commission has made several recommendations to improve the MA

FIGURE
1-4

People born in 1980 are projected to have several more years of life expectancy at age 65 than people born in 1940



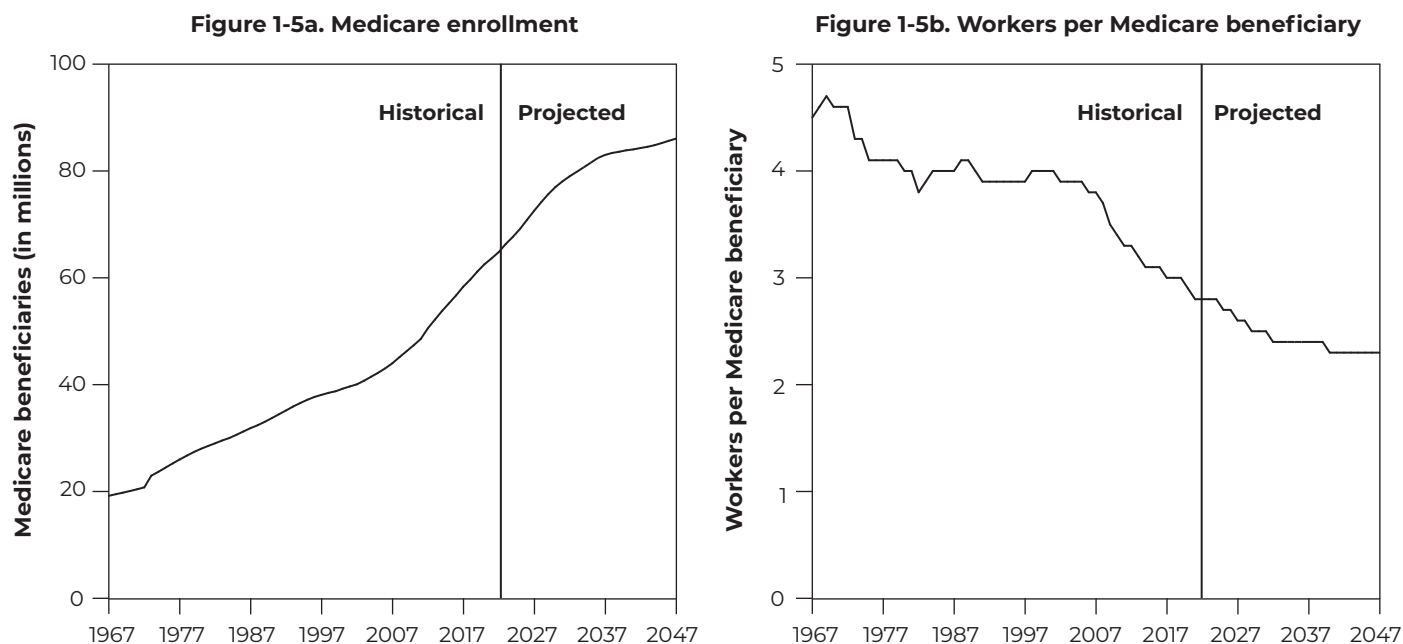
Source: The 2024 annual report of the Boards of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds.

program and believes a major overhaul of MA policies is needed (Medicare Payment Advisory Commission 2024c).

Looking to the more distant future, increasing life expectancy is projected to increase Medicare spending later in this century (Figure 1-4). Among the cohort of people born in 1940 (who are currently Medicare beneficiaries), women who reach the age of 65 are projected to have 14.7 years of additional life expectancy and men are projected to have 12.7 years of life expectancy (meaning they are expected to live until ages 80 and 78, respectively). Among those born in 1980 (future Medicare beneficiaries), women who reach 65 are projected to have 18.8 years of life expectancy and men are projected to have 14.7 years of life expectancy (meaning they are expected to live until about ages 84 and 80, respectively).

Medicare faces a financing challenge

The entire baby-boom generation will be old enough to enroll in Medicare by 2029 (Fiore et al. 2024). By that time, 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 payroll and income taxes relative to the number of Medicare beneficiaries has been declining over time and is expected to continue to do so. As shown in Figure 1-5b, around the time of Medicare’s creation, there were 4.5 workers for each Medicare beneficiary, but by 2023 there were only 2.8 workers per beneficiary, and by 2029 there are expected to be only 2.5 workers per beneficiary.

**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 2024. Part A services are financed by Medicare’s Hospital Insurance Trust Fund and beneficiary cost sharing.

Source: 2024 annual report of the Boards of Trustees of the Medicare trust funds.

The declining ratio of workers to Medicare beneficiaries creates a financing challenge for the Medicare program. Medicare Part A (which covers inpatient hospital stays, post-acute care following those stays, and hospice care) 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 year-end account balance to decline. In other years, trust-fund revenues have exceeded Part A spending (including in 2023)—creating annual surpluses that increase the trust fund’s account balance. Medicare’s Trustees currently estimate that the trust fund’s balance will rise through 2029 and then decline from 2030 on, and by 2036 the trust fund will no longer carry a positive year-end balance

(Boards of Trustees 2024). At that point, Part A services would be paid only from annual trust-fund revenues, which would be sufficient to cover only 89 percent of scheduled benefits (Boards of Trustees 2024). (The Congressional Budget Office (CBO) also tracks the trust fund’s financial status and projects that it will be depleted in a similar time frame—by 2035 (Congressional Budget Office 2024c).)

These time horizons are a decade longer than were projected before the pandemic (Boards of Trustees 2019, Congressional Budget Office 2019). The projection changed because trust-fund revenues are now expected to be higher than previously estimated and Part A spending is expected to be lower than previously estimated. On the revenue side of the ledger, Medicare’s Trustees predict that more Medicare payroll-tax revenues will be collected

**TABLE
1-2**

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

To extend Hospital Insurance Trust Fund solvency for:	Increase 2.9% Medicare payroll tax to:	or	Decrease Part A spending by:
25 years (2024–2048)	3.35%		10.6%

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 2024 annual report of the Boards of Trustees of the Medicare trust funds.

in coming years due to both the number of workers paying payroll taxes and their average wages being higher than previously projected. (For the third year in a row, the Trustees have increased their projections of the amount of payroll-tax revenues that will be collected in the coming years.) On the spending side of the ledger, the Trustees expect Part A spending to be lower than previously estimated due to (1) a correction to MA benchmark calculations (which now excludes medical education expenses associated with MA enrollees from the FFS per capita costs used in the determination of MA payments) and (2) lower projected spending on inpatient hospital and home health services, based on recent utilization trends (Boards of Trustees 2024).¹⁴

To extend the solvency of the HI Trust Fund beyond the mid-2030s, there are a number of options available to policymakers. Two that are mentioned by Medicare's Trustees are to (1) increase the Medicare payroll tax from its current rate of 2.9 percent to 3.35 percent or (2) reduce Part A spending by 10.6 percent (Table 1-2), which is equivalent to a reduction of about \$45 billion in 2025, which would then need to be maintained in subsequent years (Boards of Trustees 2024). 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 revenue increases is another option. Another way to raise revenue for the HI Trust Fund is through the type of broad economic growth experienced in the past few years; as mentioned, the trust fund's solvency has recently been extended due to more people working (and paying Medicare payroll taxes) and

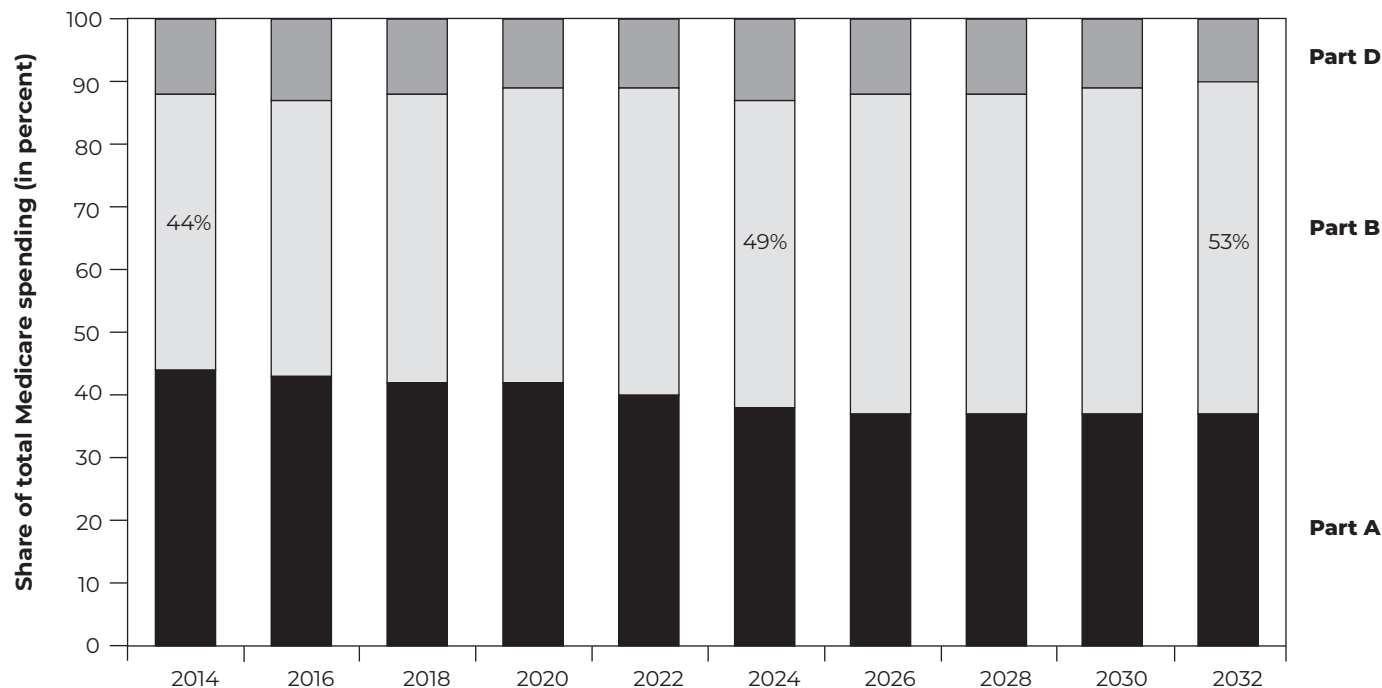
people earning higher-than-expected wages (which results in more wages being taxable).

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. Part B spending, in particular, has been consuming a growing share of Medicare spending over time, as care has shifted from the inpatient setting (paid for by Part A) to the outpatient setting (paid for by Part B). For example, spending on Part B consumed 44 percent of Medicare spending in 2014 but is estimated to have grown to 49 percent of Medicare spending in 2024; by 2032, it is projected to make up 53 percent of Medicare spending (Figure 1-6). The shift from inpatient to outpatient settings is in part related to CMS removing certain services from its “inpatient-only” list thanks to technological advancements (such as the use of cameras and robots) that have allowed procedures to be conducted using smaller incisions and less invasive approaches in a wider array of settings.

Part B and Part D benefits are paid for by the SMI Trust Fund, which in turn is mainly financed through transfers from the general fund of the Treasury (which made up 69 percent of this trust fund's revenues in 2023) and premiums paid by beneficiaries (which made up 24 percent of revenues) (Boards of Trustees 2024).¹⁵ Although there is no risk of the SMI Trust Fund becoming insolvent (since premiums and revenue transfers are intentionally set to cover the following year's estimated spending), there are other reasons to try to limit growth in the spending paid

**FIGURE
1-6**

The share of Medicare spending on Part B has been increasing as care has shifted from the inpatient to the outpatient setting



Note: In this graph, “total Medicare spending” refers to the sum of reimbursement amounts on an incurred basis for Part A, Part B, and Part D. Graph does not include spending financed by beneficiary premiums. First projected year is 2024.

Source: 2024 annual report of the Boards of Trustees of the Medicare trust funds.

for through this trust fund. As spending on Part B grows, the federal revenues that are transferred to the SMI Trust Fund grow: In 2023, 17 percent of all personal and corporate income taxes collected by the federal government were transferred to Medicare’s SMI Trust Fund to pay for Part B and Part D, and this share is projected to increase to 22 percent by 2030 (Boards of Trustees 2024). 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).

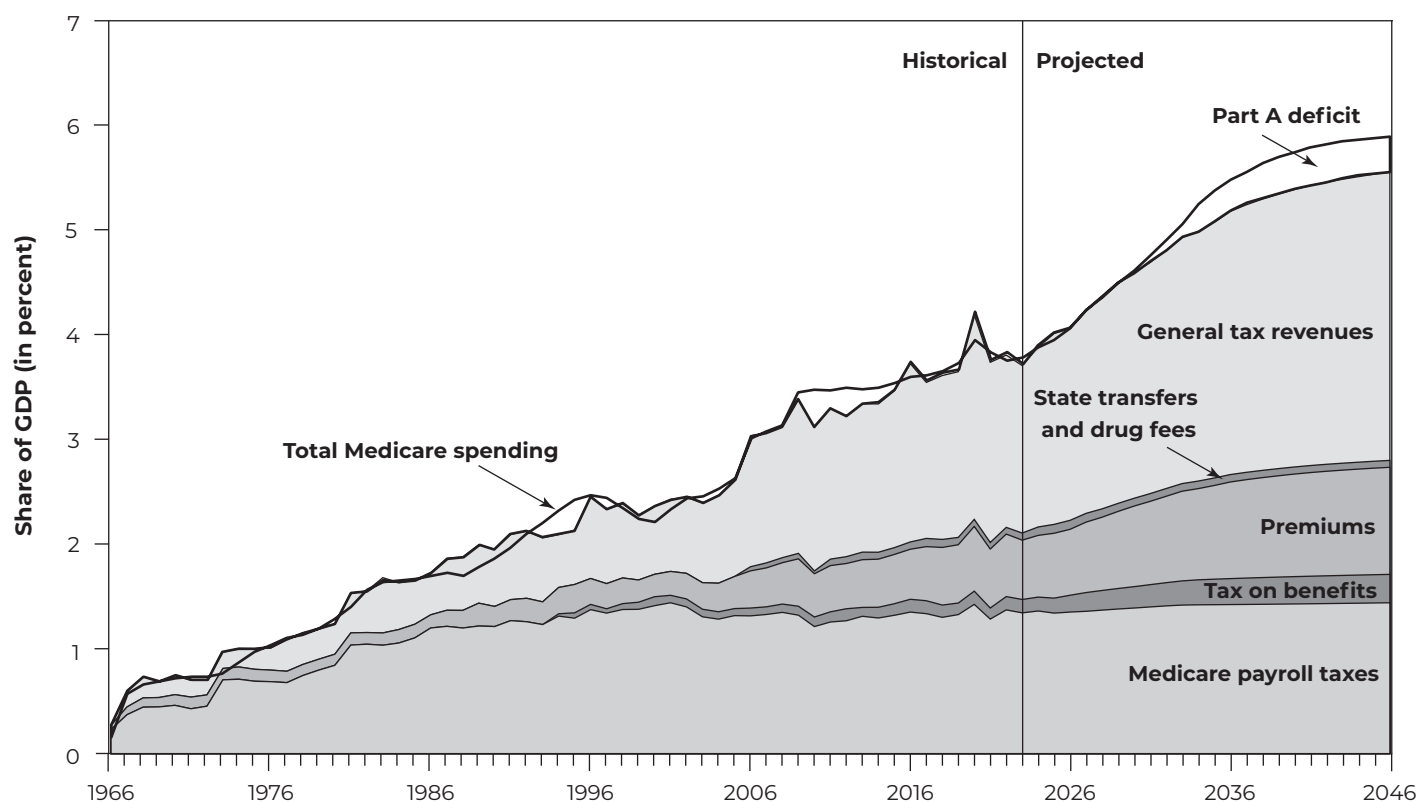
The increasing amount of general revenues spent on the Medicare program (as shown in Figure 1-7, p. 20) is also a problem because the federal government

already spends more than it collects in revenues each year (Figure 1-8, p. 21). The line at the top of Figure 1-8 represents total federal spending as a share of GDP; the 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 1-8 depict federal spending by program. By 2044, 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”

**FIGURE
1-7**

Medicare's three main funding sources are general tax revenues, Medicare payroll-tax revenues, and beneficiary premiums



Note: GDP (gross domestic product). First projected year is 2024. 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 (SMI) Trust Fund. Graph does not include interest earned on trust-fund investments (which makes up 1.4 percent of the HI Trust Fund's income and 0.7 percent of the SMI Trust Fund's income and is expected to decline in coming years as trust-fund assets decline).

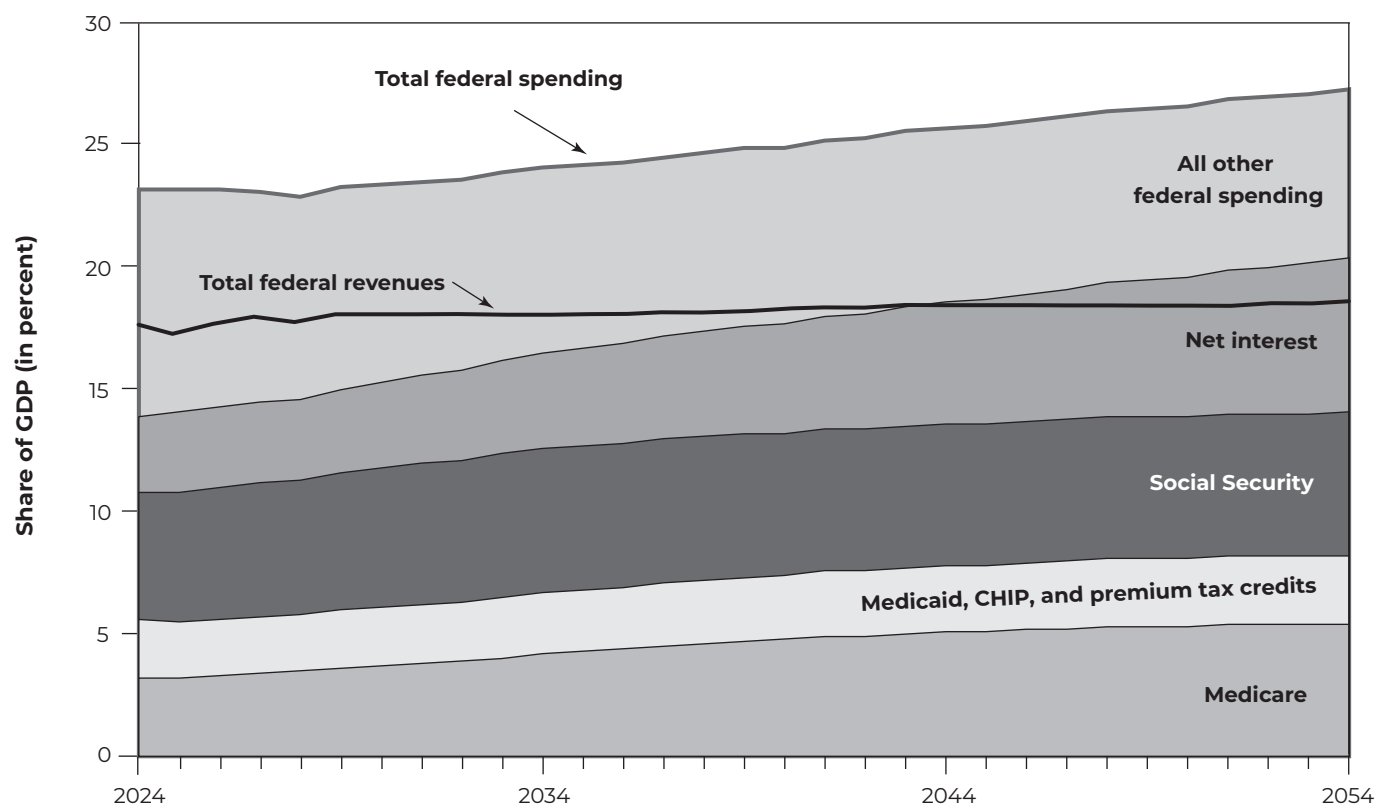
Source: 2024 annual report of the Boards of Trustees of the Medicare trust funds.

(Office of the Actuary 2024). Medicare spending as a share of GDP is projected to grow rapidly through 2040, 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 2040 onward will increase at a higher rate that is more in line with past spending growth. Such growth would mean that by 2060, Medicare spending

would constitute 6.8 percent of GDP, rather than 6.0 percent (Boards of Trustees 2024). It would also mean that a larger payroll-tax increase or Part A-spending decrease would be needed to extend the solvency of Medicare's HI Trust Fund (shown earlier in Table 1-2, p. 18). The Medicare Trustees' long-term spending projections therefore "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 2024).

**FIGURE
1-8**

Spending on Medicare, Medicaid, CHIP, premium tax credits, Social Security, and interest is projected to exceed total federal revenues by 2044



Note: CHIP (Children's Health Insurance Program), GDP (gross domestic product). "Premium tax credits" were referred to as "ACA [Affordable Care Act of 2010] Marketplace subsidies" in previous years.

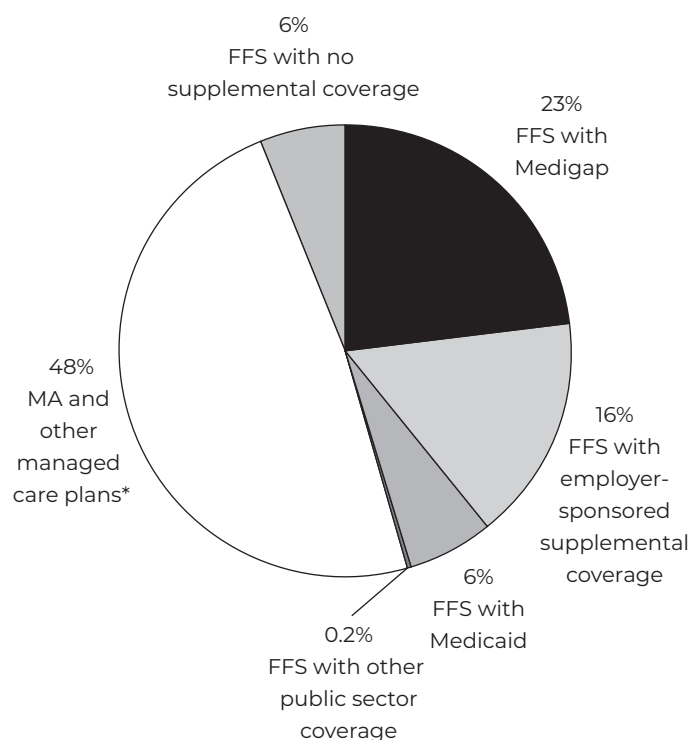
Source: Congressional Budget Office's long-term budget projections, published March 2024.

As Medicare spending increases, so too do beneficiaries' costs

In 2023, the Medicare program spent an average of \$16,710 per beneficiary on Part A, Part B, and Part D benefits—almost \$3,000 more than in 2019 (Boards of Trustees 2024, Boards of Trustees 2020). 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 coverage, but the annual cost of Part B premiums was \$2,096 in 2024 (Centers for Medicare & Medicaid Services 2023a).

The average annual cost of Part D prescription drug plan premiums in 2024 was \$516 for stand-alone drug plans and \$180 for drug coverage through an MA plan (since MA plans can use Part C rebates to "buy down" enrollees' Part D premiums) (Medicare Payment Advisory Commission 2024a).

Cost-sharing liabilities for beneficiaries in FFS Medicare averaged \$396 for Part A services and \$1,621 for Part B services in 2021 (the most recent year available for this information) (Medicare Payment Advisory Commission 2024a). (The amount of cost sharing that beneficiaries actually pay is lower when they have supplemental coverage such as a

**FIGURE
1–9****Most Medicare beneficiaries reduced their cost sharing through supplemental coverage or enrollment in a Medicare Advantage plan in 2021**

Note: FFS (fee-for-service), MA (Medicare Advantage). Our analysis assigned beneficiaries to the supplemental coverage category they were in for the most time in 2021; beneficiaries could have had coverage in other categories during 2021. The analysis includes only beneficiaries not living in institutions such as nursing homes who were enrolled in Medicare for at least one month in 2021. It excludes beneficiaries who were not in both Part A and Part B throughout their Medicare enrollment in 2021 or who had Medicare as a secondary payer. The number of beneficiaries represented in this chart is 52.5 million.
* Includes plans for beneficiaries who are also eligible for Medicaid and plans sponsored by employers.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Survey file, 2021.

Medigap plan.) Average annual cost sharing for retail prescription drugs in 2022 was \$480 for beneficiaries with stand-alone Part D plans and \$276 for those with drug coverage through an MA plan, but these amounts are expected to be lower in coming years (Medicare Payment Advisory Commission 2024a).¹⁷ (Starting in 2024, beneficiaries are no longer required to pay cost sharing when they reach the catastrophic phase of the Part D benefit; in 2025, out-of-pocket costs in Part D will be capped at \$2,000.)

The typical Medicare beneficiary has relatively modest resources to draw on when paying for premiums and cost sharing: Researchers estimate that in 2023, the median Medicare beneficiary had an annual income of \$36,000 and savings of \$103,800 (Cottrill et al. 2024).

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. The Medicare Trustees estimate that spending per FFS beneficiary on Medicare Part B and Part D premiums and cost sharing consumed 26 percent of the average Social Security benefit in 2024—up from 17 percent 20 years earlier, in 2004 (Boards of Trustees 2024).¹⁸

Most beneficiaries reduce their out-of-pocket spending by obtaining supplemental insurance coverage or by opting out of FFS Medicare and into an MA plan. In 2021, 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). Another 48 percent were enrolled in an MA plan or other managed care plan (including some who were dually eligible for Medicare and Medicaid). Only 6 percent of beneficiaries were in FFS Medicare without any supplemental coverage to reduce their cost sharing (Figure 1-9).¹⁹

Approximately one in five Medicare beneficiaries receives help paying their Part B premium (and, in some cases, their cost sharing) through their state's Medicaid program (Boards of Trustees 2024, Centers for Medicare & Medicaid Services 2024b). Approximately one in four Medicare Part D enrollees receives help with their out-of-pocket retail prescription drug costs through the Part D low-income subsidy (Boards of Trustees 2024, Medicare Payment Advisory Commission 2024a). For more information on the various types of coverage that Medicare beneficiaries can enroll in, see text box (pp. 24–26).

Cost sharing is a barrier for some beneficiaries. Among all Medicare beneficiaries, 6 percent reported having problems paying a medical bill, according to our analysis of CMS's 2022 Medicare Current Beneficiary Survey, but some subpopulations experienced affordability issues at notably higher rates. For example:

- Among beneficiaries under the age of 65 (most of whom are disabled), 18 percent reported problems paying a medical bill. Beneficiaries under age 65 tend to require more health care services than beneficiaries ages 65 and over, have lower incomes, and generally face higher Medigap premiums than beneficiaries who have reached Medicare's eligibility age of 65 (Cottrill et al. 2024, Cubanski et al. 2016, Medicare Payment Advisory Commission 2024a).
- Among partial-benefit dual-eligible beneficiaries, 28 percent reported problems paying a medical bill. (These 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 Medicare with no supplemental coverage, 12 percent reported problems paying a medical bill.

Given these findings, it is important to keep in mind that when Medicare payment rates for providers increase, premiums and cost sharing also increase for Medicare beneficiaries—some of whom already have a hard time affording health care. Restraining the annual growth in Medicare spending can help beneficiaries afford their health care since it results in lower premiums and cost sharing.

Differences in beneficiaries' access to care and health outcomes

In response to commissioner interest, the Commission reports on differences in Medicare beneficiaries' access to care and health outcomes. Research has shown that some beneficiaries have more difficulties accessing care and experience worse outcomes than others. In this section, we take a closer look at the extent to which there are differences among beneficiaries with different income levels and among those of different races and ethnicities (focusing on the three largest racial and ethnic groups, due to data availability).

Medicare beneficiaries with incomes and assets low enough to qualify for Part D's low-income subsidy

(LIS) report more problems accessing care than other beneficiaries, according to CMS's Medicare Current Beneficiary Survey. (Beneficiaries qualify for the LIS if they receive full or partial Medicaid benefits and/or, in 2024, had incomes below \$22,590 (or \$30,660 if married) and liquid assets below \$17,220 (or \$34,360 if married).)²⁰ In an analysis of CMS's beneficiary survey from 2019 (before the recent coronavirus pandemic temporarily disrupted care patterns), we found that much higher shares of LIS beneficiaries reported forgoing care that they thought they should have gotten (18 percent) compared with non-LIS beneficiaries (6 percent), and much higher shares of LIS beneficiaries reported delaying care due to cost (29 percent) compared with non-LIS beneficiaries (8 percent) (Medicare Payment Advisory Commission 2023b).

We also observed differences between LIS and non-LIS beneficiaries in our analysis of health outcomes using 2019 claims data. For example, LIS beneficiaries had higher rates of ambulatory care-sensitive hospitalizations (55.9 per 1,000 FFS beneficiaries) than non-LIS beneficiaries (41.7). LIS beneficiaries had higher rates of ambulatory care-sensitive emergency department visits (89.6 such visits per 1,000 FFS beneficiaries) compared with non-LIS beneficiaries (61.7). Among beneficiaries discharged from a hospital, LIS beneficiaries were more likely to experience a readmission (17.2 percent) than non-LIS beneficiaries (14.6 percent). And among beneficiaries with a skilled nursing facility stay, LIS beneficiaries had lower rates of successful discharge to the community (defined as not having an unplanned hospitalization or death in the next 30 days) (35 percent) compared with non-LIS beneficiaries (54 percent) (Medicare Payment Advisory Commission 2023a).

Concerns about access to care for LIS beneficiaries motivated the Commission to recommend in 2023 and 2024 and in this year's report that the Congress increase Medicare payment rates to many providers who serve LIS beneficiaries, including beneficiaries who receive full or partial Medicaid benefits (Medicare Payment Advisory Commission 2024c, Medicare Payment Advisory Commission 2023b). These recommendations would address problems with the formulas currently used to distribute safety-net payments to hospitals and would help address the issue that clinicians who serve Medicare

Medicare beneficiaries have numerous enrollment options

Once an individual becomes eligible for Medicare—either because they are age 65, they have received Social Security Disability Insurance payments for two years, or they have been diagnosed with end-stage renal disease or amyotrophic lateral sclerosis (ALS)—they must make a number of enrollment decisions.

Initially enrolling in coverage

Individuals can choose to enroll in Medicare Part A, which helps pay for inpatient hospital stays, post-acute care following those hospital stays, and hospice care. Part A is available to 99 percent of Medicare beneficiaries without a monthly premium because they or their spouse paid Medicare payroll taxes for at least 10 years (Centers for Medicare & Medicaid Services 2023a).

Individuals can also enroll in Medicare Part B, which helps pay for clinicians' services and outpatient fees. For most beneficiaries (including those in a Medicare Advantage (MA) plan), the premium for Part B is deducted from their monthly Social Security checks.²¹ In 2024, the standard Part B premium was \$174.70 per month for beneficiaries with a modified adjusted gross annual income of up to \$103,000 for a single person or \$206,000 for a married couple; beneficiaries with higher incomes pay higher Part B premiums (Centers for Medicare & Medicaid Services 2023a).

Prescription drug coverage is available through Part D, either through stand-alone plans or MA plans that include drug coverage. Part D enrollees with higher incomes are also required to pay higher premiums, based on the same thresholds noted for Part B coverage.

Late-enrollment penalties Individuals who do not enroll in Part B or Part D when they reach Medicare's eligibility age will usually owe late-enrollment penalties if they eventually do enroll in coverage.²² For example, late Part B enrollees have a life-long surcharge added to their Part B premiums that adds 10 percent for each year that they could

have signed up but did not (Centers for Medicare & Medicaid Services 2024a).

Annual enrollment options

Beyond the initial decision of whether to enroll in Medicare, beneficiaries also make an annual decision about how to receive their benefits.

Fee-for-service Medicare Unless they opt into an MA plan (described below), Medicare beneficiaries are covered through fee-for-service (FFS) Medicare, which allows them to obtain care from any health care provider who accepts Medicare. In 2024, beneficiaries in FFS Medicare owed 20 percent cost sharing for clinician services after they met their annual Part B deductible of \$240; they also owed \$1,632 for the first 60 days of each hospital admission, plus additional amounts if they required a longer hospital stay or a skilled nursing facility stay that exceeded 20 days (Centers for Medicare & Medicaid Services 2023a).

Beneficiaries in FFS Medicare can obtain subsidized prescription drug coverage by purchasing a stand-alone Medicare Part D plan. In 2024, the average premium for this type of plan was \$43 per month (see Chapter 12 for more on Part D).

Medigap Beneficiaries who want to reduce their cost-sharing liability while maintaining broad access to providers can obtain a Medigap plan, which wraps around FFS Medicare coverage. Medigap plans can be purchased by employers for their retired workers or by individuals for themselves. There are a number of standardized Medigap plans (e.g., Plan A, Plan B) that private insurers can offer, which must include the same benefits but can vary in price. The average monthly premium among current Medigap policyholders was \$217 in 2023 (Freed et al. 2024). (Subsidized supplemental coverage is available to low-income FFS beneficiaries through Medicaid, described later.) Beneficiaries who purchase a Medigap plan when they first reach age 65 are guaranteed the right to purchase any Medigap plan an insurer offers and the insurer cannot factor in

(continued next page)

Medicare beneficiaries have numerous enrollment options (cont.)

the beneficiary's health status when setting the premium;²³ beneficiaries who enroll in a Medigap plan when they first turn 65 can renew that plan indefinitely (Centers for Medicare & Medicaid Services 2023b). In general, beneficiaries who are under the age of 65 or who are over 65 and missed the six-month guaranteed-issue period are subject to underwriting in most states, which means they can face higher Medigap premiums or be denied a policy.

Medicare Advantage As an alternative to FFS Medicare, beneficiaries can opt to receive their Medicare benefits through an MA plan, which allows beneficiaries to lower their cost-sharing liability and receive additional benefits while often paying a relatively low or no additional monthly premium for their MA plan. (Aside from MA plan premiums, MA enrollees also pay the same Part B premium that beneficiaries in FFS Medicare pay.) MA plans typically offer lower cost sharing if a beneficiary seeks care from a provider in a plan's network and higher out-of-pocket costs or no coverage if they seek care from a provider outside of the plan's network.²⁴ MA plans also have an annual out-of-pocket limit on cost sharing for Part A and Part B services and, as of 2024, for Part D. To try to hold down costs, MA plans commonly engage in utilization-management strategies such as requiring beneficiaries to obtain a referral from a primary care clinician before seeing a specialist, requiring clinicians to obtain prior authorization from an insurer before furnishing certain services, and denying payment for some claims. MA plans often also offer beneficiaries prescription drug coverage as well as supplemental benefits not available in FFS Medicare such as vision, dental, and hearing benefits and non-health care benefits such as gym memberships.

Medicare beneficiaries who wish to switch from an MA plan to FFS Medicare during Medicare's annual open enrollment period can do so but will likely face higher Medigap premiums and fewer plan options than individuals who enroll in a Medigap plan when they first reach age 65. Most states' insurance

regulations allow Medigap insurers to deny coverage or vary premiums based on a beneficiary's health status if the beneficiary is buying a Medigap plan after age 65 (Centers for Medicare & Medicaid Services 2023b).²⁵

Employers can subsidize coverage for Medicare beneficiaries Some employers help pay for their retired employees' health insurance by paying for Medigap plans, sponsoring their own Medigap-like coverage that wraps around the FFS Medicare benefit package, sponsoring their own prescription drug plans, or sponsoring their own MA plans (which can include or exclude prescription drug coverage). Medicare beneficiaries who served in the military can receive health care services subsidized by the Department of Veterans Affairs (VA) or the Department of Defense (Department of Veterans Affairs 2024, TRICARE 2024).

Additional assistance for low-income beneficiaries Medicare beneficiaries with very low incomes and liquid assets can apply for Medicaid coverage that will pay their Medicare premiums (and, in some cases, their cost sharing).²⁶ Most individuals dually enrolled in Medicare and Medicaid qualify for additional benefits that are not available under FFS Medicare, such as long-term services and supports (e.g., nursing home care), vision and dental care, and nonemergency medical transportation to appointments. Dually eligible beneficiaries can obtain their Medicare benefits through FFS Medicare or an MA plan and can receive their Medicaid benefits through a FFS Medicaid program or a Medicaid managed care plan (depending on which option their state offers). Some dual enrollees receive coordinated Medicare and Medicaid benefits through a single plan, although such plans are not widely available.

Low-income beneficiaries can also get financial assistance paying for their prescription drugs through Medicare's Part D low-income subsidy (LIS), which pays for a beneficiary's Part D premium and deductible and reduces their cost sharing for drugs.

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Medicare beneficiaries have numerous enrollment options (cont.)

Medicare beneficiaries are automatically enrolled in this program if they are enrolled in Medicaid or another state program that pays their Medicare Part B premium or if they receive Supplemental Security Income benefits due to low income. If they are not automatically enrolled in the Part D LIS, Medicare beneficiaries can apply for it if they have an income below \$22,590 (or \$30,660 if married) and liquid assets below \$17,220 (or \$34,360 if married) in 2024 (Centers for Medicare & Medicaid Services 2024c).

Beneficiaries' enrollment decisions vary by race and ethnicity According to our analysis of CMS's 2022 Medicare Current Beneficiary Survey, White beneficiaries were much more likely than Black and Hispanic beneficiaries to have FFS Medicare with some type of private health insurance (obtained through an employer or purchased individually, such as a Medigap plan): 42 percent of White beneficiaries had this combination of coverage, compared with 15 percent of Black beneficiaries and 13 percent of Hispanic beneficiaries. (Medigap is also more common among beneficiaries who have high incomes, are in excellent or very good health, are eligible for Medicare due to age rather than disability, and live in a rural area (Medicare Payment Advisory Commission 2024a).) Meanwhile, enrollment in MA plans was more common among Black and Hispanic beneficiaries: 67 percent of Black beneficiaries and 65 percent of Hispanic beneficiaries were in MA plans, compared with 46 percent of White beneficiaries. Black and Hispanic beneficiaries were also more likely to be dually enrolled in Medicare and Medicaid and/or receiving the Part D LIS. For example, nearly half of Black and Hispanic beneficiaries received the LIS, compared with 12 percent of White beneficiaries. And among beneficiaries dually enrolled in Medicare and

Medicaid, Black beneficiaries were four times more likely to enroll in an MA plan than FFS coverage, Hispanic beneficiaries were three times more likely to enroll in MA rather than FFS, and White beneficiaries were twice as likely to enroll in MA rather than FFS.²⁷ There were not meaningful differences in the shares of White, Black, and Hispanic beneficiaries who had FFS Medicare with no supplemental coverage, but beneficiaries with FFS and no supplemental coverage were more likely to be under age 65, live in a rural area, and have a relatively low income of between 125 and 200 percent of the federal poverty level (Medicare Payment Advisory Commission 2024a). Differences in White, Black, and Hispanic beneficiaries' enrollment selections lead to differences by race and ethnicity in the average amount beneficiaries spend on their health insurance premiums: According to CMS's 2022 survey, White beneficiaries spent \$3,853, on average, for their health insurance premiums, while Hispanic beneficiaries spent \$2,935 and Black beneficiaries spent \$2,704.

The Commission has recommended redesigning the FFS Medicare benefit package

The Commission has recommended capping FFS beneficiaries' total out-of-pocket spending for Part A and Part B services and replacing beneficiaries' coinsurance liabilities with copayments that could vary by type of service and provider (and could be reduced or eliminated for high-value services). We have also recommended imposing an additional charge on supplemental insurance (e.g., Medigap plans) since such plans shield beneficiaries from cost sharing and thus may contribute to overuse of services (Medicare Payment Advisory Commission 2012). ■

beneficiaries who are also enrolled in Medicaid are often unable to collect the cost-sharing amounts they otherwise would. (State Medicaid programs can cover cost sharing for most dually eligible beneficiaries

but typically do not cover the full amount, and clinicians cannot bill beneficiaries for any remaining unpaid amounts.) Specifically, the Commission has recommended overhauling how safety-net payments

to hospitals are distributed and increasing them: A new add-on payment would be applied to payments for hospital inpatient and outpatient services and would vary in size based on a hospital's position on the Medicare Safety-Net Index, which is a new measure developed by the Commission that would factor in the degree to which a hospital serves beneficiaries who are dually enrolled in Medicare and Medicaid and/or receive the LIS.²⁸ Our other recommendation would increase Medicare's payment rates for physician fee schedule services by different percentages, depending on a clinician's specialty: Primary care providers' rates would increase by 15 percent, and all other clinicians' rates would increase by 5 percent when they furnish services to Medicare beneficiaries who are also enrolled in Medicaid and/or receive the LIS. (This recommendation would likely give health care providers an incentive to make their low-income Medicare patients aware of, and help them enroll in, Medicaid and the LIS.) Targeted payment increases can improve access to care for beneficiaries with lower incomes; they can also be used to influence the size and composition of the health care workforce (see text box, pp. 29–33).

The data show fewer differences in reported access to care among beneficiaries of different races and ethnicities. For example, in CMS's 2022 Medicare Current Beneficiary Survey, we found no statistically significant differences between the shares of White, Black, and Hispanic beneficiaries who had a usual source of care, saw their usual care provider in the previous 12 months, had trouble getting health care, reported forgoing care that they thought they should have gotten, or were satisfied with the ease with which they could get to a doctor from where they live. Similarly, in the Commission's 2024 survey, which was fielded among about 5,000 Medicare beneficiaries, we found that Black and Hispanic beneficiaries had similar care experiences as White beneficiaries, according to most questions in our survey. (For more detailed results from our survey, see Chapter 4.)

One of the few differences found in CMS's survey was that higher shares of Black beneficiaries (12 percent) and Hispanic beneficiaries (9 percent) reported problems paying a medical bill compared with White beneficiaries (6 percent). This finding is likely related to

Medicare beneficiaries' differing access to funds to pay for health care (Cottrill et al. 2024).

Despite similarities in reported access to care, Medicare beneficiaries of different races and ethnicities have different health outcomes. Differences in mortality rates are particularly pronounced: After adjusting for age, there were 1,263 deaths per 100,000 people among Black men in 2022, compared with 972 deaths among White men and 774 deaths among Hispanic men (Kochanek et al. 2024). (Death rates for women followed this same trend but were all lower (Kochanek et al. 2024).) We also observed differences in health outcomes among beneficiaries of different races and ethnicities in our analysis of 2019 claims data. For example, Black beneficiaries had higher rates of ambulatory care-sensitive (potentially preventable) hospitalizations (57.7 per 1,000 FFS beneficiaries) compared with Hispanic beneficiaries (48.6) and White beneficiaries (44.9). Black beneficiaries had higher rates of ambulatory care-sensitive emergency department visits (96.2 per 1,000 FFS beneficiaries) compared with Hispanic beneficiaries (84.7) and White beneficiaries (67.1). Among beneficiaries who had recently been admitted to the hospital, Black beneficiaries had higher 30-day readmission rates (17.1 percent) compared with Hispanic beneficiaries (16.3 percent) and White beneficiaries (15.0 percent). Among beneficiaries with a skilled nursing facility stay, Black and Hispanic beneficiaries had lower rates of successful discharge to the community (defined as not having an unplanned hospitalization or death in the next 30 days) (45 percent) compared with White beneficiaries (48 percent). And among beneficiaries treated by home health agencies, lower shares of Black beneficiaries (72 percent) and Hispanic beneficiaries (73 percent) were successfully discharged to the community compared with White beneficiaries (75 percent) (Medicare Payment Advisory Commission 2023a).

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

Several aspects of Medicare's payment systems hamper the program's ability to promote 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, neutral, or negative, depending on our assessment of the adequacy of Medicare payments in a given 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 to MA plans are calculated and adopting site-neutral payments for services that can safely be

provided in more than one clinical 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. ■

The health care workforce and Medicare's role in shaping it

Medicare has a role—albeit, a somewhat indirect one—in assuring access to high-quality health care through an adequately sized and well-trained workforce. The supply of health care workers has been found to affect quality of care. For example, the number of registered nurses in hospitals has been documented to affect outcomes such as mortality and readmissions (Lasater et al. 2024, Lee and Dahinten 2020, McHugh et al. 2021), and studies find that performance on hospital quality measures such as mortality and hospital-acquired infections is influenced by the number of nurses a hospital employs (Oner et al. 2021). At the population level, the supply of primary care physicians has also been documented as affecting health outcomes (Basu et al. 2019, Pierard 2014).

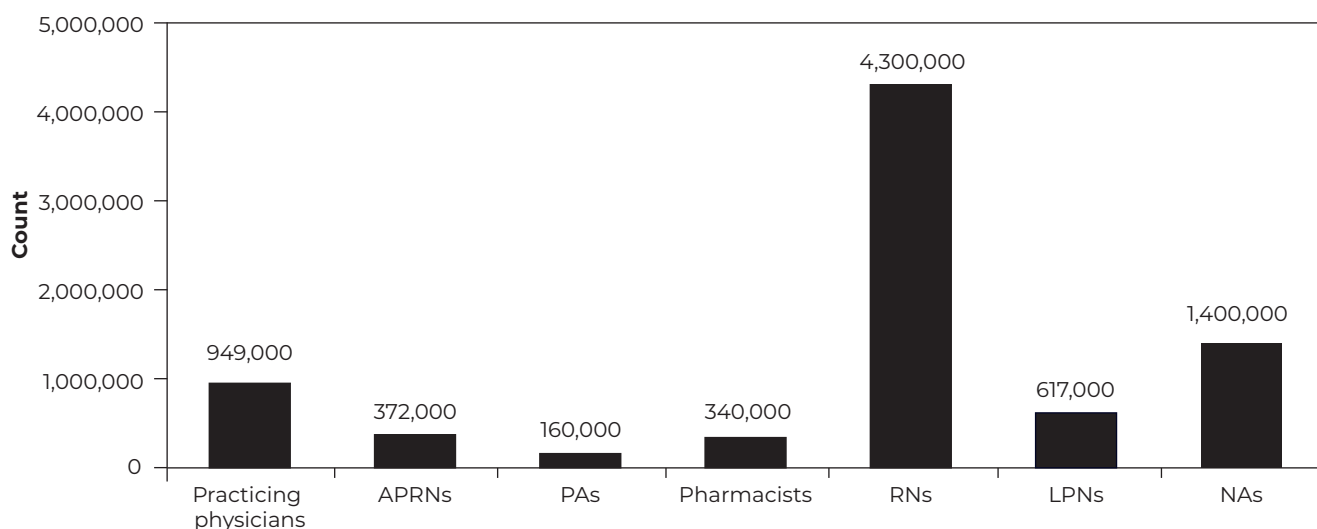
Is the size of the current health care workforce sufficient to meet the goal of providing Medicare beneficiaries with access to high-quality health care? Even counting the number of health care workers is complicated. Sources differ; counts can be based on full-time-equivalent positions, professional licenses, or individual workers. (Figure 1-10 provides one estimate of the number of selected health care workers in 2022.) And due to variability in geographic and specialty distributions of health care workers, national totals can mask shortages in particular geographic areas or medical specialties.

Half a century ago, health care workers' roles were generally differentiated, but today, some of their responsibilities overlap. Physicians can diagnose,

(continued next page)

**FIGURE
1-10**

National counts of selected types of health care workers in 2022



Note: APRN (advanced practice registered nurse), PA (physician assistant), RN (registered nurse), LPN (licensed practical nurse), NA (nursing assistant or nursing aide). The physician count is the number of active physicians; most other bars (APRNs, PAs, pharmacists, RNs, LPNs) are the number of workers active in the workforce, which consists of people working and people actively seeking employment; the NA count is a count of persons employed in the field. The number of practicing physicians shown above (per the Association of American Medical Colleges) is different from the number that the Health Resources and Services Administration (HRSA) counts as professionally active (897,000); among HRSA's count of professional active physicians, 777,000 provide patient care.

Source: Association of American Medical Colleges, 2024. U.S. physician workforce data dashboard, <https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard>; HRSA's Workforce projections, <https://data.hrsa.gov/topics/health-workforce/workforce-projections>; Bureau of Labor Statistics' Nursing assistants and orderlies, <https://www.bls.gov/ooh/Healthcare/Nursing-assistants.htm>.

The health care workforce and Medicare's role in shaping it (cont.)

order testing, and treat patients, which can include performing invasive procedures. Physician assistants (PAs) and advanced practice registered nurses (APRNs, which includes nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, and nurse midwives) can also perform these functions, including a range of invasive procedures, but sometimes with physician supervision. Pharmacists' roles have begun to overlap with traditional physician and NP/PA roles: Pharmacists can administer some vaccines without physician supervision, and in some states they can prescribe medications for certain conditions (Adams et al. 2023). Pharmacists bill Medicare for administering vaccines; their other services are included in payments for medications they dispense or are paid as "incident-to" services (although some Medicaid programs will pay pharmacists for patient care services in the ambulatory setting).

The responsibilities of different types of nursing professionals also overlap now. Registered nurses (RNs) organize care for patients and provide direct patient care; they also can order tests with physician, NP, or PA authorization, although they typically do not bill directly for their services. RNs have completed either a bachelor of science degree in nursing or a registered nurse associate-degree program or other credential; RNs must also pass a national examination to become licensed. RNs can supervise licensed practical nurses (LPNs—also known as licensed vocational nurses in a few states), home health aides, and nursing assistants (NAs—also known as nursing aides); alternatively, RNs in some settings such as home health care can be responsible for care at all levels. LPNs can perform some of the same duties as RNs, such as recording vital signs, collecting samples, providing wound care, and, in some states, administering medications. LPNs complete a certificate program and are licensed after passing a national examination. NAs provide care that requires less medical knowledge, such as measuring a patient's pulse or temperature, repositioning a patient in bed,

or feeding and bathing patients; NAs typically are required to complete a formal training program, and many states use examinations to determine their competency; Medicare requires 75 hours of training for certified NAs (RegisteredNursing 2024).

To understand whether the health care workforce is adequately sized and allocated across settings, we need to understand where different types of health care personnel work (Bureau of Labor Statistics 2023b). Nurses work in all health care settings. RNs seem to work in the widest range of settings, from schools and public health agencies to hospitals, nursing facilities, physician offices, and other outpatient settings; they also work for home health agencies, hospices, and home infusion suppliers. Data from the Bureau of Labor Statistics on nurses' most common employment settings show that hospitals employ about 56 percent of RNs, but physician offices, home health agencies, and outpatient centers account for another 17 percent, and nursing homes another 4 percent (Bureau of Labor Statistics 2022). Among LPNs, 27 percent work in nursing homes, 13 percent work in hospitals, and 12 percent work in home health care (Bureau of Labor Statistics 2023a). Among NAs, 34 percent work in nursing homes and another 21 percent work in hospitals (Bureau of Labor Statistics 2023b). Physicians, APRNs, and PAs work in all types of health care settings. Among pharmacists, 65 percent work in retail locations and 32 percent work in hospitals (Bureau of Labor Statistics 2023c).

Overlapping scopes of practice complicate efforts to assess whether there is an insufficient number of health care workers to meet the demand for services. For example, some sources report a shortage of physicians in the U.S. (Health Resources & Services Administration 2023). The Health Resources and Services Administration (HRSA) has projected a shortage of 107,850 physicians in 2026 and an expected shortage of 134,000 physicians by 2031, but the number of APRNs and PAs has been growing rapidly, thus supplementing the physician

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The health care workforce and Medicare's role in shaping it (cont.)

workforce (Bruza-Augatis et al. 2024). The most critical shortages of physicians are in primary care (family practice, internal medicine, pediatrics, and geriatrics) and psychiatry (Association of American Medical Colleges 2024, Medicare Payment Advisory Commission 2023b). The shortage of psychiatrists is exacerbated by fewer psychiatrists accepting health insurance than other physicians (Carlo et al. 2024). While HRSA data show that nonmetropolitan areas have shortages of physicians (Health Resources & Services Administration 2024b), APRNs and PAs have filled this gap to some extent by locating in rural and underserved areas (National Center for Health Workforce Analysis 2024b, Zhang et al. 2020). HRSA data suggest essentially no nationwide shortages in the total number of RNs and LPNs, but some states have apparent excesses, and nine states have shortages of 20 percent or more, so the aggregate numbers provide an incomplete picture (National Center for Health Workforce Analysis 2024a). Foreign-trained nurses add an estimated 500,000 to the supply (Pillai et al. 2024). HRSA does not track the demand or supply of NAs, but employment data from the Department of Labor show over 200,000 job openings for NAs, suggesting a mismatch between the demand and supply of this type of worker (Bureau of Labor Statistics 2024). A complete description of worker shortages requires local data and an understanding of the potential substitution among the professions. Further, it remains to be seen what impact interprofessional teams, telehealth, and even artificial intelligence could have on workforce shortages.

The number of health care workers is affected by the resources available to train them. Over the past four decades, the number of first-year students in allopathic medical schools has grown relatively slowly (increasing from 17,000 in 1980 to 23,000 in 2022). The number of first-year students in osteopathic medical schools has grown quickly but is still a smaller share of physicians (rising from 1,500 first-year students in 1980 to 10,000 in 2022) (Medicare Payment Advisory Commission

2024b). Currently, including all years of medical school students, about 94,000 students are enrolled in allopathic medical schools and 35,000 are in osteopathic schools (American Association of Colleges of Osteopathic Medicine 2024, Association of American Medical Colleges 2022a). Federal support for physician training typically begins after graduation from medical or osteopathic school through residency programs at hospitals, health centers, and other health care provider organizations. Physicians can be licensed after completing medical school plus one additional year of clinical training (referred to as their “internship” or “first-year residency”) and passing a national licensure examination, but most go on to pursue multiple years of residency training, and some obtain additional training through fellowships after residency. Physicians educated in American and Canadian medical schools filled 77 percent of residency positions in 2023; the remainder were filled by graduates of international medical schools (Association of American Medical Colleges 2023). The residency programs that have the most difficulty filling all their available positions tend to be lower-paid specialties—like family medicine, internal medicine, and pediatrics—as well as emergency medicine; these specialties end up filling many of their residency positions with international medical school graduates (Murphy 2024, National Resident Matching Program 2024).

Medicare contributes to the cost of physician training at the residency and fellowship levels through two funding mechanisms. Hospitals and certain other provider organizations that train physicians receive direct graduate medical education (DGME) payments, which are generally based on the product of three factors: their historic per resident amount (updated for inflation), their historic number of residents, and their current Medicare (fee-for-service (FFS) and Medicare Advantage (MA)) share of patient days. In addition, certain types of teaching hospitals receive a percentage increase in their prospective

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The health care workforce and Medicare's role in shaping it (cont.)

payment system rates for care provided to FFS and MA beneficiaries, referred to as indirect medical education (IME) payments, which are based on allowed residents per bed or per occupied bed. Medicare paid \$19 billion for DGME and IME in 2022.²⁹ Medicare generally does not try to influence which specialties should be trained with these funds or in which parts of the country these physicians should be trained. Additional support for training physicians comes from Medicaid, the Department of Veterans Affairs, the Department of Defense, HRSA, and teaching hospitals themselves.

Medicare does not currently support APRN or PA training.³⁰ APRNs and PAs both typically require a master's degree. APRNs are required to obtain a minimum of 500 hours of clinical training, with many programs requiring at least 750 hours, and states have variable additional requirements. APRNs with doctoral degrees obtain 1,000 hours of clinical training. PAs generally have 1,500 hours or more of clinical training. Medicare's payment rates for services provided by APRNs and PAs are 85 percent to 100 percent of physicians' payment rates, but provider organizations generally pay these types of clinicians much less than physicians, which creates strong incentives for organizations to hire (and, if needed, train) APRNs and PAs (Medicare Payment Advisory Commission 2023b). This financial incentive may help explain the strong growth observed in the number of APRNs and PAs in recent years. For example, from 2017 to 2022, the number of APRNs and PAs who billed Medicare for more than 15 FFS Medicare beneficiaries climbed more than 40 percent, increasing from 218,000 to 308,000 (Medicare Payment Advisory Commission 2024c). As a result of this rapid increase, HRSA has estimated that the supply of APRNs and PAs now exceeds the demand for this type of clinician (Health Resources & Services Administration 2024b).

Medicare does not provide financial support for pharmacist training, which typically involves a bachelor's or prepharmacy degree and a four-year

doctorate in pharmacy; pharmacists must also pass a national licensure examination and then meet additional requirements for state licensure (Virginia Health Workforce Development Authority 2024). HRSA projects that the supply of pharmacists almost fully met the demand for this type of health care professional in 2024 and will continue to do so in the future (Health Resources & Services Administration 2024b).

Beyond training an adequate supply of health professionals is the challenge of maintaining them in the workforce and in shortage locations. Physicians and RNs in the workforce are aging. The average age of practicing physicians was 54 in 2023 (DefinitiveHealthcare 2023); almost half of active physicians were 55 or older in 2021 (Association of American Medical Colleges 2022b), and 20 percent were 65 or older. A third of nurses are age 55 or older, so retirement will be a predictable drain on the workforce (Health Resources & Services Administration 2024a).

Several sources express concerns that health professionals are leaving the health care workforce midcareer. In 2022, the surgeon general created an advisory and video to inform the public of his concern about burnout in health care workers (Department of Health and Human Services 2022). A recent study using U.S. census data on health care workers reported that the exit rate in 2018 was 6 percent per quarter, but this increased to 7.7 percent per quarter by the end of 2021, with variation among states and specific demographic groups (Frogner and Dill 2022, Shen et al. 2024).

Commentators report that physician and nurse shortages predated the coronavirus pandemic but have continued to increase. Stresses during the pandemic included shortages of staff and supplies (especially personal protective equipment), lack of knowledge and experience in treating a condition with high mortality, and concern about the spread of COVID-19 to health care workers and their families

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The health care workforce and Medicare's role in shaping it (cont.)

(Biber et al. 2022, Park et al. 2023, Prasad et al. 2021). A variety of stresses that existed before the pandemic and have continued in the postpandemic period may be contributing to workers leaving their health care positions. Changes in the structure of the health care system that started well before the pandemic have led to increased pressure for documentation and other tasks besides providing direct care to patients. Physicians increasingly have contractual obligations tied to their employment that create pressures beyond simply providing good patient care (Mayes et al. 2024). For their part, nurses often express concerns about patient-to-nurse staffing ratios that they believe are unsafe (New York State Nurses Association 2024). In recent years, nurses and medical residents are increasingly unionizing, with the expectation that unions can more effectively represent their interests to the organizations employing them. Shortages of NAs may be linked to the availability of jobs in other industries that pay similar, or better, wages (Snyder et al. 2023), but these workers might return to health care jobs for higher salaries. In 2024, CMS finalized a rule that revised the nurse staffing requirements for nursing homes, with implementation beginning in May 2026 (Centers for Medicare & Medicaid Services 2024f). Many providers will need to hire additional nursing staff to meet the new requirements and improve retention of the staff they currently employ.

In addition to Medicare's substantial investment in training physicians, the program has taken some limited steps to try to incentivize physicians to practice in shortage areas. Medicare pays a 10 percent bonus on physician fee schedule payments to physicians serving in HRSA-designated health professional shortage areas, and some of Medicare's advanced payment models provide financial incentives to practitioners in rural and underserved areas. Hospitals also receive additional payments

when located in underserved areas, but it is unclear whether these increased payments to hospitals lead to better nurse staffing, higher salaries, or greater retention.

The Commission reviewed Medicare payments for DGME and IME in 2010 and 2021. In 2010, the Commission recommended that the Secretary analyze the number of residents needed by specialty and whether all specialties should be supported equally; establish standards for distributing funding for medical education, including goals for practice-based learning and integration of community-based care; and use a reduction in IME payments to empirically justified levels to fund a new performance-based GME program tied to institutions' performance on these standards. In 2021, the Commission recommended that IME payments be restructured to be made for both inpatient and outpatient services and to be transitioned to empirically justified levels.

But Medicare has relatively few tools with which to influence the health care workforce. Since our past analyses have found no clear relationship between changes to Medicare payment rates and the number of people who apply to medical school (Medicare Payment Advisory Commission 2024b), increasing payment rates for all clinicians is not likely to increase the supply of in-demand types of health care professionals. One approach might be to increase Medicare funding for medical education or implement more targeted Medicare policies aimed at clinicians in particular medical specialties or working in particular geographic areas, but such efforts to shape the composition of the workforce or alleviate personnel shortages could take years to reach fruition, given education and training requirements and the fact that Medicare is just one payer among many. ■

Endnotes

- 1 The number of people with different types of health insurance in the U.S. in 2023 was as follows: 175.6 million people had private insurance obtained through an employer; 16.2 million people had an individual health insurance plan purchased through a Marketplace; 4.0 million had some other type of individual insurance plan; 99.0 million had coverage through Medicaid or the Children's Health Insurance Program (CHIP); 65.1 million people had coverage through Medicare (including some who were also enrolled in Medicaid and 12.4 million who supplemented their Medicare coverage with a Medigap plan); 14.6 million people had some other type of public insurance (e.g., through the Department of Veterans Affairs or the Department of Defense); and 24.9 million people had no health insurance (Centers for Medicare & Medicaid Services 2024h).
- 2 The American Rescue Plan Act of 2021 increased federal subsidies of Marketplace plans in 2021 and 2022. The Budget Reconciliation Act of 2022 (P.L. 117-169) then extended these enhanced subsidies through 2025. These laws also created and extended a new monthly special enrollment period (SEP) for people eligible for advance payment of the premium tax credit who have a projected household income of 150 percent of the federal poverty level or less. The so-called "150% SEP" is available to consumers in states that operate under the Health Insurance Marketplace and use HealthCare.gov or an approved direct enrollment or enhanced direct enrollment platform; state-based Marketplaces that operate their own eligibility and enrollment platforms also have the option to offer this special enrollment period. Consumers who qualify for the 150% SEP can sign up for coverage in any calendar month through 2025, rather than being eligible to sign up for coverage only during the annual open enrollment period (November 1 through December 15) or following a qualifying life event (e.g., having a baby).
- 3 "Super" concentrated markets have a Herfindahl-Hirschman Index above 5,000.
- 4 Among beneficiaries eligible to receive their coverage through an MA plan (because they were enrolled in both Medicare Part A and Part B), 52 percent were in an MA plan in 2023. For more information on MA, see Chapter 11.
- 5 We do not see dramatic shifts in the use of other, less frequently used codes in the office/outpatient evaluation and management code set for new and established patients.
- 6 The Budget Reconciliation Act of 2022 (P.L. 117-169) is often referred to as the Inflation Reduction Act of 2022 (or IRA).
- 7 Victoza/Saxenda; Ozempic/Wegovy; Mounjaro/Zepbound.
- 8 Patients may discontinue use for various reasons, including, for example, undesirable side effects, cost, or supply shortages (BlueCross BlueShield 2024, Cohen 2024, Do et al. 2024).
- 9 Statutory text excludes Medicare coverage of drugs that may be excluded under the Medicaid drug-rebate program, which includes, among others, drugs for anorexia, weight loss, or weight gain.
- 10 In 2022, 26 percent of FFS Medicare beneficiaries had a claim for diabetes, 22 percent had one for ischemic heart disease, 20 percent had one for obesity, 19 percent had one for chronic kidney disease, and 6 percent had one for stroke (Centers for Medicare & Medicaid Services 2024d, Chronic Condition Warehouse 2024).
- 11 This analysis does not distinguish between Type 1 and Type 2 diabetes, but the Centers for Disease Control and Prevention estimates that 90 percent to 95 percent of people with diabetes have Type 2, and Type 2 diabetes is much more likely to develop in older individuals (Centers for Disease Control and Prevention 2024a, Centers for Disease Control and Prevention 2024c, Chronic Condition Warehouse 2024).
- 12 Workers and their employers split the cost of the Medicare 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 (Boards of Trustees 2024).
- 13 The HI Trust Fund's income derives from several sources, including payroll taxes (which made up 88 percent of the trust fund's income in 2023), 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 2024).
- 14 The Trustees have made three pandemic-related adjustments to their Medicare spending projections. These adjustments account for (1) the improved morbidity in the surviving population; (2) the ending of a waiver regarding the three-day inpatient stay requirement to receive skilled nursing facility (SNF) services, which they expect to decrease SNF spending and increase inpatient spending; (3) home health spending that is significantly lower than was estimated before the pandemic (Boards of Trustees 2024).

- 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 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 that 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 will end after 2024—and not be extended through legislative intervention. The Trustees also assume that annual updates to payment rates under certain Medicare payment systems will continue to be discounted by an adjustment reflective of economy-wide productivity, rather than an adjustment reflective of the lower productivity gains achieved in the health care industry (Boards of Trustees 2024).
- 17 These amounts do not include cost-sharing liability paid by Medicare on behalf of Part D enrollees who receive the low-income subsidy.
- 18 Although most people ages 65 and over supplement their Social Security benefits with income from pensions, withdrawals from individual retirement accounts, or other assets, a sizable minority rely on Social Security benefits as their primary source of income. For one in five people ages 65 and over, Social Security benefits make up three-quarters or more of their family income, and for one in seven, Social Security benefits make up 90 percent or more of their family income (Dushi and Trenkamp 2021).
- 19 The share of community-dwelling Medicare beneficiaries who report having FFS coverage with public or private supplemental coverage has declined from nearly three-quarters of beneficiaries in 2000 to nearly half of beneficiaries in 2021, according to our analysis of CMS's Medicare Current Beneficiary Survey data (Medicare Payment Advisory Commission 2024a, Medicare Payment Advisory Commission 2003).
- 20 Beneficiaries dually enrolled in Medicare and Medicaid are automatically enrolled in Part D and receive the low-income subsidy (LIS), but other LIS-eligible individuals must apply for the LIS through the Social Security Administration.
- 21 MA plans can reduce the amount deducted from enrollees' checks by "buying down" some or all of the standard Part B premium amount, but most enrollees are in plans that do not offer this benefit.
- 22 Individuals who do not qualify for premium-free Part A are also subject to a late-enrollment penalty, if the individual does not buy Part A when the individual is first eligible for Medicare. Medicare beneficiaries are exempt from Part A and Part B late-enrollment penalties if they delayed enrolling in Medicare because they had comparable coverage through another source (e.g., an employer, TRICARE) or they missed a chance to sign up because they were impacted by a natural disaster or declared emergency, they were given inaccurate or misleading information from their health plan or employer, they were incarcerated, or because they experienced other exceptional conditions (Centers for Medicare & Medicaid Services 2024j).
- 23 The initial six-month open enrollment period for Medigap starts the first month that a beneficiary is age 65 or over and has Medicare Part B.
- 24 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 except for emergency and urgently needed services. 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 11 of this report for more information on MA plan types.
- 25 However, we note that in the Medicare Advantage initial trial period, Medicare beneficiaries who were initially enrolled in a Medigap plan and switch to MA may return to FFS Medicare and their Medigap plan before the end of their first year of MA coverage without being subject to medical underwriting.
- 26 Beneficiaries with less than \$15,300 in annual income and \$9,430 in liquid assets (or \$20,688 in income and \$14,130 in assets if married) can sign up to have Medicaid pay their Medicare Part A (if needed) and Part B premiums and cost sharing. Slightly higher-income beneficiaries with income or assets above these limits but with an income below \$20,580 (or \$27,840 if married) can sign up to have Medicaid pay their Medicare Part B premiums (Centers for Medicare & Medicaid Services 2024g).
- 27 The enrollment statistics in this paragraph are based on our analysis of the 2022 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 earlier in Figure 1-9 (p. 22).

- 28 Each hospital's Medicare Safety-Net Index value would be computed using three components: (1) the share of its Medicare volume associated with beneficiaries enrolled in the LIS and/or Medicaid; (2) the share of all-payer revenue the hospital spends on uncompensated care; and (3) half of the share of total volume associated with Medicare beneficiaries.
- 29 In 2022, Medicare made DGME payments of \$5.6 billion and IME payments of \$13.4 billion; these amounts include costs for training dentists and podiatrists. Both DGME and IME payments are made on behalf of both FFS and MA beneficiaries and paid directly to organizations such as teaching hospitals (rather than included in payments made to MA plans). DGME payments are funded through both the Hospital Insurance (HI) and Supplementary Medical Insurance Trust Funds, while IME payments are funded only through the HI Trust Fund.
- 30 Section 5508 of the Affordable Care Act of 2010 authorized a five-year demonstration of support for graduate nursing education. The demonstration occurred at five sites for five years between 2012 and 2017. A report to the Congress was sent in 2017. A final evaluation released in 2019 is on the CMS website, and legislation has been proposed to continue this program.

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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 assess the adequacy of FFS Medicare payments to providers using the most recently available data, 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, 2026) 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 facilities, skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and hospice.

In this chapter

- The Commission's principles for assessing payment adequacy
- Payment-adequacy analytic framework
- Anticipated payment and cost changes in 2025
- Recommendations for FFS Medicare payment in 2026

Our goal is to identify the update to payment for each sector that will ensure both beneficiary access and good stewardship of taxpayer resources. We examine 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, how they are incorporated into our deliberations, and therefore our recommended updates vary. We use the best available data to examine indicators of payment adequacy and update information and estimates from prior years to make sure our recommendations for 2026 accurately reflect current conditions. Because of standard data lags, our assessments for the current year are based on estimates from the most recent complete data we have, generally from two years prior to the current year (for this report, 2023). We use preliminary data from 2024 when available.

In considering updates to FFS payment rates, we may make recommendations that address specific concerns within the payment systems, such as problems 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. Importantly, our focus is on assessing appropriate payment for the Medicare program; we do not adjust our update recommendations based on the payment rates of other health insurers.

The recommendations in this report, if adopted, could significantly change Medicare payment rates to providers. Ideally, payment rates will be set at a level that supports access to high-quality care provided by relatively efficient providers—that is, those with lower costs and higher quality—and provides incentives for all providers to control their costs and improve quality, thereby helping the Medicare program achieve greater value for its spending. Further, while our intent is to recommend FFS 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 often used in setting payment rates for other federal and state government programs and private health insurance. Consequently, if Medicare payments are too low to support efficient provision of high-quality care, broader access to care and provider solvency could be affected over time. At the same time, maintaining appropriate fiscal pressure on health care providers through payment-rate updates can benefit not only the

Medicare program (and the beneficiaries and taxpayers who support it) but also the overall health care system.

This chapter reviews 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, physician and other health professional services, outpatient dialysis facilities, skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and hospice. Our annual analysis leads to recommendations for updates to FFS Medicare payments in the upcoming year (this year, for 2026). For each sector, we analyze the most recently available data (2023 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 2025. Finally, we recommend how FFS Medicare payments for a given sector should change in aggregate for 2026, including whether payments should increase, decrease, or remain the same relative to current law.

The Commission updates its payment recommendations annually, and we reflect any changes that may affect provider revenues or costs in future assessments of Medicare payments. We make our recommendations relative to current law at the time we record our votes and avoid speculating on whether and how changes in external circumstances might lead to different recommendations.

Beyond questions of payment updates, within each payment system we examine how payment rates may affect providers' ability to serve Medicare beneficiaries, taking into consideration geographic, demographic, and other characteristics. We contemplate whether payment adjustments are necessary to address differences in access, incentivize quality of care, or otherwise fairly distribute FFS payments across providers in a sector. We also identify program-integrity concerns and potential remedies.

We compare our update and other policy recommendations for 2026 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.

Notably, our update work and related recommendations are setting specific. That said, the Commission has maintained that, subject to risk differentials, payment for the same services should be comparable regardless of where the services are provided. Such "site neutrality" helps to ensure that beneficiaries receive appropriate, high-quality care in the least costly setting consistent with their clinical conditions. For example, the Commission recommended in 2023 that the Congress more closely align payment rates across ambulatory settings (e.g., hospital outpatient departments, ambulatory surgery centers, and physicians' offices) for selected services that are safe and appropriate to provide in all settings and when doing so does not pose a risk to access. Because the analytic issues related to cross-setting analysis are more complex, this work is generally outside the scope of our sector-specific payment-adequacy analyses and thus is not discussed in this chapter.

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.

Lingering effects of the public health emergency and coronavirus pandemic

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 faced burnout and risks to their health and safety.

Macroeconomic trends in the wake of the pandemic—including inflation exceeding market basket updates, high interest rates, and high labor and supply costs—continue to affect providers' finances. However, our most recent measures of payment adequacy, using data primarily from 2023, indicate that the most pronounced effects of the pandemic have passed. When comparing indicators using 2023 data with indicators from earlier years that were more affected by the pandemic, we take care to interpret those changes in the appropriate context. Further, 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 2024 survey of Medicare beneficiaries ages 65 and over, telehealth continued to be widely used, with 33 percent of beneficiaries reporting using telehealth in the past year.² 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.

Growth of Medicare Advantage

Enrollment in Medicare Advantage (MA) plans continued to increase in 2024, with more than half of eligible Medicare beneficiaries enrolled in an MA plan. The extent to which the growth in MA might affect the provision of care to FFS Medicare beneficiaries is not yet clear, nor is the appropriate relationship between MA and FFS payment rates. Generally, we do not adjust our update recommendations based on payment rates of other health insurers, including MA plans. Instead,

in separate work, we address issues related to the adequacy of MA payments. Chapter 11 of this report presents our current assessment of the MA program.

The Commission's principles for assessing payment adequacy

The Commission has long maintained that Medicare should institute payment 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 (PPSs), alternative payment models such as 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 remains a concern.

Payment rates should be sufficient to provide high-quality care for beneficiaries but also be based on efficient delivery of services. We assess the adequacy of FFS Medicare payments for relatively efficient providers where possible. Efficiency is greater if the same inputs are used to produce a higher-quality output or if fewer inputs 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 a sector. These recommendations aim to better target FFS Medicare payments. For instance, in 2018, the Commission recommended that the payment weights in the skilled nursing facility (SNF) PPS be adjusted to increase payments for medically complex patients and decrease payments for patients receiving rehabilitation therapy unrelated to their care needs (Medicare Payment Advisory Commission 2018b). In 2020, we recommended that CMS replace existing adjustments in the end-stage renal disease 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 (Medicare Payment Advisory Commission 2020). In 2023, we recommended that current disproportionate-share-hospital and uncompensated-care payments be redistributed using the Commission-developed Medicare Safety-Net Index (MSNI) and that additional funding for Medicare safety-net payments be authorized to support hospitals that are key sources of care for low-income Medicare beneficiaries (Medicare Payment Advisory Commission 2023b). We continue to use the MSNI when evaluating payment adequacy and equity.

Finally, we note that our primary concern is the appropriateness of FFS Medicare payments to support FFS beneficiaries' access to care, not the adequacy of payments across all 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. For each sector, we make an assessment 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 (p. 52) 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 signal of providers' willingness to serve Medicare beneficiaries and the adequacy of Medicare payments. Poor access could indicate that Medicare payments are too low. 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 marginal profit 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 FFS Medicare beneficiaries and FFS beneficiaries' ability to access physician and other health professional services when needed. However, factors unrelated to Medicare's payment policies may also affect access to care, such as Medicare's coverage policies, changes in the delivery of health care services, local market conditions and barriers to access, and supplemental insurance, so we exercise judgment when interpreting information for this domain.

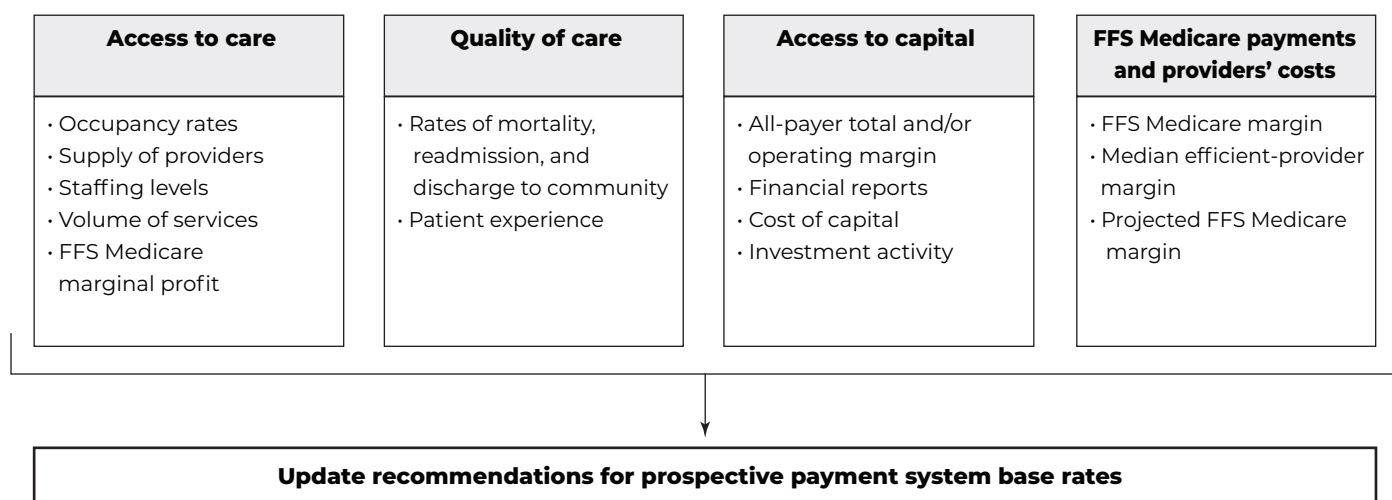
Provider capacity, supply, and staffing

FFS Medicare beneficiaries' access to care depends in part on providers' ability to meet demand with current supply. Low provider capacity, long wait times, and difficulty maintaining staffing levels can indicate inadequate payment rates. By contrast, rapid provider entry into a sector may indicate that payments are too high. Technological changes are 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.

**FIGURE
2-1**

The Commission's framework for assessing FFS Medicare payment adequacy



Note: FFS (fee-for-service). We use multiple measures of margins for different purposes in our payment-adequacy analysis (see text box). We define "FFS Medicare marginal profit" as ((FFS Medicare payments – costs that vary with volume) / FFS Medicare payments). This marginal profit is an indicator of beneficiaries' access to care. The "all-payer total margin," defined as ((payments from all payers and sources – costs of providing services) / payments from all payers and sources), is a measure of a sector's access to capital. For the hospital sector, we also evaluate the "all-payer operating margin," which is defined as ((payments from all payers and sources except investments and donations – costs of providing services) / payments from all payers and sources except investments and donations). "FFS Medicare margin," defined as ((FFS Medicare payments for services – allowable costs of providing services) / FFS Medicare payments for services), is a sector-wide measure of the relationship between FFS Medicare's payments and providers' costs for services.

Source: MedPAC.

The PHE and related policies had both positive and negative impacts on provider capacity and supply. On the one hand, waivers 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 payment rates. We will continue to monitor 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 FFS beneficiaries can

indicate 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 FFS beneficiaries could suggest that FFS Medicare's payment rates are too high. By contrast, reductions in the volume of services per capita 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.

It is important to note that changes in the volume of services are not direct indicators of access; increases and decreases can be explained by factors such as population changes, changes in disease prevalence among beneficiaries, dissemination of new and

MedPAC uses several definitions of “margin” when assessing FFS Medicare payment adequacy

Margins are a measure of profitability and are calculated as the difference between revenue and cost, divided by revenue $((\text{revenue} - \text{costs}) / \text{revenue})$. A positive margin indicates that a line of business is profitable, while a negative margin indicates a financial loss on a line of business. Unless otherwise indicated, all margins reported by MedPAC are calculated in aggregate across all included providers. The Commission uses several definitions of “margin” when assessing FFS Medicare payment adequacy:

Fee-for-service Medicare margin

The percentage of revenue from fee-for-service (FFS) Medicare that is left as profit after accounting for the allowable costs of providing services to FFS Medicare patients.

FFS Medicare marginal profit

The percentage of revenue from FFS Medicare that is left as profit after accounting for the allowable variable costs of providing services to

FFS Medicare patients. Variable costs are those that vary with the number of patients treated. By contrast, fixed costs are those that are the same in the short run regardless of the number of patients treated (e.g., building costs). If the FFS Medicare marginal profit is positive, a provider with excess capacity has a financial incentive to care for an additional FFS beneficiary; if the FFS Medicare marginal profit is negative, a provider may have a financial disincentive to care for an additional FFS beneficiary.

All-payer total margin

The percentage of revenue from all payers and sources that is left as profit after accounting for all costs.

All-payer operating margin

The percentage of revenue from all payers and sources exclusive of investments and donations that is left as profit after accounting for all costs. ■

improved medical knowledge and technology, deliberate policy interventions, and beneficiaries' preferences. A change in aggregate volume, for instance, could be attributable either to a change in services per beneficiary or a change 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 deciding 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. Although we believe Medicare FFS payment should support an appropriate portion of fixed cost of efficient care delivery, we acknowledge that 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

It is important for Medicare payment policy to support beneficiaries' access to high-quality care. However, 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 FFS 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 FFS quality-reporting programs for almost all major provider types and several pay-for-performance programs that tie FFS payment to a provider's performance on quality standards. Throughout the years, measures developed and used in public and private quality programs have proliferated, which has created 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 2021b).

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 FFS 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. Similarly, when FFS Medicare represents a relatively small share of a sector's volume, access to capital is a weak indicator of FFS Medicare payment adequacy. In recent years, access to capital may be more reflective of turbulent credit markets or other macroeconomic phenomena.

FFS Medicare payments and providers' costs

While we do consider all-payer margins as an indicator of providers' financial health, we primarily 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, and hospices—we estimate total Medicare-allowable costs and assess the relationship between FFS Medicare's payments and those costs for FFS beneficiaries. This report uses cost-report data from 2023 (2022 for hospices, due to data lags).

The coronavirus pandemic and PHE-related policy changes primarily affected FFS Medicare payments and providers' costs from 2020 until the expiration of the PHE in May 2023.³ However, MedPAC has not considered relief funds as Medicare revenue under the relevant payment system 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 during the PHE may have subsidized providers that would have otherwise exited the market. In sectors where relief-fund revenue was substantial, we calculate a FFS Medicare margin exclusive of PHE relief funds (assuming all else equal), as well as a FFS Medicare margin inclusive of relief funds. To make this latter calculation, 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 margins

We typically express the relationship between payments and costs as a FFS Medicare margin, which is calculated as aggregate FFS Medicare payments for a sector, minus the allowable costs of providing services to FFS Medicare patients, divided by FFS Medicare payments.⁴ Margins for individual providers will always be distributed around that aggregate, 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, 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 providers' efficiency, changes in coding that may influence payments, and other changes in the delivery of a product or service that may affect a provider's overall pool of patients (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 the portion of reported costs that are attributed to providing care for FFS Medicare patients. Attributing reported costs to FFS Medicare patients is challenging and reflects in part the 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.

Assessing 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. Assessing the efficiency 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 PPSs 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 because of 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 changes in the products and services delivered during a unit of care.

Our analysis focuses on the appropriateness of FFS Medicare payment rates, but ascertaining whether payments are adequate to cover the costs of efficiently providing high-quality care for Medicare beneficiaries is challenging. Assessing payments relative to costs is complicated because costs can change in response to financial pressure and strategic decisions made by providers. Analyses by MedPAC and other researchers have found that providers that face financial pressure to constrain costs generally have lower costs than those who face less pressure (Medicare Payment Advisory Commission 2011, Robinson 2011, Stensland et al. 2010, White and Wu 2014). Providers might also strategically make costly investments in an effort to

appeal to higher-paying privately insured patients. Studies have shown that hospitals with more revenue, or more potential revenue, from private patients tend to have higher costs (Garthwaite et al. 2022, Wang and Anderson 2022). As a result, providers with higher revenues can have higher cost structures and, all other things being equal, lower margins on FFS Medicare patients.⁵ Those providers with high revenues and high costs often have lower margins on their FFS Medicare patients (because of their higher costs) but higher all-payer margins (because their higher revenues from non-Medicare patients more than offset those higher costs) (Medicare Payment Advisory Commission 2021a). That view stands in contrast to arguments that costs are largely outside the control of providers and that providers (for example, hospitals) shift costs onto private insurers to offset FFS Medicare losses.

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. The Commission generally does not recommend lowering FFS Medicare payments because payments from private plans are higher or raising them if other payers (e.g., 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 to and quality of care, to ensure that FFS beneficiaries are not adversely affected by policy responses aimed at constraining costs.

Efficient-provider analysis

In accordance with our authorizing statute, the Commission also, when feasible, computes a FFS Medicare margin for relatively efficient providers.⁶ 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 these hospitals had to perform relatively better than their peers 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.

Anticipated payment and cost changes in 2025

For most payment sectors, we estimate FFS Medicare payments and providers’ costs for 2025 to inform our update recommendations for 2026. In general, to estimate payments, we first apply the annual payment updates specified in law for 2024 and 2025 to our base data (2023 for most sectors). We then model the effects of other policy changes that will affect the level of FFS Medicare payments in 2025.

Next, for each sector, we review evidence about the factors that are expected to affect providers’ costs. To estimate 2025 costs, we consider the rate of input price inflation or historical cost growth, and, as appropriate, we adjust for changes in the intensity of 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.⁷ 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 (the Medicare Economic Index). 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 considered 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 2026

The Commission's assessments 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. For example, if the statutory base payment for a sector was \$100 in 2025, an update recommendation of a 1 percent increase for a sector means that we are recommending that the base payment in 2026 for that sector be 1 percent greater, or \$101.

The Commission's recommendations may be to increase, decrease, or maintain payment levels relative to current law. When indicators of payment adequacy are positive and Medicare's payments are substantially above costs, the Commission often recommends a reduction in payment levels relative to current law to promote greater value for Medicare program resources. Alternatively, if indicators of payment adequacy are mixed or negative, the Commission may recommend increased payments to ensure beneficiary access to high-quality care. These recommendations inherently involve judgment and weighing many factors and pieces of information.

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 (MMA) 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 to ensure that FFS beneficiaries have access to high-quality, appropriate care delivered efficiently. ■

Endnotes

- 1 The Medicare Payment Advisory Commission is authorized under Title XVIII of the Social Security Act.
- 2 The results of this survey are described in more detail in Chapter 4 of this report.
- 3 Some policies have been extended beyond the expiration of the PHE.
- 4 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, we include in our FFS Medicare margin all services paid under either the inpatient or outpatient prospective payment systems (see Chapter 3 for more detail). 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.
- 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 Section 1805(b)(2)(B) 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.
- 7 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** The Congress should:
- for 2026, update the 2025 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1 percent; and
 - redistribute existing disproportionate-share-hospital and uncompensated-care payments through the Medicare Safety-Net Index (MSNI)—using the mechanism described in our March 2023 report—and add \$4 billion to the MSNI pool.

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

Hospital inpatient and outpatient services

Chapter summary

General acute care hospitals primarily provide inpatient medical and surgical care to patients needing an overnight stay and outpatient services, including procedures, tests, evaluation and management services, and emergency care. To pay hospitals for the facility share of providing these 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 2023, the FFS Medicare program and its beneficiaries spent nearly \$180 billion on services paid under the IPPS and OPPS, including \$6.7 billion in uncompensated-care payments made under the IPPS.

Assessment of payment adequacy

In 2023, FFS Medicare payment-adequacy indicators for general acute care hospitals were mixed. Beneficiary access to care remained good overall, and hospitals' all-payer margin was positive and improved. However, quality indicators were mixed, and FFS Medicare payments remained well below hospitals' costs.

Beneficiaries' access to care—Indicators of beneficiaries' access to hospital inpatient and outpatient services suggest that FFS Medicare beneficiaries maintained good access.

In this chapter

- Are FFS Medicare payments adequate in 2025?
- How should FFS Medicare payments change in 2026?

- **Capacity and supply of providers**—From fiscal year (FY) 2022 to FY 2023, hospital employment increased 3 percent to 4.7 million and the number of hospitals' inpatient beds increased 1 percent to 674,000. In addition, hospitals' occupancy rate remained at about 69 percent, and the median percentage of emergency department patients who left without being seen remained near 2 percent. The supply of hospitals was relatively steady, though about 10 more hospitals closed than opened in both 2023 and 2024, and others converted to rural emergency hospitals.
- **Volume of services**—From FY 2022 to FY 2023, the number of inpatient stays per beneficiary increased over 1 percent, to 205.3 stays per 1,000 FFS Medicare beneficiaries. In addition, from calendar year (CY) 2022 to CY 2023, the number of hospital outpatient services per beneficiary increased over 2 percent, up to 5.2 services per FFS beneficiary.
- **FFS Medicare marginal profit**—We estimate that hospitals' marginal profit on inpatient and outpatient services provided to FFS Medicare beneficiaries remained positive in FY 2023. This finding suggests that most hospitals continued to have a financial incentive to serve FFS Medicare beneficiaries.

Quality of care—In FY 2023, FFS Medicare beneficiaries' risk-adjusted hospital mortality rate was 7.6 percent, an improvement relative to the 2019 and 2022 level of 7.9 percent. FFS Medicare beneficiaries' risk-adjusted readmission rate was 15.0 percent in 2023, worse than the previous year but an improvement compared with the prepandemic rate of 15.5 percent. Most patient-experience measures improved in 2023 but continued to be at least 1 percentage point below prepandemic levels.

Providers' access to capital—From FY 2022 to FY 2023, hospitals' all-payer operating margin increased from 2.7 percent to 5.1 percent, despite a decline in coronavirus relief funds. However, within this aggregate, there continued to be substantial variation: A quarter of hospitals had an all-payer operating margin greater than 10 percent, and a quarter had an all-payer operating margin less than -4 percent. In addition, the all-payer operating margin continued to be lower among hospitals with higher values of the Commission-developed Medicare Safety-Net Index (MSNI). Other measures of hospitals' access to capital were positive in 2023: Hospitals' all-payer total margin increased over 4 percentage points, hospitals' borrowing costs increased by less than the general market, and mergers and acquisitions continued. Preliminary data suggest further improvement in hospitals' access to capital in FY 2024.

FFS Medicare payments and providers' costs—FFS Medicare payments for inpatient and outpatient services continued to be below hospitals' costs in FY 2023. From 2022 to 2023, exclusive of coronavirus relief funds, hospitals' FFS Medicare margin was stable (from -13.1 percent to -13.0 percent). Nonetheless, some hospitals—which we refer to as “relatively efficient”—consistently achieved lower costs while still performing relatively well on a specified set of quality metrics. The 2023 median FFS Medicare margin among these relatively efficient hospitals was -2 percent, exclusive of coronavirus relief funds. For 2025, we project that hospitals' FFS Medicare margin will remain stable at about -13 percent. Similarly, we project that the median FFS Medicare margin among relatively efficient hospitals will remain stable at about -2 percent.

How should FFS Medicare payments change in 2026?

The current-law updates to payment rates for 2026 will not be finalized until summer 2025, but CMS's current forecasts and other required updates are projected to increase the IPPS and OPPS base rates by over 2 percent.

Based on our assessment of the payment-adequacy indicators listed above, the Commission recommends that the Congress (1) for 2026, update the 2025 Medicare base payment rates for general acute care hospitals by the amount reflected in current law plus 1 percent and (2) redistribute existing disproportionate-share-hospital and uncompensated-care payments to hospitals through the MSNI—using the mechanism described in our March 2023 report—and increase the MSNI pool by \$4 billion. The MSNI funds would be distributed to hospitals across their FFS and Medicare Advantage 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 financial challenges.

Mandated report: Rural emergency hospitals

The Consolidated Appropriations Act (CAA), 2021, created a new rural emergency hospital (REH) designation, effective January 2023. The CAA requires the Commission to report annually on payments to REHs, beginning in March 2024.

During CY 2023, 21 hospitals converted to REHs. FFS Medicare paid about \$10 million for outpatient hospital services at these REHs and about \$30 million in fixed monthly payments to cover standby costs. FFS Medicare's monthly fixed payments were three times as high as claims-based payments, which underscores the importance of fixed payments for the viability of REHs. ■

Background

General acute care hospitals primarily provide inpatient medical and surgical care to patients needing an overnight stay and outpatient services, including procedures, tests, evaluation and management services, and emergency care. To pay hospitals for the facility share of inpatient and hospital 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 This chapter uses the term “general acute care hospital” or just “hospital” to refer to hospitals paid under the IPPS and OPSS.²

In setting these prospective rates per inpatient stay or primary outpatient service, CMS adjusts IPPS and OPSS national base payment rates for factors generally outside of hospitals’ control, such as regional wage rates and patient characteristics. Both the IPPS and OPSS 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, and the OPSS sets payments for separately payable drugs based on the manufacturer’s average sales price.³

In 2023, the FFS Medicare program and its beneficiaries spent nearly \$180 billion on services paid for under the IPPS and OPSS, including \$6.7 billion in uncompensated-care payments made under the IPPS and \$20.4 billion for separately payable items, mainly drugs, made under the OPSS (Table 3-1).⁴ FFS beneficiaries’ cost-sharing liability totaled 7 percent of IPPS payments and 17 percent of OPSS payments.

Services paid under the IPPS and OPSS were a sizable share of hospital services and accounted for a sizable share of hospital revenue

While hospitals provide a wide range of services to both FFS Medicare beneficiaries and other patients, services paid under the IPPS and OPSS continued to be a sizable share of hospital services. In FY 2023, 23 percent of all acute inpatient stays were FFS Medicare

**TABLE
3-1**

In 2023, FFS Medicare spent nearly \$180 billion on hospital services paid for under the IPPS and OPSS

	Medicare payment system	
	IPPS	OPPS
Number of hospitals	3,145	3,110
Number of users (in millions)	4.2	15.9
Volume of services (in millions)	6.6	123.8
Total Medicare payments (in billions)	\$109.3	\$70.0
Payments for base-rate-covered services (in billions)	\$102.6	\$49.6
Other payments (in billions)	\$6.7	\$20.4
Beneficiary cost-sharing liability as share of total Medicare payments	7%	17%

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), OPSS (outpatient prospective payment system). The number of hospitals that provided IPPS services is higher than the number that provided OPSS services primarily because Indian Health Services hospitals are paid under the IPPS but not OPSS and data are limited to Subsection (d) hospitals. (OPSS data on other hospitals, such as post-acute care hospitals, are not included.) “Total Medicare payments” includes the FFS Medicare program amount and beneficiary cost-sharing liability (which may be paid by the beneficiary or the beneficiary’s supplemental insurance, or it may become hospital bad debt). “Other payments” refers to uncompensated-care payments (in the case of the IPPS) and to payments for separately payable drugs, devices, blood products, and brachytherapy sources (in the case of the OPSS). The given year (2023) refers to fiscal year for inpatient services and calendar year for outpatient services, consistent with when CMS updates these payment systems.

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

**TABLE
3-2**

Hospital employment and inpatient beds increased in 2023

Capacity measure	Fiscal year					Percent change	
	2019	2020	2021	2022	2023	2019-2023	2022-2023
Employment (millions)	4.5	4.4	4.5	4.5	4.7	4.1%	3.0%
Beds (thousands)	663	669	670	667	674	1.5	1.0

Note: Data include all Subsection (d) and critical access hospitals that provided inpatient services to at least one fee-for-service Medicare beneficiary. Employment figures and numbers of beds differ from those published in prior years because this year we limited employment to Subsection (d) and critical access hospitals and included all inpatient beds, regardless of what share of time the beds were used for swing-bed or observation services. Data were imputed for hospitals that had not yet submitted 2023 cost reports at the time of our analysis. Percentage changes were calculated on unrounded data.

Source: MedPAC analysis of hospital cost reports.

stays paid under the IPPS. In addition, 18 percent of all outpatient services (as measured by charges) were FFS Medicare services paid under the OPPS.

Similarly, services paid under the IPPS and OPPS accounted for a sizable share of hospitals' revenue. Of the over \$1.2 trillion in hospitals' operating revenue in FY 2023, about 14 percent came from services provided to FFS Medicare beneficiaries paid under the IPPS or OPPS. (The share of hospitals' operating revenue from FFS Medicare across all service lines, such as physician services, is higher.)

Furthermore, like other FFS Medicare payment rates, IPPS and OPPS payments have implications beyond FFS Medicare because both Medicare Advantage and other payers use FFS payment rates in setting their rates (see Chapter 2).

Are FFS Medicare payments adequate in 2025?

Based on the most recently available data, indicators of the adequacy of IPPS and OPPS payments have been mixed. In FY 2023, FFS Medicare beneficiaries' access to hospital inpatient and outpatient services remained adequate: Hospitals continued to have the capacity to care for FFS Medicare beneficiaries and a financial

incentive to provide inpatient and outpatient services. In addition, hospitals' access to capital improved: Hospitals' all-payer operating margin increased in 2023, and preliminary data suggest further improvement in 2024. However, FFS Medicare payments continued to be lower than hospitals' costs in 2023: Excluding relief funds, hospitals' FFS Medicare margin was -13 percent, and the median FFS Medicare margin was -2 percent for relatively efficient hospitals. For FY 2025, we project stable FFS Medicare margins.

Beneficiaries maintained good access to hospital inpatient and outpatient services in 2023

Indicators of hospital capacity and supply and FFS Medicare beneficiaries' use of services all suggest that FFS Medicare beneficiaries maintained good access to hospital inpatient and outpatient services in FY 2023. Hospital employment and the number of hospital beds both increased, and hospitals' occupancy rate remained steady at 69 percent. The supply of hospitals was also relatively steady. Looking more specifically at FFS Medicare beneficiaries, the number of inpatient stays and outpatient services per beneficiary increased. In addition, hospitals' FFS Medicare marginal profit remained positive—that is, FFS Medicare payments for inpatient and outpatient services continued to exceed estimates of hospitals' costs of providing an additional inpatient or outpatient service to FFS Medicare beneficiaries.

**TABLE
3-3****Hospitals maintained available inpatient and emergency department capacity in 2023, but considerable variation remained**

Available capacity measure	2019	2020	2021	2022	2023	Percentage point change	
						2019–2023	2022–2023
Occupancy rate							
Aggregate	67%	64%	68%	69%	69%	2	0
5th percentile	13	13	13	13	12	–1	–1
95th percentile	87	83	88	89	89	2	–1
Left ED without being seen							
Median	1%	1%	2%	2%	TBD	TBD	TBD
5th percentile	1	1	2	2	TBD	TBD	TBD
95th percentile	4	4	6	7	TBD	TBD	TBD

Note: ED (emergency department), TBD (to be determined). “Occupancy rate” refers to the share of bed days that were occupied by a patient (regardless of whether the patient was receiving inpatient, observation, or swing-bed services); bed days may be higher than staffed bed days. Data include all Subsection (d) and critical access hospitals that had a complete cost report with a midpoint in the fiscal year and had non-outlier data as of our analysis. Results differ from those published last year because of newer data and methodological updates, such as identification of statistical outliers. Years are fiscal except for ED data, which are reported on a calendar-year basis. ED data for 2023 were not available at the time of our analysis. Percentage point differences were calculated on unrounded data.

Source: MedPAC analysis of hospital cost reports and CMS timely and effective care data.

Hospital capacity increased, relative to both 2022 and 2019

From FY 2022 to FY 2023, two measures of hospital capacity increased: hospital employment and the number of inpatient beds (Table 3-2). Hospital employment increased 3 percent to 4.7 million full-time-equivalent staff. The number of inpatient beds increased 1 percent, to 674,000. Both measures of capacity were higher than they were in the immediate prepandemic period.

Hospitals maintained available capacity

In FY 2023, hospitals continued to have available inpatient and emergency department (ED) capacity (Table 3-3). Hospitals’ occupancy rate was 69 percent in FY 2023, similar to the level in 2022. While the occupancy rate was 2 percentage points higher than in the immediate prepandemic period, it was still indicative of available capacity. Hospitals also continued to have adequate ED capacity: At the median hospital, about 2 percent of ED patients left without being seen in CY 2022 (the most recent year of data currently available).

However, as in past years, there was significant variation within these aggregates, with some hospitals having substantially higher available capacity while others faced capacity constraints. In FY 2023, 5 percent of hospitals had an occupancy rate under 12 percent, while another 5 percent had an occupancy rate over 89 percent. Similarly, in CY 2022, 5 percent of hospitals had over 7 percent of ED patients leave without being seen. Hospital EDs that have a high share of patients who leave without being seen may not have the staff or resources to provide timely and effective ED care.

Supply of hospitals held relatively steady in 2023, though slightly more hospitals closed than opened

In FY 2023, the supply of hospitals as measured by provider numbers was relatively steady, declining 0.2 percent to 4,556 (Table 3-4, p. 70). However, changes in the count of hospital provider numbers do not necessarily reflect changes in access; for example, they can also reflect mergers and acquisitions. Of the 4,556 hospitals that provided at least one inpatient service

**TABLE
3-4**

In 2023, the number of hospitals held relatively stable, though slightly more closed than opened, and others converted to rural emergency hospitals

Supply measure	Fiscal year					Percent change	
	2019	2020	2021	2022	2023	2019–2023	2022–2023
Unique provider numbers	4,645	4,603	4,572	4,563	4,556	–1.9%	–0.2%
Openings	12	18	11	17	7	N/A	N/A
Metropolitan	12	15	10	13	5	N/A	N/A
Rural micropolitan	0	1	0	2	0	N/A	N/A
Other	0	2	1	2	2	N/A	N/A
Closures	46	25	11	17	19	N/A	N/A
Metropolitan	28	14	7	12	11	N/A	N/A
Rural micropolitan	4	6	1	5	5	N/A	N/A
Other	14	5	3	0	3	N/A	N/A
Conversions to rural emergency hospital	N/A	N/A	N/A	N/A	17	N/A	N/A

Note: N/A (not applicable). Data include all Subsection (d) and critical access hospitals that provided inpatient services to at least one fee-for-service Medicare beneficiary. “Unique provider numbers” are those that provided at least one inpatient service to a fee-for-service Medicare beneficiary. A change in unique provider numbers does not necessarily reflect a change in access; for example, it can reflect mergers and acquisitions. “Openings” refers to a new location for inpatient services, while “closures” refers to a hospital that ceased inpatient services and did not convert to a rural emergency hospital. The counts of openings and closures do not include the relocation of inpatient services from one hospital to another under common ownership within 10 miles, nor do they include hospitals that both opened and closed within a five-year period. The number of hospital closures and openings in a given year can change from prior publications as hospitals reopen and newer data become available. Percentage changes were calculated on unrounded data. “Metropolitan” refers to counties that contain an urban cluster of 50,000 or more people; “rural micropolitan” refers to counties that contain a cluster of 10,000 to 50,000 people; all other counties are classified as “other.”

Source: MedPAC analysis of Medicare Provider Analysis and Review file, Provider of Services files, census data on metropolitan and micropolitan areas, and internet searches.

to FFS Medicare beneficiaries in FY 2023, 7 opened at some point in the year, while 19 ceased to offer inpatient services. In addition, 17 hospitals converted to REHs in FY 2023 (see text box on rural emergency hospitals, pp. 72–73).

In FY 2024, an additional 4 hospitals opened, 15 closed, and 17 converted to REHs (data not shown). Of the four hospitals that opened, all were in metropolitan areas, one is reopening as a critical access hospital, and the distance to the nearest hospital ranged from less than 2 miles to about 26 miles. Of the 15 hospitals that closed, 10 were located in metropolitan areas, 8 had fewer than 50 beds, and 5 were critical access hospitals. In addition, four of the closures were in two hospital systems. The average distance to the next-nearest hospital was 16 miles; four rural closures were more than 25 miles from the next hospital. According

to hospital press releases and news reports, FFS Medicare payment rates did not appear to be the main contributor to the financial difficulties of the hospitals that closed in 2024. Rather, many hospitals that closed in 2024 cited other financial reasons; low patient volume was the most common.⁵

FFS Medicare beneficiaries’ use of inpatient services per capita increased but remained substantially below prepandemic level

In FY 2023, inpatient stays per FFS Medicare beneficiary increased 1.5 percent, up to 205 stays per 1,000 FFS Medicare beneficiaries (Table 3-5). The increase in stays per capita primarily resulted from increases in inpatient stays for circulatory conditions, infectious diseases, and musculoskeletal conditions, which collectively more than offset a decrease in respiratory conditions; together these shifts

**TABLE
3-5****FFS Medicare beneficiaries' inpatient stays per capita increased in 2023 but remained substantially below prepandemic level**

Inpatient volume measure	Fiscal year					Percent change	
	2019	2020	2021	2022	2023	2019–2023	2022–2023
Inpatient stays per 1,000 beneficiaries	244.5	213.6	207.7	202.3	205.3	–16.0%	1.5%
Inpatient stays (millions)	9.2	7.9	7.4	7.0	6.9	–25.0	–1.3
Average length of stay (days)	4.9	5.1	5.5	5.6	5.3	7.9	–4.1

Note: FFS (fee-for-service). Data include all Subsection (d) and critical access hospitals. FFS Medicare beneficiary enrollment is limited to those who resided in the U.S. and had Part A. Percentage changes were calculated on unrounded data.

Source: MedPAC analysis of Medicare Provider Analysis and Review file and Common Medicare Environment files.

contributed to a 4.1 percent decrease in the average length of stay. (Overall, inpatient stays by FFS Medicare beneficiaries declined 1.3 percent in 2023 because the decrease in FFS Medicare beneficiaries was larger than the increase in stays per beneficiary.)

Despite the increase in 2023, the number of inpatient stays per capita remained 16 percent below that of the immediate prepandemic period, and the length of stay remained nearly 8 percent longer. These findings could reflect a continuation of the prepandemic decline in stays per capita, driven by the shift of some types of care (such as joint replacements) from inpatient to outpatient settings.

FFS Medicare beneficiaries' use of hospital outpatient services per capita increased but remained below prepandemic level

In CY 2023, hospital outpatient services per FFS Medicare beneficiary increased 2.4 percent, up to 5.2 services per FFS Medicare beneficiary (Table 3-6). The increase in outpatient services per capita primarily resulted from small volume increases in a broad range of evaluation and management, imaging, and procedure services that collectively more than offset a large drop in the number of COVID-19 specimen collection services. (Overall, outpatient services provided to FFS Medicare beneficiaries declined 1.3 percent in 2023, to 145 million, because the decrease in FFS Medicare

**TABLE
3-6****FFS Medicare beneficiaries' hospital outpatient services per capita increased in 2023 but remained below prepandemic level**

Outpatient volume measure	Calendar year					Percent change	
	2019	2020	2021	2022	2023	2019–2023	2022–2023
Outpatient services per beneficiary	5.3	4.3	5.2	5.1	5.2	–2.8%	2.4%
Outpatient services (millions)	173.3	136.6	157.6	146.9	145.0	–16.3	–1.3

Note: FFS (fee-for-service). Data include all Subsection (d) and critical access hospitals. FFS Medicare beneficiary enrollment is limited to those who resided in the U.S. and had Part B. Outpatient results differ from the results previously published because we modified the way we capture changes in policies for packaging ancillary items under the outpatient prospective payment system and because of the effects of expanded uses of comprehensive ambulatory payment classifications that occur over time. Percentage changes were calculated on unrounded data.

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

Mandated report: Rural emergency hospitals

Since 1983, when Medicare moved from paying hospitals on the basis of their costs to prospectively determined rates, policymakers have sought ways to support rural beneficiaries' access to hospital services. Historically, this support focused on making inpatient hospital services more profitable. However, inpatient volume has declined dramatically over the past 40 years, especially at rural hospitals, reducing the impact of Medicare's inpatient-centric support of hospitals and contributing to an increase in rural hospital closures. This situation led the Commission, in 2018, to recommend 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 fee-for-service (FFS) basis, the new outpatient-only hospitals would receive a fixed monthly payment to help support the standby costs of maintaining an ED in addition to outpatient prospective payment system (OPPS) rates for each outpatient service. Consistent with the Commission's recommendation, the Congress enacted the new rural emergency hospital (REH) designation in the Consolidated Appropriations Act (CAA), 2021. As an REH, a hospital will:

- not furnish inpatient care,

- have an emergency department that is staffed 24/7,
- receive fixed monthly payments from Medicare,
- be paid 105 percent of standard OPPS rates for emergency and outpatient 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 that hospitals can choose whether they want to transition to an REH. Hospitals eligible to transition to an REH are those that, as of December 27, 2020, were critical access hospitals or Subsection (d) hospitals with 50 or fewer beds in a rural county. Hospitals began to transition to REHs starting in 2023.

The CAA requires the Commission to report annually on payments to REHs. In its March 2024 report to the Congress, the Commission described the historical context that led to the creation of REHs and the characteristics of the first cohort of REHs (Medicare Payment Advisory Commission 2024). In this report, we provide updated information on the number of REHs and payments made from FFS Medicare to REHs in the first full year that the designation was available.

(continued next page)

beneficiaries was larger than the increase in services per beneficiary.)

Despite the increase in 2023, the number of outpatient services per capita in 2023 remained 2.8 percent lower than in the immediate prepandemic period (Table 3-6, p. 71). While the volume of many types of hospital outpatient services rebounded to near prepandemic levels, other types of services remained well below the level in 2019. In particular, ED visits per FFS Medicare beneficiary remained about 13 percent below the level in 2019 (data not shown). This shift could reflect FFS

Medicare beneficiaries seeking certain types of care in other settings, such as urgent care centers.

Hospitals continued to have a financial incentive to provide services to FFS Medicare beneficiaries

We estimate that, on average, FFS Medicare payments exceeded hospitals' marginal costs of treating an additional FFS Medicare beneficiary in 2023, indicating that hospitals continued to have a financial incentive to provide services to FFS Medicare beneficiaries. It is difficult to use hospital cost reports' cost-center accounting to precisely estimate the share of

Mandated report: Rural emergency hospitals (cont.)

In calendar year (CY) 2023, 21 hospitals converted to REHs. In 2024, the number of active REHs increased to 36.⁶ Because complete CY 2024 claims data were not available at the time of our analysis, we analyzed 2023 claims data for the 21 REHs in 2023.

In CY 2023, FFS Medicare paid about \$10 million for outpatient hospital services at REHs.⁷ Over \$8 million was paid through the OPPS. Because REHs get paid 105 percent of standard OPPS rates, in aggregate, these payments were about \$400,000 higher than they would have been using standard OPPS rates. The OPPS services that accounted for the highest share of spending at REHs were ED visits, drug-administration services, intraocular procedures (e.g., cataract surgery), and imaging services.

The remaining payments to REHs were for non-OPPS services, such as physical therapy and clinical laboratory fee schedule services. Non-OPPS services are not paid enhanced rates at REHs but are instead paid standard rates (e.g., physical therapy services are paid at the standard physician fee schedule rate).

In addition to claims-based payments, REHs also receive fixed monthly payments from Medicare. In CY 2023, fixed payments were about \$267,000

per month per REH after incorporating the effects of the sequester. In CY 2023, we estimate that, in aggregate, REHs received about \$30 million in monthly fixed payments. Monthly fixed payments were three times as high as FFS Medicare's claims-based payments, which underscores the importance of fixed payments for the viability of REHs.

The Commission continues to monitor the implementation and uptake of the new REH designation. In the summer of 2024, the Commission conducted site visits at REHs and other rural hospitals to discuss the new REH designation and other payment issues. As in our site visits in 2023, we heard from rural hospitals that Medicare Advantage (MA) plans tend to match FFS's claims-based payment rates for REHs but do not pay REHs fixed monthly payments. However, Medicare's fixed monthly payments to REHs are included in MA benchmarks. In the March 2024 report to the Congress, the Commission noted that excluding REH fixed payments from MA benchmarks would 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) (Medicare Payment Advisory Commission 2024). ■

hospitals' costs that increase with each additional patient. For example, the share of administrative costs that are fixed can vary substantially by hospital and the planning horizon. We therefore looked at how hospitals' aggregate costs varied from year to year and estimated that between about 75 percent and 85 percent of costs varied as volume changed.⁸ Since IPPS and OPPS payments amounted to about 85 percent of hospitals' costs, we estimate that hospitals' FFS Medicare marginal profit continued to be positive in 2023.⁹ (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.)

Direct financial incentives are not the only factors that affect hospital decision-making on whether to provide services to FFS Medicare beneficiaries. For example, hospitals may also choose to serve FFS Medicare patients to maintain their nonprofit status and support hospitals' missions.

Quality of hospital care in 2023 was mixed

In 2023, the quality of hospital care was mixed, relative to both 2022 and 2019. FFS Medicare beneficiaries' risk-adjusted hospital mortality rate improved 0.3 percentage points in 2023, and it improved relative

**TABLE
3-7****FFS Medicare beneficiaries' risk-adjusted hospital mortality rate improved in 2023 and relative to prepandemic level**

Mortality rate	Fiscal year					Percentage point change	
	2019	2020	2021	2022	2023	2019–2023	2022–2023
Risk adjusted	7.9%	8.4%	8.4%	7.9%	7.6%	–0.3	–0.3
Unadjusted	8.2	9.8	11.3	10.6	9.4	1.2	–1.2

Note: FFS (fee-for-service). "Mortality rate" refers to the share of inpatient stays that result in death during or within 30 days after the inpatient stay. Results differ from those published in prior years because of methodological updates, including removing critical access hospital stays.

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

to the prepandemic level. FFS beneficiaries' risk-adjusted readmission rate was slightly worse in 2023 than in 2022 but about 0.5 percentage points better than the immediate prepandemic period. Most patient-experience measures improved in 2023 but continued to be at least 1 percentage point lower than prepandemic levels.

Hospital mortality rate improved in 2023 and relative to prepandemic level

In FY 2023, FFS Medicare beneficiaries' risk-adjusted hospital mortality rate—defined as the share of inpatient stays that result in death during or within 30 days after the inpatient stay—improved to 7.6 percent, 0.3 percentage points lower than the level in 2022 and in 2019 (Table 3-7). Since the start of the pandemic in 2020, 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. However, from 2021 to 2023, FFS Medicare beneficiaries' hospital mortality rate improved on both an unadjusted and risk-adjusted basis.

In 2023, hospitals in rural nonmicropolitan areas had a higher risk-adjusted mortality rate (9.2 percent) compared with hospitals in rural micropolitan (8.3 percent) and hospitals in urban areas (7.5 percent) (data not shown).¹⁰ From 2021 to 2023, hospitals in rural nonmicropolitan areas had the most improvement in risk-adjusted mortality rates (1.7 percentage points). In

**TABLE
3-8****FFS Medicare beneficiaries' risk-adjusted hospital readmission rate worsened in 2023 but improved relative to prepandemic level**

Readmission rate	Fiscal year					Percentage point change	
	2019	2020	2021	2022	2023	2019–2023	2022–2023
Risk adjusted	15.5%	15.0%	14.8%	14.6%	15.0%	–0.5	0.4
Unadjusted	15.7	15.6	15.9	15.6	15.7	0.0	0.1

Note: FFS (fee-for-service). "Readmission rate" refers to the share of inpatient stays that result in a readmission for any condition within 30 days after the initial inpatient stay. Results differ from those published in prior years because of methodological updates, including removing critical access hospital stays.

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

**TABLE
3-9**

Most hospital patient-experience measures improved in 2023 but remained below prepandemic levels

H-CAHPS measure	Calendar year					Percentage point change	
	2019	2020	2021	2022	2023	2019-2023	2022-2023
Share of patients rating the hospital a 9 or 10 out of 10	73%	72%	72%	70%	72%	-1	2
Share of patients who would definitely recommend the hospital	72	71	70	69	70	-2	1
Share of patients giving top ratings for:							
Communication with nurses	81	80	80	79	80	-1	1
Communication with doctors	82	81	80	79	80	-2	1
Responsiveness of hospital staff	70	67	66	65	66	-4	1
Communication about medicines	66	63	62	62	62	-4	0
Cleanliness of hospital environment	76	73	73	72	73	-3	1
Quietness of hospital environment	62	63	62	62	62	0	0
Understanding their care when they left the hospital (care transitions)	54	52	52	51	52	-2	1
Share of patients who received discharge information	87	86	86	86	86	-1	0

Note: H-CAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems). H-CAHPS is a standardized 29-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. These results encompass all hospitals that received H-CAHPS scores. National H-CAHPS response rates from 2019 to 2023 ranged from 23 percent to 25 percent.

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

2023, for-profit hospitals had higher mortality rates (7.8 percent) than nonprofit hospitals (7.5 percent).

Hospital-readmission rate worsened in 2023 but remained better than the prepandemic level

In FY 2023, FFS Medicare beneficiaries' risk-adjusted hospital-readmission rate worsened (higher is worse) by 0.4 percentage points to 15.0 percent; however, it remained better than the 15.5 percent rate in 2019 (Table 3-8). Although unadjusted readmission rates were stable from 2019 to 2023, risk-adjusted readmission rates decreased because beneficiaries admitted to hospitals in recent years tend to have more comorbidities and thus a higher expected rate of readmission.

In 2023, hospitals in urban areas had a higher risk-adjusted readmission rate (15.1 percent) compared with hospitals in rural micropolitan and nonmicropolitan

areas (14.2 percent) (data not shown). From 2021 to 2023, hospitals in rural nonmicropolitan areas had the most improvement in risk-adjusted readmission rates (1.3 percentage points). In 2023, for-profit hospitals had higher readmission rates (15.7 percent) than nonprofit hospitals (15.0 percent).

Most patient-experience measures improved in 2023 but remained below prepandemic levels

Most hospital patient-experience measures improved from 2022 to 2023, but performance remained at least 1 percentage point below prepandemic levels for almost all measures (Table 3-9). 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. 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 2023, 72 percent of surveyed patients rated their overall hospital experience a 9 or 10 on a 10-point scale, an improvement of 2 percentage points from 2022 but still a percentage point below 2019.¹¹ 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 52 percent of surveyed patients "strongly agreeing" that they understood their care plan when they left the hospital.

Hospitals in rural areas have higher H-CAHPS results than hospitals in urban areas (Centers for Medicare & Medicaid Services 2024). For example, 74 percent of surveyed patients who received care in a rural hospital rated their overall hospital experience a 9 or 10, while 69 percent of surveyed patients who received care in an urban hospital rated their overall hospital experience highly (data not shown). Nonprofit hospitals have higher H-CAHPS results than for-profit hospitals on all but the measure of quietness in the hospital. Larger hospitals (by number of beds) have higher H-CAHPS results than smaller hospitals.

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.

Hospitals' access to capital improved in 2023

The main way that hospitals access capital to maintain, modernize, and expand their facilities is through operating profits, and these improved in FY 2023. Hospitals' all-payer operating margin increased to 5.1 percent in 2023, and the majority of hospitals had a positive operating margin, indicating that hospitals had net operating profits that could be used for hospital capital projects. Other measures of hospitals' access to capital were positive in 2023, with a larger increase in hospitals' all-payer total margin but also higher

borrowing costs. Preliminary data suggest further improvement in hospitals' access to capital in 2024.

Hospitals' all-payer margin increased in 2023

Hospitals' primary source of access to capital—operating profits—increased in FY 2023. Hospitals' all-payer operating margin increased to 5.1 percent in 2023, up from 2.7 percent in 2022 (Table 3-10). (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) The 2.4 percentage point increase in hospitals' all-payer operating margin occurred despite a decrease in coronavirus relief funds. In 2023, hospitals reported about \$3 billion in coronavirus relief funds, down from \$9 billion in 2022 (data not shown). Nonetheless, hospitals' operating revenue increased about 8 percent in 2023—the second-highest growth rate in the past 10 years. In comparison, their costs increased about 5 percent—similar to the levels in the immediate prepandemic period.

As in prior years, there was significant variation within this aggregate. A quarter of hospitals had an all-payer operating margin below -4 percent, while another quarter had a margin above 10 percent. The majority of hospitals had a positive operating margin. While there was variation within each group of hospitals, the 2023 all-payer operating margin continued to be much higher for hospitals located in urban areas than for hospitals located in rural nonmicropolitan areas. In addition, the all-payer margin remained lower among hospitals that had higher values on the Commission-developed Medicare Safety-Net Index (MSNI) (see text box, p. 78), and the MSNI continued to be a better predictor of hospitals' all-payer operating margin than the current disproportionate-share-hospital (DSH) metric.¹²

Other indicators of access to capital were positive

Hospitals' other sources of capital were positive in FY 2023 relative to FY 2022:

- **Hospitals' all-payer total margin increased.** In FY 2023, hospitals' all-payer total margin was 6.4 percent, up from 2.3 percent in 2022. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) The total margin includes operating income as well as investment and donation income. The total margin increased more than the operating margin because hospitals received about \$13 billion in

**TABLE
3-10****Hospitals' all-payer operating margin increased in 2023,
and significant variation across hospitals persisted**

Group	Fiscal year				
	2019	2020	2021	2022	2023
Including relief funds					
All					
Aggregate	6.7%	5.5%	8.8%	2.7%	5.1%
25th percentile	-1.5	-1.2	0.9	-5.5	-4.0
Median	4.3	4.6	7.2	1.6	2.8
75th percentile	11.0	11.3	14.9	9.8	10.4
Ownership					
For profit	12.5	13.0	15.4	12.9	12.9
Nonprofit	6.2	4.8	8.3	1.0	4.4
Geography*					
Metropolitan	6.9	5.5	8.8	2.8	5.3
Micropolitan	5.1	5.7	9.0	1.2	3.2
Other rural	0.9	3.9	7.7	0.9	-0.5
MSNI					
Lowest quartile	NS	NS	11.6	5.9	7.6
2nd quartile	NS	NS	9.7	3.4	7.1
3rd quartile	NS	NS	8.7	4.3	5.7
Highest quartile	NS	NS	4.9	3.1	3.7
Excluding relief funds					
All					
Aggregate	6.7	2.1	7.4	2.0	4.9
25th percentile	-1.5	-6.6	-1.8	-7.1	-4.5
Median	4.3	0.8	4.6	0.5	2.5
75th percentile	11.0	8.4	13.0	8.8	10.1
Ownership					
For profit	12.5	10.7	14.3	12.5	12.7
Nonprofit	6.2	1.2	7.0	0.2	4.1
Geography*					
Metropolitan	6.9	2.1	7.5	2.2	5.0
Micropolitan	5.1	1.2	6.5	-0.7	2.9
Other rural	0.9	-1.7	2.7	-2.5	-1.0
MSNI					
Lowest quartile	NS	NS	10.5	5.4	7.4
2nd quartile	NS	NS	8.5	2.8	7.0
3rd quartile	NS	NS	7.3	3.4	5.3
Highest quartile	NS	NS	2.7	2.2	3.3

Note: MSNI (Medicare Safety-Net Index), NS (not shown). Data are for hospitals paid under the inpatient prospective payment systems that had a complete cost report with a midpoint in the fiscal year and had non-outlier data as of our analysis. The all-payer operating margin excludes investment and donation income. "Relief funds" refers to federal or other coronavirus relief funds. Results differ from those published last year because of newer data and methodological updates, such as identification of statistical outliers and inclusion of other coronavirus relief funds. * 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."

Source: MedPAC analysis of hospital cost reports, census geographic files, and MSNI data sources.

The Commission-developed Medicare Safety-Net Index

The Commission developed the Medicare Safety-Net Index (MSNI) to identify financially vulnerable hospitals that serve large shares of low-income Medicare beneficiaries. Our conceptual framework for the development of the MSNI is detailed in our June 2022 report to the Congress (Medicare Payment Advisory Commission 2022). These hospitals are particularly vulnerable to unforeseen circumstances (such as misestimates of input price inflation) (Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2022).

We found that the MSNI was an important predictor of hospitals' all-payer margins and risk of closure—and a better predictor than the metric used in current disproportionate-share-hospital (DSH) payments.

Calculating each hospital's MSNI

Each hospital's MSNI is calculated as the sum of three components:

- low-income share of Medicare volume,
- uncompensated-care costs as share of all-payer revenue, and
- Medicare share of all-payer volume (divided by 2).

For more details on the principles for each component, see our March 2023 report to the Congress, Chapter 3, Table 3A-1.

This year we incorporated additional data sources so that, where possible, the MSNI calculation is based on both inpatient and outpatient data and on fee-for-service (FFS) and Medicare Advantage (MA) beneficiaries.¹³

Using the MSNI to reform Medicare's support of Medicare safety-net hospitals

The Commission's view is that Medicare safety-net payments should be used primarily to support Medicare safety-net hospitals, which are hospitals that provide care to large shares of low-income Medicare beneficiaries. This measure of "safety-net" status is Medicare-centric by design; safety-net definitions used by Medicaid and other payers would likely differ.

In contrast to current Medicare payments to support safety-net hospitals (DSH and uncompensated-care payments), the Commission's proposed new MSNI payments would be:

- targeted to hospitals with higher Medicare dependency, measured on a sliding scale;
- calculated as a percentage add-on for both Medicare inpatient and outpatient services; and
- made to hospitals for both their FFS and MA beneficiaries and carved out of MA benchmarks.

The current DSH and uncompensated-care payments would be replaced with payments distributed using the MSNI, and, if needed, new funds could be added using the MSNI to target hospitals most in need (Medicare Payment Advisory Commission 2024). In our simulations of replacing DSH and uncompensated-care payments with payments based on the MSNI, some hospitals would receive more payments and others would receive less. Phasing in changes (and adding additional MSNI funds) would help ease the transition for hospitals that would receive lower safety-net payments under the MSNI. ■

investment income in 2023, compared with \$7 billion in investment losses in 2022. Donation income was steadier at between \$2 billion and \$3 billion in both years.

- **Hospitals' borrowing costs increased but by less than in the general market.** In FY 2023, hospitals' borrowing costs increased. The yield on hospital municipal bonds increased from about 3.6 percent in 2022 on average to 4.4 percent in 2023

(S&P Global 2024). However, the spread between hospitals' borrowing costs and borrowing costs in the general market declined. The yield on hospital bonds fell from 1.2 percentage points above the yield of 10-year treasury bonds in 2022 to 0.6 percentage points in 2023, suggesting that bond investors see little risk of hospital defaults on their bonds.

Hospital mergers and acquisitions also continued, indicating that investors continue to be willing to put capital into acquiring hospitals. Our analysis of Levin Pro HC data for hospitals paid under the IPPS and the OPPIs found that about 110 hospitals were acquired in FY 2022, and an additional 90 hospitals were acquired in FY 2023.

Preliminary data suggest that hospitals' access to capital continued to improve in 2024

Preliminary data from selected hospitals and rating agencies suggest that hospitals' all-payer operating margin continued to increase in 2024, and for-profit hospitals continued to have higher operating margins than nonprofit hospitals. The all-payer operating margin among six large hospital systems increased about 1 percentage point in 2024.¹⁴ Among the three largest for-profit health systems, the all-payer operating margin increased by about 0.9 percentage points from the quarter ending September 30, 2023, to the quarter ending September 30, 2024, though the individual all-payer operating margins varied widely, from 6.0 percent to 13.8 percent (Community Health Systems 2024, HCA Healthcare 2024, Tenet Health 2024). To explain what drove their improved margin, these systems cited reasons such as increased admissions and revenue per admission (from 2024 contract negotiations and Medicaid supplemental revenue, among other reasons) and decreased contract-labor costs. Among the three selected large nonprofit hospital systems, the all-payer operating margin increased by about 1 percentage point from the year ending July 30, 2023, to the year ending July 30, 2024, ranging from -5.3 percent to 0.3 percent (Ascension 2024, CommonSpirit 2024, Trinity Health 2024). This gradual improvement in these three nonprofit hospitals' all-payer operating margin is consistent with rating agencies' findings for 2024. The agencies attribute some of the increase in nonprofit hospitals' all-payer operating margin in 2024 to easing labor costs and to one-time payments, such as those to offset lower payments for drugs acquired through the

340B Drug Pricing Program from 2018 to 2021 (Fitch Ratings 2024, Moody's Investors Service 2024, S&P Global Ratings 2024).¹⁵

Hospitals' borrowing costs through the bond markets were steady between 2023 and 2024. However, the spread between hospitals' borrowing costs and borrowing costs in the general market declined, with the yield on hospital bonds falling to 0.2 points above that of 10-year treasury bonds in 2024 (S&P Global 2024).

Looking forward to 2025, rating agencies project a continued slow and sustained recovery for nonprofit hospitals' access to capital, including a projected gradual improvement in nonprofit hospitals' all-payer operating margin and more favorable than unfavorable outlooks (Fitch Ratings 2024, Moody's Investors Service 2024, S&P Global Ratings 2024).

FFS Medicare payments to hospitals were lower than hospitals' costs in 2023

In FY 2023, hospitals' FFS Medicare margin remained negative but with substantial variation. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) The FFS Medicare margin remained stable from 2022 to 2023 when coronavirus relief funds were excluded. Among the subset of hospitals we identified as relatively efficient, the median FFS Medicare margin was higher than among other hospitals but still negative. Like last year, we project that hospitals' FFS Medicare margin in 2025 will remain negative and near the level in 2023.

The FFS Medicare margins we present this year reflect updates from our most recent periodic methodology reviews. The results under the updated methodology were generally similar to the prior methodology: For each of the past 10 years (2014 to 2023), hospitals' FFS Medicare margin was always within 0.8 percentage points of results using the prior methodology and mostly within 0.3 percentage points. The largest change stemmed from limiting our margin analysis to payments and costs for services paid under the IPPS and OPPIs.¹⁶ Hospitals' FFS Medicare margin on other service lines affects the overall financial effect on hospitals of providing services to FFS Medicare beneficiaries and could affect hospitals' margin on inpatient and outpatient services. However, we concluded that the most relevant margin for this

**TABLE
3-11****Hospitals' FFS Medicare margin excluding relief funds remained stable between 2022 and 2023, but significant variation persisted (cont. next page)**

Group	Fiscal year				
	2019	2020	2021	2022	2023
Including relief funds					
All					
Aggregate	-8.0%	-8.2%	-6.3%	-11.9%	-12.6%
25th percentile	-17.1	-17.2	-15.2	-21.5	-22.0
Median	-5.7	-4.4	-2.7	-8.7	-9.7
75th percentile	4.8	7.7	9.2	3.8	2.8
Ownership					
For profit	1.4	4.3	5.6	1.1	0.4
Nonprofit	-9.4	-10.2	-8.1	-13.6	-13.8
Geography*					
Metropolitan	-8.4	-8.8	-6.9	-12.3	-12.8
Micropolitan	-4.6	-2.7	-1.5	-8.7	-9.8
Other rural	0.4	5.1	8.1	0.1	-3.2
Fiscal pressure**					
Low pressure	-10.6	-10.8	-8.9	-13.9	-14.6
High pressure	4.0	7.5	5.8	-2.6	-4.3
MSNI					
Lowest quartile	NS	NS	-10.0	-16.1	-16.8
2nd quartile	NS	NS	-9.5	-14.3	-14.7
3rd quartile	NS	NS	-4.2	-8.7	-10.1
Highest quartile	NS	NS	3.2	-3.6	-4.8

chapter on assessing the adequacy of FFS Medicare payments for services paid under the IPPS and OPSS is a margin limited to those services. If FFS Medicare's payments for other service lines are too high or too low, the adequacy of payments for those services is best addressed through updates to FFS Medicare payments for those service lines. We made other minor changes, including updating our method of trimming data for statistical outliers and identifying swing-bed costs.

Hospitals' FFS Medicare margin exclusive of coronavirus relief funds remained stable but lower than prepandemic level

In FY 2023, hospitals' FFS Medicare margin including coronavirus relief funds fell to -12.6 percent, but exclusive of these funds it remained steady at about -13 percent (Table 3-11).¹⁷ The 0.7 percentage point

decline in hospitals' FFS Medicare margin from 2022 to 2023 when including coronavirus relief funds was exclusively due to a decline in relief funds. The steady FFS Medicare margin exclusive of relief funds reflects offsetting pressures. For example, both the reinstatement of sequestration on Medicare payments and higher-than-expected inflation decreased hospitals' FFS Medicare margin.¹⁸ On the other hand, the continued growth in profitable, separately payable drugs increased hospitals' FFS Medicare margin.¹⁹ While there are analytic challenges to calculating FFS Medicare margins separately for services paid under the IPPS and OPSS, we approximate that, after excluding uncompensated-care payments, hospitals' FFS Medicare margin in 2023 was roughly similar for FFS Medicare patients across inpatient and outpatient settings.²⁰

**TABLE
3-11****Hospitals' FFS Medicare margin excluding relief funds remained stable between 2022 and 2023, but significant variation persisted (cont.)**

Group	Fiscal year				
	2019	2020	2021	2022	2023
Excluding relief funds					
All					
Aggregate	-8.0%	-12.3%	-8.3%	-13.1%	-13.0%
25th percentile	-17.1	-22.2	-17.2	-22.7	-22.5
Median	-5.7	-8.6	-5.2	-10.2	-10.1
75th percentile	4.8	3.3	6.4	2.0	2.3
Ownership					
For profit	1.4	1.7	4.1	0.5	0.1
Nonprofit	-9.4	-14.6	-10.1	-14.7	-14.3
Geography*					
Metropolitan	-8.4	-12.8	-8.7	-13.3	-13.2
Micropolitan	-4.6	-7.8	-4.7	-11.3	-10.4
Other rural	0.4	-1.1	2.8	-4.1	-3.9
Fiscal pressure**					
Low pressure	-10.6	-14.4	-10.6	-14.9	-15.0
High pressure	4.0	1.4	2.5	-4.2	-5.1
MSNI					
Lowest quartile	NS	NS	-11.7	-16.9	-17.2
2nd quartile	NS	NS	-11.3	-15.2	-15.0
3rd quartile	NS	NS	-6.1	-9.9	-10.7
Highest quartile	NS	NS	0.4	-5.2	-5.4

Note: FFS (fee-for-service), MSNI (Medicare Safety-Net Index), NS (not shown). Data are for hospitals paid under the inpatient prospective payment systems (IPPS) that had a complete cost report with a midpoint in the fiscal year and had non-outlier data as of our analysis. The "FFS Medicare margin" is limited to revenue and costs for services included under the IPPS or outpatient prospective payment system (OPPS), including uncompensated-care payments and revenue and costs of separately payable drugs, including any reported discounts to drug costs under the 340B Drug Pricing Program. "Relief funds" refers to FFS Medicare's share of federal and other coronavirus relief funds. Results differ from those published last year because of newer data and methodological updates, such as limiting the set of included services to IPPS and OPPS services. * 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-FFS 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 FFS Medicare profits had been zero. "High [fiscal] pressure" hospitals are defined as those with a median non-FFS 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.

Source: MedPAC analysis of hospital cost reports, census geographic files, and MSNI data sources.

Hospitals' FFS Medicare margin remained about 5 percentage points lower than in 2019 (Table 3-11). This finding reflects in part a decline in Medicare's uncompensated-care payments from over \$8 billion in 2019 to about \$7 billion in 2023, as well as substantially higher-than-expected input price inflation in 2022 (data not shown).

As in prior years, there was significant variation within this aggregate: A quarter of hospitals had a FFS Medicare margin below -22 percent, while a quarter had a margin above 2 percent (Table 3-11). While there was variation within each group of hospitals, in aggregate:

- **For-profit hospitals' FFS Medicare margin remained positive and much higher than nonprofit hospitals' margin but fell in 2023.** For-profit hospitals' FFS Medicare margin remained positive and over 10 percentage points higher than nonprofit hospitals' margin, primarily because they have been able to constrain costs. This relationship held despite for-profit hospitals' margin declining in 2023.²¹
- **Rural hospitals' FFS Medicare margin remained higher than urban hospitals' margin but became negative in 2023.** Hospitals in rural nonmicropolitan areas continued to have a FFS Medicare margin higher than urban or rural micropolitan hospitals' margin primarily because most of these hospitals benefit from one or more special designations that provide additional FFS Medicare payments above standard IPPS and/or OPPIs payments. However, rural hospitals also received targeted coronavirus relief funds; as these payments continued to decrease, so did rural hospitals' margin, which fell from 0.1 percent in 2022 to -3.2 percent in 2023.²²
- **FFS Medicare margin remained higher at hospitals under high fiscal pressure.** The FFS Medicare margin continued to be higher at hospitals consistently under higher fiscal pressure, though the spread between the margin at high- and low-fiscal pressure hospitals has been declining. By definition, hospitals under higher fiscal pressure—that is, with a median non-FFS 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 if the hospital's FFS Medicare profits had been zero—have more constraints on their costs.²³
- **FFS Medicare margin remained higher at hospitals with higher MSNI values.** The FFS Medicare margin also continued to be higher among hospitals with higher values on the Commission-developed MSNI. This finding primarily reflects how, in general, these hospitals receive some additional FFS Medicare payments from existing Medicare safety-net payments (DSH and uncompensated-care payments). However, as we noted previously, the MSNI would better target scarce Medicare resources to hospitals that treat large shares of low-income Medicare beneficiaries (Medicare Payment Advisory Commission 2024, Medicare

Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2022).

Medicare should move toward site-neutral payments

The FFS Medicare payment rates for services provided in hospital outpatient departments (HOPDs) are generally higher than the payment rates for the same services provided in other ambulatory settings (ambulatory surgical centers and freestanding physician offices). These payment differences encourage arrangements among providers—such as consolidation of physician practices with hospitals—that result in care being billed from settings with the highest payment rates, which increases total Medicare spending and beneficiary cost sharing without material improvements in patient outcomes. The Commission contends that 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 and when doing so does not pose a risk to access (Medicare Payment Advisory Commission 2023a). For example, the Commission recommended aligning FFS Medicare payment rates across ambulatory settings for certain services that CMS deems safe and appropriate to provide outside of a hospital setting. To illustrate this concept, the Commission modeled the effect of aligning payment rates across ambulatory settings in a budget-neutral manner for 66 ambulatory payment classifications (APCs) (Medicare Payment Advisory Commission 2023a).

In the Bipartisan Budget Act (BBA) of 2015, the Congress took an approach to site-neutral payments between freestanding offices and hospitals that differs from the method recommended by the Commission. The approach in the BBA of 2015 has had a modest effect because it is largely limited to off-campus provider-based departments (PBDs) owned by hospitals that were not open when the Congress passed the BBA of 2015. We evaluated the effects of expanding this method to all off-campus PBDs (see text box on expanding the site-neutral payment policy, pp. 84–85).

Relatively efficient hospitals continued to have higher quality, lower costs, and higher margins in 2023

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 better on selected measures of quality and cost for inclusion than other hospitals. We define “efficiency” as the level of resources needed to provide a certain quality and quantity of services. However, our method does not seek to identify all hospitals that efficiently deliver hospital care. For example, we exclude from our analysis 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 (see text box on method to identify relatively efficient hospitals, p. 87).

This year, we used 2019, 2021, and 2022 historical performance to identify relatively efficient hospitals and found that about 6 percent met our criteria for costs and quality (Table 3-13, p. 86). One reason for the small number of hospitals meeting the criteria is related to the requirement of achieving relatively high performance (higher quality and lower standardized costs) across all three years of the baseline period. In this year’s analysis, the baseline period covered 2019, 2021, and 2022, which was a more difficult time for hospitals to perform consistently well because of the exclusion of 2020 when the coronavirus pandemic started and the pandemic’s continuing impacts in 2021 and 2022. Loosening the requirements (such as by requiring less consistency over three years or broadening the quality or cost thresholds) would increase the share of hospitals meeting the criteria but would include hospitals with worse quality outcomes and/or higher standardized costs in the baseline years. The baseline period will continue to shift forward by a year in future analyses, and we will continue to monitor the number and characteristics of the relatively efficient hospitals identified.

The hospitals we identified as historically relatively efficient continued to have lower costs and higher quality in 2023. In terms of quality, the relatively efficient hospitals had lower mortality and readmission rates (90 percent of the national median and 93 percent, respectively) and higher patient satisfaction scores (104 percent of the national median). They also had lower standardized FFS Medicare costs per unit, at 91 percent of the national median. These lower standardized costs allowed them to generate higher FFS Medicare margins than the comparison group.

When including relief funds, in 2023 the median relatively efficient hospital had an all-payer operating margin of 7 percent and a FFS Medicare margin of –1 percent (–2 percent when excluding relief funds).²⁴ Both of these margins were improvements relative to 2022.

As in past years, relatively efficient hospitals were spread across the country and included different categories of hospitals. For example, among for-profit and nonprofit hospitals, the shares of hospitals categorized as relatively efficient were similar. Although for-profit hospitals tend to have lower costs, nonprofit hospitals tend to have higher quality metrics.

FFS Medicare margin is projected to remain near 2023 level in 2025

We project that hospitals’ FFS Medicare margin in 2025 will be about –13 percent, similar to the level in 2023 exclusive of coronavirus relief payments. Similarly, we project the median FFS Medicare margin among relatively efficient hospitals to remain about –2 percent. These projections are based on actual payments and costs in the most recent year of complete data (2023), FFS Medicare payment policies for 2024 and 2025, and environmental changes that took place in 2024 and are anticipated in 2025.

Our projected margin reflects roughly offsetting pressures, the largest of which are:

- **Declines in coronavirus relief support.** While hospitals continued to record some federal and other coronavirus relief funds in their 2023 cost reports, the overall amounts—and therefore FFS Medicare’s share—declined in 2023, as expected. We do not project any federal or other coronavirus relief funds in 2025.

Effects of expanding the Bipartisan Budget Act of 2015's site-neutral payment policy

For over a decade, the Commission has observed that Medicare's payment rates often differ for the same service across different ambulatory settings (hospital outpatient departments, ambulatory surgical centers, and freestanding physician offices). These payment differences encourage arrangements among providers—such as consolidation of physician practices with hospitals—that result in care being billed from settings with the highest payment rates, which increases total Medicare spending and beneficiary cost sharing without material improvements in patient outcomes. To address this issue, the Commission has twice recommended aligning Medicare payment rates for selected services that are safe and appropriate to provide in all settings when doing so does not pose a risk to beneficiary access to care (Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2014).

In Section 603 of the Bipartisan Budget Act (BBA) of 2015, the Congress took a different approach to aligning Medicare payment rates (referred to as “site-neutral payments”). The BBA of 2015 focused on outpatient prospective payment system (OPPS)-covered services provided in off-campus provider-based departments (PBDs) of hospitals, which are departments of a hospital that are not located on the campus of the hospital or within 250 yards of a remote location of the hospital facility. Under this statute, OPPS payment rates for all services provided to Medicare beneficiaries in certain off-campus PBDs must be aligned with payment rates in the Medicare physician fee schedule (PFS) for services provided in freestanding physician offices. The locations that are subject to this statute are generally those that became off-campus PBDs of hospitals after the date that the BBA of 2015 was passed by the Congress, November 2, 2015. Off-campus PBDs that were established before November 2, 2015, are exempt from this statute and are allowed to bill at standard OPPS payment rates. While the Commission recommended

aligning payments for specific services provided in any hospital outpatient department (HOPD) that is covered under the OPPS, the BBA of 2015 requires that all services provided in certain hospital outpatient departments (that is, specified off-campus PBDs) are subject to site-neutral payments. In addition, where the Commission recommended that site-neutral payments be coupled with a budget-neutral adjustment that would increase the OPPS payment rates for the services that are not subject to the site-neutral payments, which results in no change in Medicare FFS spending under the OPPS, the BBA of 2015 has no accompanying budget-neutrality adjustment, which results in lower overall Medicare FFS spending.

To satisfy the requirements in the BBA of 2015, CMS set payment rates for the OPPS-covered services provided in the off-campus PBDs that are subject to the rules of the BBA of 2015 to 40 percent of the standard OPPS payment rates. Under Sections 1833(t)(1)(B)(v) and 1833(t)(21) of the Social Security Act, the affected services are no longer considered HOPD services for the purpose of payment under the OPPS and are instead paid under the PFS. Initially, these lower payment rates resulted in a small reduction in total spending in the OPPS of \$170 million because most off-campus PBDs were exempt from the site-neutral requirements in the BBA of 2015. In 2023, total spending in the OPPS was reduced by \$500 million as the number of services provided in these off-campus PBDs increased.

In 2019, CMS substantially increased the breadth of services that are subject to the site-neutral payment rates resulting from the BBA of 2015 by specifying that all clinic visits (specified by Healthcare Common Procedure Coding System (HCPCS) code G0463) provided in any exempt off-campus PBD must be subject to site-neutral payments. Because clinic visits specified by HCPCS G0463 are by far the most common service provided in off-campus PBDs, this policy change substantially increased the effects of the site-neutral payments.

(continued next page)

Effects of expanding the Bipartisan Budget Act of 2015’s site-neutral payment policy (cont.)

CMS did not extend site-neutral payments to all services in the exempt PBDs, but the Commission evaluated the effects of doing so. The Commission found that, without a budget-neutrality adjustment, expanding this site-neutral policy to all OPPS-covered services (excluding separately payable drugs but including drug administration services) would reduce payments to hospitals for OPPS services by 3.2 percent. Therefore, applying a budget-neutral adjustment would require a uniform increase of 3.2 percent to the payment rates for all OPPS-covered services that would not be affected by the site-neutral policy.

We found that applying this policy to services furnished in 2023 without a budget-neutrality adjustment would have lowered combined inpatient and outpatient FFS Medicare revenue by 0.9 percent, Medicare spending under the OPPS would have been \$1.3 billion lower, and beneficiary cost-sharing obligations would have been \$0.3 billion lower.

After applying a budget-neutrality adjustment, there would be no change in aggregate inpatient and outpatient revenue, but there would be distributional effects such as urban hospitals losing a small amount of revenue and rural hospitals gaining a small amount (Table 3-12). ■

TABLE 3-12 Expanding existing site-neutral payment policy to all OPPS-covered services provided in off-campus provider-based departments would have varying effects, 2023

Change in combined inpatient and outpatient revenue, with budget neutrality		
Hospital category	Dollar change (in millions)	Percent change
All hospitals	\$0	0.0%
Urban	-50	<-0.1
Rural	50	0.4
For profit	80	0.4
Nonprofit	-50	<-0.1
Government	-30	-0.1

Note: OPPS (outpatient prospective payment system). “Inpatient and outpatient revenue” includes payments under the relevant inpatient and outpatient prospective payment systems. Data are for hospitals that had a complete cost report with a midpoint in the fiscal year as of our analysis.

Source: MedPAC analysis of outpatient standard analytic claims files, hospital cost reports, and census geographic files.

- Declines in uncompensated-care payments. FFS Medicare’s uncompensated-care pool (and supplemental payments to hospitals located in Puerto Rico and Indian Health Services hospitals) was \$7.0 billion in 2023 and will decline to \$5.8 billion in 2025. These decreases are largely due to the decline in the national uninsured rate, which

CMS projects will fall from 9.2 percent in 2023 to 7.6 percent in 2025.

- Hospitals’ input costs grew slightly faster than expected. Based on actual market basket data through the second quarter of 2024, hospitals’ input costs increased 3.7 percent in FY 2024; however, FFS Medicare payments for FY 2024

**TABLE
3-13**

Relatively efficient hospitals performed better than other hospitals but still had a negative median FFS Medicare margin in FY 2023

Metric	Relatively efficient hospitals	Other hospitals
Number of hospitals	123	1,852
Share of hospitals in our study sample	6%	94%
Historical performance, average over 2019, 2020, 2022 (percentage of national median)		
FFS Medicare mortality rate	87%	101%
FFS Medicare readmission rate	92	101
Standardized FFS Medicare costs per unit	92	101
Current-year performance, 2023 (percentage of national median)		
FFS Medicare mortality rate	90%	101%
FFS Medicare readmission rate	93	100
Share of patients rating the hospital a 9 or 10 (out of 10)	104	99
Standardized FFS Medicare costs per unit	91	101
Current-year margins, 2023 (median percentage)		
All-payer operating margin, including coronavirus relief funds	7%	3%
All-payer operating margin, excluding coronavirus relief funds	7	2
FFS Medicare margin, including coronavirus relief funds*	-1	-9
FFS Medicare margin, excluding coronavirus relief funds*	-2	-10

Note: FFS (fee-for-service), FY (fiscal year). Data are for hospitals paid under the inpatient prospective payment systems (IPPS) that had a complete cost report with a midpoint in the fiscal year and had non-outlier data as of our analysis. "Relatively efficient" and "other" hospitals were identified based on their performance during 2019, 2021, and 2022. (For more details, see text box on our identification methodology.)

* The "FFS Medicare margin" is limited to revenue and costs for services included under the IPPS or outpatient prospective payment system, including uncompensated-care payments and revenue and costs of separately payable drugs, and is reported with and without FFS Medicare's share of federal or other coronavirus relief funds.

Source: MedPAC analysis of hospital cost reports, claims data, data to standardize costs, and CMS's summary of H-CAHPS survey results tables.

included only a 3.3 percent increase for hospitals' input costs. Actual inflation for the rest of 2024 and 2025 is not yet known; we use CMS's current estimates of input price inflation because they represent the best estimates available at this time.

- **Continued increase in profitable, separately payable drugs.** Consistent with historical trends, we project continued growth in aggregate FFS Medicare payments for separately payable drugs and their share of hospitals' FFS Medicare inpatient and outpatient revenue. Because FFS Medicare payments for separately payable drugs are set at

the average sales price plus 6 percent, which is higher than hospitals' aggregate costs of acquiring these drugs, growth in separately payable drugs increases hospitals' FFS Medicare margin.

Like all projections, ours are subject to uncertainty. For example, the inflation figure in 2025 is uncertain. Uncertainty unique to this time period exists about how hospitals will spend the \$9 billion in one-time remedy payments they received in 2024 to offset the reduced payment rates for drugs obtained through the 340B Drug Pricing Program from CY 2018 to CY 2021. To the extent that hospitals spend those funds in ways

Identifying relatively efficient hospitals

The Commission follows two principles when identifying a set of relatively efficient hospitals:

- hospitals must perform relatively well on both quality and cost metrics, and
- the performance has to be consistent.

Our assessment of efficiency is not in absolute terms but, rather, relative to a comparison group of other hospitals.

Categorizing hospitals as relatively efficient

We categorize a hospital as relatively efficient if, over the previous three years, it consistently performed at a relatively high level on either fee-for-service (FFS) Medicare mortality rates or standardized inpatient and outpatient costs, and it never performed at a relatively low level on mortality rates, readmission rates, or costs.²⁵ Specifically, we categorized a hospital as relatively efficient if it met the following criteria:

- Either FFS Medicare risk-adjusted mortality rates or standardized inpatient and outpatient cost per unit was among the best one-third of hospitals in each of the prior three years.
- FFS Medicare risk-adjusted mortality rates, risk-adjusted readmission rates, and standardized

costs per unit were never in the bottom third of all hospitals in any of the prior three years.

- At least half of the hospitals' patients rated it a 9 or 10 on the 10-point scale in the previous year (per the Hospital Consumer Assessment of Healthcare Providers and Systems survey).
- FFS Medicare and Medicaid volume metrics met required minimums.²⁶

Implications

There is no single way to identify hospitals that are operating efficiently, and we do not seek to identify all efficient hospitals, nor do we conclude that all hospitals that did not meet our criteria are inefficient. For example, lower-volume hospitals have more variation in their costs, volume, and mix of patients and are therefore less likely to have consistent performance over three years. Still, the median FFS Medicare margin among the set of hospitals we identified as relatively efficient provides some insight about whether FFS Medicare payments to hospitals are adequate to cover the cost of providing inpatient and outpatient hospital care efficiently. This analysis is a complement to other metrics we use to assess the adequacy of FFS payments. ■

that increase hospital costs (more than revenue) in 2025, our projected margin would be lower.

Looking forward to 2026, there are additional uncertainties as well as known policy changes. We do not yet know what the uncompensated-care pool will be in 2026. As finalized by CMS in rulemaking, in 2026 CMS will begin implementing an annual 0.5 percentage point decrease to the OPPS conversion factor to offset the increased payments for nondrug items and services from CY 2018 through CY 2022. This 0.5 percent reduction in outpatient revenue would reduce

the overall Medicare margin by less than 0.2 percent. While factors such as the outpatient adjustment will cause small shifts in hospitals' FFS Medicare margin, we expect hospitals' 2026 FFS Medicare margin to be similar to the projected 2025 Medicare margin of -13 percent if current law holds.

We will update 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 cycles.

How should FFS Medicare payments change in 2026?

Under current law, CMS sets the percentage update to IPPS and OPPS payment rates based on its 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 2026 will not be set until summer 2025. However, based on current CMS forecasts through the third quarter of 2024, the 2026 updates would include:

- a 2.5 percent increase in the IPPS operating rate (resulting from 3.1 percent growth in the market basket less 0.6 percentage points in productivity);
- a 2.5 percent increase in the IPPS capital base rate, plus a forecast-error adjustment; and
- a 2.0 percent increase in the OPPS base rate (the same estimated 3.1 percent market basket less 0.6 percentage point productivity adjustment as the inpatient operating rate, less the first year of 0.5 percentage point reductions to offset increased payments for nondrug items and services from 2018 to 2021, following a Supreme Court decision).

Since 2006, the Commission has made a single update recommendation for FFS Medicare's payment rates for services provided under the IPPS and OPPS. Primarily we do so because we cannot adequately apply some of the Commission's payment-adequacy indicators separately for hospital inpatient and outpatient services since hospitals typically provide both types of services. Allocating costs to inpatient and outpatient services is conceptually challenging and subject to data limitations and variation in hospitals' accounting practices. Access to capital is also fundamentally a hospital-specific, not service line-specific, measure. Moreover, at this time we do not see evidence of significant differences between inpatient and outpatient settings in FFS Medicare beneficiaries' access to care or hospitals' FFS Medicare margins.²⁷

That said, the Commission has long recognized that Medicare's payments in any sector should reflect the potential to deliver the service in other settings, suggesting the importance of considering the relationship of prices across sectors. That work, such

as the Commission's recommendation for site-neutral payments (see text box on site-neutral payments, pp. 84–85), raises complex issues beyond the scope of our update criteria. For that reason, we address such issues in separate workstreams.

Our hospital payment-adequacy indicators were mixed and suggest that combined FFS Medicare payments across inpatient and outpatient services were below costs for most hospitals, including the median “relatively efficient” hospital. We also project that this gap between payments and costs will persist under current-law updates.

In considering how hospital base payment rates should change in 2026, 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; and
- limit the need for large across-the-board payment-rate increases by directing a portion of the increase in Medicare funds to safety-net hospitals that treat large shares of vulnerable Medicare patients.

Balancing these objectives continues to be difficult.

RECOMMENDATION 3

The Congress should:

- **for 2026, update the 2025 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1 percent; and**
- **redistribute existing disproportionate-share-hospital and uncompensated-care payments through the Medicare Safety-Net Index (MSNI)—using the mechanism described in our March 2023 report—and add \$4 billion to the MSNI pool.**

RATIONALE 3

Our indicators of the adequacy of FFS Medicare payments to hospitals continued to be mixed, though a subset improved relative to last year. Beneficiaries maintained good access to hospital care, and hospitals' access to capital improved in 2023. However, indicators of the quality of care experienced by patients continued to be mixed, FFS Medicare payments were below hospitals' costs—even among the small subset of relatively efficient hospitals—and we project that the median FFS Medicare margin among relatively efficient hospitals will remain slightly negative into 2025 and 2026 under current law. Therefore, for 2026, the Commission recommends increasing payments by more than current law.

Hospitals that treat larger shares of low-income Medicare patients continue to face larger financial challenges. Therefore, this recommendation reiterates last year's recommendation that the Congress redistribute existing safety-net payments to the MSNI and add \$4 billion to the MSNI pool. As specified in more detail last year, this action would involve:

- a transition from DSH and uncompensated-care payments to payments through the MSNI;
- scaling FFS MSNI payments in proportion to each hospital's MSNI and distributing the funds through a percentage add-on to payments under the inpatient and outpatient prospective payment systems;
- paying commensurate MSNI amounts for services furnished to MA enrollees directly to hospitals and excluding them from MA benchmarks; and
- expanding the MSNI pool in future years. For example, the pool could be expanded by the same rate as Medicare's base payment rates to hospitals.

The MSNI would better target limited Medicare resources toward those hospitals that are key sources of care for low-income Medicare beneficiaries and are facing financial challenges. However, even with an additional roughly \$2 billion in FFS MSNI payments in 2026 (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), aggregate Medicare FFS safety-net payments would still be below the 2019 level because, from 2019 to 2025, there was a roughly \$3 billion decline in FFS uncompensated-care and DSH payments.

Combined, we estimate that the 1 percentage point increase above current law and the approximately \$2 billion in additional FFS MSNI payments would increase FFS Medicare base payment rates to hospitals by about 2.2 percentage points above current law. However, while the 1 percentage point increase above current law to hospital base rates would affect all hospitals equally, the shift from the current DSH and uncompensated-care payment model to the MSNI model—and the addition of \$4 billion dollars to the MSNI pool—would have distributional impacts. The hospitals that would benefit most from the new MSNI approach are hospitals with large shares of Medicare patients—in particular, large shares of low-income Medicare patients. We estimate that all major categories of hospitals (e.g., teaching, nonteaching, rural, urban, for profit, nonprofit, government, small, large) would have some hospitals that see lower and some that see higher Medicare payments under our recommendation compared with current law, but in aggregate, most categories of hospitals would see increased Medicare payments under our recommendation. The largest gains would be for rural hospitals because they tend to have larger Medicare shares and larger shares of low-income Medicare patients. We expect that the recommendation would increase rural hospitals' FFS Medicare margin by nearly 7 percentage points over current law, almost three times the percentage point increase across all hospitals. In contrast, we expect that the recommendation would decrease government hospitals' FFS Medicare margin by about 1 percentage point relative to current law because some large government hospitals have relatively few Medicare patients and currently very high uncompensated-care payments.

We anticipate that a 2025 update to hospital payment rates of current law plus 1 percent and roughly \$2 billion in FFS MSNI funds would generally be adequate to maintain FFS beneficiaries' access to hospital inpatient and outpatient care. These funds would raise hospital payment rates close to the cost of delivering high-quality care efficiently.

IMPLICATIONS 3

Spending

- Current law is expected to increase IPPS operating, IPPS capital, and OPPS payment rates by over 2 percent. This recommendation would increase spending relative to current law by \$5 billion to \$10 billion in one year and by \$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 Clinicians who provide inpatient and outpatient services at hospitals are paid separately under the physician fee schedule. FFS Medicare uses other payment systems for certain types of hospitals, such as critical access hospitals, hospitals participating in demonstrations, and hospitals that provide care to a specific population (e.g., children's hospitals) or, for inpatient services, a limited set of diagnoses (e.g., psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals). An assessment of the adequacy of these payment systems is beyond the scope of this chapter.
- 2 However, when discussing indicators of beneficiaries' access to care, we use the term "hospital" to also include other Subsection (d) hospitals that FFS Medicare pays for inpatient and outpatient services under alternative methodologies (such as demonstrations), as well as critical access hospitals. These hospitals can provide care similar to care received at hospitals paid under the IPPS and OPPTS.
- 3 A more detailed description of the IPPS and OPPTS can be found in our *Payment Basics* series at <https://www.medpac.gov/document-type/payment-basic/>.
- 4 Unless otherwise noted, all years referring to inpatient services are fiscal years, while those referring to outpatient services are calendar years, consistent with when CMS updates these payment systems.
- 5 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.
- 6 Not included in this count are two hospitals that converted to REHs but subsequently closed or had their REH status revoked. The count of active REHs was determined as of January 28, 2025, and is subject to change.
- 7 This figure does not include services beyond outpatient hospital services billed by REHs or affiliated entities, such as services billed under the physician fee schedule or services provided by rural health clinics or distinct-part skilled nursing facilities.
- 8 This range was derived from the confidence interval of our regression estimates.
- 9 In calculating the FFS Medicare marginal profit on services paid under the IPPS and OPPTS, we exclude FFS Medicare uncompensated-care payments since each hospital's annual amount does not vary with volume.
- 10 The hospital mortality- and readmission-measure results include only hospitals paid under the IPPS because that is the focus of the Commission's work on payment adequacy in this chapter. CAHs are not included for this reason. Also, CAHs (which are paid on costs) have less incentive to code comorbidities because they do not affect payment, which affects the risk adjustment of measure results.
- 11 The H-CAHPS national response rate for 2023 was 23 percent. The response rate for other provider-focused CAHPS surveys is similar (e.g., the Home Health Care CAHPS response rate was 24 percent, and the Hospice CAHPS response rate was 29 percent).
- 12 In 2023, the all-payer operating margin among the hospitals in the highest quartile of the DSH metric was 4.7 percent (1 percentage point higher than the 3.7 percent among those in the highest quartile of MSNI). In addition, the spread in all-payer operating margin between the highest and lowest quartile was wider for the MSNI than the DSH metric.
- 13 The low-income share of Medicare volume was previously based on FFS Medicare inpatient and outpatient volume. This year, on the inpatient side, we calculated the percentage of FFS and MA Medicare inpatient stays that were for low-income beneficiaries using the Medicare Provider Analysis and Review and inpatient encounter data. On the outpatient side, we continued to use the percentage of Medicare FFS outpatient volume that was for low-income FFS beneficiaries, but we plan to incorporate MA outpatient data in the future. The Medicare share of all-payer volume now incorporates both FFS- and MA-covered inpatient and outpatient volume using data from the Medicare cost reports. This component of the MSNI was previously based only on FFS- and MA-covered inpatient volume.
- 14 We reviewed the most recent financial statements for six large hospital systems: three for-profit systems (Community Health Systems, HCA Health Care, and Tenet Health) and three nonprofit systems (Ascension, CommonSpirit, and Trinity Health). Together, these six systems represent about 20 percent of all hospitals. In calculating the all-payer operating margin, we define operating expenses such as salaries, supplies, lease and rent, depreciation and amortization, and other operating expenses that are not one-time expenses unrelated to same-store operations.

- 15 As described in the Commission's March 2024 report, Chapter 3, text box on p. 70, CMS changed payment policies in response to a 2022 Supreme Court ruling. CMS reprocessed CY 2022 claims for drugs that hospitals obtained through the 340B Drug Pricing Program and provided lump-sum payments for 340B drugs provided in 2018 to 2021.
- 16 The payments and costs for IPPS and OPPS services include those for services determined by IPPS and OPPS base rates as well as uncompensated-care payments made under the IPPS and payments and costs for separately payable drugs under the OPPS.
- 17 Like last year, we report a FFS Medicare margin including a portion of coronavirus relief funds (based on FFS Medicare's share of 2019 all-payer operating revenue) because coronavirus relief funds were intended to help cover lost revenue and higher costs—including lost revenue from FFS Medicare patients and costs to treat these patients. Under the prior methodology, hospitals' FFS Medicare margin in 2023 was -12.4 percent when including relief funds and -12.7 percent exclusive of relief funds.
- 18 The Congress suspended the 2 percent sequestration on Medicare payments from May 1, 2020, through March 31, 2022; applied 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. Therefore, a smaller sequester reduction to Medicare payments was in effect for part of hospitals' FY 2022 cost-reporting period, but the full sequester reduction applied to all (or virtually all) of their 2023 cost-reporting period.
- 19 The growth in FFS Medicare spending on separately payable drugs reflects both the continued historical trend of faster growth and a policy change. Effective CY 2022, CMS increased the payment rate for non-pass-through separately payable drugs acquired through the 340B Drug Pricing Program from average sales price minus 22.5 percent to average sales price plus 6 percent. Because the average sales price plus 6 percent is higher than hospitals' aggregate costs of acquiring these drugs, growth in separately payable drugs increases hospitals' FFS Medicare margin.
- 20 The FFS Medicare margin on inpatient services is bolstered by inpatient-centric add-on payments for hospitals with certain characteristics (i.e., teaching hospitals, DSH hospitals, and certain rural hospitals). Conversely, the FFS Medicare margin on outpatient services is bolstered by the inclusion of separately payable drugs, which are paid at the average sales price plus 6 percent, and of which a subset—drugs through the 340B Drug Pricing Program—can be obtained by hospitals at significantly reduced prices. However, cost reports only measure drug-acquisition costs jointly across inpatient and outpatient services. Therefore, we cannot precisely differentiate between inpatient and outpatient margins.
- 21 Using the prior methodology, in 2023 for-profit hospitals' FFS Medicare margin including relief funds was 0.8 percent (0.4 percentage points higher than under the new methodology) and nonprofit hospitals' FFS Medicare margin was -13.9. (0.1 percentage point lower than under the new methodology) (data not shown).
- 22 Using the prior methodology, in 2023 rural nonmicropolitan hospitals' FFS Medicare margin including relief funds was -7.4 percent (4.2 percentage points lower than under the new methodology), while urban hospitals' FFS Medicare margin was -12.5 percent (0.3 percentage points higher than under the new methodology) (data not shown). The higher rural nonmicropolitan FFS Medicare margin under the new method in part reflects how hospital-based post-acute care services—which generally have low FFS Medicare margins—are a larger share of FFS Medicare revenue for rural than urban hospitals. In addition, this higher FFS Medicare margin among rural nonmicropolitan hospitals reflects a change in how we allocated costs for routine bed days across inpatient, observation, and swing-bed services. This change in swing-bed cost allocation has a larger effect on rural hospitals since only hospitals in (or reclassified as) rural areas can have swing beds. Previously, we followed the method CMS uses to estimate and carve out swing-bed costs for PPS hospitals: to assume they are equal to regional Medicare skilled nursing facility rates and state Medicaid nursing facility rates. Under the new method, we allocate costs evenly across all routine bed days, regardless of how the bed was used, given that hospitals must staff and equip inpatient beds at inpatient-service levels. If we were to have included swing-bed services in the new methodology, rural hospitals' FFS Medicare margin excluding relief funds would have been over 2 percentage points lower.
- 23 In 2023, about 11 percent of hospitals in our FFS Medicare margin analysis met the definition of “high fiscal pressure” and about 49 percent met the criteria of “low fiscal pressure” (those with a median non-FFS 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 FFS Medicare profits had been zero).
- 24 Although we updated our margin methodology, the results would have been the same under the prior methodology.
- 25 We risk adjust our mortality and readmission rates but do not adjust for patient income, consistent with the Commission's prior recommendations. We do not adjust our costs per unit for economies of scale; however, we exclude from our analyses all hospitals with fewer than 300 FFS Medicare

inpatient stays or fewer than 900 outpatient services. We standardized inpatient and outpatient costs per unit by (1) average patient severity; (2) relative labor costs (as measured by the Commission's recommended alternative wage index); (3) low-income status (as measured by the share of FFS Medicare patients who received the Part D low-income subsidy or were eligible for Medicaid); (4) teaching intensity; and (5) a portion of a hospital's outlier index (as measured by FFS Medicare outlier payments' share of total FFS base payments) since high outlier costs can indicate either unmeasured differences in illness severity or high cost structures.

- 26 We exclude from our analyses all hospitals with fewer than 300 FFS Medicare inpatient stays or fewer than 900 outpatient services. We also exclude hospitals with low shares of Medicaid inpatient days (lower than 5 percent).

- 27 We approximate that, after attempting to allocate costs across inpatient and outpatient services, excluding uncompensated-care payments, hospitals' FFS Medicare margin in 2023 was roughly similar for FFS Medicare patients across inpatient and outpatient settings. The FFS Medicare margin on inpatient services is bolstered by inpatient-centric add-on payments for hospitals with certain characteristics (i.e., teaching hospitals, DSH hospitals, and certain rural hospitals). Conversely, the FFS Medicare margin on outpatient services is bolstered by the inclusion of separately payable drugs, which are paid at the average sales price plus 6 percent, and for which a subset—drugs purchased through the 340B Drug Pricing Program—can be obtained by hospitals at significantly reduced prices. However, cost reports measure drug-acquisition costs jointly across inpatient and outpatient services. Therefore, we cannot precisely differentiate between inpatient and outpatient margins.

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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 2026, replace the current-law updates to Medicare payment rates for physician and other health professional services with a single update equal to the projected increase in the Medicare Economic Index minus 1 percentage point; 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

In 2023, traditional fee-for-service (FFS) Medicare's physician fee schedule paid for about 9,000 types of medical services provided across a variety of care settings. These services included office visits, surgical procedures, imaging, and tests delivered in physician offices, hospitals, skilled nursing facilities, 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 chiropractors, podiatrists, physical therapists, psychologists, and other types of health professionals. The Medicare program and its beneficiaries paid \$92.4 billion in 2023 for fee schedule services billed by about 1.4 million clinicians and delivered to 28.2 million FFS beneficiaries, accounting for just under 17 percent of spending in FFS Medicare. Spending on clinician services by FFS Medicare and its beneficiaries was \$0.7 billion higher in 2023 than in 2022, representing a 0.7 percent increase in total spending. This increase is largely attributable to a 3.3 percent decrease in the number of beneficiaries enrolled in FFS Medicare and 4.2 percent growth in spending per FFS beneficiary.

Assessment of payment adequacy

In 2023 and 2024, most clinician payment-adequacy indicators remained positive or improved, but clinicians' input costs are estimated to have grown faster than the historical trend.

In this chapter

- Are FFS Medicare payments adequate in 2025?
- How should FFS Medicare payments change in 2026?

Beneficiaries' access to care—In the Commission's 2024 survey, Medicare beneficiaries reported access to clinician services that was comparable to or, in most cases, better than that of privately insured people.

In response to a request from the House Committee on Appropriations, our survey began asking respondents to quantify wait times this year. We found that the number of weeks Medicare beneficiaries reported waiting for appointments with new clinicians was comparable to or better than the wait times reported by privately insured people. Our findings are consistent with those of other national surveys, which have found that people ages 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.

Other surveys also find that Medicare beneficiaries report having relatively good access to care. But some subgroups of beneficiaries report more access problems. In our analysis of CMS's 2022 Medicare Current Beneficiary Survey, we found that beneficiaries under age 65 and those with low incomes were more likely to report having trouble getting health care and to report delaying care due to cost compared with other Medicare beneficiaries.

Other surveys indicate that the share of clinicians accepting Medicare is comparable to the share accepting private insurance, despite private health insurers' higher payment rates. And almost all clinicians who bill Medicare accept physician fee schedule amounts as payment in full and do not seek higher payments from patients for fee schedule services.

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 primary care physicians has slowly declined, the number of specialists has steadily increased, and the number of APRNs and PAs has climbed rapidly. The number of clinicians per FFS beneficiary has grown, partially attributable to a decline in the number of FFS beneficiaries.

Interest in becoming a clinician remains high. Over the last 40 years, the number of applicants to U.S. medical schools has grown, exceeding population growth, and has picked up in recent years. The number of APRNs and PAs has grown rapidly, suggesting robust interest in becoming these types of clinicians. In addition, for each year between 2016 and 2021, the number of clinicians who

began billing the fee schedule for the first time was larger than the number who stopped billing the fee schedule.

The number of clinician encounters per FFS beneficiary has increased over time, with faster growth from 2022 to 2023 (4.3 percent) compared with the average annual growth rate from 2018 to 2022 (0.5 percent). Growth rates varied by clinician specialty and type of service. From 2022 to 2023, the number of primary care physician encounters per FFS beneficiary declined by 0.1 percent, specialist physician encounters increased by 2.7 percent, and APRN and PA encounters increased by 10.1 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 2023, risk-adjusted rates of ACS hospitalizations and ED visits remained below (that is, better than) prepandemic levels and continued to vary across health care markets. Between 2022 and 2023, 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 or to their full panel of patients. Instead, we rely on indirect measures of how clinicians' payments compare with the costs of providing services.

To assess clinicians' incentives to treat Medicare beneficiaries versus patients with other types of insurance, we compare Medicare payment rates with private-insurance rates. In 2023, preferred provider organizations' (PPOs') payment rates for clinician services were, on average, 140 percent of FFS Medicare's payment rates—up from 136 percent in 2022. A 2022 survey by the American Medical Association suggests 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).

Since the Commission lacks data that would allow us to determine whether providers' revenues are greater than their costs and whether delivering clinician services is therefore profitable, we examine clinician compensation levels as a rough proxy for all-payer profitability. Clinician compensation levels

suggest that providing clinician services is profitable. In 2023, the median physician earned \$352,000, according to SullivanCotter compensation data. Median compensation for advanced practice providers (e.g., nurse practitioners (NPs), PAs) was lower, at \$138,000, but has been growing more quickly than physician compensation in recent years. From 2019 to 2023, advanced practice providers' compensation grew by 4.4 percent per year, on average, while physicians' compensation grew by 3.3 percent per year. (As a point of reference, inflation averaged 4.5 percent per year over this period.) 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 and many employed physicians' compensation may not be directly tied to fee schedule payments—making clinician compensation an indirect measure of Medicare's payment adequacy. Compensation remained much lower for primary care physicians (\$296,000) than for most specialists in 2023 (e.g., \$496,000 for surgical specialties)—a disparity that may help explain why the share of physicians pursuing primary care in the U.S. has been declining.

Physician fee schedule spending per FFS beneficiary grew for most types of services in 2023, despite payment rates for many types of services declining from 2022 to 2023. Among broad service categories, growth rates were 4.2 percent for evaluation and management services, 4.2 percent for imaging, 3.7 percent for other (i.e., nonmajor) procedures, 7.2 percent for treatments, and 4.9 percent for tests. Spending per FFS beneficiary declined by 0.1 percent for major procedures.

Growth in clinicians' input costs as measured by the Medicare Economic Index (MEI) has moderated from recent highs during the coronavirus pandemic and is expected to moderate further in the coming years. Currently, MEI growth is projected to be 3.3 percent in 2024 and 2.8 percent in 2025. Nevertheless, we anticipate that increases in clinicians' input costs in 2024 and 2025 will be larger than the increases in FFS Medicare payment rates that are scheduled under current law. Although past updates have not kept pace with the growth in clinicians' input costs, the volume and intensity of clinician services per FFS beneficiary have increased substantially over time, suggesting (along with the Commission's broader findings on access to care) that below-MEI updates have not impeded access to date. Increased volume and intensity have also resulted in markedly higher physician fee schedule spending over time.

How should payment rates change in 2026?

Under current law, Medicare fee schedule payment rates are scheduled to increase by 0.75 percent for clinicians in advanced alternative payment models (e.g., accountable care organization models that involve some financial risk) and 0.25 percent for all other clinicians. Given recent inflation, input-cost increases in 2026—which are currently projected to be 2.3 percent—could be difficult for clinicians to absorb. Yet current payments to clinicians appear to be adequate, according to many of our indicators.

Given these mixed findings, the Commission recommends, for calendar year 2026, that the Congress replace the current-law updates to Medicare payment rates for physician and other health professional services with a single update equal to the projected increase in the MEI minus 1 percentage point. Based on CMS's MEI projections at the time of this publication, the update recommendation for 2026 would be equivalent to 1.3 percent, which is above current-law updates of 0.75 percent or 0.25 percent. The recommendation would be a permanent update that would not expire at the end of 2026 and therefore would be built into subsequent years' payment rates. This approach differs from 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 enact our March 2023 recommendation to 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 (LIS).) These add-on payments would increase Medicare payment rates by 15 percent for primary care clinicians and by 5 percent for all other clinicians for fee schedule services furnished to FFS Medicare beneficiaries with low incomes. The Commission has determined 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.

All else being equal, 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 specialty and share of services furnished to beneficiaries with low incomes. 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. (These add-on payments would be paid entirely by the Medicare program; LIS beneficiaries would not owe higher cost sharing.)

We estimate that the combination of the recommended update and safety-net policies would increase fee schedule revenue for the average clinician by 3.0 percent. The effects would vary by provider specialty. We estimate that 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.

This recommendation would balance the need to provide adequate payments to clinicians with the need to limit growth in beneficiaries' cost sharing and premiums. ■

Background

To determine fee-for-service (FFS) Medicare payment rates under the physician fee schedule, CMS establishes relative values for a wide range of services. In 2023, Medicare's physician fee schedule paid for about 9,000 types of medical services.¹ Services' relative values are multiplied by the physician fee schedule's conversion factor (a fixed dollar amount equal to \$32.35 in 2025) to produce a total payment amount for each service.² Medicare's physician fee schedule pays for a wide range of clinician services for FFS beneficiaries, including office visits, surgical procedures, imaging, and tests. When these services are delivered in certain facilities, such as hospitals or ambulatory surgical centers, CMS makes an additional payment through a separate facility 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), resulting in higher spending than if the service were delivered in a nonfacility setting.

Physician fee schedule spending constituted just under 17 percent of spending in FFS Medicare (Boards of Trustees 2024).³ In 2023, the FFS Medicare program and its beneficiaries paid \$92.4 billion for physician fee schedule services, which is \$0.7 billion more than in 2022. This figure represents a 0.7 percent increase in total spending, which is a function of a 3.3 percent decrease in the number of beneficiaries enrolled in FFS Medicare and 4.2 percent growth in spending per FFS beneficiary.

In 2023, just over 1.4 million clinicians, including physicians, advanced practice registered nurses (APRNs), physician assistants (PAs), chiropractors, podiatrists, physical therapists, psychologists, and other types of health professionals, billed the Medicare physician fee schedule for services. The number of clinicians billing the fee schedule in 2023 was higher than the previous year.

Are FFS Medicare payments adequate in 2025?

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 2023 and 2024, most indicators of physician payment adequacy remained positive or improved, but clinicians' input costs grew faster in this period than the historical trend.

Medicare beneficiaries' access to care is comparable to that of the privately insured

Although directly measuring access to care is challenging, most of our indicators suggest FFS Medicare beneficiaries have relatively good access to care. In the Commission's 2024 survey, Medicare beneficiaries continued to report access to care that is comparable to or, in most cases, better than that of privately insured people. The share of clinicians accepting Medicare is high and comparable to 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, although they have the option, as "nonparticipating" providers, to balance bill beneficiaries for higher amounts. If they elect to "opt out" of the program, clinicians treating FFS Medicare beneficiaries can also choose to forgo all FFS Medicare payments and set the price they charge patients—yet few choose to do this. The overall number of clinicians billing FFS Medicare has grown in recent years. The composition of the clinician workforce billing the fee schedule continues to change, with the number of primary care physicians slowly declining, the number of specialists growing at a modest rate, and the number of APRNs and PAs growing rapidly. The number of clinician encounters per beneficiary increased in 2023 for most types of services.

Most beneficiaries report 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 2024 survey was

completed by over 10,000 respondents in the summer of 2024 and, as with prior years, was weighted to produce nationally representative results.⁴ The Commission's survey includes Medicare beneficiaries in both FFS Medicare and in Medicare Advantage (MA) plans. We believe this group is representative of the experiences of FFS beneficiaries because in our and others' analyses of data from CMS's Medicare Current Beneficiary Survey, FFS beneficiaries and MA enrollees tend to report comparable experiences accessing care (Koma et al. 2023, Ochieng and Fuglesten Biniek 2022).

Consistent with last year, our 2024 survey found that Medicare beneficiaries reported access to care that was comparable to or, in most cases, better than that of privately insured people. (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, consistent with prior years.) (See Table 4-A1, p. 135, in this chapter's appendix for some of our key findings for Medicare beneficiaries versus privately insured people.)

We also draw on findings from local focus groups that we conduct to ask beneficiaries and clinicians about their experiences with health care.⁵ New in this year's focus groups, we held separate groups with beneficiaries enrolled in traditional FFS Medicare and those enrolled in MA plans and, where relevant, we highlight similarities or differences in experiences.

Relatively high satisfaction with overall access to care Our 2024 survey found that the vast majority of Medicare beneficiaries ages 65 and over (95 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 (97 percent) compared with privately insured people (93 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 (88 percent) compared with privately insured people (79 percent). In our focus groups, Medicare beneficiaries in both FFS Medicare and MA plans reported high satisfaction

with their insurance coverage, with the vast majority of participants rating their coverage as “excellent” or “good” (NORC at the University of Chicago 2024).

Nearly all Medicare beneficiaries have a primary care provider In our 2024 survey, 96 percent of Medicare beneficiaries reported having a primary care provider (PCP) compared with 91 percent of privately insured people. This finding is consistent with what we gathered from our focus groups, in which nearly all beneficiaries we spoke with reported having a regular source of primary care.

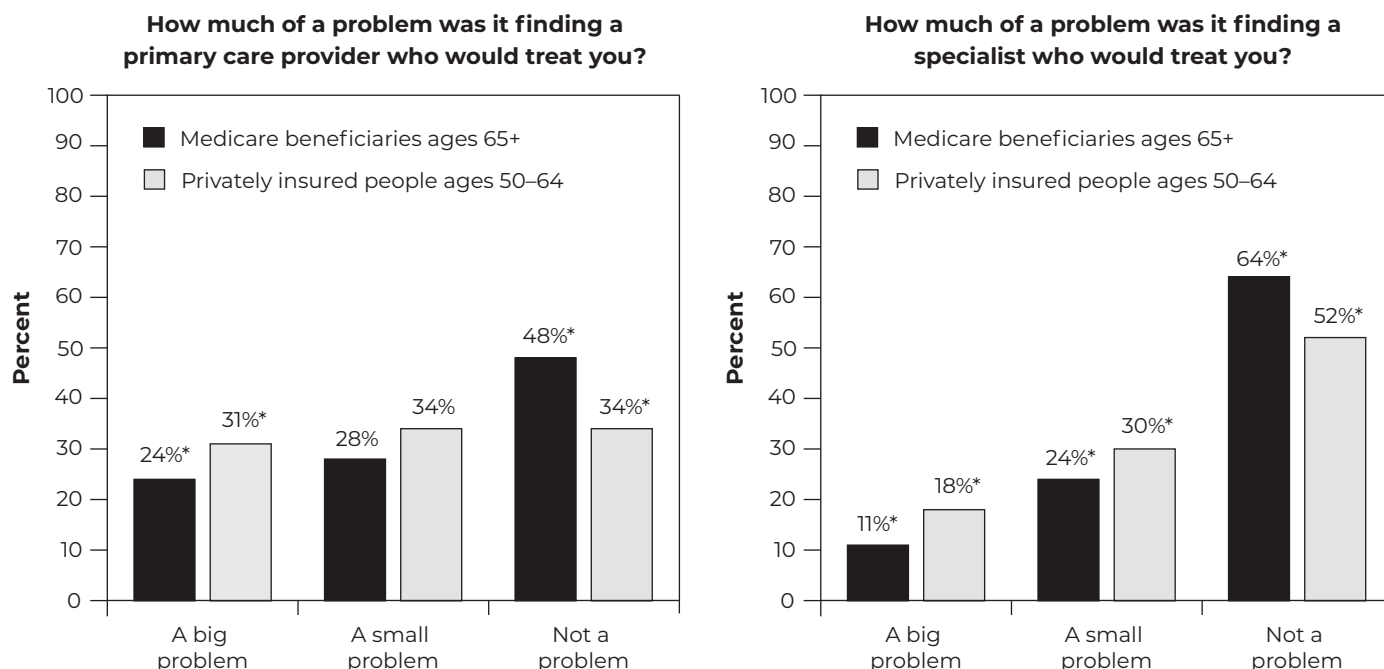
Our survey found that Medicare beneficiaries were slightly less likely to report receiving all or most of their primary care from a nurse practitioner (NP) or PA (19 percent) compared with privately insured people (23 percent). In our focus groups, beneficiaries reported a mix of physicians, NPs, and PAs as their designated PCP. Some beneficiaries reported that they go to practices that employ a mix of clinician types and said that they alternate their appointments among different clinicians or see whoever is available.

Medicare beneficiaries report fewer problems finding a new clinician than privately insured people In our 2024 survey, 11 percent of Medicare beneficiaries and 16 percent of privately insured people reported looking for a new primary care provider. Among those respondents, a smaller share of Medicare beneficiaries reported experiencing a “big” or “small” problem finding a new one (52 percent) compared with privately insured people (66 percent) (Figure 4-1). These amounts are equivalent to 5 percent of all Medicare beneficiaries and 10 percent of all privately insured people experiencing difficulty finding a new primary care provider. In our survey and focus groups, reasons beneficiaries cited for looking for a new PCP included that (1) their former PCP retired, stopped practicing, or moved away; (2) their PCP's practice had changed ownership and the beneficiary's experience of care had been negatively affected; (3) the beneficiary had moved; (4) a PCP was no longer in network; or (5) a PCP had switched to a concierge model.

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 experiencing a “big” or “small” problem finding a new specialist (36 percent) compared with

**FIGURE
4-1****Fewer Medicare beneficiaries reported problems finding a new clinician compared with privately insured people in MedPAC's 2024 survey**

Among survey respondents who tried to get a new [primary care provider/specialist] in the past 12 months . . .



Note: We received completed surveys from 4,926 Medicare beneficiaries and 5,200 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. Components may not sum to 100 percent due to rounding.

* Statistically significant difference between Medicare and private-insurance groups (at a 95 percent confidence level).

Source: MedPAC's 2024 access-to-care survey, fielded by Gallup from July 25 to September 9, 2024.

privately insured people (48 percent) (Figure 4-1). These figures are equivalent to 11 percent of Medicare beneficiaries and 16 percent of privately insured people experiencing a problem finding a specialist, since more people look for a specialist than a PCP in a given year.

Most patients looking for a new mental health professional experience problems finding one In our 2024 survey, 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 8 percent of privately insured people. However, among those looking for a new mental health professional, a majority experienced problems finding one (62 percent of Medicare beneficiaries and 74 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 6 percent of privately insured people experiencing a problem finding a mental health professional. Findings from our survey and other sources suggest that a sizable share of mental health professionals do not accept Medicare or private insurance (Ochieng et al. 2022). For example, a 2024 survey of psychologists found that 34 percent did not accept any type of insurance (American Psychological Association 2024). That survey also found that 53 percent of psychologists did not have openings for new patients.

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 (22 percent). Survey respondents had less difficulty getting an appointment for an illness or injury: Among those needing this type of appointment, only 7 percent of Medicare beneficiaries reported “usually” or “always” waiting longer than they wanted, compared with 14 percent of privately insured people. One theory for our finding 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 who work full time.

In our focus groups, most beneficiaries described having timely access to primary care. For acute issues, beneficiaries reported that they could typically get in faster than they could for a routine visit. We asked beneficiaries about their experiences dealing with urgent medical issues or how they would handle one in the future. Some beneficiaries explained that their approach would depend on the severity of the issue, when it happened (i.e., during or outside of regular business hours), and the distance to different options for care.

For more findings about wait times for different types of appointments, see text box on Medicare beneficiaries’ access to care.

Patients sometimes forgo care but not necessarily due to difficulties accessing it In our 2024 survey, a smaller share of Medicare beneficiaries reported forgoing care that they thought they should have received in the past 12 months (18 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 or they just put it off (cited by about half of those who reported forgoing care). Medicare beneficiaries were much less likely to report forgoing care because they thought it would cost too much (7 percent of those reporting forgoing care) compared with privately insured individuals (23 percent of those reporting forgoing care)—equivalent to 1 percent of all

Medicare beneficiaries and 6 percent of all privately insured people. Among people who reported forgoing care, comparable shares of Medicare beneficiaries and privately insured people reported doing so because they could not get an appointment soon enough (22 percent of Medicare beneficiaries who reported forgoing care and 21 percent of privately insured people who reported forgoing care, equivalent to 4 percent of all Medicare beneficiaries and 6 percent of all privately insured people).

Few differences in access by race/ethnicity in our survey White, Black, and Hispanic Medicare beneficiaries reported similar experiences accessing care, according to most questions in our survey. We did, however, find differences on a few questions. Black beneficiaries were more likely to report “never” waiting longer than they wanted to get an appointment for regular or routine care (60 percent) compared with White beneficiaries (50 percent) and Hispanic beneficiaries (52 percent). And among beneficiaries who had tried to get a new primary care provider, Black beneficiaries were much more likely to report that the reason they did so was that they had switched health insurance plans (e.g., had switched into a new MA plan) and therefore needed to find a provider who participated in the new plan (26 percent) compared with White beneficiaries (7 percent) and Hispanic beneficiaries (5 percent). (See Table 4-A2 (p. 136) in the appendix for additional survey results for White, Black, and Hispanic beneficiaries.)

Few differences between rural and urban beneficiaries’ reported access to care Urban and rural Medicare beneficiaries reported comparable experiences and satisfaction levels on most questions in our survey. That said, there were some differences between these two groups. A higher share of rural beneficiaries reported receiving all or most of their primary care from an NP or PA (30 percent) compared with urban beneficiaries (17 percent). A lower share of rural beneficiaries reported looking for a new specialist (26 percent) compared with urban beneficiaries (33 percent). Among those who needed an appointment for regular or routine care in the past year, rural beneficiaries were more likely to report “never” having to wait longer than they wanted to get an appointment (57 percent) compared with urban

Congressional request on Medicare beneficiaries' access to care

The House Committee on Appropriations requested that the Commission report on Medicare beneficiaries' access to care, including the share of primary care providers that refuse to accept or limit the acceptance of new Medicare patients and Medicare patients' wait times for visits with new primary care providers. We report findings on these key access-to-care indicators in this text box and discuss other access-to-care indicators elsewhere in this chapter (pp. 103-106 and pp. 112-120).

Committee report language

Medicare Beneficiaries' Access to Care.—The Committee is concerned that despite MedPAC's conclusion in its March 2024 Report to the Congress, Medicare and Medicare Advantage patients report longer wait times for routine health care appointments than patients with private health insurance plans. The Committee requests a report on Medicare beneficiaries' access to care, including the share of primary care providers that refuse to accept or limit the acceptance of new Medicare patients and data on Medicare patients' wait times for visits with new primary care providers.

Medicare beneficiaries' wait times for appointments

For many years, the Commission's annual survey has asked beneficiaries and privately insured people how often they experienced excessive waits for various types of appointments (see p. 106). In 2024, we added new questions to our survey that asked respondents to quantify how long their waits were for appointments. We found that among Medicare beneficiaries who tried to get a new primary care provider in the past year, 34 percent reported waiting two weeks or less for their first appointment, another 29 percent waited three to eight weeks, and 18 percent waited more than eight weeks (Figure 4-2, p. 108). Among Medicare beneficiaries who tried to get a new specialist, 33 percent reported waiting two weeks or less for their

first appointment, 44 percent waited three to eight weeks, and 16 percent waited more than eight weeks (Figure 4-2).

Wait times reported by Medicare beneficiaries were comparable to or, in some cases, shorter than those reported by privately insured people. In Figure 4-2, asterisks identify statistically significant differences in the shares of Medicare beneficiaries and privately insured people who reported wait times of particular lengths. For example, Medicare beneficiaries were slightly more likely to be seen by a new primary care provider in one to two weeks and slightly less likely to be seen in three to five weeks compared with privately insured people. Medicare beneficiaries were also slightly more likely to be seen by a new specialist in less than one week and slightly less likely to wait six weeks or more for such an appointment.

These wait times suggest that a small but sizable minority of patients are experiencing substantial wait times for a first appointment with a new clinician. One way to free up time for clinicians to see more patients would be to reduce overly burdensome administrative tasks that consume clinicians' time, such as fee-for-service (FFS) Medicare's Merit-based Incentive Payment System (MIPS), which one study found consumed 202 hours of practice staff time (including 54 hours of physician time) per physician per year (Khullar et al. 2021). The Commission has recommended eliminating MIPS in part because it is overly burdensome and has not produced meaningful quality data for patients or the Medicare program (Medicare Payment Advisory Commission 2018b). MIPS is not the only burdensome quality measure-reporting program that clinicians face; one study estimated that physicians and their staff spend, on average, 785 hours per physician per year dealing with various payers' quality measure-reporting programs and that physicians could care for an additional nine patients per week if they did not have these obligations (Casalino et al. 2016).

(continued next page)

Congressional request on Medicare beneficiaries' access to care (cont.)

Figure 4-2 also shows that among Medicare beneficiaries who tried to get a new primary care provider, 15 percent had not yet scheduled an appointment with a new primary care provider. In

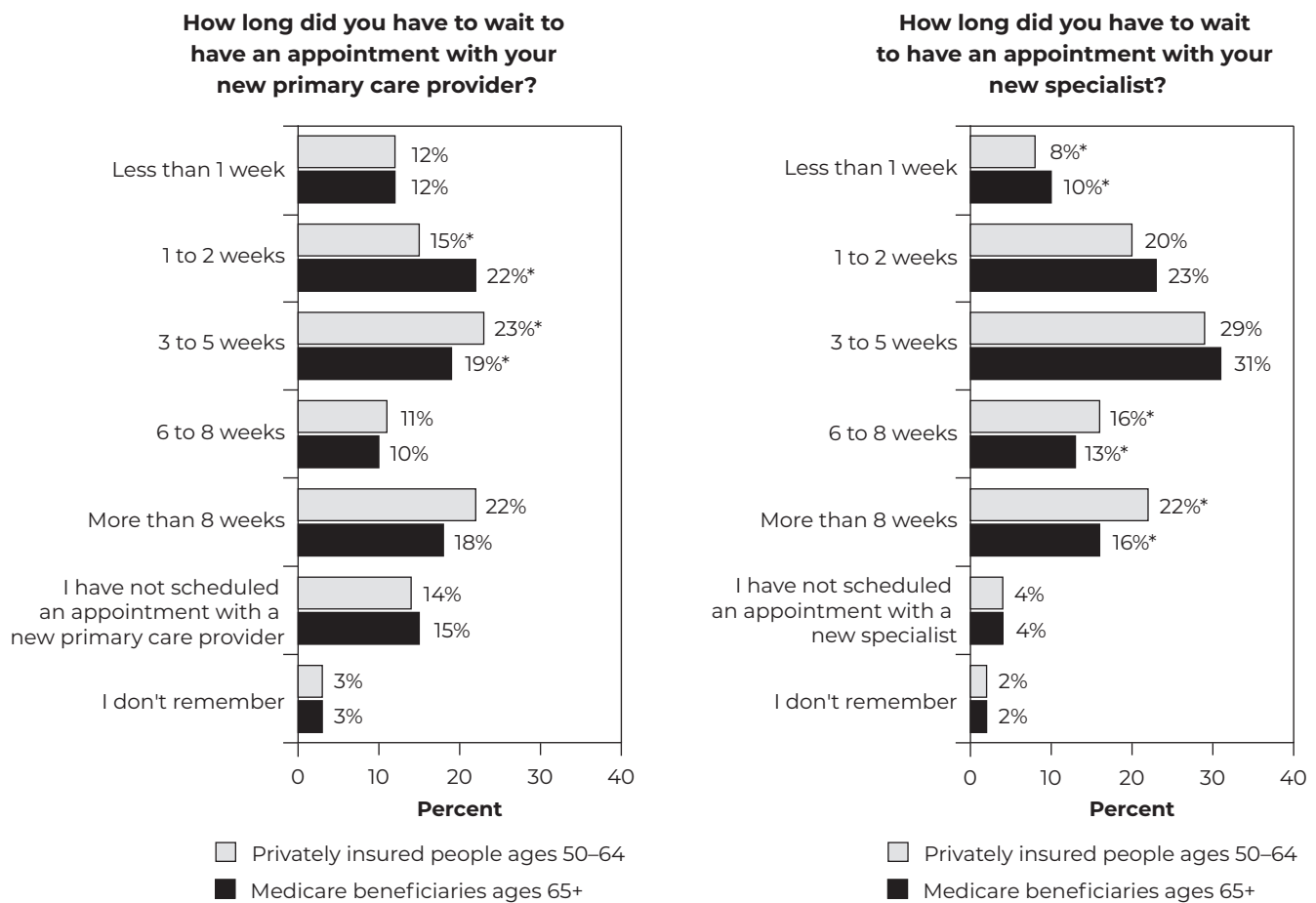
contrast, among those looking for a new specialist, only 4 percent had not yet scheduled their first appointment. (A similar difference was observed among the privately insured.) As noted earlier,

(continued next page)

**FIGURE
4-2**

Medicare beneficiaries' reported wait times for a first appointment with a new clinician were comparable to or better than those of the privately insured, 2024

Among survey respondents who tried to get a new [primary care provider/specialist] in the past 12 months . . .



Note: These questions were asked of only the subsets of survey respondents who reported looking for a new primary care provider in the past 12 months (552 Medicare beneficiaries and 816 privately insured people) and who looked for a new specialist (1,657 Medicare beneficiaries and 1,913 privately insured people). Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. Medicare beneficiaries surveyed include both those with fee-for-service Medicare and those enrolled in Medicare Advantage plans since our analysis of the Medicare Current Beneficiary Survey finds that these two groups of beneficiaries report comparable wait times and MedPAC's survey does not differentiate between these two groups.

* Statistically significant difference between Medicare and private-insurance groups (at a 95 percent confidence level).

Source: MedPAC's 2024 access-to-care survey, fielded by Gallup from July 25 to September 9, 2024.

Congressional request on Medicare beneficiaries' access to care (cont.)

other questions in our survey find that a much higher share of Medicare beneficiaries report problems finding a new primary care provider (52 percent of those looking) than report problems finding a new specialist (36 percent of those looking) (see Figure 4-1, p. 105).

Once beneficiaries find a new clinician and establish a care relationship with them, subsequent appointments seem to be easier to schedule, according to our analysis of CMS's 2022 Medicare Current Beneficiary Survey (MCBS), which is a larger survey fielded among Medicare beneficiaries of all ages. The MCBS does not differentiate between appointments scheduled with new versus existing clinicians, and it finds that among Medicare

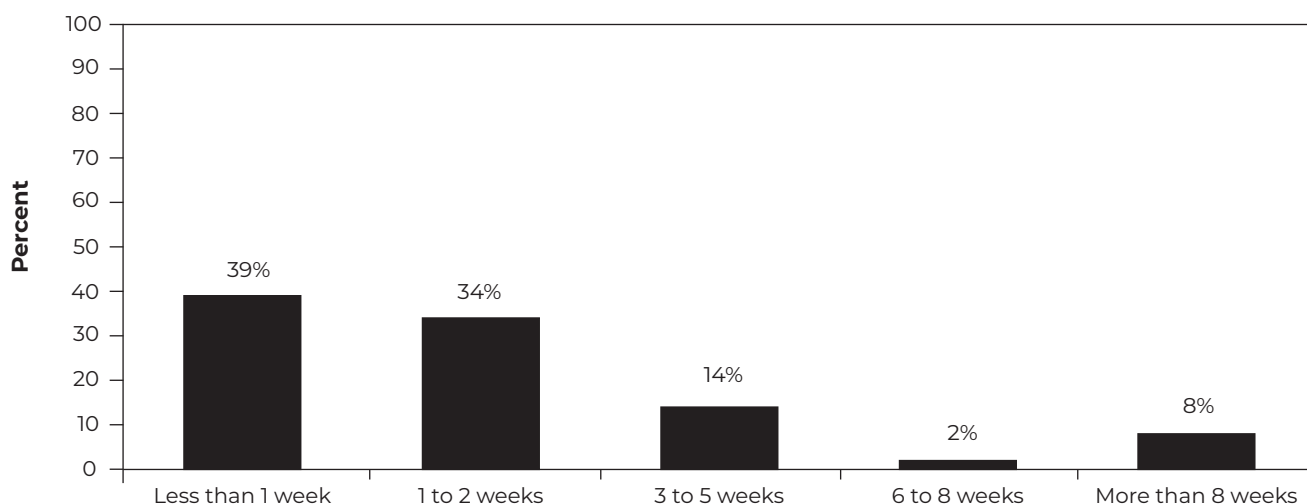
beneficiaries who recently had a doctor's office visit scheduled after the beneficiary reached out to a doctor's office to set it up, 39 percent of these beneficiaries were seen in less than one week and 34 percent were seen in one to two weeks (Figure 4-3).⁶ Another 14 percent reported waiting three to five weeks for their appointment, and 10 percent reported waiting six weeks or longer. These are much shorter wait times than those reported in our survey (shown in Figure 4-2), which focused only on wait times for a beneficiary's first appointment with a new clinician.

In our focus groups, beneficiaries' experiences accessing specialty care varied, with reported wait times as a new patient ranging from a couple

(continued next page)

**FIGURE
4-3**

For doctors' office visits with all types of clinicians (new and existing), most Medicare beneficiaries reported wait times of two weeks or less for their most recent appointment, 2022



Note: The graph reflects the experiences of 3,281 Medicare beneficiaries of all ages (including those under the age of 65) who reported having a doctor's office visit that was scheduled after they contacted a doctor's office to set up an appointment; it does not include appointments scheduled after a provider reached out to a beneficiary to schedule a visit, visits scheduled at a prior visit, or standing appointments. Survey results are weighted to be nationally representative of continuously enrolled Medicare beneficiaries in 2022 (including both those with fee-for-service Medicare and those in Medicare Advantage plans, since our analysis of this survey finds that these two groups of beneficiaries report comparable wait times and MedPAC's survey groups together these two types of beneficiaries).

Source: MedPAC analysis of CMS's 2022 Medicare Current Beneficiary Survey.

Congressional request on Medicare beneficiaries' access to care (cont.)

of weeks to multiple months, with the longest wait times being between 6 and 12 months. Several beneficiaries reported long wait times for specialty care even when dealing with an acute medical issue. Consistent with the survey findings described above, many beneficiaries reported that wait times as a new patient tended to be much longer than as an established patient.

Our analysis of MCBS data also found that, among beneficiaries who had recently scheduled a doctor's office visit, a higher share of beneficiaries reported waiting less than one week for a visit with a primary care physician (44 percent) compared with those seen by a specialist (28 percent) (data not shown). This difference may reflect primary care providers' common practice of squeezing in existing patients for same- or next-day appointments when patients have an urgent health issue (since a core tenet of primary care is providing "first-contact" care to patients when they have a health issue (Starfield et al. 2005)). In contrast, when we looked at visits that had been booked at a prior appointment (which are, presumably, nonurgent), there was no difference by physician specialty in the shares of beneficiaries who reported being seen within one week (34 percent of beneficiaries were seen this quickly, whether they were seen by a primary care physician or a specialist) (data not shown).

Clinicians' Medicare acceptance rates

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

In a 2022 survey by the American Medical Association (AMA), among nonpediatric physicians accepting new patients, 85 percent reported accepting all new Medicare patients and another 11 percent reported accepting some new Medicare

patients; only 2 percent said they accepted only new privately insured patients (American Medical Association 2023b). The AMA survey found that the 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). 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). (One specialty with notably low acceptance of Medicare was psychiatry: Among psychiatrists taking new patients, only 80.7 percent 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 found that Medicare beneficiaries were less likely than privately insured people to encounter providers who did not accept their insurance. Specifically, the survey found that 83 percent of Medicare beneficiaries said they had not encountered a doctor or hospital that was not covered by their insurance in the past year. This figure compares favorably with the 73 percent of people with employer-sponsored insurance and the 57 percent of people with individual health insurance purchased through a Marketplace who

(continued next page)

Congressional request on Medicare beneficiaries' access to care (cont.)

reported not encountering this barrier. The KFF survey also found that 76 percent of Medicare beneficiaries said they had not encountered a doctor who was covered by their insurance but lacked available appointments in the past year; in contrast, only 61 percent of people with employer-sponsored insurance and 57 percent of people with Marketplace insurance reported not encountering this barrier (Pollitz et al. 2023).

Our own survey has found that Medicare beneficiaries are less likely to encounter a doctor's office that does not accept their insurance compared with privately insured people. In 2024, among Medicare beneficiaries who had problems finding a new primary care provider in the past year, 14 percent reported encountering a doctor's office that did not accept their insurance (equivalent to 1 percent of all Medicare beneficiaries). In contrast, among privately insured people who had problems finding a primary care provider, 27 percent encountered a doctor's office that did not accept their insurance (equivalent to 3 percent of all privately insured people). A similar trend was observed for specialists: Among Medicare beneficiaries who had problems finding a new specialist, 13 percent reported encountering a doctor's office that did not accept their insurance (equivalent to 1 percent of all Medicare beneficiaries), while among privately insured people who experienced a problem finding a new specialist, 27 percent encountered a doctor's office that did not accept their insurance (equivalent to 4 percent of all privately insured people).

CMS administrative data also confirm that a high share of clinicians accept Medicare. In 2023, 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 2023, 99.7 percent of fee schedule claims were paid at Medicare's standard payment rate. If clinicians elect to opt out of the program, they can choose the price they charge patients and bill beneficiaries directly for their services but receive no payment from Medicare. The number of clinicians who opted out of Medicare as of September 2024 (46,400) was extremely low compared with the 1.4 million clinicians who participated in the program in 2023 (Centers for Medicare & Medicaid Services 2024c).⁷

There are many reasons that clinicians may choose to accept FFS Medicare despite payment rates that are usually lower than commercial rates. A sizable share of most clinicians' patients are covered by FFS Medicare, and if these clinicians opted to accept only commercially insured patients, they might not be able to fill their schedules. In addition, almost all hospitals accept FFS Medicare patients, and hospitals may expect their employed physicians to take FFS Medicare patients given the important role these patients play. And although commercial insurers' payment rates may be higher than FFS Medicare's rates, commercial insurers do not pay all claims submitted to them. In contrast, FFS Medicare pays all "clean" claims within 30 days of their receiving a claim (and owes providers interest on any late payments). Commercial insurers also often impose burdensome requirements on clinicians that take time to complete, such as requiring clinicians to complete prior-authorization paperwork. A 2023 survey by the AMA found that physicians complete an average of 43 prior authorization requests per week, requiring 12 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 does not require prior authorization. The relative lack of utilization management and the administrative simplicity of billing FFS Medicare may help offset the program's lower payment rates. ■

beneficiaries (49 percent). Rural beneficiaries were also more likely to report that they were able to be seen by a new primary care provider in one to two weeks (34 percent) compared with urban beneficiaries (among whom only 19 percent reported wait times of this length). (See Table 4-A3 (p. 137) in this chapter's appendix for additional survey results for rural and urban beneficiaries.)

Other surveys also find that Medicare beneficiaries report having relatively good access to care Our 2024 survey's overall finding that Medicare beneficiaries reported access to care that is comparable to or, in most cases, 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 having a problem with their health insurance, and less likely to report issues affording medical bills (Pollitz et al. 2023).

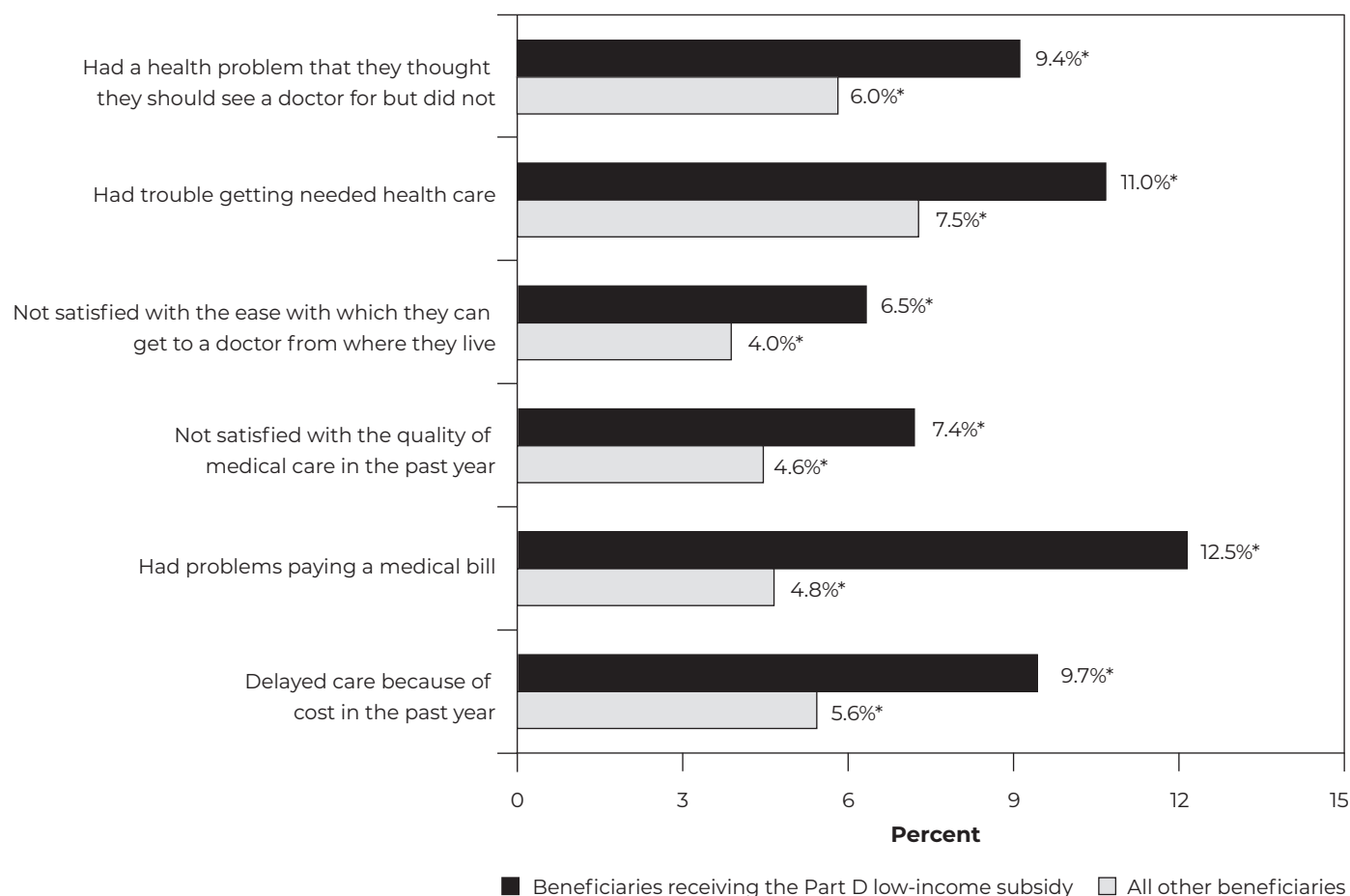
Our survey findings are also consistent with several federally funded surveys that find that Medicare-aged people report better access to care than younger adults—which could mean that gaining Medicare coverage makes it easier for some people to access health care. For example, data from the Medical Expenditure Panel Survey and the National Health Interview Survey have been combined to find that around age 65, when most people gain eligibility for Medicare, there are fewer reports of being unable to get necessary care and being unable to get necessary care because of cost (Jacobs 2021). Analysis of the National Health Interview Survey has also 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 2023). And analysis of the Behavioral Risk Factor Surveillance System survey has found that, compared with people with employer-sponsored or individually purchased private 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).

Our analysis of CMS's 2022 Medicare Current Beneficiary Survey (MCBS) also found that Medicare

beneficiaries reported good access to care. Because the MCBS is an in-depth survey fielded among a large sample of Medicare beneficiaries, this data source allows us to isolate the experiences of FFS beneficiaries, specifically (in contrast to our own survey, which does not differentiate between FFS beneficiaries and MA enrollees). In 2022, the MCBS found that 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 customary care provider usually or always spent enough time with them, and 90 percent were satisfied with the availability of care by specialists. A relatively small share (8 percent) reported experiencing trouble getting care in the past year—more often due to cost than to clinicians not accepting Medicare. Most beneficiaries (85 percent) said they were satisfied with their out-of-pocket costs for medical services, but a small share (4 percent) had a problem paying a medical bill.

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 have disabilities). For example, our analysis of 2022 MCBS data found that beneficiaries under the age of 65 were twice as likely as beneficiaries ages 65 and over to report having trouble getting health care (15 percent vs. 7 percent) and to report forgoing care that they thought they should have received (12 percent vs. 6 percent). They were over three times more likely to report having a problem paying a medical bill (18 percent vs. 5 percent) and to report delaying care due to cost in the past year (16 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 the older group (Cubanski et al. 2016, Medicare Payment Advisory Commission 2023a).

Beneficiaries with low incomes report obtaining less care In general, beneficiaries with low incomes report worse access to care than higher-income beneficiaries (Figure 4-4). Our analysis of 2022 MCBS data found that 9.4 percent of Medicare beneficiaries with incomes and assets low enough to qualify for the Part D low-income subsidy (LIS) reported forgoing care that they thought they should have received in the past year, compared

**FIGURE
4-4****Low-income Medicare beneficiaries report worse access to care than higher-income beneficiaries, 2022**

Note: Beneficiaries are eligible for the Part D low-income subsidy if (1) they have limited assets and incomes of 150 percent of the federal poverty level or less or (2) they are dually enrolled in Medicare and Medicaid. Survey results are weighted to be nationally representative of continuously enrolled Medicare beneficiaries (including both those with fee-for-service coverage and those enrolled in Medicare Advantage plans).

* Statistically significant difference between beneficiaries eligible and automatically receiving the Part D low-income subsidy versus all other beneficiaries (at a 95 percent confidence level).

Source: MedPAC analysis of CMS's 2022 Medicare Current Beneficiary Survey.

with 6.0 percent of higher-income beneficiaries. LIS beneficiaries were also more likely to report having trouble getting health care compared with higher-income beneficiaries (11.0 percent vs. 7.5 percent). A greater share of LIS beneficiaries was unsatisfied with the ease with which they could get to a doctor from where they live (6.5 percent vs. 4.0 percent) and unsatisfied with the quality of their medical care (7.4 percent vs. 4.6 percent). They were much more

likely to report having problems paying a medical bill (12.5 percent vs. 4.8 percent) and more likely to delay care due to cost (9.7 percent vs. 5.6 percent).

Multiple factors may cause beneficiaries with low incomes to report worse access to care than higher-income beneficiaries, such as living in areas with fewer clinicians or being unable to access clinicians (e.g., due to cost concerns, transportation issues, local clinicians not taking new patients). For example, studies have

The Commission's 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). The Commission reaffirmed this recommendation in its March 2024 report to the Congress (Medicare Payment Advisory Commission 2024). 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).⁸ 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 beneficiaries with low incomes 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.⁹ 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).

Using 2019 data, we estimate that providers were unable to 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 these low-income beneficiaries, and it would thus reduce the financial penalty involved in treating these patients.

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found that the number of primary care physicians and PAs per capita tends to be lower in low-income counties compared with higher-income counties; in contrast, NPs are more evenly distributed across counties or even slightly more prevalent in counties with lower incomes (Davis et al. 2018, Liu and Wadhera 2022, Xue et al. 2019).

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).

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

From 2018 to 2023, the total number of clinicians billing the fee schedule increased by an average of 2.2 percent per year, faster than FFS Medicare enrollment growth. The mix of clinicians has also changed over time.

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

Some clinicians treat a disproportionate share of low-income beneficiaries. Nine percent of primary care clinicians and 8 percent of non-primary care clinicians who billed the physician fee schedule in 2019 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 low incomes are at risk of lower revenue, we support providing a higher add-on rate for services furnished by primary care clinicians (including providers such as nurse practitioners and physician assistants) because they typically serve as a beneficiary's primary point of contact with the health care system. In addition, primary care clinicians generally receive less Medicare revenue and total compensation than specialists, and thus they have a greater need for safety-net payments (Neprash et al. 2023). Concerns have also been raised about the decline in the number of primary care physicians who serve fee-for-service beneficiaries and declining numbers of new physicians choosing to specialize in primary care, which safety-net payments could help address.

Using 2019 data, all else being equal, 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 in 2019. 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 for 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 (1) many LIS beneficiaries are already enrolled in plans designed for enrollees who are dually eligible for Medicare and Medicaid and (2) plans can operate their own initiatives to support clinicians who serve low-income beneficiaries. ■

We limited this part of our analysis to clinicians who billed for more than 15 FFS 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).¹⁰ 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 (p. 116) provides both the absolute number of clinicians who billed the fee schedule for more than 15 beneficiaries and the number of clinicians who met that threshold per 1,000 FFS Medicare beneficiaries. In prior reports, when calculating clinician-to-beneficiary ratios, we have included the total number of Medicare Part B beneficiaries enrolled in either FFS Medicare or MA in the denominator (i.e., the total number of

**TABLE
4-1****The number of clinicians billing Medicare's physician fee schedule has increased, and the mix of clinicians has changed, 2018–2023**

Year	Number (in thousands)					Number per 1,000 FFS 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
2018	139	462	237	174	1,012	4.2	13.9	7.1	5.2	30.4
2019	138	468	258	180	1,044	4.2	14.2	7.8	5.4	31.6
2020	135	468	268	172	1,043	4.2	14.5	8.3	5.3	32.3
2021	134	472	286	180	1,072	4.3	15.3	9.3	5.8	34.8
2022	133	477	308	184	1,102	4.5	16.1	10.4	6.2	37.2
2023	132	483	327	189	1,131	4.6	16.8	11.4	6.2	39.5

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. Numbers exclude nonperson providers, such as clinical laboratories and independent diagnostic-testing facilities. Components may not sum to totals due to rounding.

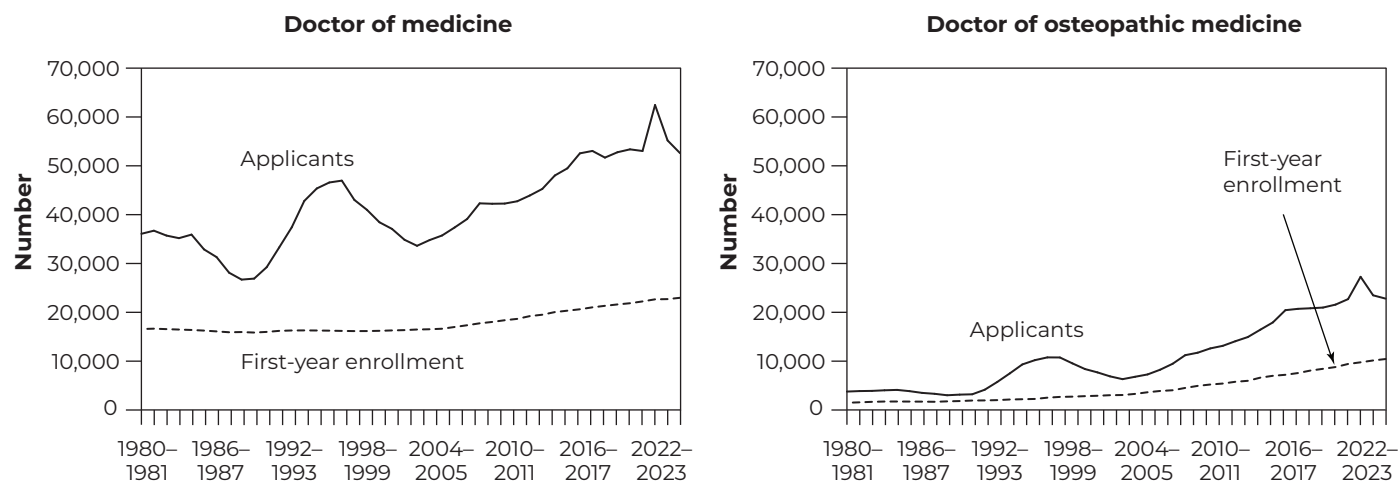
Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and the 2024 annual report of the Boards of Trustees of the Medicare trust funds.

Medicare beneficiaries). We included both groups of beneficiaries because there was an assumption that all clinicians furnished services to both FFS and MA beneficiaries, so the clinician per beneficiary ratios should reflect that assumption by including all Part B beneficiaries. However, our analysis of MA encounter data indicates that a small but growing number of clinicians may see only MA beneficiaries and not beneficiaries enrolled in FFS Medicare. Since our count of clinicians is generated from FFS claims, MA-only clinicians would not be included in the numerator (i.e., count of clinicians). Including MA enrollees but not MA-only clinicians creates a mismatch between the numerator and denominator in our ratio calculation. Therefore, we have stopped including MA beneficiaries in the denominator for these calculations and now include only Part B beneficiaries enrolled in FFS Medicare. Although this measure has shortcomings because it does not provide the broadest view of how many clinicians are caring for Medicare beneficiaries,

a FFS-only approach is consistent with the way we calculate encounters, service units, and allowed charges per 1,000 beneficiaries. In the future, we plan to continue analyzing MA encounter data to identify MA-only clinicians and possibly include them in future analyses of access to care.

Using our threshold, we found that the total number of clinicians billing the fee schedule between 2018 and 2023 grew from about 1.0 million to 1.1 million. Over the same period, the total number of clinicians per 1,000 FFS Medicare beneficiaries increased from 30.4 to 39.5.

While the total number of clinicians billing the fee schedule rose between 2018 and 2023, trends varied by type and specialty of clinician. Since 2018, the number of primary care physicians (which include physicians specializing in family medicine, internal medicine, pediatric medicine, and geriatric medicine, with an adjustment to exclude hospitalists) billing the fee schedule declined from 139,000 to 132,000—a net

**FIGURE
4-5****First-year enrollment and the number of medical school applicants have increased over the last two decades**

Note: Data were accessed on December 16, 2024. For the “doctor of medicine” figure, matriculants are referred to as “first-year enrollment” for comparability across figures.

Source: Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine.

loss of about 7,000 primary care physicians by 2023 (an average annual decline of 1.0 percent). However, the number of beneficiaries enrolled in FFS Medicare also declined over this period. As a result, the number of primary care physicians per 1,000 FFS Medicare beneficiaries increased over the period from 4.2 to 4.6. The total number of specialist physicians grew from 462,000 to 483,000, and the ratio of specialist physicians to every 1,000 beneficiaries increased from 13.9 to 16.8. Over the same five-year period, the number of APRNs and PAs billing the fee schedule grew rapidly from about 237,000 to 327,000 (an average increase of 6.6 percent per year), or from 7.1 per 1,000 beneficiaries to 11.4 per 1,000 beneficiaries.¹¹ Meanwhile, the number of other practitioners, such as physical therapists and podiatrists, increased, as did the ratio of these practitioners per 1,000 beneficiaries.

Interest in becoming a clinician remains high

In the long term, access to health care also depends on new physicians and other types of clinicians entering the workforce. While less immediately related to the adequacy of fee schedule payment rates than some

of our measures, we examine applications to medical school and first-year enrollment as proxies for students’ interest in and ability to become a physician. To supplement this analysis, we also examine the growth of other clinician specialties, such as PAs, and the extent to which clinicians started and stopped billing FFS Medicare.

Physicians in the U.S. hold a degree as either a doctor of medicine (MD) or doctor of osteopathic medicine (DO). Despite year-to-year variations (e.g., an increase in medical school applications during the coronavirus pandemic), the long-term trend reflects an increasing number of applicants and first-year enrollees at both MD- and DO-granting educational institutions (Figure 4-5). For example, from the 1980-1981 academic year to the 2023-2024 academic year, the number of applicants to MD-granting institutions rose from about 36,000 to 53,000, an average increase of 0.9 percent per year, and the number of applicants to DO-granting institutions climbed from about 4,000 to 23,000, an average increase of 4.3 percent per year (Figure 4-5).

In addition, growth in applications and first-year enrollment has exceeded total U.S. population growth and has been faster in more recent years. For example, from the 1980–1981 academic year to the 2023–2024 academic year, first-year enrollment in MD or DO programs combined increased by an average of 1.4 percent per year compared with total U.S. population growth of 0.9 percent per year over the same period. In the most recent decade (from the 2013–2014 to the 2023–2024 academic years), first-year enrollment in MD or DO programs increased even faster (2.3 percent per year), while the total U.S. population grew more slowly (0.6 percent per year).

In addition to physicians, APRNs and PAs represent an increasingly large share of the clinician workforce, and the number of these clinicians has grown rapidly, suggesting robust interest in becoming an APRN or PA. For example, the number of certified PAs in the U.S. has quadrupled over the last two decades, increasing from about 43,500 in 2003 to 95,600 in 2013 to 178,700 in 2023 (National Commission on Certification of Physician Assistants 2023, National Commission on Certification of Physician Assistants 2014).

After medical school, graduates complete a residency (often at a teaching hospital) where they gain additional practical training in delivering medical care. Data suggest that residency programs that train physicians to become specialists usually have an easy time filling all of their available positions, while lower-paid specialties—like family medicine, internal medicine, and pediatrics—and emergency medicine have a harder time filling all of their residency positions and end up filling many positions with international medical school graduates (Murphy 2024, National Resident Matching Program 2024).

The Commission has examined trends in the number of clinicians who stopped billing FFS Medicare, in addition to new clinicians entering the workforce. Annual changes in the number of clinicians who stop billing the fee schedule (exiting clinicians) and start billing the fee schedule (entering clinicians) could signal future access problems for beneficiaries if the number of exiting clinicians exceeds the number of entering clinicians or if there is a large increase in exiting clinicians. For each year between 2016 and 2021, the number of entering clinicians, as a share of all clinicians, was larger than the number of exiting clinicians (Medicare

Payment Advisory Commission 2023c). These trends varied somewhat by specialty. In particular, the share of primary care physicians who exited was higher than the share who entered in multiple years. Nevertheless, in the aggregate, the net growth in the overall number of clinicians suggests that there is an adequate supply to treat beneficiaries.

Academic research suggests that Medicare payment rates have modest effects on physician retirements. For example, one paper found that, among 55- to 70-year-old physicians, a 10 percent increase in professional earnings driven by changes in payment rates leads to a 0.5 percentage point decline in the probability of retirement that year (Gottlieb et al. 2023).

The total number of clinician encounters per FFS beneficiary grew from 2018 to 2023

We use the quantity of beneficiaries' encounters with clinicians as another measure of access to care. We use a claims-based definition of encounters.¹² Clinicians 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. In 2023, about 98 percent of beneficiaries enrolled in FFS Medicare had at least one encounter.¹³

The total number of encounters per FFS Medicare beneficiary grew from 21.8 in 2018 to 23.2 in 2023 (Table 4-2), and the average annual growth rate was 1.3 percent over that period.

The change in the number of encounters per FFS beneficiary varied by specialty and type of provider. For instance, the number of encounters per FFS beneficiary furnished by primary care physicians declined from 2018 to 2023, and the number of per beneficiary encounters provided by other types of clinicians was either stable or increased (Table 4-2).¹⁴ Encounters with APRNs and PAs grew the fastest. Encounters with all types of clinicians declined from 2019 to 2020 due to the effects of the pandemic. These encounters started increasing in 2021, except for encounters with primary care physicians, which remained flat through 2023.

Encounters per beneficiary with primary care physicians fell by an average of 5.9 percent annually from 2018 to 2022. During this period, these

**TABLE
4-2**

Total encounters per FFS beneficiary were higher in 2023 compared with 2018, and the mix of clinicians furnishing them changed

Specialty category	Encounters per FFS beneficiary						Percent change	
	2018	2019	2020	2021	2022	2023	Average annual 2018–2022	2022–2023
Total (all clinicians)	21.8	22.3	19.8	21.6	22.3	23.2	0.5%	4.3%
Primary care physicians	4.0	3.5	3.1	3.1	3.1	3.1	–5.9	–0.1
Specialists	12.8	12.9	11.4	12.3	12.4	12.8	–0.6	2.7
APRNs/PAs	2.2	2.5	2.4	2.7	3.0	3.3	7.9	10.1
Other practitioners	3.3	3.4	2.9	3.5	3.7	4.0	3.1	8.6

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 the 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 2024 annual report of the Boards of Trustees of the Medicare trust funds.

encounters declined by 12.7 percent from 2018 to 2019 and another 11.1 percent from 2019 to 2020; the decline has remained flat since then, falling by just 0.1 percent in 2023.

After declining 11.8 percent from 2019 to 2020 (from 12.9 to 11.4), encounters per beneficiary with specialists grew by 8 percent in 2021 (to 12.3). By 2023, encounters with specialist physicians had almost returned to prepandemic levels, after growing by 2.7 percent from 2022 to 2023.

The largest increase in encounters was among APRNs and PAs, which grew by an average of 7.9 percent from 2018 to 2022 and by 10.1 percent in 2023. There was broad growth across different types of services in APRN and PA encounters: From 2022 to 2023, APRNs and PAs delivered 10.6 percent more E&M services, 14.9 percent more “other procedures,” 9.7 percent more treatment services, 12.4 percent more imaging, and 12.7 percent more tests (APRNs and PAs furnish services in both primary care and non–primary care practices) (data not shown).

The number of encounters with APRNs and PAs has grown rapidly, yet we are likely undercounting the number of fee schedule encounters provided by these clinicians due to “incident-to” billing. 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), which is consistent with the Commission’s own research on this topic (Medicare Payment Advisory Commission 2019). 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

**TABLE
4-3**

Encounters per FFS beneficiary across service types, 2018–2023

Type of service	Encounters per FFS beneficiary			Percent change	
	2018	2022	2023	Average annual 2018–2022	2022–2023
Total (all services)	21.8	22.3	23.2	0.5%	4.3%
Evaluation and management	12.9	13.0	13.5	0.2	3.4
Major procedures	0.2	0.2	0.2	–0.2	2.4
Other procedures	2.3	2.3	2.4	0.0	4.2
Treatments	2.5	2.9	3.2	3.5	9.0
Imaging	4.2	4.1	4.3	0.1	3.5
Tests	2.0	2.0	2.1	0.0	4.9
Anesthesia	0.5	0.5	0.6	–0.3	2.6

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 totals 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 were 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 calculations were made on unrounded data.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and the 2024 annual report of the Boards of Trustees of the Medicare trust funds.

substituting for physician primary care visits or specialty care services.

After a period of relatively slow growth during the pandemic, beneficiaries experienced a return to rapid growth in the number of encounters for most types of medical services. From 2018 to 2022, the number of encounters per beneficiary increased for most types of services, but growth was restrained by the effects of the pandemic (Table 4-3). From 2022 to 2023, encounters grew more rapidly, with some differences across broad service categories. For example, the number of E&M encounters per beneficiary (which includes E&M office visits, hospital outpatient visits, and services provided during an inpatient stay) provided by all clinicians rose 3.4 percent, from 13.0 to 13.5. Over the same period, encounters for major procedures grew at the smallest rate (2.4 percent), while encounters involving treatment (such as physical therapy, treatment for cancer, and dialysis)¹⁵ had the highest growth rate (9.0 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 (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 any given 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

**TABLE
4-4**

Distribution of risk-adjusted rates of ambulatory care-sensitive hospitalizations and emergency department visits across hospital service areas, 2023

	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	22.3	31.4	42.7	1.9
Ambulatory care-sensitive ED visits	38.2	60.5	89.6	2.3

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: Analysis of 2023 FFS Medicare claims data.

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)). 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: Ambulatory care-sensitive hospitalizations and emergency department visits

The Commission worked with a contractor to develop two claims-based outcome measures—ACS hospitalizations and ED visits—to compare quality of care within and across different populations (e.g., FFS Medicare in different local market areas), given the

adverse impact on beneficiaries and high cost of these events (RTI International 2024). 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. However, measure results may also reflect differences in health care access, referral patterns, and specialist availability across markets areas. The measures also may not pinpoint the exact areas in ambulatory care where improvements are needed.

Consistent with previous years, in 2023, the distribution of risk-adjusted rates of avoidable hospitalizations and ED visits per 1,000 FFS Medicare beneficiaries varied widely across Dartmouth Atlas Project-defined hospital service areas (HSAs).¹⁶ 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 2.3 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 increased (worsened) from 2021 to 2023 but remained below prepandemic rates (data not shown). For example, in 2019 the median ACS ED-visit rate per HSA was 75 per 1,000 FFS beneficiaries, which declined to 54.2 per 1,000 FFS beneficiaries in 2021 but rose in 2023 with a median rate of 60.5 per 1,000 FFS beneficiaries in 2023. During the coronavirus pandemic, there was a significant drop in overall ED visits due to people avoiding hospitals for noncritical issues, so we would expect some accompanying decline in ACS ED visits. ACS ED-visit rates remain below prepandemic levels, and it is difficult to untangle whether and how much of the decline in these visits is due to these and other changes in ED use or because of improved access to or quality of care.

Consistent with prior years, we have found differences in rates of ACS hospitalizations and ED visits across groups of Medicare beneficiaries, which could indicate differential access to high-quality ambulatory care (Medicare Payment Advisory Commission 2023b). In 2023, beneficiaries receiving the Part D low-income subsidy (a proxy for low income) had ACS hospitalization and ED visit rates that were 1.3 times higher than those of other beneficiaries. Black beneficiaries had a rate of ACS hospitalizations that was 1.6 times higher than that of Asian/Pacific Islander beneficiaries and a rate of ACS ED visits that was almost two times higher than that of Asian/Pacific Islander beneficiaries. Beneficiaries residing in rural areas had about the same ACS hospitalization rate as beneficiaries living in urban areas. However, beneficiaries in rural areas had ACS ED-visit rates that were 1.4 times higher than beneficiaries residing in urban areas.

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 2022 and 2023, FFS-CAHPS scores were relatively stable. The 2023 FFS-CAHPS score for "getting needed care and seeing specialists" was 80 (score on a scale of 0 to 100), which was the same as in 2022, but the score has been trending downward over the past several years (Table 4-5). The score for "rating of health plan (FFS Medicare)" was 83, and the score for "rating of health care quality" was 85; both scores have been stable over the past few years. In 2023, 73 percent of surveyed beneficiaries reported receiving an annual flu vaccine, which was a decline of 4 percentage points from 2022. All 2023 FFS-CAHPS measure scores for urban residents were similar to the national average (Centers for Medicare & Medicaid Services 2024e). FFS-CAHPS measure scores for rural residents were similar to the national average, except for the annual flu vaccine rate, which was below the national average (data not shown).

Clinicians' revenues and compensation have increased, while 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 to Medicare beneficiaries or to their full panel of patients more generally. Instead, we rely on indirect measures of how clinicians' payments compare with the costs of providing services. We find that clinician compensation has grown in recent years, but that Medicare payment-rate updates have grown more slowly than clinicians' input-cost growth, especially in the last few years. We also find that the volume and intensity of clinician services per FFS beneficiary have increased substantially over time, suggesting that below-MEI updates have not impeded access to date. Increased volume and intensity have also resulted in markedly higher physician fee schedule spending over time.

**TABLE
4-5****Medicare FFS-CAHPS performance scores, 2019–2023**

CAHPS composite measure	2020	2021	2022	2023	Score change, 2022–2023
Getting needed care and seeing specialists	83	81	80	80	0
Getting appointments and care quickly	78	76	75	82	N/A*
Care coordination (e.g., personal doctor always or usually discusses medication, has relevant medical record, helps with managing care)	85	85	85	86	1
Rating of health plan (FFS Medicare)	84	83	83	83	0
Rating of health care quality	86	85	85	85	0
Annual flu vaccine	77	77	77	73	–4

Note: FFS (fee-for-service), CAHPS (Consumer Assessment of Healthcare Providers and Systems), N/A (not applicable). Questions in Rows 1 to 3 have response options of “never,” “sometimes,” “usually,” and “always.” CMS converts these responses to linear mean scores 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. “Plan” in Row 4 refers to the FFS Medicare program. FFS-CAHPS response rates from 2019 to 2023 range from 28 percent to 29 percent. CMS halted collection of the 2019 beneficiary experience survey at the start of the coronavirus pandemic in 2020; thus we do not include 2019 scores.

* CMS revised which CAHPS survey items are scored in the “getting appointments and care quickly” composite measure, which may cause fluctuation in scores compared with prior years. Therefore, we do not report the change in scores over time.

Source: FFS-CAHPS mean scores reported by CMS.

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.¹⁷ (Increasing the conversion factor by 1 percent, for example, 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) a budget-neutrality adjustment if necessary. The statutorily required budget-neutrality adjustment is a percentage calculated by CMS to ensure that any changes it has made to the relative values of specific billing codes in the fee schedule do not, in and of themselves, increase or decrease total fee schedule spending. During years in which the relative values for some services are increased, for example, and CMS anticipates these changes would result in an increase in total fee schedule spending, a negative budget-neutrality adjustment is made to offset those

costs. The net effect of an increase in relative values for some services and an across-the-board downward adjustment in the conversion factor redistributes fee schedule spending among different services but does not increase or decrease expected total spending.

Statutory updates to the conversion factor are currently specified in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (shown in the “Update” rows of Table 4-6 (p. 124)). 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 qualifying clinicians in advanced alternative payment models (A-APMs) and by 0.25 percent per year for all other clinicians.¹⁸ (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 many office and outpatient E&M visits upon the

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 (not cumulative)	5%	5%	5%	5%	3.5%	1.88%*
Other clinicians						
Update	0%	0%	0%	0%	0%	0.25%
MIPS adjustments (not cumulative)**	(-7% to +1.8%)	(-9% to +1.9%)	(-9% to +2.3%)	(-9% to +8.3%)	(-9% to TBD)	(-9% to TBD)
All clinicians						
Payment increase (not cumulative)	3.75%	3.0%	2.5%	1.25% and then 2.93%	N/A	N/A
Sequestration (not cumulative)	0%	0% (3 months), -1% (3 months), -2% (6 months)	-2%	-2%	-2%	-2%

Note: A-APM (advanced alternative payment model), MIPS (Merit-based Incentive Payment System), TBD (to be determined), N/A (not applicable). "Not cumulative" 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 2.93 percent in the latter part of 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). The fee schedule update in 2024 equaled 1.25 percent from January 1, 2024, through March 8, 2024, and was replaced by an update of 2.93 percent from March 9, 2024, through December 31, 2024, at which point the update expired.

* The A-APM bonus is worth 1.88 percent in 2026 and is then not available in subsequent years.

** The maximum positive MIPS adjustments shown for 2021 through 2024 are the highest adjustments actually made in those years, while the maximum adjustments for 2025 and 2026 are yet to be determined.

Source: MedPAC analysis of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA); the Coronavirus Aid, Relief, and Economic Security (CARES) 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.

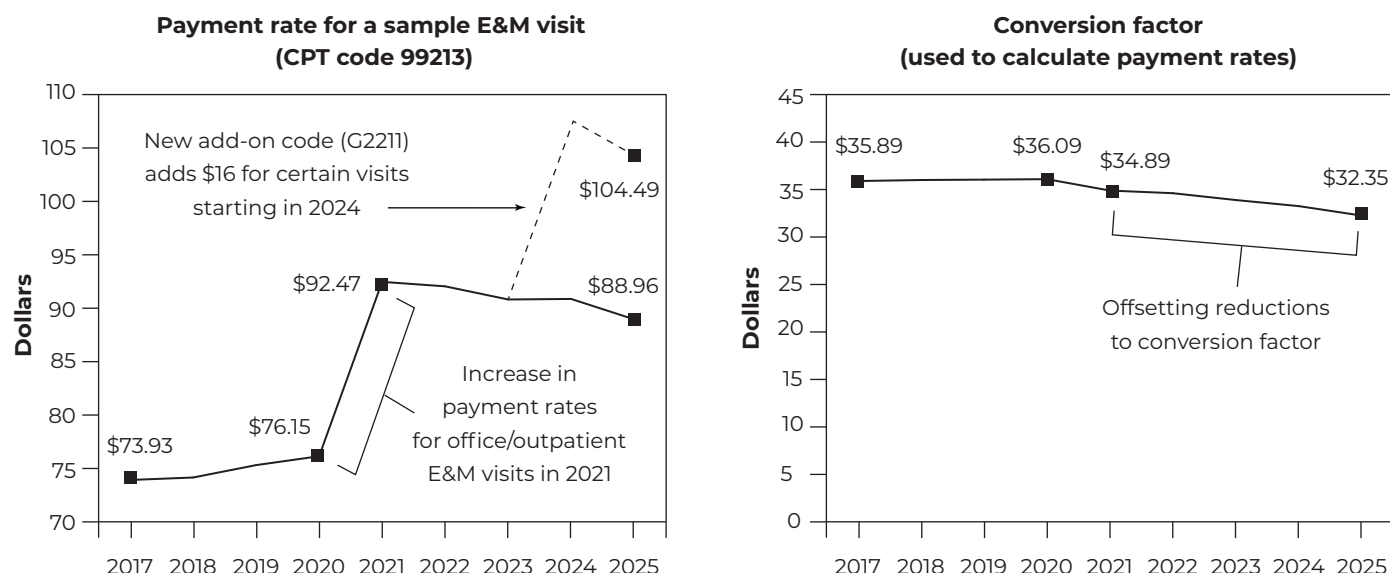
recommendation of the AMA/Specialty Society Relative Value Scale Update Committee. Increasing the payment rates for these billing codes required an offsetting -6.8 percent budget-neutrality adjustment to the fee schedule's conversion factor so that the change in payment rates for E&M visits did not increase expected spending under the fee schedule. 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 temporary increases to the conversion factor from 2021 through 2024 (shown in the "Payment increase (not cumulative)" row of Table 4-6).

These increases effectively phased 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 4-6), while the conversion factor has gradually declined (shown at right in Figure 4-6).

In 2024, part of the 3.4 percent decline in the conversion factor that year (captured at right in Figure 4-6) is also offsetting the cost of a new add-on code that will add another \$16 to the payment rate for office/outpatient E&M visits provided by clinicians

**FIGURE
4-6**

An increase to payment rates for office/outpatient E&M visits and a new add-on payment for certain office visits required offsetting decreases to the physician fee schedule's 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. G2211 is an add-on code available to be billed with office/outpatient E&M visit codes when a clinician has a longitudinal relationship with a patient and meets other requirements.

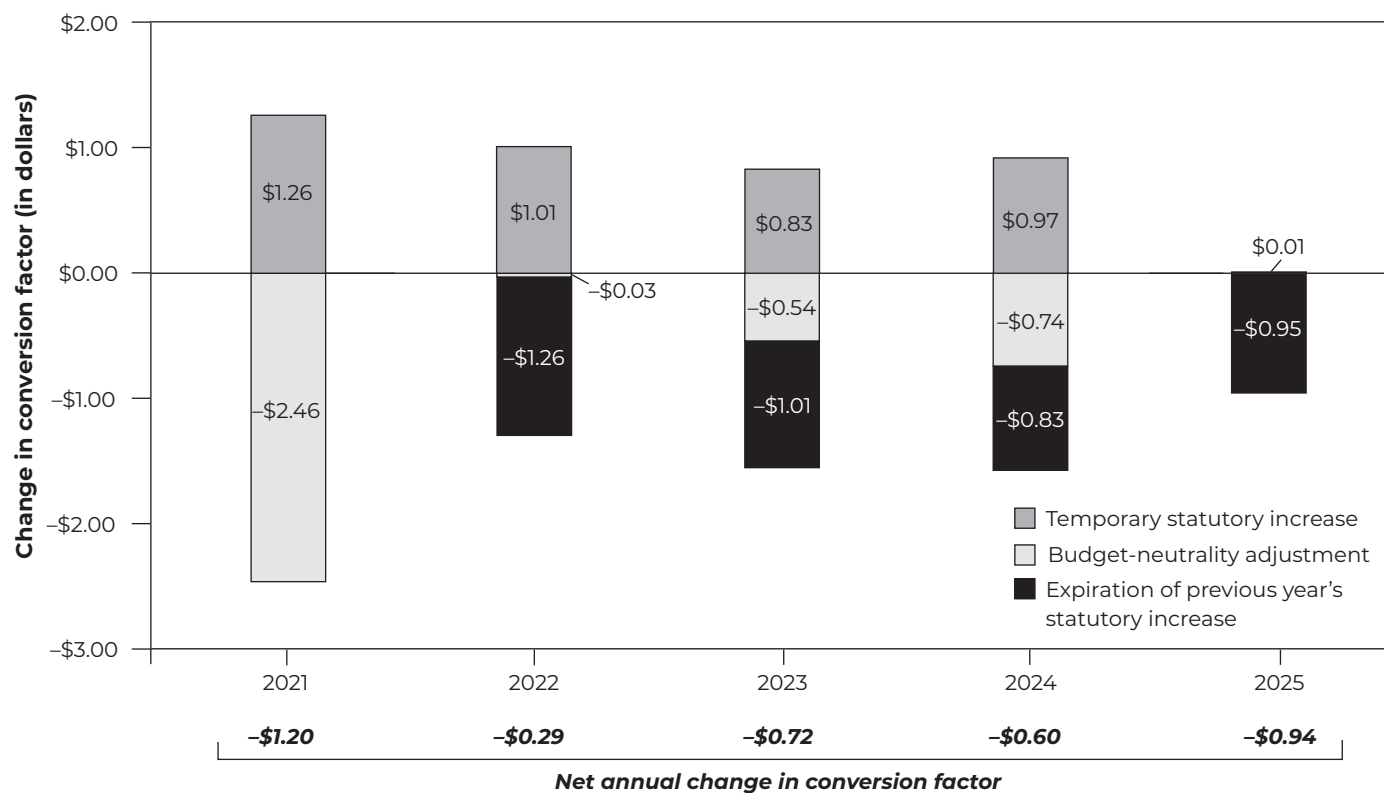
Source: CMS. Search the physician fee schedule (interactive billing code–payment rate look-up website), <https://www.cms.gov/medicare/physician-fee-schedule/search/overview>.

who have an ongoing relationship with a patient (shown as the dotted line in Figure 4-6). 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).

Figure 4-7 (p. 126) shows net annual changes in the conversion factor resulting from budget-neutrality adjustments, temporary one-year increases over the 2021 to 2025 period, and the expiration of those temporary increases.

Figure 4-7 (p. 126) shows that in 2021, when CMS substantially increased relative values for several commonly performed E&M services, the increase in payment rates for these services (combined with other adjustments) required a budget-neutrality adjustment of $-\$2.46$. This adjustment was partially offset by

an increase of $\$1.26$, resulting from the Congress's temporary statutory increase of 3.75 percent in 2021, for a net change in the conversion factor of $-\$1.20$ that year. 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 ($-\$0.54$) from additional increases in E&M values, and the Congress's temporary statutory increase of 2.5 percent ($\$0.83$). In 2024, the net $\$0.60$ decline in the conversion factor resulted from the expiration of the previous year's temporary increase ($-\$0.83$), another temporary increase ($\$0.97$), and a budget-neutrality adjustment ($-\$0.74$) to offset

**FIGURE
4-7****Recent declines in the conversion factor result from several countervailing effects**

Note: Changes shown for 2025 are based on information published in the final rule for the physician fee schedule for that payment year. Components may not sum to totals due to rounding.

Source: Centers for Medicare & Medicaid Services 2024b, Centers for Medicare & Medicaid Services 2023a, Centers for Medicare & Medicaid Services 2022, Centers for Medicare & Medicaid Services 2021, Centers for Medicare & Medicaid Services 2020.

the cost of a new add-on code that added \$16 to the payment rate for office/outpatient E&M visits provided by clinicians who have an ongoing relationship with a patient.

Under current law, there is no scheduled update to the conversion factor for 2025. If there are no statutory changes, in 2025 the conversion factor will be reduced by \$0.94, which would result from the expiration of the temporary 2.93 percent increase in the latter part of 2024 (–\$0.95) and a very small positive budget-neutrality adjustment (\$0.01). In 2025, the conversion factor will be \$3.74 less than what it was in 2020 (data not shown).

Allowed charges per FFS beneficiary grew at a higher rate from 2022 to 2023 than during previous years

Despite the recent reduction in the conversion factor, the total payments that clinicians received per FFS beneficiary grew from 2022 to 2023, in part because of increases in the volume and/or intensity of services they deliver. We measure the total payments a clinician receives using allowed charges (which include Medicare payments and beneficiary cost-sharing liabilities) for services furnished to FFS beneficiaries that are paid under the physician fee schedule.¹⁹

From 2022 to 2023, across all services, allowed charges per beneficiary rose by 4.2 percent (Table 4-7).

**TABLE
4-7****Growth in allowed charges per FFS beneficiary varied by type of service, 2018–2023**

Type of service	Change in units of service per FFS beneficiary		Change in allowed charges per FFS beneficiary		Share of allowed charges, 2023
	Annual average 2018–2022	2022–2023	Annual average 2018–2022	2022–2023	
All services	1.3%	5.4%	2.2%	4.2%	100.0%
Evaluation and management	0.3	3.5	2.8	4.2	51.7
Imaging	0.5	3.8	1.3	4.2	10.8
Major procedures	–0.5	2.1	–0.5	–0.1	6.9
Other procedures	0.7	5.1	1.5	3.7	12.7
Treatments	5.8	11.5	4.4	7.2	10.2
Tests	0.3	5.2	1.1	4.9	4.8
Anesthesia	–0.5	2.3	–0.9	0.3	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. The Restructured BETOS Classification System (RBCS) is used to group clinically similar services into categories and subcategories.

Source: MedPAC analysis of Medicare claims data for 100 percent of FFS beneficiaries and the 2024 annual report of the Boards of Trustees of the Medicare trust funds.

Among broad service categories, growth rates were 4.2 percent for E&M services, 4.2 percent for imaging services, 3.7 percent for other procedures (i.e., procedures that are not considered major procedures), 7.2 percent for treatments, 4.9 percent for tests, and 0.3 percent for anesthesia. Allowed charges per beneficiary for major procedures fell by 0.1 percent. Growth in all categories was higher in 2023 than it was during the 2018 to 2022 period. This period included slow or negative growth during the pandemic, but spending largely rebounded in 2021 and 2022. For most categories, the growth in allowed charges in 2023 was also higher than the average annual rate of growth in the years immediately prior to the pandemic, which averaged 2.0 percent from 2015 to 2019 (data not shown). The exceptions were major procedures and anesthesia, which declined or grew more slowly from 2022 to 2023 than they did over the 2015 to 2019 period.

We also present data on changes in units of service per beneficiary. For most types of service, a unit represents one individual service, such as an office visit, surgical

procedure, or imaging scan. As measured by units of service per beneficiary, the volume of clinician services grew more quickly over the 2022 to 2023 period (5.4 percent) than it did in 2018 to 2022 (1.3 percent per year), which included the pandemic, during which volume for various types of services experienced relatively slow growth or declined (Table 4-7). Volume growth during both periods varied by type of service, but growth rates for all types of service were higher in 2023 than during the 2018 to 2022 period.

The similarity of overall volume and spending growth in 2023 suggests that much of the growth that year was driven by increased volume. Spending can also be affected by increased intensity of the services being delivered, which often does not result in changes in volume. For example, if providers substitute computed tomography (CT) scans with contrast for CT scans without contrast, the allowed charges for imaging services would increase at a higher rate than would units of service for imaging. Differences in allowed charges from volume may also be partly attributable to increases or decreases in Medicare’s payment rates for

certain services, such as the recent increases in rates for E&M services. Decreases in allowed charges relative to service volume can also be related to the shift of services from freestanding offices to the outpatient hospital setting, where fee schedule payments are generally still made but payment rates are lower.

Among the broad service categories shown in Table 4-7 (p. 127), treatments had the highest rate of growth in allowed charges and units of service. 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 13.5 percent from 2022 to 2023 and grew by more than 60 percent over the 2018 to 2023 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, which eliminated annual caps on spending for therapy services for each beneficiary unless a medical exemption was granted. Providers that exceed a specified spending threshold are now permitted to attest to medical necessity by including a modifier on the claims.

Over the same five-year period, spending per beneficiary for major procedures decreased. The decline in spending among major procedures was largely driven by changes in major digestive/gastrointestinal procedures and vascular procedures (average of -4.6 percent and -1.0 percent, respectively). There was also a decline in spending per beneficiary for other (i.e., nonmajor) vascular procedures (average of -3.6 percent). The number of services per beneficiary and payment rates for many of these procedures have declined since 2018, but the number of gastroenterologists and vascular surgeons billing FFS Medicare has been stable.

Average payment rates of private-insurance PPOs grew faster than, and 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.²⁰ In 2023, the average PPO payment rate for clinician services was 140 percent of FFS Medicare's average payment rate, up from 136 percent in 2022.

The ratio in 2023, as in prior years, varied by type of service. For example, private-insurance rates were 109 percent of Medicare rates for care-management and coordination E&M visits but 203 percent of Medicare rates for CT scans.

The gap between private-insurance rates and Medicare rates has grown over time as Medicare rates have increased more modestly than private-insurance rates: In 2011, private-insurance rates were 122 percent of Medicare rates. However, as we noted earlier, clinicians accept Medicare at rates similar to those of private insurance, and some academic research suggests that increasing Medicare fee schedule rates might not necessarily narrow the gap between Medicare and private-insurance rates. Specifically, one paper found that a \$1.00 increase in Medicare rates led to a corresponding \$1.16 increase in private-insurance rates (Clemens and Gottlieb 2017).

The growth in private-insurance rates may result in part from greater consolidation of physician practices and hospitals' acquisition of physician practices, which give providers greater leverage to negotiate higher prices for clinician services with private plans (Medicare Payment Advisory Commission 2020). In recent years, the share of physicians in larger groups and employed by hospitals has risen substantially (Kane 2023). For example, according to an AMA survey, from 2012 to 2022, the share of physicians who were either directly employed by a hospital or part of a practice with hospital ownership increased from about 29 percent to 41 percent (Kane 2023).

Studies have found 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 most cited 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).²¹

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 2024, Medical Group Management Association 2023, Medical Group Management Association 2022, Whaley et al. 2021). A 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, having stable income, not having to pay for malpractice insurance, good work-life balance, working with large teams and staff, and having to spend less time on rules and regulations. The top drawbacks cited were having less autonomy, having to comply with more workplace rules, having less income potential, having to meet mandatory performance targets, lack of job security, and not being as productive as they would like (McKenna 2022).

Clinician compensation is increasing

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 all-payer profitability. Clinician compensation levels indicate that total revenues are greater than costs and that providing clinician services is therefore profitable. These compensation levels also give some assurance 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 and many employed physicians' compensation may not be directly tied to fee schedule payments—making

clinician compensation an indirect measure of Medicare's payment adequacy. That said, academic research suggests that changes in Medicare fee schedule payment rates directly affect physician earnings. One study found that a 10 percent increase in Medicare payment rates led to a 2.4 percent increase in professional earnings of 40- to 55-year-old physicians (Gottlieb et al. 2023).

According to SullivanCotter's latest clinician compensation and productivity surveys, after the high rate of growth observed in median physician compensation from 2021 to 2022 (9 percent), physician compensation grew at a more typical rate from 2022 to 2023 (3 percent).^{22,23}

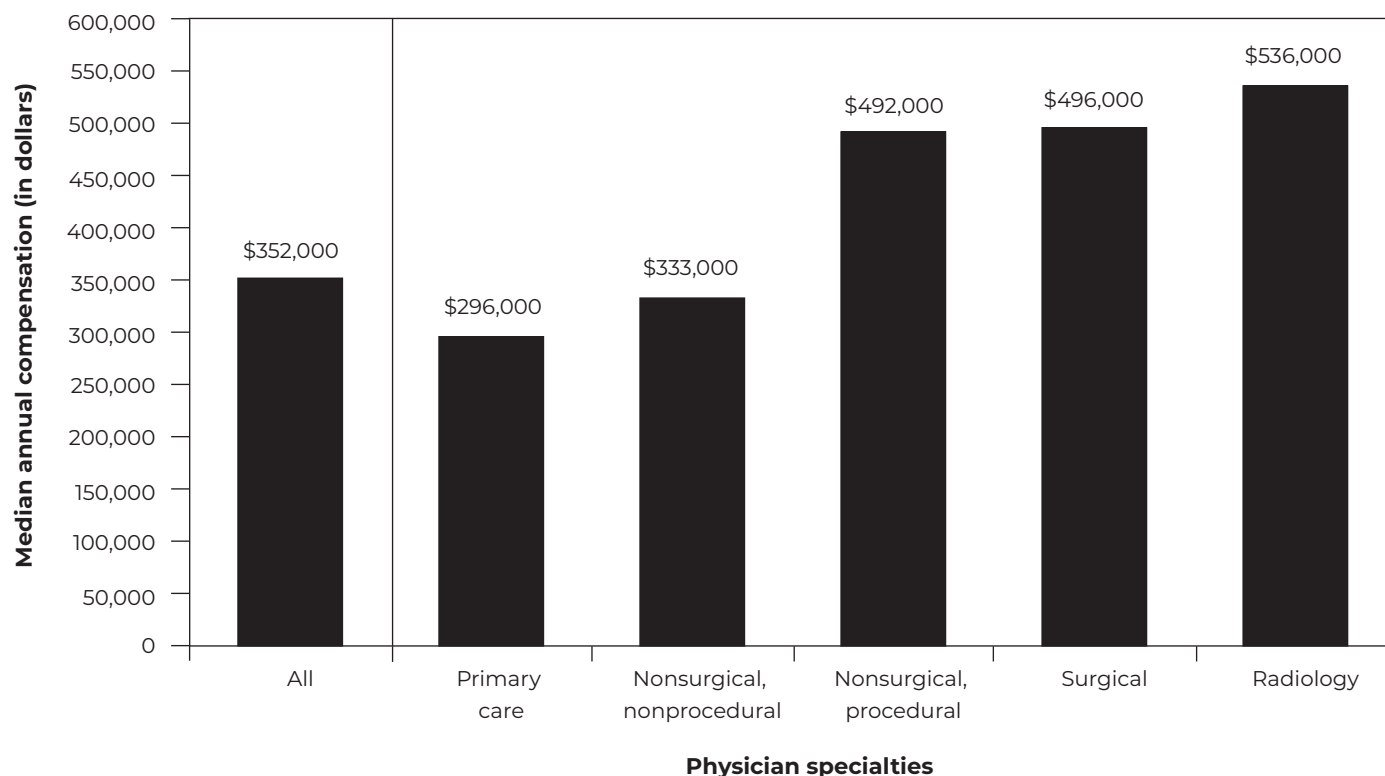
Over a longer, four-year period from 2019 to 2023, physician compensation grew by an average of 3.3 percent per year. (As a point of reference, inflation averaged 4.5 percent per year over this period.) There was substantial variation across physician specialties over this period: Compensation grew more quickly for a number of specialties that mainly provide E&M office visits, such as family medicine (5.0 percent per year, on average), rheumatology (4.8 percent), internal medicine (4.7 percent), and neurology (4.6 percent). Compensation grew more slowly for specialties like pulmonology (1.2 percent), ophthalmology (2.2 percent), nephrology (2.4 percent), radiology (2.5 percent), and dermatology (2.5 percent).²⁴

Median compensation for advanced practice providers (e.g., NPs, PAs) grew twice as fast as physician compensation from 2022 to 2023 (6 percent), in line with the growth rate observed from 2021 to 2022 (5 percent). From 2019 to 2023, compensation for advanced practice providers grew by an average of 4.4 percent per year (keeping pace with inflation).

By 2023, compensation for the median physician was \$352,000, and compensation for the median advanced practice provider was \$138,000.²⁵ As shown in Figure 4-8 (p. 130), physician compensation varied substantially by specialty, with the median primary care physician earning much less (\$296,000) than the median physician in a surgical specialty (\$496,000). In contrast, compensation differences for advanced practice providers in different specialties were much smaller, with only about \$25,000 separating the median clinician in the highest- and lowest-paid specialties (data not shown).

**FIGURE
4-8**

Compensation for primary care physicians is lower than for most specialists, 2023

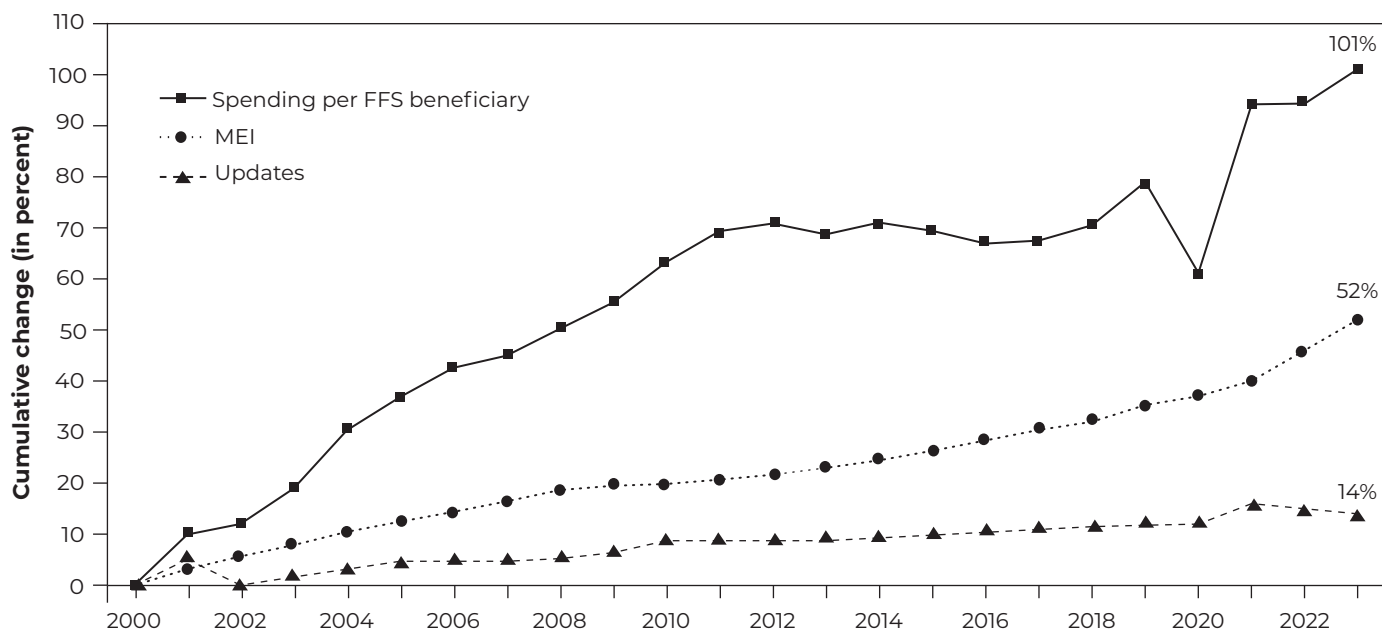


Note: Figure includes all physicians who reported their 2023 annual compensation in the survey ($n = 115,610$). All numbers are rounded to the nearest thousand. "Compensation" refers to median total cash compensation adjusted to reflect full-time work and does not include employer retirement contributions 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, 2024.

The large compensation disparity between primary care physicians and most specialists may help explain why a declining share of physicians are pursuing careers in primary care. However, primary care physicians' incomes have been increasing more quickly than other specialties over the past few years, perhaps due in part to recent increases to payment rates for some billing codes commonly used by primary care providers and new codes that have been added to the Medicare physician fee schedule that are geared toward primary care providers. Primary care physicians' compensation has the potential

to continue to increase in 2025, when new per beneficiary payments will become available to pay for a wide variety of advanced primary care management services such as coordinating care transitions and communicating with patients by email. These new payments will range from \$15 to \$110 per beneficiary per month, depending on a patient's number of chronic conditions and whether they are dually enrolled in Medicare and Medicaid as a qualified Medicare beneficiary. We will monitor the uptake of these new codes.

**FIGURE
4-9****Physician fee schedule spending per FFS beneficiary grew substantially faster than the MEI or fee schedule payment updates, 2000–2023**

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) and include updated total-factor productivity data that CMS released as part of the second quarter of 2024 market basket data. Spending per FFS beneficiary is based on incurred spending under the physician fee schedule. The graph shows updates to payment rates in nominal terms. Fee schedule updates do not include Merit-based Incentive Payment System adjustments or bonuses for participating in advanced alternative payment models. One-time payment increases of 3.75 percent in 2021, 3.0 percent in 2022, and 2.5 percent in 2023 are included.

Source: MedPAC analysis of Medicare regulations, CMS market basket data, and reports from the Boards of Trustees of the Medicare trust funds.

Growth in input costs accelerated in recent years but is moderating

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 increases in 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. Unlike many other market baskets, the MEI has long been adjusted for a measure of productivity growth. Therefore, reported MEI growth figures include a built-in adjustment for total-factor 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).

MEI growth was 1 percent to 2 percent per year for several years before the coronavirus pandemic and was 2.1 percent in 2020.²⁶ MEI growth then increased to 2.3 percent in 2021 and 4.4 percent in 2022. MEI growth slowed slightly to 4.0 percent in 2023 and is projected to moderate further in the coming years—to 3.3 percent in 2024, 2.8 percent in 2025, and 2.3 percent in 2026.²⁷

From 2000 to 2023, cumulative MEI growth has far exceeded updates to physician fee schedule payment rates (Figure 4-9). Over that period, the MEI increased cumulatively by 52 percent compared with 14 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 101 percent over the same time period.²⁸ The substantial growth in volume and intensity (and the Commission's broader finding

that Medicare beneficiaries report relatively good access to care) suggests that below-MEI updates have not impeded access and that simply comparing changes in fee schedule updates with MEI growth is insufficient to capture changes over time in clinicians' ability to provide services to Medicare beneficiaries.

In the past, some research has found that increasing fee schedule payment rates led to reductions in the volume and intensity of fee schedule services and, conversely, that declining payment rates led to increased volume and intensity (Congressional Budget Office 2007, Office of the Actuary 1998). Using this logic, some stakeholders have suggested that the large increases in volume and intensity that have driven the growth in fee schedule spending per beneficiary over more than two decades represent clinicians' responses to fee schedule payment rates that declined (after adjusting for inflation) over that period. However, more recent research suggests a positive relationship between payment rates and volume and intensity: That is, volume and intensity increase as payment rates increase. For example, one study found that, among 40- to 55-year-old physicians, a 10 percent increase in payment rates led physicians to bill 4.4 percent more relative value units (RVUs)—3.9 percent more procedures (nearly all of which is driven by performing procedures on additional patients rather than doing procedures more frequently for the same number of patients) and additional shifts to relatively higher-paid procedures (Gottlieb et al. 2023).²⁹ Other research has found that the relationship between payment rates and the volume of care is greater for elective procedures, such as cataract surgery, than less discretionary services (Clemens and Gottlieb 2014). This evolving body of research suggests that increasing fee schedule rates will likely lead to an increased provision of care, and it could increase Medicare and beneficiary spending.

How should FFS Medicare payments change in 2026?

Under current law, Medicare fee schedule payment rates are expected to grow by 0.75 percent for clinicians in advanced alternative payment models (e.g., accountable care organization models that involve some financial risk) and 0.25 percent for all other

clinicians in 2026. Based on many of our indicators, current payments to clinicians appear to be adequate to ensure access to care. But given recent inflation, ongoing cost increases that exceed payment updates 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 low-income beneficiaries, Medicare should provide additional support to clinicians who serve this population.

RECOMMENDATION 4

The Congress should:

- **for calendar year 2026, replace the current-law updates to Medicare payment rates for physician and other health professional services with a single update equal to the projected increase in the Medicare Economic Index minus 1 percentage point; 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.**

RATIONALE 4

Overall, access to clinician services for Medicare beneficiaries appears to be comparable to, or better than, that of privately insured individuals, though quality of care is difficult to assess. Clinicians' fee schedule payments per FFS beneficiary and their all-payer compensation have continued to rise, but input costs are projected to continue to grow faster than Medicare's payment rates in coming years.

Current law calls for payment rates to increase by 0.25 percent or 0.75 percent in 2026. The Commission is concerned that these relatively low payment increases 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 recommendation is that the Congress replace the

updates set to take effect in 2026 with the projected increase in the MEI for 2026 minus 1 percentage point.

The MEI is currently projected to grow by 2.3 percent in 2026, so this recommendation would yield an estimated increase in payment rates of 1.3 percent (2.3 percent minus 1 percentage point = 1.3 percent) from 2025. 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, the Commission contends that, for reasons set forth in previous years' physician update chapters, it is important to provide additional financial support to clinicians who furnish care to low-income beneficiaries (Medicare Payment Advisory Commission 2024, Medicare Payment Advisory Commission 2023c) (see text box, pp. 114–115). The recommendation therefore calls for the Congress to enact add-on payments to clinicians for physician fee schedule services furnished to low-income Medicare beneficiaries. The add-on payments would equal the allowed charge amounts for physician fee schedule services furnished to low-income beneficiaries multiplied by 15 percent when provided by primary care clinicians and 5 percent for all other clinicians. These new add-on payments would be consistent with the safety-net clinician recommendation in our March 2023 and March 2024 reports.

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. (These add-on payments would be paid entirely by the Medicare program; low-income beneficiaries would not owe higher cost sharing.)

We estimate that relative to payment rates in 2025, the combination of our MEI minus 1 percentage point update and our safety-net add-on payments would increase the average clinician's Medicare fee schedule revenue by 3.0 percent in 2026, 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.

IMPLICATIONS 4

Spending

- Current law is expected to increase payment rates by 0.75 percent for clinicians in advanced alternative payment models and by 0.25 percent for all other clinicians in 2026. This recommendation would increase program spending relative to current law by \$2 billion to \$5 billion in 2026 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 A P P E N D I X A

Key findings from the Commission's 2024 access-to-care survey

**TABLE
4-A1**

Medicare beneficiaries reported access to care that is comparable to or, in most cases, better than that of privately insured people, 2022–2024

Survey question	Medicare beneficiaries (ages 65 and older)			Privately insured (ages 50–64)		
	2022	2023	2024	2022	2023	2024
Providers that 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	97% ^{ab}	–	91% ^a	93% ^{ab}
Providers with 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	88 ^a	–	77 ^a	79 ^a
Long wait for 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	51 ^a	40 ^{ab}	37 ^a	36 ^a
Sometimes	32 ^{ab}	39	37 ^a	40 ^a	40	42 ^a
Usually	8 ^a	9 ^a	9 ^a	12 ^a	14 ^a	14 ^a
Always	4 ^a	4 ^a	4 ^a	8 ^a	8 ^a	8 ^a
For illness or injury						
Never	67 ^a	65 ^a	65 ^a	58 ^{ab}	55 ^a	54 ^a
Sometimes	26 ^a	27 ^a	28 ^a	29 ^a	30 ^a	32 ^a
Usually	4 ^a	6 ^a	5 ^a	8 ^a	10 ^a	9 ^a
Always	3 ^a	2 ^a	2 ^a	5 ^a	5 ^a	5 ^a
Tried to get a new provider: “In the past 12 months, have you tried to get a new . . . ?” (Share answering “yes”)						
Primary care provider	11 ^a	12 ^a	11 ^a	14 ^a	15 ^a	16 ^a
Specialist	26 ^b	32	31	29 ^b	33	34
Problems finding 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?” (Percentages in parentheses are the overall share of all respondents with this insurance.)						
Primary care provider						
Not a problem	46 (5)	45 ^a (5)	48 ^a (5)	38 (5)	32 ^a (5)	34 ^a (5)
Small problem	32 (4)	32 (4 ^a)	28 (3 ^a)	33 (5)	35 (5 ^a)	34 (5 ^a)
Big problem	22 (2 ^a)	23 ^a (3 ^a)	24 ^a (2 ^a)	29 (4 ^a)	33 ^a (5 ^a)	31 ^a (5 ^a)
Specialist						
Not a problem	68 ^a (18)	64 ^a (20 ^a)	64 ^a (20 ^a)	59 ^{ab} (17)	54 ^a (18 ^a)	52 ^a (17 ^a)
Small problem	22 (6 ^{ab})	23 ^a (7 ^a)	24 ^a (8 ^a)	26 (7 ^{ab})	28 ^a (9 ^a)	30 ^a (10 ^a)
Big problem	10 ^a (3 ^a)	13 ^a (4 ^a)	11 ^a (3 ^a)	15 ^a (4 ^{ab})	18 ^a (6 ^a)	18 ^a (6 ^a)
Forgoing care: “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	18 ^a	24 ^{ab}	27 ^a	27 ^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, approximately 5,000 of each group in 2023, and approximately 5,000 of each group in 2024; sample sizes for particular questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage. To account for the longitudinal nature of the data, all comparisons were adjusted for multiple pairwise testing using a Bonferroni correction.

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

^b Statistically significant difference between 2024 and 2023 or between 2024 and 2022 within the same insurance group (at a 95 percent confidence level).

Source: MedPAC’s access-to-care surveys conducted in the summers of 2022, 2023, and 2024.

**TABLE
4-A2**

Few statistically significant differences in White, Black, and Hispanic Medicare beneficiaries' access to care in 2024

Survey question	Medicare beneficiaries (ages 65 and older)			Privately insured (ages 50–64)		
	White	Black	Hispanic	White	Black	Hispanic
Received health care in past year: “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	94%	95% ^a	92% ^a	89%	87% ^{ab}
Providers that 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”)	97 ^a	97	95	92 ^a	95	95
Providers with 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”)	88 ^a	92	89	79 ^a	85	81
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	97 ^a	91 ^a	92	90 ^a
Long wait for 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	50 ^a	60 ^{ab}	52 ^a	36 ^a	44 ^a	32 ^a
Sometimes	37 ^a	34	36	42 ^a	39	48
Usually	10 ^a	3 ^{ab}	8	14 ^a	12 ^a	13
Always	4 ^a	4	3	8 ^a	5	8
For illness or injury						
Never	65 ^a	66	61	55 ^a	62	46
Sometimes	28	29	31	31	28	38
Usually	5 ^a	3	6	9 ^a	6	12
Always	2 ^a	2	2	5 ^a	4	4
Forgoing care: “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	18	21	27 ^a	23	32

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. To account for the longitudinal nature of the data, all comparisons were adjusted for multiple pairwise testing using a Bonferroni correction.

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

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

Source: MedPAC’s access-to-care survey conducted in summer 2024.

**TABLE
4-A3**

Few statistically significant differences between urban and rural Medicare beneficiaries' access to care in 2024

Survey question	Medicare beneficiaries (ages 65 and older)		Privately insured (ages 50–64)	
	Urban	Rural	Urban	Rural
Tried to get a new provider: “In the past 12 months, have you tried to get a new . . . ?” (Share answering “yes”)				
Primary care provider	11% ^a	10%	16% ^a	14%
Specialist	33 ^b	26 ^b	35 ^b	28 ^b
Problems finding 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?” (Percentages in parentheses are the overall share of all respondents with this insurance in this type of geographic area.)				
Primary care provider				
Not a problem	47 ^a (5)	53 (5)	34 ^a (5)	36 (5)
Small problem	29 (3 ^a)	23 (2 ^a)	34 (5 ^a)	40 (6 ^a)
Big problem	24 (3 ^a)	24 (2)	33 (5 ^a)	23 (3)
Specialist				
Not a problem	65 ^a (21 ^{ab})	62 ^a (16 ^b)	52 ^a (18 ^{ab})	49 ^a (13 ^b)
Small problem	24 (8 ^a)	25 (6)	30 (10 ^a)	34 (9)
Big problem	11 ^a (3 ^a)	13 (3)	18 ^a (6 ^a)	18 (5)
Long wait for 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 ^{ab}	57 ^{ab}	34 ^{ab}	45 ^{ab}
Sometimes	38 ^a	33	43 ^a	37
Usually	9 ^a	8	15 ^a	10
Always	4 ^a	3 ^a	8 ^a	7 ^a
For illness or injury				
Never	64 ^a	67	53 ^{ab}	60 ^b
Sometimes	29 ^a	26	33 ^a	27
Usually	5 ^a	5 ^a	9 ^a	10 ^a
Always	2 ^a	2	5 ^a	4
Forgoing care: “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	27 ^a	28 ^a

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. To account for the longitudinal nature of the data, all comparisons were adjusted for multiple pairwise testing using a Bonferroni correction.

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

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

Source: MedPAC’s access-to-care survey conducted in the summer 2024.

Endnotes

- 1 Our count includes unique Healthcare Common Procedure Coding System codes for which Medicare made at least one payment during the year. We treat codes that have modifiers as a single code, and we do not include codes that clinicians could have billed for but did not.
- 2 For further information, see the Commission's *Payment Basics: Physician and Other Health Professional Payment System* at https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_Physician_FINAL_SEC.pdf.
- 3 Although most clinician services are paid under the physician fee schedule, some are paid through federally qualified health centers, rural health clinics, and critical access hospital Method II billing.
- 4 Our survey is fielded among a sample drawn from the Gallup Panel. The Gallup Panel is a probability-based panel generated by random-digit-dial and 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 in English or Spanish, depending on panelists' preferences. We paid respondents a \$5 incentive to complete the survey or \$10 if they were a member of a subgroup whose response rate we were trying to increase. Among eligible individuals invited to participate in our survey, 48 percent completed it. Questions asked of all Medicare beneficiaries ages 65 and over ($n = 4,926$) have a margin of error of ± 1.74 percentage points at the 95 percent confidence level, and questions asked of all privately insured people ages 50 to 64 ($n = 5,200$) have a margin of error of ± 1.75 percent.
- 5 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 2024, 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. New for this year, we held separate groups with beneficiaries enrolled in FFS Medicare and those enrolled in MA for both the Medicare-only and dually eligible beneficiary groups. 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 PAs.
- 6 Other types of doctor's office appointments asked about in the MCBS are appointments scheduled after a provider contacted a patient to schedule a visit, appointments scheduled at a prior visit, and standing appointments.
- 7 Clinicians who opted out of Medicare were concentrated in the specialties of behavioral and mental health (58 percent), oral health (19 percent), and primary care (9 percent) (Centers for Medicare & Medicaid Services 2024c).
- 8 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 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.
- 9 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.
- 10 A substantial number of clinicians bill for 15 or fewer beneficiaries in a given year, but they account for a small share of services and allowed charges. For example, in 2023, 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.
- 11 APRNs include clinical nurse specialists, nurse practitioners, certified registered nurse anesthetists, and certified nurse midwives.
- 12 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.

- 13 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 is found in the 2024 Medicare Trustees' report.
- 14 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.
- 15 Physical therapy includes stretching, strength training (with or without weights), and heat or cold therapy. Medicare beneficiaries are also eligible to receive occupational therapy to treat hand and arm disorders and to help with activities of daily living (such as getting dressed and bathing), and speech therapy, which provides treatment to regain and strengthen speech and language skills.
- 16 The roughly 3,400 Dartmouth Atlas Project-defined HSAs are a collection of ZIP codes whose residents are hospitalized chiefly in that area's hospitals.
- 17 Payment rates for a service can also change because of adjustments to the relative value units for that service.
- 18 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 qualifying for the A-APM bonus, payment adjustments through the Merit-based Incentive Payment System (MIPS), which can be positive, neutral, or negative depending on a clinician's performance on measures of quality, cost, participation in clinical-improvement activities, and use of health information technology. Beginning in 2027, the A-APM bonus will no longer be available, but MIPS payment adjustments will continue for clinicians not in A-APMs. In 2024, about 386,000 clinicians (roughly 27 percent of the clinicians who bill Medicare) received MACRA's A-APM participation bonus (Centers for Medicare & Medicaid Services 2024a). Another 493,000 clinicians received a positive MIPS adjustment to their physician fee schedule payments from Medicare, of up to 8.26 percent (about four times the maximum in past years) (Centers for Medicare & Medicaid Services 2024d). About 87,000 clinicians received a negative MIPS adjustment to their payment rates, up to -9 percent (Centers for Medicare & Medicaid Services 2024d). Another 44,000 clinicians received a neutral (0 percent) MIPS adjustment because their MIPS score was the same as the MIPS performance threshold. We estimate that roughly 430,000 clinicians were ineligible for A-APM bonuses or MIPS adjustments (e.g., because they saw a low volume of Medicare beneficiaries).
- 19 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.
- 20 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 MA claims.
- 21 Less commonly selected reasons for selling a practice to a hospital in the AMA's survey were to better compete for employees, to increase availability of additional services that patients need, and to make it easier to participate in risk-based payment models.
- 22 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.
- 23 The growth rates reported in this statement were calculated using a sample restricted to staff clinicians who were in SullivanCotter's sample in both 2022 and 2023.
- 24 The growth rates reported in this paragraph were calculated using a sample restricted to staff clinicians who were in SullivanCotter's sample in both 2019 and 2023.
- 25 The dollar amounts reported in this sentence were calculated using all staff clinicians in SullivanCotter's 2023 sample.
- 26 MEI-growth data included in this chapter differ from data 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 final rule for payment year 2025 uses MEI growth from the second quarter of 2024 (i.e., actual historical MEI growth from the third quarter of 2023 to the second quarter of 2024). MEI growth reported in this chapter for 2025 is based on projected MEI growth from the fourth quarter of 2025 (i.e., projected MEI growth from the first quarter of 2025 to the fourth quarter of 2025). We also incorporate a productivity adjustment to match the period from which MEI growth was analyzed.

- 27 MEI-growth projections in this chapter are as of the third quarter of 2024 and are subject to change.
- 28 The growth in fee schedule spending per beneficiary, especially during the second half of this period, was restrained by the shift of services from clinician offices to hospital outpatient departments. For example, the Commission found that from 2012 to 2017, had shifts in site of service not occurred, average annual growth in the total number of RVUs billed (RVU values multiplied by units of service) would have been 1.5 percent per year instead of 1.1 percent, with larger differences for imaging services and tests (Medicare Payment Advisory Commission 2019). These figures represent lower-bound estimates of the effects of site-of-service shifts for fee schedule services because we were unable to adjust for shifts among certain types of services, such as radiation therapy, chemotherapy injections, and other tests. While this trend lowers fee schedule spending (because fee schedule payment rates are lower when a service is furnished in a facility), it increases Medicare's total spending generated by fee schedule services (fee schedule spending plus associated hospital outpatient spending).
- 29 Research conclusions on the relationship between prices and volume may vary for several reasons, such as the permanence of the price increase and the population studied. For example, the literature studying the effects of price on utilization for Medicaid beneficiaries is mixed (Medicaid and CHIP Payment and Access Commission 2025).

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CHAPTER

5

Outpatient dialysis services

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

- 5** For calendar year 2026, the Congress should update the 2025 Medicare base payment rate for outpatient dialysis services by the amount determined under current law.

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

Outpatient dialysis services

Chapter summary

Outpatient dialysis services are used to treat most individuals with end-stage renal disease (ESRD). In 2023, about 262,000 beneficiaries with ESRD on dialysis were covered under fee-for-service (FFS) Medicare and received dialysis from more than 7,700 dialysis facilities. In 2023, the FFS Medicare program and its beneficiaries spent \$8.1 billion for outpatient dialysis services.

Assessment of payment adequacy

Our payment-adequacy indicators for outpatient dialysis services are generally positive.

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 2022 and 2023, the number of in-center treatment stations was steady while the number of Medicare beneficiaries on dialysis enrolled in either FFS Medicare or Medicare Advantage (MA) declined, likely due to the excess mortality experienced by the population with ESRD during the coronavirus pandemic. In addition, over the last decade, the adjusted rate of

In this chapter

- Are FFS Medicare payments adequate in 2025?
- How should FFS Medicare payments change in 2026?

new ESRD cases has declined. Between 2022 and 2023, the share of total treatments furnished by freestanding dialysis facilities in the home continued to increase.

- **Volume of services**—The 11 percent decline in FFS treatments between 2022 and 2023 is largely due to the shift of beneficiaries on dialysis from FFS Medicare to MA, after the removal of a statutory provision that had prevented most beneficiaries on dialysis from enrolling in MA plans. The share of beneficiaries on dialysis enrolled in FFS Medicare fell by 18 percent in 2021—the first year of the statutory change—and by about 12 percent annually between 2021 and 2023. At the same time, the per treatment use of ESRD drugs in the payment bundle (including selected erythropoiesis-stimulating agents used in anemia management) has continued to decline since 2010 with little to no measurable impact on beneficiaries' health outcomes.
- **FFS Medicare marginal profit**—An estimated FFS Medicare marginal profit of 17 percent in 2023 suggests that dialysis providers have a financial incentive to continue to serve Medicare beneficiaries.

Quality of care—Rates of all-cause hospitalization, emergency department use, and mortality among FFS beneficiaries on dialysis held relatively steady between 2022 and 2023, as did measures of their experience receiving in-center hemodialysis. The share of beneficiaries dialyzing at home, which is associated with greater 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 prospective payment system (PPS), the two largest dialysis organizations have grown through acquisitions of and mergers with midsize dialysis organizations. In 2023 and 2024, facility closures and consolidations by each of the two largest dialysis organizations aimed to reduce overcapacity related to the increasing use of home dialysis and the decline in patient census in some markets.

FFS Medicare payments and providers' costs—Between 2022 and 2023, FFS Medicare payment per treatment in freestanding dialysis facilities (which provide the vast majority of FFS dialysis treatments) grew by 3 percent while cost per treatment rose by 2 percent. In 2023, a decline in cost growth was observed across most cost categories, including capital, ESRD drugs, and labor.

Consequently, the FFS Medicare margin rose from -1.1 percent in 2022 to -0.2 percent in 2023. We project a 2025 FFS Medicare margin of 0 percent. This projection does not account for the add-on payments for new ESRD drugs and phosphate binders in 2024 and 2025, which may increase FFS Medicare payments relative to facilities' costs.

How should FFS Medicare payments change in 2026?

Under current law, the FFS Medicare base payment rate for dialysis services is projected to increase by 1.7 percent in 2026. Though the FFS Medicare margin is low, other indicators of payment adequacy are generally positive. Thus, the Commission recommends that, for calendar year 2026, the Congress update the 2025 base payment rate for outpatient dialysis services 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 patients on dialysis 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 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 patients with ESRD 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 that result from the loss of kidney function.

In 2023, roughly half of Medicare's beneficiaries with ESRD on dialysis were covered by fee-for-service (FFS) Medicare and half were enrolled in Medicare Advantage (MA).

- In January 2023, roughly 216,400 beneficiaries on dialysis were covered under FFS Medicare while nearly 211,900 beneficiaries on dialysis were enrolled in MA.
- By December 2023, the number of FFS beneficiaries on dialysis declined to 199,800 while the number of MA beneficiaries on dialysis increased to 220,300.

About 7,700 dialysis facilities provided outpatient dialysis services to FFS beneficiaries in 2023. The dialysis sector is highly consolidated, with two large dialysis organizations (LDOs)—Fresenius Medical Care and DaVita—dominating the industry. In 2023, these LDOs accounted for three-quarters of facilities and FFS Medicare treatments. Moreover, in 2023, the five largest dialysis organizations accounted for roughly 87 percent of facilities and FFS Medicare treatments.

Medicare pays facilities that provide dialysis services to FFS beneficiaries using a prospective payment system (PPS) bundle that includes ESRD drugs and services, such as laboratory services.^{1,2} The unit of payment is a dialysis treatment; FFS Medicare's payment rate is based on a regimen of three dialysis treatments

per week. In 2023, the FFS Medicare program and its beneficiaries spent \$8.1 billion for outpatient dialysis services. This total includes nearly \$26 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 2022 (the most recent year of data available), Part D gross spending for ESRD oral-only drugs that have not yet been included in the PPS—several phosphate binders—totaled nearly \$0.7 billion for FFS beneficiaries on dialysis.

Characteristics of fee-for-service beneficiaries on dialysis, 2023

Compared with other FFS Medicare beneficiaries, FFS beneficiaries on dialysis are disproportionately younger, male, and Black or Hispanic (Table 5-1). In 2023, 72 percent of FFS beneficiaries on dialysis were under 75 years old (with 43 percent under 65 years old), 58 percent were male, 29 percent were Black, and 15 percent were Hispanic. By comparison, among other FFS Medicare beneficiaries, 57 percent were under 75 years old (with 10 percent under 65 years old), 45 percent were male, 7 percent were Black, and 5 percent were Hispanic. A greater share of FFS beneficiaries on dialysis resided in urban areas compared with other FFS beneficiaries (84 percent vs. 79 percent).

FFS beneficiaries on dialysis are more likely than all other FFS beneficiaries to have full Medicaid benefits (38 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 (61 percent vs. 23 percent) (data not shown).

Over the last decade, the adjusted rate of new ESRD cases, or incidence rate, in the U.S. population (which includes patients of all types of health coverage who initiate dialysis or receive a kidney transplant) has declined. Between 2012 and 2022 (the most recent year of data available), the adjusted incidence rate decreased by 1 percent per year, from 425 per million people to 381 per million people (United States Renal Data System 2024b). This decline may be attributable to changes such as better management of ESRD-related comorbidities but also to the excess mortality during the coronavirus pandemic.³ We estimate that nearly 65,000 FFS beneficiaries began dialysis in 2023 (a decline of 2 percent compared with 2022).

The share of beneficiaries on dialysis enrolling in Medicare Advantage plans has increased rapidly since 2021

Historically, Medicare beneficiaries with ESRD generally had traditional FFS coverage because they were largely prohibited from enrolling in MA plans, with a few exceptions: Beneficiaries could enroll in a plan specifically designed for ESRD enrollees, and those beneficiaries who had enrolled in MA before being diagnosed with ESRD could stay in the plan after they were diagnosed. Beginning in January 2021, the 21st Century Cures Act permitted beneficiaries on dialysis to enroll in MA plans. As a result of this statutory change, the share of beneficiaries on dialysis enrolled in MA plans increased rapidly from 25 percent in January 2020 to 52 percent by December 2023 (Figure 5-1, p. 154).

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 beneficiaries without ESRD, including the availability of supplemental benefits (e.g., dental, hearing, and vision services) and lower cost-sharing liability. 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. In exchange for additional benefits, MA plan enrollees accept provider networks and utilization-management tools such as higher cost sharing to access providers who are not in their plan's network. A 2021 policy change by CMS that excludes outpatient dialysis facilities from the list of specialty providers subject to Medicare's network-adequacy evaluation could affect access for some MA beneficiaries on dialysis. If MA plans choose to include fewer dialysis facilities in their network, travel time for some MA beneficiaries to a dialysis facility could be affected. Researchers show that increased travel time to a facility increases the number of missed treatments and is associated with worse outcomes for patients, and difficulty with transportation more generally is also associated with missed dialysis treatments and increased morbidity and mortality in patients with ESRD (Moist et al. 2008). (See the Commission's comment letter on changes to the MA program for contract year 2021 for more discussion about proximity to a dialysis facility and dialysis care (Medicare Payment Advisory Commission 2020a).)

**TABLE
5-1****FFS beneficiaries on dialysis are disproportionately young, male, Black, and Hispanic compared with other FFS beneficiaries, 2023**

	Share of FFS beneficiaries:	
	Beneficiaries on dialysis	Other beneficiaries
Age		
Under 45 years	10%	3%
45–64 years	33	7
65–74 years	29	47
75–84 years	21	31
85+ years	7	12
Sex		
Male	58	45
Female	42	55
Race		
White	43	80
Black	29	7
Hispanic	15	5
Asian	6	3
All others	7	4
Residence, by type of county		
Urban	84	79
Micropolitan	9	11
Rural, adjacent to urban	4	5
Rural, not adjacent to urban	2	4

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. Components may not sum to 100 percent due to rounding.

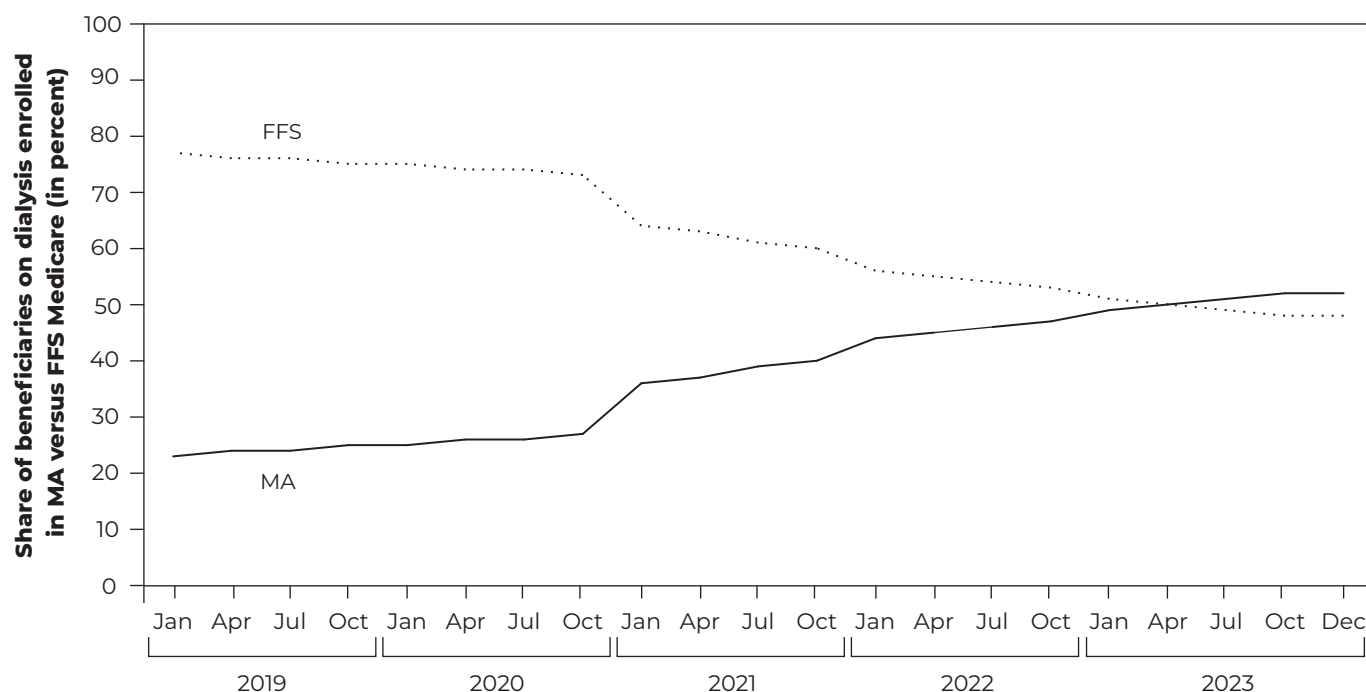
Source: Data compiled by MedPAC from enrollment data and claims submitted by dialysis facilities to CMS, 2023.

Given the magnitude of total health care expenses incurred annually by beneficiaries on dialysis (for dialysis and other outpatient and inpatient services and Part D drugs—averaging nearly \$102,000 in 2022, with beneficiary out-of-pocket liability averaging nearly \$14,000), these beneficiaries face significant out-of-pocket expenses when they are enrolled in FFS with no secondary or supplemental coverage. Thus, they might enroll in MA because MA plans are required by statute to offer a maximum out-of-pocket (MOOP) limit on annual spending that is not

available in FFS Medicare. The mandatory MOOP limit was \$8,850 for in-network services in 2024 (and \$13,300 for in- and out-of-network services covered by preferred provider organizations (PPOs)), but most plans elect to offer a lower MOOP limit: In 2023, about three-quarters of conventional MA plans had MOOPs lower than the mandatory limit (Medicare Payment Advisory Commission 2023). Beneficiaries who have full Medicaid coverage, as well as qualified Medicare beneficiaries (QMBs) with partial dual eligibility, have their cost sharing covered by Medicaid but may

**FIGURE
5-1**

The share of beneficiaries on dialysis enrolling in MA plans continued to increase between 2021 and 2023



Note: MA (Medicare Advantage), FFS (fee-for-service). Beginning in 2021, the 21st Century Cures Act permits beneficiaries on dialysis to enroll in MA plans.

Source: Data compiled by MedPAC from CMS enrollment data and risk-score files, 2019–2023.

still find it desirable to enroll in an MA plan for the supplemental benefits offered (see text box on MA dialysis beneficiaries switching between plans and coverage options, pp. 158–159).

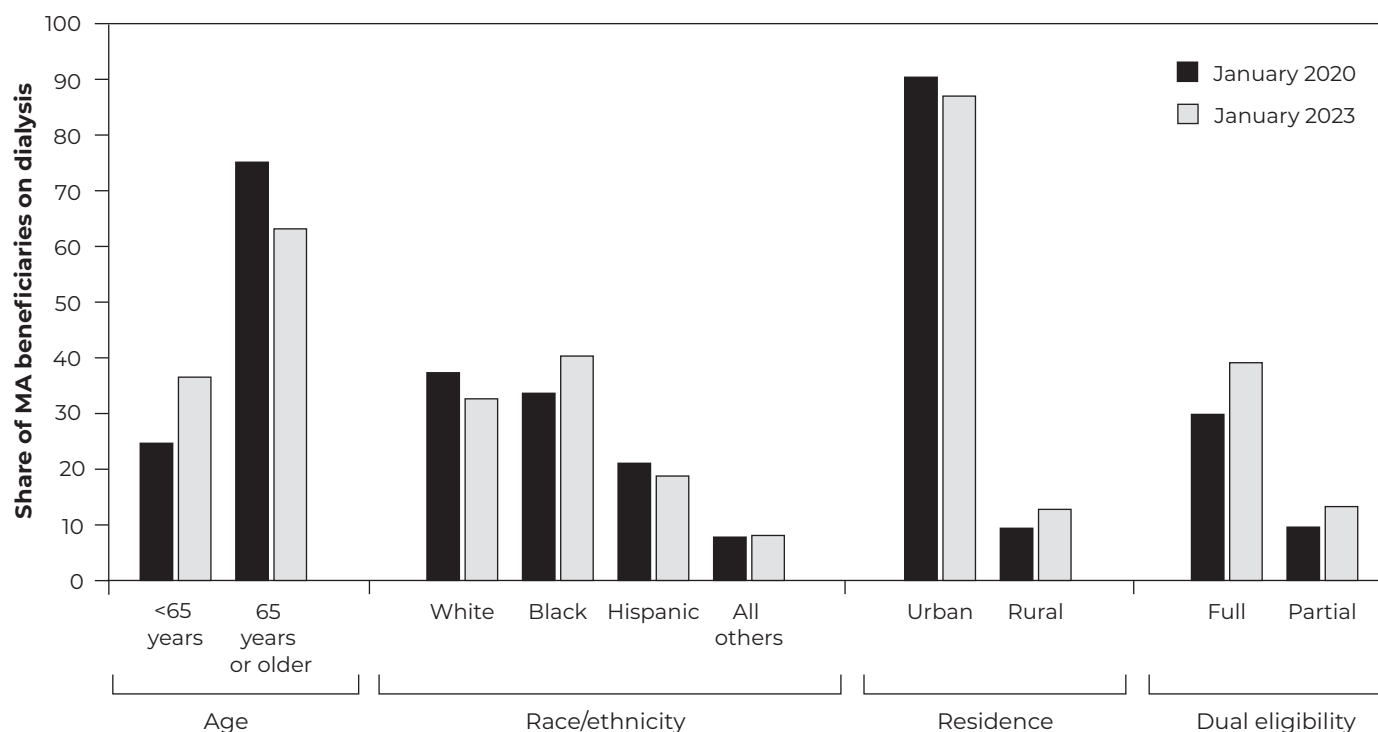
Beneficiaries who do not have their cost sharing covered by Medicaid and prefer FFS Medicare may seek to limit cost-sharing liability by purchasing a Medigap policy; however, beneficiaries with ESRD, particularly those under age 65, may face difficulties obtaining Medigap insurance. Among FFS beneficiaries without cost sharing covered by Medicaid, those on dialysis are less likely to purchase a Medigap plan than FFS beneficiaries who are not on dialysis (32 percent vs. 49 percent in 2023)⁴ 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.⁵

- *The affordability of a Medigap plan.* Even though beneficiaries with ESRD who are under 65 must be offered at least one Medigap plan in 36 states, the insurer can charge a higher premium based on age, sex, or existing health conditions, depending on state insurance-rating rules.⁶

Changes in the characteristics of MA beneficiaries on dialysis, 2020 to 2023 Before the 21st Century Cures Act, beneficiaries with ESRD under age 65 and not already enrolled in MA before the onset of ESRD were

**FIGURE
5-2****The composition of MA beneficiaries on dialysis changed between 2020 and 2023**

Note: MA (Medicare Advantage). Beneficiaries on dialysis were identified using the risk-score file, and fee-for-service Medicare versus MA enrollment was identified using CMS enrollment data. "Residence" reflects the beneficiary's county of residence in one of two categories, urban or rural (the latter category includes micropolitan, rural adjacent to urban, and rural nonadjacent to urban) based on an aggregation of the Urban Influence Codes.

Source: Data compiled by MedPAC from CMS enrollment data, risk-score file, U.S. Census delineation file, CMS-2728, 2020 and 2023.

not eligible to enroll in most MA plans. Since the removal of enrollment barriers in 2021, a greater share of MA beneficiaries with ESRD in 2023 are under age 65 (a 12 percentage point increase since 2020) (Figure 5-2). A lower share of MA beneficiaries with ESRD in 2023 are new to dialysis in 2023 (less than one in five) than in 2020 (about one in four) (data not shown).

Between 2020 and 2023, the composition of MA beneficiaries on dialysis also changed by race and ethnicity and dual eligibility. A greater share of MA beneficiaries on dialysis in 2023 than in 2020 were Black (a 7 percentage point increase) and dually eligible for Medicare and Medicaid (a 9 percentage point and 4 percentage point increase for full-

and partial-benefit dually eligible beneficiaries, respectively). These enrollment trends are consistent with MA growth over time among beneficiaries without ESRD (Medicare Payment Advisory Commission 2024, Meyers et al. 2021, Xu et al. 2023). There was a corresponding 17 percentage point increase in the share of MA beneficiaries on dialysis enrolled in dual-eligible special needs plans, from 17 percent in 2020 to 35 percent in 2023.

Characteristics of MA beneficiaries on dialysis, 2023

By 2023, a greater share of MA beneficiaries than FFS beneficiaries on dialysis were older, Black, partially dually eligible, and residing in urban areas (Table 5-2).

**TABLE
5-2****A greater share of MA beneficiaries than FFS beneficiaries on dialysis are over age 65, Black, dually eligible for Medicare and Medicaid, and urban residents, 2023**

	Share of beneficiaries on dialysis:	
	FFS	MA
Total	216,400	211,900
Age		
Under 45 years	10%	6%
45–64 years	34	31
65–74 years	28	33
75–84 years	21	24
85+ years	7	7
Sex		
Male	59	56
Female	41	44
Race		
White	43	33
Black	30	40
Hispanic	15	19
Asian	6	5
All others	6	3
Residence, by type of county		
Urban	83	87
Rural	16	13
Dual eligibility		
Fully dually eligible for Medicaid	38	39
Partially dually eligible for Medicaid	7	13
Not dually eligible for Medicaid	56	48
Part D enrollment		
Yes	73	98
No	27	2
New to dialysis vs. existing dialysis		
New	18	18
LDO	73	74
Non-LDO	27	26
Existing	83	82

Note: MA (Medicare Advantage), FFS (fee-for-service), LDO (large dialysis organization (DaVita and Fresenius Medical Care)). Beneficiaries on dialysis were identified using the risk-score file, and FFS versus MA enrollment was identified using CMS enrollment data. "Residence" reflects the beneficiary's county of residence in one of two categories, urban or rural (the latter category includes micropolitan, rural adjacent to urban, and rural nonadjacent to urban) based on an aggregation of the Urban Influence Codes. Data as of January 2023. Components may not sum to 100 percent due to rounding.

Source: Data compiled by MedPAC from CMS enrollment data, risk-score file, U.S. Census delineation file, CMS-2728, 2023.

In 2023, 64 percent of MA beneficiaries on dialysis were 65 years or older (with 31 percent being 75 years or older), 40 percent were Black, 13 percent had partial dual eligibility, and 87 percent resided in urban areas. By comparison, among FFS beneficiaries on dialysis, 56 percent were 65 years or older (with 28 percent being 75 years or older), 30 percent were Black, 7 percent had partial dual eligibility, and 83 percent resided in urban areas. Among MA beneficiaries on dialysis, 58 percent were covered by the top three MA parent organizations in 2023 (UnitedHealth Group Inc., Humana Inc., and CVS Health Corporation; data not shown).

Medicare pays for dialysis services under the fee-for-service ESRD prospective payment system

To treat ESRD, beneficiaries on dialysis receive care from two principal providers: (1) 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.⁷ 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 beneficiaries on dialysis. 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. 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 it is not required to disclose such information to patients, researchers, or members of the public.

The Commission's payment-adequacy indicators pertain to Medicare's payments to dialysis facilities for services provided to FFS beneficiaries under the ESRD PPS (see the Commission's March 2021 report, Chapter 12, on MA plan payments to dialysis facilities

for services provided to MA beneficiaries on dialysis) (Medicare Payment Advisory Commission 2021). 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. For adult beneficiaries on dialysis, 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).⁸ Medicare pays facilities furnishing dialysis treatments in the facility or in a patient's home for up to three treatments per week, unless 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.⁹ The two-year transitional drug add-on payment adjustment (TDAPA) for Korsuva (an antipruritic) ended March 31, 2024, while the TDAPA for Jesduvroq (used to treat anemia) will conclude on September 30, 2025. Under current regulations, both drugs will be paid under a post-TDAPA for three years at the end of each drug's TDAPA period.¹⁰ The two-year transitional payment adjustment for new and innovative equipment and supplies (TPNIES) for the Tablo Hemodialysis System concluded in December 2023.¹¹

Are FFS Medicare payments adequate in 2025?

To address whether payments for 2025 are adequate to cover the costs to efficiently provide care and to determine how much payments should change in the update year (2026), 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

Switching between plans and coverage among beneficiaries on dialysis

Each year during the annual open enrollment period between October 15 and December 7, Medicare beneficiaries may switch between fee-for-service (FFS) and Medicare Advantage (MA) coverage or between MA plans for beneficiaries who are already in MA. MA enrollees have an additional window to make changes during the MA open enrollment period, January 1 through March 31. Those beneficiaries who are dually eligible for Medicare and Medicaid may switch their plans or coverage quarterly through the first three quarters of the year. All beneficiaries may qualify to switch plans or their coverage during special enrollment periods (SEPs) throughout the year. As more beneficiaries on dialysis continue to enroll in MA, it is important to monitor the prevalence of switching as a measure of their experience in the MA program.

Between-year switching

We examined switching behavior among beneficiaries with ESRD on dialysis by comparing beneficiaries' coverage (FFS vs. MA) and plan enrollment between December and January each year. Following the 21st Century Cures Act, there was a surge in beneficiaries switching from FFS to MA between December 2020 and January 2021 (about 37,000 beneficiaries, or 9 percent of all beneficiaries on dialysis). Fewer beneficiaries switched from FFS to MA in subsequent years (about 15,600, or 4 percent, between December 2021 and January 2022 and 13,000, or 3 percent, between December 2022 and January 2023). Each year between 2020 and 2023, fewer than 2,000 (or 0.5 percent) MA beneficiaries on dialysis disenrolled from MA to enroll in FFS (Figure 5-3). By contrast, between December 2022 and January 2023, approximately 2 percent of MA beneficiaries without ESRD switched from FFS to MA, and another 0.3 percent disenrolled from MA to FFS. The number of beneficiaries on dialysis staying in MA but switching plans between years grew over time, from about 11,000 beneficiaries, or 3 percent, between December 2020 and January 2021 to about 21,500 beneficiaries, or 5 percent, between December 2022

and January 2023. A similar share of MA beneficiaries without ESRD switched between MA plans between December 2022 and January 2023 (5 percent).

Midyear switching

Beneficiaries may switch their MA plans midyear for any number of reasons, including various life events that qualify them for SEPs, dissatisfaction with their current plan, or in response to marketing by MA plans. Switching MA plans midyear, however, may impact these beneficiaries' cost-sharing liabilities because switching to a plan offered by a different parent organization or to a different plan type within the same parent organization will reset beneficiaries' contributions toward the maximum out-of-pocket (MOOP) amount (Centers for Medicare & Medicaid Services 2016). Whether and how many MA beneficiaries are aware of the financial repercussions of their plan switch is unknown.

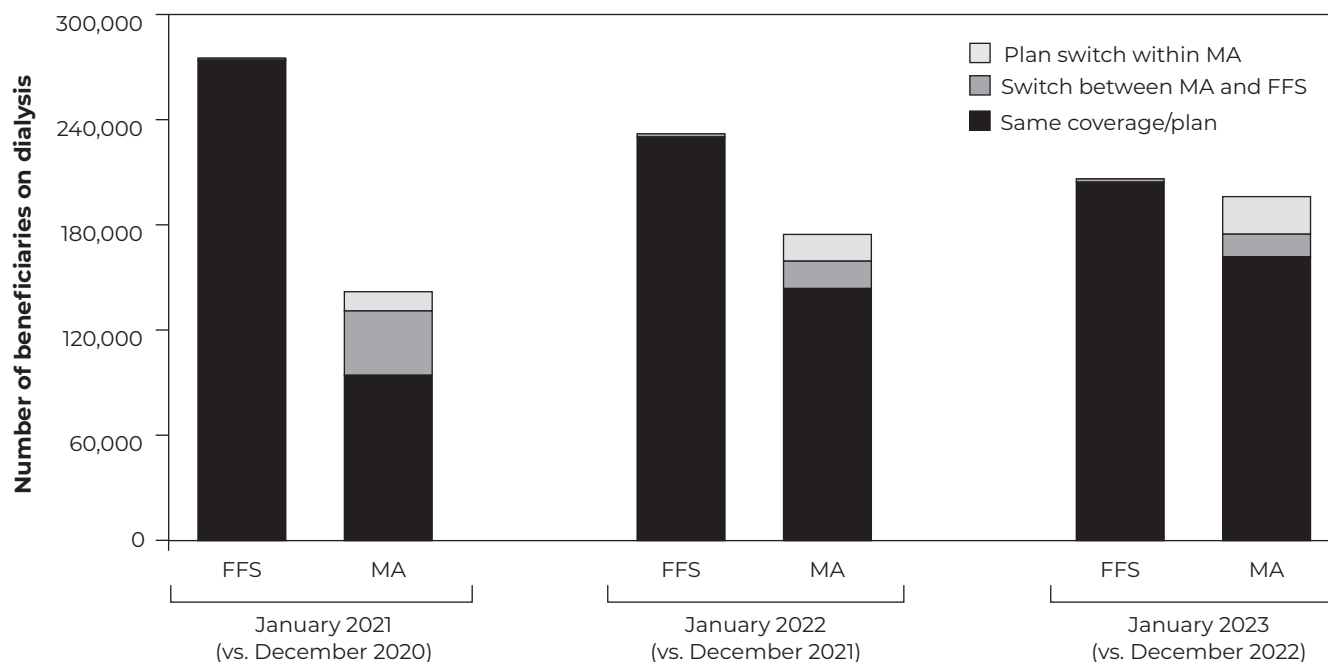
Resetting beneficiaries' contributions toward their MOOP will increase the cost-sharing liabilities for beneficiaries without Medicaid benefits, as well as those with partial dual eligibility (minus qualified Medicare beneficiaries (QMBs) with partial dual eligibility). In addition to increasing the financial burden on beneficiaries, MOOP resets may also result in greater unpaid patient balances for dialysis facilities; without a MOOP reset, MA plans would assume responsibility sooner for the 20 percent coinsurance for dialysis treatments once the MOOP is reached. In 2023, approximately 9,000 (or 7 percent) of non-dual-eligible MA beneficiaries on dialysis and 3,000 (or 17 percent) of partial dual-eligible MA beneficiaries on dialysis (excluding partially dual-eligible QMBs) made a midyear switch that would have resulted in a MOOP-contribution reset. Among MA beneficiaries without ESRD, 4 percent of non-dual-eligible beneficiaries and 16 percent of partial dual-eligible beneficiaries (excluding partially dual-eligible QMBs) made a midyear switch that would have resulted in a MOOP-contribution reset.

(continued next page)

Switching between plans and coverage among beneficiaries on dialysis (cont.)

FIGURE 5-3

A growing share of MA beneficiaries on dialysis are switching plans between years



Note: MA (Medicare Advantage), FFS (fee-for-service). The bars represent enrollment changes between December of the prior year and January of the labeled year. Only beneficiaries enrolled in Medicare and on dialysis for the two consecutive months (December–January) are included in this figure. For example, the 2023 bars represent enrollment changes between December 2022 and January 2023. “Same coverage/plan” represents beneficiaries who are enrolled in FFS or MA both years. “Switch between MA and FFS” represents beneficiaries who switch enrollment between MA and FFS in December of the prior year to January of the next year. “Plan switch within MA” represents beneficiaries who are enrolled in MA both years but in different MA plans. For the MA bars, switchers are people who were in FFS in December of the previous year. For the FFS bars, switchers are people who were in MA in December of the previous year.

Source: Data compiled by MedPAC from CMS enrollment data and risk-score file, 2020–2023.

Beneficiaries with full dual eligibility and QMBs with partial dual eligibility have their cost sharing paid for by Medicaid and will not experience the impact of such a MOOP-contribution reset. In 2023, about 17,500 (or 15 percent) of dually eligible MA beneficiaries on dialysis who have their cost sharing paid for by Medicaid (i.e., all those with full

Medicaid benefits plus partially dual-eligible QMBs) made a midyear switch that would have reset their MOOP contribution. A similar share (14 percent) of dually eligible MA beneficiaries without ESRD who have their cost sharing paid for by Medicaid made a midyear switch that would have reset their MOOP contribution. ■

are positive. The FFS Medicare margin rose from –1.1 percent in 2022 to –0.2 percent in 2023 because providers’ cost per treatment grew more slowly in

2023 than in 2022 and because payment per treatment increased more than cost per treatment in 2023.

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 beneficiaries on dialysis under the PPS—shows that beneficiaries' access to care remains generally favorable.

Capacity has exceeded demand from patients on dialysis across all insurance types

In 2023, there were 7,714 dialysis facilities nationwide. FFS Medicare accounted for about 37 percent of all treatments furnished by freestanding providers.¹² Between 2019 and 2022, growth in the number of dialysis facilities and in-center treatment stations exceeded growth in the number of patients on dialysis, across all insurance types. During that period, the number of facilities and their capacity to provide care—as measured by dialysis treatment stations—both grew by 1 percent annually (Table 5-3). By comparison, the number of patients on dialysis of all types of health coverage declined by nearly 1 percent per year between 2019 and 2022 (most current year of data available) (United States Renal Data System 2024a).

The number of facilities' in-center treatment stations grew more slowly between 2022 and 2023 compared with the annual growth from 2019 through 2022 (0.3 percent per year vs. 1.0 percent per year) but exceeded growth in the number of Medicare beneficiaries on dialysis. Between 2022 and 2023, the number of FFS and MA enrollees on dialysis declined by 2 percent. The slower growth of in-center capacity and the number of facilities from 2022 to 2023 compared with 2019 through 2022 may have been in response to declining demand for ESRD services. Between 2022 and 2023, total dialysis treatments (across all payers) declined by 1 percent and total in-center treatments furnished by freestanding dialysis facilities declined by 2 percent. The decline in demand may be attributable to factors such as the following:

- Excess mortality in the population of patients with ESRD during the coronavirus pandemic. One of the LDOs reported in 2023 that the excess mortality negatively affected same-market treatment growth (Fresenius Medical Care 2023d).

- The decline in the incidence of ESRD during the past decade (by 1 percent per year between 2012 and 2022) (United States Renal Data System 2024b).
- The increase in the use of home dialysis, which has reduced the demand for in-facility treatments. Based on data from Medicare claims, 56 percent of facilities offered home dialysis in 2023, up from 53 percent in 2022. In addition, the CMS Innovation Center's mandatory ESRD Treatment Choices (ETC) Model rewards dialysis facilities and clinicians who are part of the model for increasing home dialysis use and kidney transplantation among adult beneficiaries on dialysis and penalizes facilities and clinicians who are not.

In response to lower patient census in some markets and increasing use of home dialysis, the two LDOs have closed and merged some of their facilities in recent years. In 2022 and 2023, the total number of facilities operated by the two LDOs declined in each year by 2 percent (DaVita 2024a, DaVita 2022b, Fresenius Medical Care 2024b). Closing or merging facilities improves efficiency by, for example, consolidating management and saving on fixed expenses such as rent and medical director fees (DaVita 2024b).

For-profit, freestanding facilities provide most dialysis treatments: In 2023, freestanding facilities furnished 96 percent of FFS treatments, and for-profit facilities furnished 90 percent (Table 5-3). Between 2022 and 2023, capacity (as measured by the number of in-center stations) grew at both freestanding and hospital-based facilities by 0.3 percent, and at for-profit facilities by roughly 1 percent, while capacity at nonprofit facilities fell by roughly 5 percent.

The capacity of facilities in urban and rural areas in 2023 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 2022 and 2023, capacity at urban facilities grew by 0.4 percent while capacity at all rural facilities declined by 1 percent (data not shown). In June 2020, the Commission recommended that the Secretary replace the ESRD PPS's low-volume payment adjustment (LVPA) and rural adjustment with a single payment adjustment—a low-volume

**TABLE
5-3**

Low growth in the capacity of freestanding and for-profit dialysis organizations between 2022 and 2023

	2023				Average annual percent change			
	Total number of FFS treatments	Total number of facilities	Total number of stations	Mean number of stations	2019–2022		2022–2023	
					Number of facilities	Number of stations	Number of facilities	Number of stations
All dialysis facilities	27.4 million	7,714	138,542	18	1%	1%	–2%	0.3%
Share of total								
Freestanding	96%	95%	96%	18	1	1	–2	0.3
Hospital based	4	5	4	14	–3	–3	–2	0.3
Urban	86	84	87	19	1	1	–2	0.4
Micropolitan	10	10	9	16	0	0	–2	0.3
Rural, adjacent to urban	2	4	3	14	–2	–1	–5	–3
Rural, not adjacent to urban	1	2	1	12	–1	–1	–5	–4
For profit	90	90	90	18	1	1	–2	1
Nonprofit	10	10	10	17	–1	–1	–7	–5
Two LDOs	75	74	75	18	1	1	–3	–0.1
All others	25	26	25	17	1	0	0	2

Note: FFS (fee-for-service), LDO (large dialysis organization (DaVita and Fresenius Medical Care)). “Location” reflects the type of county (urban, micropolitan, rural adjacent to urban, or rural nonadjacent to urban) in which the provider is located, based on an aggregation of the Urban Influence Codes. Components 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.

and isolated (LVI) adjustment—to better support isolated, low-volume dialysis facilities that are critical to ensuring beneficiary access (Medicare Payment Advisory Commission 2020b). Instead, in the ESRD PPS final rule for 2025, CMS modified the LVPA policy by creating two-tiered adjustments for ESRD facilities: one adjustment for facilities that furnish fewer than 3,000 treatments and one for facilities that furnish between 3,000 and 3,999 treatments. CMS did not change the current 0.8 percent rural-facility adjustment (Centers for Medicare & Medicaid Services 2024b).

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

Another component of access is whether providers have a financial incentive to expand the number of FFS Medicare beneficiaries they serve. To assess this component, we examine the FFS Medicare marginal profit—the percentage of revenue from FFS Medicare that is left as profit after accounting for the allowable variable costs of providing services to FFS Medicare patients. (Variable costs are those that vary with the number of patients treated. By contrast, fixed costs are those that are the same in the short run regardless of

the number of patients treated (e.g., rent.) If the FFS Medicare marginal profit is positive, a provider with excess capacity has a financial incentive to care for an additional FFS beneficiary; if the FFS Medicare marginal profit is negative, a provider may have a disincentive to care for an additional FFS beneficiary. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.)

FFS Medicare payments in 2023 exceeded dialysis facilities' marginal costs by an average of 17 percent, a positive indicator of patient access, in that facilities with available capacity have a financial incentive to treat FFS Medicare beneficiaries.

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

The decline in the number of FFS beneficiaries on dialysis and in FFS treatments accelerated considerably beginning in 2021, after the enactment of the 21st Century Cures Act.¹³ As beneficiaries with ESRD shifted to MA in 2021 through 2023, the number of FFS beneficiaries on dialysis fell 12 percent per year, on average, and the number of FFS treatments fell 12 percent per year. The effect of removing the statutory bar is highlighted by the roughly 8 percent drop in the number of FFS dialysis treatments between December 2020 and January 2021 and the additional 31 percent drop in FFS treatments furnished between January 2021 and December 2023. Although the number of FFS beneficiaries on dialysis and the number of treatments declined between 2022 and 2023, the number of dialysis treatments per beneficiary per week remained steady at 2.8.¹⁴

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; thus, the more units of a drug provided, the higher Medicare payments were. 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 were previously billed separately.

Table 5-4 shows changes between 2010 and 2023 (the most current year for which complete data are

available) in the per treatment use of the leading ESRD drugs, which we aggregate into five therapeutic groups: erythropoiesis-stimulating agents (ESAs), iron agents, calcimimetics, vitamin D agents, and other products.¹⁵ We estimated per treatment use by multiplying ESRD drug units per treatment reported on CMS claims by each drug's 2023 average sales price (ASP) plus 0 percent—that is, holding price constant.¹⁶ Thus, the change in our measure of drug use over time reflects shifts in the intensity of ESRD drugs prescribed to FFS beneficiaries on dialysis, which could reflect a combination of effects, such as changes in the (1) mix of drugs within a given therapeutic group furnished to beneficiaries, (2) share of beneficiaries receiving any ESRD drug in the five therapeutic groups, and (3) dose per treatment of a given drug.

As shown in Table 5-4, 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 example, between 2010 and 2011, ESRD drug 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 lead to increased risk of morbidity and mortality, which resulted in the Food and Drug Administration changing the ESA label in 2011.

Most recently, between 2022 and 2023, holding price constant, use across the five groups declined by 7 percent; this decline partly reflects the shift to less costly clinically similar products within a therapeutic group. For example, the share of FFS beneficiaries on dialysis who received epoetin beta increased between 2022 and 2023. This increase is linked to the transition by one LDO's patients from epoetin alfa to epoetin beta (DaVita 2022b). Thus, among the four ESA products in 2022 and 2023, use (as measured by units per treatment) of epoetin beta and the epoetin alfa biosimilar increased while use of darbepoetin and epoetin alfa reference product declined. The Commission has previously reported other shifts over time in the use of ESAs and vitamin D agents (paricalcitol, doxercalciferol, and calcitriol) due to price competition among the products in each category (Medicare Payment Advisory Commission 2022).

Some of the change in ESRD drug use between 2022 and 2023 reflects changes in the share of FFS

**TABLE
5-4**

Under the ESRD PPS, use of ESRD drugs per treatment has declined, partly attributable to the shift to less costly, clinically similar products

	Pre-ESRD PPS estimated use of ESRD drugs*	Percent of aggregate change between:		
	2010	2010–2011	2010–2023	2022–2023
ESAs	\$41	–23%	–61%	–9%
Iron agents	4	–10	–24	–3
Vitamin D agents	2	–19	–73	–16
Calcimimetics	N/A	N/A	N/A	–4
Other drugs	2	–43	–85	–8

Note: ESRD (end-stage renal disease), PPS (prospective payment system), ESA (erythropoiesis-stimulating agent), N/A (not available). The ESRD PPS began in 2011. ESAs include epoetin alfa reference, epoetin alfa biosimilar, epoetin beta, and darbepoetin. Iron agents include iron sucrose, sodium ferric gluconate, ferumoxytol, and ferric carboxymaltose. Vitamin D agents include calcitriol, doxercalciferol, and paricalcitol. Calcimimetics include 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. Since 2021, calcimimetics have been paid under the ESRD PPS base rate.

* 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 2023 average sales price (ASP) plus 0 percent. Because 2023 ASP data are not available for cinacalcet (a calcimimetic), we used the payment limit for CMS's transitional drug add-on payment adjustment for the fourth quarter of 2020 and updated it to 2023 dollars using the pharmaceutical Producer Price Index. By holding the price constant, we account for the different billing units assigned to a given drug.

Source: MedPAC analysis of 100 percent of claims submitted by dialysis facilities to CMS.

beneficiaries on dialysis receiving an ESRD drug. Overall, the share of FFS beneficiaries on dialysis prescribed drugs to treat anemia—ESAs and iron agents—remained stable between 2022 and 2023, while the share of beneficiaries prescribed drugs that treat bone and mineral metabolism disorders—calcimimetics and vitamin D agents—declined by 1 percentage point and 2 percentage points, respectively. 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 decline of beneficiary health status from January 2010 through December 2022 (Centers for Medicare & Medicaid Services 2023a).

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

In 2022 and 2023, use of the emergency department (ED) by FFS beneficiaries on dialysis, as well as their 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. In-center hemodialysis patient-experience measures also remained steady. Use of home dialysis and the number of kidney transplants increased during this period.¹⁷

Quality under the ESRD PPS

Our analysis of available claims and enrollment data for FFS beneficiaries on dialysis 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, averaging 2.0 percent per month in 2021 and 2022 and 1.9 percent in 2023.
- Between 2021 and 2023, the share of FFS beneficiaries on dialysis who were admitted to a short-stay hospital (beneficiaries with at least one admission in a given month) remained relatively

steady, averaging 14 percent per month. During the same period, 30-day readmission rates on an annual basis remained relatively steady at 21 percent of admissions.

- Between 2021 and 2023, the share of FFS beneficiaries on dialysis who used the ED on an outpatient basis (beneficiaries with at least one ED visit in a given month) remained steady, averaging 18 percent per month.

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 2021 and 2023, the share of beneficiaries receiving adequate dialysis remained steady, averaging between 97 percent and 98 percent of beneficiaries on hemodialysis and between 92 percent and 93 percent of beneficiaries receiving peritoneal dialysis (PD). There was little difference between rural and urban areas in the share of beneficiaries on hemodialysis and PD receiving adequate dialysis.

We assess the quality of anemia management by examining changes over time in (1) beneficiaries' hemoglobin levels, as assessed by a blood test that measures the level of hemoglobin (the protein that carries oxygen in red blood cells); and (2) frequency of red blood cell transfusions.¹⁸ 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 grams per deciliter (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 2021 and 2023, median hemoglobin levels remained constant, averaging 10.5 g/dL. During this period, the share of FFS beneficiaries on dialysis with lower (less than 10 g/dL) and higher (exceeding 12 g/dL) hemoglobin levels remained steady, averaging 31 percent and 6 percent of beneficiaries, respectively. There was little difference in the hemoglobin status of beneficiaries on dialysis residing in rural versus urban areas. Between 2021 and 2023, rates of blood transfusion remained relatively steady, averaging between 2.7 percent and 2.8 percent per month.

Patient-experience measures

The In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH-CAHPS) survey provides patient ratings of their dialysis facility, center staff, and nephrologist for their communications, care, operations, and provision of information (Centers for Medicare & Medicaid Services 2024a). Among survey respondents, 60 percent to 80 percent gave the top ratings across the three composite and three global ratings (Table 5-5). Patient experience remained relatively stable between reporting years 2022 and 2024. Survey results did not differ between urban and rural facilities (data not shown).

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). The share of beneficiaries dialyzing at home steadily increased from 9 percent per month in 2011 to 17 percent per month in 2023. Differences by race have persisted over time: Although about 29 percent of FFS Medicare beneficiaries with ESRD are Black, only 23 percent of beneficiaries who dialyze at home are Black.

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 of treatment options, as well as physicians' training and preference). For example, nephrology trainees have 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).¹⁹

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 patients new to dialysis more than doubled, from 15 percent to 34 percent. To augment the use of home dialysis, the health care

**TABLE
5-5**

In-center hemodialysis patient experience scores, 2022–2024

ICH-CAHPS measures	2022	2023	2024
Share of patients giving top ratings for:			
Nephrologists' communication and caring	68%	67%	67%
Quality of dialysis center care and operations	64	64	64
Providing information to patients	80	79	79
Share of patients rating a 9 or 10 out of 10 (best possible):			
Rating of the nephrologist	61	59	59
Rating of the dialysis center staff	66	64	65
Rating of the dialysis facility	70	69	69

Note: ICH-CAHPS (In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems). The ICH-CAHPS is a survey of patient experiences with the dialysis facility, facility doctors and staff, and care received. The survey's measures included in the table are "top box," or the most positive, response to ICH-CAHPS survey items. The most favorable ratings for the first three measures include those who report "always," while ratings for the next three measures are the percentage of patients who gave a score of 9 or 10 on a scale of 0 (worst possible) to 10 (best possible). Survey results are publicly reported twice a year, based on data from the two most recent survey periods. Each year, spring survey data are collected from April through July and fall survey data are collected from November through January. The years indicate reporting years: Data for reporting year 2024 include surveys collected between April 2023 and December 2023. Among facilities reporting ICH-CAHPS data (2,308 facilities in reporting year 2024), the survey response rate ranged between 25 percent and 28 percent.

Source: CMS summary of national average for ICH-CAHPS survey measures, 2022–2024.

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 annual Medicare spending for patients on dialysis (roughly \$98,000) was more than twice the annual spending for 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 can 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; transplant center policies; and, specific to beneficiaries enrolled in MA, contracts between MA networks and transplant centers.

Between 2022 and 2023, according to the Organ Procurement and Transplantation Network, the number of kidney transplants increased by 7 percent, to 27,332 (Table 5-6, p. 166).²⁰ 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). Between 2014 and 2023, the share of transplants for Black and Hispanic patients rose (Table 5-6).

**TABLE
5-6**

Between 2022 and 2023, the number of kidney transplants increased

	2014	2022	2023
Total transplants	17,108	25,500	27,332
Share of total transplants from live donors	32%	23%	23%
Share receiving a transplant			
White	50	41	40
Black	25	29	30
Hispanic	16	20	20
Asian	6	8	8
All others	2	2	2

Note: 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. Components may not sum to 100 percent due to rounding.

Source: Organ Procurement and Transplantation Network.

Most dialysis providers appear to have adequate access to capital

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 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 (a corporate venture arm 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).

- To optimize its portfolio, Fresenius Medical Care entered into an agreement in 2023 to sell National Cardiovascular Partners with 21 facilities providing outpatient cardiac-catheterization and vascular laboratory services (Fresenius Medical Care 2023d). In addition, Fresenius Medical Care announced completion of the first phase of the company's first global dialysis dataset, the Apollo database project, which is the company's foundation for its long-term artificial intelligence goals. The database is the largest multinational, longitudinal database of its kind. It is intended to advance patient quality and outcomes by making kidney-disease care more personalized and precise, and it provides information about the clinical care furnished to more than 540,000 patients on dialysis (Fresenius Medical Care 2023b).

In recent public financial filings, the two LDOs reported generally positive financial performance related to their dialysis business for 2024, including improvements in productivity and earnings growth (DaVita 2024d, Fresenius Medical Care 2024a). Both

companies reported improved operating income margins, operating income, and net income in the third quarter of 2024 compared with the third quarter of 2023. Other positive results reported by both LDOs as of the third quarter 2024 include higher growth in revenue per treatment compared with the cost of patient care per treatment (4 percent vs. 1 percent, respectively) (DaVita 2024d) and positive organic revenue growth (Fresenius Medical Care 2024a).

Since 2010, both LDOs 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 patients with ESRD and CKD. 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 the CMS Innovation Center's current Kidney Care Choices Model.

The two LDOs, in addition to operating three-quarters of all dialysis facilities, are both 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. For example, this LDO 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 patients on

dialysis. In 2022, Part D spending on Velphoro for FFS beneficiaries on dialysis was nearly \$250 million. 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. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) Using cost-report data submitted by freestanding dialysis facilities to CMS, we estimated that the 2023 all-payer margin was roughly 15 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.²¹ 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 but about 32 percent of its revenues from U.S. dialysis patients, while patients with government coverage account for 90 percent of its treatments and 68 percent of its revenues from U.S. dialysis patients (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). Similarly, researchers found that in 2017, the median MA payment for dialysis was 27 percent above FFS rates, and the payments were higher to LDOs than to regional chains and independently owned dialysis facilities (Lin et al. 2022).

Medicare payments and providers' costs: Lower cost growth contributed to increase in FFS Medicare margin in 2023

Between 2022 and 2023, Medicare's payments per FFS dialysis treatment increased 3 percent while total costs per treatment rose by 2 percent. In 2023, the FFS Medicare margin rose to -0.2 percent from -1.1 percent in 2022. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.)

Medicare payments for outpatient dialysis services

Between 2022 and 2023, FFS per capita annual spending for outpatient dialysis services (i.e., for dialysis treatments furnished by ESRD freestanding and hospital-based facilities) increased by 2 percent to nearly \$31,000. Total FFS Medicare spending for these services, however, declined 8 percent from 2022, to \$8.1 billion. As discussed earlier in the chapter, the decline is predominantly due to MA plans' increasing enrollment of beneficiaries on dialysis beginning in 2021. A statutory update (of 3 percent) increased the base ESRD PPS payment rate in 2023.

Between 2021 and 2022, Part D spending for ESRD oral-only phosphate binders declined for FFS beneficiaries on dialysis

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 regulation and statute); therefore, we track Part D spending for this group. Between 2021 and 2022 (the most recent year for which data are available), spending for phosphate binders furnished to FFS beneficiaries on dialysis declined by 13 percent to \$0.7 billion.²² The decline in total spending for phosphate binders for FFS beneficiaries on dialysis is linked to the substantial increase in beneficiaries on dialysis enrolling in MA in 2021. Among FFS beneficiaries on dialysis who used phosphate binders, per capita spending in 2021 and 2022 increased by 4 percent to \$4,500 per patient. Similar shares (ranging from 66 percent to 68 percent) of FFS beneficiaries on dialysis with Part D coverage were prescribed phosphate binders in 2021 and 2022, and Part D spending for phosphate binders accounted for a similar share of their Part D spending in each year (ranging from 32 percent to 34 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, phosphate binders will be paid for under the ESRD PPS.²³ Dialysis facilities will receive a TDAPA payment based on 100 percent of each product's ASP plus a fixed-rate addition of \$36.41 per monthly claim for at least two years (2025 and 2026).²⁴ CMS derived the fixed-rate addition of \$36.41 based on the weighted average of Medicare expenditures for phosphate binders per month under

Part D for all phosphate binders used in a month, using utilization patterns in 2023 among Part D-eligible beneficiaries. According to the agency, the monthly fixed-rate addition approximates 6 percent of ASP and is intended to offset the incremental operational cost incurred by dialysis facilities in storing, managing, and dispensing phosphate binders to patients, as such costs were not addressed when the ESRD PPS base rate was implemented in 2011 (Centers for Medicare & Medicaid Services 2024b). CMS and others expect that beneficiary access to phosphate binders will be increased by their inclusion in the ESRD PPS because not all FFS beneficiaries on dialysis are enrolled in Part D or have drug coverage comparable with Part D:

- According to CMS: "We have seen that incorporating Medicare Part D drugs into the ESRD PPS has had a significant positive effect of expanding access to such drugs for beneficiaries who do not have Medicare Part D coverage, with significant positive health equity impacts" (Centers for Medicare & Medicaid Services 2024b).
- According to one of the LDOs: "Given our experience with calcimimetics, we strongly believe this [phosphate binders paid under the ESRD PPS] will provide more patients with access to these drugs since many of our patients do not have Part D coverage" (DaVita 2024c).

Providers' costs for outpatient dialysis services under the ESRD PPS

We examine aggregate dialysis-facility costs using 2022 and 2023 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 2022 and 2023, total cost per treatment rose by 2 percent, from \$286 per treatment to nearly \$291 per treatment.

- Labor and overhead costs increased by 4 percent and 14 percent, respectively, and accounted for 35 percent and 30 percent of 2023 providers' cost per treatment, respectively.
- Costs dropped for:
 - capital-related assets and laboratory services, which each declined by 8 percent and

accounted for 17 percent and 1 percent of the cost per treatment, respectively, in 2023; and

- ESRD drugs, which declined by 15 percent and accounted for 7 percent of cost per treatment in 2023, and supplies, which declined by 1 percent and accounted for 10 percent of providers' cost per treatment in 2023.

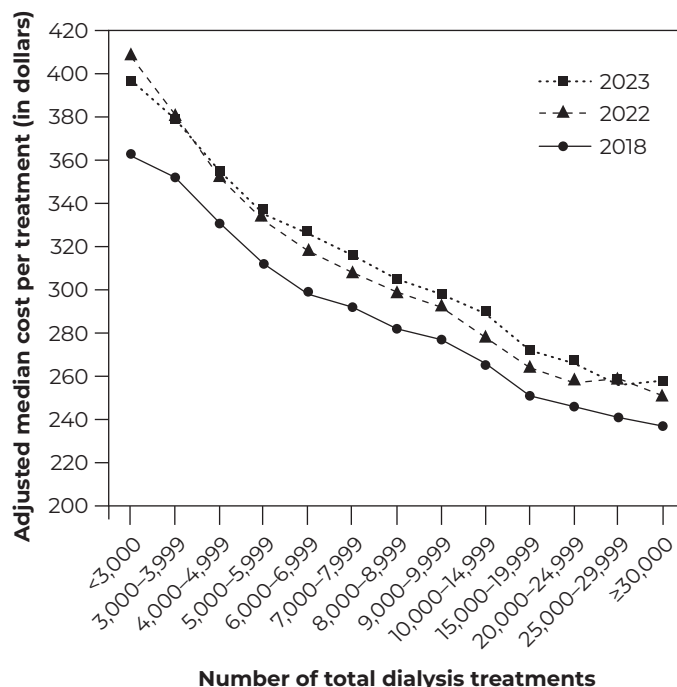
The 2 percent overall cost growth in 2023 is moderate compared with the 6 percent increase in cost per treatment between 2021 and 2022. The decline in cost growth in 2023 relative to 2022 is attributable to the drop in cost per treatment experienced by all cost categories except for labor and overhead. Our finding that labor costs grew more slowly in 2023 than in 2022 (4 percent per treatment vs. 7 percent per treatment, respectively) is consistent with announcements by the LDOs that their labor performance was better in 2023 than in 2022 (DaVita 2024b, Fresenius Medical Care 2023c). By contrast, overhead costs rose sharply in 2023 compared with 2022 (14 percent per treatment vs. 7 percent per treatment).

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 2022 and 2023, per treatment costs fell by 3 percent for facilities in the 25th percentile of cost growth, compared with a rise of 8 percent for facilities in the 75th percentile. The growth in cost per treatment is related to facility size. Between 2022 and 2023, 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 nearly 4 percent) compared with all other facilities (with cost growth averaging 2 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 2023, labor cost varied by \$44 per treatment, and capital costs varied by \$31 per treatment. The Commission has 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).

FIGURE 5-4

Higher-volume freestanding dialysis facilities had lower cost per treatment, 2018–2023



Note: Cost per treatment is adjusted to remove geographic 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.

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 a statistically significant relationship between the total number of treatments and cost per treatment (correlation coefficient equaled -0.5) in each year between 2018 and 2023 (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 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 2023.²⁵

The 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 2.3 percent in 2021 and -1.1 percent in 2022. Due to lower cost growth and because growth in payment per treatment exceeded growth in cost per treatment, dialysis facilities' FFS Medicare margin rose in 2023, to -0.2 percent. While the margin has varied over time—including some periods in which it was negative or near zero and other periods where it was substantially positive—beneficiaries' access to care has remained positive throughout.

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 drugs (Figure 5-5). During the initial years of the ESRD PPS, the FFS Medicare margin increased as providers furnished fewer ESRD drugs per treatment. Between 2014 and 2017, facilities' financial performance under FFS Medicare reversed, and the 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 FFS Medicare margin increased due to the profitability of the calcimimetics paid under the TDAPA policy—to 2.1 percent in 2018 and 8.4 percent in 2019 (Figure 5-5).^{26,27} In 2020, the 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 ASP plus 6 percent to ASP plus 0 percent. In 2021, the FFS Medicare margin declined again to 2.3 percent due to increasing cost per treatment for all cost categories (except ESRD drug costs).

The FFS Medicare margin further declined to -1.1 percent in 2022, partly due to growth in labor and capital costs, which both increased by 7 percent between 2021 and 2022, well above the historical average. The increase in the FFS Medicare margin from -1.1 percent to -0.2 percent in 2023 is partly attributable to (1) lower capital, ESRD-drug, lab, and supply cost per treatment compared with 2022; (2) lower growth in labor cost per treatment compared with 2022 (4 percent vs. 7 percent, respectively); and (3) growth in the FFS payment per treatment exceeding the growth in providers' cost per treatment (DaVita 2022b, Fresenius Medical Care 2022). Partially offsetting these factors were increases in overhead cost per treatment between 2022 and 2023 and declining total treatment volume between 2022 and 2023. The two LDOs experienced a 0.3 percent decline in total treatment volume (across all payers) between 2022 and 2023 (DaVita 2024a, Fresenius Medical Care 2024b). Additionally, unlike in previous years, add-on payments (for the drug Korsuva and for the Tablo Hemodialysis System) may not have had a material effect on dialysis facilities' FFS Medicare margin because of the limited use of these services, as found by MedPAC analysis of claims data.

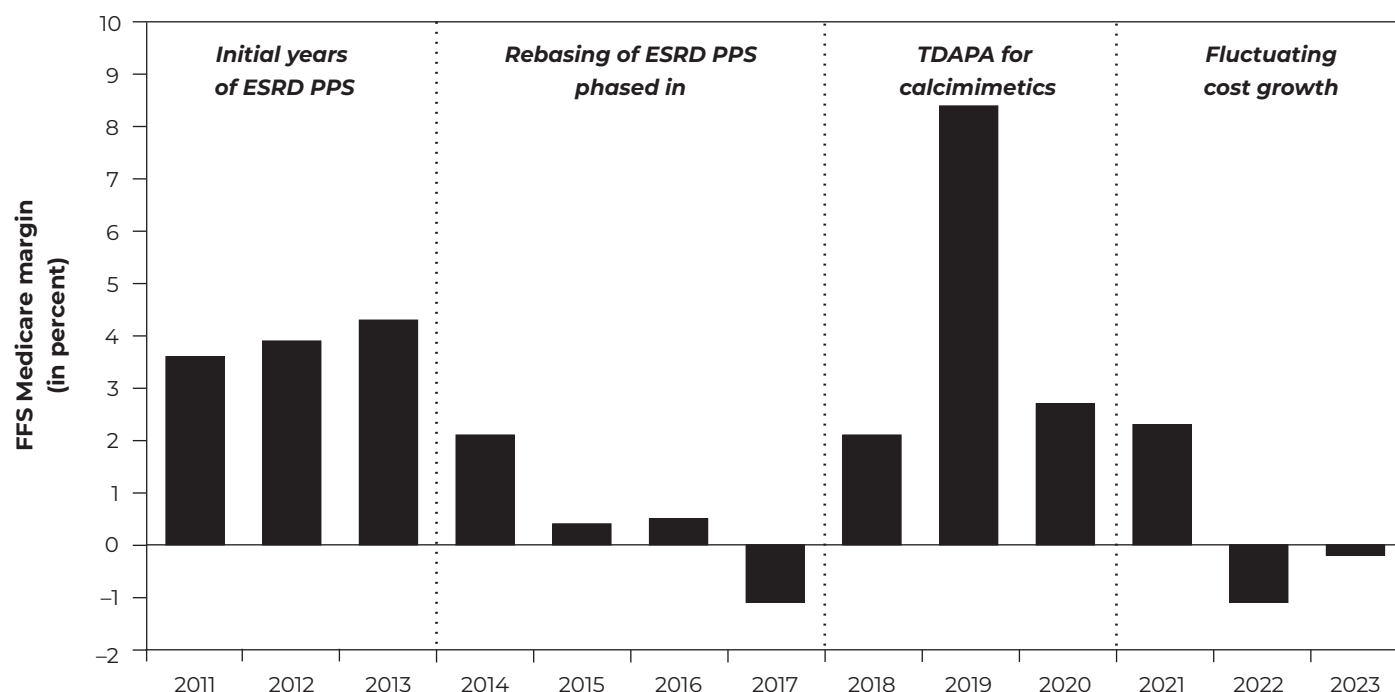
The FFS Medicare margin varies by treatment volume

FFS Medicare margins in 2023 decidedly varied by treatment volume: Facilities in the lowest-volume quintile had margins below -19 percent, while facilities in the top-volume quintile had margins of over 7 percent (Table 5-7, p. 172). Urban facilities averaged higher margins than rural facilities (0.6 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 2023, urban facilities averaged roughly 11,000 treatments while rural facilities averaged nearly 7,700 treatments (data not shown). Higher-volume facilities had lower cost per treatment (Figure 5-4, p. 169).

Although some rural facilities in 2023 have benefited from the ESRD PPS's 23.9 percent low-volume adjustment (for those furnishing fewer than 4,000 treatments) and 0.8 percent rural adjustment, the Commission has found that neither adjustment appropriately targets low-volume, geographically

**FIGURE
5-5**

**FFS Medicare margin has varied over time,
but beneficiaries' access to care has remained stable**



Note: FFS (fee-for-service), 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.

isolated facilities that are critical to beneficiary access (Medicare Payment Advisory Commission 2016, Medicare Payment Advisory Commission 2015, Medicare Payment Advisory Commission 2014). Beginning in 2025, dialysis facilities furnishing fewer than 3,000 treatments will receive a 28.9 percent upward adjustment, and those furnishing between 3,000 and 3,999 treatments will receive an 18.3 percent upward adjustment per the two-tiered LVPA policy finalized in the 2025 ESRD PPS final rule. CMS contends that this modification will better target payment increases to facilities with higher costs (Centers for Medicare & Medicaid Services 2024b). 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 2020b).

Projecting payments and costs for 2025

We project that the FFS Medicare margin will slightly increase in 2025, to 0 percent in aggregate. To estimate the projected 2025 margin, the Commission considers providers' cost growth between 2018 and 2023 and policy changes affecting payments in 2024 and 2025. These factors include:

- statutory updates to the dialysis base payment rate (based on the ESRD market basket offset by a productivity adjustment) of 2.1 percent in 2024 and 2.2 percent in 2025;

**TABLE
5-7**

In 2023, the FFS Medicare margin of freestanding dialysis facilities varied by treatment volume

Provider type	FFS Medicare margin	Share of freestanding dialysis facilities	Share of freestanding dialysis-facility treatments
All	-0.2%	100%	100%
Urban	0.6	84	88
Rural	-4.5	16	12
Treatment volume (quintile)			
Lowest	-19.0	20	8
Second	-11.2	20	13
Third	-3.3	20	18
Fourth	1.6	20	24
Highest	7.5	20	38

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 from the Dialysis Compare database.

- reductions in payments of 0.16 percent in 2024 and 0.37 percent in 2025 due to the ESRD Quality Incentive Program; and
- reductions in payments in 2024 and 2025 due to the ETC Model (CMS Innovation Center's mandatory model), which CMS estimates will total \$10 million in 2024 and \$14 million in 2025 (Centers for Medicare & Medicaid Services 2024b).

Factors not considered in this projection that could have a positive effect on providers' financial performance include:

- add-on payments in 2024 and 2025 for new ESRD drugs (daprodustat that treats anemia, difelikefalin that treats pruritus, and taurolidine and heparin sodium that reduce incidence of catheter-related bloodstream infections) and in 2025 for phosphate binders; and
- both LDOs' productivity efficiencies in 2024; for example, one LDO reduced ESRD drug costs by switching its patients to epoetin beta, and both LDOs have been maximizing their capacity

utilization by merging and closing facilities and promoting home dialysis.

How should FFS Medicare payments change in 2026?

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 2025 is low. Under current law, Medicare's base payment rate under the ESRD PPS will be increased in 2026 based on the forecasted increase in the ESRD market basket less a forecasted increase in productivity. The final update for 2026 will not be set until summer 2025, but CMS currently forecasts a 1.7 percent increase in the base payment rate. The final 2026 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 to the base payment rate, Medicare pays dialysis facilities for qualifying new drugs that treat a

condition included in 1 of 11 functional categories of products that are covered under the ESRD PPS under a TDAPA and a post-TDAPA for a five-year period. The new ESRD drugs paid under such add-on payment policies may increase FFS Medicare payments relative to facilities' costs. Specifically, CMS does not reconcile the cost and utilization of the new drug paid under an add-on payment in 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. Essentially, the current add-on payment policies for ESRD drugs in an existing ESRD functional category create a second (duplicative) payment for new ESRD drugs that treat the same clinical condition as drugs already included in the payment bundle.

The TDAPA for phosphate binders that began in 2025 may increase FFS Medicare payments relative to facilities' costs like the TDAPA for calcimimetics did between 2018 and 2020 (Figure 5-5, p. 171). Although some stakeholders have raised concerns that paying for phosphate binders under the ESRD PPS may have a negative effect on their financial performance, three of the five largest dialysis organizations operate their own pharmacies, which gives them advantages such as managing costs and maintaining greater control of and more complete information on their patients' prescriptions (Centers for Medicare & Medicaid Services 2024b, Government Accountability Office 2023).

Indeed, there is some evidence that dialysis facilities have generally become more efficient under the ESRD PPS, as measured by declining use of most injectable ESRD 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: increased demand for home dialysis, the excess mortality during the coronavirus pandemic, and the slowly declining incidence of ESRD over the past decade.

RECOMMENDATION 5

For calendar year 2026, the Congress should update the 2025 Medicare base payment rate for outpatient dialysis services 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 ESRD drugs under the ESRD PPS. Indicators of quality of care have generally remained stable. The FFS Medicare margin was -0.2 percent in 2023 and is projected to be 0 percent in 2025. We do not yet know the effect of Medicare's add-on payments for new renal dialysis drugs and phosphate binders on facilities' financial performance in 2024 and 2025, but our prior analysis showed that add-on payments for calcimimetics between 2018 and 2020 contributed to a substantial increase in facilities' FFS Medicare margin during that period. The two LDOs—companies that account for three-quarters of dialysis facilities—recently made optimistic statements about their dialysis business; for example, each reported increasing treatment volume and decreasing mortality, and both achieved productivity gains in 2024 (DaVita 2023b, Fresenius Medical Care 2023c). Low-volume dialysis facilities, which tend to have higher costs due to fewer economies of scale, may be helped by increased payments paid under the ESRD PPS's refined low-volume payment adjustment beginning in 2025.

IMPLICATIONS 5

Spending

- Current law is expected to increase the base payment rate by 1.7 percent in 2026. This recommendation would have no effect on federal program spending relative to the statutory update.

Beneficiary and provider

- We expect beneficiaries on dialysis to continue to have good access to outpatient dialysis 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 In this chapter, the term “drugs” refers to both drugs and biologics. The term “biologics” refers to biological products.
- 3 The term “excess death” refers to the difference between observed and expected deaths based on historical trends. For example, Kim and researchers estimated that among persons with ESRD, the number of observed deaths during the coronavirus pandemic between March and August 2020 was 16 percent higher than the expected number of deaths, and excess deaths were substantially higher among Black and Hispanic persons with ESRD (Kim et al. 2021). More discussion of this topic can be found at https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch6_v2_SEC.pdf.
- 4 Our analyses of CMS enrollment and supplemental coverage data show that in 2023, approximately 43 percent of FFS beneficiaries on dialysis without cost sharing covered by Medicaid had no supplemental coverage (that is, coverage from other sources, such as Medigap or employer-sponsored health plans) compared with 26 percent of all other FFS beneficiaries without cost sharing covered by Medicaid.
- 5 Once beneficiaries with ESRD turn 65, for a six-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; 36 states require insurers to offer at least one Medigap plan to beneficiaries under age 65, but only 26 states require insurers to offer a plan to those entitled to Medicare due to ESRD (American Kidney Fund 2024, Freed et al. 2024).
- 6 Some FFS beneficiaries on dialysis get financial assistance from the American Kidney Fund, a nonprofit organization whose funding sources include dialysis providers and pharmaceutical manufacturers, through need-based grants to pay for health insurance premiums, prescription medications, and other items and services.
- 7 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, and whether the beneficiary receives dialysis in a facility or at home.
- 8 For pediatric beneficiaries on dialysis (ages 17 years and under), the base rate is adjusted for age and type of dialysis.
- 9 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; and drugs approved that changed from prescription to over-the-counter availability. CMS identifies these drugs using the application-classification code for new drugs, which the FDA assigns to a given drug.
- 10 CMS calculates the TDAPA and post-TDAPA payments differently. The TDAPA payment for new, qualifying drugs is based on the number of units of the new drug furnished to the beneficiary multiplied by average sales price plus 0 percent. CMS pays a post-TDAPA on all ESRD PPS claims; the payment rate is case-mix adjusted and set at 65 percent of estimated expenditure levels for the given ESRD drug in the prior year.
- 11 Unlike for new ESRD drugs paid under a TDAPA, a substantial clinical improvement standard is used to determine eligibility for a TPNIES add-on. According to CMS, the two-year TDAPA for new ESRD drugs in an existing functional category does not include a standard for substantial clinical improvement because “allowing all new drugs to be eligible for TDAPA will provide an opportunity for the new drugs to compete with other similar drugs in the market which could mean lower prices for all drugs. We believe drug manufacturers understand that if they are to compete with drugs currently in the ESRD PPS bundle, they need to not only be better, but they also must come in at a lower price in order to continue to be utilized by the facilities in the post-TDAPA period. The 2-year TDAPA period gives the innovative product an opportunity to demonstrate its clinical value and financial worth, while buffering the risk to both the manufacturer and the facility. If the facility finds the product sufficiently worthy of use among its patients, then the manufacturer has an incentive to keep the price lower than the drug it is replacing that is currently in the bundle. In addition, the effectiveness of drugs can depend on age, gender, race, genetic predisposition and comorbidities. Innovation can provide options for those that do not respond to a certain

- preferred treatment regimen the same way the majority of patients respond” (Centers for Medicare & Medicaid Services 2018). 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 in our *Payment Basics* series, 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 Some portion of the decline in 2021 in the number of FFS beneficiaries on dialysis 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).
 - 14 Medicare pays for up to three dialysis treatments per week, though exceptions can be made with medical justification (Centers for Medicare & Medicaid Services 2023b).
 - 15 ESAs include epoetin alfa reference, epoetin alfa biosimilar, epoetin beta, and darbepoetin. Iron agents include iron sucrose, sodium ferric gluconate, ferumoxytol, and ferric carboxymaltose. Vitamin D agents include calcitriol, doxercalciferol, and paricalcitol. Calcimimetics include cinacalcet and etelcalcetide. Other drugs include daptomycin, vancomycin, alteplase, and levocarnitine.
 - 16 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 2023 average ASP, with one exception. Because 2023 ASP data were not available for cinacalcet, we used CMS’s TDAPA payment limit for the fourth quarter of 2020 and updated it to 2023 dollars using the pharmaceutical Producer Price Index. By holding the price constant, we account for the different billing units assigned to a given drug.
 - 17 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.
 - 18 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.
 - 19 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 https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_medpac_ch6_sec.pdf).
 - 20 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.
 - 21 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 2023, Medicare spending for outpatient dialysis services for FFS beneficiaries with AKI was \$75 million, a 4 percent increase compared with 2022. 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.
 - 22 Between 2017 and 2019, the FDA approved generic versions of several types of phosphate binders (including lanthanum, sevelamer carbonate, and sevelamer hydrochloride).
 - 23 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 the inclusion of oral-only ESRD drugs in the ESRD PPS bundled payment until January 1, 2025.
 - 24 In the final rule, CMS said that the agency intends to reevaluate the amount of the monthly fixed-rate addition in next year’s rulemaking.

- 25 The FFS Medicare margin includes Medicare's payments and providers' allowable costs for qualifying ESRD drugs and items paid under the TDAPA, post-TDAPA, and TPNIES.
- 26 In 2019, there was an anomalous increase compared with prior years in non-ESRD-related drug costs for facilities associated with a dialysis organization.
- 27 The sharp increase in the 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 2026, the Congress should reduce the 2025 Medicare base payment rates for skilled nursing facilities by 3 percent.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • 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 a recent 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 2023, about 14,500 freestanding SNFs furnished about 1.6 million Medicare-covered stays to 1.2 million fee-for-service (FFS) beneficiaries. The FFS Medicare program and its beneficiaries spent \$30 billion for SNF services.

Assessment of payment adequacy

Overall, our indicators of payment adequacy were mostly positive. Although supply and utilization declined, these outcomes do not reflect the adequacy of Medicare's FFS payments.

Beneficiaries' access to care—Changes in the indicators of access were mostly positive.

- **Capacity and supply of providers**—The number of SNFs declined by about 1 percent in 2024. Given that Medicare is a small share of most nursing homes' business and that its payment rates are high relative to costs, it is unlikely that the closures reflect the adequacy of Medicare's payments. In 2023, 88 percent of Medicare beneficiaries

In this chapter

- Are FFS Medicare payments adequate in 2025?
- How should FFS Medicare payments change in 2026?
- Minimum staffing requirements set to begin in May 2026
- Medicaid trends

lived in a county with three or more SNFs or swing-bed facilities—the same share since 2018. However, beneficiaries who live in counties with high average occupancy rates or who require specialized services could face access problems.

- **Volume of services**—Utilization decreased between 2022 and 2023 as inpatient hospital stays were again required for SNF admissions starting in May 2023 when the public health emergency (PHE) waivers expired. (During the PHE, the three-day inpatient stay prerequisite for Medicare-covered SNF admissions was suspended, allowing SNFs to admit beneficiaries and to “skill in place” nursing home residents who did not have a prior hospital stay.) Between 2022 and 2023, Medicare-covered SNF admissions per 1,000 FFS beneficiaries decreased by 12 percent, and Medicare-covered SNF days per 1,000 FFS beneficiaries decreased by 8 percent.
- **Occupancy rate**—Occupancy rates continued to recover from the PHE period’s lows, reaching 84 percent in October 2024. Many providers reported closing beds and denying admissions due to workforce challenges.
- **FFS Medicare marginal profit**—In 2023, the FFS Medicare marginal profit (an indicator of whether SNFs with excess capacity have an incentive to treat more Medicare beneficiaries) was 31 percent for freestanding facilities.

Quality of care—Quality indicators were stable. In the two-year period from 2022 through 2023, the median facility risk-adjusted rate of discharge to the community from SNFs was 50.9 percent, similar to the rate for the 2021 and 2022 two-year period (50.7 percent). Also in the 2022 and 2023 two-year period, the median facility risk-adjusted rate of potentially preventable readmissions was 10.4 percent, similar to the rate in the 2021 and 2022 period. Staffing levels of registered nurses and nursing staff turnover rates were similarly unchanged. 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—The sector continues to be attractive to investors. In the first six months of 2024, there were 144 publicly announced merger and acquisition transactions, on pace for record transaction volume, indicating interest in the sector. In 2023, the all-payer total margin—the percentage of revenue from all payers and all lines of business that is left after accounting for all costs—improved from –1.3 percent in 2022 to 0.4 percent in 2023. Total

margins may be understated, given the complex arrangements many nursing homes have with third parties.

FFS Medicare payments and providers' costs—From 2022 through 2023, FFS Medicare payments per day to freestanding SNFs increased 2.4 percent, while cost per day increased 3.8 percent. The FFS Medicare margin for freestanding SNFs was 22 percent in 2023, a slight decline from 23 percent in 2022. These margins are higher than previously reported because we implemented a periodic update to our methodology to account for facility-level and payer-mix differences in the costs of treating Medicare patients. 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 23 percent in 2025.

How should Medicare payment rates change in 2026?

Based on our assessment of the payment-adequacy indicators listed above, Medicare's FFS payment rates need to be reduced to align aggregate payments more closely with aggregate costs. However, some uncertainty remains about the costs associated with new nurse staffing requirements that were recently finalized by CMS (see below). The Commission therefore proposes a modest reduction to the payment rates and recommends that, for fiscal year 2026, the Congress reduce the 2025 base payment rates for skilled nursing facilities by 3 percent.

Minimum staffing requirement set to begin May 2026

Nurse staffing levels are key to patient outcomes and comprise a high share of SNF costs. In May 2024, CMS issued a final rule revising the staffing requirements for nursing homes that will be implemented in May 2026. We estimate that if the new staffing requirements had been fully implemented in 2024, 30 percent of nursing homes could be exempt from at least one of the staffing hour requirements and 12 percent could be exempt from all the staffing hour requirements. Of the nonexempt facilities, less than one-quarter would meet all the required minimums for hours per resident day under the full effect of the rule. However, the majority of facilities had staffing levels that were within 80 percent or 90 percent of the minimums. That said, those facilities would incur large expenses to meet the staffing requirements. Nonexempt facilities that did not meet applicable requirements tended to have higher FFS Medicare margins compared with other facilities.

Medicaid trends

As required by the Affordable Care Act of 2010 (ACA), we report on Medicaid use and spending and non-FFS Medicare margins in nursing homes. Almost all SNFs are also long-term care nursing facilities, and Medicaid finances most long-term care services provided in SNFs. Some state programs also cover the SNF copayments for beneficiaries who are dually eligible for Medicare and Medicaid and who stay more than 20 days in a SNF. Between December 2023 and October 2024, the number of Medicaid-certified facilities declined 1.1 percent, to about 14,300 facilities. In 2023, FFS Medicaid spending (federal and state) was \$42.5 billion, 5.6 percent more than in 2022. The average non-FFS Medicare margin (which includes all other payers, funds related to the public health emergency, and all lines of business except FFS Medicare SNF services) was -4.1 percent, an improvement from 2022. The improvement reflects the increases in base payment rates made by many states. ■

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 2023, the fee-for-service (FFS) Medicare program and its beneficiaries spent about \$30 billion under the SNF prospective payment system (PPS) for 1.6 million FFS Medicare-covered SNF stays. Medicare also paid \$2 billion for SNF care provided in hospital 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.^{2,3} Medicare's SNF PPS pays SNFs for each day of service.⁴ For beneficiaries who

qualify for SNF care, Medicare pays 100 percent of the daily amount for the first 20 days. Beginning on Day 21, beneficiaries are responsible for copayments through Day 100 of the covered stay; in 2025, the copayment is \$209.50 per day. This copayment structure impacts the use of SNF services. Our analysis of claims from 2023 found that the share of stays discharged on Day 20 (3.6 percent) is higher relative to the share discharged on Day 19 (2.5 percent) and Day 21 (2.6 percent). The evidence on whether shorter stays affect patient outcomes is mixed. One study found that stays that were one day shorter were associated with higher readmissions rates, while another found that shorter stays were not associated with worse mortality rates, rates of hospitalization for fall-related injuries, or all-cause hospitalization rates (McGarry et al. 2021, Werner et al. 2019).

FFS Medicare's daily payments to SNFs are determined by adjusting base payment rates for geographic differences in labor costs and for case mix. The case-mix system, the Patient-Driven Payment Model (PDPM), considers the clinical reason for treatment, comorbidities, and functional status at admission in setting payment rates so that providers are paid more to treat medically complex patients who are more costly to treat. Payments are no longer based on minutes of

Skilled nursing facility care provided in swing beds

With approval from CMS, certain Medicare-certified hospitals may provide skilled nursing services in the hospital beds normally used to provide acute care services. These are called “swing beds,” and they are typically located in small rural hospitals and critical access hospitals (CAHs). In 2023, about 4 percent of skilled nursing facility (SNF) care was provided in swing beds. That year, the fee-for-service (FFS) Medicare program paid \$2 billion for about 67,000 Medicare-covered swing-bed stays. In 2023, 89 percent of swing-bed stays were in CAHs and 11 percent were in short-term acute care hospitals.

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. Spending on CAH swing beds accounted for 98 percent of program spending on swing beds, owing to the much higher average daily rate (about \$2,600 per day) for CAH swing-bed days compared with the average SNF PPS daily rate (about \$530 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 2023**

Type of SNF	Facilities	Medicare-covered stays	Medicare spending
Total	14,500	1,583,000	\$25 billion
Freestanding	97%	98%	98%
Hospital based	3	2	2
Urban	73	85	87
Rural	27	15	13
For profit	73	75	79
Nonprofit	22	22	18
Government	5	3	3

Note: SNF (skilled nursing facility). Components 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. 187. The facility count differs from the count in Table 6-2 (p. 190) because this table includes only SNFs that billed Medicare for services in 2023.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review file for calendar year 2023.

therapy provided and are calculated using information gathered from a standardized patient assessment instrument called the Minimum Data Set (MDS).

After a dramatic drop in the therapy minutes per stay immediately following the change in the case-mix system on October 1, 2019 (total minutes decreased 23 percent in the first three months), the provision of therapy continued to decrease 9 percent through 2022 (Medicare Payment Advisory Commission 2023). Between 2023 and 2024, therapy minutes per stay stabilized (increasing 0.3 percent). In addition to lowering the amount of therapy provided, providers have an incentive to lower their therapy costs by shifting therapy modalities to group or concurrent therapy (these types are lower cost because multiple patients receive therapy at the same time). These lower-cost modalities can comprise up to 25 percent of total therapy minutes. While the share of individual therapy has declined slightly, it remains the predominant form of provision, making up 93 percent of minutes.

Skilled nursing facility sector profile

A SNF 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 the majority of this care. In freestanding facilities in 2023, FFS Medicare-covered days made up just 8 percent of facility days in the median facility compared with 63 percent of facility days paid by Medicaid. The share of FFS Medicare-covered days in 2023 declined from 10 percent in 2022, in part due to the continued growth of Medicare Advantage (MA) enrollment and an increase in the share

of Medicaid days. As FFS Medicare's share of covered days declined, so did its share of facility revenue, which fell from 17 percent in 2022 to 14 percent in 2023. (Because of FFS Medicare's relatively high payment rates, the program makes up a larger share of facility revenue than covered days.)

SNFs are overwhelmingly freestanding, and the majority are for profit

In 2023, 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-three percent of providers were for profit. Rural facilities make up the minority of SNFs, SNF stays, and SNF spending. (About 16 percent of FFS SNF users saw a rural provider; data not shown.) About 4 percent of SNF care was provided in swing-bed facilities.

Freestanding SNFs vary in size. In 2023, the median SNF had 100 beds, while 10 percent of facilities had 176 or more beds and 10 percent of facilities had 51 beds or fewer. Nonprofit facilities and rural facilities are generally smaller than for-profit and urban facilities. However, the majority (59 percent) of small facilities (fewer than 50 beds) in 2023 were in urban areas.

The SNF sector is fragmented and characterized by independent providers and regional and local 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, many SNFs have separate companies to operate the facility and to hold the property. This separation protects the nursing home from potential lawsuits and can infuse cash into the business. 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.

Private equity (PE) investment makes up about 5 percent of all facilities, and real estate investment trusts (REITs) make up another 9 percent (Stevenson et al. 2023).⁵ This research, as well as work done by others, identified gaps and errors in the ownership data (Chen et al. 2024, 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). Providers will be required to furnish this information when initially enrolling or revalidating their enrollment (required every five years) and when there are changes in their ownership information. To improve the accuracy of ownership and third-party information, CMS required all SNFs to revalidate this information by May 1, 2025 (Centers for Medicare & Medicaid Services 2024d).

Are FFS Medicare payments adequate in 2025?

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, FFS Medicare payments in relation to costs to treat Medicare beneficiaries, and the relationship between Medicare's payments and SNFs' costs. Overall, our indicators of payment adequacy were positive.

Beneficiaries' access to care: SNF supply and utilization declined while occupancy rates increased

To assess FFS beneficiaries' 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 2024 but reflected factors other than the adequacy of Medicare's payments

In the first nine months of 2024, the number of SNFs and swing beds participating in the Medicare program declined 1.2 percent from 2023 to 14,600 (Table 6-2, p. 190). Note that providers that stop participating in the program (either voluntarily or due to termination by Medicare) have not necessarily closed. No longer participating in the program could indicate that the facility was purchased by another entity and has a new provider number or that the facility remained open

**TABLE
6-2**

Supply of SNFs continued to decline in 2024

	2020	2021	2022	2023	2024
Count of Medicare-participating SNFs	15,150	15,100	14,950	14,800	14,600
Percent change from prior year		-0.5%	-0.9%	-1.0	-1.2

Note: SNF (skilled nursing facility). The figure for 2024 was calculated through October; it does not include data from the full calendar year. Counts include active providers serving Medicare beneficiaries in the calendar year for Medicare-certified SNFs in the 50 states and the District of Columbia. Counts do not include nursing facilities that are not Medicare certified. Percent changes were calculated on unrounded data.

Source: MedPAC analysis of active provider counts from CMS's Quality, Certification and Oversight Reports, accessed on October 3, 2024.

but stopped accepting Medicare patients (to become a nursing facility for long-stay residents only).

Since 2021, the year-to-year declines have been fairly consistent and are likely related to several factors that lowered utilization, such as states shifting to more home- and community-based long-term care, staffing difficulties that limit how many beds can remain open, reportedly low Medicaid payment rates for long-term care, and patient preference for receiving care in non-SNF settings when possible. Interestingly, the rate of closures during the pandemic did not increase, in part due to strategies that providers took to dampen the impact of staffing shortages (such as freezing admissions and closing beds) and additional government funds related to the public health emergency (such as the Provider Relief Fund) (Assistant Secretary for Planning and Evaluation 2024). Because Medicare constitutes a small share of most SNFs' businesses and its payment rates are high relative to the cost of care (see p. 201), the closures do not reflect the adequacy of Medicare's payments.

Of the 16 new facilities, one-third were nonprofit. Of 71 terminations as of October 2024, three-quarters were for-profit facilities, and all but 11 closed at their own initiative (i.e., they were not terminated by the program). The number of terminations decreased from 2023 to 2024.

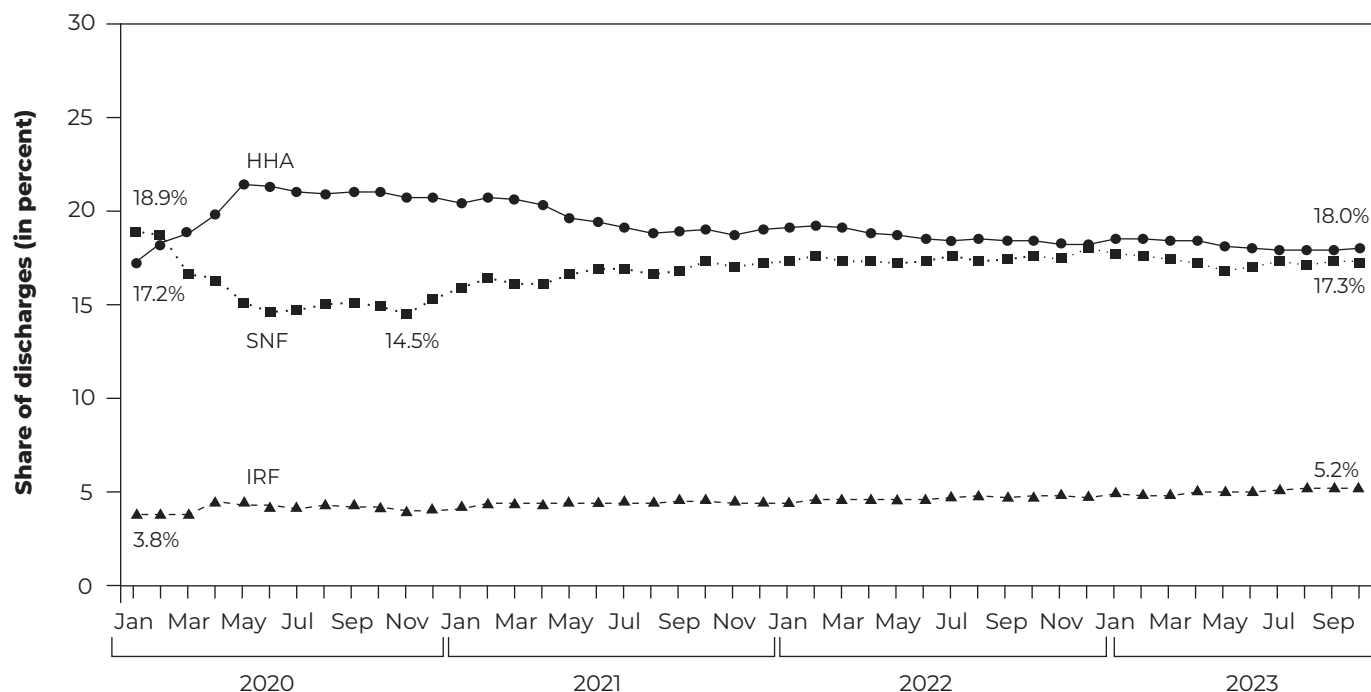
In 2023, 88 percent of Medicare beneficiaries with Part A coverage lived in counties with three or more SNFs or swing-bed facilities and 5.9 percent of beneficiaries lived in counties with no or only one SNF or swing-

bed facility, similar to the share in 2022 (5.8 percent). However, the presence of a facility alone does not ensure access. Beneficiaries who live in areas with very high occupancy rates may have a harder time accessing SNF care close to home. As of July 2024, about 9 percent of beneficiaries lived in a county where the average SNF occupancy rate was greater than 90 percent. About 48 percent lived in a county where the average SNF occupancy rate was between 80 percent and 90 percent, and 41 percent 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. As of November 2024, among SNFs that terminated participation in Medicare between 2019 and 2024, the median travel distance for facilities that closed in metropolitan areas (2.0 miles) was similar to the median distance for those that closed in rural areas (2.5 miles).⁶ However, the mean travel distances varied more (less than three miles for urban closures compared with eight miles for rural closures), indicating long travel distances for some beneficiaries living in rural areas.

The rate of SNF use after an inpatient discharge stabilized in 2023 at below prepandemic level

In January 2020, immediately before the pandemic, SNFs were the most common first post-acute care (PAC) destination after discharge from an inpatient

**FIGURE
6-1****Monthly share of IPPS discharges to SNFs, home health services, and IRFs, January 2020 to October 2023**

Note: HHA (home health agency), IPPS (inpatient prospective payment systems), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility).

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

hospital stay, accounting for 46 percent of all FFS discharges to a PAC destination (data not shown), or 18.9 percent of all FFS discharges (Figure 6-1). During the pandemic, the SNF share of all FFS discharges dropped to 14.5 percent as the number of inpatient discharges declined and beneficiaries avoided nursing homes. During 2021, SNFs slowly regained some of the lost volume, but since 2022, the share has remained fairly stable at around 17 percent—below the prepandemic level.

SNF occupancy had mostly recovered to prepandemic levels as of October 2024

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. 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. Since then, occupancy rates have increased to about where they were before the PHE. In October 2024, the median national SNF occupancy rate was 84 percent; one-quarter of SNFs had greater than 92 percent occupancy, and one-quarter of SNFs had occupancy rates of 71 percent or less.

SNF employment remained below prepandemic levels but showed gains through November 2024

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 a PHE-low in March 2022, the number of employees in the SNF sector declined nearly 15 percent (Bureau of Labor Statistics 2024). Overall employment in the sector has been growing since the second quarter of

**TABLE
6-3****SNF admissions and days in 2023**

Volume measure	2019	2020	2021	2022	2023	Change	
						2019–2023	2022–2023
Covered admissions per 1,000 FFS beneficiaries	55	50	49	54	47	–14%	–12%
Covered days per 1,000 FFS beneficiaries	1,447	1,429	1,361	1,500	1,385	–4	–8
Covered days per admission	26.1	28.5	28.0	28.0	29.0	12	5

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 SNF use. Percent changes were calculated on unrounded data.

Source: MedPAC analysis of 2019–2023 Medicare Provider Analysis and Review and Common Medicare Environment data.

2022, but in November 2024 it remained 7 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, the industry reports that inadequate staffing levels have limited access for prospective residents. An industry-sponsored survey of 411 providers reported in March 2024 that about half of those surveyed had turned away potential residents and 19 percent had closed a unit, wing, or floor (American Health Care Association 2024). Hospitals have reported delays in transferring patients to SNFs, raising lengths of stays in acute care (Siddiqi 2024).

SNF admissions and days decreased in 2023

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 2021b). Several factors likely contributed to this decline, including a contemporaneous reduction in the inpatient hospital stays needed to qualify for SNF coverage. Although we did not 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.⁷

During the first two years of the pandemic (2020 and 2021), SNF use per FFS beneficiary declined sharply (Table 6-3). Between 2019 and 2021, admissions per FFS

beneficiary fell 11 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. (During the PHE, the three-day inpatient stay required for Medicare-covered SNF admissions was suspended, allowing SNFs to admit beneficiaries and to “skill in place” nursing home residents who did not have a prior hospital stay.) The following year (in 2022), SNF admissions and covered days per 1,000 FFS beneficiaries increased.

Between 2022 and 2023, FFS days and admissions dropped by over 10 percent. On a per FFS beneficiary basis, SNF admissions and days were down 12 percent and 8 percent, respectively (Table 6-3). Much of the decline is likely due to the expiration of the three-day hospital-stay waiver in May 2023. PHE-waiver admissions without a COVID-19 diagnosis accounted for approximately 15 percent of all SNF stays throughout the entire PHE (Avalere 2024). Because admissions per 1,000 FFS beneficiaries decreased more than the decline in days, the covered days per admission rose 5 percent. We will continue to monitor length of stay to see whether the lower levels of utilization persist.

We previously reported on differences across beneficiary subgroups in the use of SNFs. Black beneficiaries, Hispanic beneficiaries, and beneficiaries dually eligible for Medicare and Medicaid are less likely to use high-quality SNFs and facilities that specialize in

post-acute skilled care (as opposed to long-term care services) (Medicare Payment Advisory Commission 2024). Increased specialization in skilled care may exacerbate existing racial and economic disparities in access to high-quality SNF care (Werner et al. 2021). Clinical characteristics can also shape a beneficiary's access to specialized SNF care. One study found that facilities with higher shares of Medicare patients were more likely to have the resources needed to treat obese patients, indicating that access to these specialized services is uneven across facilities (Orewa et al. 2024). Another study found that short-stay beneficiaries with Alzheimer's disease and related dementias were less likely to be admitted to higher-quality SNFs compared with beneficiaries without these conditions (Kosar et al. 2023).

Over the coming year, we plan to examine SNF use by MA enrollees. Although we have not analyzed utilization management data from MA plans, interviews with hospital discharge planners and trade press articles suggest that MA plans use prior authorization and denials to manage admissions and length of stay.

SNFs with available capacity continued to have a strong financial incentive to admit Medicare beneficiaries

Another component of access is whether providers have a financial incentive to expand the number of FFS Medicare beneficiaries they serve. To assess this component, we examine the FFS Medicare marginal profit—the percentage of revenue from FFS Medicare that is left as profit after accounting for the allowable variable costs of providing services to FFS Medicare patients. (Variable costs are those that vary with the number of patients treated. By contrast, fixed costs are those that are the same in the short run regardless of the number of patients treated (e.g., rent).) If the FFS Medicare marginal profit is positive, a provider with excess capacity has a financial incentive to care for an additional FFS beneficiary; if the FFS Medicare marginal profit is negative, a provider may have a disincentive to care for an additional FFS beneficiary. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.)

In 2023, the FFS Medicare marginal profit among freestanding SNFs was 31 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.

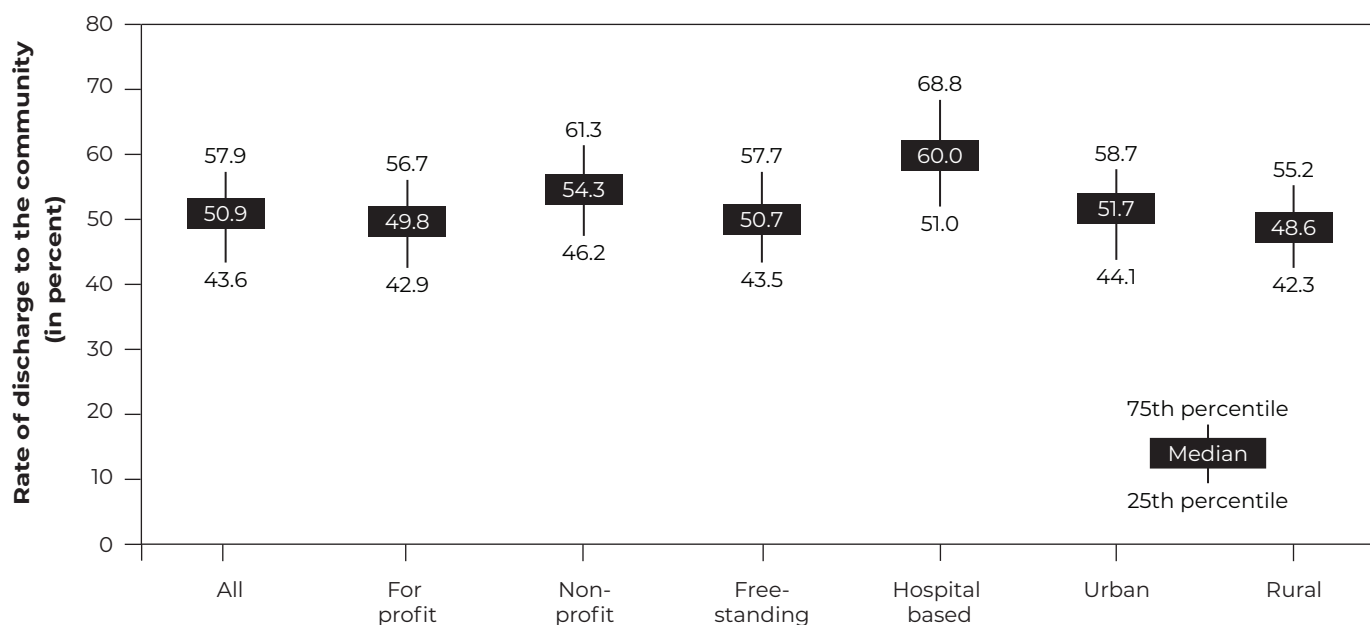
Quality of care: All measures were stable but varied across facilities

We report two claims-based outcome measures for SNFs (risk-adjusted potentially preventable hospital readmissions after discharge and risk-adjusted discharge to the community) and two measures of staffing (risk-adjusted registered nurse hours per resident day and total nurse staffing turnover rates).

Discharge to the community

The measure of discharge to the community is a SNF's risk-adjusted 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).⁸ Baseline nursing facility residents—those who were nursing facility residents before 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 providing recuperative nursing care, rehabilitation to improve functional ability, discharge planning care and coordination, and patient and family education.

In fiscal year (FY) 2022 and FY 2023 (combined), the national average observed rate of discharge to the community was 45 percent, and the median facility risk-adjusted rate of discharge to the community was 50.9 percent. The risk-adjusted rate has been fairly stable over time. The most recent result is similar to the FY 2021 and FY 2022 period (when it was 50.7 percent), but both rates are slightly worse than the rate for the FY 2018 and FY 2019 period, when it was 51.7 percent. In FY 2022 and FY 2023, one-quarter of facilities had a risk-adjusted rate below 43.6 percent and one-quarter had a rate above 57.9 percent (Figure 6-2, p. 194). Median rates varied considerably by

**FIGURE
6-2****Median and interquartile range of SNFs' risk-adjusted rates of discharge to the community in FY 2022 and FY 2023**

Note: SNF (skilled nursing facility), FY (fiscal year). Data include SNFs in the 50 states and the District of Columbia and cover 24 months (FY 2022 and FY 2023 combined). The measure of “discharge to the community” is a SNF’s risk-adjusted 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. Rates are computed from Medicare claims for eligible Medicare Part A-covered SNF stays and do not include swing-bed stays. Providers with fewer than 25 cases and missing data were excluded, and the analysis includes 12,063 providers.

Source: MedPAC analysis of claims-based outcome measures from CMS’s Provider Data Catalog.

ownership, facility type, location, and size. Nonprofit SNFs and hospital-based SNFs had higher (better) rates than for-profit SNFs and freestanding SNFs. Urban facilities had higher rates than rural facilities, and very rural SNFs (rural nonmicropolitan) had still lower rates (46.7 percent; data not shown). Smaller facilities had higher rates than larger facilities, reflecting their relatively large shares of hospital-based SNFs, urban SNFs, and nonprofit SNFs (data not shown). The within-group variation in rates was consistent across groups (about a 1.3-fold difference between the 25th percentile and 75th percentile).

Potentially preventable readmissions

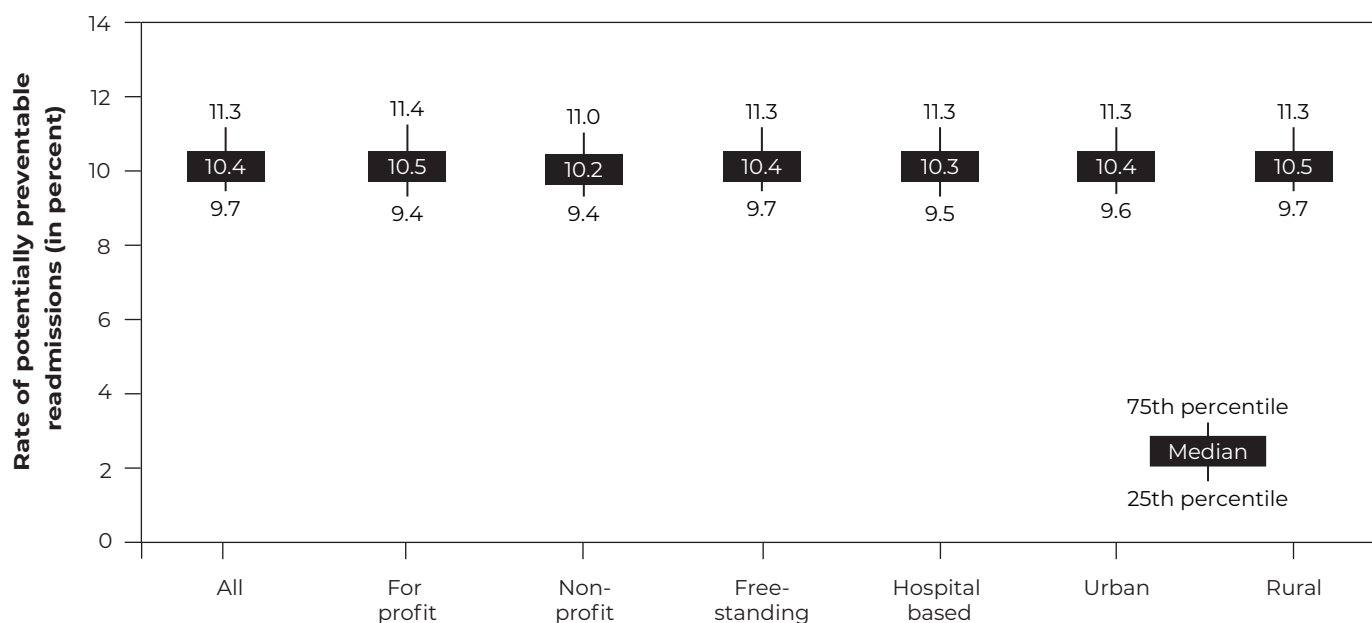
Potentially preventable readmissions after discharge from the SNF are calculated as the percentage of patients discharged from a SNF stay who were

readmitted to a hospital within 30 days for a medical condition that might have been prevented (lower percentages are better) (RTI International 2016). 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.

During the FY 2022 and FY 2023 period, the national average observed rate of potentially preventable readmissions was 10.3 percent, similar to the FY 2021 and FY 2022 period when it was 10.4 percent (data not shown). The median facility-level risk-adjusted rate of potentially preventable readmissions was 10.4 percent (Figure 6-3). One-quarter of facilities had rates below 9.7 percent and one-quarter had rates above 11.3 percent. This rate was the same as for the FY 2021 and FY 2022 period (data not shown).⁹ The differences in

**FIGURE
6-3**

Median and interquartile range of SNFs' risk-adjusted rates of potentially preventable readmissions in FY 2022 and FY 2023



Note: SNF (skilled nursing facility), FY (fiscal year). Data include SNFs in the 50 states and the District of Columbia and cover 24 months (FY 2022 and FY 2023 combined). The measure of “potentially preventable readmissions” after discharge from the SNF 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. Providers with fewer than 25 cases and missing data were excluded, and the analysis includes 12,063 providers.

Source: MedPAC analysis of claims-based outcome measures from CMS's Provider Data Catalog.

the median rates were small across ownership, facility type, location, and SNF size (data on size is not shown). The across-group and the within-group variations were relatively small.

In addition to potentially preventable readmissions after the SNF stay, readmissions that occur during the stay are an important gauge of the care SNFs provide. In fiscal year 2028, CMS will include potentially preventable readmissions that occur any time within the entire SNF stay as a performance measure in the SNF value-based purchasing (VBP) program (see text box on the SNF VBP program, p. 198). This measure will replace the rate of all-cause readmissions within 30 days of admission to the SNF that is included in the current VBP. When these new data become available, we will report the rates of readmission during the entire SNF stay.¹⁰

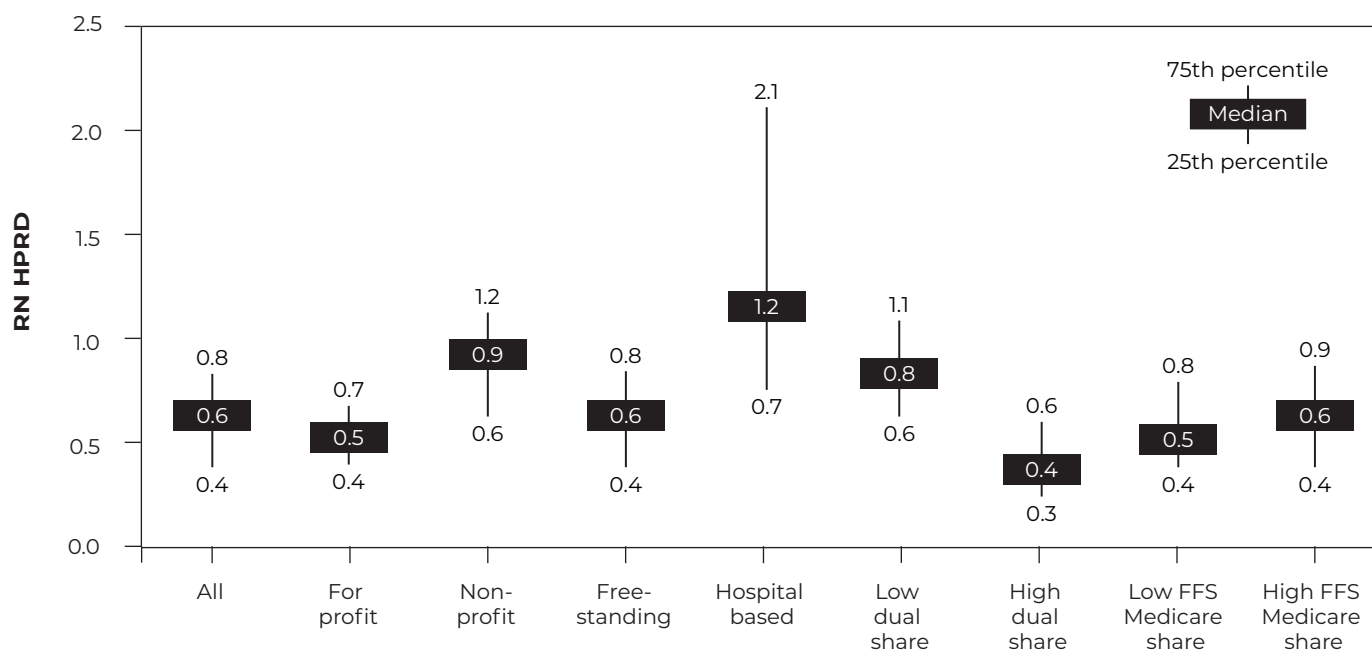
Readmissions and discharge to the community measures assess key outcomes of SNF care, but they do not capture all aspects of quality in SNFs. Ideally, we could also measure other outcomes and the experience of SNF care for Medicare beneficiaries in a Part A stay. However, lack of data on patient experience and concerns about the validity of function data derived from the MDS limit our set of quality measures, as discussed below.

Staffing measures

While the Commission has long tracked the quality of care using outcome measures, more recently it expanded its focus to include staffing measures because staffing plays a key role in shaping the quality of care in nursing homes and SNFs. The National Academies of Sciences concluded that the number and

**FIGURE
6-4**

SNFs' median and interquartile range of acuity-adjusted RN hours per resident day by facility characteristics, 2023



Note: SNF (skilled nursing facility), RN (registered nurse), HPRD (hours per resident day), FFS (fee-for-service). "Low dual share" is the bottom quartile of the fully and partially dual-eligible beneficiary share of FFS Medicare stays, and "high dual share" is the top quartile of the fully and partially dual-eligible beneficiary share of FFS Medicare days. "Low FFS Medicare share" is the bottom quartile of FFS Medicare beneficiary share of total facility days, and "high FFS Medicare share" is the top quartile of FFS Medicare beneficiary share of total facility days. Staffing ratios for the year are determined by averaging the quarterly values of the calendar year for each provider. All Medicare- and Medicare/Medicaid-certified SNFs with valid data are included.

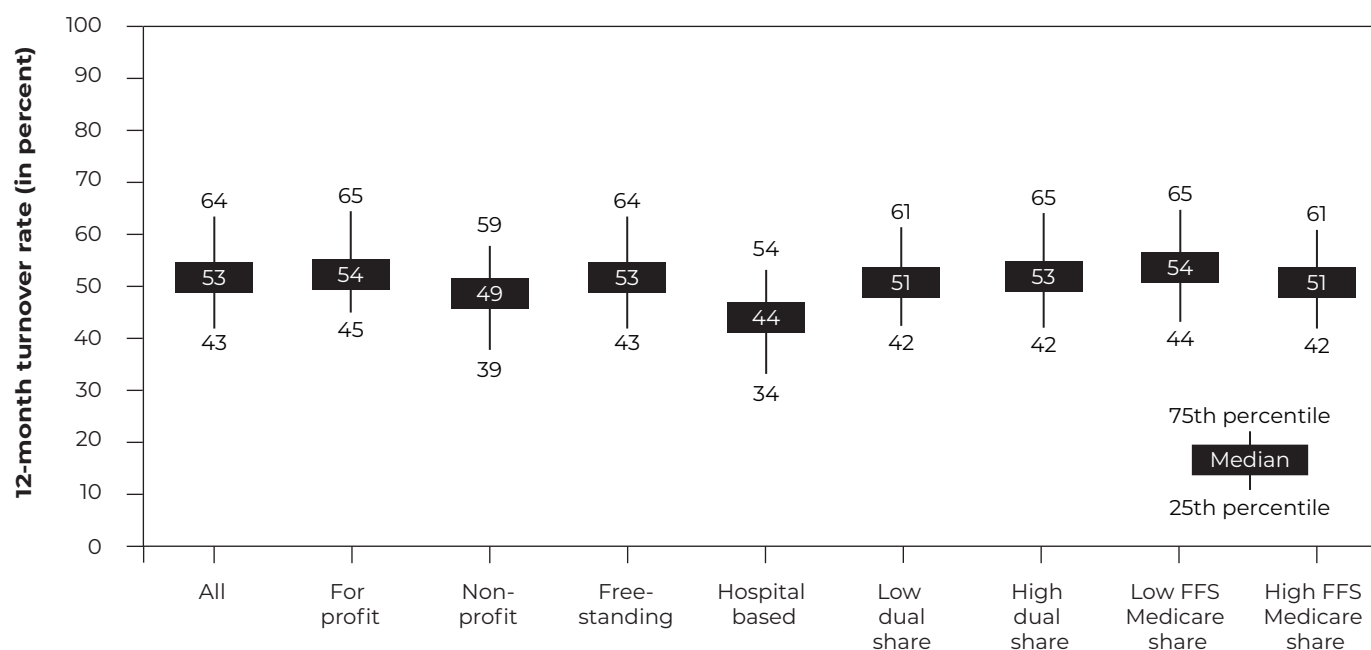
Source: MedPAC analysis of quarterly nursing facility staffing measures from CMS's Provider Data Catalog, Medicare freestanding SNF cost reports, and CMS Common Medicare Environment.

continuity of staff can impact quality of life and patient safety in a SNF (National Academies of Sciences 2022). We previously summarized the literature concluding that having more registered nurses (RNs) per resident day has been associated with better outcomes and lower staff turnover rates (Medicare Payment Advisory Commission 2024). In their review of the literature in a report to CMS, researchers at Abt Associates noted that the higher staffing levels were associated with fewer pressure ulcers, emergency department visits, and rehospitalizations (White and Olsho 2023).

We examined two staffing measures that researchers found are related to nursing home quality: the level of RN staffing and total staff turnover (Clemens et al.

2021, Gorges and Konetzka 2020, Kennedy et al. 2020, Mukamel et al. 2022). Although nursing facility staffing ratios and turnover rates refer to the entire facility (not just to Medicare-covered stays), these broad measures are likely to reflect the care beneficiaries receive during Medicare-covered stays. Many nursing homes (those with beds that are dually certified for Medicare and Medicaid) can use their beds interchangeably for long-stay residents and short-stay patients, and indeed, many beneficiaries switch between Medicare-covered PAC and long-term care covered by other payers.

In 2023, the median SNF provided 0.6 case-mix-adjusted RN hours per resident day (HPRD) (Figure 6-4). Freestanding SNFs had lower median case-mix-

FIGURE 6-5**SNFs' median and interquartile range of acuity-adjusted total nursing staff 12-month turnover rates by facility characteristics, 2023**

Note: SNF (skilled nursing facility), RN (registered nurse), FFS (fee-for-service). "Low dual share" is the bottom quartile of the fully and partially dual-eligible beneficiary share of FFS Medicare stays, and "high dual share" is the top quartile of the fully and partially dual-eligible beneficiary share of FFS Medicare days. "Low FFS Medicare share" is the bottom quartile of FFS Medicare beneficiary share of total facility days, and "high FFS Medicare share" is the top quartile of FFS Medicare beneficiary share of total facility days. Staffing ratios for the year are determined by averaging the quarterly values of the calendar year for each provider. 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, Medicare freestanding SNF cost reports, and CMS Common Medicare Environment.

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). Metropolitan facilities (0.6 HPRD) had case-mix-adjusted RN staffing similar to that at very rural facilities (defined as "rural nonadjacent," 0.7 HPRD) (data not shown). The HPRD for facilities with low shares of dually eligible beneficiaries was double that for facilities with high shares (0.8 HPRD compared with 0.4 HPRD). Facilities with high Medicare shares had higher HPRD than facilities with low shares, but the differences were smaller. 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 and unmeasured differences in case mix.

The 12-month nursing staff turnover rate as of 2023 was 53 percent for the median SNF, and one-quarter of facilities had turnover rates greater than 64 percent (Figure 6-5).¹¹ A facility can have a high turnover rate because it has very high turnover for select positions (but otherwise relatively stable staffing) or high turnover facility-wide. For-profit SNFs and freestanding SNFs had higher turnover rates compared with nonprofit SNFs and hospital-based SNFs. Urban facilities (53 percent) had turnover rates similar to rates at very rural facilities (51 percent), although RN-specific turnover was higher in urban facilities (51 percent) than in very rural facilities (44 percent) (data not shown).

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 (CAA), the Congress granted authority to the Secretary to add up to nine more measures to the SNF VBP program and required that CMS establish minimum case counts and measure counts for a SNF to be included in the program.

In response to congressional action, CMS has made substantial revisions to the program. It expands the measure set from one (hospital readmissions) to a total of eight by fiscal year (FY) 2027 (Centers for Medicare & Medicaid Services 2024c). In FY 2026, the first three measures will be added: infections requiring hospitalization, total nurse staffing per resident day, and staff turnover rates. In FY 2027, four more measures will be added: discharge to community, the percentage of long-stay residents who have a fall with major injury, discharge function score for SNF patients, and hospitalizations per 1,000 long-stay residents. In FY 2028, CMS will replace the 30-day all-cause readmission rate with a within-stay potentially preventable readmission measure. To improve measure reliability, CMS established minimum case counts for a minimum

number of measures. In FY 2026, when there will be four measures in the program, providers will be required to meet the minimum counts for two of them. In FY 2027, providers will have to meet the minimum counts for four of the eight measures. In addition, CMS extended the performance period to two years for two measures.

Beginning in FY 2027, the VBP program will include a health-equity adjustment that will increase VBP payments for SNFs that provide high-quality care and services for high proportions of dually eligible beneficiaries. The adjustment will vary depending on the number of measures for which the SNF has top performance and on its share of dually eligible beneficiaries.

The changes made to the program broadly address three of the concerns the Commission previously raised about the program—the program should score a small set of performance measures (not just one), incorporate strategies to ensure reliable measure results, and account for differences in patient social risk factors using a peer-grouping mechanism (Medicare Payment Advisory Commission 2021a). The Commission identified two other shortcomings: The design may not encourage all providers to improve, and the entire provider-funded incentive pool should be budget neutral and paid out each year. These provisions are in statute and require congressional action to change. ■

Differences were small between facilities with high and low shares of dually eligible beneficiaries and between high and low shares of FFS Medicare beneficiaries.

CMS will implement new minimum staffing requirements beginning in May 2026

In May 2024, CMS finalized rules that revise the current staffing requirements for nursing homes, adding new

minimums and making current RN requirements stricter (Centers for Medicare & Medicaid Services 2024b). The new requirements will be phased in over time, with urban facilities beginning in May 2026 and rural facilities beginning in 2027.¹² The Commission has not taken a position on the staffing rule. We examine current staffing levels relative to the staffing rule (p. 209).

Patient-experience data are not collected for SNF patients

The Medicare program does not collect data on beneficiaries' experience of their SNF care or their informal primary caregivers' experiences with SNFs. In 2021, the Commission recommended that the Secretary finalize patient-experience measures for SNFs and begin to report them. The Commission also noted that such measures should become part of the measure set for the SNF value incentive program (see text box on the SNF VBP program) (Medicare Payment Advisory Commission 2021a). In the SNF proposed rule for 2024, CMS proposed adopting a patient-experience survey but opted not to implement this provision (Centers for Medicare & Medicaid Services 2023c). In 2025, CMS requests information on patient-experience measures and stated it would consider the comments in future measure development (Centers for Medicare & Medicaid Services 2024c).

Patient function is a key SNF outcome, but the accuracy of the data needs to be validated

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. 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 noted 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 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 2021a).

In FY 2024, CMS finalized its approach to validating the MDS information used in the value-based purchasing program: randomly selecting up to 1,500 SNFs on an annual basis and requesting up to 10 randomly selected medical records from each. In the FY 2025 final rule, CMS adopted the same approach to validate the MDS data used in the SNF Quality Reporting Program.

To decrease the reporting burden on providers, the same records would be used for both purposes. The validation process will begin in FY 2027; for providers that do not submit the requested information within the specified timeframe, CMS will lower the market basket update by 2 percentage points.

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. Currently, 35 states and the District of Columbia maintain some form of CON program (National Conference of State Legislatures 2024). 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. After a record-high average price per bed in 2022 (\$114,200), prices dropped over 14 percent in 2023 to \$97,700, though these were still higher than prepandemic levels (Irving Levin Associates LLC 2024c).¹³ Prices dipped for three reasons: More distressed assets entered the market, there were fewer high-priced facilities for sale, and financing was more difficult (Irving Levin Associates LLC 2024c).

The first six months of 2024 saw a significant increase in the number of transactions (144 between January and June 2024, compared with 81 in all of 2023), indicating that the market is strong (Irving Levin Associates LLC 2024a, Irving Levin Associates LLC 2024c). This growth partly reflects smaller deals because financing

large transactions has become more difficult (Irving Levin Associates LLC 2024b). SNFs continue to offer attractive yields to investors, especially when considering the additional sources of revenue from other businesses (such as hospice) and incentives to grow one's patient population. Low-performing assets may offer even more opportunity because a new owner may be able to expand referrals and improve payer mix, efficiencies, and case-mix coding (Irving Levin Associates LLC 2024a). For example, in 2024 the Ensign Group, the PACS group, and CareTrust REIT continued to expand their portfolios (CareTrust REIT 2024, Ensign Group 2024, PACS Group Inc. 2024). The Ensign Group reported that it will continue to expand in new states and in states where it already has holdings. Also potentially affecting industry transactions are allegations of questionable practices, which could affect a company's performance and slow its expansion if investors shy away or penalties are levied (Business Wire 2024, Hindenburg Research 2024).

It remains to be seen how the staffing rule, if it is implemented, will affect SNFs' access to capital (see section on the staffing rule, p. 209). According to a poll of dealmakers conducted by Senior Care Investor, when asked how the staffing rule would impact lenders' ability to lend for SNFs, 64 percent said they would be "somewhat" impacted, 15 percent said "not at all," and 21 percent said "significantly" (Irving Levin Associates LLC 2024d).

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 FY 2024, HUD financed 220 projects, an increase from 196 projects in 2023 (Department of Housing and Urban Development 2024, Department of Housing and Urban Development 2023). The total HUD-insured amount in 2024 was \$3.2 billion, compared with \$2.9 billion in 2023. Though the projects and insured amounts increased from last year, both are down about 30 percent since 2020. A minority of facilities access capital via private equity, as discussed above, in addition to HUD and commercial bank loans (ATI Advisory 2022).

The SNF sector remains attractive for investors because demand is expected to increase from an

aging population and the setting's relatively low costs compared with other institutional PAC such as inpatient rehabilitation facilities. Recent increases in hiring have improved occupancy rates; many Medicaid programs have increased rates (see section on Medicaid, p. 213); and, for providers that borrowed or are considering borrowing, interest rates were lowered in September 2024. 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 rose in 2023

In 2023, the estimated all-payer total margin for freestanding SNFs (reflecting all lines of business, all payers, and investment income) was 0.4 percent, up from -1.3 percent in 2022. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) In 2023, 47 percent of SNFs had negative all-payer total margins, down from 51 percent in 2022. PHE-related 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. These relief funds continued through part of 2023, though the aggregate amount dropped by over 50 percent compared with 2022. Provider relief funds were about a quarter of their 2022 peak. Without these additional funds, the all-payer total margin would have been about -3.7 percent in 2022 and about -0.6 percent in 2023.

Because the all-payer total margin includes Medicaid-funded long-term care, state policies regarding the level of Medicaid payments, including base rates and supplemental payments, significantly affect the overall financial performance of this setting. 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 that the 2019 median base payments (that exclude other supplemental payments from Medicaid) covered 86 percent of costs (Medicaid and CHIP Payment and Access Commission 2023). The continued expansion of enrollment in MA, with its lower payment rates, also factors into the total margin. One study of payments and costs from 2017 through 2019 found that as MA penetration in a county increased, the average total

margin of SNFs in the county decreased (Marr and Shen 2024).

The lack of transparency in reporting of third-party transactions and related entities makes it difficult to know if we are accurately assessing the finances of nursing facilities. Nationally, over three-quarters of nursing facilities reported payments to related third parties (including real estate companies, management companies, pharmacies, and medical supply companies) (Harrington et al. 2024). One study of nursing facilities in Illinois (a state that requires detailed financial reporting) examined costs before and after nursing facilities entered into a related-party agreement (Gandhi and Olenski 2024). The study found that facilities' costs increased due to inflated sales-leaseback agreements and costly management fees owed to the related-party entity. After reestimating nursing home profits based on what costs would have been without the inflated costs, it found that the reported profits were only 32 percent of actual industry profits—that is, 68 percent of the actual profits were “hidden” in inflated costs.

High FFS Medicare rates effectively subsidize other payers with lower rates, such as Medicaid and possibly MA. While some have argued that FFS 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 FFS Medicare payment rates that are far in excess of providers' costs is poor policy for several reasons, discussed below.

Higher FFS Medicare payment rates could create undesirable incentives The differential between Medicare's payment rates and those of other payers, such as Medicaid, encourages providers to select patients based on payer source. It also encourages providers to rehospitalize facility residents who are dually eligible (i.e., enrolled in both Medicare and Medicaid) to qualify them for a Medicare-covered SNF stay at a higher payment rate, and it encourages providers to extend the length of a Medicare-covered SNF stay to receive additional payment. Disparities in the use of SNFs could be exacerbated if Medicare rates were increased, thereby widening the differential between Medicare and Medicaid rates.

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. Furthermore, facilities located in states with relatively high Medicaid rates receive the same “subsidies” as those located in states with relatively low rates.

Maintaining or raising Medicare's payment rates 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's relatively high rates effectively subsidize long-term care, which is not a covered benefit.

Medicare payments and providers' costs: FFS Medicare margins remained high in 2023

In 2023, the FFS Medicare margin for freestanding SNFs was 22 percent, a slight drop from 23 percent in 2022 (see text box on the calculation of Medicare margins, pp. 202–205). FFS Medicare margins for individual facilities varied considerably across providers, as in prior years. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.)

Trends in FFS spending and cost growth

In 2023, FFS Medicare spending on care in SNFs (excluding care in swing beds) was \$25 billion, a decrease of 8 percent compared with 2022. This decrease in overall spending is a function of slowed volume and the payment reductions CMS made to adjust for the overpayments that had resulted from the implementation of the Patient-Driven Payment Model (PDPM) case-mix system. Though intended to be budget neutral, the new case-mix system raised payments by an estimated 4.6 percent compared with what would have been paid under the old case-mix

Updated methodology to calculate FFS Medicare margins

To calculate freestanding skilled nursing facilities' (SNFs') fee-for-service (FFS) Medicare margins, we use the Medicare cost report. Beneficiaries in a Medicare-covered SNF stay are more costly to treat than the average nursing home resident; we recognize this difference by adjusting the apportioning of a facility's nursing labor costs between FFS Medicare stays and non-FFS Medicare stays. Using patient-assessment data, we estimate a nursing component case-mix index (CMI) for each case and, for each facility, aggregate these to two groups—FFS Medicare and non-FFS Medicare cases (such as Medicaid, Medicare Advantage, and other payers). Nursing CMIs can be reasonably compared across payers, but other case-mix-adjusted components cannot. We adjust each facility's nursing labor costs by its ratio of the FFS Medicare nursing CMI to non-FFS Medicare nursing CMI. Because the nursing CMI for FFS Medicare

cases is higher than that for other cases, using this ratio as a multiplier raises the calculated nursing costs of treating beneficiaries in a Medicare-covered SNF stay.

SNFs are unique from many other facilities in that the same facility often provides vastly different care to its long-stay residents and short-stay patients (who are covered by separate payers), but the facility usually relies on the same labor to deliver both services; further, this labor represents an unusually high share of facility costs. Thus, in our SNF analyses, we adjust the labor allocations between payers when calculating the cost of labor.

In earlier work, researchers from Abt Associates found that in 2017, under the old case-mix system (Resource Utilization Groups, Version IV, or RUG-IV), the FFS Medicare to non-FFS Medicare ratio

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system (Centers for Medicare & Medicaid Services 2022). CMS responded to the overpayments by lowering payments 2.3 percent in FY 2023 and FY 2024 (Centers for Medicare & Medicaid Services 2022).

Between 2022 and 2023, the average payment per day in freestanding SNFs increased 2.4 percent while costs per day increased 3.8 percent. Changes in payments per day in 2023 reflect the combined effect of the market basket increase to the base rate and the adjustment for past overpayments under the PDPM (as discussed above). Payments also incorporate the forecast-error corrections made in both years (CMS makes these adjustments when its historical estimate of the market basket differs from the actual market basket by at least 0.5 percentage points—either too high or too low).

Cost growth outpaced the growth in payments in part due to the declines in volume, which would raise the fixed costs per day. Routine costs per day increased in

2023, but the growth rate continued to slow down. The growth in routine costs reflects labor cost trends in 2023. Wage data for the SNF sector from the Bureau of Labor Statistics show that hourly wages in the sector grew 3.3 percent in 2023, the smallest growth since 2018. Preliminary data for the first six months of 2024 indicate a similar trend, with wages growing 1.7 percent (Bureau of Labor Statistics 2024). Total cost growth in 2023 was partially driven by an increase in ancillary costs per day. Although these costs fell year over year from 2019 through 2022, ancillary costs per day rose by 4 percent from 2022 to 2023. For the first year since the implementation of the PDPM, ancillary costs grew in 2023. This change was largely driven by overall increases in per day physical therapy, occupational therapy, and drug costs, which grew for both the FFS Medicare portion and the entire facility. Administrative costs per day grew in line with previous years.

Consistent with past years, cost growth and the level of costs varied by ownership. In 2023, nonprofit providers

Updated methodology to calculate FFS Medicare margins (cont.)

was roughly 1.41—meaning that in aggregate, facilities were estimated to require 41 percent more nursing labor in FFS Medicare than non-FFS Medicare. Applying this ratio raised FFS Medicare costs and lowered the FFS Medicare margin compared with what it would have been without the adjustment. In 2023, Abt reestimated the ratio for 2021 under the new case-mix system (the Patient-Driven Payment Model, or PDPM) for cases with the requisite patient-assessment information. This ratio for FFS Medicare to non-FFS Medicare cases dropped to 1.17, largely because the new case-mix system does not consider the provision of therapy in defining case-mix groups. Under RUG-IV, the majority of FFS Medicare cases were assigned to high-therapy case-mix groups, which had higher nursing CMI weights than other case-mix groups. Under the PDPM, most FFS Medicare cases were

assigned to lower-weighted groups and, as a result, the difference between FFS Medicare and non-FFS Medicare cases shrank. Last year, we did not use this ratio in constructing margins because we could not assign all cases to PDPM case-mix groups (the patient-assessment items required to assign cases using the PDPM were not required of all cases until October 2023). Instead, we opted to continue using the higher RUG-IV ratio last year in reporting the 2022 FFS Medicare margins.

This year, Abt reestimated the FFS Medicare to non-FFS Medicare nursing ratios using the first two quarters of fiscal year 2024, when providers were required to record information needed to assign cases to the PDPM case-mix system for all cases. Abt again found the ratio of FFS Medicare to non-FFS Medicare nursing CMI to be 1.17. Given these consistent results, we believe that the updated

(continued next page)

reported larger increases in cost per day than for-profit providers did (4 percent vs. 2 percent). This difference was largely driven by ancillary costs. In 2023, nonprofit providers had 14 percent higher aggregate 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.

SNF FFS Medicare margins remain 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 2023, the FFS Medicare margin for freestanding SNFs was 22 percent, not including federal relief funds (see text box on updated methodology to calculate Medicare margins). For the 24th consecutive year, the FFS Medicare margin

for freestanding SNFs was 10 percent or higher (data not shown). The margin was slightly lower than in 2022 (23 percent).

In 2023, hospital-based SNFs (which account for 2 percent of program spending on SNFs) continued to have substantial negative FFS Medicare margins. The FFS Medicare margin for hospital-based SNFs was -41 percent, similar to -43 percent in 2022. 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.

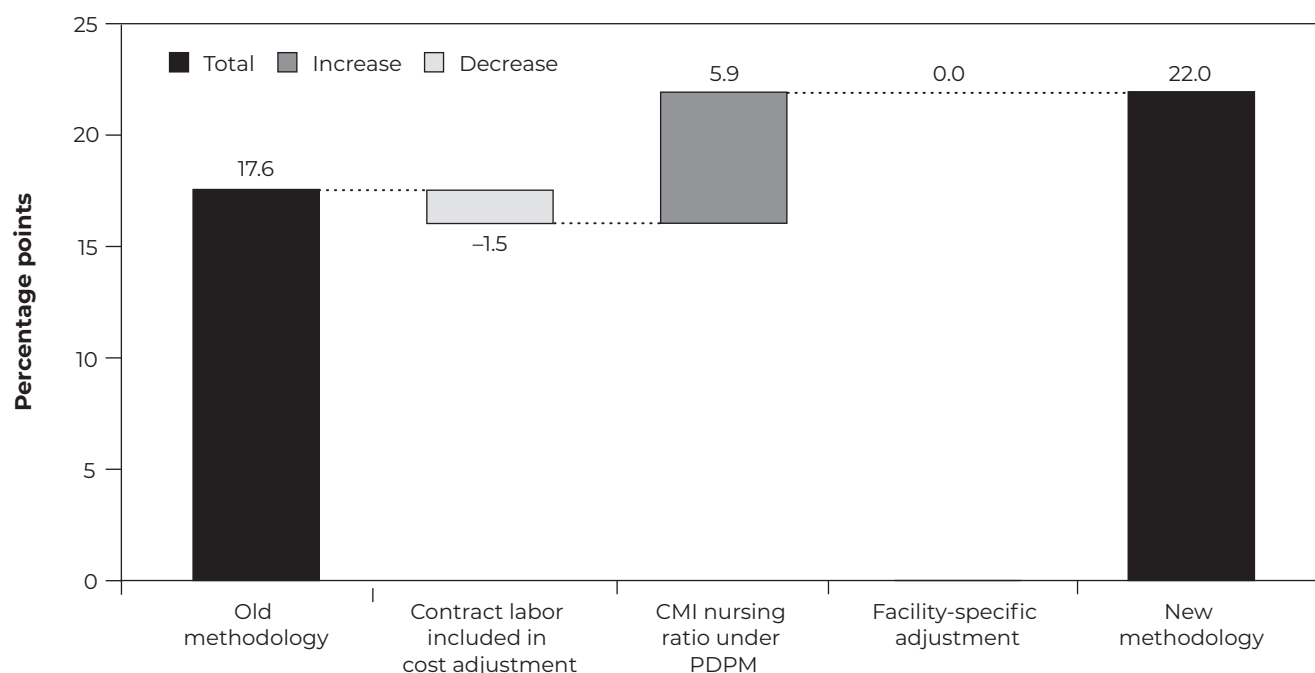
FFS Medicare margins varied widely in 2023

FFS Medicare margins for freestanding SNFs varied widely: One-quarter of SNFs had FFS Medicare margins that were 32 percent or higher, and one-quarter had

Updated methodology to calculate FFS Medicare margins (cont.)

**FIGURE
6-6**

Effects of new margin methodology on 2023 SNF FFS Medicare margin, by change



Note: SNF (skilled nursing facility), FFS (fee-for-service), CMI (case-mix index), PDPM (Patient-Driven Payment Model). The revised methodology includes contract-labor costs in the routine costs that are adjusted for differences between FFS Medicare and non-FFS Medicare stays. The revised CMI is based on the nursing component of the PDPM. The adjustments were calculated for each facility.

Source: MedPAC analysis of Medicare freestanding SNF cost reports and MDS data.

ratios better reflect the differences in nursing costs. Using the latest PDPM data results in a lower aggregate CMI ratio that lowers FFS Medicare costs and thus raises the FFS Medicare margins in aggregate by about 6 percentage points compared with previously reported margins (Figure 6-6).

We made two other refinements to the estimate. First, we also now adjust the costs of contract labor by the CMI ratio because of increasing use of contract labor in the past few years. This change has the effect of raising calculated FFS Medicare costs for facilities, thus lowering FFS Medicare margins by about 2 percentage points. Second, we

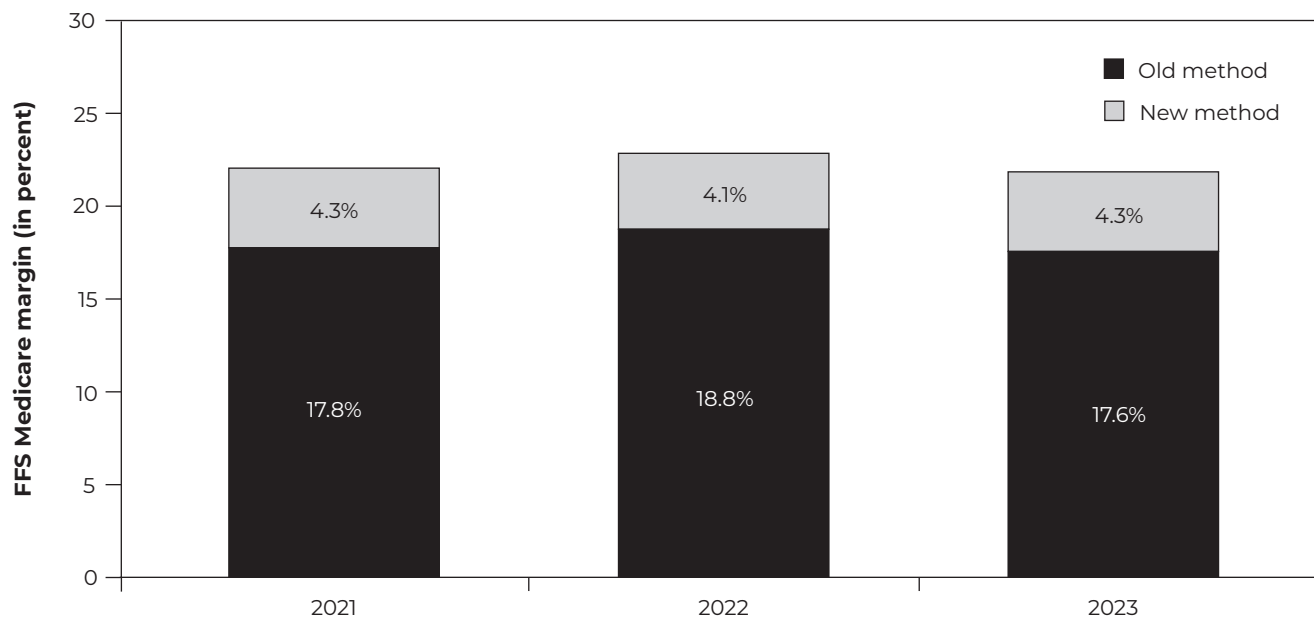
calculate a facility-specific ratio and apply it to each facility's nursing costs. Ratios vary considerably across nursing homes; nonprofit facilities and small facilities have lower ratios compared with other facilities. Previously, we had calculated an aggregate ratio and applied it to all facilities. By itself, applying facility-specific ratios did not change the aggregate margin across all facilities, but because the ratios varied by provider, it affected the margins for individual SNFs. For example, although the overall aggregate ratio was 1.17, nonprofit facilities tended to have lower ratios. Calculating the FFS Medicare

(continued next page)

Updated methodology to calculate FFS Medicare margins (cont.)

**FIGURE
6-7**

SNF FFS Medicare margins under new and old methodology, 2021-2023



Note: SNF (skilled nursing facility), FFS (fee-for-service).

Source: MedPAC analysis of Medicare freestanding SNF cost reports and MDS data.

margin for nonprofit facilities using a facility's specific ratio resulted in applying a ratio lower than 1.17 in many cases, thus lowering the calculated FFS Medicare nursing costs and raising their FFS Medicare margin compared with the margin we previously reported.

Factoring in all of the refinements, the 2022 FFS Medicare margin would have been 19 percent under the old methodology; under the new approach, that margin is 23 percent (Figure 6-7). Because certain groups of facilities have lower CMI ratios compared with the overall average, the aggregate margins of some groups (such as nonprofit facilities) have changed substantially.

As the methodology affects only the costs allocated to FFS Medicare (and not total costs), the

overall all-payer total margins for facilities remain unaffected by this methodological change. The new calculations result in lowered margins for non-FFS Medicare payers that offset the increase in the FFS Medicare margin.

We also updated our hospital-based SNF inpatient margin methodology. Previously, our hospital-based inpatient margins reflected only SNFs in acute inpatient prospective payment system and critical access hospitals. This year, we include SNFs based in other types of hospitals, such as long-term care hospitals, inpatient rehabilitation facilities, and inpatient psychiatric facilities. Though this change added only about 50 hospital-based SNFs, the number of hospital-based SNFs is not large to begin with, and thus margins have shifted. ■

**TABLE
6-4****Variation in freestanding
SNF FFS Medicare
margins persisted in 2023**

Provider group	FFS Medicare margin, 2023
All providers	21.9%
25th percentile of FFS Medicare margins	10.6
75th percentile of FFS Medicare margins	32.0
For profit	25.1
Nonprofit	7.3
Urban	22.2
Rural	20.3
Frontier	15.8
Cost per day: High	11.8
Cost per day: Low	35.1
Small (20–50 beds)	4.0
Large (100–199 beds)	24.2
Low-volume facility	6.9
High-volume facility	26.8
Low LIS share	10.9
High LIS share	30.2

Note: SNF (skilled nursing facility), FFS (fee-for-service), LIS (low-income 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-volume facility" is the top quintile of total facility days, and "low-volume facility" is the bottom quintile of total facility days. "LIS share" is the share of SNF users who receive the low-income subsidy in the Part D drug benefit. "Low LIS share" is the bottom quartile of 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 2023 Medicare freestanding SNF cost reports and SNF Medicare Provider Analysis and Review data.

margins that were 10.6 percent or lower (Table 6-4). 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 they had lower payments but higher costs per day (data not shown). The FFS Medicare margin for urban SNFs was about 2 percentage points higher than for rural SNFs in 2023. 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 FFS Medicare margin than facilities with 100 to 199 beds. And low-volume facilities (bottom quintile of total facility days) had a lower 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 over 20 percentage points higher than SNFs with the highest (in the top 25th percentile) cost per day. SNFs with high shares of stays for patients receiving the low-income subsidy (LIS) (in the top quartile of the distribution of LIS shares) have much higher margins than facilities with low shares (30.2 percent compared with 10.9 percent). Facilities with a high LIS share of stays had lower costs per day (13 percent lower) and higher Medicare payments per day (11 percent higher) (data not shown).

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 (data not shown). 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 may be more likely than low-margin SNFs to care for beneficiaries with low incomes: On average, high-margin SNFs had 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. 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

a higher nursing CMI. Economies of scale also affect the difference in financial performance. In 2023, the median high-margin SNF had more beds and higher daily census than the median low-margin SNF.

Projecting payments and costs for 2025

To project the FY 2025 FFS Medicare margin for freestanding SNFs, the Commission considered the relationship between SNF costs and Medicare payments in 2023 as a starting point. The projection is especially sensitive to the uncertainties of estimating costs, whereas the payment updates have been set. To estimate 2025 costs, we used CMS's Office of the Actuary's November 2024 estimates of the market baskets for 2024 (3.7 percent) and 2025 (3.1 percent) (Centers for Medicare & Medicaid Services 2024a). The annual market basket indicates how SNFs' costs for a fixed basket of inputs will change, including estimates of 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. For FY 2025, we adjusted facilities' costs that are associated with complying with new policies that are likely to affect costs. For instance, CMS began to impose stronger civil monetary penalties for facilities that do not comply with federal requirements to participate in the Medicare and/or Medicaid program (estimated to increase costs). Our adjustments were based on CMS's estimates, prorated for our 2023 sample of providers (Centers for Medicare & Medicaid Services 2024c).¹⁴

In addition, we assumed that urban facilities would begin to incur higher nursing costs in 2025, in anticipation of new staffing requirements (see section on the staffing rule, p. 209). To approximate the added costs of compliance, we started with CMS's estimate for the first full year of the new rule (\$1.4 billion), prorated this amount to the facilities included in the 2023 cost-report analysis, and inflated the figure to 2025 dollars (Centers for Medicare & Medicaid Services 2024b). We then apportioned a share to FFS Medicare based on FFS Medicare's share of payments, and we assumed urban facilities would begin to take on these costs during the last six months of FY 2025 as they add staff to meet the 2026 staffing requirements.

The actual costs of the staffing rule could differ from the estimate for many reasons. CMS assumed RN

hours could be reallocated perfectly to meet the 24/7 (24 hours a day, 7 days a week) requirement, and that nursing-staff real wages would increase by an average 2.3 percent annually. Cost estimates would be higher or lower if the assumptions are not correct. CMS also did not model exemptions or possible cost savings and assumed that facilities would not replace nurses with lower-cost nursing aides to meet the total nursing requirement. Accounting for these factors could lower the cost estimate and would raise the projected 2025 Medicare margin.

Staffing costs could also increase if states raise Medicaid payment rates for nursing homes in response to the staffing minimums. Higher payment rates could enable facilities to hire more staff, thereby raising facilities' costs. Although states have not explicitly raised rates or supplemental payments in FY 2024 and FY 2025 as a direct response to the rule, several have increased Medicaid funding, coinciding with rising calls to address workforce concerns (see Medicaid section, p. 213).

To estimate payments in FY 2024 and FY 2025, we increased payment rates by the updates specified in the final rules for those years (Table 6-5, p. 208). The updates include the market basket with productivity adjustments and forecast-error corrections to market basket estimates made in earlier years. 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 2025 for freestanding SNFs is 23 percent. We expect the margin to increase in 2025 relative to 2023 because payment updates are projected to exceed cost growth in 2024 and 2025 due to the large forecast-error adjustments raising 2024 and 2025 payment rates. Different assumptions about changes in costs, case mix, and revenues could raise or lower the projection.

We project that the impact of the anticipated staffing rule will be small in FY 2025—a decline of less than half a percentage point. Medicare is a small share of nursing homes' revenues, and we projected that only urban providers affected by the rule in 2026 would increase their hiring. The impact will be larger if providers not affected by the rule in 2026 also hire new staff and incur higher labor costs. In future years, as the rule is

**TABLE
6-5**

SNF payment updates for fiscal years 2023–2025

	2023	2024	2025
Updates based on forecasts			
Market basket	3.9%	3.0%	3.0%
Productivity	–0.3	–0.2	–0.5
Forecast-error correction	1.5	3.6	1.7
Parity adjustment	–2.3	–2.3	N/A
Total	2.7	4.0	4.2

Note: SNF (skilled nursing facility), N/A (not applicable). 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.

Source: CMS SNF final rules for fiscal years 2023–2025.

phased in, the cost to comply with the rule would grow and lower margins.

How should FFS Medicare payments change in 2026?

In 2026, current law is expected to increase payment rates by 2.2 percent (an estimated market basket of 2.8 percent minus a productivity adjustment of 0.6 percent). CMS will revise its estimates before the publication of the FY 2026 final rule (which must be published before August 1, 2025). CMS also corrects for overestimates and underestimates of the SNF market basket two years prior to the rulemaking year (meaning the FY 2026 payment update will correct for under- or overestimates of the FY 2024 market basket). If CMS determines that it over- or underestimated the market basket by more than 0.5 percentage points in FY 2024, it will apply the correction in FY 2026. Currently, because the FY 2024 official market basket underestimated the actual FY 2024 market basket by 0.7 percentage points, the FY 2026 correction would result in an increase of 0.7 percentage points. On net, if all these changes are implemented, the update would be a 2.9 percent increase in 2026 (a projected market basket of 2.8 percent plus a 0.7 percent forecast-error correction minus a 0.6 percent productivity adjustment).

The FFS Medicare margin in 2025 will depend on many factors. 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 how staffing costs change as a result of the new staffing rule. Under any plausible scenario, Medicare margins are likely to remain high, indicating that the SNF PPS exerts too little pressure on providers to control costs. Not surprisingly, FFS Medicare remains a preferred payer for SNFs.

FFS Medicare margins were high again in 2023. Although the level of the Medicare margin might indicate that a larger reduction to the FFS payment rates is required to better align payments and costs, there is uncertainty about the costs associated with the staffing changes finalized in 2024 (discussed below). Therefore, the Commission has opted to recommend a more modest reduction to the payment rates.

RECOMMENDATION 6

For fiscal year 2026, the Congress should reduce the 2025 Medicare base payment rates for skilled nursing facilities by 3 percent.

RATIONALE 6

The level of Medicare's payments indicates that a reduction is needed to better align aggregate payments to aggregate costs. The freestanding SNF FFS Medicare margin was 22 percent in 2023. With the market basket updates and the likely forecast-error adjustments, we project that the freestanding SNF FFS Medicare margin will be 23 percent in 2025. Thus, FFS payments will remain more than adequate to ensure beneficiary access to SNF care even if payments are lowered. Last year, the Commission recommended a 3 percent reduction to the payment rates when the projected margin was considerably lower than what we estimate for 2025.

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 2023—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. It is not sound policy to raise payments for all providers to address the poor financial 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 VBP program with a 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 2021a).

IMPLICATIONS 6

Spending

- Current law is expected to increase payment rates by 2.9 percent in FY 2026. This recommendation would lower spending relative to current law by between \$2 billion and \$5 billion over one year and between \$10 billion and \$25 billion over five years.

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.

Minimum staffing requirements set to begin in May 2026

As noted above, nurse staffing levels have been shown to be key to patient outcomes. In May 2024, CMS issued a final rule revising its staffing requirements for nursing homes, with implementation beginning in May 2026 (Centers for Medicare & Medicaid Services 2024b). We compared current staffing levels to the revised requirements. Had all of the staffing requirements been in effect in 2024, we estimate that more than three-quarters of providers would not have met all the minimum requirements. However, we expect that many facilities could be exempted from at least one of the minimum requirements because they are in labor market shortage areas. In this section, for brevity, we refer to these potentially exempted facilities as “exempted,” although it is possible a facility's application for exemption could be denied. We refer to facilities unable to apply for a labor shortage exemption as “nonexempted.” We also found that the majority of facilities were within range of meeting each of the individual requirements: Their staffing levels were 80 percent or 90 percent of the minimums.

The staffing requirements

CMS's final rule on staffing minimums requires all facilities (that is, all facilities that do not meet exemption criteria discussed below) to meet specific hours per resident day (HPRD) for three categories of caregivers and will be phased in over time (Centers for Medicare & Medicaid Services 2024b). Starting in May 2026, urban facilities must have a total nurse staffing (including RNs, licensed practical nurses, and nurse aides (NAs)) ratio of 3.48 HPRD and an RN on site 24/7.¹⁵ The following year, they must have an RN ratio of 0.55 HPRD and an NA ratio of 2.45 HPRD. Rural facilities have longer to comply with the rules: The total nurse HPRD and 24/7 RN requirements will be in place starting in May 2027, and the RN and NA HPRD requirements will begin in May 2029.

The staffing ratios are not adjusted for a facility's mix of cases, though facilities will still be required to have “sufficient” staff to meet the care needs of their residents. That is, facilities treating complex cases would be expected to have higher staffing ratios to comply with the current requirement of “sufficient

nursing staff” to meet care needs and ensure residents’ safety. CMS noted that it needed more time to consider facility-specific case-mix-adjusted HPRD requirements and that it may consider this approach in future rulemaking.

Facilities not meeting the requirements will be subject to standard enforcement actions by CMS, including termination of the provider agreement with CMS, denying Medicare and/or Medicaid payments for all services, or imposing civil monetary penalties. CMS will post a facility’s noncompliance on its Care Compare website.

A facility can apply for a temporary exemption from some or all of the requirements if it is located in a workforce shortage area (the area’s RN, NA, or total worker-to-population ratio is at least 20 percent below the national average), is making a good-faith effort to hire, and documents its financial commitment to staffing.¹⁶ A facility that is exempted from the 24/7 RN requirement would be required to have an RN available 16 hours a day, 7 days a week. CMS’s preliminary analyses found that the share of facilities that would be exempted varied considerably depending on the staffing requirement (Centers for Medicare & Medicaid Services 2024b).¹⁷

Industry representatives filed lawsuits against CMS and the Department of Health and Human Services (HHS) to dismiss the staffing rule, arguing that CMS exceeded its statutory authority; the Congress had already set staffing minimums (in the 1987 Nursing Home Reform Act); the one-size-fits-all approach does not consider a facility’s circumstances; and that CMS failed to show that the Congress granted it the authority to impose new requirements or increase existing ones. Twenty-one states have challenged the rule (Marselas 2024).

Impact of the staffing rule on facility costs

CMS estimated that the new requirements would raise nursing homes’ costs by \$1.43 billion for the first year that the minimum requirements are in place and an average of \$4.3 billion per year over 10 years. Industry stakeholders’ estimates of the average annual cost are higher, ranging from an estimate of \$6.8 billion to \$7.1 billion (Emerson et al. 2024, LeadingAge 2023). The estimates differ in the assumptions made about the hiring of employees, the year of the data used, and

whether the estimate was in 2021 dollars (the year of the CMS estimate) (Centers for Medicare & Medicaid Services 2024b). None of the estimates considered the likelihood that many facilities would be exempt from specific provisions, although exempt facilities would still incur some cost in applying for exemptions and meeting exemption criteria (such as documenting efforts to hire and their financial commitment to staffing). The impact on Medicare costs would be much smaller given the small share that SNF days constitute for most facilities.

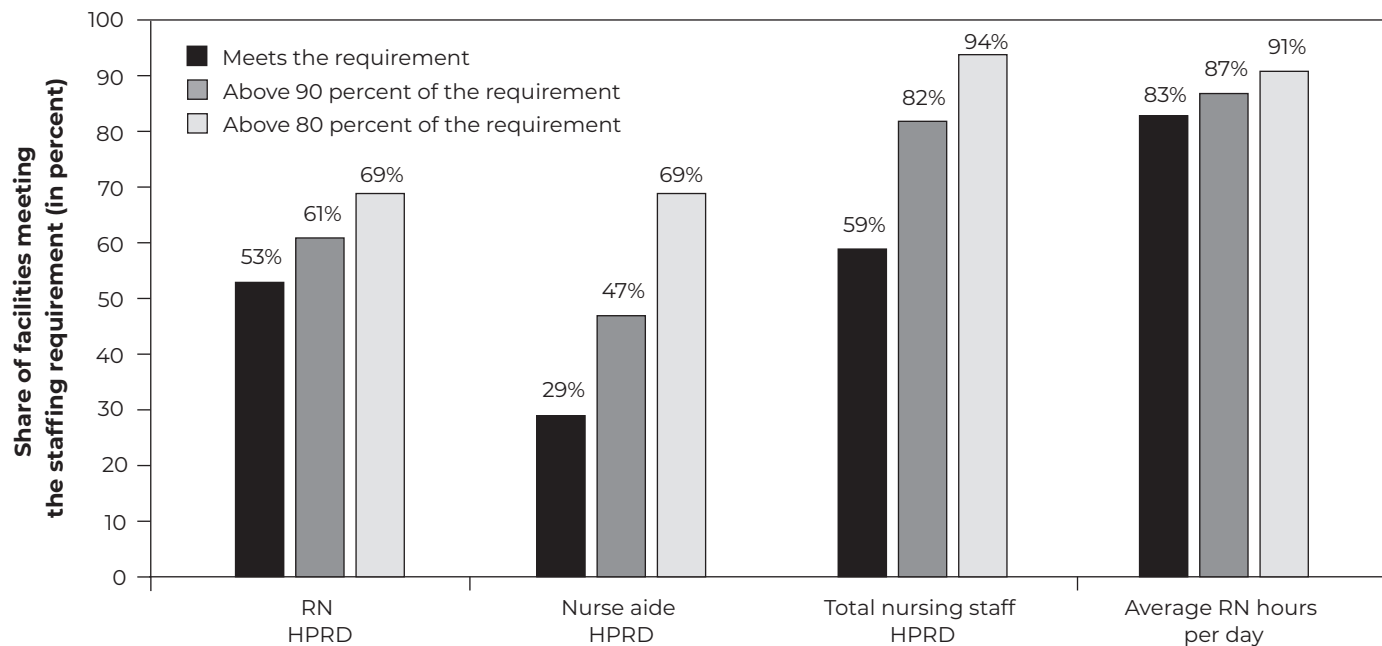
The majority of facilities would currently not meet all minimums applicable to them, but many are close

We estimated that if the rule had been fully implemented in 2024, less than 22 percent of facilities that were nonexempt from at least one minimum would meet all the minimums required of them (a facility can be exempt from one or more requirements because of labor shortages in their area, as determined based on first-quarter 2024 Nursing Compare data). We also found that many facilities (30 percent) could be exempt from at least one of the minimum requirements, and 12 percent could be exempt from all the requirements.¹⁸ (Facilities that would be exempt from the 24/7 RN requirement might still have to provide 16 hours of RN care a day.) A larger share of rural facilities could be exempt from at least one requirement compared with urban facilities (69 percent compared with 15 percent, respectively). Twenty-one percent of rural facilities could be exempt from all requirements compared with 9 percent of urban facilities.

We examined the share of nonexempt facilities that met each requirement and, if they did not, the shares that were close to meeting it. Only 23 percent of facilities met all the HPRD minimums required of them under the full effect of the rule (that is, considering only the HPRD categories each facility would not be exempted from). However, looking at individual requirements, a substantial number of facilities are operating reasonably close to the required hours. To define “reasonably close,” we examined how many facilities’ HPRD were 90 percent and 80 percent of the minimum (Figure 6-8). For example, we checked how many facilities had at least 3.132 total nursing staff HPRD (90 percent of the required 3.48 HPRD). We made this calculation for each minimum of the rule.

**FIGURE
6-8**

Estimated shares of nonexempt facilities that meet each of the fully phased-in staffing requirements



Note: RN (registered nurse), HPRD (hours per resident day). A nonexempt facility does not meet the definition of being located in a labor shortage area (the area's RN, nursing aide, or total worker-to-population ratio is at least 20 percent below the national average), seven days a week. "Total nursing staff" includes RNs, nursing aides, and licensed practical nurses. Average RN hours per day approximates whether a facility meets the requirement to have an RN on-site 24 hours a day. Estimates are based on circumstances in 2024.

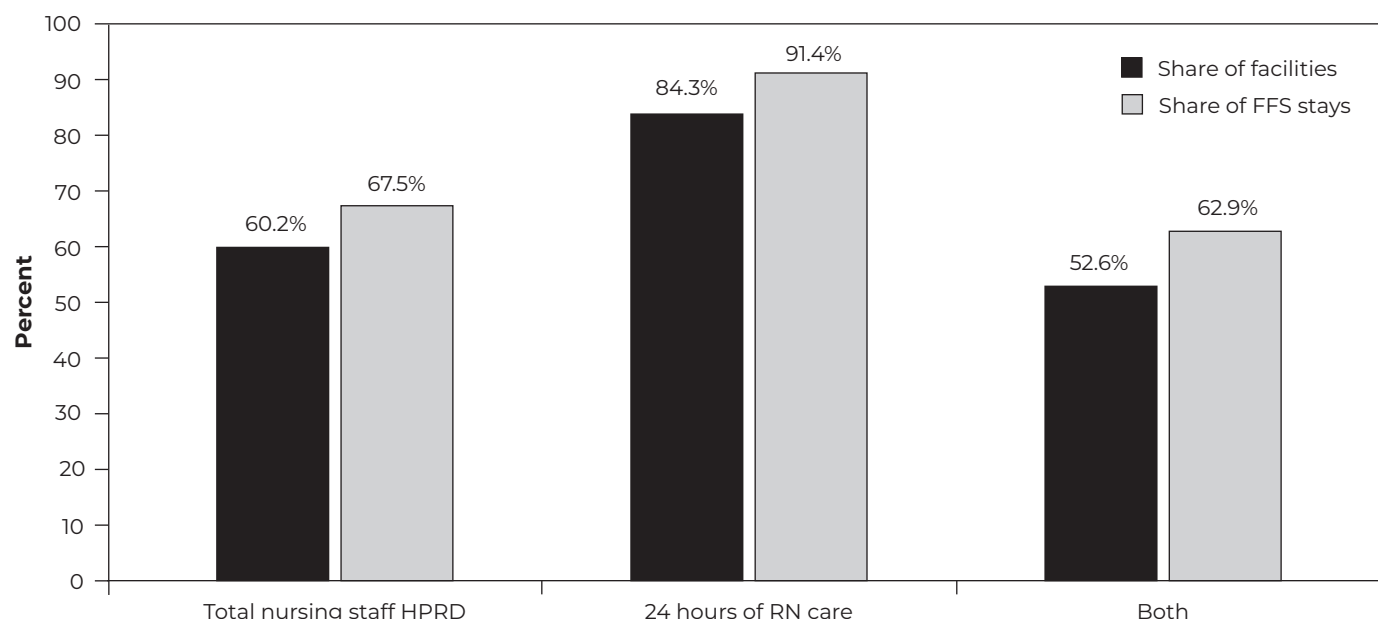
Source: MedPAC analysis of Bureau of Labor Statistics, U.S. Census, and Nursing Home Compare Data, 2024.

However, adding staff hours to fully meet the rule could still represent significant costs for these facilities, given the high share of facilities' costs that is labor.

Just over half (53 percent) of nonexempt facilities currently would meet the RN HPRD (0.55 HPRD), but 61 percent have HPRD above 90 percent of the requirement (0.495 HPRD), and 69 percent have ratios above 80 percent (0.44 HPRD). Just 29 percent of nonexempt facilities would meet the NA requirement (2.45 HPRD), but 69 percent had ratios above 80 percent of the requirement (1.96 HPRD). The majority (59 percent) of nonexempt facilities would meet the total nurse staffing requirement (3.48 HPRD), and most nonexempt facilities (94 percent) had ratios above 80 percent of the requirement (2.784 HPRD). Although data do not exist to model the 24/7 aspect of the 24/7 RN rule, we examined the number of facilities that

averaged 24 hours per day of RN care. A facility could provide an average of 24 hours of RN care per day by staffing more than one RN during a shift and not have an RN on-site every hour of the day. Of the nonexempt facilities, 83 percent averaged 24 hours per day of RN care, though not necessarily 24/7.

Rural and frontier county facilities, which are generally smaller than urban facilities, may be less likely to have an RN present for an average of 24 hours per day, perhaps because the administrator determines that fewer RN hours are needed to adequately care for their smaller resident populations. However, these rural and frontier facilities were more likely to meet their HPRD minimums. Because HPRD minimums are a function of the number of residents, smaller and rural facilities are currently more likely to meet HPRD minimums due in part to staff hours being averaged over fewer residents.

**FIGURE
6-9****Estimated share of urban nonexempt facilities meeting the May 2026 requirements**

Note: HPRD (hours per resident day), RN (registered nurse), FFS (fee-for-service). A nonexempt facility does not meet the definition of being located in a labor shortage area (the area's RN, nurse aide, or total worker-to-population ratio is at least 20 percent below the national average), seven days a week. Total nursing staff includes RNs, nursing aides, and licensed practical nurses. Whether a facility meets the requirement to have an RN on-site 24 hours a day was estimated as the average RN hours per day. Unless exempt from a requirement, urban facilities must meet the total staffing HPRD and the 24-hours-per-day nursing requirements. Estimates are based on circumstances in 2024.

Source: MedPAC analysis of Bureau of Labor Statistics, U.S. Census Bureau, and Nursing Home Compare Data, 2024.

Estimated shares of urban facilities not meeting the requirements in 2026

Urban facilities will be the first to come under the staffing rule. They will face minimum requirements in May 2026: the level of total nursing staff (3.48 HPRD) and 24/7 RN coverage. The majority (60 percent) of nonexempt urban facilities currently would meet the total nursing HPRD requirement (Figure 6-9). A larger share (84 percent) of facilities currently provide an average of 24 hours per day of RN care, though not necessarily 24/7. Of the urban facilities required to meet both May 2026 requirements (3.48 total nurse staffing minimum and 24 hours of RN care per day), only 53 percent currently meet them. For both measures, the facilities meeting the requirements account for larger shares of FFS days.

When fully implemented, the rule is likely to pose significant challenges for nursing homes, especially since they compete (often unsuccessfully) with hospitals and other providers that are also facing nursing workforce shortages. Recruitment and retention in the long-term care sector has always been difficult, and the problems were exacerbated by the coronavirus pandemic, when many health care workers left the field altogether. In a 2024 survey of 441 nursing homes, the American Health Care Association found that most facilities were actively trying to hire more staff and had raised wages as part of their recruitment and retention strategies (American Health Care Association 2024). The rule could place additional financial pressures on facilities that are already operating with thin total margins, especially those serving a higher proportion of Medicaid patients.

That said, we found that nonexempt facilities that did not meet applicable requirements tended to have higher FFS Medicare margins. For example, we examined facilities that would not be exempt from the total nurse staffing HPRD rule and therefore would have to hire more staff to meet the requirement. Among these facilities, the FFS Medicare margin was 29 percent for urban facilities and 25 percent for rural facilities. In contrast, nonexempt facilities that already meet this rule requirement had lower FFS Medicare margins of 20 percent in urban areas and 15 percent in rural.

Possible unintended effects of the rule

The rule could have unintended effects. The mix of nursing staff could change because the rule does not set minimums for licensed practical nurses (LPNs) (CMS stated that the research did not find conclusive evidence of a relationship between LPN HPRD and outcomes). Facilities could lower their use of LPNs to meet the aide and RN requirements. The requirements could also have spillover effects on nonclinical staffing. One study of state minimum requirements found that indirect staffing (including dietary, housekeeping, and activities staff) decreased after nursing minimums were implemented (Bowblis 2011, Chen and Grabowski 2015). Another effect could be that facilities with staffing levels above the new requirements could reduce their staffing. Studies of states' experiences found that, in addition to raising HPRD for facilities with low staffing levels, state minimums lowered staffing at facilities that were already above the requirements (Chen and Grabowski 2015, Mueller et al. 2006, Park and Stearns 2009). If nursing homes successfully hire staff away from other settings, the rule could negatively affect the staffing levels for these other settings' providers. As it does every year, the Commission will continue to monitor staffing levels, facility closures, and beneficiary access.

Medicaid trends

Section 2801 of the Affordable Care Act of 2010 (ACA) requires the Commission to examine spending, use, and financial performance trends in the Medicaid program for providers that have 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 separately 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 dually eligible beneficiaries (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2023, 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. Some state Medicaid programs pay dually eligible beneficiaries' Medicare copayments that begin on Day 21 of a SNF stay. Medicaid also pays 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. Similar to stays for non-dually eligible beneficiaries, discharges for dually eligible beneficiaries increased on Day 20. In addition, dually eligible beneficiaries were more likely to have stays past Day 20 or Day 100, possibly as a result of Medicaid coverage of cost sharing. For beneficiaries in long-term care stays who are enrolled in Part B or Part D, Medicare pays for covered Part B and Part D services.

Count of Medicaid-certified nursing homes

The number of Medicaid-certified nursing facilities has been declining steadily for years. Between 2016 and 2019, the number of active nursing facilities decreased on average 0.3 percent per year. Historically, factors contributing to closures include 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 number of nursing facility terminations slowed. Between December 2023 and October 2024, the number of nursing facilities certified as Medicaid providers declined 1.1 percent from 14,500 to 14,300 (Table 6-6), but has since picked up. By comparison, the average annual percent change between 2019 and 2022 was -0.7 percent.

**TABLE
6-6****The number of active nursing facilities certified as Medicaid providers declined slightly from 2023 to 2024**

	2019	2020	2021	2022	2023	2024
Number of facilities	15,000	14,800	14,800	14,600	14,500	14,300
Change from prior year		-0.8%	-0.6%	-0.9%	-1.0%	-1.1%

Note: The figure for 2024 was calculated through October; it does not include data from the full calendar year. Counts include dually certified skilled nursing facilities/nursing facilities, distinct-part skilled nursing facilities/nursing facilities, and nursing facilities. Counts are for Medicaid-certified nursing facilities in the 50 states and the District of Columbia. Percentage changes were calculated on unrounded data.

Source: MedPAC analysis of active provider counts from CMS's Quality and Certification Oversight Reports (QCOR) online reporting system for 2019–2024.

Of all Medicaid nursing homes active in January 2024, 68 had terminated as of October, and the majority (58) of terminations were voluntary. Providers that terminated participation in the Medicaid program may have remained open but no longer accept Medicaid residents, may have closed, or may have been purchased by another entity and changed provider numbers. The share of facilities terminated varied by state. States with the highest termination rates during the period included Missouri (19 percent), Texas (9 percent), and Indiana (7 percent). This geographic variation in closure rates may result in differences in access to services across markets. During the same time period, 22 providers opened, and half of those were for profit.

Spending

FFS spending on Medicaid-funded (combined state and federal funds) nursing home services totaled \$42.5 billion in 2023. This spending excludes payments to nursing homes made by managed care organizations. Spending increased by 5.6 percent between 2022 and 2023, compared with an average decline of 0.9 percent per year between 2019 and 2022. As of June 2024, 24 states operated Medicaid managed care for long-term services and supports (ADvancing States 2024).

The Families First Coronavirus Response Act (FFCRA), 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 2023. Many states used at

least a portion of this FMAP increase to raise payments to nursing facilities. A survey of Medicaid budget trends for FY 2024 and FY 2025 found that only five states reported decreases in base rates or supplemental payments (Hinton et al. 2024). Over three-quarters of the responding states (49) reported raising rates in both fiscal years 2024 and 2025 (Hinton et al. 2024). States with notable nursing facility rate increases included Iowa, Montana, Nevada, Ohio, Rhode Island, and Texas. Montana increased its base rates by 33 percent, phased in over FY 2024 and FY 2025 (Towhey 2023). Colorado will increase its Medicaid rates by a cumulative 14.5 percent through 2026 (Marselas 2023). Many states reported increasing base rates and supplemental payments in both years.

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, Illinois, Massachusetts, and North Carolina made staff wage increases a condition of receiving increased Medicaid reimbursement rates (Musumeci et al. 2022, Reiland 2022). 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 nursing homes' provider taxes to raise federal matching funds. In FY 2024, 46 states levied provider taxes on nursing facilities to

**TABLE
6-7**

Freestanding SNFs' all-payer total margin and non-FFS Medicare margins improved in 2023

Type of margin	2019	2020	2021	2022	2023
All-payer total margin	0.8%	3.2%	3.6%	-1.3%	0.4%
Non-FFS Medicare margin	-3.1	-1.8	-0.9	-7.6	-4.1

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 reported federal pandemic-related relief funds. "Non-FFS Medicare margin" includes the revenues and costs associated with Medicaid, Medicare Advantage, other private payers, and self-pay for all lines of business. Margins shown are aggregates.

Source: MedPAC analysis of Medicare freestanding skilled nursing facility cost reports for 2019 to 2023.

increase federal matching funds (Hinton et al. 2024). The augmented federal funding may be split with the nursing facilities to increase their payments.¹⁹

Freestanding SNFs' all-payer total and non-FFS Medicare margins improved in 2023

An all-payer margin is the percentage of revenue from all payers (including all FFS Medicare, Medicare Advantage, Medicaid, and private insurers) and sources (including all lines of business plus investment income) after accounting for all costs. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) In 2023, the all-payer margin for freestanding SNFs was 0.4 percent, up from -1.3 percent in 2022 (Table 6-7). Forty-six percent of SNFs had negative total margins, a decrease from the 51 percent in 2022. The improvement reflects

the increases in Medicaid base payment rates made by many states, as discussed above. The non-FFS Medicare margin for freestanding SNFs in 2023 was -4.1 percent. Non-FFS Medicare margins are the profitability of all lines of business and all payers exclusive of FFS Medicare-covered SNF services. The improvement in the non-FFS Medicare margin reflects the increases in payment rates made by 43 states in FY 2023 (Hinton et al. 2023).

In 2023, freestanding SNFs' all-payer total margins varied considerably. The median was 0.7 percent; 25 percent of SNFs had all-payer total margins of -6.6 percent or lower, and 25 percent of freestanding SNFs had all-payer total margins of 7.1 percent or higher; 46 percent of freestanding SNFs had negative all-payer total margins (data not shown). ■

Endnotes

- 1 A “spell of illness” ends after 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 department 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 had 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 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.
- 3 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. Coverage ends when a skilled service is no longer needed (e.g., maintenance services performed by the patient alone or with assistance from an unskilled caregiver).
- 4 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.
- 5 Another study that made different assumptions in its estimates found higher shares of nursing homes with REITs and PE (16 percent and 13 percent, respectively (Williams et al. 2024)). Notably, these estimates do not consider divestments.
- 6 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.
- 7 Many alternative payment models target the use of PAC in order 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 the number and length of SNF stays 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).
- 8 “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 FFS Medicare claim.
- 9 The rates for 2021 to 2022 and for 2022 to 2023 are not comparable with earlier periods because CMS updated the list of diagnosis codes in diagnosis categories that are considered potentially preventable readmissions but were excluded in the original development of this measure. This change makes the measure more comprehensive but incomparable with previous time periods.
- 10 We examined the all-cause readmissions within 30 days of admission to the SNF (referred to as the 30-day post-admission rate) and found that rates increased slightly between 2022 and 2023 and were more variable than post-discharge rates. Smaller hospital-based facilities, nonprofit facilities, and rural facilities tended to perform better than other SNFs. The 30-day post-admission and post-discharge rates were not strongly correlated. Because the 30-day post-admission measure could include a mix of days when the beneficiary is under the care of a facility and after discharge from the SNF, and includes only a portion of a stay if it is longer than 30 days, the Commission prefers a measure that gauges readmissions that occur only during the (entire) SNF stay (Medicare Payment Advisory Commission 2015).
- 11 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 for inclusion in the turnover measure. For the total nurse-turnover measures, the annual turnover percentage is calculated using this formula: Turnover = total number of employment spells that ended in turnover / 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 2023). Starting July 2024, a spell is considered to end in turnover when the individual has at least 90 consecutive days without working, instead of 60 days. (For additional information, see Centers for Medicare & Medicaid Services 2023a.)

- 12 The current staffing standards require nursing homes to have (1) an RN on duty 8 consecutive hours per day, seven days a week; (2) a licensed nurse—either an RN or a licensed practical nurse—on duty 24 hours per day, seven days a week; and (3) “sufficient” nursing staff with the appropriate competencies and skill sets to match patients’ care needs and ensure resident safety (without specifying a minimum number of nurses per resident). The current standards translate to 0.3 hours of nursing time per resident day for a 100-bed facility (Medicaid and CHIP Payment and Access Commission 2022). As of 2023, many states (38 plus the District of Columbia) have additional staffing requirements, but their specifications vary.
- 13 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. A sale by a provider to an 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 an REIT that then leases the property to an unrelated third party is considered an arm’s-length sale.
- 14 In FY 2025, CMS estimated that changes to the civil monetary penalties on net would increase SNF costs. Currently, providers that do not comply with participation requirements are assessed either a per day or a per instance penalty based on the severity and scope of harm (or potential harm) to

residents, and providers cannot be assessed for multiple instances (e.g., noncompliance on different days of the survey) for the same deficiency. Beginning in FY 2025, a facility that is out of compliance can be assessed for both types of penalties and for multiple instances for the same deficiency.

- 15 Nurse aides must meet minimum training standards but are not limited to certified nursing aides.
- 16 The exemption will remain in place until a facility’s next recertification survey unless it becomes ineligible for an exemption. A facility is ineligible for an exemption if it is a special-focus facility, did not submit its payroll data to CMS (as required), or was cited within the past year for a pattern of or widespread insufficient staffing or it had an incident that caused or was likely to have caused serious harm or death.
- 17 It is estimated that 19 percent of rural facilities could be exempt from the aide requirement, 40 percent from the total nursing requirement, and 67 percent from the RN requirement. Estimates of the shares of total facilities that could be exempt from the staffing ratios are 23 percent from the aide requirement, 22 percent from the total nursing requirement, and 29 percent from the RN requirement (Centers for Medicare & Medicaid Service 2024b).
- 18 Our analyses assumed that facilities that met the “labor shortage” definition would apply for an exemption from the requirement.
- 19 Under a nursing home provider tax, states tax all 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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CHAPTER

7

Home health care services

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

- 7** For calendar year 2026, the Congress should reduce the 2025 Medicare base payment rate 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 2023, about 2.7 million fee-for-service (FFS) Medicare beneficiaries received home health care, and the program spent \$15.7 billion on those services. In that year, there were over 12,000 HHAs certified to participate in Medicare.

Assessment of payment adequacy

The indicators of FFS Medicare payment adequacy for home health care were positive in 2023.

Beneficiaries' access to care—Supply and volume indicators show that FFS beneficiaries have good access to home health care.

- **Capacity and supply of providers**—The number of HHAs participating in the Medicare program increased by 3.4 percent in 2023. However, this increase was due almost entirely to growth in the number of HHAs in Los Angeles County, California. Excluding this county, the number of participating HHAs declined by 2.8 percent. Still, in 2023 over 98 percent of FFS 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 this chapter

- Are FFS Medicare payments adequate in 2025?
- How should FFS Medicare payments change in 2026?

- **Volume of services**—The number of 30-day periods per FFS Medicare beneficiary declined by 1.8 percent in 2023. This decline was driven by a decrease in the use of home health care after acute care hospital discharge, which increased in 2020 and then began to decline, although it remained higher in 2023 than in prepandemic years. The number of full 30-day periods per FFS user of home health was stable at 3.1. The average number of in-person visits per 30-day period has declined since 2020, but the decline slowed in 2023.
- **FFS Medicare marginal profit**—Due to anomalies related to cost allocation on the home health cost report, we were unable to compute the FFS Medicare marginal profit for 2023.

Quality of care—During the two-year period from January 1, 2022, to December 31, 2023, the median risk-adjusted rate of discharge to the community from HHAs was 80.6 percent, an increase (improvement) of 1.3 percentage points relative to the median from January 1, 2021, to December 31, 2022. The median rate of potentially preventable readmissions after discharge was 3.8 percent from January 1, 2021, to December 31, 2023.

Providers' access to capital—Access to capital is a less important indicator of Medicare payment adequacy for home health care because this sector is less capital intensive than other health care sectors. In 2023, the all-payer margin for freestanding HHAs was 8.2 percent, indicating that many HHAs yield positive financial results that should appeal to capital markets. In recent years, private equity and health insurance companies have shown substantial interest in HHAs. According to industry reports, investor interest in home health care services has slowed since 2023, but the slowdown comes after a peak period for HHA mergers and acquisitions in previous years.

FFS Medicare payments and providers' costs—The annual increase in cost per 30-day period has fluctuated substantially since 2020. In 2021, the cost per 30-day period declined by 2.9 percent, while in 2022 and 2023, the cost per 30-day period increased by about 3.4 percent each year. The increases resulted from higher costs per visit, but those costs were partially offset by fewer in-person visits per full 30-day period. Even with this cost increase, payments remained high: FFS Medicare margins for freestanding HHAs averaged 20.2 percent in 2023. These margins indicate that FFS Medicare payments in 2023 far exceeded costs. In aggregate, Medicare's payments have been substantially greater than costs for more than 20 years. From 2001 to 2022, the FFS Medicare margin for

freestanding HHAs averaged 17.1 percent. We project a FFS Medicare margin of 19 percent for 2025.

How should payments change in 2026?

Our 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 2026, the Congress should reduce the 2025 base payment rate by 7 percent. ■

Background

Medicare home health care services consist 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 2023, about 2.7 million fee-for-service (FFS) Medicare beneficiaries received home care, and the program spent \$15.7 billion on home health care services under the home health prospective payment system (PPS).

FFS Medicare requires that a physician, nurse practitioner, clinical nurse specialist, or physician assistant certify a patient's eligibility for home health care.¹ FFS 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 of 2018 (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 care 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).² Thirty-day periods with relatively few visits are paid on a per visit basis through a low-use payment adjustment (LUPA); the threshold for the LUPA varies from two to five in-person

visits, depending on the payment group to which a 30-day period has been assigned. Full 30-day periods—periods that meet or exceed the LUPA threshold—receive the full case-mix-adjusted 30-day payment under the PDGM and accounted for about 93 percent of volume in 2023 (about 7 percent of 30-day periods were subject to the LUPA).

The BBA of 2018 requires the Commission to assess the impact of the changes to the home health PPS on agency payments and costs and on the delivery and quality of care. The act also requires the Commission to provide interim and final reports to the Congress. In March 2022, the Commission submitted its interim report, which described recent changes in use and costs of care but noted that any observed initial impact of the new payment system was confounded by the disruptions associated with the coronavirus public health emergency (Medicare Payment Advisory Commission 2022). The Commission will submit its final report on the impact of recent changes to the home health PPS in March 2026.

Home health payments have historically been high relative to costs

Payments for home health care have substantially exceeded costs since Medicare established the PPS. In 2001, the first year of the PPS, average FFS Medicare margins for freestanding HHAs equaled 23 percent. (FFS Medicare margins reflect the extent to which an agency's revenue from FFS Medicare patients equals, exceeds, or falls below the cost of providing care for these patients.) FFS Medicare margins have remained high ever since the PPS was implemented, with HHAs often keeping cost growth lower than the rate of inflation projected in the home health market basket. The number of visits provided while a beneficiary has home health care has also declined over time. These factors have contributed to HHAs' high margins, which have averaged 17.1 percent over the period 2001 to 2022.

While the changes required by the BBA of 2018 substantially altered the home health PPS, they were not designed to change the overall level of FFS Medicare's payments for home health care services. The act requires CMS to set the base rate for the PDGM at a level that is budget neutral relative to 2019, a year when the Commission reported high FFS Medicare margins (over 15 percent) for freestanding agencies.

Under the BBA of 2018, CMS is required to make permanent adjustments (increases or decreases) when it estimates that home health care spending will deviate from the level expected absent BBA of 2018 changes. The statute requires temporary (one-year) adjustments when CMS identifies overpayments or underpayments that occurred in a prior year.

In the 2025 final rule for the home health PPS, CMS determined that a permanent reduction equal to 3.950 percent would be necessary to meet the BBA of 2018 budget-neutrality target for 2025 and future years. However, CMS implemented only half of the permanent reduction it identified as necessary, or a -1.975 percent adjustment for 2025. Assuming CMS's estimate of the budget-neutral level does not change, in future years CMS is required to recover the balance of any spending above the level required by the BBA of 2018 by implementing another reduction. CMS examined spending prior to 2024 (for 2020 through 2023) and found it was \$4.461 billion above the budgetary targets. Future rulemakings are expected to implement the temporary adjustments to the home health base rate to cover this overage.

Are FFS Medicare payments adequate in 2025?

To examine the adequacy of FFS Medicare's payments for home health care, 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 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 2023

Supply and volume indicators show that almost all FFS Medicare beneficiaries reside in an area with home health agencies that serve beneficiaries. 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 18.2 percent in the first 10 months of 2023 relative to the prior year but remained higher than the prepandemic rate in

2019. Data reported by HHAs to CMS indicate that 96.1 percent of home health services were initiated in a timely manner in 2023, a rate that was stable relative to 2022.

Supply of HHAs did not change substantially, and almost all beneficiaries live in an area served by at least one home health agency

The number of home health agencies (HHAs) is one indicator of the overall size of the industry, but it is a limited measure of capacity. HHAs can vary in size and the services they provide. For example, in 2023 the HHA at the 95th percentile of beneficiary census served 1,204 FFS Medicare beneficiaries, while the median HHA provided care to 114 FFS Medicare beneficiaries. 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 staff directly employed by an HHA may not be an effective measure of the supply of home health care because HHAs can use contract staff to meet their patients' needs. The presence of a provider also does not measure an HHA's ability to take additional patients. For other Medicare providers, such as inpatient hospitals and skilled nursing facilities (SNFs), administrative data are available to measure occupancy, such as the share of their beds that are occupied for a given period, to assess their available capacity. However, a similar measure is not available for home health care. Because of these limitations, we also review other access-to-care indicators such as utilization and information on timely initiation of care reported by HHAs.

In 2023, 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 FFS Medicare population. This definition may overestimate the local supply of agencies because HHAs need not serve the entire ZIP code to be counted as serving it, and this measure does not assess the capacity of agencies relative to beneficiary demand (i.e., agencies may not have capacity to serve additional beneficiaries who require home health care).³ At the same time, the definition may understate local supply if HHAs are willing to serve a ZIP code but did not

**TABLE
7-1**

Number of HHAs increased in 2023

	2019	2020	2021	2022	2023	Average annual percent change	
						2019–2023	2022–2023
Participating home health agencies	11,356	11,386	11,506	11,657	12,057	1.5%	3.4%

Note: HHA (home health agency).

Source: MedPAC analysis of the CMS Provider of Services file, home health standard analytic file, and the 2024 annual report of the Boards of Trustees of the Medicare trust funds. In previous years, MedPAC reported the number of HHAs using data from CMS survey and certification files, which are no longer available, so this report's count of HHAs in 2022 and previous years differs because of the use of the Medicare Provider of Services file.

receive a request to do so in the previous 12 months. The analysis excludes beneficiaries with unknown ZIP codes. In 2023, the share of FFS Medicare beneficiaries living in a ZIP code with two or more HHAs and the share of FFS Medicare beneficiaries living in a ZIP code with five or more HHAs were similar to the rates we reported last year.

The supply of HHAs approved to operate in Medicare (“participating HHAs”) increased in 2023 (Table 7-1). On a per capita basis, the number of HHAs per Medicare beneficiary (including both Medicare Advantage (MA) beneficiaries and FFS Medicare beneficiaries) has been relatively steady. A large spike in the number of HHAs in Los Angeles County, California, in 2023 drove an increase in the overall number of participating HHAs of 3.4 percent, but after excluding this county, the number of HHAs decreased by 2.8 percent relative to the prior year.

Declines in FFS Medicare home health volume and spending in 2023 reflect reductions in FFS enrollment, FFS hospitalizations, and per capita use of home health care

The total number of FFS Medicare beneficiaries using home health care and the total number of 30-day periods continued to decline in 2023, falling 4.4 percent and 3.9 percent, respectively (Table 7-2, p. 232). Much of the decline in FFS volume has been driven by a reduction in the number of beneficiaries in FFS Medicare, as a growing share of beneficiaries enroll

in MA. Controlling for FFS enrollment, the number of 30-day periods in 2023 decreased by 1.8 percent. At the same time, the share of FFS beneficiaries using home health has also declined, falling 2.3 percent in 2023. Lower use of inpatient hospital care among FFS beneficiaries likely has contributed to the decline in use of home health care, since a hospital stay is a common precursor to home health care. The number of IPPS discharges per 1,000 Part A beneficiaries in FFS Medicare has generally declined since 2019, such that the per capita number of IPPS discharges in 2023 is 16.0 percent lower than in 2019 (data not shown). While fewer beneficiaries are receiving home health care services in 2023 relative to the prior year, the number of 30-day periods delivered per FFS home health user held steady at about 3.1.

Home health utilization was lower on a per capita basis in rural areas, averaging 22.1 thirty-day periods per 100 FFS Medicare beneficiaries in rural counties compared with 24.2 thirty-day periods per 100 FFS Medicare beneficiaries for urban counties in 2023 (Table 7-3, p. 233). The average use in rural counties in micropolitan statistical areas was comparable with rural counties outside these areas.

Decline in total home health care spending but increasing payments per home health user and home health visit Trends in overall FFS Medicare home health care spending tracked with utilization; spending decreased by 2.6 percent to \$15.7 billion in 2023 (Table 7-2, p. 232). Medicare spending per FFS user of home

**TABLE
7-2****In 2023, the share of FFS Medicare beneficiaries receiving home health care declined**

FFS Medicare volume	2019	2020	2021	2022	2023	Average annual percent change	
						2019–2023	2022–2023
FFS users of home health (in millions)	3.3	3.1	3.0	2.8	2.7	–4.8%	–4.4%
Share of FFS beneficiaries using home health care	8.5%	8.1%	8.3%	8.0%	7.8%	–2.0	–2.3
30-day periods (in millions)	N/A	N/A	9.3	8.6	8.3	N/A	–3.9
30-day periods per 100 FFS Medicare beneficiaries	N/A	N/A	25.5	24.3	23.9	N/A	–1.8
30-day periods per FFS Medicare beneficiary who received home health care	N/A	N/A	3.1	3.0	3.1	N/A	0.5
Visits per FFS user	2.6	2.1	2.1	2.0	1.9	–7.2	–2.5
Total payments (in billions)	\$17.9	\$17.1	\$16.9	\$16.1	\$15.7	–3.2	–2.6
Payment per FFS Medicare user of home health care	\$5,437	\$5,591	\$5,588	\$5,703	\$5,811	1.7	1.9
Medicare payment per in-person visit	\$180	\$211	\$220	\$232	\$237	7.2	2.1

Note: FFS (fee-for-service), N/A (not applicable). CMS implemented a 30-day period as the unit of payment in 2020, so no data on 30-day periods are available for 2019. Not all claims in January and February of 2020 were paid under the new Patient-Driven Groupings Model, so we do not have a full year of data on 30-day periods for 2020. Percentage changes were calculated on unrounded data.

Source: MedPAC analysis of home health standard analytic files and the 2024 annual report of the Boards of Trustees of the Medicare trust funds.

health care increased by 1.9 percent, reflecting slight increases in the average payment per 30-day period and in the number of 30-day periods per home health user.⁴

From 2019 to 2023, the total number of in-person home health visits delivered to FFS beneficiaries declined by 9.7 percent per year, on average. While some of this decline is due to lower rates of home health care use, another factor is the declining provision of in-person visits per full 30-day period (Table 7-6, p. 235). Though the aggregate number of in-person visits has declined, FFS Medicare spending per in-person visit has increased, climbing from \$180 per visit in 2019 to \$237 per visit in 2023 (Table 7-2).⁵ While this FFS Medicare

spending per visit calculation does not include visits provided via telehealth or remote patient-monitoring technologies (discussed on p. 235), including them would not change per visit Medicare expenditures substantially because data for 2023 (the only year of data available) indicate that only 1.2 percent of 30-day periods included telehealth or remote monitoring.

Share of beneficiaries receiving home health care after hospitalization declined in the first 10 months of 2023

The share of discharges to HHAs decreased to 18.2 percent in the first 10 months of 2023, but home health care remained the most frequent formal post-acute care (PAC) site used after discharge. Before the

**TABLE
7-3****In 2023, use of home health by FFS Medicare beneficiaries was higher in urban counties****30-day periods per 100
FFS Medicare beneficiaries**

Urban counties	24.2
Rural counties	22.1
Rural counties in micropolitan statistical areas	22.2
All other rural counties (not in micropolitan statistical areas)	22.1
All counties	23.9

Note: FFS (fee-for-service). Rural counties are classified based on the boundaries of micropolitan statistical areas established by the U.S. Census Bureau. Under the Census Bureau's definition, micropolitan statistical areas are labor-market and statistical areas in the U.S. centered on an urban cluster (urban area) with a population of at least 10,000 but fewer than 50,000 people. Micropolitan statistical areas consist of the county or counties containing the core plus any other counties with strong commuting ties to the core counties.

Source: MedPAC analysis of home health standard analytic files and Common Medicare Environment file.

pandemic, SNFs were the most frequent first PAC destination among beneficiaries receiving formal PAC, with home health care services being the second most frequent (Table 7-4). In 2020, the two sites of care switched ranks in their share of use after an inpatient

hospital stay: Use of SNF services after hospitalization fell and use of home health care after hospitalization climbed. Since then, the share of IPPS discharges to SNFs has increased, and the share discharged to home health care has decreased. Even so, the share of FFS

**TABLE
7-4****FFS Medicare beneficiaries' first post-acute care site after an IPPS hospital stay, 2019–2023**

	2019	2020	2021	2022	First 10 months of 2023
Total IPPS discharges (in millions)	9.0	7.5	7.1	6.8	5.6
Share of discharges with:					
No PAC service after discharge	60.8%	59.0%	58.6%	58.4%	58.8%
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	41.2
First PAC site following IPPS discharge (as share of total discharges):					
Skilled nursing facility	18.7	15.9	16.6	17.4	17.3
Home health agency	15.8	20.1	19.6	18.6	18.2
Inpatient rehabilitation facility	3.7	4.1	4.4	4.7	5.0
Long-term acute care hospital	0.9	1.0	0.8	0.8	0.8

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), PAC (post-acute care). MedPAC reports the first 10 months of 2023 because some home health claims that followed the IPPS discharges in the last two months of that year are not available for analysis.

Source: MedPAC analysis of Medicare Provider Analysis and Review and home health standard analytic file.

**TABLE
7-5**

The share of home health services that were reported as initiated in a timely manner remained high in 2023

	2018	2019	2021	2022	2023
Share of home health stays that were initiated in a timely manner	94.6%	95.5%	95.7%	95.9%	96.1%

Note: Data include Medicaid, Medicare Advantage, and fee-for-service Medicare beneficiaries.

Source: Home Health Compare, 2024.

Medicare beneficiaries receiving home health care after IPPS discharge in the first 10 months of 2023 was 2.4 percentage points higher than the 2019 rate (Table 7-4, p. 233).

HHAs reported that most home health services were initiated in a timely manner, though measure limitations may affect results

One important measure of access is the timely initiation of home health care. CMS tracks this measure based on data reported by HHAs, and the measure is included in CMS's 5-star quality rankings for HHAs. The share of home health services (including FFS Medicare and MA stays) that were reported as being initiated in a timely manner was stable at about 96 percent for the 12-month period ending June 30, 2023 (Table 7-5).⁶ For this measure, home health services are considered initiated in a timely manner if the care begins on the start-of-care date ordered by the physician who referred the patient to home health care. If this date has not been indicated by the physician, care is considered timely if it begins within two days of the receipt of the referral by the HHA or, if the hospital discharge to home health care occurs after the receipt of the referral, within two days of inpatient discharge. Though these data suggest that timely access to care remains strong, the measure is subject to several limitations. The period of time in which care can begin and be considered timely is not fixed (e.g., two days after discharge), so if there are delays in sending a referral to an HHA, then care initiated with a substantial gap may be counted as timely. In addition, the date of a physician order may reflect the administrative practices of specific physicians or HHAs. 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 because agencies would typically only begin care after an order has been placed. Another limitation of this measure is that it does not reflect patients who were eligible for home health care but never received it. Nevertheless, a decline in the rate could suggest an issue with beneficiary access to home health care.

In-person visits during a full 30-day period have declined since 2019

In 2023, there were 1.7 fewer visits per full 30-day period, or 16.7 percent fewer, relative to 2019 (Table 7-6).⁷ The decline occurred in two phases: In 2020, the first year of the PDGM, the number of in-person therapy (physical, occupational, and speech-language pathology) visits per full 30-day period declined by 1.0 visits (almost 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. After this initial decline, the number of in-person therapy visits per full 30-day period remained relatively steady through 2023. By contrast, there was little change in the number of skilled nursing visits per full 30-day period in 2020 relative to the prior year, but the number of these visits per 30-day period decreased by 0.5 visits from 2020 to 2023. In total, skilled nursing visits fell by 11.7 percent. (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 by 35.6 percent between 2019 and 2023.) The total number of in-person visits per full 30-day period declined by 1.2 percent in 2023.

Many factors may have contributed to the decline in visits per full 30-day period since 2019. As noted above,

**TABLE
7-6**

Since 2020, the number of home health in-person visits per full 30-day period has declined

Volume measure	2019	2020	2021	2022	2023	Cumulative percent change 2019–2023	Percent change 2022–2023
Total visits per full 30-day period	10.2	9.2	8.8	8.6	8.5	–16.7%	–1.2%
Visits per full 30-day period by discipline:							
Physical therapy, occupational therapy, and speech–language pathology	4.9	3.9	3.9	4.0	3.9	–19.0	–0.9
Skilled nursing	4.6	4.6	4.3	4.1	4.1	–11.7	–1.3
Medical social services and home health aide	0.8	0.7	0.6	0.5	0.5	–35.6	–5.0

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. A 30-day period is classified as “full” when the number of in-person visits meets or exceeds the threshold established for the payment group to which the 30-day period has been assigned (which ranges from two to six in-person visits). Visit counts have been rounded. Percentages were calculated on unrounded data.

Source: MedPAC analysis of 2019 home health Limited Data Set file and standard analytic files, 2019 through 2023.

changes in the incentives underlying the payment system likely changed provider behavior. Fewer in-person visits could also, in part, reflect trends related to the coronavirus pandemic, such as beneficiary reluctance to receive services in the home and provider staffing challenges.

Since the implementation of the home health PPS in 2000, fewer home health aide visits are provided during a typical stay. In recent years, this decline has continued, falling from 0.7 visits per 30-day period in 2019 to 0.5 visits per 30-day period in 2023 (data not shown). Some have questioned whether this decrease means that Medicare beneficiaries are not receiving services they are entitled to under the Medicare home health benefit (Center for Medicare Advocacy 2019). FFS Medicare margins for freestanding HHAs have been substantially higher than costs since the implementation of the PPS in 2000, so Medicare payments should be adequate to cover costs for needed aide services. Since aide services cost less than skilled nursing and therapy services, it is reasonable to expect agencies to maximize the use of lower-cost care.

Telehealth and remote patient-monitoring services are covered under the home health care benefit but were not used by many FFS Medicare beneficiaries in 2023

Under the Medicare home health benefit, HHAs are permitted to provide two types of digital services: audio or video telehealth visits and remote patient monitoring. Though these services have been covered for several years, HHAs began voluntary reporting of these services for 30-day periods beginning on or after January 1, 2023, and mandatory reporting for services initiated on or after July 1, 2023. In past years, we have noted that the lack of data has limited our ability to assess the recent changes in the number of in-person visits received by home health beneficiaries.

The claims data for 2023 (including both the voluntary and the mandatory reporting periods) indicate that 1.2 percent of 30-day periods included a telehealth visit or remote patient monitoring, and about 14 percent of HHAs provided at least one telehealth or remote patient-monitoring service to an FFS Medicare beneficiary. Skilled nursing care accounted for about 80 percent of the telehealth visits provided in 2023. The small number of beneficiaries receiving these services,

**TABLE
7-7****Utilization, length of stay, and home health visits differed by home health stay type, 2021**

	Community admitted	Posthospital	Difference (community admitted minus posthospital)
Total (millions)	1.8	2.0	-0.2
Average length of stay (in days)	93.9	57.9	35.9
Average visits per stay:	26.6	19.9	6.7
By discipline:			
Skilled nursing	14.9	9.0	5.9
Therapy	9.6	9.8	-0.3
Medical social work	0.1	0.1	<0.1
Home health aide	2.0	1.0	1.0
Share of stays (in days):			Percentage point difference
30 or less	33.0%	43.1%	-10.1
31-60	31.1	36.7	-5.6
61-120	17.9	12.3	5.7
121+	18.0	8.0	10.1
Total	100.0	100.0	N/A

Note: N/A (not applicable). A home health "stay" is a series of 30-day periods with a gap of no more than 10 days between consecutive 30-day periods. The gap is measured as the number of days between the last visit of a 30-day period and the first visit of a subsequent 30-day period. Stays with a hospital or skilled nursing facility stay preceding their longest home health stay were categorized as posthospital; stays not preceded by these services were categorized as community-admitted stays. "Length of stay" has been measured from the first visit of the first 30-day period in a stay to the last visit in the last 30-day period in a stay. Percentages were calculated on unrounded figures.

Source: Medicare Provider Analysis and Review 2021 and 2022, home health standard analytic file 2021 and 2022, Medicare Current Beneficiary Survey 2021.

and the limited number of HHAs providing them, indicates that most clinical care in the home health benefit is still provided in person.

Beneficiaries admitted to home health care from the community have longer stays While FFS Medicare pays for home health care in 30-day periods, many beneficiaries receive more than one 30-day period. The length of home health stays, which are back-to-back series of consecutive 30-day periods, varies widely; this variation likely reflects a myriad of factors. There were 3.9 million home health stays initiated in 2021, and the mean length of stay was 75.1 days. In 2021, 51.2 percent of stays were posthospital or postinstitutional PAC, and 49.8 percent were admitted from the community.

There were some differences in the length of stays and the mix of home health services beneficiaries received.

Community-admitted stays were 63.8 percent longer on average than posthospital or postinstitutional PAC stays, with mean lengths of 93.9 days and 57.9 days, respectively (Table 7-7). Community-admitted stays averaged 6.7 more visits per stay, likely reflecting the longer length of stay. However, the mix of services was different across the two stay types, with skilled nursing being the most frequently provided service for community-admitted stays and therapy (primarily physical therapy) the most frequently provided service for posthospital stays.

There were similarities and differences in the demographic and clinical characteristics of community-admitted beneficiaries and posthospital or postinstitutional beneficiaries (Table 7-8).⁸ Community-admitted beneficiaries were slightly older.

**TABLE
7-8****Community-admitted and posthospital or postinstitutional PAC users of home health care had similarities and differences in select characteristics, 2021**

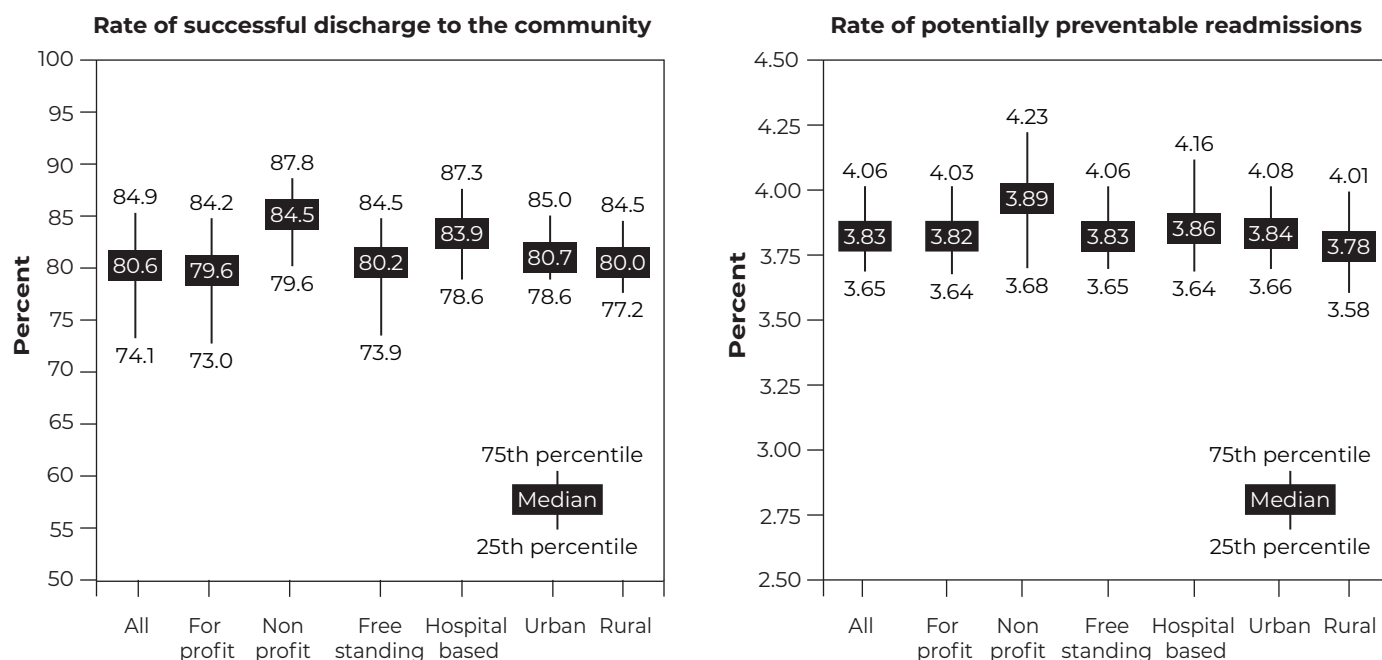
	Community admitted	Posthospital	Percentage point difference
Number of FFS beneficiaries (millions)	1.4	1.7	N/A
Mean age	78.8	76.8	N/A
Share of beneficiaries:			
Male	37.9%	42.7%	-4.8%
Part D low-income subsidy or Medicare/Medicaid dually eligible beneficiary	32.7	23.3	9.5
Rural	19.0	17.8	1.2
Decedent in 2021	13.7	11.9	1.8
White/Caucasian	80.7	83.6	-3.0
Rates of selected conditions (ranked by percentage point difference):			
Alzheimer's disease, related disorders, and dementia	39.3	29.1	10.8
Pressure and chronic ulcers	23.8	18.3	5.5
Peripheral vascular disease	35.5	31.2	4.3
Rheumatoid arthritis/osteoarthritis	64.1	62.0	2.2
Depression	41.2	39.3	1.9
Hypothyroidism	28.6	28.4	0.2
Diabetes	43.9	43.8	0.1
Hypertension	87.9	90.2	-2.4
Chronic obstructive pulmonary disease	25.5	29.3	-3.8
Congestive heart failure	37.6	42.2	-4.6
Ischemic heart disease	49.0	55.7	-6.7
Hyperlipidemia	70.1	77.5	-7.4
Chronic kidney disease	52.8	60.2	-7.4
Anemia	50.4	62.6	-12.1

Note: FFS (fee-for-service), N/A (not applicable). FFS beneficiaries have been categorized based on the service use preceding their longest home health stay in 2021. Beneficiaries with a hospital or skilled nursing facility stay preceding their longest home health stay in 2021 were categorized as "posthospital." Beneficiaries without these services preceding their longest home health stay have been categorized as "community-admitted" beneficiaries. Incidence of clinical conditions are based on data from the Medicare Beneficiary Summary File Chronic Condition files and Other Conditions files. The classifications of conditions in those files reflect diagnoses recorded during either a one-year period (using 2021 claims) or a two-year period (using 2020 and 2021 claims). Percentage point changes were calculated on unrounded data.

Source: Home health standard analytic files 2020, 2021, and 2022; Master Beneficiary Summary File 2021; Medicare Provider Analysis and Review files 2021 and 2022.

Also among community-admitted beneficiaries, there was a lower share of male beneficiaries and a higher share who qualified for the Part D low-income drug subsidy or Medicaid. The two groups of beneficiaries had many common chronic conditions or serious

clinical conditions, with the difference in the frequency between the two groups equal to or less than 3 percentage points for 20 of 35 conditions.⁹ However, there were some substantial differences. For example, the rate of Alzheimer's disease and dementia was 10.8

**FIGURE
7-1****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-adjusted 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. The measure is calculated as the risk-adjusted percentage of those patients who were readmitted to an acute care hospital for a medical condition that might have been prevented in the 30-day period that begins 2 days after the end of the home health stay. Lower rates are better. Data for “successful discharge” cover the two-year period from January 1, 2022, to December 31, 2023; data for potentially preventable readmissions cover the 36-month period from January 1, 2021, to December 31, 2023.

Source: MedPAC analysis of claims-based outcome measures from the Provider Data Catalog.

percentage points higher for community-admitted beneficiaries relative to posthospital beneficiaries, and the rate of anemia was 12.1 percentage points lower for community-admitted beneficiaries relative to posthospital beneficiaries.

Marginal profits

Another component of access is whether providers have a financial incentive to expand the number of FFS Medicare beneficiaries they serve. To assess this component, we examine the FFS Medicare marginal profit—the percentage of revenue from FFS Medicare that is left as profit after accounting for the allowable

variable costs of providing services to FFS Medicare patients. (Variable costs are those that vary with the number of patients treated. By contrast, fixed costs are those that are the same in the short run regardless of the number of patients treated (e.g., rent).) If the FFS Medicare marginal profit is positive, a provider with excess capacity has a financial incentive to care for an additional FFS beneficiary; if the FFS Medicare marginal profit is negative, a provider may have a disincentive to care for an additional FFS beneficiary. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) Due to anomalies related to cost allocation on the home health cost report, we were unable to compute the FFS

Medicare marginal profit for 2023. We note, however, that because the FFS Medicare marginal profit excludes fixed costs included in our other financial measures, the FFS Medicare marginal profit for HHAs would be higher than the FFS Medicare margin reported later in this chapter.

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. We report two outcome measures for HHAs: risk-adjusted potentially preventable hospital readmissions after discharge and risk-adjusted discharge to the community. The quality measure of the return to home or community shows the rate at which patients stay home and remain 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 increased from 79.3 percent in the period from January 1, 2021, to December 31, 2022 (data not shown), to 80.6 percent in the period from January 1, 2022, to December 31, 2023. There was over 10 percentage points of variation across the interquartile range where HHAs at the 25th percentile and 75th percentile had rates of 74.1 percent and 84.9 percent, respectively (Figure 7-1, first graph). For-profit HHAs had a lower median rate of discharge to community in 2023 compared with nonprofit HHAs.

Potentially preventable readmissions after discharge are calculated as the percentage of patients discharged from home health care services who were readmitted to a hospital for a medical condition that might have been prevented in the 30-day period beginning 2 days after the end of home health care services (lower percentages are better; a home health stay had to be preceded by a hospital stay to be included in this measure). For January 1, 2021, to December 31, 2023, the median rate of home health stays with a potentially preventable readmission was 3.83 percent. The median rates of potentially preventable rehospitalization did not differ substantially across ownership categories or facility type. In the January 1, 2021, to December 31, 2023, period, potentially preventable rehospitalization rates varied across the 25th and 75th percentiles with

rates of 3.65 percent and 4.06 percent, respectively (Figure 7-1, second graph).

Most patient-experience measures remained stable

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. 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 both posthospital and community-admitted home health beneficiaries.

HH-CAHPS ratings in 2023 were relatively stable compared with prior years, and most patients reported high rates of positive responses.¹⁰ (Data for 2020 are unavailable because CMS waived the requirement to collect HH-CAHPS data for the first six months of 2020 due to the coronavirus public health emergency.) The share of patients reporting (1) a high satisfaction rating with HHAs (9 or 10 on 10-point scale) and (2) that HHAs communicated well with them increased by 1 percentage point (Table 7-9, p. 240). The ratings for HHAs were high for major subgroups of HHAs, though there were some differences across groups. Rural agencies had higher rates of patient satisfaction compared with urban agencies (Table 7-10, p. 241).

Providers' access to capital is adequate

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. Yet indicators suggest that HHAs have adequate access to capital. One measure the Commission assesses is the overall profitability of HHAs, which examines the profitability for all health care payers that HHAs serve (including FFS Medicare, Medicare Advantage, and other payers). In 2023, the all-payer margin for freestanding HHAs was 8.2 percent, indicating that many HHAs yield positive financial results that should appeal to capital markets. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) Few HHAs access capital through publicly traded shares or through public debt such as issuance of bonds.

**TABLE
7-9****Most patient-experience measures did not change in 2023**

HH-CAHPS measure	2019	2021	2022	2023	Percentage point change, 2022-2023
Share of patients rating the HHA a 9 or 10 out of 10	84%	84%	84%	85%	1
Share of patients who would definitely recommend the home health agency to friends or family	78	77	78	78	0
Share of patients who reported that their home health provider:					
Gave care in a professional way	88	88	88	88	0
Communicated well with them	85	85	85	86	1
Discussed medicines, pain, and home safety with them	83	81	82	82	0

Note: HHA (home health agency), HH-CAHPS (Home Health 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 due to the coronavirus public health emergency. Data include fee-for-service Medicare, Medicare Advantage, and Medicaid beneficiaries.

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

While there has been significant acquisition activity by the larger for-profit firms in recent years, there have been notable swings in the number of HHAs purchased by investors since 2020. In 2021 and 2022, the reported number of investor purchases increased relative to prior years, with the number of transactions lower in 2023 and 2024 (Braff Group 2024). This change may reflect several factors, such as (1) higher interest rates reducing demand from investors for acquisition, (2) large insurers seeing no need to expand their footprint in the sector, and (3) challenges in the home health market such as increasing MA enrollment or the BBA of 2018 budget-neutrality adjustments to FFS Medicare payments. Even with the slowdown in since 2023, some firms continue to expand their operations. For example, in 2024 the Pennant Group acquired an \$80 million home health operation in Washington and Idaho, and Choice Health at Home, a multistate firm that operates home health care and hospice agencies, acquired a chain of HHAs in Oklahoma for

\$260 million (Donlan 2024, Famakinwa 2024). These acquisitions suggest that, while the overall volume of acquisitions has declined, access to capital is adequate for some agencies seeking to expand.

Some of the largest publicly traded HHA companies have been acquired in recent years. In 2021, Humana completed its purchase of Kindred at Home (Waddill 2021). In 2023, Optum Health Care, a subsidiary of UnitedHealth Group, completed its purchase of LHC Group and has a pending acquisition of Amedisys (Landi 2024, Pifer 2023). According to industry analysts, these acquisitions reflect several trends, including efforts to expand population-based health care services, better manage spending and utilization of home health care services, and capture revenues that are paid to providers for services to plan beneficiaries (Irving Levin Associates LLC 2023, Pifer 2023). The acquisitions suggest that large investors viewed the publicly traded for-profit HHAs, which receive a significant share of their revenues from FFS Medicare, as attractive investments.

**TABLE
7-10****Patient-experience measures were higher for rural HHAs, 2023**

HH-CAHPS measure	Urban	Rural
Share of patients rating the home health agency a 9 or 10 out of 10	84%	89%
Share of patients who would definitely recommend the home health agency to friends or family	78	84
Share of patients who reported that their home health provider:		
Gave care in a professional way	88	91
Communicated well with them	85	89
Discussed medicines, pain, and home safety with them	81	85

Note: HHA (home health agency), HH-CAHPS (Home Health Care Consumer Assessment of Healthcare Providers and Systems). HH-CAHPS is a standardized survey of patients' evaluations of home health agencies. 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. Data include fee-for-service Medicare, Medicare Advantage, and Medicaid beneficiaries.

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

Medicare payments and providers' costs: FFS Medicare margins remain historically high

In 2023, the Medicare FFS margin for freestanding HHAs was 20.2 percent in aggregate, down from 22.1 percent in 2022. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) FFS Medicare margins varied across providers but were positive for most HHAs. As noted earlier, HHAs' FFS Medicare margins have averaged 17.1 percent from 2001 to 2022.

The annual increase in cost per 30-day full period has fluctuated since the PDGM was implemented. In 2021, the cost per full 30-day period declined by 2.9 percent, while in 2022 and 2023, the cost per full 30-day period increased by an average of 3.4 percent each year. Even with these fluctuations, the annual change in cost per 30-day period was 29 percent lower than the annual increases in inflation indicated by the home health market basket for these years. The increase in cost per full 30-day period in 2023 was due to higher costs per visit, but a small reduction in the number of visits slightly offset the growth in total cost per 30-day period.

The FFS Medicare margin for freestanding HHAs was over 20 percent in 2023

In 2023, the FFS Medicare margin for freestanding HHAs was 20.2 percent, with wide variation across HHAs (Table 7-11, p. 242). The margin ranged from 3.8 percent for the HHA at the 25th percentile to 30.8 percent for the HHA at the 75th percentile of the margin distribution (data not shown). For-profit HHAs had higher FFS Medicare margins than nonprofit HHAs, and urban HHAs had similar FFS Medicare margins compared with rural HHAs. Agencies with higher volume had better financial results, likely reflecting the economies of scale possible for larger operations. For example, the FFS Medicare margin for HHAs in the bottom quintile of volume averaged 12.6 percent, compared with 22.4 percent for HHAs in the top quintile of volume. While agencies' financial performance varies, FFS Medicare payments are generally well in excess of HHA costs. These overpayments have consequences for the Medicare program since they increase the financial pressure on the Medicare trust fund and raise Part B premiums paid by Medicare beneficiaries.

**TABLE
7-11****FFS Medicare margins for freestanding home health agencies, 2019–2023**

	2019	2020	2021	2022	2023	Share of home health agencies, 2023	Share of periods, 2023
All	15.4%	20.2%	24.9%	22.2%	20.2%	100%	100%
Geography							
Majority urban	16.1	20.0	24.8	22.3	20.2	86	87
Majority rural	14.2	21.6	25.2	22.0	20.1	14	13
Type of ownership							
For profit	17.4	22.7	26.1	23.6	21.5	93	87
Nonprofit	11.4	12.4	20.2	16.4	13.3	7	13
Volume quintile							
First (smallest)	9.7	11.6	14.0	13.7	12.6	20	3
Second	11.4	14.0	15.9	14.5	13.9	20	7
Third	13.3	17.0	19.3	17.0	15.0	20	11
Fourth	14.1	18.8	22.8	21.0	19.4	20	20
Fifth (largest)	17.5	22.4	28.3	24.8	22.4	20	60

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 they 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. Percentage changes were calculated on unrounded data. Percentages may not sum to 100 due to rounding.

Source: MedPAC analysis of Medicare home health cost report files from CMS.

In 2023, the average FFS Medicare margin for hospital-based HHAs was -16.5 percent (data not shown). The lower FFS Medicare 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 costs in the inpatient hospital setting.

FFS Medicare margin for 2025 projected to decline relative to 2023 but remain high

In modeling 2025 FFS Medicare margins, we incorporate policy changes that will go into effect between the year of our most recent data, 2023, and the year for which we are making the margin

projection, 2025. Table 7-12 shows the major payment-policy changes in 2024 and 2025, including a permanent reduction to the base payment rate of -1.975 percent, as required to maintain budget neutrality following the implementation of the PDGM classification system and associated changes to the PPS. Based on these policies and assumptions, the Commission projects a FFS Medicare margin of 19 percent in 2025 for freestanding HHAs (data not shown).

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 and 2023, the cost per 30-day period increased by about 3.4 percent each year. The Commission's projected margin assumes

TABLE
7-12

Home health PPS payment policy changes in 2024 and 2025

	2024	2025
Home health PPS policy changes:		
Home health market basket	3.3%	3.2%
Productivity	-0.3	-0.5
Budget-neutrality adjustment under BBA of 2018	-2.890	-1.975
Outlier threshold adjustment	0.4	-0.4
Total	0.8	0.5

Note: PPS (prospective payment system), BBA (Bipartisan Budget Act). The impact of the budget-neutrality adjustment applies to all non-low-use payment adjustment (LUPA) periods, and so the net reduction on aggregate payments (which include both LUPA and non-LUPA periods) for 2024 and 2025 is less than the percentage indicated.

Source: MedPAC analysis of home health final rules for 2024 and 2025.

that for 2024 and 2025, the rates of cost increase will average 1.3 percent per year, the average for 2021 through 2023.

How should FFS Medicare payments change in 2026?

Under current law, FFS Medicare’s payment rates to HHAs are increased annually based on the projected increase in the HHA market basket, less an amount for productivity improvement. CMS will revise its estimates before setting rates for 2026; however, CMS’s third quarter 2023 projections indicate a 2.4 percent payment update in 2026 (an estimated market basket increase of 3.0 percent minus a productivity adjustment of 0.6 percent). The payment-adequacy indicators for Medicare home health services are positive and show that FFS Medicare 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 FFS Medicare program. Further, excessive FFS Medicare payments reduce the incentives for HHAs to furnish care efficiently.

As discussed above, for 2025 CMS implemented a permanent reduction to the 30-day period base rate of 1.975 percent, half the amount required by law to

maintain budget neutrality after 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 1.975 percent to keep spending at the level required by law. We note that, even after such a reduction, FFS Medicare payments to HHAs would remain far above costs.

RECOMMENDATION 7

For calendar year 2026, the Congress should reduce the 2025 Medicare base payment rate 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. FFS 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 FFS Medicare margin was 20.2 percent in 2023, and we project that it will be 19 percent in 2025.

As noted earlier, the BBA of 2018 requires reductions to home health care payments, but the recommendation is not intended to be additive to the BBA of 2018 adjustments. Under this recommendation, the base rate for 2026, net of all payment changes in 2026, would be 7 percent lower than the 2025 base rate.

IMPLICATIONS 7

Spending

- Current law is expected to increase payment rates by 2.4 percent in 2026. This recommendation would decrease federal program spending by \$750 million to \$2 billion in 2025 and by \$10 billion to \$25 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 Medicare 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/2024/10/MedPAC_Payment_Basics_24_HHA_FINAL_SEC.pdf.
- 3 As of November 2024, 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 ZIP codes in which an HHA has provided services in the past 12 months.
- 4 The average payment per full 30-day period increased by 0.6 percent to \$2,022 in 2023.
- 5 These payment amounts 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 Patient-Driven Groupings Model were included).
- 6 For the purpose of this measure, home health services are measured as a period of time that begins at the initiation of home health care services and continues to the end of services, typically discharge. Referred to as a “quality episode,” this unit of measure may be a single 30-day period or several consecutive 30-day periods, depending on the length of service for FFS Medicare beneficiaries.
- 7 A 30-day period is classified as “full” when the number of in-person visits meets or exceeds the threshold established for the payment group to which the 30-day period has been assigned (which ranges from two to five in-person visits).
- 8 Beneficiaries were assigned to these categories based on the type of stay they had in 2021; beneficiaries with multiple stays were assigned to the category with the longest length of stay.
- 9 These 20 conditions include depression, osteoporosis, mobility impairments, cerebral palsy, epilepsy, hypothyroidism, diabetes, glaucoma, cystic fibrosis, endometrial cancer, fibromyalgia, leukemias and lymphomas, lung cancer, colorectal cancer, breast cancer, prostate cancer, cataracts, asthma, and hypertension (not all 20 conditions are included in the table).
- 10 CMS reported a 24 percent response rate for the HH-CAHPS in 2023.

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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 2026, the Congress should reduce the 2025 Medicare base payment rate for inpatient rehabilitation facilities by 7 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. Care provided in IRFs is supervised by rehabilitation physicians and includes services such as physical and occupational therapy, rehabilitation nursing, and speech-language pathology. In 2023, the fee-for-service (FFS) Medicare program and its beneficiaries spent \$9.6 billion on 404,000 IRF stays in about 1,200 IRFs nationwide. The FFS Medicare program accounted for about 51 percent of IRF stays.

Assessment of payment adequacy

In 2023, IRF payment-adequacy indicators were positive.

Beneficiaries' access to care—Our analysis of IRF supply and volume of services provided and of IRFs' marginal profit under the IRF prospective payment system (PPS) suggests that access remains adequate.

- **Capacity and supply of providers**—Between 2022 and 2023, the number of IRF beds increased by 3 percent. The aggregate IRF occupancy rate remained relatively stable at 69 percent, indicating that in markets with IRFs, capacity is more than adequate to meet demand.

In this chapter

- Are FFS Medicare payments adequate in 2025?
- How should FFS Medicare payments change in 2026?

- **Volume of services**—From 2022 to 2023, the total number of FFS Medicare stays in IRFs increased by about 7 percent, and stays per FFS beneficiary increased by about 10 percent. In 2023, the average length of stay was 12.5 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 40 percent for freestanding IRFs—a very strong indicator of access.

Quality of care—For the two-year period of 2022 through 2023, the median facility risk-adjusted rate of discharge to the community from IRFs was 67.2 percent, essentially stable from the prior period of 2021 through 2022. The median facility risk-adjusted rate of potentially preventable readmission remained relatively stable at 8.8 percent compared with the rate of 8.6 percent over the period from 2021 through 2022 and was higher for freestanding and for-profit providers than for hospital-based and nonprofit facilities.

Providers' access to capital—Between 2022 and 2023, freestanding IRFs' all-payer total margin rose from 8 percent to about 10 percent. For-profit corporations continued to open new IRFs and enter joint ventures with other organizations, suggesting strong access to capital. Hospital-based IRFs access capital through their parent hospitals.

FFS Medicare payments and providers' costs—In 2023, IRFs' average payment per stay increased by less than 1 percent while average cost per stay declined slightly after several years of higher growth. As a result, IRFs' FFS Medicare margin rose to 14.8 percent, up from 13.7 percent in 2022.

How should payment rates change in 2026?

Given our positive payment-adequacy indicators, the recommendation is that, for fiscal year 2026, the 2025 IRF base payment rate should be reduced by 7 percent. This recommendation would continue to provide IRFs with sufficient revenue to maintain FFS Medicare beneficiaries' access to IRF care while bringing IRF PPS payment rates closer to the cost of efficiently delivering high-quality care. ■

Background

After illness, injury, or surgery, some patients need intensive inpatient rehabilitative care, including services such as physical and occupational therapy, rehabilitation nursing, and speech–language pathology. These 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 hospitals. 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. Fee-for-service (FFS) Medicare payments for inpatient IRF services are based on a per stay prospective payment system (PPS).² In 2023, about 1,200 IRFs furnished 404,000 Medicare-covered stays. FFS Medicare spending on IRF services was \$9.6 billion (\$9.5 billion in program spending and \$0.1 billion in beneficiary cost-sharing liability). FFS Medicare beneficiaries accounted for about 51 percent of IRF stays.³

Medicare facility requirements for IRFs

To qualify as an IRF for Medicare payment, a facility must meet the Medicare conditions of participation for acute care hospitals (ACHs). 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; 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 plan of care 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 patients' stays based on the inpatient hospital PPS rather than the IRF PPS.

During the coronavirus public health emergency (PHE), some of the requirements were waived.⁵ When the PHE ended on May 11, 2023, requirements were reinstated.

Medicare coverage criteria for beneficiaries

Medicare applies additional criteria to specify 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 the IRF stay, a nonphysician practitioner who is determined by the IRF to have specialized

training and experience in inpatient rehabilitation 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 2025?

To examine the adequacy of FFS Medicare payments, we analyze beneficiaries' access to care (including 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

Nevertheless, our analysis of IRF supply and volume of services suggests that, in markets with IRFs, 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 2023 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 2023, the supply of IRFs grew, with more openings (49) than closures (24). The majority of new IRFs were freestanding for-profit facilities and opened in markets in which another IRF was already serving beneficiaries; most closures were nonprofit hospital-based facilities in areas with another IRF. After rising by less than 1 percent per year between 2019 to 2022, the number of IRFs increased by 2.1 percent between 2022 and 2023, climbing from 1,181 to 1,206 (Table 8-1). The majority of IRFs (1,051) were located in urban areas, and 155 were located in rural areas (13 percent).

About two-thirds of IRFs in urban areas were hospital-based facilities compared with 92 percent among IRFs in rural areas (data not shown).

The growth in the number of IRFs was driven by a 7.4 percent increase in freestanding IRFs in 2023 compared with the prior year (Table 8-1). In contrast, the number of hospital-based IRFs continued to decline, falling by 0.1 percent between 2022 and 2023. Freestanding IRFs tended to be larger facilities compared with hospital-based IRFs: In 2023, 95 percent of freestanding IRFs had 25 or more beds, while most hospital-based IRFs (60 percent) had fewer than 25 beds (data not shown).

Nationwide, the number of IRF beds grew by about 3 percent, with an increase in beds in freestanding for-profit IRFs and a slight decrease in beds in the hospital-based nonprofit IRFs. In 2023, the aggregate IRF occupancy rate remained relatively stable at 69 percent compared with 68 percent in the prior year. From 2022 to 2023, the aggregate occupancy rate increased slightly among freestanding IRFs (from 71 percent to 73 percent) and remained stable at about 65 percent among hospital-based IRFs. In general, larger IRFs had higher occupancy rates than smaller IRFs. These rates suggest that, in markets with IRFs, capacity is adequate to meet demand for IRF services.

In 2022, less than 30 percent of hospital service areas (HSAs) had one or more IRFs.⁷ (By comparison, 97 percent of HSAs contained at least one skilled nursing facility (SNF).) Of markets with IRFs, most had only hospital-based IRFs (67 percent) or only freestanding IRFs (18 percent), and about 15 percent had both types. (In interviews conducted last year with a small set of ACH discharge planners and executives regarding discharges to an IRF or SNF, interviewees did not distinguish between IRF services received in hospital-based or freestanding IRFs (L & M Policy Research 2023)). Seventy percent of Medicare beneficiaries (including those in FFS and Medicare Advantage) lived in HSAs with IRFs; only about 30 percent of FFS Medicare beneficiaries lived in an HSA without an IRF. Some beneficiaries who lived in these HSAs traveled to other areas to receive IRF care or received rehabilitative care from other post-acute care (PAC) providers.

IRFs are intended to provide a more intense level of therapy under direct medical supervision, but other

**TABLE
8-1**

The number of for-profit and freestanding IRFs grew in 2023

Type of IRF	Share of Medicare FFS stays 2023	Number of IRFs					Average annual percent change 2019–2022	Percent change 2022–2023
		2019	2020	2021	2022	2023		
All IRFs	100%	1,152	1,159	1,181	1,181	1,206	0.8%	2.1%
Urban	94	1,000	1,004	1,021	1,021	1,051	0.7	2.9
Rural	6	152	155	160	160	155	1.7	–3.1
Freestanding	61	299	310	329	345	371	4.9	7.4
Hospital based	39	853	849	852	836	835	–0.7	–0.1
Nonprofit	30	634	623	620	602	598	–1.7	–0.7
For profit	66	393	414	436	457	503	5.2	10.1
Government	5	116	113	115	111	105	–1.5	–5.4

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.

providers also furnish post-acute care services in communities with and without IRFs. SNFs provide post-acute care in an institutional setting, and home health agencies, hospital outpatient departments, comprehensive outpatient rehabilitation facilities, and independent therapy providers furnish such care at a beneficiary’s home or on an outpatient basis. Given the number and distribution of these other providers, it is unlikely that IRFs are the only provider of post-acute care services available to Medicare beneficiaries in any given area.

Few evidence-based guidelines exist to help direct beneficiaries to the post-acute care setting with the best outcomes. 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, stroke guidelines established by the American Heart Association/American Stroke Association outline best practices in rehabilitation care for stroke patients (e.g., prevention of falls and skin breakdown and pain management) and recommend placement in IRFs over SNFs for patients who qualify for IRF services (Winstein et al. 2016).

In 2023, IRF stays per beneficiary exceeded prepandemic levels

The number of IRF stays for FFS Medicare beneficiaries increased substantially in 2023 after falling at the start of coronavirus pandemic in 2020 (Table 8-2, p. 254). From 2022 to 2023, the number of stays rose by 7.3 percent, and the number of stays per 10,000 FFS beneficiaries rose by 10.4 percent. Stays per FFS Medicare beneficiary in 2023 were well above prepandemic levels (120 stays per 10,000 FFS beneficiaries in 2023 compared with 107 in 2019). Growth in the number of stays per FFS beneficiary was higher among freestanding IRFs (12 percent higher than the prior year) than for hospital-based IRFs (7 percent) (data not shown). The average length of stay decreased in 2022 and 2023, after increasing during the coronavirus pandemic, falling to just below prepandemic levels (Table 8-2, p. 254).

Patterns of use in IRFs

In 2023, the most common condition treated by IRFs was stroke—accounting for almost one-sixth of stays—followed by “other neurological conditions” and “debility.”

**TABLE
8-2****IRF stays per FFS Medicare beneficiary increased to above prepandemic levels in 2023**

	2019	2020	2021	2022	2023	Average annual percent change 2019–2022	Percent change 2022–2023
Inpatient stays (thousands)	404	374	373	376	404	0.0%	7.3%
Inpatient stays per 10,000 beneficiaries	107	101	104	109	120	2.8	10.4
Average length of stay (days)	12.6	12.9	12.9	12.8	12.5	–0.2	–2.3

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). Percentage changes were calculated on unrounded data.

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

The distribution of stay types differs by type of IRF and ownership (Table 8-3). For example, in 2023, only 13 percent of stays in freestanding for-profit IRFs were admitted for rehabilitation following a stroke, compared with 21 percent of stays in hospital-based nonprofit IRFs. By contrast, 20 percent of stays in freestanding for-profit IRFs were admitted with “other neurological conditions,” more than twice the share admitted to hospital-based nonprofit IRFs. Stays for “fracture of the lower extremity” made up a larger share of stays in hospital-based for-profit facilities than in all other IRF types. The share of stays with “debility,” “brain injury,” and “other orthopedic conditions” were similar across IRF types. The distribution of stay types was relatively stable between 2019 and 2023 (data not shown). The Commission has previously reported that some stay 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 indicates an incentive to treat more Medicare beneficiaries

Another component of access is whether providers have a financial incentive to expand the number of FFS Medicare beneficiaries they serve. To assess this component, we examine the FFS Medicare marginal profit—the percentage of revenue from FFS Medicare that is left as profit after subtracting the variable costs of providing services to FFS Medicare patients.

(Variable costs vary with the number of patients treated. By contrast, fixed costs do not vary (at least in the short run) regardless of the number of patients treated (e.g., rent).) If the FFS Medicare marginal profit is positive, a provider with excess capacity has a financial incentive to care for an additional FFS beneficiary; if the FFS Medicare marginal profit is negative, a provider may have a disincentive to care for an additional FFS beneficiary. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.)

When FFS Medicare payments exceed providers’ total costs for providing those services, examining the FFS Medicare marginal profit does not yield any additional information about the adequacy of FFS Medicare payment rates. Moreover, it is difficult to use cost reports to precisely estimate IRFs’ variable costs. However, when using our estimates from prior work—that about 80 percent of IRFs’ costs were variable—in 2023, IRFs’ FFS Medicare marginal profit was 31 percent in aggregate, 18 percent among hospital-based IRFs, and 40 percent for freestanding IRFs. If we had instead used the 85 percent upper-bound estimate from our hospital analysis of the share of costs that was variable, IRFs’ FFS Medicare marginal profit would still have been substantially positive at 28 percent. Both estimates of marginal profit suggest that IRFs with available beds have a strong financial incentive to admit FFS Medicare

**TABLE
8-3**

Mix of FFS Medicare IRF stays differed by provider type and selected conditions, 2023

Condition	Freestanding		Hospital based	
	For profit	Nonprofit*	For profit	Nonprofit*
All (share of stays)	57%	5%	9%	29%
Percent of total				
Stroke	13	21	14	21
Other neurological conditions	20	7	10	7
Fracture of the lower extremity	10	10	15	13
Debility	14	14	16	14
Brain injury	12	12	13	12
Other orthopedic conditions	9	7	8	7
All other conditions	22	27	23	25

Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility). "Other neurological conditions" includes neuromuscular disorders, multiple sclerosis, Parkinson's disease, and polyneuropathy included in the neurological impairment group. "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, as well as hip and knee replacements. "Brain injury" includes both traumatic and nontraumatic injuries. Freestanding proprietary IRFs are more likely to have stays in certain subcategories of the "other neurological conditions": neuromuscular conditions (such as myasthenia gravis, motor neuron disease, post-polio syndrome, muscular dystrophy, and other myopathies) and other neurological disorders (such as other extrapyramidal disease, abnormal movement disorders, and hereditary ataxia). Column components may not sum to 100 percent due to rounding.
* "Nonprofit" columns include government IRFs.

Source: MedPAC analysis of Inpatient Rehabilitation Facility Patient Assessment Instrument data from CMS.

patients. Therefore, in future years, the Commission may consider whether to continue to report the marginal profit when Medicare total payments more than cover providers' total costs.

Quality of care: Discharge to the community and potentially preventable readmissions

In our assessment of payment adequacy, the Commission prioritizes quality measures tied to clinical outcomes. We report two outcome measures for IRFs: risk-adjusted potentially preventable hospital readmissions after discharge and risk-adjusted discharge to the community, which are claims-based outcome measures developed by CMS. CMS publicly reports facility-level measures after providers are given an opportunity to review the data. The measures are updated annually and cover a 24-month period. The most recent available data, released in October

2024, cover fiscal year (FY) 2022 through FY 2023. Data from this period indicate that, in aggregate, rates of successful discharge to the community and potentially preventable readmissions were stable compared with the previous 24-month period.

Readmissions and community-discharge measures assess key outcomes of IRF care, but they do not capture all aspects of quality in IRFs. Ideally, we could 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 ability to assess the quality of IRF care.

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 (higher rates are better) (Centers for Medicare & Medicaid Services 2023).⁸ 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.

From FY 2022 through FY 2023, the median facility risk-adjusted rate of successful discharge to the community was 67.2 percent, almost exactly the same as the rate for FY 2021 and FY 2022, which was 67.3 percent (latter figure not shown). About one-quarter of facilities had a risk-adjusted rate below 63.8 percent and one-quarter had a rate above 70.3 percent (Figure 8-1). Discharges to community by rural IRFs were slightly lower than for urban IRFs (with a median of 66.1 percent compared with 67.4 percent, respectively) (data not shown).

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 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 2022 and FY 2023 period, the median facility-level risk-adjusted rate of potentially preventable readmissions was 8.8 percent (relatively similar to 8.6 percent for the FY 2021 and FY 2022 period). In 2023, about one-quarter of facilities had a risk-adjusted rate below 8.4 percent and one-quarter had a rate above 9.3 percent (Figure 8-1). The rate was higher (worse) among freestanding and for-profit providers than for hospital-based and nonprofit providers (Figure 8-1). The rate of potentially preventable readmissions was the same for urban and rural IRFs (data not shown).

Patient-experience data are not collected for IRF patients

Patient experience is an important measure of quality. Research finds that, across the health care system, improving patient experience correlates with better health outcomes and adherence to treatment plans (Boulding et al. 2011, Navarro et al. 2021). The Commission has recommended the general use of patient-experience surveys for beneficiaries who use SNF services (Medicare Payment Advisory Commission 2022, Medicare Payment Advisory Commission 2018).

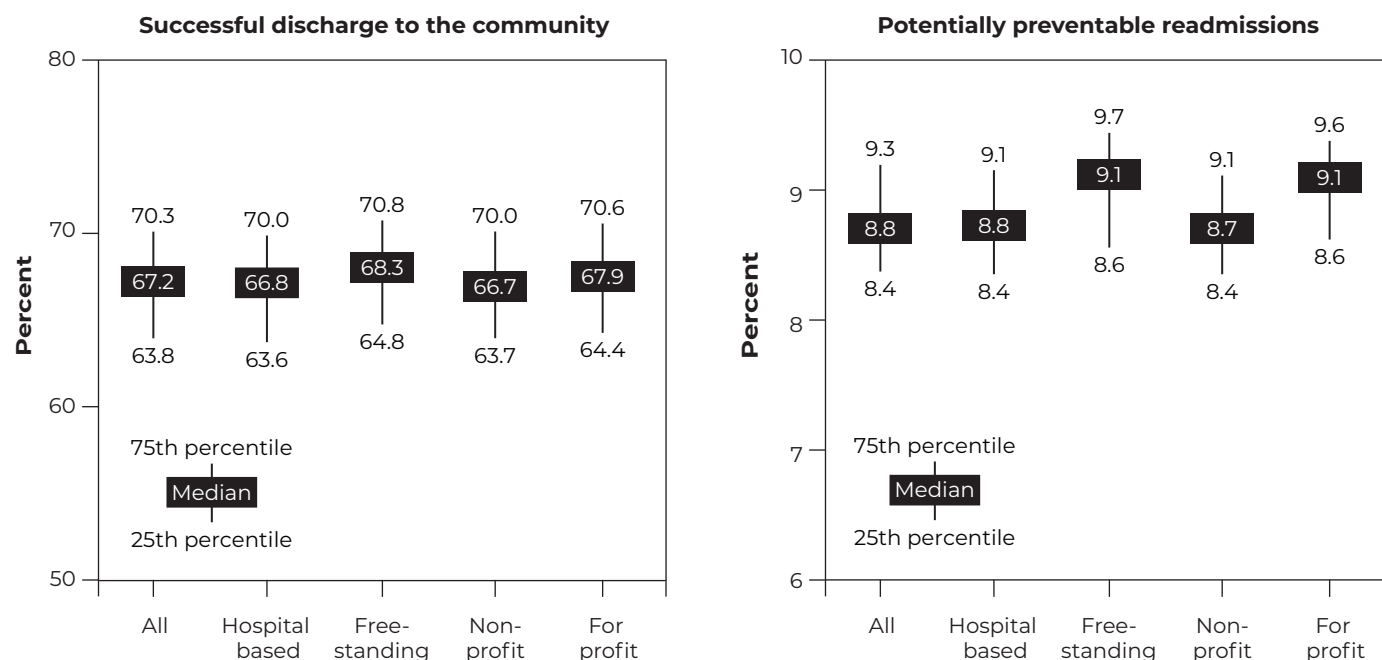
CMS has developed a survey of patients' experience of IRF care for public use but is not requiring or collecting results through the Quality Reporting Program (Centers for Medicare & Medicaid Services 2023).⁹ In order to implement the survey, CMS would need to develop patient-experience measures based on the survey responses and develop a process for third-party vendors to collect survey results.

Concerns about the validity of function data limit our set of IRF quality measures

We did not assess measures of provider-reported functional improvement, even though functional outcomes are critically important to patients in need of rehabilitative care. 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 report it as 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. The reporting of assessment data must be improved such that these outcomes can be adequately assessed. In our June 2019 report to the Congress, the Commission discussed strategies to improve the assessment data, the importance of monitoring the 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).

IRFs' access to capital remained strong for freestanding IRFs in 2023

More than 60 percent of IRFs are hospital-based units that access any necessary capital through their parent

**FIGURE
8-1****Median and interquartile range of IRFs' risk-adjusted rates of discharge to the community and potentially preventable readmissions in FY 2022 and FY 2023**

Note: IRF (inpatient rehabilitation facility), FY (fiscal year). The measure of “potentially preventable readmissions” (in the 30 days postdischarge) captures all unplanned, potentially preventable readmissions for beneficiaries who received services in an IRF. “Successful discharge to community” includes beneficiaries discharged to the community who did not have an unplanned rehospitalization and/or die in the 31 days following discharge. Both measures are defined uniformly and risk adjusted across post-acute care settings. 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 Care Compare data from CMS.

hospitals to maintain, modernize, or expand. Overall, as detailed in the hospital chapter of this report (Chapter 3), ACHs' access to capital generally improved in 2023. The all-payer operating margin for hospitals paid under the inpatient prospective payment systems increased to 5.1 percent in 2023, up from 2.7 percent in 2022, despite a decline in coronavirus relief funds. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) In addition, investment income for these hospitals increased. Hospitals' borrowing costs increased in 2023 and remained elevated 2024, but the increase was less than in the general market.

In 2023, the all-payer total margin for freestanding IRFs increased to about 10 percent, up from 8 percent in 2022.¹⁰ However, the spread in all-payer margins

across groups of freestanding IRFs varied by ownership: For-profit freestanding IRFs' all-payer total margin was about 13 percent in 2023, remaining steady over the last few years, while the all-payer margin for the small number of nonprofit freestanding IRFs continued to be much lower at 1 percent, though it did grow substantially from -6 percent in 2022.

In 2023, the IRF industry's largest corporation, Encompass Health, which owned almost 44 percent of freestanding IRFs and accounted for about 32 percent of all FFS Medicare IRF stays, opened eight IRFs with a combined total of 395 beds and added 46 beds to its existing IRFs. Encompass Health's growth continued in 2024 when it added six new hospitals with a combined total of 280 beds and a 40-bed satellite plus 110 beds to existing facilities. According to its latest investor

report, the company has 16 additional IRFs under development.

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, though recently two smaller health care corporations that own and operate freestanding IRFs announced plans to build more facilities (ClearSky Health 2024, PAM Health 2024).

Medicare payments and providers' costs: IRFs' FFS Medicare margin remained strong in 2023

In 2023, IRFs' FFS Medicare payments per stay grew faster than IRFs' costs per stay. As a result, the FFS Medicare margin increased in 2023 and remained strong at 14.8 percent. Margins continued to vary widely across types of IRFs, with higher margins in IRFs that were freestanding, for profit, urban, larger, and with a greater share of FFS Medicare days. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.)

In 2023, IRFs' payments per stay increased slightly while costs declined

From 2022 to 2023, IRFs' payments per stay grew by 0.9 percent, which was less than in recent years. However, over the same period, IRFs' costs per stay declined by 0.4 percent. Payments and costs per stay varied by type of IRF; notably, among freestanding IRFs, payments per stay increased by 1.5 percent while their costs increased by 0.2 percent. Among hospital-based IRFs, payments per stay increased by 0.5 percent while costs per stay grew by 0.3 percent. Aggregate costs declined because costs per stay are generally lower for freestanding IRFs than for hospital-based IRFs, and growth in the number of stays in freestanding IRFs has been outpacing growth at hospital-based IRFs.

Two factors likely contribute to substantially lower costs per stay among freestanding IRFs than in hospital-based IRFs. First, freestanding IRFs tend to be larger than hospital-based ones. In 2023, almost all freestanding IRFs had more than 25 beds, with about 30 percent having more than 65 beds; by contrast, about 65 percent of hospital-based IRFs had fewer than 25 beds, with about 10 percent having 10 or fewer beds. Because of their size, freestanding IRFs are more likely

to achieve economies of scale. Higher occupancy rates in freestanding IRFs (73 percent in 2023 vs. 65 percent for hospital-based IRFs) also contribute to economies of scale.

Margins vary widely

In 2023, the IRF FFS Medicare margin was 14.8 percent, up from 13.7 percent in 2022. The FFS Medicare margin increased for nearly all subgroups of IRFs we examined, though significant variation in margins persisted (Table 8-4). For example, hospital-based IRFs' FFS Medicare margin was 1.0 percent, compared with 24.2 percent for freestanding IRFs. Overall, the FFS Medicare margin was higher for IRFs that were freestanding, for profit, urban, and larger (25 or more beds). In contrast, the FFS Medicare margin continued to be lower among IRFs that were hospital based, nonprofit, and small (fewer than 25 beds). IRFs in the smallest bed-size category (1 to 10 beds) were primarily hospital-based IRFs, and IRFs in the largest bed-size category (65 or more beds) were primarily freestanding IRFs. Notably, the FFS Medicare margin was higher for IRFs with a high share of FFS Medicare days.

FFS Medicare margins also vary by IRFs' share of low-income patients (Table 8-4). Like the disproportionate-share-hospital adjustment for acute care hospitals paid under the inpatient PPS, IRFs receive low-income-patient (LIP) payments that are intended to offset costs incurred by treating a large or disproportionate share of low-income patients.¹¹ Nevertheless, the FFS Medicare margin in IRFs that serve a higher share of beneficiaries with low incomes is generally lower than the margin of other IRFs: In 2023, the FFS Medicare margin for IRFs with a large share of low-income patients (those with an LIP share of 25 percent or more) was 5.4 percent, compared with 19.1 percent for IRFs with a small LIP share (less than 5 percent). The LIP share in 2023 differed slightly between freestanding providers (about 14 percent) and hospital-based providers (about 16 percent) (data not shown).

Numerous factors contribute to lower margins in hospital-based IRFs

The Commission has long noted the substantial difference between hospital-based and freestanding IRFs' FFS Medicare margins. Several factors likely contribute to this difference:

**TABLE
8-4****IRFs' FFS Medicare margin rose in 2023**

Type of IRF	2019	2020	2021	2022	2023
All IRFs	14.1%	13.3%	16.9%	13.7%	14.8%
Hospital based	1.7	1.4	5.7	0.8	1.0
Freestanding	24.6	23.4	25.9	23.3	24.2
Nonprofit	1.1	-0.3	5.3	-0.5	-0.2
For profit	24.2	23.4	25.3	22.7	23.5
Government	N/A	N/A	N/A	N/A	N/A
Urban	14.5	13.6	17.3	14.1	15.0
Rural	7.6	9.0	11.7	7.7	11.2
Number of beds					
1 to 10	-9.1	-7.3	-2.7	-6.5	-5.3
11 to 24	1.6	2.2	5.7	1.1	1.0
25 to 64	15.8	14.8	18.6	15.0	16.6
65 or more	20.9	19.3	22.2	19.8	20.4
Share of FFS Medicare days					
<50%	9.2	8.0	11.8	6.6	7.2
50% to 75%	18.0	17.0	20.3	18.1	19.3
>75%	17.9	21.1	24.6	21.6	20.5
Low-income patient share					
0% to 5%	15.9	15.5	19.6	17.4	19.1
5% to 10%	18.0	16.9	19.4	16.4	17.8
10% to 15%	15.4	14.4	17.7	13.6	13.9
15% to 20%	13.9	14.1	15.4	14.3	15.3
20% to 25%	2.5	5.8	17.6	6.2	12.1
>25%	6.5	5.3	9.6	9.9	5.4

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.

- *Higher costs per stay in hospital-based IRFs:* In 2023, on average, standardized cost per stay was \$21,000 for hospital-based IRFs compared with \$15,000 for freestanding IRFs. Although on average both routine and ancillary costs per stay were higher among hospital-based IRFs, routine costs

per stay were substantially higher among hospital-based IRFs than freestanding IRFs. The amount of IRFs' routine costs per stay (such as room and board) may depend, to some extent, on how the parent hospital allocates its overall routine costs to its IRF subunit; presumably, a larger share of

routine costs at freestanding IRFs would be directly related to IRF services. In addition, higher costs at hospital-based IRFs can stem, in part, from a relative lack of economies of scale because facilities tend to be smaller and have lower occupancy rates (65 percent vs. 73 percent for freestanding IRFs, as discussed above).

- *Differences in patient mix not accounted for by the payment system:* As noted previously, there are also marked differences in hospital-based and freestanding IRFs' mix of stays. In 2023, compared with hospital-based IRFs, freestanding IRFs admitted a smaller share of patients with stroke as the primary reason for rehabilitation and a larger share of patients with a diagnosis in the "other neurological conditions" category (Table 8-3, p. 255).¹² The Commission previously reported on profitability differences among different types of stays: Notably, "other neurological" stays were among the most profitable, with payments in aggregate exceeding costs by 26 percent in 2019 (Medicare Payment Advisory Commission 2024). In contrast, stroke stays were among the least profitable case types in IRFs. As we noted in our March 2024 report, using an alternative method to set payment weights in the IRF PPS would yield more uniform profitability across case-mix groups (Medicare Payment Advisory Commission 2024).¹³ This change could also help to reduce providers' incentives to code patients as more functionally impaired (thereby increasing case-mix severity and payment rates). The Commission has previously reported findings that were suggestive of such differential coding between freestanding and hospital-based IRFs.¹⁴
- *Differential prevalence of outlier stays:* Hospital-based IRFs' higher costs and patient mix may contribute to their increased likelihood of outlier stays, which are stays with extraordinarily high costs. In 2023, hospital-based IRF providers accounted for about 40 percent of FFS stays in 2023 and 78 percent of high-cost outlier stays. Although outlier payments diminish the financial loss per outlier stay, by design, outlier payments do not completely cover facilities' costs. Since outlier payments cover only a portion of the excess costs, having more outliers has the potential to lower margins.

Despite hospital-based IRFs' higher costs and lower margin compared with freestanding IRFs, they have a financial incentive to admit Medicare patients. The FFS margin among hospital-based IRFs is about 1 percent, which is substantially higher than the ACH margin (about -13 percent in 2023 as reported in Chapter 3). Moreover, ACHs can discharge eligible patients to their IRF subunits, enabling the hospital to open beds to additional acute care patients. Indeed, the FFS margin among ACHs with IRF subunits is slightly higher than the margin among ACHs without IRF subunits.

How should FFS Medicare payments change in 2026?

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 2026 will not be set until summer 2025; however, using CMS's third-quarter 2023 projections of the market basket and productivity, the update would increase IRF payment rates by 2.6 percent.

The payment-adequacy indicators for Medicare IRF services are positive and show that FFS Medicare payments continue to substantially exceed costs, as they have for many years. The high FFS Medicare margin indicates that the IRF PPS exerts too little pressure on providers to control costs.

RECOMMENDATION 8

For fiscal year 2026, the Congress should reduce the 2025 Medicare base payment rate for inpatient rehabilitation facilities by 7 percent.

RATIONALE 8

Our indicators of access to care are positive. In 2023, the number of IRFs and stays per FFS beneficiary increased. The FFS Medicare marginal profit remained robust in 2023, at 18 percent for hospital-based IRFs and 40 percent for freestanding IRFs. IRFs' FFS Medicare margin of 14.8 percent in 2023 and our projected margin of 16 percent for 2025 indicate that FFS Medicare payments continue to substantially exceed the costs of caring for beneficiaries. The IRF

PPS base payment rate must be reduced to better align aggregate payments to aggregate costs.

IMPLICATIONS 8

Spending

- Current law is expected to increase the IRF base payment rate by 2.6 percent. This recommendation would decrease Medicare spending relative to current law by between \$750 million and \$2 billion

in one year and by between \$10 billion and \$25 billion over five years.

Beneficiary and provider

- We do not expect this recommendation to have an adverse effect on FFS Medicare beneficiaries' access to care or out-of-pocket spending. Given the current level of payments, we expect that the recommendation may increase financial pressure for some providers. ■

Endnotes

- 1 In markets without IRFs, beneficiaries who need skilled nursing care or therapy services on an inpatient basis are usually admitted to skilled nursing facilities, which have less extensive requirements regarding the amount of therapy and the frequency and level of medical supervision their patients must receive.
- 2 More information about the prospective payment system for IRFs is available at https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_IRF_FINAL_SEC.pdf.
- 3 Among freestanding IRFs in 2023, about 48 percent of all payments were for FFS Medicare patients. The FFS Medicare share of total IRF payments could not be calculated for hospital-based IRFs due to data limitations on the cost reports.
- 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 International Classification of Diseases, 10th Revision, Clinical Modification, 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. The algorithm is described at <https://www.cms.gov/files/document/specifications-determining-irf-60-rule-compliance.pdf>, but changes to the diagnosis lists were made in the fiscal year 2023 rule and are posted on the CMS website.
- 5 During the PHE, some exceptions were made to IRF requirements. These included flexibility in applying the 60 percent rule, freezing the IRF's teaching-status payments at levels prior to the PHE, and flexibility for facilities responding to information requests related to appeals (Centers for Medicare & Medicaid Services 2020).
- 6 During the PHE, some exceptions were made to IRF Medicare coverage criteria for beneficiaries. These included waiver of the rule requiring three hours of therapy five days a week, allowing telehealth visits to replace the face-to-face visits required at least three times per week, and allowing weekly interdisciplinary team meetings to take place electronically (Centers for Medicare & Medicaid Services 2020).
- 7 HSAs are local health care markets for hospital care. An HSA is a collection of ZIP codes where Medicare residents receive most of their hospitalizations from hospitals in that area. There are 3,435 HSAs. See <https://www.dartmouthatlas.org>.
- 8 "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 FFS Medicare claim.
- 9 <https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-patient-experience-care>.
- 10 Hospital cost reports do not require hospitals to report an all-payer margin specifically for their IRFs or other hospital-based units.
- 11 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 plus the share of Medicaid days out of all inpatient days.
- 12 Compared with hospital-based IRFs, freestanding IRFs (which are mostly for profit) are more likely to have stays in certain subcategories of the "other neurological conditions": neuromuscular conditions (such as myasthenia gravis, motor neuron disease, post-polio syndrome, muscular dystrophy, and other myopathies) and other neurological disorders (such as other extrapyramidal disease, abnormal movement disorders, and hereditary ataxia).
- 13 We simulated the effect of replacing CMS's current hospital-specific relative-value method for setting payment weights in the IRF PPS with the "average-cost" method that is used in other Medicare payment systems (Medicare Payment Advisory Commission 2024).
- 14 In an analysis of data from 2013, we found that, within case types, 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 case types 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 interrater reliability of the IRF Patient Assessment Instrument to help ensure payment accuracy and improve program integrity.

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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 2026, the Congress should eliminate the update to the 2025 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 either traditional FFS Medicare or Medicare Advantage (MA). In 2023, more than 1.7 million Medicare beneficiaries (including more than half of decedents) received hospice services from about 6,500 providers, and Medicare hospice expenditures totaled \$25.7 billion.

Assessment of payment adequacy

The indicators of FFS Medicare payment adequacy for hospices are positive.

Beneficiaries' access to care—In 2023, indicators of beneficiaries' access to care were positive. The number of hospice providers increased substantially, and measures of hospice utilization increased.

- **Capacity and supply of providers**—In 2023, the number of hospice providers increased by more than 10 percent as more for-profit

In this chapter

- Are FFS Medicare payments adequate in 2025?
- How should FFS Medicare payments change in 2026?

hospices entered the market, a trend that has continued for more than a decade. Particularly rapid market entry of providers in a few states where CMS has raised program-integrity concerns contributed to the large growth in 2023.

- **Volume of services**—The share of decedents using hospice increased to 51.7 percent in 2023, up from 49.1 percent in 2022 and similar to the prepandemic high of 51.6 percent in 2019. The number of hospice users and total days of hospice care also increased in 2023. For decedents, average lifetime length of stay increased by about 1 day in 2023 to 96.2 days. Between 2022 and 2023, median length of stay was stable at 18 days. For hospice patients receiving routine home care, the frequency and length of in-person hospice visits by hospice staff increased slightly in 2023, to an average of 3.9 visits per week, each about an hour long.
- **FFS Medicare marginal profit**—In 2023, on average, FFS Medicare payments to hospice providers exceeded marginal costs by 14 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 very high and topped out for most providers (i.e., scores are so high and unvarying that one can no longer make meaningful distinctions among providers or gauge improvement in performance). Measures of the provision of in-person visits in the last days of life for patients receiving hospice routine home care were stable or increased slightly between 2022 and 2023, but the frequency of nurse visits was still below the prepandemic level.

Providers' access to capital—Hospices are generally not as capital intensive as many other provider types because they do not require extensive physical infrastructure. Continued growth in the number of for-profit providers (an increase of more than 10 percent in 2023) and reports of continued investor interest in the sector suggest that capital is available to these providers. Less is known about access to capital for nonprofit freestanding providers. 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 2022 because of the data lag required to calculate cap-overpayment amounts. Between 2021 and 2022, average costs per day

increased by 3.8 percent. The aggregate FFS Medicare margin for 2022 was 9.8 percent, down from 13.3 percent in 2021. If Medicare's share of pandemic-related relief funds is included, the aggregate FFS Medicare margin for 2022 was about 10.4 percent. Cost growth slowed in 2023, with hospices' average cost per day increasing by 3.0 percent. We project an aggregate FFS Medicare margin for hospices of about 8 percent in 2025.

How should FFS Medicare payments change in 2026?

Based on the positive indicators of payment adequacy and the strong FFS Medicare margins, current payment rates appear sufficient to support the provision of high-quality care without an increase to the payment rates in 2026. The Commission recommends that the Congress eliminate the update to the hospice base payment rates for fiscal year 2026. ■

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 2023, more than 1.7 million Medicare beneficiaries received hospice services, and Medicare hospice expenditures totaled about \$25.7 billion.

The hospice benefit covers services that are reasonable and necessary for palliation of the terminal illness and related conditions. The hospice benefit covers a broad set of palliative services (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 illness 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 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 illness continues to engender a life expectancy of six 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 illness 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 2023. 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 2023, 89 percent of Medicare hospice patients received at least one day of RHC, 18 percent received at least one day of GIP, 5 percent received at least one day of IRC, and 2 percent received at least one day of CHC (with some patients receiving more than one level of hospice care over the course of their hospice stay). The per diem payment for RHC 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.

When the Congress established the hospice benefit, it included a "cap" limiting the aggregate Medicare payments that an individual hospice can receive.² 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 annual cap amount, it must repay the excess to the program. Unlike the daily hospice payments, the cap is not adjusted for geographic differences in costs. The hospice aggregate

cap in 2025 (\$34,465) is equivalent to the amount that Medicare pays for an RHC hospice stay of about 179 days (assuming a wage index of 1.0). Because the cap is applied in the aggregate across the provider's entire patient population (including both short and long stays) and not at the stay level, a hospice provider can furnish a substantial number of long stays and remain under the cap.³ In 2023, we estimate that 22.6 percent of hospices, which provided care to about 6 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 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 or 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 to pay the MA plan for Part D services and Part C rebates, 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 making this recommendation, the Commission expressed concern that the carve-out of hospice from the MA benefits package fragments financial responsibility and accountability for care. The Commission stated that including hospice in the MA benefits package could have a number of potential benefits: It would give plans responsibility for the full continuum of care and promote integrated, coordinated care; it would give MA plans greater incentive to develop and test innovative programs to improve end-of-life care; and it would be a step toward synchronizing accountability for hospice across Medicare platforms (MA, accountable care organizations, and FFS) (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 voluntary 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's evaluation report, about 9,630 beneficiaries in 2021 and 19,065 beneficiaries in 2022 received hospice paid for by MA plans (Eibner et al. 2023, Khodyakov et al. 2022). We estimate that these figures indicate the MA-VBID model financed care for about 1 percent in 2021 and 2 percent in 2022 of all MA beneficiaries who received hospice care in those years. In 2024, 13 MA organizations, comprising 78 plan benefit packages that cover 690 counties in 19 states and Puerto Rico, furnished hospice benefits under the VBID model (Centers for Medicare & Medicaid Services 2023a). In March 2024, CMS announced that the hospice component of the MA-VBID model would sunset in December 2024, citing plan-implementation challenges and declining numbers of participating plans as reasons for the decision (Centers for Medicare & Medicaid Services 2024a).⁶

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). In more recent years, additional studies on this topic have had varied results, and debate about hospices' effect on Medicare spending continues.⁷ The Commission has additional research underway in this area.

**TABLE
9-1**

Increase in total number of hospices driven by entry of for-profit providers

Category	2019	2020	2021	2022	2023	Average annual percent change 2019–2022	Percent change 2022–2023
All hospices	4,840	5,058	5,358	5,899	6,535	6.8%	10.8%
For profit	3,434	3,693	4,025	4,581	5,068	10.1	10.6
Nonprofit	1,256	1,217	1,189	1,170	1,151	–2.3	–1.6
Government	148	145	141	138	136	–2.3	–1.4
Freestanding	3,937	4,191	4,516	5,076	5,567	8.8	9.7
Hospital based	428	412	394	382	365	–3.7	–4.5
Home health based	456	436	431	420	414	–2.7	–1.4
SNF based	19	19	17	17	17	–3.6	0.0
Urban	3,973	4,193	4,501	5,051	5,701	8.3	12.9
Rural	861	856	849	834	833	–1.1	–0.1

Note: SNF (skilled nursing facility). The providers included in this analysis submitted at least one paid hospice claim in a given year. 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) and reflect the hospice's office location. 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 SNF). Some categories do not sum to totals because of missing data for some providers. Missing data on ownership and hospice type particularly affect the most recent year (2023), for which we lack data on ownership for 180 providers and type of hospice for 172 providers.

Source: MedPAC analysis of Medicare cost reports, Provider of Services file, and Medicare hospice claims data from CMS.

Are FFS Medicare payments adequate in 2025?

To address whether payments in 2025 are adequate to cover the costs of efficient delivery of care and how much providers' payments should change in the coming year (2026), 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. Overall, our indicators of FFS Medicare payment adequacy for hospice care are positive.

Beneficiaries' access to care: Hospice supply grew substantially, and use increased

Our analysis of access indicators—including trends in the supply of providers, use of hospice services, and FFS Medicare marginal profit—shows that beneficiaries' access to care in 2023 was favorable.

Capacity and supply of providers: Supply of hospices continued to grow in 2023, driven by an increase in for-profit providers

In 2023, 6,535 hospices provided care to Medicare beneficiaries, a 10.8 percent increase from the prior year (Table 9-1). Market entry of for-profit, freestanding providers drove the growth in supply. Particularly rapid market entry of providers in a few states where CMS has raised program-integrity

concerns contributed to the large growth in number of providers in 2023. We report on changes in the capacity and supply of hospice providers but caution that 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 of data from 2008 and 2019 found that hospice-use rates across states appear unrelated to a state's number of hospice providers per 10,000 beneficiaries (data not shown) (Medicare Payment Advisory Commission 2021).

In 2023, the number of for-profit hospices grew by more than 10 percent (Table 9-1, p. 273). Between 2022 and 2023, the number of hospices with nonprofit ownership or government ownership declined, continuing the downward trend observed from 2019 to 2022. In 2023, among the hospices for which we have data, about 80 percent of providers were for profit; however, they furnished care to 57 percent 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 by almost 10 percent in 2023.⁸ The number of home health-based and hospital-based hospices declined in 2023, while the number of skilled nursing facility (SNF)-based providers was unchanged.⁹ In 2023, based on available data, we found that about 87 percent of hospices were freestanding, and these hospices furnished care to 84 percent of Medicare hospice patients (latter data not shown).

The number of rural hospices was generally stable in 2023, after falling about 1 percent per year between 2019 and 2022 (Table 9-1, p. 273). As of 2023, we estimate that 87 percent of hospices were located in urban areas and 13 percent were in rural areas; about 17 percent of Medicare beneficiaries (including beneficiaries in FFS and MA) lived in rural areas in 2023. 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 areas. Further, some urban hospices provide services in rural areas. Indeed, as discussed below, the share of rural decedents using hospice grew in 2023 (Table 9-2).

In 2023, the substantial growth in the number of hospice providers was concentrated in a few states. Between 2022 and 2023, several states had large gains in the raw number of hospices: California gained 425 hospices (a 26 percent increase), Texas gained 81 hospices (a 10 percent increase), Arizona gained 35 hospices (a 17 percent increase), Georgia gained 19 hospices (an 8 percent increase), and Nevada gained 16 hospices (a 16 percent increase). The 2023 growth in the number of providers in these five states combined (about 19 percent) substantially exceeded the growth in the number of providers excluding these five states (about 2 percent). Substantial market entry in several of these states is a continuation of trends seen over a longer time horizon. From 2019 to 2022, California, Texas, Arizona, and Nevada all experienced average annual growth in the number of hospice providers that exceeded the national average growth rate, with California and Texas experiencing the largest gains in the raw number of providers (California gained 621 providers and Texas gained 176 providers over that period). 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 2023, beyond the five states with the greatest growth in the number of providers, other states and the District of Columbia had more modest changes, with 26 additional states experiencing an increase in the number of providers, 12 experiencing no change, and 8 experiencing a decrease. The two states with the biggest decline in the number of hospices were Pennsylvania (eight hospices) and Louisiana (three hospices); hospice use among decedents in these states increased between 2022 and 2023 despite the decline in the number of providers.

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

**TABLE
9-2****In 2023, the share of decedents using hospice increased overall
and across all beneficiary subgroups****Share of Medicare decedents who used hospice**

	2010	2019	2022	2023	Average annual percentage point change 2010–2022	Percentage point change 2022–2023
All decedent beneficiaries	43.8%	51.6%	49.1%	51.7%	0.4	2.6
FFS beneficiaries	42.8	50.7	49.1	51.7	0.5	2.6
MA beneficiaries	47.2	53.2	49.2	51.7	0.2	2.5
Dually eligible for Medicaid	41.5	49.3	43.9	46.6	0.2	2.7
Not Medicaid eligible	44.5	52.4	51.1	53.6	0.6	2.5
Age						
<65	25.7	29.5	26.6	28.6	0.1	2.0
65–74	38.0	41.0	37.7	40.2	0.0	2.5
75–84	44.8	52.2	49.4	51.9	0.4	2.5
85+	50.2	62.7	61.8	64.0	1.0	2.2
Race/ethnicity						
White	45.5	53.8	51.7	54.3	0.5	2.6
Black	34.2	40.8	37.4	39.7	0.3	2.3
Hispanic	36.7	42.7	38.2	40.4	0.1	2.2
Asian American	30.0	39.8	38.0	39.2	0.7	1.2
North American Native	31.0	38.5	37.2	39.4	0.5	2.2
Sex						
Male	40.1	46.7	43.9	46.3	0.3	2.4
Female	47.0	56.3	54.4	56.9	0.6	2.5
Beneficiary location						
Urban	45.6	52.8	50.2	52.6	0.4	2.4
Micropolitan	39.2	49.7	47.3	50.1	0.7	2.8
Rural, adjacent to urban	39.0	49.5	47.9	50.9	0.7	3.0
Rural, nonadjacent to urban	33.8	43.8	42.1	44.9	0.7	2.8
Frontier	29.2	36.2	35.3	37.1	0.5	1.8

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 definitions. 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 on 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 Environment and hospice claims data from CMS.

and abuse” (Tilden 2022). Further, the California auditor’s report stated that “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).

In recent years, CMS has announced a number of steps to increase program-integrity efforts for hospice providers overall and specifically in four states. In August 2023, for newly enrolled hospices in Arizona, California, Nevada, and Texas, CMS stated that it was implementing a provisional period of enhanced oversight that involves the agency conducting medical review before making payments on these providers’ claims (Centers for Medicare & Medicaid Services 2023b). In September 2024, CMS announced it was expanding prepayment medical review in those four states (Centers for Medicare & Medicaid Services 2024c). In August 2023, CMS also indicated that it was 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 (Centers for Medicare & Medicaid Services 2023b).

Volume of services: Measures of hospice use increased in 2023

Nationally, the share of Medicare decedents using hospice increased in 2023, rebounding to prepandemic levels. In 2023, 51.7 percent of Medicare decedents received hospice services, up from 49.1 percent in 2022 and similar to the 2019 rate of 51.6 percent (Table 9-2, p. 275). The hospice-use rate, which had increased in the prior decade from 2010 to 2019, declined in the first two years of the pandemic to 47.3 percent in 2021 as beneficiary deaths outpaced growth in the number of hospice users (2021 data not shown) (Medicare Payment Advisory Commission 2023). The hospice-use rate began increasing again in 2022, growing by 1.8 percentage points that year and by an additional 2.6 percentage points in 2023 (2022 growth rate not shown).

In 2023, the share of decedents using hospice increased across all subgroups examined (Table 9-2, p. 275). 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 eligible for Medicaid (i.e., not dually eligible for Medicare and Medicaid). Hospice use among beneficiaries with end-stage renal disease, a group that has lower-than-average hospice use, increased to 31 percent in 2023, up from 29 percent in 2022 (data not shown). In 2023, hospice-use rates were similar for FFS and MA decedents.

Between 2022 and 2023, hospice-use rates increased among all racial and ethnic groups examined—White, Black, Hispanic, Asian American, and North American Native beneficiaries. Nevertheless, hospice-use rates continued to be higher for White decedents (Table 9-2, p. 275). 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 and advance care planning, 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 2023, decedents’ hospice-use rates increased across all categories of rural and urban counties (Table 9-2, p. 275). Historically, a greater share of urban decedents than rural decedents have used hospice. However, the difference in hospice use rates between decedents in urban and rural counties has lessened over time as hospice use rates grew more in rural counties than urban counties between 2010 and 2023 (Table 9-2). Hospice use is lowest among beneficiaries in frontier counties, although hospice use in these areas has also grown.

In 2023, measures of hospice use for all hospice enrollees (not just decedents) increased. That year, 1.74 million Medicare beneficiaries received hospice services, a slight increase (1.3 percent) from 2022. The number of hospice days furnished also increased 5.7 percent to about 138 million days (Table 9-3).¹⁰

Hospice length of stay increased in 2023 Average lifetime length of stay among decedents was 96.2 days in 2023, up from 95.3 days in 2022 (Table 9-3). Median length of stay was stable at 18 days. Most hospice

**TABLE
9-3**

Hospice use increased in 2023

					Average annual percent change		Percent change
	2010	2019	2022	2023	2010–2019	2019–2022	2022–2023
Hospice use among Medicare decedents							
Number of Medicare decedents (in millions)	1.99	2.32	2.64	2.50	1.7%	4.3%	–5.2%
Number of Medicare decedents who used hospice (in millions)	0.87	1.20	1.30	1.29	3.6	2.6	–0.3
Average lifetime length of stay among decedents (in days)	87.0	92.5	95.3	96.2	0.7	1.0	0.9
Median lifetime length of stay among decedents (in days)	18	18	18	18	0 days	0 days	0 days
Medicare use and spending for all hospice users (not limited to decedents)*							
Total spending (in billions)	\$12.9	\$20.9	\$23.7*	\$25.7*	5.5	4.3*	8.3*
Number of Medicare hospice users (in millions)	1.15	1.61	1.72*	1.74*	3.8	2.3*	1.3*
Number of hospice days for all hospice beneficiaries (in millions)	81.6	121.8	130.2*	137.7*	4.6	2.3*	5.7*

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 the 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 model of MA value-based insurance design beginning 2021. According to CMS contractor evaluation reports, 19,065 MA beneficiaries received hospice care under the model in 2022 (Eibner et al. 2023, Khodyakov et al. 2022). An evaluation report with data on experience in the third year of the model (2023) is not available yet.

Source: MedPAC analysis of data from the Common Medicare Environment and hospice claims data from CMS.

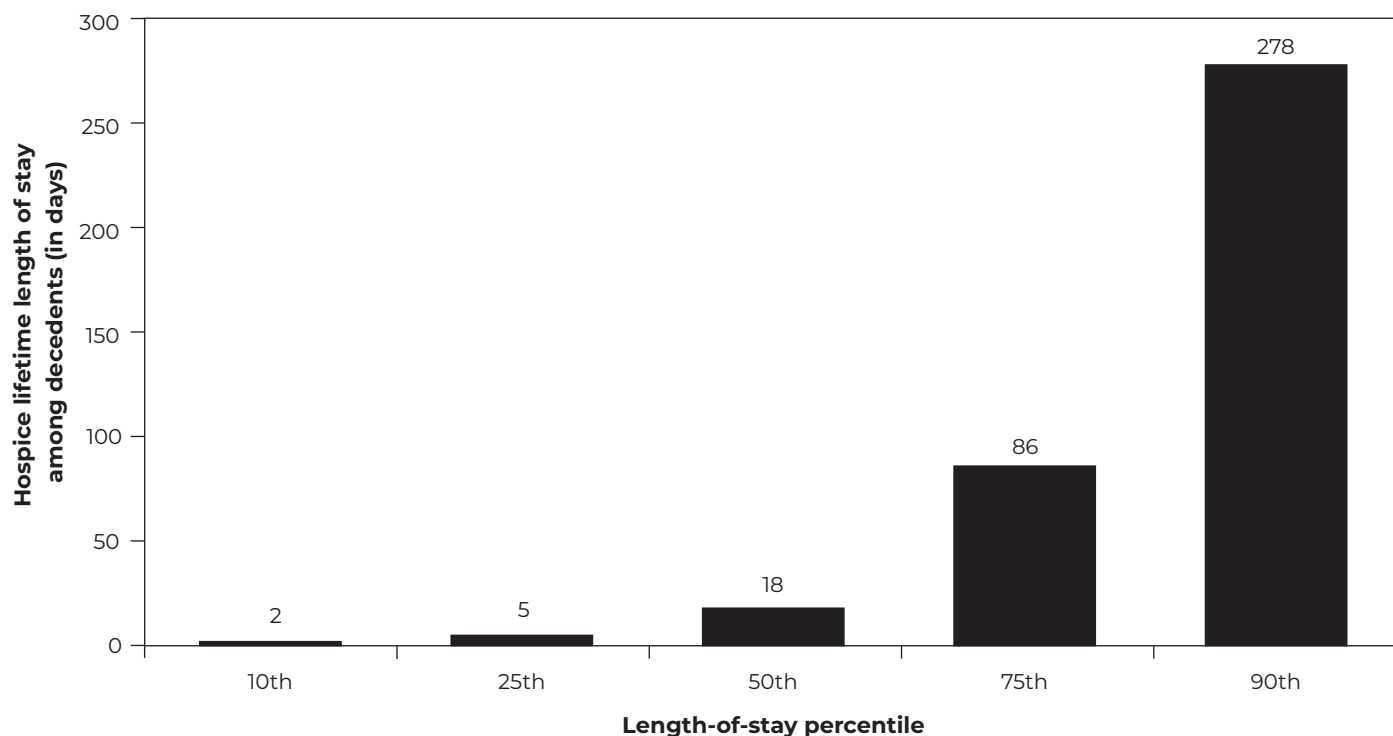
decedents have short stays, but some have very long stays (Figure 9-1, p. 278). Between 2022 and 2023, length of stay among decedents with the shortest stays remained the same (2 days at the 10th percentile and 5 days at the 25th percentile), and it increased among those with longer stays (from 84 days to 86 days at the 75th percentile and from 275 days to 278 days at the 90th percentile) (Figure 9-1; 2022 data not shown).

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 2023, average lifetime length of stay was longer among decedents

**FIGURE
9-1**

Most hospice decedents had relatively short stays, but some had very long stays, 2023



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 Environment and the Medicare Beneficiary Database from CMS.

admitted to hospice for neurological conditions and chronic obstructive pulmonary disease (164 days and 131 days, respectively) than among decedents with cancer (51 days). Length of stay was also longer among patients in assisted-living facilities (169 days) or nursing facilities (113 days) compared with patients at home (97 days).

For-profit hospices have substantially longer average lengths of stay than nonprofit hospices (115 days compared with 72 days, respectively, in 2023). For-profit hospices have more patients admitted for 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 admitted for neurological conditions, average length of

stay was 187 days for for-profit hospices and 130 days for nonprofit hospices.¹¹ These differences in patient mix and length of stay contribute to the variation observed among providers' profit margins, discussed below. (See our March 2021 report to Congress for a text box discussing approaches that could be explored to modify the hospice payment system to reduce variation in profitability by length of stay and address aberrant utilization patterns by some providers (Medicare Payment Advisory Commission 2021).)

Although most patients have short hospice stays, long stays account for the majority of Medicare spending on hospice. In 2023, Medicare spent more than \$15 billion, just over 60 percent of hospice spending that year,

for patients with stays exceeding 180 days (Table 9-4). About \$5.8 billion of that spending was for 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. We estimate that in 2022, about 22.6 percent of hospices exceeded the aggregate payment cap, up from 18.9 percent in 2021 (Table 9-5, p. 280).¹² On average, each above-cap hospice exceeded the cap by about \$419,000 in 2022, down slightly from \$451,000 in 2021. The share of hospices exceeding the cap varies widely by state. We estimate that most states had a relatively low share (5 percent or fewer or in some cases none) of their providers exceeding the cap in 2022. The states with the greatest entry of new providers are also the states with the highest share of the state’s hospices over the cap. We estimate that over half of hospices in California exceeded the cap in 2022 and roughly a quarter of hospices in Texas, Nevada, and Arizona. 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 (Medicare Payment Advisory Commission 2024, Medicare Payment Advisory Commission 2012). Recent studies have raised questions about the effect of the cap on beneficiary outcomes and Medicare spending (Coe and Rosenkranz 2023, Gruber et al. 2023). The Commission has further research underway concerning the cap.

In-person hospice visits increased slightly in 2023 In 2023, the average number and length of hospice in-person visits increased slightly (Table 9-6, p. 281). In 2023, beneficiaries enrolled in hospice received on

TABLE 9-4 About 60 percent of Medicare hospice spending was for patients with stays exceeding 180 days, 2023

	Medicare hospice spending, 2023 (in billions)
All hospice users in 2023	\$25.7
Beneficiaries with LOS > 180 days	15.6
Days 1-180	5.0
Days 181-365	4.8
Days 366+	5.8
Beneficiaries with LOS ≤ 180 days	10.1

Note: LOS (length of stay). “LOS” reflects the beneficiary’s lifetime days with hospice as of the end of 2023 (or at the time of discharge in 2023 if the beneficiary was not enrolled in hospice at the end of 2023). All spending reflected in the chart occurred only in 2023. Components 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).

average 3.9 visits per week, with nurse, aide, and social worker visits accounting for 1.8, 1.9, and 0.3 visits per week on average (Table 9-6).¹³ Each visit in 2023 was about an hour long on average, across the different types of staff. In-person nurse and social worker visits, which declined modestly during the pandemic, rebounded to the prepandemic level in 2023. Aide visits also increased modestly in 2023 but remained below the prepandemic level.

In 2020 through mid-2023, some in-person 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 2020 through 2023.

**TABLE
9-5**

Hospices that exceeded Medicare's annual payment cap, 2018–2022

Year	2018	2019	2020	2021	2022
Estimated share of hospices exceeding the cap	16.3%	19.0%	18.6%	18.9%	22.6%
Average payments over the cap per hospice exceeding it (in thousands)	\$334	\$384	\$422	\$451	\$419
Payments over the cap as a share of overall Medicare hospice spending	1.3%	1.7%	1.8%	2.0%	2.3%

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. The cap years for 2018 through 2022 are 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.

Hospices with available capacity continued to have a strong financial incentive to admit Medicare beneficiaries Another component of access is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. To assess this component, we examine the FFS Medicare marginal profit—the percentage of revenue from FFS Medicare that is left as profit after accounting for the allowable variable costs of providing services to Medicare patients.¹⁴ (Variable costs are those that vary with the number of patients treated. By contrast, fixed costs are those that are the same in the short run regardless of the number of patients treated (e.g., rent).) If the FFS Medicare marginal profit is positive, a provider with excess capacity has a financial incentive to care for an additional beneficiary; if the FFS Medicare marginal profit is negative, a provider may have a disincentive to care for an additional beneficiary. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) We found that the 2022 FFS Medicare marginal profit for hospice providers was roughly 14 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 available indicators appear stable

Scores on available quality metrics, including the Consumer Assessment of Healthcare Providers and

Systems (CAHPS) hospice survey were stable in the most recent period. Scores on a composite of seven processes of care at admission were very high in 2023 and topped out for most providers. Measures of the provision of in-person visits at the end of life were stable or increased slightly in 2023, but the frequency of nurse visits remained below the prepandemic level.

Consumer Assessment of Healthcare Providers and Systems

The Hospice Quality Reporting Program requires hospice providers to participate in a CAHPS hospice survey.¹⁵ The survey gathers information from the patient's informal caregiver (typically a family member) after the patient's death.¹⁶ 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.

**TABLE
9-6****In-person hospice visits increased in 2023, with nurse and social worker visits reaching prepandemic levels**

	2019	2021	2022	2023	Percent change 2022–2023
Average number of visits per week					
All visits	4.3	3.8	3.9	3.9	1%
Nurse visits	1.8	1.7	1.7	1.8	2
Aide visits	2.2	1.8	1.8	1.9	1
Social worker visits	0.3	0.3	0.3	0.3	1
Average length per visit (in minutes)					
All visits	60	58	56	61	7
Nurse visits	57	55	54	61	14
Aide visits	63	61	60	61	1
Social worker visits	52	50	49	58	20
Average visit time per week (in minutes)					
All visits	258	218	218	237	9
Nurse visits	104	94	93	107	16
Aide visits	137	111	111	116	2
Social worker visits	17	13	14	16	21

Note: Analysis includes only routine home care days and visits. “Visits” refers to in-person visits only and excludes postmortem visits. “Nurse visits” include both registered nurse and licensed practical nurse visits. “Visit length” is reported by providers in number of 15-minute increments, rounded to the nearest 15-minute increment. We calculate minutes per visit by multiplying the number of 15-minute increments by 15. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare hospice claims data from CMS.

Sector-wide CAHPS scores—as measured by the median hospice’s share of caregivers who reported the “top box,” meaning the most positive, survey response in eight domains—were stable in the most recent period (January 2022 to December 2023) compared with the prior period (January 2021 to December 2022) (Table 9-7, p. 282). Similar to the prior period, for the median hospice, 82 percent of caregivers in the most recent period rated the hospice a 9 or 10, and 85 percent would definitely recommend the hospice. Caregivers most frequently gave top ratings on measures of providing emotional support and treating patients with respect (91 percent of caregivers chose the most positive response in those areas in the most

recent period). Roughly three-quarters of caregivers gave hospices top ratings for providing help for pain and symptoms, providing timely care, and training caregivers (Table 9-7, p. 282).

Hospices that predominantly care for beneficiaries that reside in rural areas receive somewhat higher CAHPS scores than those that care for beneficiaries in urban areas. For the CAHPS analysis, we consider a hospice to be rural or urban based on the type of county in which the majority of beneficiaries treated by the hospice reside. In the most recent period, the median rural hospice received CAHPS scores that ranged from 2 percentage points to 5 percentage points higher than

**TABLE
9-7****Scores on hospice CAHPS quality measures**

	Median performance across hospice providers			
	Previous period (January 2021 to December 2022)	Most recent period (January 2022 to December 2023)		
		All	Urban	Rural
Share of caregivers rating the hospice a 9 or 10	82%	82%	81%	85%
Share of caregivers who would definitely recommend the hospice	85	85	84	89
Share of caregivers who give top ratings on:				
Providing emotional support	90	91	90	92
Treating patients with respect	91	91	91	93
Help for pain and symptoms	75	75	74	78
Hospice team communication	81	81	81	84
Providing timely help	78	78	77	82
Caregiver training	76	76	75	79

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" (the most positive survey response) across all providers. In this analysis, a hospice is considered "rural" if more than half of the beneficiaries it serves reside in a rural county (defined as a micropolitan, rural adjacent, or rural nonadjacent county). In the most recent period, between 3,033 and 3,045 hospice providers had publicly reported CAHPS scores for these measures. These hospices accounted for just over half of all hospices in 2022.

Source: CAHPS hospice survey data from CMS.

the median urban hospice across the eight CAHPS measures (Table 9-7). For example, scores were 4 percentage points or 5 percentage points higher for the median rural hospice compared with the median urban hospice for the share of caregivers who gave top ratings on help for pain and symptoms, providing timely help, and caregiver training; who rated the hospice a 9 or 10; and who would definitely recommend the hospice.

Recent studies have also indicated that CAHPS scores vary by ownership status. In an analysis of CAHPS data from the second quarter of 2017 to the first quarter of 2019, Anhang Price and colleagues found that nonprofit providers were more likely to be high performers and less likely to be low performers (as measured by being 3 percentage points above or below the national average CAHPS score in a domain on the CAHPS survey) than for-profit providers (Anhang Price et al. 2023). Analysis

of hospice CAHPS data from January 2021 to December 2022 by Soltoff and colleagues found that nonprofit hospices had higher average scores on CAHPS measures than two types of for-profit providers (those owned by chains or private-equity firms and those with other types of for-profit ownership) (Solttoff et al. 2024).¹⁷

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. Looking at the distribution of caregiver responses across providers on the CAHPS survey in the most recent period, for the median hospice, 10 percent of patients' informal caregivers gave the bottom rating

on help for pain and symptoms (i.e., reported that 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 in the most recent period in 2023, and those figures were similar to the prior period.

In December 2024, CMS began implementing the new Hospice Special Focus Program (mandated by the Consolidated Appropriations Act, 2021), which identifies providers with the poorest performance based on selected quality indicators (Centers for Medicare & Medicaid Services 2023c). Under this program, CMS identifies the poorest-performing hospices based on an algorithm that reflects the following quality indicators: condition-level deficiencies identified by state survey agencies or accrediting organizations (i.e., who carry out “surveys” (inspections) to determine compliance with Medicare conditions of participation), 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 selects from among the 10 percent of hospices with the poorest performance on the algorithm for inclusion in the Special Focus Program. The selected hospices will be subject to more frequent surveys by state survey agencies, 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. In February 2025, CMS announced it was ceasing implementation of the Hospice Special Focus Program for calendar year 2025 so the agency could further evaluate the program (Centers for Medicare & Medicaid Services 2024b).

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 (shortness of breath) 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 96.6, up slightly from 96.2 percent in the previous period. The consistently high scores on the composite measure suggest that it has topped out in its ability to distinguish meaningful differences in quality for most hospices.

In August 2022, CMS added two new claims-based process measures to public reporting.¹⁸ 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 (CHC or GIP).¹⁹ In the most recent reporting period, from January 2021 to December 2022, 14 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. Providers’ performance varied substantially on this measure, ranging from 40 percent at the 25th percentile to 70 percent at the 75th percentile in the most recent period (from January 2021 through December 2022), similar to the prior reporting period.

**TABLE
9-8**

Measures of in-person nurse and social worker visits during the last seven days of life were stable or increased slightly from 2022 to 2023, but some remained below 2019 levels

	2019	2021	2022	2023
Nurse visits in last 7 days of life				
Share of days with visit	66%	63%	63%	63%
Average length of each visit (in minutes)	67	63	63	71
Average visit time per day (in minutes)	44	40	40	45
Social worker visits in last 7 days of life				
Share of days with visit	10%	9%	9%	10%
Average length of visits (in minutes) ^a	60	57	54	55
Average visit time per day (in minutes)	6	5	5	5

Note: ^a“Nurse visits” includes both registered nurse and licensed practical nurse visits. “Visit length” is reported by providers in number of 15-minute increments, rounded to the nearest 15-minute increment. We calculate minutes per visit by multiplying the number of 15-minute increments by 15.

Source: MedPAC analysis of Medicare hospice claims data from CMS.

The Commission has also used claims data to examine the aggregate trend from 2019 to 2023 in nurse and social worker in-person visits in the last seven days of life. Between 2022 and 2023, the average frequency and length of nurse and social worker visits in the last seven days of life were stable or increased slightly between 2022 and 2023 (Table 9-8). Compared with the prepandemic 2019 levels, in 2023 nurse visits during the last seven days of life were on average slightly less frequent, but slightly longer than in 2019. For social worker services, visit frequency in the last seven days of life was similar in 2019 and 2023, but visit length was slightly shorter in 2023.

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 contends that outcome measures such as patient-reported pain and other symptom-management measures warrant further exploration.

Beginning in fiscal year 2026, hospices will report data using a new hospice patient-assessment instrument (referred to as the Hospice Outcomes & Patient Evaluation (HOPE)). The new instrument will collect information at additional times during the hospice episode (not just at admission and discharge) and will collect additional types of data about patient characteristics and symptoms, which may offer the opportunity for new types of quality measures. CMS has finalized two new process-quality measures that will be collected via the HOPE instrument: timely reassessment of pain impact and timely reassessment of nonpain symptom impact.

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, high 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 2023, the aggregate rate of live discharge (that is, live discharges as a share of all discharges) was 18.5 percent, up from 17.3 percent in 2022. Hospice claims data show “beneficiary revocation” and “beneficiary not terminally ill” were the most common reasons reported for live discharge (accounting for 6.7 percent and 6.2 percent of hospice discharges, respectively), followed by “moved out of area” (2.7 percent), “transferred hospice” (2.6 percent), and “discharge for cause” (0.4 percent).²⁰ Among providers with more than 30 discharges, the median live-discharge rate was about 21 percent, but 10 percent of those providers had live-discharge rates of 56 percent or more in 2023. Hospices with very high live-discharge rates were disproportionately for-profit and recent entrants to the Medicare program and had an above-average rate of exceeding the aggregate payment cap. For example, our comparison of above- and below-cap hospices in 2022 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 18 percent for below-cap hospices and 55 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 be less beneficial to patients and families than enrolling earlier. These short stays are generally unrelated to the adequacy of Medicare’s hospice payment rates. Very short hospice stays occur across

a wide range of diagnoses. In some cases, short stays may be the result of a rapid change in a patient’s health condition. Broader issues in the health care delivery system that precede the hospice referral also likely contribute to short stays (Medicare Payment Advisory Commission 2022). 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 conventional care to palliative care or may prefer exhausting 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 beneficiaries deferring hospice care, resulting in short hospice stays.

Multiple factors influence the decision to enroll in hospice. One such factor is the interactions that beneficiaries and their families have with clinicians upstream in the health care delivery system before hospice enrollment. Broader health care delivery-system services or initiatives may offer potential to improve end-of-life care quality, such as advance care-planning visits (which have been covered by Medicare since 2016), or new payment models CMS is testing such as accountable care organizations, the Dementia Guide Model, MA VBIID model, and the recent Medicare Care Choices Model (Medicare Payment Advisory Commission 2024).²¹

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 2023, the number of for-profit providers grew by more than 10 percent, indicating that these providers have been able to access capital. Recent financial reports for five publicly traded hospice companies generally indicate strong financial performance as of the third quarter of 2024 (Addus 2024, Amedisys

2024, Chemed 2024, Enhabit 2024, Pennant 2024). Average daily census grew modestly or substantially among these five companies in the third quarter of 2024. Admission trends varied, with three companies experiencing admission increases and two experiencing decreases. Among the publicly traded companies that report hospice-specific margins, margins increased in the third quarter of 2024 (Amedisys 2024, Chemed 2024, Enhabit 2024). Several of the publicly traded hospice companies acquired another hospice provider or opened additional locations in 2023 or 2024 (Addus 2024, Chemed 2024, Enhabit 2024, Pennant 2024). The hospice sector also continues to garner 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 has a pending agreement to acquire Amedisys (two large home health and hospice companies) (Parker 2023). However, overall hospice mergers and acquisition activity has slowed over the period from 2022 to 2024 following several years of increased activity (Braff Group 2024, Mertz-Taggart 2024). Some analysts attribute the slowdown in mergers and acquisitions to the recent high-interest-rate environment and expect an increase in mergers and acquisitions as interest rates decline (Parker 2024, Vossel 2024). Less is known about access to capital for nonprofit freestanding providers. 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 91 percent of hospice days in 2022, and hospices' FFS Medicare margins are strong.

Medicare payments and costs: Aggregate payments exceed costs

In 2022, the FFS Medicare margin was 9.8 percent, down from 13.3 percent in 2021, as per day cost growth outpaced growth in per day payments. (See the text box in Chapter 2 on the different margin measures

MedPAC uses to assess provider profitability.) Hospice costs per day increased 3.8 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 2022 because of the data lag required to calculate cap overpayment amounts.) FFS Medicare margins varied widely across hospice providers. Hospice profitability is closely related to length of stay, with hospices with longer stays having higher margins. Hospices with a large share of patients in nursing facilities and assisted-living facilities also have higher FFS Medicare margins.

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 2022 and 2023, Medicare hospice spending increased 8.3 percent, largely reflecting a 3.8 percent update to hospice base payment rates in 2023 and a 5.7 percent increase in total days of care in 2023, which was offset by the reinstatement of the sequester (which was in full effect for 2023 as opposed to partially in effect for 2022). Not included in the payment totals are the coronavirus pandemic-related federal relief funds for some providers. According to the Medicare cost reports, pandemic-related relief funds in cost-report year 2022 totaled about \$150 million. 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 91 percent of all hospice patient days in 2022). On a per day basis, Medicare's average payment to hospice providers was about \$186 in 2023, up 2.4 percent from 2022.

Hospice costs

In 2023, hospice costs per day across all levels of care for hospice providers with cost-report data averaged about \$167, rising 3.0 percent from 2022.

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 2023, freestanding hospices had lower average 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 likely contribute to provider-based hospices' higher costs compared with freestanding providers.²² 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

Between 2021 and 2022 (the year of our margin estimate), hospice costs per day grew 3.8 percent. Cost growth outpaced growth in per day payments (which largely reflected the annual payment update of 2.0 percent in 2022 and reinstatement of the sequester in mid-2022). As a result, the aggregate FFS Medicare margin for hospice providers in 2022 was 9.8 percent, down from 13.3 percent in 2021 (Table 9-10, p. 288).²³ FFS Medicare margins varied widely across individual hospice providers: -13.4 percent at the 25th percentile, 8.1 percent at the 50th percentile, and 23.6 percent at the 75th percentile (data not shown). Our estimates of FFS Medicare 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.²⁴ In addition, these margin estimates do not include federal pandemic relief funds that were received by hospice providers in 2022. However, if a portion of these relief funds that freestanding hospice providers received in 2022 were included in our margin estimates, the FFS Medicare margin with relief funds was 10.4 percent (compared with 9.8 percent excluding relief funds).²⁵

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, p. 288).

**TABLE
9-9**

Total hospice costs per day varied by type of provider, 2023

Average total cost per day	
All hospices	\$167
Freestanding	161
Home health based	180
Hospital based	259
For profit	148
Nonprofit	201
Urban	168
Rural	157

Note: "Cost per day" reflects aggregate costs per day for all types of hospice care combined (routine home care, continuous home care, general inpatient care, and inpatient respite care) divided by the total number of days of hospice 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.

In 2022, freestanding hospices had a higher aggregate FFS Medicare margin (12.4 percent) than home health-based (3.8 percent) or hospital-based hospices (-23.5 percent) (Table 9-10). Provider-based hospices typically have lower FFS Medicare 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 2022, the aggregate FFS Medicare margin was considerably higher for for-profit hospices (16.1 percent) than for nonprofit hospices (0.3 percent). The aggregate FFS Medicare margin for freestanding nonprofit hospices was higher (5.1 percent; data not shown) than the margin for nonprofit hospices overall. Generally, hospices' FFS Medicare margins vary by the provider's volume: Hospices with more patients have higher margins on average. Hospices in urban areas had a slightly higher aggregate FFS Medicare margin (10.0 percent) than those in rural areas (8.1 percent).

**TABLE
9–10****Hospice providers' aggregate FFS Medicare margins
by selected characteristics, 2018–2022**

Category	Share of		FFS Medicare margin				
	Hospice providers, 2022	Hospice patients, 2022	2018	2019	2020	2021	2022
All	100%	100%	12.4%	13.4%	14.2%	13.3%	9.8%
Freestanding	86	83	15.1	16.2	16.7	15.5	12.4
Home health based	7	9	8.4	9.7	11.2	10.9	3.8
Hospital based	6	8	–16.5	–18.4	–18.2	–15.6	–23.5
For profit	78	55	19.0	19.2	20.5	19.2	16.1
Nonprofit	20	43	3.8	6.1	5.8	5.2	0.3
Urban	86	89	12.6	13.6	14.3	13.4	10.0
Rural	14	11	10.3	11.5	13.5	12.3	8.1
Patient volume (quintile)							
Lowest	20	2	–3.1	–4.5	–2.1	–4.4	–12.3
Second	20	4	5.6	6.2	4.9	3.1	–6.4
Third	20	9	13.8	13.5	14.2	13.3	5.5
Fourth	20	18	14.0	15.8	17.9	15.5	12.2
Highest	20	67	12.7	13.9	14.4	14.0	11.7
Below cap	77	94	12.6	13.8	14.8	14.0	10.8
Above cap (excluding cap overpayments)	23	6	10.3	10.0	7.7	2.5	–1.6
Above cap (including cap overpayments)	23	6	21.8	22.5	22.8	21.8	18.5
Share of stays > 180 days							
Lowest quintile	20	27	–3.0	–2.5	–0.4	0.0	–4.1
Second quintile	20	29	8.5	10.3	11.8	11.1	8.2
Third quintile	20	20	16.8	19.9	20.0	20.5	17.8
Fourth quintile	20	17	20.8	22.8	24.1	22.2	18.6
Highest quintile	20	7	17.6	13.4	13.4	9.7	2.7
Share of patients in nursing facilities and assisted-living facilities							
Lowest half	50	44	6.1	6.6	7.5	7.1	1.8
Highest half	50	56	17.3	18.7	18.9	17.6	15.1

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.

Margins also vary by whether a hospice exceeds the aggregate cap. In 2022, below-cap hospices had an aggregate FFS Medicare margin of 10.8 percent. Above-

cap hospices had a high FFS Medicare margin in 2022 before the return of overpayments (18.5 percent) and a slightly negative estimated margin after the return

of overpayments (–1.6 percent) that year (Table 9-10). Although our estimate of above-cap hospices’ “margin after the return of overpayments” assumes that 100 percent of cap overpayments are returned to the government, the Office of Inspector General (OIG) audits suggest that some portion of cap overpayments may be uncollectible. For example, OIG audits of three Medicare claims-processing contractors found that the share of cap overpayments that were classified as uncollectible (meaning at least 180 days delinquent and unlikely to be collected) varied, ranging from 4 percent to 20 percent to 27 percent across the three contractors (Office of Inspector General 2024, Office of Inspector General 2022, Office of Inspector General 2021).²⁶

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, we found that the 2022 aggregate FFS Medicare margin ranged from –4.1 percent for hospices in the lowest quintile to 18.6 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 an aggregate FFS Medicare margin of 2.7 percent after the return of cap overpayments, but without the hospice aggregate cap, these providers’ aggregate FFS Medicare margin would have been 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 margins than other hospices can (Table 9-10). For example, in 2022, the 50 percent of hospices with the highest share of patients residing in nursing facilities and assisted-living facilities had an aggregate FFS Medicare margin of about 15 percent compared with a margin of about 2 percent for providers with fewer patients residing in facilities. The higher aggregate FFS Medicare 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 2025 aggregate FFS Medicare margin

To project the 2025 aggregate FFS Medicare margin, we model the policy changes that went into effect between 2022 (the year of our most recent margin estimates) and 2025. For 2023, we assume rates of payment and cost growth based on preliminary data for that year. For 2024 and 2025, we assume revenue growth based on the annual payment updates in 2024 (3.1 percent) and 2025 (2.9 percent). The updates for these years reflect the statutorily required market basket update and productivity adjustment. In addition, our margin projection reflects full 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 payment-rate penalty that providers face for not reporting quality data, which increased in 2024 to 4 percent. In addition, we assume a rate of cost growth similar to historical trends. Taking these factors into account, we project an aggregate FFS Medicare margin of about 8 percent for hospices in 2025.

How should FFS Medicare payments change in 2026?

Under current law, Medicare’s base payment rates for hospice care are updated annually based on the projected increase in the hospice market basket, less an amount for productivity improvement. The final update for 2026 will not be set until summer 2025; however, using CMS’s third-quarter 2026 projections of the market basket (3.1 percent) and productivity adjustment (0.6 percent) would increase hospice payment rates by 2.5 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. Current payment rates appear sufficient to support the provision of high-quality care without an increase to the base payment rates in 2026.

RECOMMENDATION 9

For fiscal year 2026, the Congress should eliminate the update to the 2025 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 2023, the number of providers increased by more than 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 increased and median length of stay was stable. The 2022 FFS Medicare marginal profit was about 14 percent. Access to capital remains adequate: The number of for-profit providers increased by more than 10 percent, and financial reports suggest that the sector continues to be viewed favorably by investors. The 2022 aggregate FFS Medicare margin was 9.8 percent (10.4 percent if pandemic relief funds are included). The projected 2025 aggregate FFS Medicare margin is about 8 percent.

IMPLICATIONS 9

Spending

- Current law is expected to increase payment rates by 2.5 percent in fiscal year 2026. 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 five 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. ■

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 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 RHC payment rate.
- 3 For example, for a hypothetical hospice with a wage index of 1.0 whose patients received only RHC, if half of the hospice's patients each had a length of stay of 30 days, the other half could have an average length of stay of up to 335 days before that provider would exceed the cap. The length-of-stay patterns in this hypothetical example are much longer than typical for the hospice population (for patients with both short and long stays) because median lifetime length of stay among decedents in 2023 was 18 days, and length of stay was 278 at the 90th percentile.
- 4 Throughout this chapter, we use the term "FFS Medicare" as equivalent to the CMS term "original Medicare."
- 5 When an MA enrollee elects hospice, the beneficiary remains in the MA plan for Part D drugs and supplemental 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 A CMS contractor report evaluated the effect of the hospice VBID model on use, quality, and costs, with data available for the first year (2021) or the first and second year (2021 and 2022) of the model, depending on the analysis (Eibner et al. 2023). The report notes that hospice VBID participation was heavily concentrated in Puerto Rico. Beneficiaries residing in Puerto Rico accounted for 55 percent in 2021 and 31 percent in 2022 of all beneficiaries enrolled in MA plans that participated in the hospice VBID model. The report evaluated the first-year effect of the hospice MA-VBID model on utilization and quality using data from 2019 (two years prior to the model) and 2021 (the first year of the model) and a difference-in-difference model that compared trends for beneficiaries enrolled in MA plans participating in the hospice VBID model with other MA beneficiaries. The evaluation found that hospice use and patterns of care did not appear to be significantly affected by the VBID model in 2021. In terms of quality, the report indicated that hospice CAHPS scores were higher among VBID-participating plans than the comparison group in 2021, with the increased CAHPS scores driven by Puerto Rican beneficiaries. In terms of effects on MA Prescription Drug plan (MA-PD) bids, premiums, and supplemental benefits, the evaluation found that VBID participation was associated with lower MA-PD bids in 2021 and 2022, higher supplemental benefit costs in 2021 and 2022, and a lower MA-PD premium in 2021 but not 2022. The evaluation found no effect of the model on costs to Medicare in 2021 (2022 data were not available). In the first two years of the model, the report indicated that less transitional concurrent care, hospice supplemental benefits, and nonhospice palliative care were provided 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 reported some implementation challenges (e.g., related to adapting information technology systems, data-reporting burden, and communications).
- 7 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).
- 8 We are missing data on certain hospice characteristics (ownership and hospice type) for more providers than typical in 2023—about 2.6 percent of providers that year. In recent years, new hospice entrants have mostly been for-profit, freestanding providers, so missing data on provider characteristics for 2023 likely understate growth in these categories. However, it is also possible that providers lacking data on ownership or hospice type for 2023 are nonprofit or

government owned or are home health-, hospital-, or SNF-based providers, which would lessen the estimated decline in these categories.

- 9 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 SNF). The type of cost report does not necessarily reflect where patients receive care. For example, all hospice types may serve some nursing facility patients.
- 10 This comparison of hospice use across years is based on paid Medicare claims. These data slightly understate hospice use in 2022 and 2023 because they exclude beneficiaries who received hospice care that was paid for by MA plans participating in the hospice VBID demonstration. In 2022, about 19,065 beneficiaries received hospice care that was paid for by MA plans participating in the hospice VBID demonstration, according to a CMS contractor evaluation report. A report for 2023 is not yet available.
- 11 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 2023, the 75th percentile length of stay for hospice decedents with neurological conditions who were treated by for-profit hospices was 232 days compared with 143 days at nonprofit hospices; the 90th percentile length of stay was 543 days at for-profit hospices and 387 days at nonprofit hospices.
- 12 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.
- 13 Nurse visits include visits furnished by registered nurses and licensed practical nurses (LPNs). In 2023, LPN visits made up 17 percent of all nurse visits furnished. The share of hospice nurse visits furnished by LPNs has increased slightly over the last few years, from 15 percent in 2019 to 17 percent in 2023. Data on hospice visits do not include visits by spiritual counselors or chaplains. CMS does not require hospices to report visits by these types of practitioners. The hospice conditions of participation require that hospices make an assessment of a patient's and family's spiritual needs and provide spiritual counseling to meet these needs in accordance with the patient's and family's acceptance of this

service, and in a manner consistent with patient and family beliefs and desires.

- 14 Throughout this chapter, we refer to margins as "FFS Medicare margins" because they reflect FFS Medicare payments for hospice services. Included in these margins are FFS Medicare payments to hospice providers for care furnished to FFS Medicare and MA beneficiaries who are enrolled in hospice.
- 15 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. 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 2023d).
- 16 The hospice CAHPS response rate was 29 percent in the most recent period (CAHPS Hospice Survey 2024).
- 17 Both Soltoff et al. (2024) and Anhang Price et al. (2023) examined CAHPS performance among different types of for-profit ownership. Although the studies used different ownership category definitions, the findings had some similarity. Anhang Price et al. found that for-profit hospices owned by chains, and Soltoff found that for-profit hospices owned by chains or private-equity firms, had generally lower CAHPS scores than other types of for-profit hospices (Anhang Price et al. 2023, Soltoff et al. 2024).
- 18 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.
- 19 The Medicare conditions of participation require hospices to have the capacity to furnish all four levels of hospice care, including high-intensity levels of care.
- 20 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.

- 21 The Medicare Care Choices Model (MCCM) permitted certain terminally ill FFS beneficiaries who were eligible for, but not enrolled in, hospice to enroll in the MCCM and receive palliative and supportive care from a hospice provider while continuing to receive “curative” care from other providers. MCCM eligibility was limited to beneficiaries with a life expectancy of 6 months or less who met several criteria (diagnoses of cancer, congestive heart failure, chronic obstructive pulmonary disease, or HIV/AIDS; at least one hospital encounter and at least three office visits in the last 12 months; no election of hospice in the last 30 days; and lived in a traditional home continuously for the last 30 days). An evaluation of the MCCM 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 because of greater hospice use and lower acute care costs at the end of life (Kranker et al. 2022). The evaluation also reported that MCCM enrollees were more likely to receive better-quality end-of-life care (as measured by less aggressive care in the last 30 days of life). The report cautioned against broadly extrapolating from these findings because the model involved a very small number of beneficiaries and hospice providers.
- 22 In our March 2017 report, the Commission examined indirect costs for provider-based and freestanding hospices. Indirect costs include, among others, management and administrative costs, accounting and billing, and capital costs. In 2014, indirect costs made up 32 percent of total costs for freestanding hospices, compared with 40 percent for home health-based hospices and 42 percent for hospital-based hospices (Medicare Payment Advisory Commission 2017). We noted that the structure of the cost report for provider-based hospices likely results in some overallocation of overhead costs that are not actually related to the hospices’ operations or management. We also noted that it is possible that provider-based hospices have higher indirect costs for certain overhead activities. For example, provider-based hospices might have higher indirect costs than freestanding providers if administrative staff wages are higher for parent providers (e.g., hospitals or home health agencies) or if provider-based hospices expend more administrative resources coordinating with their parent provider. This pattern of higher indirect costs among provider-based hospices was observed historically over a number of years (from 2008 to 2014), and, although the data are old, it seems

likely that it continues to be a factor (Medicare Payment Advisory Commission 2017, Medicare Payment Advisory Commission 2010).

- 23 The aggregate FFS Medicare margin is calculated as follows: ((sum of total Medicare payments to all providers) – (sum of total Medicare costs of all providers) / (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.
- 24 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 2022 by at most 1.3 percentage points and 0.3 percentage points, respectively.
- 25 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 helped 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 2022 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 2022 cost reports toward hospices’ care of Medicare beneficiaries in 2022.
- 26 If we had assumed 20 percent of cap overpayments were not collected, our estimate of above-cap hospices’ FFS Medicare margin after the return of overpayments would increase almost 5 percentage points (from –1.6 percent to 3.2 percent), and the aggregate FFS Medicare margin for all hospices would increase less than 1 percentage point (from 9.8 percent to 10.2 percent).

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C H A P T E R

10

**Ambulatory surgical center
services: Status report**

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 2023, about 6,300 ASCs treated 3.4 million fee-for-service (FFS) Medicare beneficiaries. FFS Medicare program and beneficiary spending on ASC services was about \$6.8 billion. The volume of ASC surgical procedures per FFS beneficiary rose by 5.7 percent in 2023 and at an annual average rate of 0.6 percent from 2018 to 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 more specialized staff and control over their work environment.

Over 90 percent of ASCs are for profit and located in urban areas. The concentration of ASCs varies widely across states, ranging from 35 ASCs per 100,000 Part B beneficiaries (FFS and Medicare Advantage combined) in Maryland to 3 or fewer ASCs per 100,000 Part B beneficiaries in the District of Columbia, Kentucky, and Vermont. Relative to hospital outpatient departments (HOPDs), ASCs are less likely to provide surgical procedures to FFS Medicare beneficiaries who are disabled, have Medicaid

In this chapter

- Supply of ASCs and volume of services continued to grow in 2023
- Little change in ASC Quality Reporting Program measures
- Aggregate Medicare payments rose substantially in 2023, continuing a trend
- Ambulatory surgical centers should submit cost data

coverage, or are ages 85 or older. About 68 percent of ASCs that billed Medicare in 2023 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, of which pain management and orthopedics were the most common. From 2018 to 2023, the specialties that grew most rapidly were pain management and cardiology.

The most common FFS Medicare procedure in ASCs in 2023 was extracapsular cataract removal with intraocular lens insertion, accounting for almost 19 percent of ASCs' FFS Medicare volume and 19 percent of spending. The 20 most common surgical procedures made up about 69 percent of ASCs' FFS Medicare volume in 2023, 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 7.8 percent from 2018 through 2022 and by 15.4 percent in 2023. Because FFS Medicare payment rates are lower in ASCs than in 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 liability is lower as well. However, it is possible that a shift of services from HOPDs to ASCs could increase the overall volume of surgical procedures, which would partially offset the reduction in total Medicare spending and beneficiaries' cost sharing.

Policymakers know little about the costs that ASCs incur in treating beneficiaries because Medicare does not require ASCs to submit cost data, unlike its requirements for other types of facilities. As a result, it is not possible to properly evaluate the level of Medicare's payments relative to costs for ASCs. The Commission contends that ASCs could feasibly provide cost data, as other small providers such as home health agencies and hospices do. Beginning in 2010 through 2022, the Commission recommended that the Congress require ASCs to submit cost data and reiterated this recommendation in 2023 and 2024. In addition, we encourage CMS to synchronize the ASC Quality Reporting Program's measures with measures included in the Hospital Outpatient Quality Reporting Program to facilitate comparisons between ASCs and HOPDs. ■

An ambulatory surgical center (ASC) is a facility that primarily provides outpatient surgical procedures to patients who do not require an overnight stay. Outpatient surgical procedures are also provided in hospital outpatient departments (HOPDs) and, in some cases, physicians' offices. Fee-for-service (FFS) Medicare covers more than 3,700 surgical procedures in ASCs, though historically volume has been concentrated in a small number of procedures.

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. The rationale for this policy is to encourage provision of these services in the lowest-cost setting.

Payment rates in the ASC payment system are the product of a set of relative weights and a conversion factor (or base payment amount). The relative weights, which indicate each procedure's resource intensity relative to other procedures, used in the ASC payment system are the same as those in the OPPS. The ASC conversion factor (\$54.90 in 2025) is less than that used in the OPPS (\$89.17 in 2025), but since 2019, CMS updated the ASC conversion factor using the same method used to update the OPPS conversion factor: the hospital market basket index minus the multifactor productivity adjustment.¹

For many years, the Commission reviewed available Medicare payment-adequacy indicators for ASCs to make recommendations on appropriate updates to the ASC payment system. Our payment-adequacy indicators pointed to a robust industry, with long-

term growth in the number of ASCs, the volume of services provided to FFS Medicare beneficiaries, and total FFS Medicare payments. However, CMS has never required ASCs to submit cost data, and information about the quality of care has been of limited value. The Commission recommended that CMS require ASCs to submit cost data; in the absence of those data, the Commission has opted not to make an update recommendation since 2022. Instead, we provide a status report on ASCs, examining beneficiaries' access to ASC care, growth in the number of ASCs, growth in Medicare's payments to ASCs, and, to the extent possible, the quality of care provided in ASCs.

Supply of ASCs and volume of services continued to grow in 2023

The number of ASC facilities increased in 2023, as did the volume of ASC services provided to FFS Medicare beneficiaries. Access to ASCs may be preferable to patients and physicians compared with HOPDs, the provider type most like 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 increased in 2023

From 2022 through 2023, the number of Medicare-certified ASCs rose 2.5 percent to 6,308 ASCs, compared with growth of 2.2 percent, on average, from 2018 through 2022 (Table 10-1, p. 302). During 2023, 250 new ASCs opened while 95 ASCs closed or merged with other facilities for a net increase of 155 facilities.

Numerous factors have likely influenced the long-term growth in the number of ASCs:

- 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) as well as angioplasty in ambulatory settings.²

**TABLE
10-1**

Number of ASCs grew, 2018–2023

	2018	2022	2023	Average annual change
				2018–2022
Total number of ASCs	5,650	6,153	6,308	2.2%
New	226	221	250	N/A
Closed or merged	136	93	95	N/A

Note: ASC (ambulatory surgical center), N/A (not applicable). 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.

Source: MedPAC analysis of Provider of Services file from CMS, 2024.

- 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.³
- 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.
- Some states have eliminated or softened their certificate-of-need (CON) laws, such as South Carolina eliminating CON requirements for ASCs in 2023 and North Carolina eliminating CON requirements for ASCs located in counties with populations over 125,000.

**TABLE
10-2**

Most ASCs were for profit and located in urban areas, 2018 and 2023

Type of ASC	ASCs that were:		
	Open in 2018	Open in 2023	New in 2023
For profit	95.2%	95.3%	95.2%
Nonprofit	3.6	3.7	4.8
Government	1.2	1.0	0.0
Urban	93.4	93.8	96.8
Rural	6.6	6.2	3.2

Note: ASC (ambulatory surgical center). We defined “urban” as being in metropolitan statistical areas (MSAs) and “rural” as being outside MSAs. We calculated percentages using unrounded data.

Source: MedPAC analysis of CMS Provider of Services file, 2024.

**TABLE
10-3**

FFS Medicare patients treated in ASCs differ from patients treated in HOPDs, 2023

Percentage of FFS Medicare patients that are in each category

Characteristic	ASC	HOPD
Dual-eligibility status		
Not dually eligible	91.1%	85.0%
Dually eligible	8.9	15.0
Age		
< 65 (disabled)	5.9	9.8
65–84	88.6	81.5
85 +	5.5	8.7
Sex		
Male	43.8	46.5
Female	56.2	53.5

Note: FFS (fee-for-service), ASC (ambulatory surgical center), HOPD (hospital outpatient department). All differences between ASC and HOPD patients are statistically significant ($p < 0.05$). This analysis excludes beneficiaries who received services that are not covered under the ASC payment system.

Source: MedPAC analysis of carrier and outpatient standard analytic claims files for 2023 and the Common Medicare Environment file.

Most ASCs are for profit, and geographic distribution is uneven

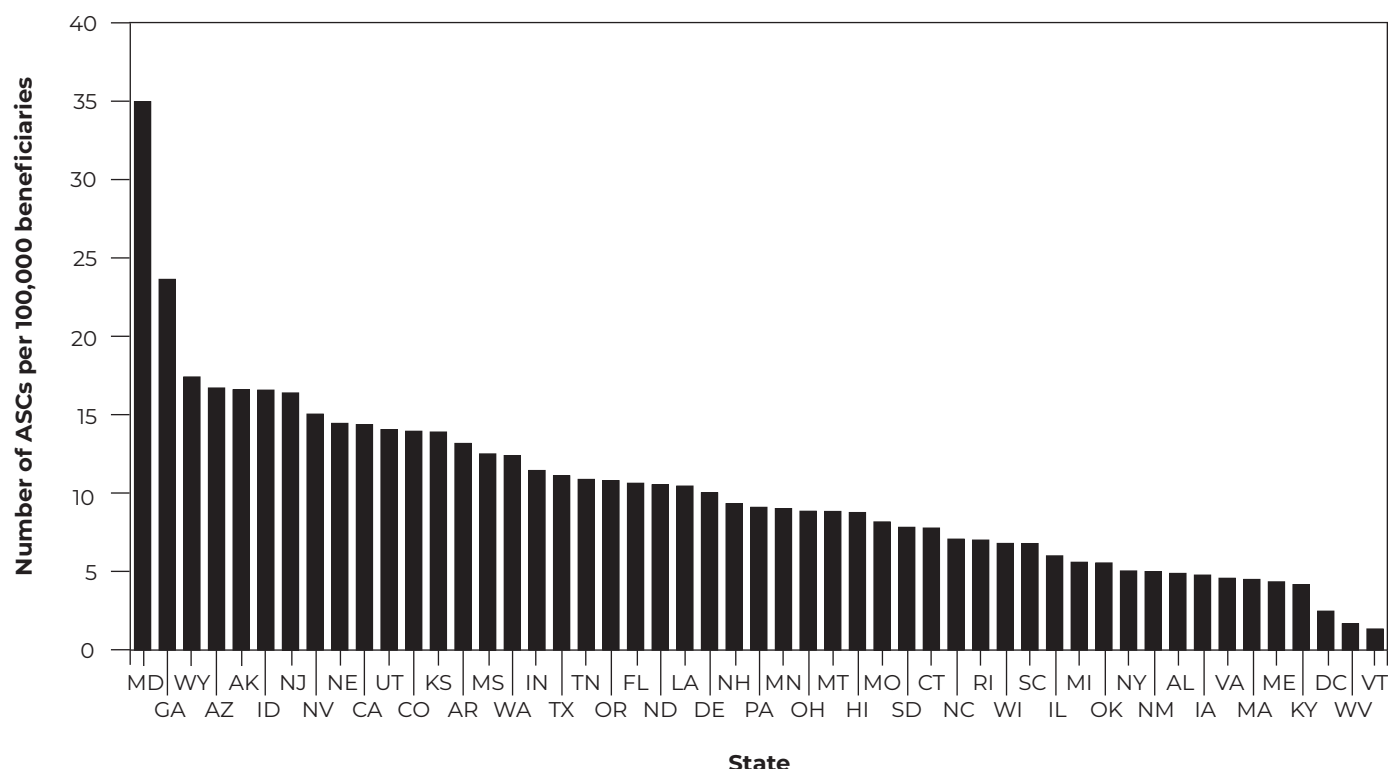
Consistent with previous years, most ASCs in 2023 were for profit (95.3 percent) (Table 10-2). Because most ASCs are for-profit entities, they have an incentive to provide profitable services. As the number of ASCs grows, if ASCs act on this incentive, there is the potential for ASCs to account for an increasingly larger share of the profitable ambulatory procedures, leaving the less profitable ambulatory procedures to other settings, primarily HOPDs.

ASCs were also disproportionately located in urban areas in 2023 (93.8 percent) (Table 10-2). Stakeholders contend that rural areas typically lack the surgical specialists needed for ASCs and that the lower population density in rural areas makes them less viable locations for ASCs. 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)—

are less likely to receive care in ASCs than are urban beneficiaries, defined as those living in an MSA. In 2023, 8.6 percent of rural beneficiaries received care in an ASC compared with 12.6 percent of urban beneficiaries (data not shown). Moreover, the profile of FFS beneficiaries who receive their ambulatory surgeries in ASCs differs from those who receive their ambulatory surgeries in HOPDs. ASCs are less likely than HOPDs to serve Medicare beneficiaries who are dually eligible for Medicare and Medicaid, those who are ages 85 and older, and those who are under age 65 and eligible for Medicare because of disability (Table 10-3). Geographic areas that have high social risk factors have low ASC penetration, which helps to explain why ASCs have a relatively low share of FFS Medicare patients who are dually eligible or disabled (Medicare Payment Advisory Commission 2024). The low presence of FFS Medicare patients ages 85 and older may be due to physicians directing frail patients to HOPDs, where it may be safer to provide surgical services.

The concentration of ASCs varies widely across states. At the close of 2023, Maryland had the most ASCs per Medicare beneficiary (35 ASCs per 100,000 Part B beneficiaries (both FFS and Medicare Advantage)),

**FIGURE
10-1****Number of ASCs per beneficiary varied widely by state, 2023**

Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of CMS Provider of Services file for 2024 and the Common Medicare Environment file.

followed by Georgia, Wyoming, and Arizona (respectively, 24, 17, and 17 ASCs per 100,000 Part B beneficiaries) (Figure 10-1). 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).⁴

Several factors contribute to variation in ASCs per Part B beneficiary among states. One factor that appears to have a strong effect is whether a state has a CON law for ASCs. However, even among the 22 states (plus the District of Columbia) that have CON laws, the stringency varies. For example, Nevada, which has a relatively weak CON law for ASCs, has one of the highest concentrations of ASCs per Medicare beneficiary; by contrast, Vermont has very strict CON laws and has by far the lowest number of ASCs per Medicare beneficiary. Moreover, some states have

characteristics that appear to overwhelm the effects of having or not having a CON law. For example, Maryland has a strong CON law but has by far the most ASCs per Medicare beneficiary, likely due to the presence of an all-payer global-budget revenue model in the state that excludes care provided by ASCs. To help hospitals meet their budgets, it appears that they avoid providing many ambulatory surgical procedures in the hospitals, resulting in these procedures being provided in ASCs. New Mexico, by contrast, does not have a CON law for ASCs but has only about half as many ASCs per 100,000 Part B beneficiaries (5) as the average among all states (10), perhaps due to the large number of sparsely populated rural areas in the state.

According to surveys, most ASCs have partial or complete physician ownership (Ambulatory Surgery Center Association 2023, Ambulatory Surgery Center

Association 2021, Leapfrog 2019). Physician owners of ASCs receive additional income through distributions of facility profits according to their ownership 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, five corporate entities are considered major holders of ASCs: United Surgical Partners International, AmSurg, Surgical Care Affiliates, HCA Healthcare, and Surgery Partners Holdings. From 2018 to 2023, the number of ASCs in which these five entities had some degree of ownership increased by 15.7 percent from 1,152 to 1,333, and the share of ASCs in which these entities had an ownership stake increased from 20.0 percent to 21.1 percent (Hawkins et al. 2023).

As noted above, ASCs offer several advantages for surgeons because they can customize their surgical environments and hire specialized staff, which allows them to perform more procedures in ASCs than in HOPDs in the same amount of time, earning more revenue from professional fees. For beneficiaries, ASCs offer shorter nonoperative times than HOPDs (Imran et al. 2019). In addition, because 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), the cost to beneficiaries (via cost sharing) is lower, as is the cost to the Medicare program (as well as taxpayers).⁵

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 and in rural areas limits the extent to which beneficiaries can access care in ASCs. Further, it is possible that shifting services from HOPDs to ASCs could increase the volume of surgical procedures, which would partially offset any associated reduction in total Medicare spending and beneficiaries' cost sharing.

Research indicates that when an ASC enters a market or a physician who performs surgical procedures in HOPDs and/or ASCs becomes an ASC owner, surgical procedures shift from HOPDs to ASCs and overall outpatient surgical volume in the market 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. Within these markets, the volume of procedures provided in ASCs was greater than the decline in procedures provided in hospitals (Hollenbeck et al. 2015). Munnich and colleagues found that most physicians that 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, and this change was not statistically significant. In summary, research indicates that increased ASC presence in a market causes a shift of outpatient procedures from HOPDs to ASCs, and it might increase the total number of outpatient procedures by a small amount.

Specialization of ASCs largely unchanged; some growth in pain management and cardiology

In 2023, 68 percent of ASCs that billed Medicare specialized in a single clinical area. Gastroenterology and ophthalmology were the most common specialties, with each comprising about 20 percent of all ASCs that provided services to FFS Medicare beneficiaries. The remaining 32 percent of ASCs were multispecialty facilities, providing services in more than one clinical specialty (Table 10-4, p. 306).⁶ In 2023, the most common multispecialty ASCs were those focusing on pain management and orthopedic services or gastroenterology and ophthalmology (combined, 8 percent of all ASCs were multispecialty and focusing on one of those two specialties).⁷ From 2018 to 2023, the

**TABLE
10-4****Specialization of ASCs billing Medicare in 2018 and 2023**

Type of ASC	2018		2023	
	Number of ASCs	Share of all ASCs	Number of ASCs	Share of all ASCs
Single specialty	3,277	65%	3,917	68%
Gastroenterology	1,071	21	1,193	21
Ophthalmology	1,046	21	1,152	20
Pain management	612	12	800	14
Dermatology	197	4	197	3
Urology	127	3	152	3
Podiatry	87	2	62	1
Cardiology	55	1	221	4
Orthopedics/musculoskeletal	33	1	83	1
Respiratory	26	1	36	1
OB/GYN	14	<1	15	<1
Neurology	4	<1	5	<1
Other	5	<1	1	<1
Multispecialty	1,784	35	1,827	32
More than 2 specialties	1,313	26	1,345	23
Pain management and orthopedics	292	6	262	5
Gastroenterology and ophthalmology	179	4	220	4
Total	5,061	100	5,744	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. The total number of ASCs in this table is less than the total number of ASCs listed in Table 10-1 (p. 302) because the ASCs included in this table are limited to those in the 50 states and the District of Columbia that had a paid Medicare claim, while the ASCs in Table 10-1 include all ASCs in the 50 states, the District of Columbia, and Puerto Rico. Columns containing the "shares of all ASCs" do not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare carrier file claims, 2018 and 2023.

number of ASCs specializing in pain management and cardiology services grew most rapidly.

Volume of services per beneficiary rose in 2023

For several years, aggregate volume of ASC services provided to Part B FFS beneficiaries declined as the number of beneficiaries in FFS Medicare decreased and the number in Medicare Advantage rose. That decline in the number of FFS beneficiaries was mitigated somewhat by a slow but steady increase in the number of services per Part B FFS beneficiary, which rose at an

average annual rate of 0.6 percent from 2018 to 2022. However, in 2023, the number of services per Part B FFS beneficiary rose by 5.7 percent, causing an increase in aggregate ASC services provided to Part B FFS beneficiaries of 2.2 percent (Table 10-5).

The relatively strong volume growth in 2023 was driven by increased volume of the highest-volume procedures such as colonoscopies and cataract procedures as well as large percentage increases in the volume of total knee arthroplasty (33 percent) and total hip arthroplasty (34 percent) (data not shown).

**TABLE
10-5**

Volume of ASC services per FFS beneficiary rose in 2023

	2018	2022	2023	Average annual change	
				2018–2022	2022–2023
Volume of Medicare FFS services (in millions)	6.8	6.2	6.4	–2.3%	2.2%
Part B FFS beneficiaries (in millions)	33.3	29.6	28.7	–2.9	–3.3
Volume per 1,000 FFS beneficiaries	205.4	210.2	222.1	0.6	5.7

Note: ASC (ambulatory surgical center), FFS (fee-for-service).

Source: MedPAC analysis of physician/supplier standard analytic claims files, 2018–2023, and the 2024 Medicare Trustees' report.

Services that have historically contributed the most to overall ASC volume continued to be a large share of the total in 2023. For example, in both 2018 and 2023, extracapsular cataract removal with intraocular lens insertion had the highest volume, accounting for 18.6 percent of the total in 2018 and 18.5 percent in 2023 (Table 10-6, p. 308). Moreover, 18 of the 20 most frequently provided ASC services in 2018 were among the 20 most frequently provided in 2023. These services made up about 70 percent of ASC Medicare volume in 2018 and 69 percent in 2023.

Relative to the highest-volume surgical procedures, there was more change among the highest-revenue surgical procedures, reflecting a shift to higher-complexity services in ASCs. Two of the highest-revenue services in 2023—total knee arthroplasty and total hip arthroplasty—were not covered under the ASC payment system in 2018. For another high-revenue procedure in 2023—percutaneous laminotomy or laminectomy—revenue increased by a factor of 20 over the 2018 level.

A longstanding feature of the services provided in ASCs to FFS Medicare beneficiaries is that despite the ASC payment system covering over 3,700 procedures, the provision of ASC services has been concentrated in a relatively small number of procedures. Of the surgical procedures provided to FFS Medicare beneficiaries in ASCs, 75 percent of the volume was concentrated in 31 procedures, and 75 percent of the FFS Medicare revenue was concentrated in 59 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 provide is not clear.⁸ 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 in 2020 and made them services covered under the ASC payment system.

Another factor that may limit the breadth of ASC services is that 320 surgical procedures that are not on the IPO list are covered under the OPPIs 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 that they would be low volume in ASCs.⁹

Little change in ASC Quality Reporting Program measures

CMS established the Ambulatory Surgical Center Quality Reporting (ASCQR) Program in 2012 (Centers for Medicare & Medicaid Services 2011). Under this

**TABLE
10-6**

For FFS beneficiaries, the 20 most frequently provided ASC services in 2018 were similar to those provided in 2023

Procedure name	2018		2023	
	Percent of volume	Rank	Percent of volume	Rank
Extracapsular cataract removal with IOL insert	18.6%	1	18.5%	1
Upper GI endoscopy, with biopsy: single or multiple	7.9	2	7.4	3
Colonoscopy and biopsy	6.9	3	6.7	4
Colonoscopy with lesion removal, snare technique	6.1	4	7.7	2
Injection transforaminal epidural: lumbar or sacral	4.7	5	4.2	5
After cataract laser surgery	4.1	6	3.7	6
Injection paravertebral facet joint: lumbar or sacral, single level	3.4	7	3.1	7
Injection interlaminar epidural: lumbar or sacral	2.7	8	1.9	9
Colorectal cancer screening, high-risk individual	2.1	9	2.4	8
Diagnostic colonoscopy	1.7	10	1.2	15
Destroy lumbar/sacral facet joint, single	1.7	11	1.9	10
Colorectal cancer screening, not high-risk individual	1.7	12	1.6	11
Injection procedure for sacroiliac joint, anesthesia	1.4	13	1.5	12
Extracapsular cataract removal complex without ECP	1.4	14	1.3	13
Cystourethroscopy	1.2	15	1.3	14
Injection paravertebral facet joint: cervical or thoracic, single level	1.1	16	1.1	16
Injection interlaminar epidural: cervical or thoracic	1.0	18	0.8	18
Upper GI endoscopy diagnostic brush wash	0.9	17	0.7	22
Blepharoplasty upper eyelid	0.9	19	1.0	17
Upper GI endoscopy, guide wire insertion	0.8	20	0.6	23
Total	70.2		68.6	

Note: FFS (fee-for-service), ASC (ambulatory surgical center), IOL (intraocular lens), GI (gastrointestinal), ECP (endoscopic cyclophotocoagulation). Percentages may not sum to totals due to rounding.

Source: MedPAC analysis of physician/supplier standard analytic files from 2018 and 2023.

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).

The ASCQR Program currently has four claims-based measures tied to unplanned hospitalizations for several important ASC specialties: gastrointestinal, orthopedics, urology, and general surgery (Table 10-7). 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 implement additional quality measures to make the ASCQR Program more effective (see text box on CMS's new measures, pp. 310–311).

**TABLE
10-7****ASCs' performance on quality measures improved on one measure, was unchanged on other measures, 2018-2023**

Description of quality measure	Median		
	2018	2022	2023
ASC-12: Facility 7-day risk-standardized hospital visit rate after outpatient colonoscopy (per 1,000 colonoscopies)	12.2%	9.8%	9.8%*
ASC-17: Unplanned hospital visits within 7 days after orthopedic ASC procedure (per 1,000 procedures)	N/A	2.2	2.2
ASC-18: Unplanned hospital visits within 7 days of urology ASC procedure (per 1,000 procedures)	N/A	5.1	5.1
ASC-19: Facility-level 7-day hospital visit rate after general surgery procedures performed at ASCs (per 1,000 procedures)	N/A	1.0	1.0

Note: ASC (ambulatory surgical center), N/A (not applicable). "General surgery procedures" include abdominal, alimentary tract, breast, skin, wound, and varicose vein-stripping procedures.

* 2023 value is statistically different from 2018 value ($p < 0.05$).

Source: MedPAC analysis of data on quality measures for ambulatory surgical centers from CMS, 2018, 2022, and 2023.

From 2018 to 2023, ASCs statistically significantly improved their performance on ASC-12: Facility 7-day risk-standardized hospital visit rate after colonoscopy (Table 10-7). From 2022 to 2023, all four measure results were stable with no statistically significant changes.

Medicare beneficiaries can access the ASC-covered surgical procedures in HOPDs, so it is useful to compare the quality of care in ASCs to the quality in HOPDs. Only one quality measure listed in Table 10-7 is in the Outpatient Quality Reporting (OQR) Program: ASC-12, facility 7-day risk-standardized hospital visit rate after outpatient colonoscopy. In 2022 (the most recent year for the OQR data), the median value in HOPDs for this measure was 13.1 (data not shown), worse than the ASC value of 9.8.

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 implement additional quality measures to make the ASCQR Program more effective (see text box on CMS's new measures, pp. 310-311).

Aggregate Medicare payments rose substantially in 2023, continuing a trend

In 2023, ASCs received \$6.8 billion in FFS Medicare payments and beneficiaries' cost sharing (Table 10-9, p. 312). Spending by the FFS Medicare program was \$5.4 billion, and beneficiary cost-sharing liability was \$1.4 billion (data not shown).

Payments per FFS beneficiary rose at an average annual rate of 7.8 percent from 2018 through 2022 and by 15.4 percent in 2023 (Table 10-9, p. 312). The increase in 2023 reflects a 3.9 percent increase in the ASC conversion factor, a 5.7 percent increase in per capita volume, a 5.0 percent increase in the average relative weight of ASC services, and a 0.1 percent effect from an increase in spending from 2022 to 2023 on separately paid drugs provided to Medicare beneficiaries treated in ASCs.

Although the ASC payment system covers over 3,700 surgical procedures, the revenue that ASCs receive for providing services to FFS Medicare beneficiaries is concentrated in a relatively small number of

CMS is adding measures to the Ambulatory Surgical Center Quality Reporting Program, but further improvement is needed

CMS has been adding measures to the Ambulatory Surgical Center Quality Reporting (ASCQR) Program and has started collecting data on those measures (the data are not yet available). In 2024, CMS started collecting data on measures for four “never events,” and in 2025, CMS will collect data on nine new measures (but three measures are voluntary in 2025) (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 includes four measures that are claims based and measure clinical outcomes

(ASC-12, ASC-17, ASC-18, and ASC-19; Table 10-7, p. 309), these measures exclude many services provided at ASCs, such as eye procedures and pain management. To improve the ASCQR Program, and 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

(continued next page)

**TABLE
10-8**

Measures that CMS has recently added to the Medicare ASC Quality Reporting Program

Description of quality measure	First year of data collection
Patient burn	2024
Patient fall	2024
Wrong site, wrong side, wrong patient, wrong procedure, wrong implant	2024
All-cause hospital transfer/admission	2024
Facility commitment to health equity	2025
Screening for social determinants of health*	2025
Screen positive for social drivers of health*	2025
Five patient experience measures from the Outpatient and Ambulatory Survey of the Consumer Assessment of Healthcare Providers and Systems (CAHPS)	2025
About facilities and staff	
Communication about procedure	
Preparation for discharge and recovery	
Overall rating of facility	
Recommendation of facility	
Risk-standardized patient-reported outcome-based performance measure following elective primary total hip arthroplasty and/or total knee arthroplasty**	2025

Note: ASC (ambulatory surgical center).

* This measure will be voluntary for submission by facilities in 2025. It will become mandatory in 2026.

** This measure 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, 2025.

CMS is adding measures to the Ambulatory Surgical Center Quality Reporting Program, but further improvement is needed (cont.)

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.**

CMS has considered an SSI measure for ASCs in the past (Centers for Medicare & Medicaid Services 2011), but 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).

- **Claims-based outcome measure for cardiology services.**

Cardiology has become 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. ■

procedures. As noted above, in 2023, 59 procedures accounted for 75 percent of the Medicare revenue from surgical procedures (data not shown).

ASCs do not submit cost reports, so we cannot analyze the financial standing for all ASCs. However, the Pennsylvania Health Care Cost Containment Council (PHC4) collects total operating costs and total operating revenue from all ASCs in Pennsylvania, which allows for the calculation of operating margins

for those ASCs. For 2023, the operating margin for the Pennsylvania ASCs was 24 percent, which is consistent with their historical operating margins of 23 percent to 25 percent from 2007 through 2022 (Pennsylvania Health Care Cost Containment Council 2024).¹¹ The data collected by PHC4 can be used to evaluate margins, but the data are somewhat limited and could not be used to create accurate ASC payment rates or an ASC-specific price index that could be used to update ASC payment rates.

**TABLE
10-9**

FFS Medicare payments to ASCs rose rapidly, 2018–2023

	2018	2022	2023	Average annual percentage change	
				2018–2022	2022–2023
FFS Medicare payments (billions)	\$5.1	\$6.1	\$6.8	4.7%	11.6%
FFS Medicare payments per FFS beneficiary	\$152	\$205	\$236	7.8%	15.4%

Note: FFS (fee-for-service), ASC (ambulatory surgical center). “FFS Medicare payments” include program spending and beneficiary cost sharing for ASC facility services. Payments include spending for new-technology intraocular lenses. Percentage changes were calculated on unrounded data.

Source: MedPAC analysis of data from the Office of the Actuary at CMS and data from physician/supplier standard analytic files.

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 and 2024. Cost data 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 relative weights, which are based on HOPD charges adjusted to cost. To the extent that the cost structures of HOPDs and ASCs differ, 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 has indicated that such data should not be used to develop an ASC-specific market basket. Instead, the industry has suggested that CMS could establish an HOPD market basket and use it to update payments in both the ASC payment system and the OPPS (Ambulatory Surgery Center Association 2024).

However, the Commission has asserted that the cost structures of ASCs and HOPDs are likely very different. ASCs tend to be single specialty, for profit, and are not required to comply with the Emergency Medical Treatment and Active Labor Act of 1986 (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). Therefore, using an HOPD-specific market basket for both settings would likely result in inaccurate ASC payments.

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 2024). The state of Pennsylvania has required ASCs to submit these data since at least 2005, with no apparent dampening effect on investor interest. From 2005 to 2018, the number of ASCs in Pennsylvania rose from 153 to 242 (an average of 3.6 percent per year). ■

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/2024/10/MedPAC_Payment_Basics_24_ASC_FINAL_SEC.pdf.
- 2 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 in ASCs to FFS Medicare beneficiaries in 2020. The number of these procedures rose to 38,600 in 2023.
- 3 By statute, coinsurance for a service paid under the OPPS cannot exceed the Medicare Part A inpatient hospital deductible (\$1,684 in 2025). 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 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 2023 were total knee arthroplasty and total hip arthroplasty.
- 4 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, which has resulted in Maryland hospitals operating 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.
- 5 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 (\$1,684 in 2025), while the ASC system does not have a limit on beneficiary cost sharing. These services constituted 1.8 percent of ASC volume in 2023.
- 6 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.
- 7 The percentages for these two multispecialty categories in Table 10-4 (p. 306) add to 9 percent, but the unrounded percentages add to 8 percent.
- 8 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 the OPPS, CMS has received comments from stakeholders recommending that CMS eliminate the IPO list, while other stakeholders have recommended that CMS maintain the list (Centers for Medicare & Medicaid Services 2020).
- 9 Procedures covered under the ASC payment system are those that CMS determines are safe to provide in the ASC setting and lists in the ASC covered procedures list. CMS covers procedures under the OPPS that are not on the inpatient-only (IPO) list, which includes services that CMS deems unsafe to provide outside the inpatient setting. In 2021, CMS began a three-year phase-out of the IPO list that was slated for completion in 2023 (Centers for Medicare & Medicaid Services 2020). However, CMS paused this phase-out in 2022 and largely added back to the IPO list the services that had been removed from the IPO list in 2021 (Centers for Medicare & Medicaid Services 2021).
- 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.”
- 11 The margins for 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.

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CHAPTER 11

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, which gives Medicare beneficiaries the option of receiving benefits from private plans rather than from traditional fee-for-service (FFS) Medicare. In 2024, the MA program included 5,678 plan options offered by 175 organizations, enrolled about 33.6 million beneficiaries (54 percent of Medicare beneficiaries with both Part A and Part B coverage), and paid MA plans an estimated \$494 billion (not including payments for drug coverage offered by MA plans). To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, plan generosity (including enhanced financial protections and supplemental benefits), and payments for MA plan enrollees relative to spending for beneficiaries enrolled in FFS Medicare. We also provide updates on risk adjustment, risk-coding practices, favorable selection of enrollees into MA, 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 FFS Medicare, while others may prefer features of MA, like reduced

In this chapter

- Robust MA enrollment, plan availability, and rebates
- Higher payments to MA plans stem from favorable selection and coding intensity
- Industry concentration, integration, and financial condition
- Quality in MA
- Commission recommendations to improve MA payment policies
- Technical Appendix 11-A: Favorable selection
- Technical Appendix 11-B: Coding intensity

premiums and cost-sharing liability. MA plans are required by statute to offer an out-of-pocket spending limit that is not included in FFS Medicare, and plans can reduce cost-sharing liability, offer integrated Part D benefits, and provide supplemental benefits that generally are not available to beneficiaries in FFS unless they purchase additional health insurance coverage or pay for the services out of pocket. The Commission has separately expressed concerns about the FFS program, including a benefit design that exposes beneficiaries to substantial financial risk, use of low-value care that can stem from open networks and the general absence of utilization management, and Medigap policies that include first-dollar coverage. 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 nearly record-high level of supplemental benefits. From 2018 to 2024, the share of eligible Medicare beneficiaries enrolled in MA rose from 37 percent to 54 percent. In 2025, the average Medicare beneficiary has a choice of 42 plans offered by an average of eight organizations.

In 2025, we estimate that Medicare will spend 20 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates into a projected \$84 billion. The higher payments we estimate relative to FFS vary significantly across MA parent organizations and are not an estimate of plan profits and administrative expenses. These increased payments to MA plans are the primary source of funding for supplemental benefits, which include coverage of non-Medicare services (services not covered by Part A and Part B) and better financial protection for MA enrollees relative to beneficiaries in FFS Medicare without supplemental coverage. The rebates that plans use to finance these benefits have nearly doubled since 2018 and account for a projected 17 percent of payments to all MA plans (some of which goes to plan administrative expenses and profit).

In 2025, the Medicare program pays conventional plans \$2,255 per beneficiary for supplemental benefits (including \$180 for plan administrative expenses and profit). On average, plans project using about 38 percent of these funds to reduce cost sharing for MA enrollees, 25 percent for non-Medicare services, about 23 percent to enhance plans' Part D benefit through lower

premiums or reduced cost sharing, about 6 percent to reduce MA enrollees' Part B premiums, and about 8 percent for administrative expenses and profit. However, currently there is no reliable information about the extent to which beneficiaries use these benefits or about their value.

The relatively higher payments to MA plans are financed by the taxpayers and beneficiaries who fund the Medicare program. Higher MA spending increases Part B premiums for all beneficiaries, including those in FFS Medicare; the Commission estimates that Part B premium payments will be about \$13 billion higher in 2025 because of higher Medicare payments to MA plans (equivalent to roughly \$198 per beneficiary per year).

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, in total, private plans have never been paid less than FFS Medicare because of policies that increase payments to MA above FFS payments and distort the nature of plan competition in MA. For example, MA benchmarks are set above FFS spending in many markets in part to encourage more uniform plan participation across the country. 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).

The two largest factors responsible for higher payments to plans in recent years are favorable selection and coding intensity. "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. "Coding intensity" refers to the tendency for more diagnosis codes to be recorded for MA enrollees, which causes risk scores—and payments—for the same beneficiaries to be higher when they are enrolled in MA than they would be in FFS. Both favorable selection and coding intensity lead to pricing errors that cause CMS's risk-adjustment system to set the payment rate too high for a given MA enrollee.

Favorable selection may stem from a variety of factors, including beneficiary propensities for using care for reasons unrelated to their health, differences in health status that are not accounted for by risk scores, or provider practice styles, among other reasons. Similarly, MA coding intensity is driven by several

factors, including MA plans' documenting diagnoses more comprehensively than providers in FFS Medicare, submitting fraudulent diagnostic data, and other reasons. Separately identifying all of these different factors is challenging and in many cases is not possible given available data. However, regardless of the causes, favorable selection of enrollees in MA and higher MA coding intensity increase Medicare's payments to plans. Higher payments to MA plans fund more generous benefits, but those higher payments increase Medicare spending and create an imbalance, and policymakers must weigh the added cost with the unmeasured value of the added benefits. Past experience with reductions in MA payments has demonstrated that plans can adjust their bidding behavior and lessen effects on plan participation and beneficiary enrollment while achieving program savings.

The Commission contends that important reforms are needed to improve Medicare's policies of paying and overseeing MA plans. First, reforms are needed to reduce the level of Medicare payments to MA plans. Relatively higher levels of payment stem largely from coding intensity and favorable selection. Second, the program that is used to reward plans for better quality is administratively burdensome, adds significantly to program costs, and does not meaningfully improve quality. Relatedly, beneficiaries lack meaningful quality information when choosing among MA plans. Third, MA benchmarks generate a number of inequities, including "cliff" effects from dividing counties into quartiles, caps on benchmarks, and benchmarks that are skewed by the inclusion of FFS-spending data for beneficiaries with only Part A coverage. Fourth, Medicare must address the challenges, burdens, and care disruptions for beneficiaries that stem from the process of choosing between plans and from changes to provider networks. Finally, the Commission finds that plan-submitted data about beneficiaries' health care encounters are incomplete, and we lack information about the use of many MA supplemental benefits. Without these data, policymakers cannot fully understand enrollees' use of services, which limits policymakers' ability to oversee the program and assess the value that enrollees get from supplemental benefits.

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, because of Medicare's fiscal situation, the growth in subsidization of supplemental benefits should be considered with attention to their value.

In the Commission's view, current policy does not allow policymakers to understand and assess how beneficiaries are using or valuing those benefits.

Medicare payments to plans—In 2025, Medicare's payments to MA plans will total a projected \$538 billion (about \$507 billion excluding projected payments for enrollees with end-stage renal disease). As noted above, we project that Medicare's payments to MA plans in 2025 (including rebates that finance supplemental benefits) will be \$84 billion more, or about 20 percent higher, than if MA enrollees were enrolled 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.

Favorable selection—When setting MA benchmarks, CMS implicitly assumes that if MA enrollees were in FFS, their average Medicare spending would be equal to that of current FFS enrollees in the same county after adjusting for differences in risk scores. Favorable selection into MA causes risk scores to systematically 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 cannot be attributed to any plan activity (such as utilization management or coding practices). Favorable selection can pertain to health status (relative to the risk-based payments that MA plans receive) but can also pertain to factors such as beneficiary propensities for seeking care for reasons that are unrelated to their health.

We estimate that favorable selection increased MA payments in 2022 by roughly 10 percent above what the program would have paid under FFS Medicare. We project that in 2025, favorable selection will increase MA payments by roughly 11 percent above what the program would have paid under FFS Medicare, or \$44 billion of the \$84 billion in higher total payments to MA plans. We found relatively little variation in favorable selection by MA market penetration; that is, we estimate that favorable selection persists as the share of MA enrollees in a market increases. In addition, there were larger favorable-selection effects on MA enrollees with higher risk scores, implying that selection persists even as beneficiaries with more chronic conditions

enroll in MA. These two findings highlight the fact that selection can grow even when sicker beneficiaries join MA because selection is driven by the tendency for risk scores to overpredict what FFS spending would have been for MA enrollees, not the average risk. In other words, Medicare's payments to MA plans can be too high even for enrollees with expensive health conditions. In fact, beneficiaries with higher risk scores can exhibit greater selection because there is more potential for overprediction.

The Commission's estimates of favorable selection are reasonably robust and in line with a growing body of research that also estimates substantial effects from favorable selection on Medicare payments to MA plans.

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. Indeed, research has shown that diagnoses are reported inconsistently from year to year even for FFS beneficiaries with chronic conditions such as kidney failure or paraplegia. Instead, FFS providers may be more likely to focus on diagnoses that are a primary reason for a visit. 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. 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). In addition, 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 that is due to lower coding incentives in FFS Medicare, variation in diagnostic discretion, fraud, 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. In response to a congressional request, we include in this chapter an analysis of the differences in incentives between FFS Medicare and MA plans to document

diagnoses, as well as estimated rates of documenting chronic conditions in subsequent years in MA and FFS Medicare.

We estimate that in 2023, MA risk scores were about 17 percent higher than scores for similar FFS beneficiaries due to higher coding intensity. (Last year, the Commission adopted a new method of estimating the effects of coding intensity; see Chapter 13 of our March 2024 report and Technical Appendix 11-B (p. 388) for more information on our method of estimating coding intensity.) We project that in 2025, MA risk scores will be about 16 percent higher than scores for similar FFS beneficiaries after 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 2025, the adjustment will reduce MA risk scores by the minimum amount, 5.9 percent, resulting in MA risk scores that will remain about 10 percent higher than they would have been if MA enrollees were in FFS Medicare. Those higher scores will result in a projected \$40 billion of the \$84 billion in higher total payments to MA plans.

We continue to find that coding intensity varies significantly across MA plans: 15 percent of MA enrollees are in plans that have coding intensity that falls below the 5.9 percent reduction (and even below FFS levels), and other plans code far above that amount, including 16 MA organizations with average coding intensity that is more than 20 percent higher than FFS levels. Among the 10 largest MA organizations, we estimate a 26 percentage point variation in average coding intensity. Higher coding intensity allows some plans to offer more supplemental 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 address any residual impact of coding intensity. In analysis of risk scores for 2020 through 2023, 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 our recommendation, along with the exclusion of chart reviews from risk adjustment, would reduce the heterogeneity in observed coding intensity across MA organizations.

Quality in MA—The MA quality-bonus program increases MA payments by about \$15 billion annually. In 2025, 69 percent of MA enrollees are in a plan that received a quality-bonus increase to its benchmark. At the same time, beneficiaries in MA and FFS report similar satisfaction with their coverage. Enrollees in both MA and FFS tend to rate their coverage and access to care highly—a trend that has held over time. For example, scores for all measures on the MA and FFS Consumer Assessment of Healthcare Providers and Systems surveys, except annual flu vaccine, were above 80 percent from 2018 to 2023. ■

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. 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 has fewer incentives to coordinate care and is limited in its ability to make care delivery more efficient.¹

The Commission strongly supports including 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 FFS Medicare, while others may prefer features of MA, like reduced premiums and cost-sharing liability. MA plans are required by statute to offer an out-of-pocket spending limit that is not included in FFS Medicare. MA plans also can offer integrated Part D benefits, provide supplemental benefits not covered by Part A or Part B of Medicare, and reduce cost-sharing liability and premiums. For 2025, we estimate that conventional MA plans (those available to all MA enrollees) will receive an average rebate from CMS of \$2,255 per enrollee (or \$2,075 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 amount will be allocated to reducing beneficiaries' cost sharing or Part B and Part D premiums. In exchange for these benefits, MA plan enrollees accept provider networks and utilization-management tools such as higher cost sharing to access providers who are not in their plan's network. Because private plans and FFS Medicare have structural aspects that appeal to different segments of the Medicare population, the Commission supports payment policies that do not unduly favor MA or FFS.

The Commission has expressed concern about the FFS benefit design and has recommended changes to give beneficiaries better protection against high out-of-pocket (OOP) spending and to create incentives for them to make better decisions about their use of

discretionary care. Protecting beneficiaries against high OOP spending would enhance the overall value of the FFS benefit and mitigate the need for beneficiaries to purchase supplemental insurance (Medicare Payment Advisory Commission 2012a). The Commission's recommendation also creates clearer incentives for beneficiaries to make better decisions about their use of care through adjustments and refinements in cost sharing based on evidence of service value while holding the aggregate beneficiary cost-sharing liability about the same as under current law. Finally, our recommendation would add a charge on supplemental insurance (such as Medigap) to recoup at least some of the additional costs resulting from the higher service use that supplemental insurance imposes on the Medicare program while still providing beneficiaries the choice to buy supplemental coverage if they wish to do so.

Each year, as required by law, 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, plan generosity (including enhanced financial protections and supplemental benefits), 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, favorable selection of enrollees into MA, the structure of the MA market, and the current state of quality reporting 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.² 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:

- **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.
- **Regional PPOs**—These plans must 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. For instance, regional PPOs may meet Medicare access requirements by arranging for enrollees to obtain plan-covered services through noncontracted providers at in-network cost-sharing levels for enrollees.

Two additional plan classifications cut across plan types: special-needs plans (SNPs) and employer group plans. SNPs offer benefit packages tailored to specific populations (that is, 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 and are not available to all Medicare beneficiaries, so they are not included in our analysis of bids or plan availability.

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 decreasing a plan's payment rate for beneficiaries who are likely to have lower medical expenses. The general purpose of risk adjustment is to accurately predict costs on average for a group of beneficiaries with similar attributes that affect health care costs, thereby reducing incentives for plans to avoid beneficiaries with certain unprofitable attributes and to attract those with profitable attributes.

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 its costs of providing the Part A and Part B benefit package for a beneficiary of average spending. The benchmark

is the maximum amount of Medicare payment set by law for an MA plan to provide Part A and Part B benefits.⁴ (Medicare also pays many plans for providing the Part D drug benefit, but those payments are determined through the Part D bidding process and are not discussed here.) 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).

For 2025, almost 100 percent of plans bid below their benchmarks. For these plans, the base rate is the plan's bid plus a "rebate" equal to 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).⁵ 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).

The rebate that plans receive must be used to provide supplemental benefits to enrollees in the form of lower cost sharing, lower premiums, or coverage of non-Medicare services (benefits not covered by Part A or Part B). 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's 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 supplemental benefits, and high-FFS-spending counties have benchmarks lower than FFS spending with the goal of generating Medicare savings because MA plans have greater

opportunity to produce spending efficiencies in these areas. 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 2024 to the 107.5 percent quartile in 2025 would have a blended rate of 103.75 percent in 2025.

By statute, plans that are 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 has repeatedly recommended that an MA quality-incentive program be budget neutral (that is, financed with a share of plan payments) and focused on measures tied to clinical outcomes and patient experience (Medicare Payment Advisory Commission 2020a, Medicare Payment Advisory Commission 2019, Medicare Payment Advisory Commission 2012b, Medicare Payment Advisory Commission 2004).

How Medicare calculates risk scores

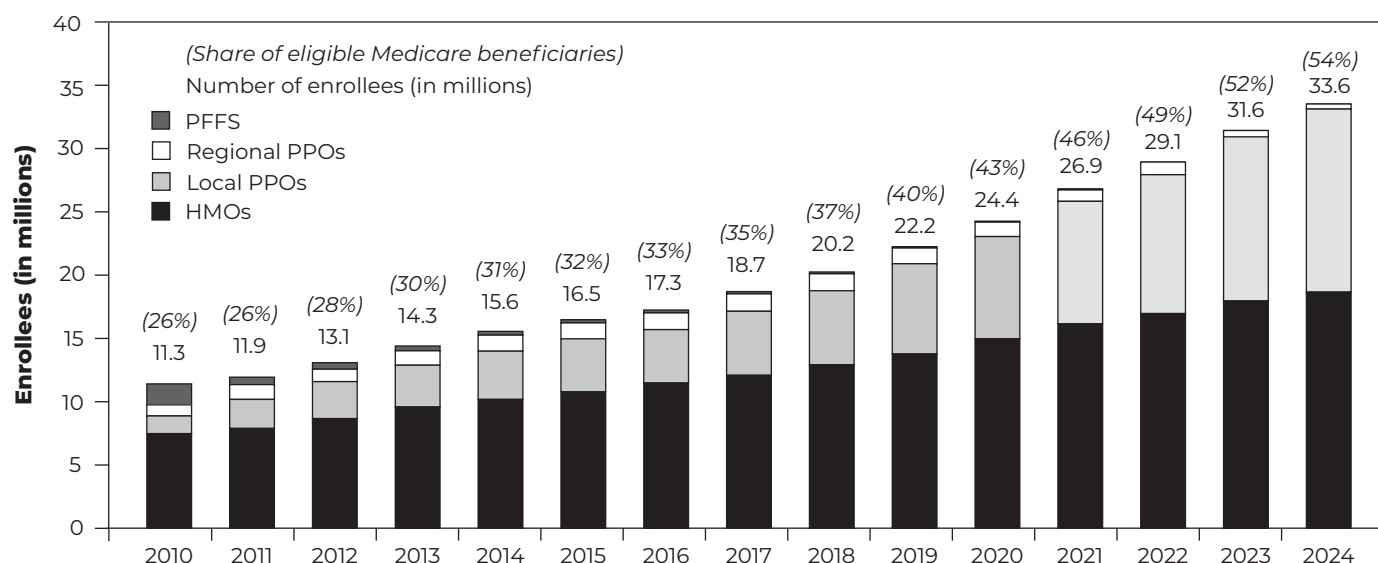
Risk scores are beneficiary-level index values that indicate the expected Medicare costs for an enrollee relative to the national average FFS beneficiary. How well Medicare's payments to MA plans match their enrollees' costliness depends in large part on how well the risk scores predict the expected 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 four HCCs for chronic kidney disease listed here in order of highest severity: Stage 5, Stage 4, Stage 3B, and Stage 3 (except Stage 3B). 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 applicable to that beneficiary.

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 year are used to predict Medicare costs for the following 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 "sufficiently clinically specific to minimize opportunities for gaming or discretionary coding" (Pope et al. 2004). CMS has two requirements aimed at ensuring 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 verify 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

**FIGURE
11-1****Share of eligible Medicare beneficiaries enrolled in Medicare Advantage has more than doubled since 2010**

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 to July 2024.

diagnoses (Schulte and Hacker 2022).¹¹ For example, 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). (See text box for update on RADV audits, pp. 364–365.)

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 relative to the 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 do drive differences between actual spending for MA enrollees and the expected spending based on MA risk scores. Some of these factors are reflected in our estimates of the effects of favorable selection into MA and of higher diagnostic-coding intensity in MA.

Robust MA enrollment, plan availability, and rebates

Substantial growth in MA-plan enrollment, availability, and rebates indicates a robust MA program. As of 2024, more than half of eligible Medicare beneficiaries were enrolled in MA plans. For 2025, the average beneficiary has access to 42 plans sponsored by eight organizations. Rebates that finance supplemental benefits are at nearly record-high levels.

**TABLE
11-1**

Enrollment growth in local PPOs continued to outpace growth in other plan types in 2024

	MA enrollment (in millions)		Percent change in enrollment (2023–2024)
	July 2023	July 2024	
Total MA-eligible beneficiaries	60.4	61.7	2%
Total MA enrollment	31.6	33.6	6
Plan type			
HMO	18.1	18.7	3
Local PPO	12.9	14.5	12
Regional PPO	0.5	0.4	–27
PFFS	<0.05	<0.05	–8
Restricted-availability plans included in totals above			
SNPs*	6.1	6.9	13
Employer group*	5.5	5.8	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. We present them separately to provide a more complete picture of the MA program.

Source: MedPAC analysis of CMS enrollment files.

In 2024, 6 percent growth in MA plan enrollment; 54 percent of eligible Medicare beneficiaries enrolled in MA plans

Between July 2023 and July 2024, enrollment in MA plans grew by 6 percent—or 2 million enrollees—to 33.6 million enrollees, while the total MA-eligible population (beneficiaries with both Part A and Part B coverage) grew only 2 percent. Between 2023 and 2024, MA enrollment rose from 52 percent to 54 percent of eligible Medicare beneficiaries (Figure 11-1). The share of eligible Medicare beneficiaries enrolled in MA has more than doubled since 2010. MA has become increasingly attractive to beneficiaries because plans provide cost-sharing reductions, non-Medicare benefits, and a cap on out-of-pocket expenses at little or no premium. Many beneficiaries with care needs that are met within plan networks and coverage policies will likely have lower total financial

liability (premiums and cost sharing) compared with beneficiaries who stay in FFS and purchase the most comprehensive supplemental coverage (Ippolito et al. 2024). 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 Medigap premiums) (Keohane et al. 2015).¹²

Among plan types, recent growth in MA enrollment has been disproportionately higher among local PPOs. Although HMOs continued to enroll the most beneficiaries (19 million) in 2024, enrollment in local PPOs grew faster (12 percent) than in HMOs (3 percent) (Table 11-1). Between 2023 and 2024, enrollment in local PPOs grew by 1.6 million, accounting for more than three-quarters of the overall increase in MA enrollment. Local PPOs may appeal to beneficiaries

because they provide a greater degree of coverage for services received outside of a plan's provider network (relative to the lack of out-of-network coverage provided under HMOs). (Enrollees in PPOs pay higher cost sharing for services received out of network than for services received in network.)

Increased SNP enrollment accounted for nearly 40 percent of all MA enrollment growth between 2023 and 2024. In 2024, SNP enrollment grew by 13 percent—a continuation of the rapid growth (above 10 percent per year) observed over the last five 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 11 percent (data not shown). Local PPO SNPs have proliferated since 2018, rising from 4 percent of SNP enrollment to 19 percent in 2024. Altogether, in 2024, Medicare beneficiaries who were eligible to enroll in SNPs were predominantly enrolled in HMOs, while enrollment of beneficiaries who did not qualify for a SNP was more evenly distributed between HMOs and PPOs.

Enrollment patterns differ in urban and rural areas. In 2024, the majority (56 percent) of eligible urban beneficiaries were enrolled in MA compared with 47 percent of eligible beneficiaries residing in rural counties.¹³ However, the growth of MA enrollment in rural areas has been faster in recent years. In 2024, MA enrollment in rural areas grew by 8 percent (compared with 6 percent growth in urban areas). The predominant plan type often differs between urban and rural areas as well. In 2024, 39 percent of rural MA enrollees were in HMO plans compared with about 59 percent of urban enrollees. By contrast, 58 percent of rural enrollees were in local PPOs compared with 40 percent of urban enrollees.

Geographic variation in the growth of MA has resulted in some areas having a very high share of eligible Medicare beneficiaries enrolled in MA and other areas having a relatively low share. In some states (including Iowa, Kansas, Maryland, Massachusetts, and Nebraska), less than 40 percent of eligible Medicare beneficiaries are enrolled in MA; however, a relatively small share of the MA-eligible population (less than 10 percent) lives in such states. In contrast, in 30 states (including California, New York, Ohio, Pennsylvania, and Texas) and Puerto Rico, home to more than three-quarters of

eligible Medicare beneficiaries, more than half of the eligible population was enrolled in an MA plan in 2024. In 10 of these 30 states (including Alabama, Florida, Georgia, Louisiana, and Michigan), encompassing roughly 20 percent of eligible beneficiaries, the share enrolled in MA exceeded 60 percent. MA enrollment is particularly high in some metropolitan areas (e.g., El Paso, TX; Grand Rapids, MI; Greensboro, NC; Miami, FL; Pittsburgh, PA; Rochester, NY) and in Puerto Rico, where more than 75 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, more than half of eligible Medicare beneficiaries are enrolled in MA plans.

Availability of MA plans remains high in 2025

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 2025, with most Medicare beneficiaries having access to many plans. Measures of availability were similar relative to 2024. While almost all beneficiaries have had access to some type of MA plan since 2006, local HMOs and PPOs have become more widely available in recent years (Table 11-2). In 2025, nearly 100 percent of Medicare beneficiaries have an HMO or local PPO plan operating in their county of residence, unchanged from 2024.¹⁴

The availability of SNPs continues to be high across the types of special-needs populations served (Table 11-2). In 2025, 95 percent of beneficiaries reside in areas where SNPs serve beneficiaries who are dually eligible for Medicare and Medicaid (unchanged from 2024), 85 percent live where SNPs serve beneficiaries with chronic conditions (up from 72 percent in 2024), and 80 percent live where SNPs serve institutionalized beneficiaries (up from 78 percent in 2024). Overall, 99 percent of beneficiaries reside in counties served by at least one type of SNP (data not shown). 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 institutional SNP, a beneficiary would typically reside in a skilled nursing facility that has a relationship with the plan.

**TABLE
11-2****Access to Medicare Advantage plans remains high**

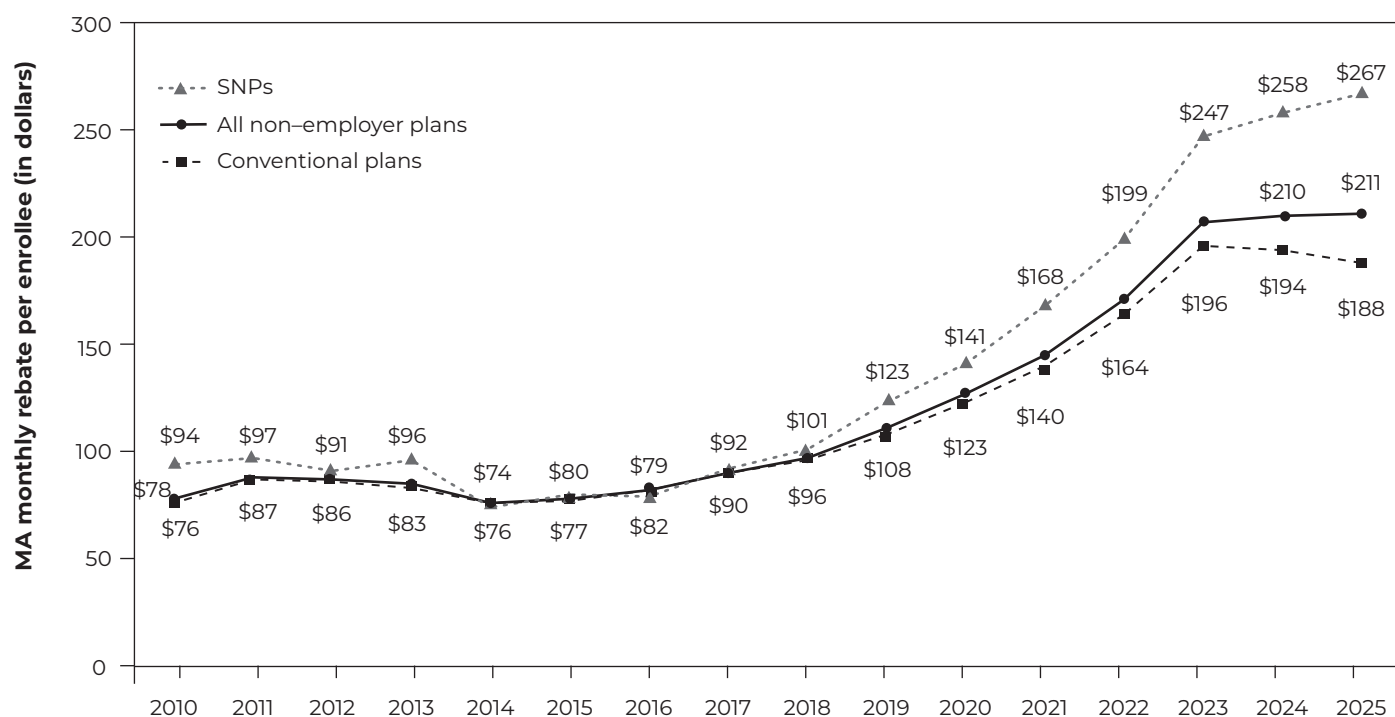
Type of plan	Share of Medicare beneficiaries with access to at least one MA plan				
	2021	2022	2023	2024	2025
Any MA plan	99%	99%	>99.5%	>99.5%	>99.5%
Local CCP	98	99	99	>99.5	>99.5
Regional PPO	72	74	74	74	68
PFFS	34	35	29	30	29
Special-needs plans					
Dual eligible	92	94	94	95	95
Chronic condition	57	59	66	72	85
Institutional	72	74	77	78	80
Zero-premium plan with drug coverage	96	98	99	99	99
Average number of choices					
County weighted	18	22	26	28	28
Beneficiary weighted	32	36	41	43	42
Average number of insurers					
County weighted	4	5	5	6	6
Beneficiary weighted	7	8	8	8	8

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. This table's figures exclude employer-only plans and Medicare Medical Savings Account plans. Special-needs plans are included in the three rows of special-needs plans but excluded from all other rows. For 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 2025, the share of Medicare beneficiaries includes only beneficiaries with both Part A and Part B coverage (i.e., 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.

In 2025, nearly 100 percent of eligible Medicare beneficiaries (unchanged from 2024) have access to at least one "zero-premium" plan with drug coverage—that is, a conventional (open to all MA-eligible beneficiaries) MA plan that includes Part D drug coverage and charges no Part C or Part D premium (enrollees may pay the Medicare Part B premium) (Table 11-2).¹⁵ About 76 percent of MA enrollment is projected to be in these zero-premium plans (data not shown). Also in 2025, 99 percent of beneficiaries (unchanged from 2024) have access to at least one plan

that offers some reduction in the Part B premium (data not shown); about 32 percent of 2025 conventional MA enrollment is projected to be in these premium-reduction plans (a substantial increase from 12 percent in 2024); and the average monthly premium reduction is \$44 for enrollees in one of these plans (data not shown). As plans have increasingly offered Part B–premium reductions, MA enrollees may become increasingly attracted to the direct assistance these benefits provide.

**FIGURE
11-2****MA rebates for conventional plans and SNPs have more than doubled since 2017**

Note: MA (Medicare Advantage), SNP (special-needs plan). Employer group 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 supplemental 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. Data for 2010 to 2020 differ slightly (by less than \$2, on average) from the amounts we reported in previous years, which did not account for plans' adjustments for beneficiaries with Medicare as a secondary payer.

Source: MedPAC analysis of data from CMS on plan bids.

In most counties, beneficiaries have access to many MA plans. In 2025, the average number of plans available in a county is 28 plans (unchanged from 2024) (Table 11-2, p. 333). 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 2025 has 42 available plans, similar to 43 plans in 2024. An additional measure of plan access is the number of insurers offering products to the average beneficiary. In 2025, the average beneficiary can choose from plans sponsored by eight organizations (unchanged from 2024); 97 percent of beneficiaries have access to MA plans sponsored by at least three organizations, 95 percent of beneficiaries can choose from plans sponsored by at least four organizations,

and 90 percent of beneficiaries can choose from plans sponsored by at least five organizations (data not shown). Given the large number of plan choices, the Commission has expressed concern that beneficiaries may find it difficult to discern differences in plan benefit packages in order to make an optimal choice (Medicare Payment Advisory Commission 2023a).

MA rebates, which plans use to provide supplemental benefits to enrollees, remain at nearly record levels in 2025

Rebates to MA plans continue to be at nearly record levels in 2025. Plans must use those rebates to provide supplemental benefits—such as lower cost sharing, lower premiums, or benefits not covered by Part A

**TABLE
11-3****Conventional MA plans project that rebates will be used to reduce cost sharing, to cover Part B and Part D premiums, and to offer non-Medicare benefits in 2025**

	Rebate (per member per month)		2025 percent change	Share of total rebate	
	2024	2025		2024	2025
Total	\$194	\$188	-3%	100%	100%
Supplemental benefit type					
Cost sharing	75	80	6	39	43
Non-Medicare supplemental	53	53	1	27	28
Part D supplemental	34	29	-16	18	15
Part D premium	24	15	-39	13	8
Part B premium	7	11	50	4	6

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 cap on beneficiaries' out-of-pocket expenses. 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. Components may not sum to totals due to rounding.

Source: MedPAC analysis of data from CMS on plan bids.

or Part B (such as vision, hearing, dental, and fitness benefits). Plans also use some of the rebate to cover their administrative costs and as profit.

Rebates for non-employer plans reached a nominal record high of \$210 per enrollee per month in 2025—a slight increase from \$209 per enrollee per month in 2024.¹⁶ These rebates account for 17 percent of plan payments, unchanged from 2024. Rebates for conventional MA plans—excluding employer plans and SNPs—average \$188 per enrollee per month (\$2,255 annually per enrollee; \$2,075 after subtracting plan projections for administrative costs and profit), a decrease from the record high \$196 per enrollee per month in 2023 (Figure 11-2). While modestly declining since 2023, the average MA rebate among conventional plans remains nearly twice as high as it was in 2018. For SNPs, the average rebate is significantly higher—\$267 per member per month in 2025—and has continued to increase in recent years. Since 2019, the monthly average rebate for SNPs has increasingly outpaced the rebates for conventional plans. These higher rebates

have coincided with higher enrollment growth in SNPs and greater coding intensity for MA enrollees who are eligible for Medicaid (many of whom are enrolled in SNPs) relative to other MA enrollees. We will continue working to understand why rebates are increasingly diverging between SNPs and conventional plans.

We assess plans' use of rebates based on projected rebate allocations included in plans' bids, but we do not have reliable information about enrollees' actual use of supplemental benefits. In 2025, the share of plan rebates allocated toward cost-sharing reductions is projected to increase relative to 2024 levels (Table 11-3). Plans project that \$80 per enrollee per month in rebates (43 percent of rebate dollars, an increase from 39 percent in 2024) will go toward reducing cost sharing for Medicare services, 6 percent more relative to 2024. Plans allocate a portion of those dollars toward their projected administrative costs and profit of providing cost-sharing reductions.¹⁷ In addition, the projected rebates allocated to cost-sharing reductions include coverage for the beneficiary maximum out-of-

pocket (MOOP) cap on plan-approved Part A and Part B expenses. In 2025, plans project that, on average, their liability for the MOOP limit will be \$14 per enrollee per month—equivalent to 7 percent of rebates (unchanged from 2024; data not shown) and 1 percent of projected plan payments (unchanged from 2024; data not shown).^{18,19} Cost-sharing reductions lower a beneficiary's out-of-pocket expenses and reduce the likelihood that a beneficiary will reach their MOOP limit. All cost-sharing reductions, including the MOOP limit, are subject to plan coverage policies. In addition, for beneficiaries who switch MA insurers midyear during a special enrollment period, their MOOP limit does not include the OOP expenses accumulated earlier in the year from their previous plan.²⁰

In 2025, plans project that 28 percent of rebates (averaging \$53 per enrollee per month) will be used for non-Medicare-covered supplemental benefits. Plans allocate a portion of those dollars toward their projected administrative costs and profit of providing non-Medicare supplemental benefits.²¹ Coverage for vision, hearing, and dental services are some of the most common types of supplemental benefits.²² These benefits address health challenges that many seniors face as they age and for which there is limited coverage under FFS Medicare. In 2025, nearly all MA enrollees (in both non-SNPs and SNPs) are in plans that offer some coverage of dental, vision, or hearing services (Freed et al. 2024). Plans may also offer nonmedical supplemental benefits such as nonemergency transportation services, assistance paying for over-the-counter items, meals, and gym memberships. The share of plans offering these types of benefits—and the share of enrollees in such plans—has risen as MA rebates have increased.

Other uses of rebate dollars in 2025 are for Part D supplemental benefits (15 percent of projected rebates), reductions in Part D premiums (8 percent of projected rebates), and reductions in Part B premiums (6 percent of projected rebates) (Table 11-3, p. 335). MA plans cannot allocate administrative expenses or profit to Part B–premium reductions, but administrative expenses and profit for Part D–premium reductions and Part D supplemental benefits may be included in plans' Part D bids.²³ Since 2022, plans have allocated an increasing share of rebates toward reductions in Part B premiums and a decreasing share of rebates toward reductions in Part D premiums (data not shown).²⁴

As Medicare spending on MA rebates grows, it is increasingly important for policymakers to understand how plans use rebates and the extent to which enrollees use the supplemental benefits that rebates fund. Based on bid data, we know how much Medicare pays to plans in the form of rebates, but little else. Although plans are required to submit encounter data for supplemental benefits, the limited data that plans have reported have been found to be unreliable.²⁵ Altogether, the data that Medicare collects are insufficient for examining the use of supplemental benefits, making it impossible to know how much plans spend on each type of benefit, which enrollees use each benefit (and how frequently), or whether service use differs by such factors as age, sex, race, disability status, and geographic area. Without this information, it is difficult to assess the impact of these benefits on enrollees' health and to determine whether Medicare's spending on these benefits is in line with the value they provide or the cost of providing them (Government Accountability Office 2023).²⁶

Higher payments to MA plans stem from favorable selection and coding intensity

The Commission estimates that MA payments (including rebates that finance supplemental benefits) substantially exceed what would have been spent on those beneficiaries had they been in FFS, continuing the trend of higher levels of payment throughout the history of Medicare's payment policy for managed care. Before applying any adjustments for favorable selection or coding intensity, we estimate that Medicare payments to MA plans have generally been similar to historical spending for FFS beneficiaries with both Part A and Part B coverage. But the effects of favorable selection (prior to any coding differences) have consistently caused the risk scores of MA enrollees to overpredict what their spending would have been in FFS—increasing MA payments by an estimated 11 percent (\$44 billion) above FFS spending in 2025. In addition, diagnostic coding by MA plans overstates the health differences between MA and FFS enrollees assumed in risk scores—further increasing MA payments by an estimated 10 percent (\$40 billion) above FFS spending in 2025.

In 2025, Medicare's payments to MA plans will total a projected \$538 billion (about \$507 billion after

**TABLE
11-4**

MA payments estimated to be substantially above what FFS spending would have been due to the effects of coding intensity and favorable selection

	Share of FFS spending in 2025		
	Benchmarks	Bids	Payments
Overall estimate	130%*	100%*	120%
Estimated before coding and selection	108*	83*	100
Estimated coding effect	+10	+8	+10
Estimated selection effect	+11	+9	+11

Note: MA (Medicare Advantage), FFS (fee-for-service). The “overall estimate” of benchmarks, bids, and payments as a share of FFS spending incorporates all three components of the Commission’s methodology for comparing payments: a base comparison of MA payments with FFS spending that standardizes for differences in risk scores and geography but does not account for the effects of coding intensity and favorable selection; an adjustment to that base comparison for favorable selection; and an adjustment for coding intensity. The values in the “estimated before coding and selection” row reflect estimates using only the base comparison, without adjusting for the effects of coding intensity and favorable selection. The values in the third and fourth rows are the additive adjustments to the base comparison for the effects of coding and selection. Estimates do not include beneficiaries with end-stage renal disease. More details on our methodology can be found later in this chapter and in the technical appendixes to this chapter. Components may not sum to totals 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.

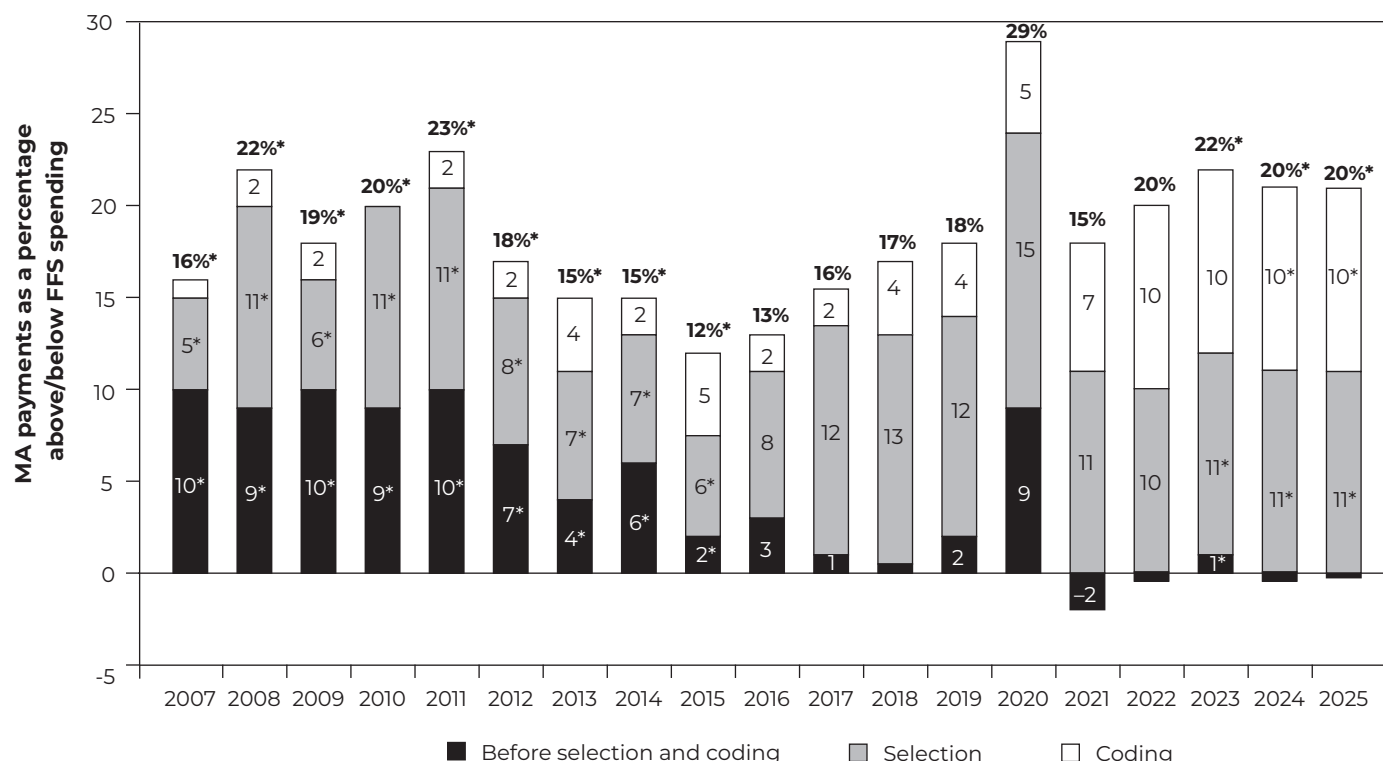
excluding projected payments for enrollees with end-stage renal disease).²⁷ We estimate that, because of differences between MA and FFS in coding intensity and selection, Medicare spends 20 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates into a projected \$84 billion—or 17 percent of total payments to MA plans, excluding end-stage renal disease payments—in 2025.²⁸ The payments above FFS spending correspond with our projections of plan rebates in 2025, which we also estimate to be 20 percent of FFS spending and 17 percent of total payments to plans. These higher payments relative to FFS Medicare vary significantly across MA organizations (as shown by the variation in the effects of coding intensity across MA organizations, among other factors). In addition, these payments above what would have occurred in FFS are not an estimate of plan profits and administrative expenses. Instead, these additional payments are the primary source of funding used to provide more generous supplemental benefits and better financial protection for MA enrollees, which help attract enrollees and increase plans’ total revenues.

We reach this estimate by first projecting actual payments to MA plans in 2025. We project that those payments, on average, will be equal to about 100 percent of CMS’s projections of FFS spending in 2025 (Table 11-4) and that benchmarks and bids will be 108 percent and 83 percent of FFS spending, respectively.

However, to accurately compare MA and FFS spending, we must ensure that the two populations are comparable by accounting for differences in coding intensity and favorable selection. “Coding intensity” refers to the tendency for more diagnosis codes to be recorded for MA enrollees, which causes risk scores for the same beneficiaries to be higher when they are enrolled in MA than they would be in FFS. “Favorable selection” into MA occurs when beneficiaries with lower actual spending relative to their risk scores 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 (including coding intensity). As in prior years, we have made technical refinements to our methods for estimating coding intensity and favorable selection, and these updates are reflected in both projected and historical comparisons of MA payments and FFS spending.²⁹

**FIGURE
11-3**

Higher MA payments relative to what estimated spending would have been in FFS since 2007



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates of MA payments relative to what spending would have been in FFS before selection and coding are less than 0.5 percent for 2018, 2022, 2024, and 2025. Estimates of MA payments related to coding are less than 0.5 percent for 2007 and 2010. We exclude MA payments for beneficiaries with end-stage renal disease. Components may not sum to totals due to rounding. * Specified values were derived from projected data (for 2023 to 2025) or earlier versions of the methodologies for estimating each component (for 2007 to 2015). Values without an asterisk were estimated using historical data and the current and most comprehensive version of the methodology for estimating each component. See text for details.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files.

Accounting for greater coding intensity and favorable selection in MA increases our projections of benchmarks, bids, and plan payments as a share of FFS spending. Indeed, we project that benchmarks in 2025 are 130 percent of FFS spending, indicating that Medicare could spend up to 30 percent more, in aggregate, for beneficiaries enrolled in MA than it would if those same beneficiaries were in FFS Medicare. Actual MA payments are 120 percent of FFS spending because most plans bid below those benchmarks.

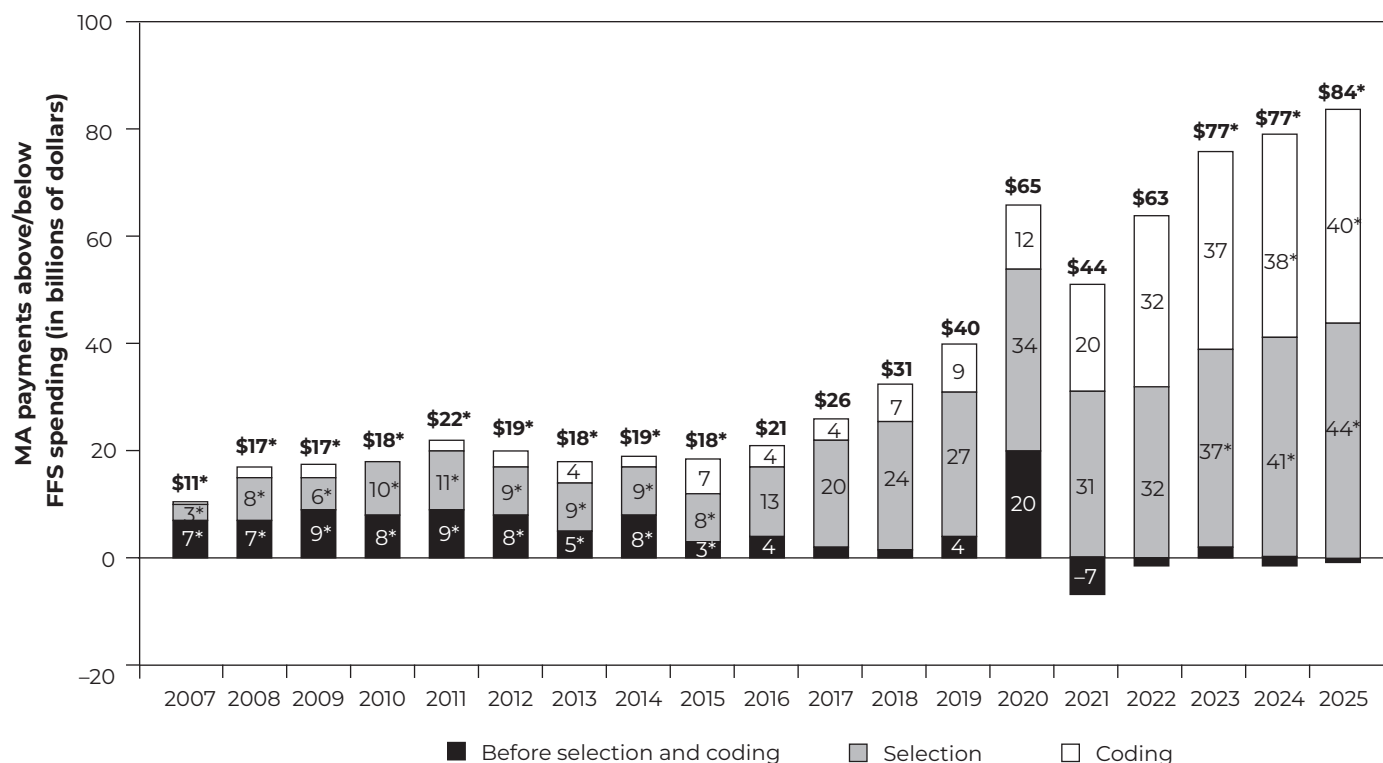
We project that—after accounting for coding intensity and favorable selection—plan bids in 2025 are 100 percent of FFS spending, meaning that under the existing payment system, on average, plans estimate

that their costs to provide the standard Medicare benefit are about the same as FFS Medicare's costs. On average, 13 percent of plans' bids are projected to be nonmedical expenses for administration and profit.

Our review of private-plan payments suggests that over a 40-year history, the many iterations of full-risk contracting with private plans have never yielded aggregate savings for the Medicare program. 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

**FIGURE
11-4**

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 relative to what spending would have been in FFS before selection and coding are less than \$3 billion for 2017, 2018, 2022, 2023, 2024, and 2025. Estimates of MA payments related to coding are less than \$3 billion for 2007, 2008, 2009, 2010, 2011, 2012, and 2014. We exclude MA payments for beneficiaries with end-stage renal disease. Components may not sum to totals due to rounding.

* Specified values were derived from projected data (for 2023 to 2025) or earlier versions of the methodologies for estimating each component (for 2007 to 2015). Values without an asterisk were estimated using historical data and the current and most comprehensive version of the methodology for estimating each component. See text for details.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files.

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).

Figure 11-3 shows that since 2007, payments to MA plans have been substantially above the amount FFS Medicare would have spent for the same beneficiaries, primarily due to the effects of favorable selection and coding intensity. Throughout the 19-year period from 2007 through 2025, we estimate that MA payments were at least 8 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 16 percent above FFS spending. This change is largely explained by declining benchmarks resulting from ACA policies. However, after changes to benchmarks were fully implemented in 2017, MA payments increased relative to FFS spending through 2025—driven by the combined effects of coding intensity and selection.

Figure 11-4 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 (ESRD), which we exclude from all of our analyses and estimate

will account for about 6 percent of MA payments in 2025.³⁰) We estimate that Medicare will pay MA plans a total of \$84 billion more in 2025 than the program would have spent if enrollees had been in FFS Medicare.

Our current methodology for estimating MA payment comparisons has three components. These three components are estimated separately and are then combined in a single calculation of MA spending relative to FFS. First, we estimate a base comparison of MA payments relative to an estimate of FFS spending that is standardized for differences in average risk scores and geography but does not account for the effects of coding intensity and favorable selection. Second, we estimate the effect of favorable selection and use that estimate to adjust the base comparison of MA payments with FFS spending. Third, we estimate the effect of coding intensity and use that estimate to make an additional adjustment to the base comparison. We use historical data to estimate the effect of each of the three components on MA payments for the most recent year for which data are available (2022 for the base-comparison and favorable-selection components, 2023 for coding intensity) and earlier years. We then project what we expect each component to be through 2025 in years for which data are not yet available, to provide the Congress with our best estimate for the current year. Those projections are subject to uncertainty. In future reports, we will provide updated payment comparisons for those years using historical data. More details on the methods used for estimating each of the components can be found later in this chapter and in the technical appendixes to this chapter.

Before accounting for the effects of coding intensity and favorable selection, MA payments are generally similar to what FFS spending would have been

The first component of the Commission's payment comparison involves constructing a base comparison of MA payments with FFS spending for beneficiaries with similar risk scores and counties of residence. We begin with that base comparison because it aligns with how CMS constructs its estimates of risk-standardized FFS spending that are used to set county benchmarks. However, that base comparison does not account for how coding intensity and favorable selection cause CMS's estimates of risk-standardized FFS spending to overpredict costs for the average MA enrollee. Those

effects are incorporated as separate components in the Commission's payment comparisons.

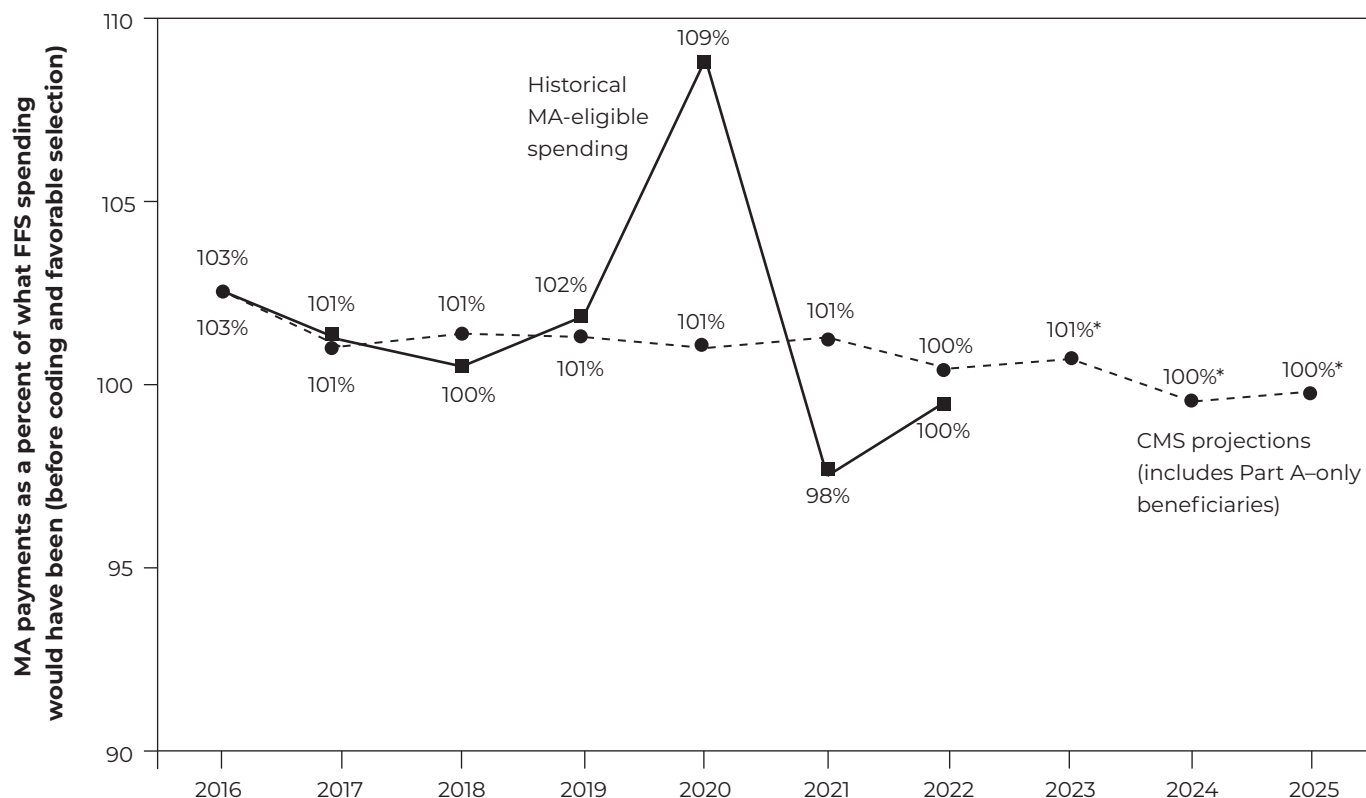
The Commission's estimate that Medicare payments to MA plans in 2025 average 100 percent of projected FFS spending—without any adjustments for coding intensity or favorable selection—reflects several aspects of MA payment policy (Table 11-4, p. 337). First, benchmarks are set above projected FFS spending in some counties and below FFS spending in other counties. Second, benchmarks are increased based on plan quality scores—resulting in quality-bonus payments that are financed with additional program dollars. We estimate that quality bonuses will account for about 3 percent (an estimated \$15 billion) of MA payments in 2025. Combining both of those factors, we project benchmarks to be 108 percent of FFS spending in 2025 before accounting for coding and selection. Third, payments to MA plans are below benchmarks because bids are generally lower than benchmarks, and plans receive a percentage (based on quality score) of the difference between bids and benchmarks in additional payment.

The Commission uses historical data on the actual FFS spending of beneficiaries with both Part A and Part B coverage (that is, people who would be eligible to enroll in MA) to estimate the base payment comparison for the most recent year for which data are available (2022).³¹ Our estimates of the base payment comparison for years in which we do not have historical data (2023 to 2025) rely instead on CMS's projections of FFS spending. Those projections differ from the actual FFS spending of MA-eligible beneficiaries for several reasons, including that the projections include Part A-only enrollees and that CMS's projection of the FFS-spending trend is subject to uncertainty. The method that CMS uses to produce its FFS projections has been criticized because it includes beneficiaries who have Part A but not Part B coverage, while MA enrollees are required to have both Part A and Part B coverage. The Commission has recognized this shortcoming in the CMS methodology and previously recommended that CMS calculate MA benchmarks using FFS-spending data only for beneficiaries with both Part A and Part B coverage (Medicare Payment Advisory Commission 2021a, Medicare Payment Advisory Commission 2017).

Despite the shortcomings in CMS's projections, our analysis of historical data shows that the projections

**FIGURE
11-5**

Part A-only beneficiaries included in CMS's projections had no systematic effect on the Commission's base comparison of MA payments with FFS spending



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates have not been adjusted for MA coding intensity and favorable selection of beneficiaries who choose to enroll in MA plans (i.e., underlying differences in risk-adjusted spending between the MA and FFS populations that are not captured by risk scores and would increase MA payments relative to FFS spending). Relative to prior estimates, estimates using historical data have been corrected to reflect no sequestration adjustment on MA payments from CMS in 2021. Estimates include both claims and nonclaims FFS spending. Estimates of actual MA payments in 2020 include remittances related to plans' medical loss ratios. Relative to estimates originally published from 2016 through 2019, prospective estimates are revised to reflect payments to employer plans and adjustments for MA enrollees with Medicare as a secondary payer. Prospective estimates use the figures for FFS per beneficiary spending that CMS's Office of the Actuary generates to determine the MA benchmarks that plans use when submitting bids. Those FFS-spending figures are calculated by summing (1) risk-adjusted Part A FFS monthly spending for all Part A enrollees and (2) risk-adjusted Part B FFS monthly spending for all Part B enrollees.

* Specified values used projected data.

Source: MedPAC analysis of bid data, Medicare enrollment, Medicare claims spending, and risk-adjustment files.

have not systematically impacted our base comparison of MA spending with FFS payments.³² We estimated the base comparison of MA payments with FFS spending using both CMS's projections and the observed FFS spending of MA-eligible beneficiaries in each year from 2016 to 2022 (Figure 11-5). Both methods produced results that were within 1 percentage point of each other for every year except 2020 and 2021, which were

affected by the coronavirus pandemic. The similarity of the estimates for the two methods indicates that relying on CMS's projections of FFS spending (including adjustments for Medicare as a secondary payer) for estimating differences in MA and FFS spending has not introduced meaningful error in our analysis, and we expect that relying on CMS's projections has a minimal effect on our payment comparisons for 2023 to 2025.³³

We will continue to compare how our estimates differ between using CMS's projections and using historical data. Should a systematic difference between the two emerge, we will consider incorporating an adjustment to our base payment comparison for the years that rely on projected data.

Prior to coding differences, favorable selection causes risk-based payments to overpredict spending for MA enrollees

The second component of the Commission's payment comparison adjusts the base comparison of MA payments relative to FFS spending for favorable selection. When setting MA benchmarks and paying plans for each enrollee, CMS implicitly assumes that if MA enrollees were in FFS Medicare, their average Medicare spending would be equal to that of current FFS enrollees in the same county after adjusting for differences in risk scores. However, applying MA risk scores to FFS spending averages may overpredict the actual spending that MA enrollees would have had in FFS for two reasons: coding intensity and favorable selection. The Commission's estimates of coding intensity are discussed in the next section of this chapter.

"Favorable selection" refers to the tendency for Medicare's risk-adjustment model to—on average—overpredict the spending that the MA-enrolled population would have had if they were enrolled in the FFS program, even for beneficiaries with similar coding intensity. Favorable selection can occur due to unmeasured differences in health status but can also result from factors such as differences in beneficiaries' propensities to seek care for reasons that are unrelated to their health (Medicare Payment Advisory Commission 2024).

Risk models are imperfect, and beneficiaries with the same risk score typically have a wide distribution of actual spending relative to the spending predicted by their risk score (Lieberman et al. 2023). Each year, a mix of beneficiaries enroll in MA who either have lower spending than predicted by their risk score or higher spending than predicted by their risk score. The MA program as a whole will experience favorable selection if the average MA enrollee has less spending than predicted by their risk score (prior to any effects from plans' utilization management and coding efforts).

Because favorable selection occurs when beneficiaries systematically spend less than is predicted by their risk score, higher-risk beneficiaries (including dually eligible beneficiaries) are not necessarily unfavorable to MA plans. Indeed, our estimates show evidence of favorable selection for beneficiaries with both low risk scores and high risk scores.

The effect of favorable selection may vary over time. Our estimates reflect some periods of relatively high favorable selection and some periods with lower favorable selection. Those differences over time reflect a combination of factors, including changes to Medicare's risk-adjustment model and changes in the composition of beneficiaries who choose MA and FFS. If the share of beneficiaries in MA continues to increase, 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, which would tend to increase their preference for care and may increase favorable selection in MA. Our analysis finds that favorable selection persists as the share of MA enrollees in a market increases, which is consistent with another study that found that selection was prevalent in counties with high MA penetration (Lieberman et al. 2023).

The Commission has developed and refined its methodology for estimating the effect of favorable selection over several years (Medicare Payment Advisory Commission 2024, Medicare Payment Advisory Commission 2023a, Medicare Payment Advisory Commission 2012a). We use our current methodology to estimate an aggregate selection percentage for the entire population of MA enrollees—except for those with ESRD, who are paid for under a different model—in each year beginning in 2016. That methodology produces a comprehensive estimate that accounts for favorable selection prior to enrolling in MA, the attrition of unfavorable enrollees out of MA, and the change in selection (including regression to the mean) for beneficiaries who remain enrolled in MA.^{34,35}

A substantial body of research has found evidence of favorable selection in MA and provides support for the Commission's estimates and methodology (Brown et al. 2014, Curto et al. 2021, Curto et al. 2019, Fuglesten Biniek et al. 2024, Goldberg et al. 2017, Government Accountability Office 2021, Jacobs and Kronick 2018, Jacobson et al. 2019, Lieberman et al. 2023, Medicare Payment Advisory Commission 2023a, Medicare Payment Advisory Commission 2012a, Meyers et al. 2019, Newhouse et al. 2015, Rahman et al. 2015, Riley 2012, Ryan et al. 2023, Teigland et al. 2023). The Commission's method uses data from the portion of the MA population who previously switched (i.e., "switchers") to MA from the FFS program to estimate selection for the entire population of MA enrollees, including those who enrolled upon their initial eligibility for Medicare. Analyses of switchers have been used in other studies (Jacobson et al. 2019, Lieberman et al. 2023, Newhouse et al. 2015, Teigland et al. 2023). A recent white paper also estimated favorable selection among MA beneficiaries who enrolled upon their initial eligibility for Medicare and found estimates that were even larger than our estimates for switchers in similar years (Teigland et al. 2023).³⁶ That study provides support for our approach that generalizes estimates based on switchers to the newly eligible population.

We made several technical improvements to our methods this year, including updating certain components to more comprehensively account for mortality differences between the MA and FFS populations. More detail on our methodology for estimating favorable selection can be found in Technical Appendix 11-A (p. 377).

Evidence of favorable selection throughout the period from 2007 to 2022

We estimate that favorable selection of the overall MA population resulted in MA payments that were 10 percent above FFS spending in 2022, a slight decrease from 11 percent above FFS spending in 2021 (Figure 11-6, p. 344). The selection percentage was below 100 percent in every year during the 2016 to 2022 period, indicating that the spending that the FFS program would incur for the MA population would be lower than what would be predicted by their risk score. Between 2017 and 2022, the selection percentage

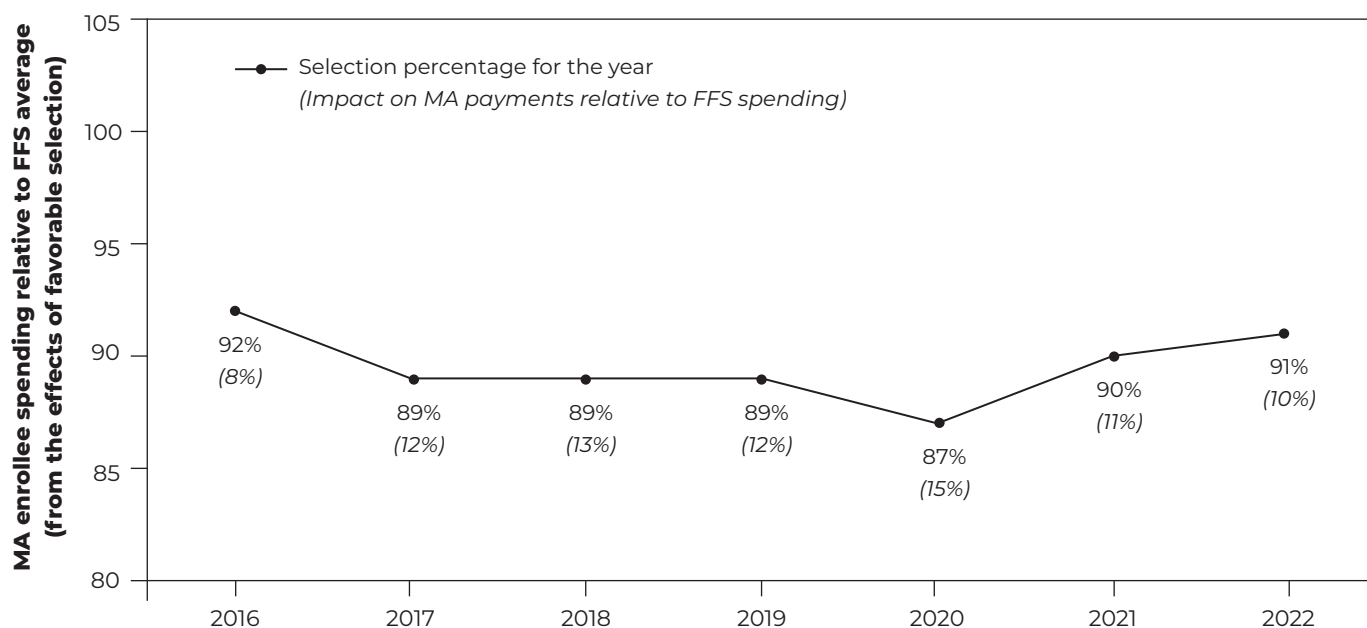
increased from 89 percent to 91 percent. On net, favorable selection persisted throughout the study period even as a larger share of Medicare beneficiaries enrolled in MA, including enrollees who had higher risk scores. The estimates presented in Figure 11-6 use the Commission's comprehensive method. We discuss that method in greater detail in Technical Appendix 11-A accompanying this chapter.

Below, we present several analyses using a simple version of our favorable-selection method that compares the FFS spending of beneficiaries who switched from FFS to MA in the following year ("recent switchers") with the spending of beneficiaries who remained in FFS ("stayers"), standardizing for differences in risk score and county of residence. Using this simple method allows us to estimate favorable selection over a longer period and to examine patterns of favorable selection by beneficiary characteristics to provide more information about factors affecting favorable selection.

Using the simple method, we found evidence of favorable selection among recent switchers into MA during their last year in FFS throughout the period from 2007 to 2022 (Figure 11-7, p. 345). We estimate that the selection percentage ranged from 87 percent to 96 percent during the period. Favorable selection was highest in 2022 (MA enrollee local-area spending was 12.6 percent less than predicted by their risk score, a selection percentage of 87.4).

Beneficiaries with high risk scores before MA entry had the most favorable selection in 2022 We examined whether the level of risk score that beneficiaries had before entering MA influenced the level of favorable selection in 2022. We grouped beneficiaries into categories based on their risk score in the year prior to enrolling in MA.³⁷ The selection percentage of each category was calculated as the sum of FFS spending for future MA enrollees in their respective risk-score category divided by the sum of their predicted spending (adjusted for their county of residence). We found that beneficiaries with higher risk scores prior to MA enrollment had more pre-entry favorable selection (Figure 11-8, p. 346).

In 2022, MA entrants had higher levels of favorable selection as their risk scores increased. In other words,

**FIGURE
11-6****Evidence of substantial favorable selection annually from 2016 to 2022**

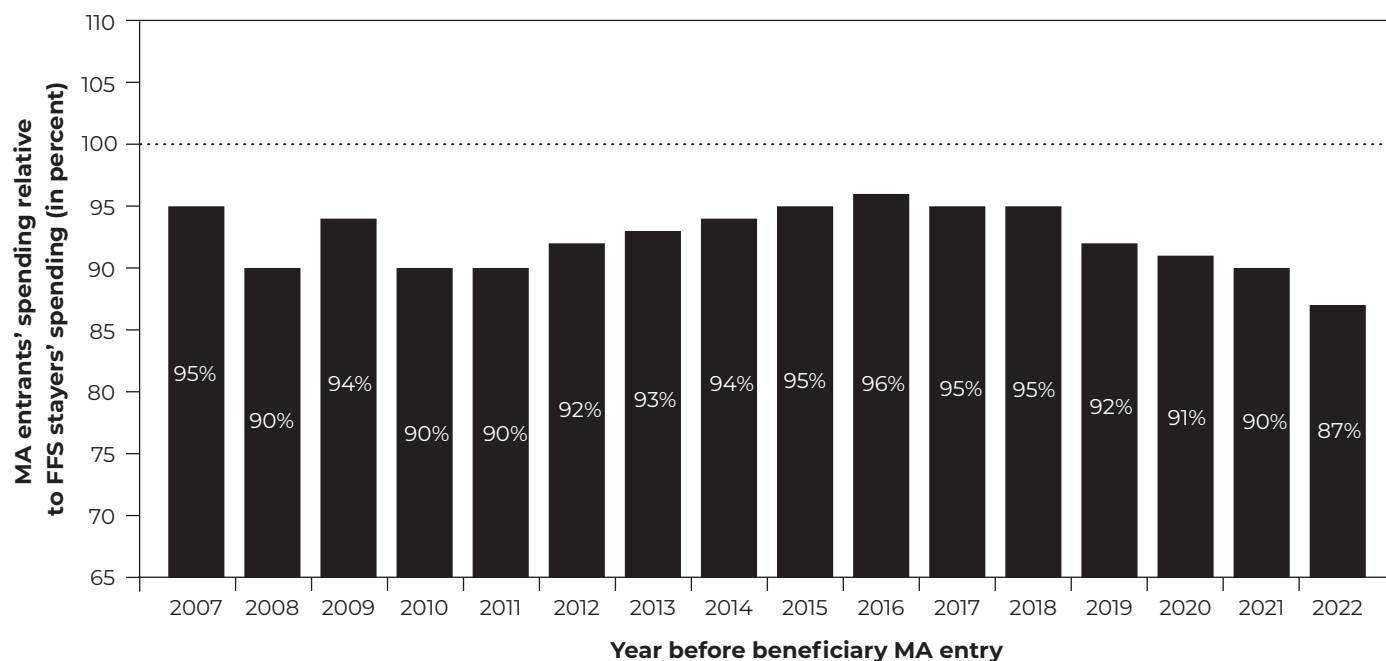
Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates were constructed using the Commission's comprehensive method for estimating favorable selection. Selection percentages are computed as the ratio of the estimated spending that the FFS program would have incurred for MA enrollees relative to the spending predicted by their county benchmark and Medicare's risk-adjustment model. Selection percentage values further below 100 percent indicate greater favorable selection. Estimates are rounded to the nearest percent.

Source: MedPAC analysis of Medicare enrollment (2006–2022), Medicare claims spending (2007–2022), and risk-adjustment files (2007–2022).

Medicare's payments to MA plans can be too high even for enrollees with expensive health conditions. For example, beneficiaries in the three highest categories of risk scores had the lowest selection percentages (85 percent and below, meaning the highest levels of favorable selection). This finding indicates that those categories (corresponding to beneficiaries with high severity of chronic illness) all had the highest levels of pre-entry favorable selection. In contrast, beneficiaries in the three lowest categories of risk scores before entering MA had the highest selection percentages (98 percent and above), suggesting that beneficiaries with low severity of chronic illness tended to be unfavorable in 2022.

These findings indicate that favorable selection can occur even among those beneficiaries with high

risk scores. In fact, we estimate that in 2022, MA enrollees with high risk scores tended to be the most favorable to MA plans. Several factors could account for favorable selection among future MA entrants with high risk scores. One potential factor is the race and ethnicity of those beneficiaries. Black and Hispanic beneficiaries may have high risk scores due to their incidence of chronic illness and rates of dual enrollment in Medicare and Medicaid. One recent study found that the CMS-HCC model overpredicted the risk-standardized spending for Black and Hispanic beneficiaries, on average, suggesting that these groups have below-average service use relative to their risk scores (McWilliams et al. 2023). That suggests that as MA plans enroll a higher share of Black and Hispanic beneficiaries, the average risk-standardized spending of their enrollees may become more favorable.

**FIGURE
11-7****Beneficiary FFS spending in the year before MA enrollment
indicates favorable selection for recent entrants from 2007 to 2022**

Note: FFS (fee-for-service), MA (Medicare Advantage). Estimates were constructed using the Commission's simple method for estimating favorable selection. "MA entrants" are beneficiaries who switched from FFS to MA in the following year. "FFS stayers" are beneficiaries who remained in FFS in the following year. "Spending" reflects the year prior to MA entry and is risk standardized. Values further below 100 percent indicate greater 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 (2006–2023), Medicare claims spending (2007–2022), and risk-adjustment files (2007–2022).

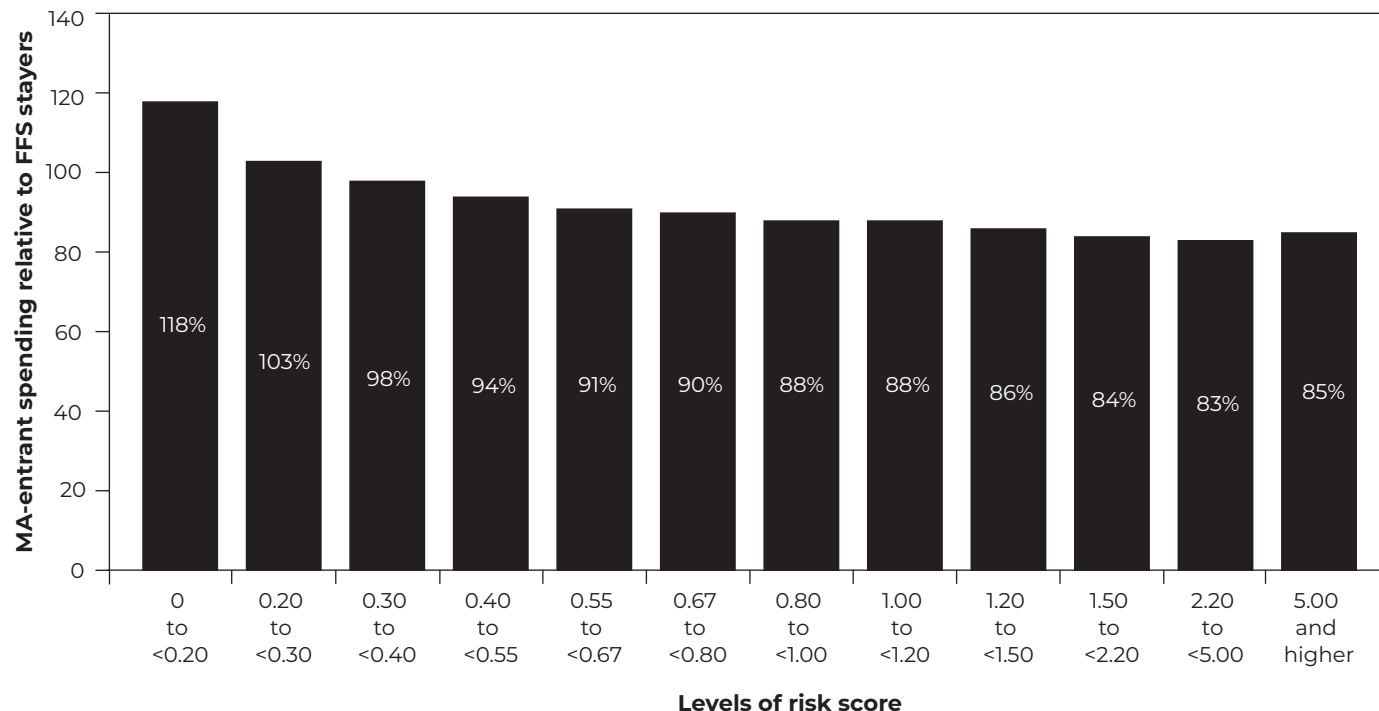
Similarly, as MA plans enroll populations with higher levels of chronic illness, the level of favorable selection may increase rather than decrease. We did not adjust our analyses of favorable selection to control for race and ethnicity or social risk factors beyond the factors included in the CMS–HCC model used for MA risk adjustment and payment. Controlling for additional factors would reduce the accuracy of our estimates and could increase our estimate of favorable selection.³⁸

Favorable selection of recent MA entrants was similar in counties with high and low MA penetration Some observers have posited that favorable selection will decrease as the share of Medicare beneficiaries enrolling in MA continues to increase. To analyze this hypothesis, we examined whether the level of

a county's MA penetration influenced the level of favorable selection in 2022 using our simple method that focuses on recent MA entrants. We found very little difference in selection between markets with low MA penetration and markets with high penetration (Figure 11-9, p. 347). In 2022, MA entrants in markets with high penetration had the same pre-entry selection percentage (89 percent) as MA entrants in markets with low penetration. Thus, we do not find evidence that high MA penetration affects MA favorable selection. In markets where MA penetration increases to very high levels, MA benchmarks will be set based on an increasingly small group of FFS beneficiaries. It is not clear whether the smaller share of FFS beneficiaries will continue to be different in ways that are not

**FIGURE
11-8**

Beneficiaries with high risk scores before MA entry had the highest estimated favorable selection in 2022



Note: MA (Medicare Advantage), FFS (fee-for-service). Risk-score levels reflect the pre-entry risk scores for MA enrollees. Due to scaling, values for risk scores of less than 0.20 may appear truncated. Estimates were constructed using the Commission's simple method for estimating favorable selection. "MA entrants" are beneficiaries who switched from FFS to MA in the following year. "FFS stayers" are beneficiaries who remained in FFS in the following year. Spending reflects the year prior to MA entry and is risk standardized. Lower MA-entrant spending relative to FFS stayers' spending 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 (2021–2023), Medicare claims spending (2022), and risk-adjustment files (2022).

captured by risk adjustment and be unfavorable relative to beneficiaries who enter MA.

Coding differences increase payments to MA plans in 2025 by an estimated \$40 billion and continue to generate inequity across plans

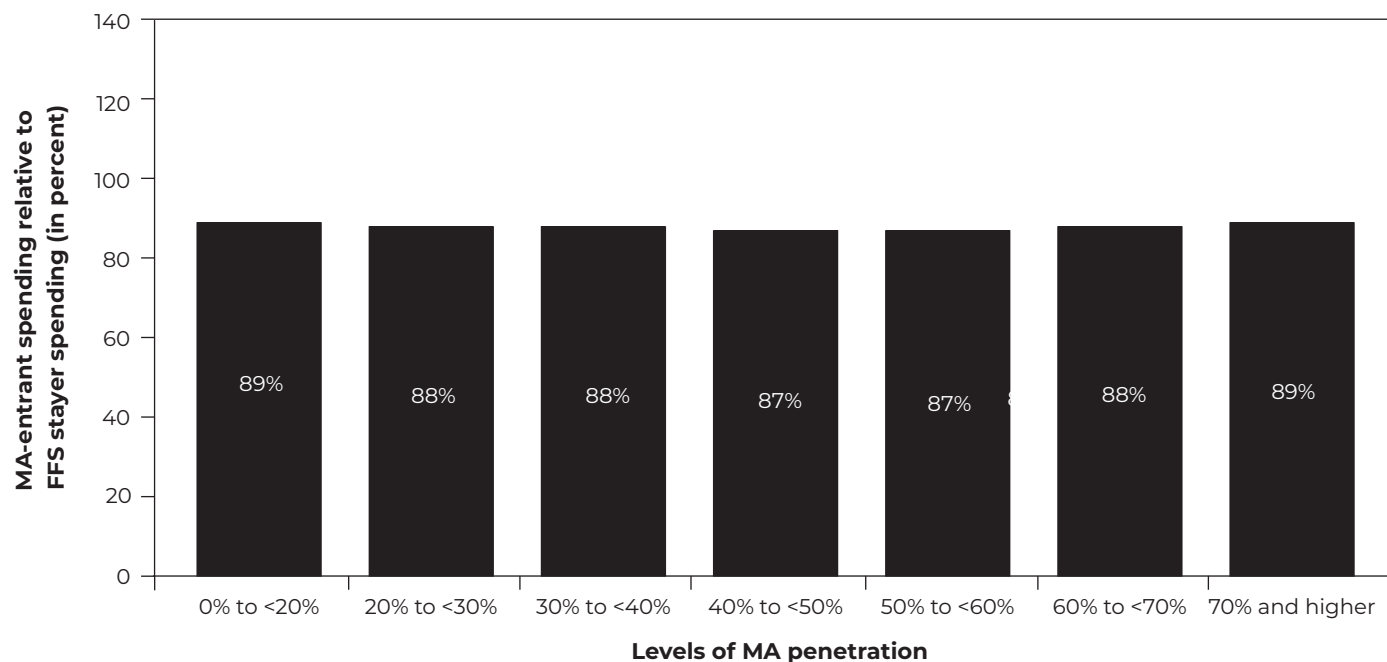
The third component of the Commission's payment comparison adjusts the base comparison of MA payments relative to FFS spending for coding intensity. Payments to MA plans are risk adjusted to account for differences in health status. Higher risk scores increase payments to plans for enrollees with higher expected Medicare spending. MA enrollees' risk scores are based

on demographic information and diagnoses that plans submit to CMS. Our estimates of coding intensity are independent of our estimates of the effects of favorable selection because we estimate selection prior to MA enrollment and subsequent changes in selection using FFS data.

Documenting additional diagnosis codes raises plan-enrollees' risk scores, generating two distinct benefits for MA plans: (1) increasing the monthly payments that MA plans receive from Medicare and (2) increasing the rebates plans use to provide supplemental benefits to enrollees. Plans that document relatively more diagnosis codes have a competitive advantage over other plans.

**FIGURE
11-9**

Estimated favorable selection before MA enrollment was similar in counties with high and low MA penetration in 2022



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates were constructed using the Commission's simple method for estimating favorable selection. "MA entrants" are beneficiaries who switched from FFS to MA in the following year. "FFS stayers" are beneficiaries who remained in FFS in the following year. 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 (2021–2023), Medicare claims spending (2022), and risk-adjustment files (2022).

Documenting an additional HCC for an enrollee can significantly increase Medicare's payment to a plan for that enrollee. Because of the increased financial incentives for MA plans to code more diagnoses and the additional tools, such as health risk assessments and chart reviews, that MA plans use to capture diagnoses—tools that are not features of FFS Medicare—coding intensity is higher in MA than in FFS and payments to MA plans are higher than intended.

For 2025, we project that MA risk scores will be about 16 percent above risk scores for comparable FFS beneficiaries. This difference is only partially offset by CMS's coding-intensity adjustment that reduces MA risk scores by 5.9 percent. The net effect is a 10 percent increase in MA risk scores due to coding intensity,

leading to \$40 billion in higher projected payments to MA plans in 2025. Between 2007 and 2025, we estimate that MA coding intensity will have generated \$224 billion in aggregate higher payments to MA plans.

The Commission's approach to estimating coding intensity compares MA and FFS risk scores, controlling for age, sex, Medicaid eligibility, and institutional status and then identifying differences in risk scores as due to differences in coding intensity. More details on the methodology can be found in Technical Appendix 11-B (p. 388).

Coding intensity varies significantly across MA organizations. As a result, CMS's across-the-board adjustment for coding intensity, which reduces all MA

risk scores by the same amount, generates inequity across organizations 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.

In our March 2016 report to the Congress, the Commission recommended a multipronged approach that would fully account for the impact of coding differences between MA and FFS, improve the equity of the adjustment across MA contracts, and improve incentives to reduce costs and improve quality. The Commission's approach to reducing MA coding intensity has been to address the mechanisms that generate coding differences 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 would be consistent with the Commission's approach.

Documenting more diagnosis codes increases payments to plans

Among the 20 most common HCCs in MA—which have payment 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's payment to a plan. We can illustrate how coding additional HCCs increases payment to a plan for Medicare-covered services using average FFS Medicare spending.³⁹ 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. This distinction can lead to relative underreporting of diagnoses in FFS. 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 more completely reported. Because Medicare's risk model is based on diagnostic-coding patterns in FFS, 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 that MA plans use to capture diagnoses—tools that 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 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. (See text box “Congressional request on Medicare Advantage and fee-for-service diagnostic-coding practices,” for more information about how MA and FFS coding practices differ for specific conditions.)

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,

Congressional request on Medicare Advantage and fee-for-service diagnostic-coding practices

The House Committee on Appropriations requested that the Commission report on differential coding in Medicare Advantage (MA) and fee-for-service (FFS) Medicare. The Committee requested that MedPAC analyze how different incentives in FFS and MA contribute to different relative rates of diagnostic coding for beneficiaries enrolled in the two parts of the program. The Committee also requested an analysis of associated effects on payment differences.

Committee report language

Differential Coding in Medicare Fee For Service.—The Committee is aware of the dynamic noted in MedPAC’s 2024 Report to the Congress that FFS Medicare claims offer little incentive to record all relevant diagnoses of FFS patients. The Committee directs MedPAC to, within 12 months of enactment of this Act, issue a report estimating the extent to which this incentive results in different relative rates of diagnostic coding for Medicare Advantage and FFS beneficiaries and the extent to which such coding differences may result in payment differentials between Medicare Advantage and FFS.

Evaluating diagnostic-coding differences between MA and FFS Medicare

Diagnostic-coding differences for MA and FFS beneficiaries can arise for several reasons. Coding differences can reflect MA plans’ ability to document more diagnoses than FFS providers, potentially 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. In some cases, the additional diagnosis codes submitted by plans may reflect fraudulent diagnoses, those for which the patient did not meet clinical criteria. 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 Inc. et al. 2016, United States of America ex rel. James M. Swoben v. Secure Horizons 2017). Lawsuits and risk-adjustment data-validation audits seek to address higher MA coding due to fraud or insufficient documentation, but even if fraudulent diagnoses were eliminated, other sources of differential diagnostic coding would remain.

Applying diagnostic criteria to individual patients can involve judgment, and diagnostic criteria may be interpreted differently by MA plans compared with providers treating FFS patients. CMS developed a set of diagnostic-coding principles to ensure that diagnostic codes were applied appropriately in risk adjustment (Pope et al. 2004). Principle 10 addresses the varying specificity in diagnostic criteria, which could allow for different diagnostic criteria to be applied in MA compared with FFS Medicare, especially for diagnoses with more clinical discretion. Principle 10 states, “Discretionary diagnostic categories should be excluded from payment models. Diagnoses that are particularly subject to intentional or unintentional discretionary

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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 in the first year

Congressional request on Medicare Advantage and fee-for-service diagnostic-coding practices (cont.)

coding variation or inappropriate coding by health plans/providers . . . should not increase cost predictions. Excluding these diagnoses reduces the sensitivity of the model to coding variation and coding proliferation.” CMS excluded some codes that exhibited the greatest differences in MA- and FFS-coding rates from the most recent risk-adjustment model (V28), introduced in 2024, but other diagnostic codes included in the model are likely to have some degree of discretion.

Providers generally have fewer incentives to submit diagnosis codes for their FFS patients compared with the incentives that MA plans have to submit codes for their enrollees. In MA, plans receive higher payments when additional diagnosis codes are recorded on inpatient, outpatient, and professional claims, or when additional diagnoses are submitted through health risk assessments and chart reviews. In FFS, providers generally do not receive higher payments when additional diagnoses are recorded on outpatient and professional claims or on health risk assessments, and chart reviews are not submitted through FFS Medicare. That difference in incentives suggests that at least some of the relatively higher coding intensity in MA that the Commission and others have estimated is because fewer FFS patients are coded with diagnoses that would be applicable to them, which is sometimes referred to as “incomplete coding.”

While the difference in incentives to submit diagnosis codes in the two programs is clear, it is challenging to estimate how much of the difference in coding intensity between the two programs arises because of differing incentives. Without analyzing data from medical records, it is impossible to know whether beneficiaries would have met the criteria for all diagnosis codes that were not recorded.

Parsing the reasons for diagnostic-coding differences is challenging, and in some cases data do not exist. In responding to the Committee’s

request, we assessed the available measure of coding completeness that we think is most related to different incentives to document diagnoses: the rates of follow-up coding for chronic conditions that are expected to persist from year to year. For the chronic conditions that we analyze, nearly all patients who are diagnosed with a condition in one year are expected to meet the clinical criteria for the condition in the following year. Therefore, we can reasonably classify diagnoses that were not recorded in the following year as instances of incomplete coding. This analysis, however, is not able to estimate all instances of incomplete coding in MA and FFS, such as the coding of chronic conditions that are never diagnosed for a beneficiary and the coding of conditions that are not expected to persist from year to year.

We find evidence of incomplete coding for nearly all of the 52 chronic conditions that we analyzed for both FFS and MA beneficiaries, with substantial variation in the rates of follow-up diagnoses across the different conditions. The rates of follow-up coding were lower (that is, coding was less complete) for FFS beneficiaries for 35 out of the 52 conditions we analyzed, and 12 of the conditions had follow-up rates that were more than 5 percentage points lower in FFS than MA. However, two conditions had follow-up rates that were more than 5 percentage points higher in FFS than MA. This analysis suggests that while diagnoses are coded incompletely in both MA and FFS, incomplete coding is somewhat more common in FFS than in MA.

Because the Commission’s analysis of follow-up coding focuses on only one mechanism whereby coding completeness may influence payments to MA plans, we are unable to estimate specifically how much payments to plans are affected by differences in coding completeness or accuracy. The Commission estimates that, in 2025, payments to MA plans will be \$40 billion (10 percent) higher due to differences in coding intensity that arise

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Congressional request on Medicare Advantage and fee-for-service diagnostic-coding practices (cont.)

for any reason. That estimate is discussed in more detail in the main text. Regardless of the reasons, higher coding intensity in MA relative to FFS causes payments to MA plans to be higher than they would be if coding practices were comparable.

Analysis of follow-up coding in the MA and FFS programs

To evaluate the completeness of follow-up coding in FFS and in MA, our staff physician reviewed the diagnosis codes associated with each hierarchical condition category (HCC) and identified 52 HCCs (of 86 HCCs in the V24 CMS-HCC model) that represent chronic conditions for which we would expect the condition, if coded in one year, to persist in the following year for nearly all beneficiaries. First, we looked at beneficiaries in FFS with Part A and Part B for 2022 and 2023 and analyzed how often beneficiaries who had those chronic-condition HCCs coded in 2022 were coded with the same HCC or a related, higher-severity HCC in 2023. (Related HCCs are ranked into hierarchies based on severity, and only the highest-severity HCC counts toward a risk score when more than one HCC in the hierarchy is identified for a beneficiary.) Next, we performed the same analysis for beneficiaries in MA for 2022 and 2023. Figure 11-10 (p. 352) shows the estimates from that analysis.

We found wide variation in the rates of follow-up coding within both the MA and FFS populations. In FFS Medicare, seven chronic-condition HCCs had follow-up rates above 90 percent and seven had follow-up rates below 50 percent. In MA, five chronic-condition HCCs had follow-up rates above 90 percent and five had follow-up rates below 50 percent. HCCs contain a large variety of conditions, both symptoms and diseases, some of which may resolve over time or may become so chronic or stable that practitioners no longer need to actively treat the condition and therefore do not code the condition according to coding guidelines.⁴⁰ These results are similar to those found by other researchers assessing chronic

conditions in the V22 risk model for 2017 to 2019 (Ghoshal-Datta et al. 2024).

In addition, we find that most of the chronic-condition HCCs have similar rates of follow-up coding in MA and FFS Medicare. Of the 52 chronic-condition HCCs, 38 had MA follow-up coding rates within 5 percentage points of FFS. Among these HCCs, the rates of follow-up coding were more often higher in MA, with 23 HCCs having higher MA follow-up rates and 11 having higher FFS follow-up rates (and 4 showing no difference in follow-up coding rates).

To help assess why some chronic-condition HCCs had larger differences in MA and FFS follow-up coding rates, we consider whether an HCC is part of a hierarchy and the relative MA and FFS coding rates in a single year when accounting for differences in age, sex, and Medicaid eligibility (Figure 11-11, p. 353).

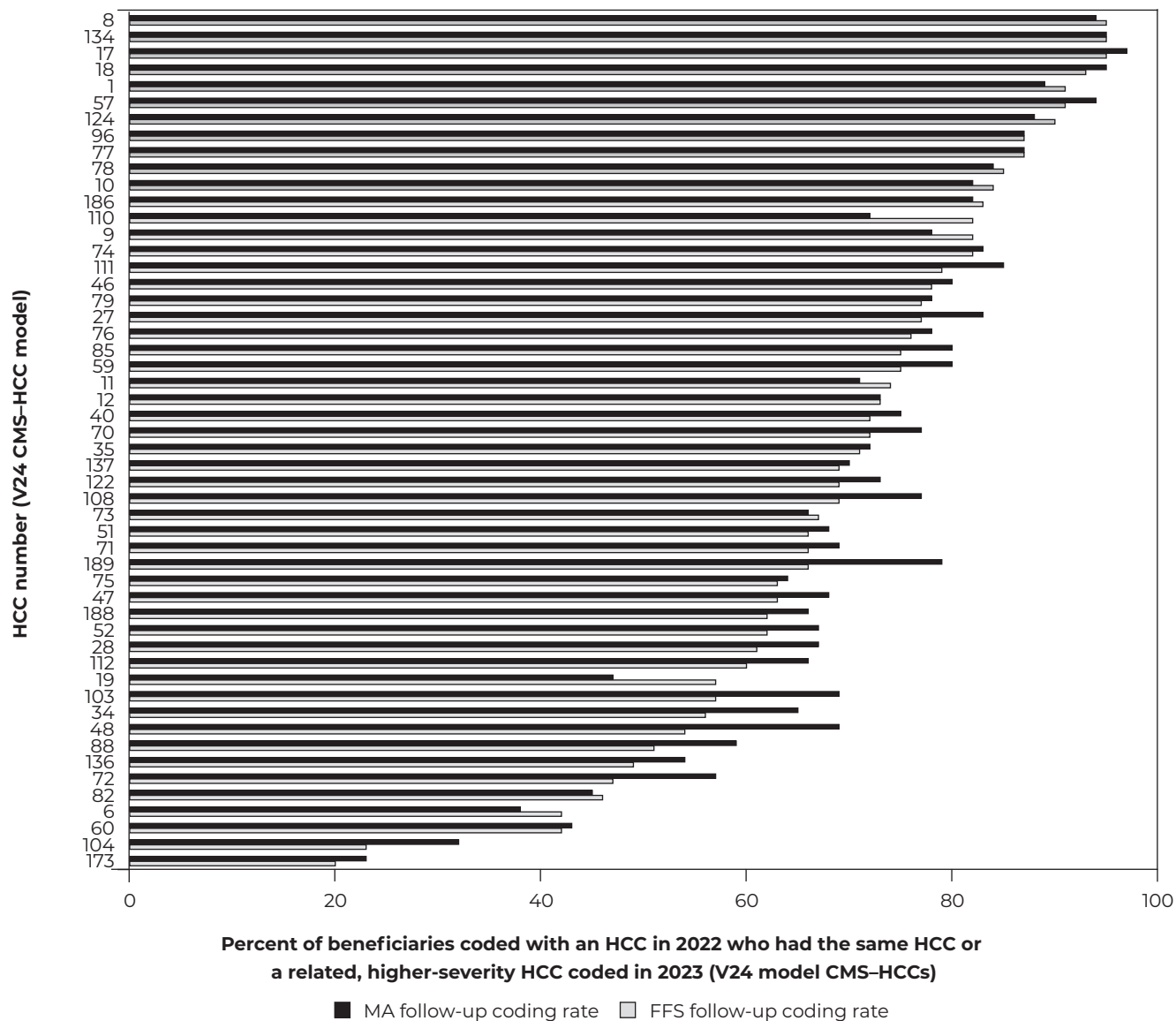
We first consider the two HCCs that had follow-up rates that were 10 percentage points higher in FFS than in MA: diabetes without complication (HCC 19) and cystic fibrosis (HCC 110). Diabetes without complication is the lowest-severity HCC in a hierarchy that includes diabetes with chronic complications (HCC 18) and diabetes with acute complications (HCC 17).⁴¹ Comparing MA and FFS coding rates for a single year, we find that the three diabetes HCCs collectively are coded 38 percent more often in MA than in FFS (accounting for differences in age, sex, and Medicaid eligibility), demonstrating higher overall coding of diabetes in MA. However, we find that coding rates for diabetes with chronic complications are 52 percent higher in MA than in FFS, and coding rates for diabetes with acute complications are 12 percent higher, while coding rates for diabetes without complications are 19 percent lower (see Figure 11-11). MA had a 10 percentage point lower rate of follow-up coding for diabetes without complication (47 percent compared with 57 percent).

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Congressional request on Medicare Advantage and fee-for-service diagnostic-coding practices (cont.)

**FIGURE
11-10**

Wide variation in the persistence of coding chronic-condition HCCs for MA and FFS, but more conditions had higher persistence in MA, 2022–2023



Note: HCC (hierarchical condition category), MA (Medicare Advantage), FFS (fee-for-service). Beneficiaries were either enrolled in FFS Medicare for all of 2022 and 2023 or MA for all of 2022 and 2023. Follow-up rates of diagnostic coding were calculated as the share of beneficiaries with an HCC coded in 2022 who were also coded with the same HCC or a related, higher-severity HCC in 2023. For V24 HCC descriptions and coefficients, see Table VI-1 of CMS's announcement of MA payment rates for calendar year 2020.

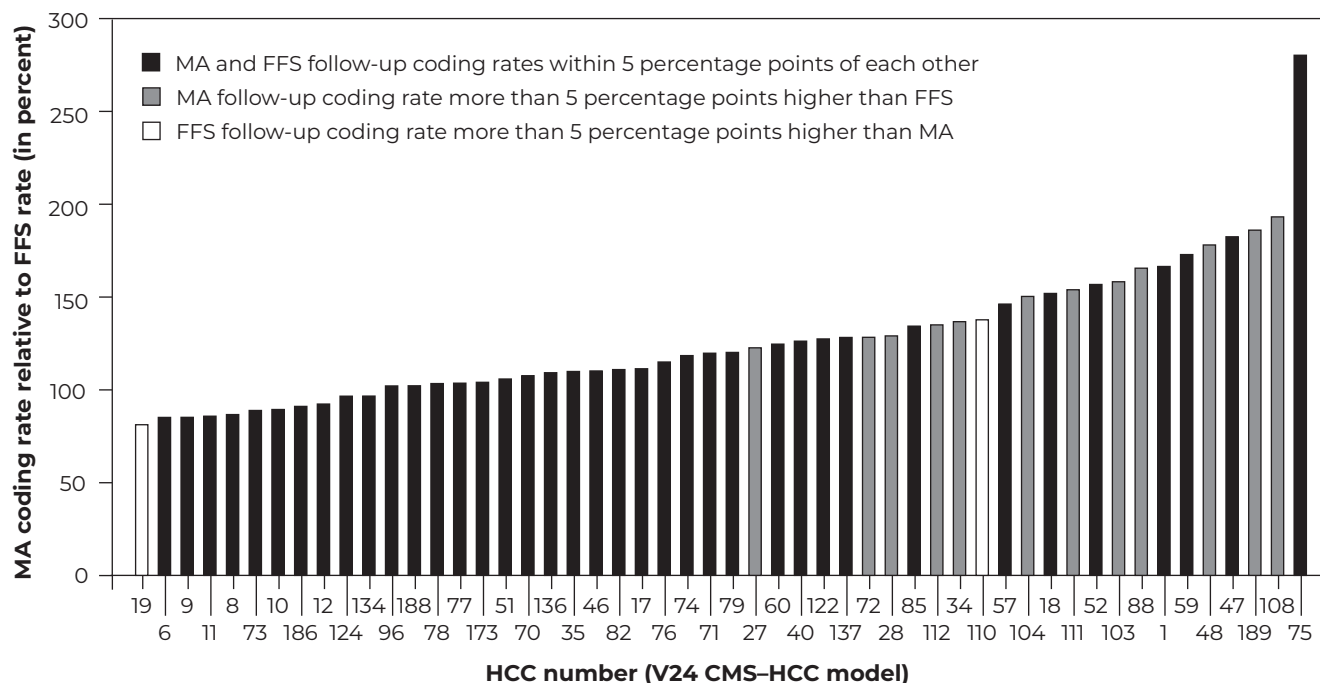
Source: MedPAC analysis of Medicare enrollment and risk-score files for 2022 and 2023.

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Congressional request on Medicare Advantage and fee-for-service diagnostic-coding practices (cont.)

FIGURE
11-11

Chronic conditions with higher MA follow-up coding rates compared with FFS also have higher demographic-adjusted MA coding rates, 2023



Note: MA (Medicare Advantage), FFS (fee-for-service). Beneficiaries were either enrolled in FFS Medicare for all of 2022 and January of 2023 or in MA for all of 2022 and January of 2023. Differences in MA and FFS HCC-coding rates account for differences in age, sex, and Medicaid eligibility. For V24 HCC descriptions and coefficients, see Table VI-1 of CMS's announcement of MA payment rates for calendar year 2020. For each HCC, the figure shows the ratio of the MA coding rate over the FFS coding rate, where 100 percent indicates similar rates of coding.

Source: MedPAC analysis of Medicare risk score and enrollment files for 2022 and 2023.

Cystic fibrosis is the highest-severity HCC in a hierarchy along with chronic obstructive pulmonary disease (HCC 111) and fibrosis of lung and other chronic disorders (HCC 112). Beneficiaries with cystic fibrosis account for only 0.1 percent of all beneficiaries with one of the HCCs in this hierarchy. For a single year, we find that MA rates of coding cystic fibrosis are 38 percent higher than in FFS Medicare, and MA rates of coding for any of these three HCCs are 53 percent higher than in FFS Medicare. However, MA had a 10 percentage point

lower rate of follow-up coding for cystic fibrosis, 72 percent versus 82 percent in FFS.

Next, we consider the 12 HCCs that had follow-up rates that were more than 5 percentage points higher in MA than in FFS. These HCCs tended to have lower follow-up rates for all beneficiaries (these HCCs tend to be on the left side of Figure 11-11), and all have higher single-year coding rates in MA than in FFS, ranging from 23 percent higher to 94 percent higher (accounting for differences in age,

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Congressional request on Medicare Advantage and fee-for-service diagnostic-coding practices (cont.)

sex, and Medicaid eligibility), shown in medium gray in Figure 11-11. Higher single-year MA coding rates appear to be associated with higher MA follow-up rates. One possible reason for this association is that higher MA coding may be caused by plans using a simple diagnostic tool in a way that lacks clinical consensus. For example, if a diagnosis is based on a noninvasive test that can be conducted in a beneficiary's home, MA plans may incorporate this test into an in-home health risk assessment, leading to higher overall MA coding for that condition. At least one MA insurer has been using a noninvasive device to test for vascular disease during in-home visits. The manufacturer of the test states that it is a stand-alone device for diagnosing vascular disease, but some doctors disagree. Noninvasive testing for this disease more than doubled in MA between 2018 and 2021 while remaining relatively stable in FFS Medicare (Ross et al. 2024). We find that vascular disease (HCC 108) is documented almost twice as often in MA than in FFS when accounting for differences in age, sex, and Medicaid eligibility (Figure 11-11).

Conclusion

Because the risk-adjustment model is calibrated on FFS spending and diagnoses, when MA coding intensity is higher than in FFS Medicare—regardless of the reason—it increases payments to MA plans above FFS spending. Estimating the share of diagnostic-coding differences associated with any one reason is difficult. In our analysis, we attempt to assess the impact of different incentives to document diagnosis codes in MA and FFS Medicare by estimating rates of follow-up coding in MA and FFS Medicare. We found that follow-up coding rates were somewhat lower for FFS beneficiaries for most, but not all, chronic conditions. Our analysis suggests that while diagnoses are coded incompletely in both MA and FFS, “incomplete coding” is somewhat more common in FFS than in MA. Finally, we caution that neither MA nor FFS coding practices are likely to produce “accurate” diagnostic coding given the incompleteness in diagnosis codes that we found in both FFS and MA and the allegations of fraudulent diagnostic-coding practices in MA made by the Department of Justice and a number of industry whistleblowers. ■

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). The Government Accountability Office used a risk-score-prediction model to estimate coding intensity for 2010 through 2012, and those estimates align very closely to the Commission's estimates over that same time period (Government Accountability Office 2013). A new study focusing on diagnoses submitted on hospital claims has found higher levels of MA coding intensity for beneficiaries who subsequently had a health assessment in a skilled nursing facility (Kosar et al. 2024).

Starting in 2010, a series of congressional mandates require 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 (which is generally thought to mean a risk model that has coefficients estimated using MA encounter data, rather than FFS claims 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 2025.⁴²

The Commission's method for estimating coding intensity compares MA and FFS risk scores, controlling for age, sex, Medicaid eligibility, and institutional status, and identifies differences in risk scores as due to differences in coding intensity. We introduced that method in 2024. After revising our method of estimating coding intensity, the Commission found that the new method and the older method the Commission had been using, despite different methodological approaches, produced substantially similar estimates of plan coding intensity over the period 2007 through 2021. A detailed description of those methods can be found in Chapter 13 of our March 2024 report to the Congress, along with the research leading to the revisions. This year, we made additional revisions to exclude Puerto Rico from our coding-intensity estimate because accurate data on Medicaid eligibility are not available.⁴³ This revision reduced our coding-intensity estimates by about 1 percentage point from what we previously reported. We also modified how we weight new enrollees so that the estimate more accurately reflects the share of payments associated with new and continuing (those with risk scores based on diagnosis codes) enrollees. More details on our methodology for estimating MA coding intensity can be found in Technical Appendix 11-B.

Figure 11-12 (p. 356) shows the impact, for 2007 through 2023, 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). MA coding intensity has been above FFS levels since 2007 and has increased steadily, with a few exceptional years, to about 17 percent in 2023. CMS's coding-intensity adjustment began in 2010 and has been lower than overall MA coding intensity since 2011.

We estimate that MA coding intensity increased, on average, by 1.1 percentage points per year from 2007 through 2013 and by 1.4 percentage points per year for 2017 through 2021. Deviations from the typical trend of growing MA coding intensity occurred in 2014, 2016, and 2017, which we attribute to two factors: (1) A new version of the risk-adjustment model was phased in for 2014, 2016, and 2017 that 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).

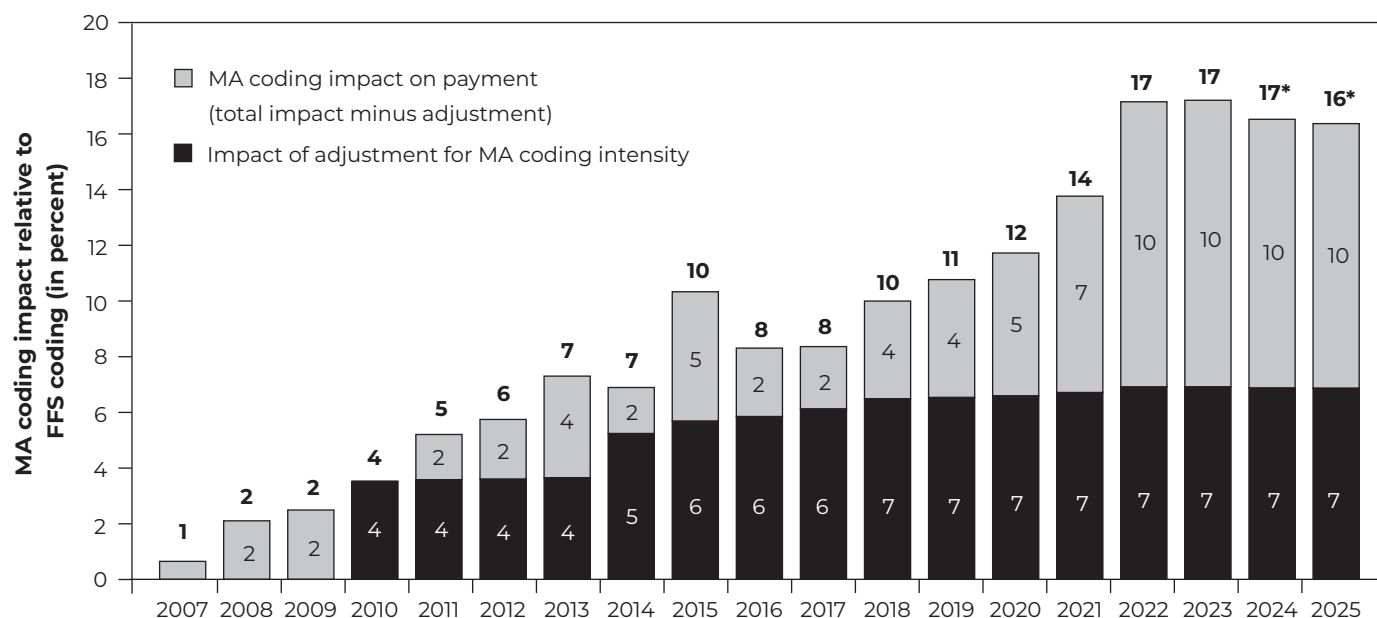
Average MA risk scores in 2021 (which were based on diagnoses on claims for services provided in 2020) were lower than 2020 risk scores, reflecting the reduction in service use in the first year of the pandemic. However, because the reduction in MA risk scores in 2021 was less than the reduction in risk scores for comparable FFS beneficiaries, estimated MA coding intensity continued to increase in 2021. We estimate a 3.4 percentage point increase in coding intensity from 2021 to 2022, which may have reflected efforts by plans 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.

Between 2022 and 2023, we estimate that overall MA coding intensity remained steady at 17 percent. Over this period, FFS risk scores grew much faster than in prior years (more than three times faster than from 2021 to 2022) and slightly outpaced the rate of MA risk-score growth. It is possible that postpandemic risk-score trends returned to normal rates a year earlier for MA than FFS due to MA plans' coding efforts in 2021 (affecting 2022 risk scores). Coding intensity increased by about 1.7 percentage points on average between 2021 and 2023, which is similar to the trend from 2017 through 2021.

Because the data required to estimate coding intensity are not yet available for 2024 and 2025, we project coding intensity for those years based on the annual trend from 2019 through 2023, an increase of 1.6 percentage points per year. We estimate that phasing in the V28 risk-adjustment model effectively reduced the coding-intensity estimate for 2024 by -2.3 percentage points and by -1.8 percentage points in 2025 for a net change in coding intensity of -0.7 percentage points from 2023 to 2024 and of -0.2 percentage points from 2024 to 2025. (See Technical Appendix 11-B, section titled "Impact of phasing in the V28 risk-adjustment model" (p. 390), for more details.) There is uncertainty

**FIGURE
11-12**

**Estimated impact of coding intensity on MA risk scores
was larger than the coding adjustment, 2007–2025**



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 because their risk scores are not based on diagnostic coding. Beneficiaries residing in Puerto Rico are excluded. 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 2025, we calculate 1.16×5.9 percent = 0.069 or about 7 percent. Components may not sum to totals due to rounding.

* For 2024 and 2025, we project coding intensity based on the annual trend from 2019 through 2023, an increase of 1.6 percentage points per year. Then we reduced the annual trend by our estimate of the effect of the phase-in of the V28 risk-adjustment model, which is –2.3 percentage points in 2024 and –1.8 percentage points in 2025. See Technical Appendix 11-B section titled, “Impact of phasing in the V28 risk-adjustment model” (p. 390) for more details.

Source: MedPAC analysis of CMS enrollment and risk-score files.

about the impact of moving to the V28 model for MA coding intensity. We will continue to monitor those effects and will update our analysis as we are able. We expect to have risk-score data for 2024, the first year of the V28 implementation, for our March 2026 report.

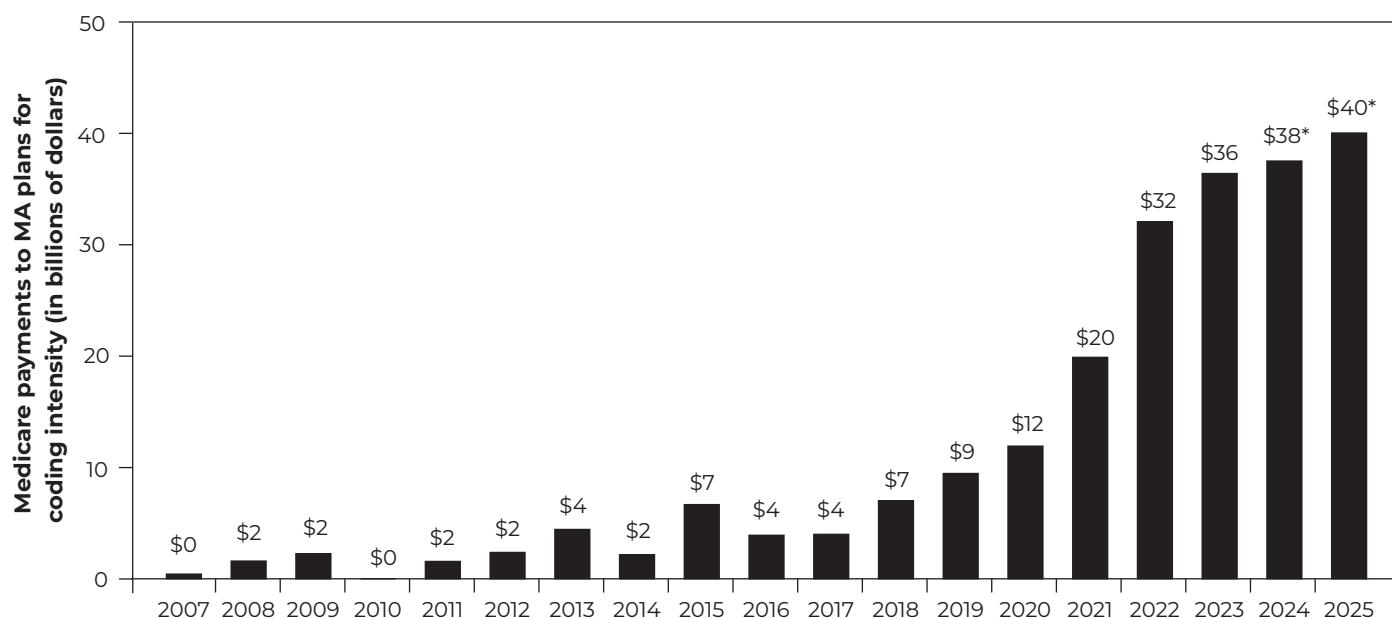
For 2025, we project that MA risk scores will be about 16 percent above risk scores for comparable FFS beneficiaries. This difference is only partially offset by CMS’s coding-intensity adjustment, which reduced MA risk scores by 5.9 percent. The net effect is a 10 percent increase in MA risk scores due to coding intensity,

leading to \$40 billion in higher projected payments to MA plans.

Between 2007 and 2023, MA coding intensity resulted in \$146 billion in increased payments to MA plans (Figure 11-13). Using our projection, we estimate that MA coding intensity in 2024 and 2025 will increase program spending by another \$38 billion and \$40 billion, respectively. In total, we estimate that between 2007 and 2025, MA coding intensity will have generated \$224 billion in higher aggregate payments to MA plans.

**FIGURE
11-13**

MA coding intensity has increased payments to plans by an estimated \$146 billion through 2023 and is projected to generate nearly \$78 billion more in 2024 and 2025



Note: MA (Medicare Advantage). Estimates for 2007 through 2023 are based on the Commission's estimate of coding intensity after accounting for CMS's coding adjustment. In all years, Medicare spending for MA plans is based on the Medicare Trustees' reports and excludes spending for beneficiaries with end-stage renal disease.

* For 2024 and 2025, we project coding intensity based on the annual trend from 2019 through 2023, an increase of 1.5 percentage points per year. Then we reduced the annual trend by our estimate of the effect of the phase-in of the V28 risk-adjustment model, which is -2.3 percentage points in 2024 and -1.8 percentage points in 2025. See Technical Appendix 11-B, section titled "Impact of phasing in the V28 risk-adjustment model" (p. 390), for more details.

Source: MedPAC analysis of CMS enrollment and risk-score files and the Medicare Trustees' reports.

Documenting additional diagnosis codes increases plan rebates and can distort competition among plans

Documenting additional diagnostic codes increases the size of MA plans' rebates, which in turn allows plans to offer their enrollees more supplemental benefits than plans that document fewer additional diagnoses. For a plan submitting a bid below its benchmark (nearly all plans in 2025), 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, 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 supplemental benefits. In sum, plans can translate greater coding intensity into the ability to offer more supplemental benefits, giving them a competitive advantage over their competitors in attracting enrollees.

MA payment policies aim to give plans an incentive to lower spending and improve quality by allowing them to offer more supplemental benefits. By reducing health care costs, plans can reduce their

**TABLE
11-5****Illustrative example: A plan that codes more diagnoses
can offer its enrollees more supplemental 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 supplemental 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.

* Plan A and Plan B at 3.5 stars have a rebate percentage of 65 percent. Plan Z at 5 stars has a rebate percentage of 70 percent.

bids, increasing their rebate and supplemental 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).⁴⁴ These policies are intended to benefit beneficiaries through improved quality, more supplemental 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 supplemental benefits regardless of whether they reduce costs or improve quality.

Table 11-5 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. Plan A and Plan Z have an expected risk score of 0.97, while Plan B has an expected risk score of 1.03 due to coding more diagnoses. All three plans have bids below the risk-adjusted benchmark and provide supplemental benefits funded by rebates. However, because Plan B has a higher risk score, its rebate is larger than Plan A's

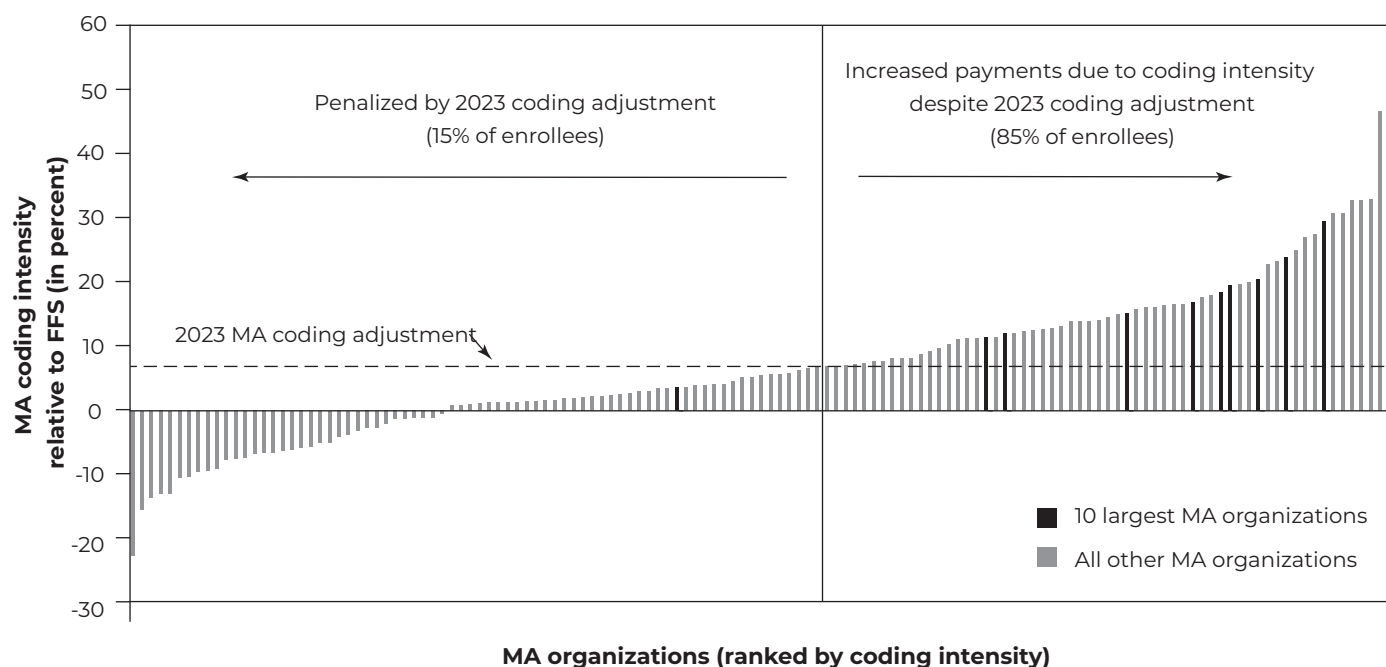
rebate (\$52 per month vs. \$15 per month), so it can offer enrollees more supplemental benefits. Plan B's coding efforts have therefore given it an unfair competitive advantage over Plan A.

In addition, increased coding intensity can influence the size of the rebate more than MA quality bonuses can. The higher risk score of Plan B, which has only 3.5 stars, gives it an advantage over bonus-level Plan Z, 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 supplemental benefits than are provided through quality bonuses.

The plans illustrated in Table 11-5 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 2023.⁴⁵ Figure 11-14 shows MA coding intensity relative to FFS coding, broken out by MA parent organization, excluding beneficiaries who reside in Puerto Rico or are enrolled in chronic-condition special-needs plans and organizations with fewer than 2,500 enrollees in the analysis.

**FIGURE
11-14**

Coding intensity relative to FFS varied widely across MA organizations, 2023



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 because their risk scores are not based on diagnostic coding. Beneficiaries residing in Puerto Rico or enrolled in a chronic-condition special-needs plan are excluded from the analysis, as well as organizations with fewer than 2,500 enrollees.

Source: MedPAC analysis of CMS enrollment and risk-score files.

Consistent with prior years, we find that about half of organizations (covering 15 percent of MA enrollees) have coding intensity below CMS's 2023 coding adjustment and are thereby penalized by the adjustment, while the other half of organizations (covering 85 percent of MA enrollees) have coding intensity that increases their payment even after accounting for the 2023 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 further 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 10 largest MA organizations (covering 81 percent of MA enrollees), from about 4 percent to 29

percent above FFS levels. Nine of the 10 largest MA organizations had greater coding intensity than the 2023 coding adjustment and therefore received a net increase in payment due to their 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 (Geruso and Layton 2020, Kronick and Chua 2021, Kronick and Welch 2014).

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.⁴⁶

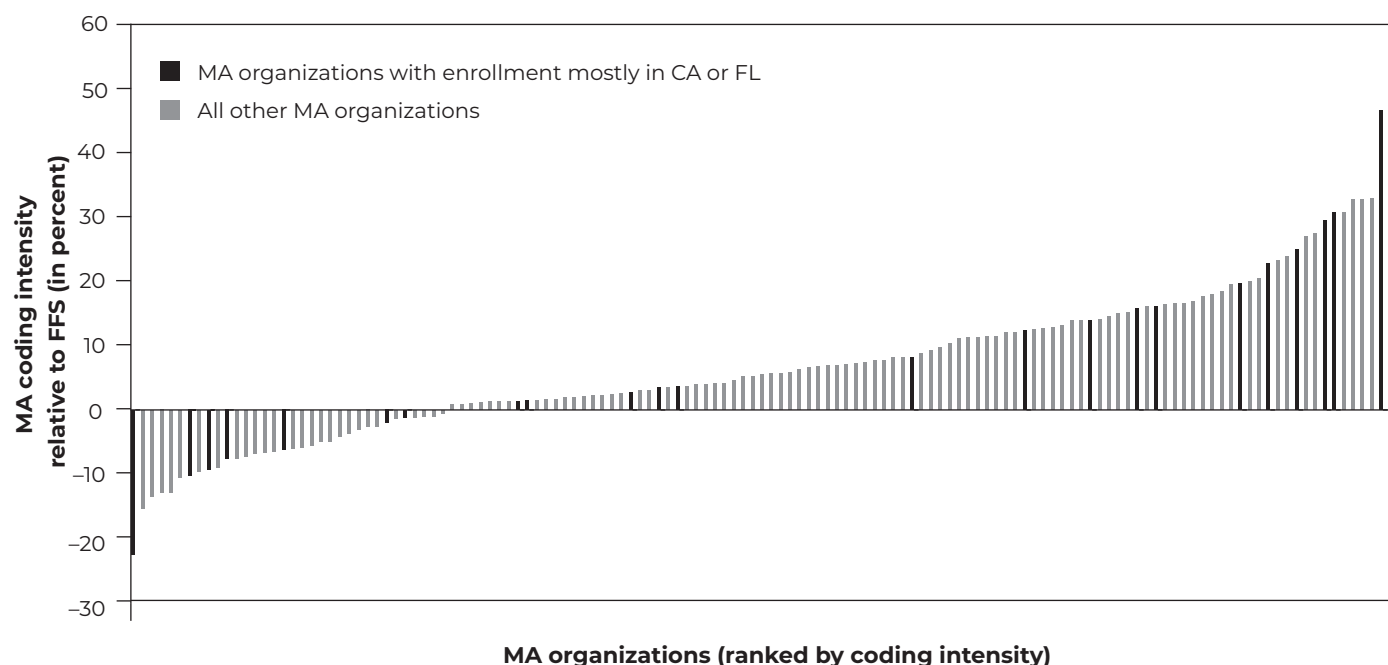
Capitated arrangements in California and Florida may exacerbate coding intensity In the course of reviewing our coding-intensity estimates by MA organization, we found that several organizations with the highest levels of diagnostic coding are located in California and Florida. Of the 24 MA organizations offering plans primarily in California and Florida (i.e., organizations with a majority of their enrollment in California or Florida), 7 were among the 17 organizations with the highest estimated coding intensity across the nation, including 4 of the 8 organizations with the highest levels of estimated coding intensity (Figure 11-15). These four organizations had MA risk scores that ranged from 29 percent higher to 56 percent higher than scores for comparable FFS beneficiaries.

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,” which may explain why these California- and Florida-focused organizations account for so many of the highest-coding organizations. Under the delegated model, the responsibility for health care delivery and the 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 do not have data that would allow us to confirm that the plans offered by the highest-coding California and Florida organizations use the delegated model, we reviewed the share of 2022 provider payments that were capitated for the top seven such organizations. Of these seven organizations, four organizations had a greater share of provider payments that were capitated than the national average (36 percent in 2022), including three organizations for which more than half of provider payments were capitated. 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 coding intensity, and such payments are not necessary to sustain the model's incentives.

MA plans' use of health risk assessments to increase diagnostic 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.⁴⁷ Health risk assessments may be part of a plan's care-management approach and should continue to be used for that purpose when they are used to improve patient care. However, when health risk assessments identify diagnosis codes that are not documented on subsequent encounters with providers, which would demonstrate that the condition was under active management, those codes should not be used for risk adjustment and for making payments to plans. 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

**FIGURE
11-15****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). 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. Beneficiaries residing in Puerto Rico or enrolled in a chronic-condition special-needs plan are excluded from the analysis, as well as organizations with fewer than 2,500 enrollees.

Source: MedPAC analysis of CMS enrollment and risk-score files.

Justice 2022). (More information about these concerns is in the chapter on MA in our March 2023 report.)

We analyzed 2022 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.⁴⁸ In 2022, about 7.7 million MA enrollees had a health risk assessment that identified at least one HCC, and a total of 17.1 million unique HCCs were identified through health risk assessments. Of those, 3.5 million beneficiaries had a health risk assessment that was the only source for at least one of the HCCs identified, and a total of 5.7 million HCCs (one-third of all HCCs identified on health risk assessments) were identified only on a health risk assessment. Six HCCs each

generated more than \$900 million in payments from these assessments, accounting for about half of all payments generated by health risk assessments.⁴⁹ We found that diagnostic coding that was associated with only health risk assessments accounted for \$15 billion in payments to MA plans in 2023, or a little more than 3 percent of all payments to MA plans. About 80 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. Other researchers found similar estimates of the impact of health risk assessments, contributing about \$12 billion in payments to MA plans in 2020 (James et al. 2024). That research also found differences in the use of health risk assessments across parent organizations.

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 in plan encounter data.

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.⁵⁰ 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 violate Medicare's rules governing the reporting of diagnoses (United States of America ex rel. Benjamin Poehling v. UnitedHealth Group Inc. et al. 2016, United States of America ex rel. James M. Swoben v. Secure Horizons 2017, United States of America v. Anthem Inc. 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 2022 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 2022, about 12.0 million MA enrollees had a chart review that identified at least one HCC, and a total of 33.2 million unique HCCs were identified on chart reviews. Of enrollees with a chart review, 5.8 million beneficiaries had a chart review that was the only source of an HCC, and a total of 9.0 million HCCs (about 27 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.⁵¹ We found that in 2023, chart reviews alone accounted for about \$24 billion in payments to MA plans, or about 6 percent of all payments to MA plans.

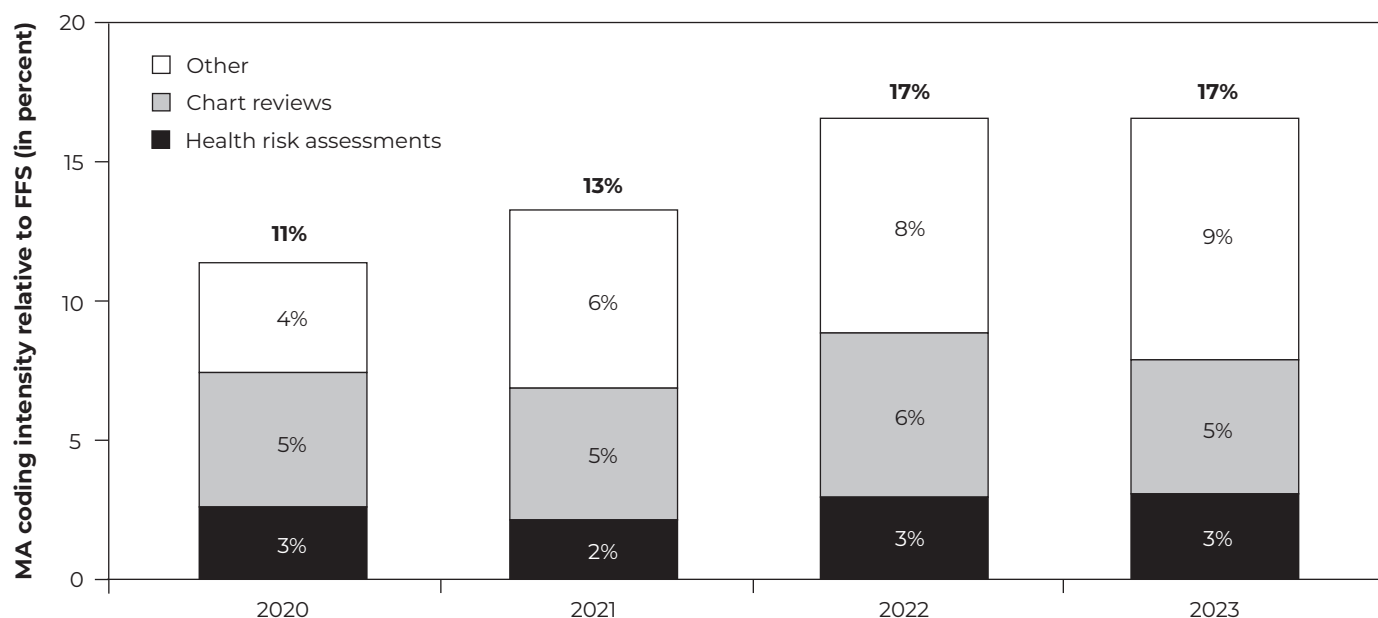
We estimate that chart reviews and health-risk assessments together accounted for about \$34 billion in payments to MA plans, or about 8 percent of all payments to MA plans in 2023.⁵² Combined with our finding that all sources of coding intensity resulted in MA risk scores that were about 17 percent higher than risk scores for comparable FFS beneficiaries in 2023, we conclude that health risk assessments and chart reviews together accounted for about half of all MA coding intensity (Figure 11-16). Our estimates are similar to the results of another researcher's analysis in terms of the overall magnitude of the impact and of the trend in the growing impact of health risk assessments and chart reviews on payments to MA plans from 2016 to 2021 (Jacobs 2024).

The Commission's 2016 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 MA coding intensity has been to address the mechanisms that generate coding differences first (e.g.,

**FIGURE
11-16**

Chart reviews and health risk assessments accounted for about half of overall MA coding intensity, 2020–2023



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 2023. The underlying diagnoses were reported during health care encounters in the previous year, 2019 through 2022, respectively. “Other” sources of coding intensity can result from pay-for-coding programs, patient-assessment forms, transferring coding incentives from plans to providers via subcapitation, and other mechanisms. Components may not sum to totals due to rounding.

Source: MedPAC analysis of CMS enrollment and risk-score files and the Medicare Trustees’ reports.

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

Update on risk-adjustment data-validation audits

Medicare payments to Medicare Advantage (MA) plans are based, in part, on diagnostic data that plans submit to CMS. Program rules state that, to be used for payment, diagnoses submitted for risk adjustment must result from a hospital inpatient stay, hospital outpatient visit, or face-to-face visit with a physician or other health care professional; diagnoses also must be supported by evidence in the patient's medical record. MA organization leadership signs an attestation stating that the submitted diagnostic data are accurate.

CMS conducts risk-adjustment data-validation (RADV) audits after payments have been made to the plan to check whether plan-submitted diagnoses are supported by the medical record as required by Medicare. If diagnoses do not meet requirements, plans are required to return payments to Medicare. These overpayments for diagnoses that do not

meet program requirements are not the same as payments for higher MA coding intensity; however, there is an unknown amount of overlap between them.

For RADV audits through 2017, CMS has been using a protocol that audits roughly 5 percent of MA contracts per year, uses a sample of 201 enrollees in each contract across three strata of beneficiaries with low, medium, and high risk scores, calculates an error rate for the sample population, and then calculates the overpayment amount for the sample of audited beneficiaries. RADV audits of MA contracts have been limited, and their results are largely unreported. Audits of 2007 risk-adjustment data identified diagnoses that did not meet risk-adjustment criteria and determined that average overpayment rates were well over 10 percent for most contracts under audit (Schulte 2016). CMS

(continued next page)

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 their FFS beneficiaries. We note that using two years of diagnostic data would help address the underreporting 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 burden to providers if they were required to assist with the collection of medical charts for FFS beneficiaries, and the resources required for the Medicare program to review those charts

to identify diagnoses allowable for risk adjustment. 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 illustrative 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 RADV audits.⁵³ 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

Update on risk-adjustment data-validation audits (cont.)

recovered \$13.7 million in overpayments from audits of 37 contracts, based on overpayments for only the 7,437 beneficiaries included in the audit sample (Centers for Medicare & Medicaid Services 2017). No audits were conducted for payment years 2008, 2009, or 2010. Kaiser Health News obtained, through a Freedom of Information Act request, summaries of the preliminary results for 90 audits completed during 2011, 2012, and 2013 and found that 71 audits uncovered net overpayments, with 23 audits finding overpayments of \$1,000 or more per beneficiary (Schulte and Hacker 2022).

For audits of 2018 and subsequent years, CMS finalized an audit method that would allow CMS to recover overpayments by extrapolating the error rate of the sampled enrollees to a larger population of audit-eligible enrollees in the contract. The majority of MA enrollees would be eligible for audit, as nearly 70 percent of MA enrollees had at least one hierarchical condition category (HCC) in

2022, and only a small fraction of these enrollees would be excluded from the audit sample for other reasons.⁵⁴ However, in November 2024, CMS released a guidance document restricting the audit-eligible population to a much narrower set of enrollees in a given contract. Audits of 2018 data will focus only on two sets of beneficiaries: beneficiaries in the top decile of a contract's enrollees based on the greatest expected reduction in their risk score as a result of a RADV audit (based on CMS's improper-payment prediction model) or contract enrollees who had all of their HCCs supported only by chart reviews (Centers for Medicare & Medicaid Services 2024c). The first group of beneficiaries is roughly one-tenth of the beneficiaries who would have been audit eligible under pre-2018 methods. For the second group, we estimate that between 2 percent and 3 percent of all MA enrollees (or between 3 percent and 4 percent of MA enrollees with at least one HCC) had all of their HCCs supported by only chart reviews, and those enrollees had an average of 1.5 HCCs. ■

on this recommendation, estimates of MA coding intensity net of CMS's coding adjustment were much smaller than they are for 2025. 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 2024, the MA program included 5,678 plan options offered by 175 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 2024. The continued growth in MA enrollment, the substantial number of plans offered by several organizations, and plans' ability to provide generous supplemental 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), given that the margins reported in plan bids may provide an incomplete picture of insurers' financial condition. Given our declining confidence in the salience and accuracy of plan-reported margins, we focus on more reliable indicators of the financial health of the MA program, such as plan availability and enrollment. As noted above, substantial growth in MA plan availability and enrollment indicates a robust MA program.

MA market was heavily concentrated locally and nationally in 2024

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 shown that markets with more competition are associated with increased MA-benefit generosity and lower MA premiums (Cabral et al. 2018, Pelech 2018, Pizer and Frakt 2002, 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 (Frakt et al. 2012, Pelech 2017).⁵⁵

Over the last decade, enrollment in MA 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 2024, the share of total MA enrollment in the three largest firms (UnitedHealth Group, Humana, and CVS Health) rose from 32 percent to 59 percent. Much of the growth of these firms—particularly UnitedHealth Group and Humana—has been driven by enrollment increases in counties in which the insurers have offered plans for many years (Hnath et al. 2024). However, all three have also significantly expanded the number of counties in which they offer plans. For example, UnitedHealth Group expanded from offering coordinated-care plans (i.e., HMO or PPO plans) in 41 percent of counties (a service area covering 68 percent of MA-eligible beneficiaries) in 2013, to 54 percent of counties (covering 81 percent of eligible enrollees) in 2020, to 85 percent of counties (covering 95 percent of eligible enrollees) in 2024 (Table 11-6).⁵⁶ Humana and CVS Health have also expanded their service areas, and all three organizations now offer plans in counties that are home to more than 85 percent of MA-eligible beneficiaries. A recent study found that some of the service-area expansions for these three insurers were due to the companies acquiring existing MA contracts from another insurer (Hnath et al. 2024).⁵⁷ For example, acquisitions accounted for 30 percent of new county participation for UnitedHealth Group between 2012 and 2023 (acquisitions accounted for 16 percent and 5 percent of new county participation for CVS Health and

Humana, respectively) (Hnath et al. 2024). However, the study found that nationally, for all MA insurers, only 15 percent of total market-entry events were attributable to acquisitions. These findings suggest that the service-area expansions of large national insurers have (at the time of market entry) generally served to introduce new competition into local markets and are not simply an artifact of changes in ownership of existing competitors.

Between 2023 and 2024, the share of enrollees covered by these top three organizations rose by 1 percentage point to 59 percent (4 percentage points higher than in 2020) (Table 11-6).⁵⁸ Among conventional plans (i.e., plans available to all Medicare beneficiaries, excluding SNPs and employer group plans), the top three organizations nationwide had 57 percent of enrollment in 2024—an increase from 56 percent in 2023.⁵⁹

Given the relevance of local competition for MA enrollees, we place greater importance on examining competition at the county level (Table 11-6). Measures of local market concentration were mixed in 2024. Excluding employer plans and SNPs, in 2024, enrollment in the largest organization in each county (regardless of the insurers' national enrollment) accounted for 42 percent, on average, of all MA enrollment in the county. Enrollment in the top three organizations in each county accounted for 81 percent, on average, of all MA enrollment (unchanged from 2023 but less than the 83 percent observed in 2020). 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 94 percent in 2023 to 95 percent in 2024 (data not shown).⁶⁰ The geographic expansion of large national insurers has contributed to the changing 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 (data not shown).

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 steadily gaining market share in areas that have historically been very concentrated. Estimates for 2025 indicate that the average beneficiary will have access

**TABLE
11-6****Medicare Advantage enrollment became increasingly concentrated nationally but slightly less concentrated at the county level, July 2020–July 2024**

Plan type	Share of MA-eligible beneficiaries living in counties in which insurer offers an MA plan*			Percentage point change in share	
	2020	2023	2024	2020–2024	2023–2024
Conventional plans					
Top 3 nationwide					
UnitedHealth Group Inc.	81%	94%	95%	+14%	+1%
Humana Inc.	87	92	93	+5	+1
CVS Health Corporation	78	84	88	+10	+4
All MA plans					
Top 3 nationwide					
UnitedHealth Group Inc.	26	29	28	+2	–1
Humana Inc.	18	18	18	0	0
CVS Health Corporation	11	11	13	+2	+2
Conventional plans					
Top 3 nationwide					
UnitedHealth Group Inc.	23	25	24	+1	–1
Humana Inc.	22	22	21	–1	–1
CVS Health Corporation	9	9	12	+3	+3
County level (weighted average)**					
Top organization	45	43	42	–3	–1
Top 2 organizations	69	67	66	–3	–1
Top 3 organizations	83	81	81	–2	0

Note: MA (Medicare Advantage). Includes only MA plans (coordinated-care plans, private-fee-for-service plans, and Medical Savings Account plans). Excluded are cost-reimbursed plans and Medicare–Medicaid demonstration plans. “Conventional plans” excludes special-needs plans and employer group plans, which have restricted availability. Components may not sum to totals, differences, and market shares due to rounding.

* Counties in Connecticut are excluded due to changes over time in how the state’s counties are tabulated.

** County-level shares of MA enrollment reflect the beneficiary-weighted average of the top organizations in each county.

Source: MedPAC analysis of July 2020–2024 enrollment data and CMS Landscape files.

to many MA plans offered by a substantial number of organizations, as illustrated earlier in this chapter. 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.

Vertical integration of Medicare Advantage plans and providers

MA organizations are increasingly integrating vertically, with provider and insurer lines of business having common ownership (or other financially aligned arrangements). The Commission has previously found that vertical integration is highest in organizations in which a provider-based organization owns and operates a health plan, although the share of enrollees in such vertically integrated plans has eroded over time (Chartis Group 2024, Johnson et al. 2017, Medicare Payment Advisory Commission 2024).

However, insurer-led integration has accelerated in recent years, and several of the largest MA organizations (MAOs) have invested significantly in the acquisition of provider businesses, suggesting that insurers see advantages to owning a greater share of the health care supply chain (CVS Health 2023, Humana 2022, Humana 2021, Humana 2020, Signify Health 2023, UnitedHealth Group 2023, UnitedHealth Group 2022).

MA payment policy—though not the only factor influencing firms' decisions to integrate—likely promotes such arrangements by incentivizing efficient care delivery, rewarding plans that record diagnoses more thoroughly, and providing bonuses to plans that perform well on quality measures (Medicare Payment Advisory Commission 2024). Although the evidence regarding the relationship between plan-provider integration and efficiency, coding intensity, and quality is limited, MAOs may view integration as a way to influence providers' activities more directly to achieve the outcomes incentivized under MA's capitated payment structure. Researchers have also suggested that payments to plan-owned providers may offer an opportunity for MAOs to retain a higher share of profits within the parent organization while meeting medical loss ratio requirements (Frank and Milhaupt 2023, Frank and Milhaupt 2022).

No public data provide a systematic accounting of ownership relationships between MA plans and health care providers, which poses a significant barrier to studying the effects of vertical integration. However, CMS requires MAOs to submit limited 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.⁶¹ While the submitted data are projections and not a 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 11-17 illustrates that the degree of vertical integration in MA varies widely across parent organizations and is highest in provider-owned plans. Among these plans, the share is highest in plans owned by health systems (data not shown).⁶²

The data show that large national insurers, on average, remain significantly less vertically integrated than their provider-owned competitors. However, at least one large national insurer is now significantly more vertically integrated than many provider-owned plans. This finding is particularly noteworthy given that large national organizations insure a significant share of MA enrollees nationwide, so trends in the organization of the businesses can affect millions of beneficiaries. While the information presented here is reported at the parent-organization level, health care markets operate primarily at a local level, and national statistics do not necessarily describe the markets in which most beneficiaries live.

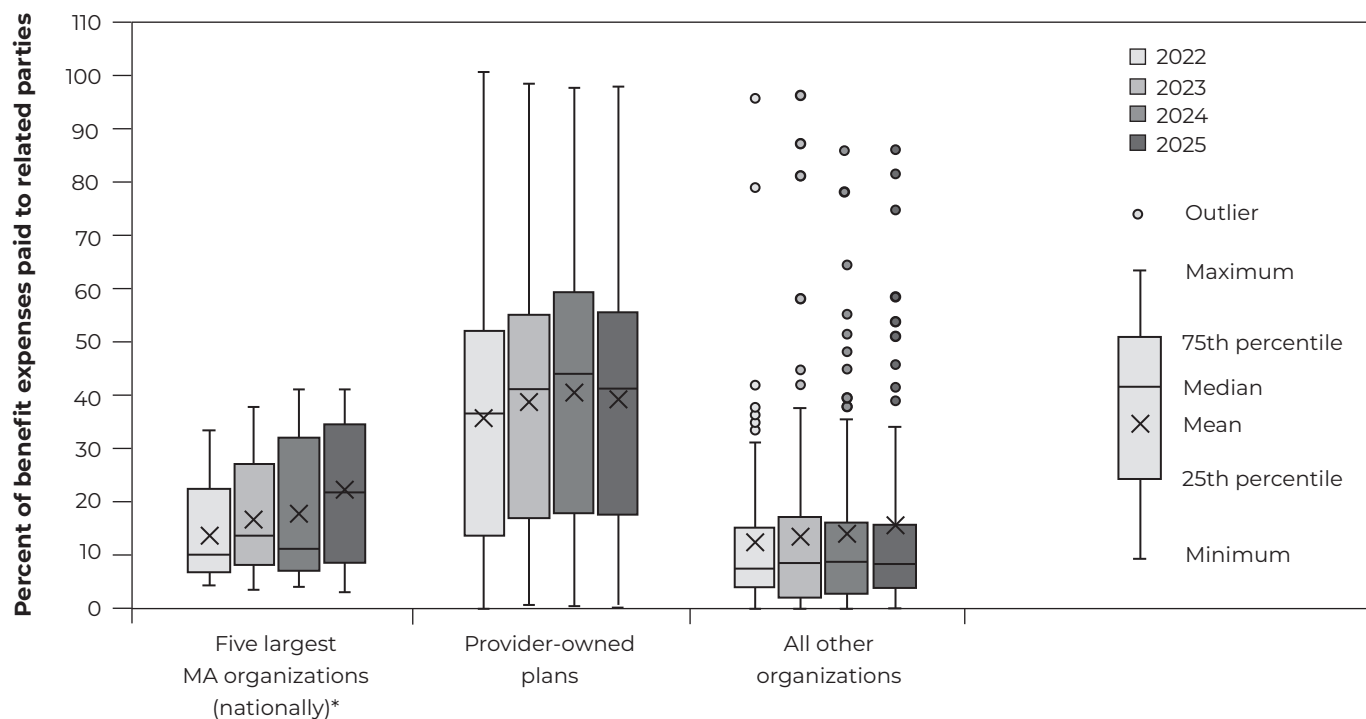
Altogether, we find that the MA industry is increasingly vertically integrated and that such integration may enable MAOs to achieve higher profitability under current MA payment policy. The Commission plans to continue monitoring trends in integration in MA and evaluating its effects on enrollees and the function of the program.

MA margins

The continued growth in MA enrollment, the substantial number of plans offered by several organizations, and plans' ability to provide generous supplemental 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 2024). However, we have become increasingly concerned about the appropriateness of focusing on plan margins (instead of other metrics

**FIGURE
11-17**

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. “Outliers” are values greater than 1.5 times the difference between the values at the 75th and 25th percentile. “Maximum” and “minimum” are the values for the category when outliers are excluded.

Source: MedPAC analysis of data from CMS on plan bids, MMIT Directory of Health Plans.

of 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 business (Ortaliza et al. 2024, Ortaliza et al. 2023). Because Medicare beneficiaries have higher costs than other populations, 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, the per enrollee revenues that remain after covering medical costs may tend to be higher in MA relative to individuals covered under other lines of business. 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 to employee and broker compensation, investments, advertising, lobbying, infrastructure, and returns to shareholders (in for-profit plans).

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 between insurers and providers increases. The Commission stated in its March 2024 report to the Congress that it would consider not reporting plan margin data in future years. Given our declining confidence in the salience and accuracy of plan-reported margins, we omit these data and focus on more reliable indicators of the financial health of the MA program, such as plan availability and enrollment (Medicare Payment Advisory Commission 2024).

Quality in MA

The Commission has long held that MA presents opportunities for innovation to achieve higher-quality

care at lower cost. It is important for the Medicare program to monitor MA plan performance and quality to ensure that beneficiaries have access to high-quality health care. Beneficiaries also need good information about the quality of 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 (Medicare Payment Advisory Commission 2020a, Medicare Payment Advisory Commission 2019). Nonetheless, these measures are the basis for the MA quality-bonus program (QBP), which increases MA payments by about \$15 billion annually. However, because it is important to understand beneficiaries' experience with their coverage in the MA and FFS programs, this year we report patient-experience scores, which are less subject to the challenges of current Medicare quality reporting for MA and FFS beneficiaries. Here we provide a brief overview of the current MA QBP and indicators of patient experience in MA compared with FFS from the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys of these groups.

CMS assessment of MA quality

It is important for Medicare to ensure that MA plans provide good quality care to their enrollees. Quality measurement and rewards can promote better plan quality and support beneficiary choice of plans. In 2006, CMS introduced the MA star-rating system composed of measures tied to clinical quality, administrative capability, and patient experience.⁶³ Medicare currently collects close to 100 MA quality measures, over 40 of which are used to determine a star rating from 1 to 5 for each MA contract.^{64,65} These ratings are made available through the Medicare Plan Finder website to enable beneficiaries to compare across plans. As required by the ACA, since 2012 the MA star-rating system has been the basis of the QBP, which increases benchmarks for MA contracts rated 4 stars or higher.⁶⁶ 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. Beneficiaries enrolled in an MA plan with less than 5 stars can use a once-a-year special enrollment period to switch to a 5-star plan outside of the open enrollment period.

The share of MA contracts receiving quality bonuses has been declining in recent years but remains consistently high. Forty-one percent of rated MA contracts are in bonus status for 2025, a decrease from 44 percent in 2024 and 51 percent in 2023 (Centers for Medicare & Medicaid Services 2024a).⁶⁷ Sixty-nine percent of MA enrollees are enrolled in bonus-status contracts in 2025, compared with 75 percent in 2024 and 72 percent in 2023. Under the coronavirus public health emergency (PHE), CMS relaxed quality-reporting rules, boosting the average star rating from 4.06 in 2021 (before the PHE rule change) to 4.37 in 2022. The rules reverted for the 2023 plan year, and the average star rating has declined to 3.95 in 2025. The share of enrollees in plans achieving 5 stars has also returned to levels more similar to the prepandemic norm—from 27 percent in 2022 to 3 percent in 2025.

Patient-experience scores in MA and FFS Medicare

Good information on the quality and experience of care that MA enrollees receive—and how it compares with FFS Medicare—is necessary for beneficiaries and policymakers to properly evaluate program and plan options. However, several data and methodological challenges affect the ability to compare performance across MA and FFS:

- data completeness and comparability (e.g., lack of clinical data),
- differences in coding intensity across plans and between MA and FFS, and
- favorable selection in MA.

The Commission has discussed its concerns with these limitations in previous reports (Medicare Payment Advisory Commission 2024, Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2020a, Medicare Payment Advisory Commission 2020b, Medicare Payment Advisory Commission 2016b). Despite these challenges, the Commission has expressed a strong interest in assessing the quality of care that Medicare beneficiaries receive. To that end, this year we include a summary of MA- and FFS-CAHPS patient-experience measures.

Patient-experience measures are an important indicator of quality of care because they assess

whether something that should happen (such as getting needed care quickly) 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. Although not free from the challenges of measuring MA and FFS quality, patient-experience measures are less subject to some of the challenges in comparing MA and FFS outcomes that we have discussed in previous reports.

The Agency for Healthcare Research and Quality's CAHPS surveys generate standardized and validated measures of patient experience. CMS annually fields a CAHPS survey among a sample of FFS beneficiaries to measure beneficiaries' experience of care with Medicare and their FFS providers.⁶⁸ MA organizations are required to contract with a third-party survey vendor to collect CAHPS survey responses from a random sample of each MA contract's enrollees. No FFS administrative claims data or MA plan-submitted encounter data are used in calculating the CAHPS scores, so issues of MA encounter-data completeness and differences in coding intensity do not pose the same degree of challenge as other quality measures when comparing MA and FFS results.

FFS-CAHPS are sampled at the state level, and MA-CAHPS are sampled from contracts. To calculate national FFS and MA scores, CAHPS measures are case-mix adjusted for beneficiary characteristics and weighted at the state and contract level, respectively.⁶⁹ Case-mix adjustment can help control for some differences in beneficiary characteristics among those surveyed, but it does not standardize for all potential differences between the two populations. For instance, differences in the geographic composition of the MA and FFS populations are not included in the adjustment.⁷⁰ Table 11-7 (p. 372) presents CAHPS measure scores for the most recent year available, 2023.

Beneficiaries in both the MA and FFS programs rated their coverage and experience favorably overall in 2023. Many CAHPS measure results were similar for the MA and FFS populations; a few showed small differences (Table 11-7, p. 372). The 2023 MA-CAHPS measure score for “getting needed care and seeing specialists” was 81 (scored on a scale of 0 to 100), which is similar to

**TABLE
11-7****Differences between MA-CAHPS and FFS-CAHPS scores are small, 2023**

CAHPS measure	MA	FFS
Getting needed care and seeing specialists	81	80
Getting appointments and care quickly	83	82
Care coordination (e.g., personal doctor always or usually discusses medication, has relevant medical record, helps with managing care)	86	86
Customer support	90	87
Rating of health plan	88	83
Rating of health care quality	87	85
Annual flu vaccine	71	73

Note: MA (Medicare Advantage), CAHPS (Consumer Assessment of Healthcare Providers and Systems), FFS (fee-for-service). The first four measures are composite measures of multiple survey questions which have responses of “never,” “sometimes,” “usually,” and “always.” CMS converts these to a linear mean score on a 0 to 100 scale. The fifth and sixth measures are global rating measures in which survey questions have responses of 1 to 10, which CMS also converts to a linear mean score on a 0 to 100 scale. The annual flu vaccine measure has a yes/no response. “Plan” in “rating of health plan” refers to the Medicare FFS program or MA, respectively. The FFS-CAHPS response rate was 28 percent, and the MA-CAHPS response rate was 33 percent. In 2023, CMS revised which CAHPS survey items are scored in the “getting appointments and care quickly” composite measure, which may cause fluctuation in scores compared with prior years.

Source: MA-CAHPS and FFS-CAHPS national mean scores published by CMS, 2023.

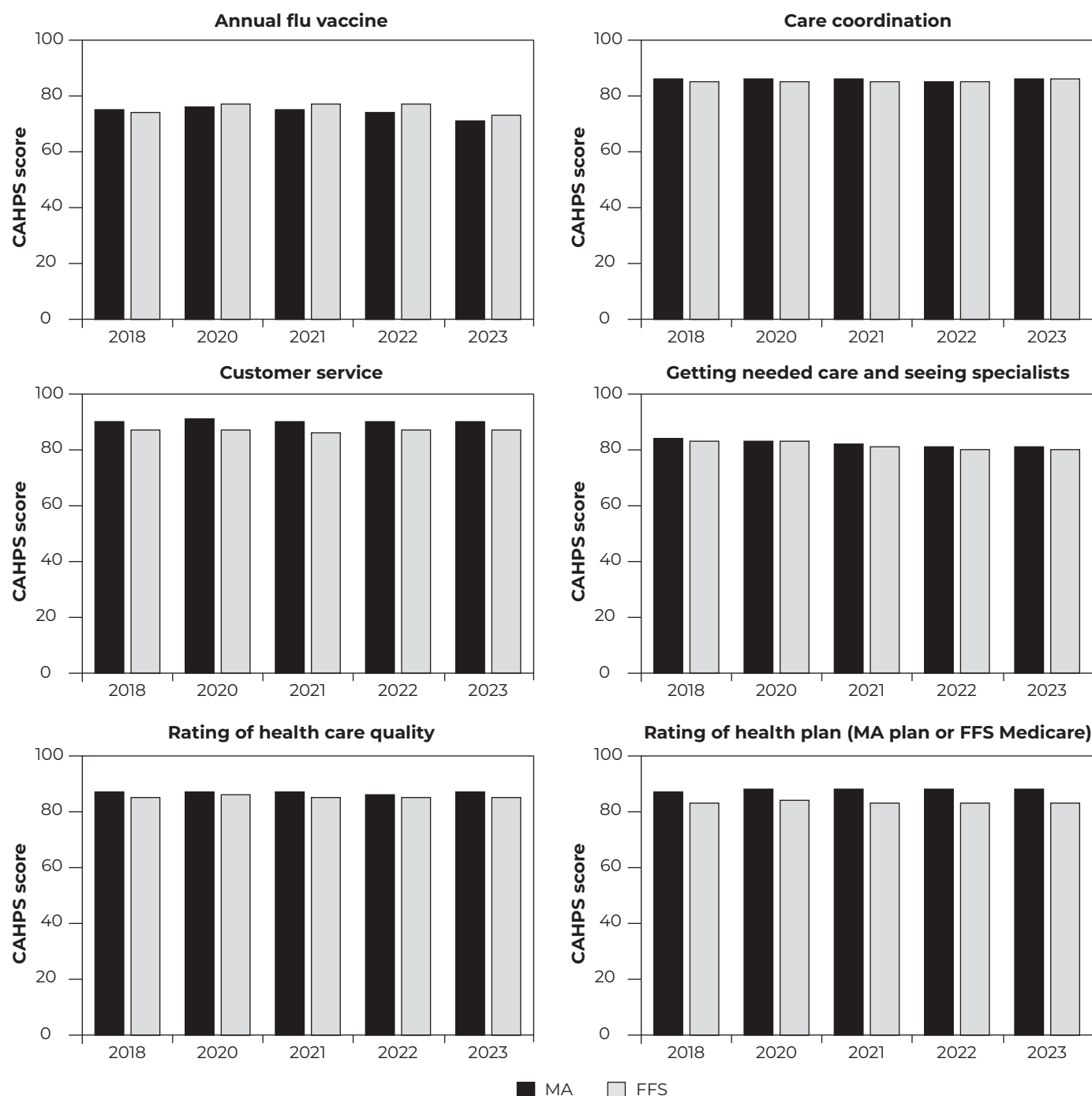
the FFS-CAHPS measure score of 80. The FFS- and MA-CAHPS scores for the “care coordination” measure were both 86. MA-CAHPS scores were slightly higher than FFS-CAHPS scores for the “customer support,” “rating of health plan,” and “rating of health care quality” measures; however, the FFS-CAHPS score for “annual flu vaccine” was slightly higher than the MA-CAHPS score.

The 2023 results were in keeping with previous years; beneficiaries in both programs generally rated their coverage and experience highly, and differences in the experiences of MA and FFS beneficiaries on these measures were small. For example, the MA- and FFS-CAHPS scores for the “care coordination” measure were about the same and virtually unchanged from 2018 to 2023 (Figure 11-18). Beneficiaries reported “get[ting] needed care and see[ing] specialists” at nearly identical rates across programs and over time.

The Commission recognizes that these relatively high and consistent scores do not imply perfect access to care in either MA or FFS Medicare. CAHPS surveys target a random sample of all enrollees, not just those who have sought care during the survey period. The

pattern of responses among subsets of this population (for instance, those with serious health needs) may be quite different. Certain other subsets of enrollees, such as those residing in institutional settings, are also excluded from participation. Further, CAHPS survey items focus on breadth of access to care, not the specifics of cases in which problems have been experienced. While the Commission has expressed concern that the small share of beneficiaries with the greatest health needs may disproportionately experience access problems, the CAHPS survey is not designed to capture the depth of those problems. For this reason, the Commission aims to contextualize the results of these broad, population-level surveys with findings from our annual focus groups, and we are beginning to explore other potential indicators of access and quality in MA, such as prior authorization, provider networks, and reasons for disenrollment from MA plans.

There are other ways of measuring quality outside of patient experience; however, the Commission previously reviewed the literature on studies using other measures and found the literature to be inconclusive.⁷¹ We found wide heterogeneity in

**FIGURE
11-18****MA-CAHPS and FFS-CAHPS measure scores are consistently high, 2018-2023**

Note: MA (Medicare Advantage), CAHPS (Consumer Assessment of Healthcare Providers and Systems), FFS (fee-for-service). The annual flu vaccine measure has a yes/no response. "Care coordination," "customer service," and "getting needed care and seeing specialists" are composite measures in which survey questions have responses of "never," "sometimes," "usually," and "always." CMS converts these to a linear mean score on a 0 to 100 scale. The ratings of health care quality and health plan are global rating measures in which survey questions have responses of 1 to 10, which CMS also converts to a linear mean score on a 0 to 100 scale. "Plan" in "rating of health plan" can refer to either an MA plan or the FFS Medicare program. The FFS-CAHPS response rate was 28 percent, and the MA-CAHPS response rate was 33 percent. CMS revised which CAHPS survey items are scored in the "getting appointments and care quickly" composite measure, which may cause fluctuation in scores compared with prior years. For this reason, we did not include this measure in the time series. The 2019 CAHPS surveys were halted due to the coronavirus pandemic. We report values for 2018 to include a prepandemic comparison year.

Source: MA-CAHPS and FFS-CAHPS national mean scores published by CMS, 2023.

terms of study populations, metrics evaluated, and data sources used. Some studies found that MA outperformed FFS, some found that FFS outperformed MA, and some were unable to conclude that one program was better than the other. In studies reporting multiple outcomes, results did not consistently point to higher performance in one program than the other. Three major challenges—data completeness and comparability, differences in coding intensity across plans and between MA and FFS, and favorable selection in MA—impacted all included studies to varying extents, limiting our ability to draw conclusions.

Earlier reviews found similarly wide heterogeneity in study design and quality and came to similar conclusions (Agarwal et al. 2021, Ochieng and Fuglesten Biniek 2022). With respect to CAHPS scores specifically, Agarwal and colleagues’ review included six studies, conducted between 2009 and 2019; they concluded that the evidence on experience of care did not show meaningful differences between the aggregate performance of MA plans and FFS Medicare (Agarwal et al. 2021). Overall, MA enrollees and FFS Medicare beneficiaries reported similar levels of satisfaction with care, across these studies and the survey data we have analyzed. Despite these challenges, it is necessary to understand the quality of care that Medicare beneficiaries receive, for both beneficiary decision-making and program-monitoring purposes. The Commission will continue to explore available data sources to better understand beneficiary experiences with the MA program.

Commission recommendations to improve MA payment policies

The Commission is concerned that current Medicare policy to pay MA plans and incentivize high-quality care does not serve beneficiaries or taxpayers. The Commission has found that CMS’s coding-intensity adjustment is inadequate to address the higher level of MA diagnostic coding we estimate for 2025 and the resulting higher payments to MA plans and generates inequity across MA parent organizations. At the same time, the quality-bonus program boosts plan payments for 69 percent of MA enrollees but does not effectively promote high-quality care. Further, when we account for the effects of higher coding intensity and of favorable selection in MA, we estimate that MA

plan bids in 2025 are, on average, roughly equal to the costs of covering the Medicare benefit under FFS. For some enrollees, the supplemental benefits fill gaps in the Medicare benefit by adding coverage for services that are not included in traditional Medicare.⁷² 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 Medicare. But MA payment policies distort the goal of plans competing to improve quality and reduce health care costs; instead, these 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 so that beneficiaries can choose among Medicare coverage options. But the rapid growth of MA enrollment and spending elevates the urgent need for important reform of Medicare’s policies of paying and overseeing MA plans. As MA enrollment continues to grow, higher payments to plans will worsen Medicare’s fiscal sustainability.

Overall, we estimate in 2025 that Medicare is paying MA plans 20 percent, or \$84 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. Paying MA plans more than FFS spending for beneficiary care also creates inequities among beneficiaries since beneficiaries in FFS Medicare help finance the higher payments that MA plans use to provide supplemental benefits for their enrollees (benefits that FFS beneficiaries generally must pay for out of pocket or through supplemental insurance). We estimate that aggregate Part B premiums will be about \$13 billion (10 percent) higher in 2025 because of payments above FFS spending (equivalent to about \$198 per beneficiary per year).⁷³ Further, incentives for efficient delivery of care are undermined by paying MA plans more than the program pays for FFS beneficiaries. 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

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 Affordable Care Act of 2010 (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 2016c.

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 11-8 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 2016c); (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-QBP 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 the incentives for MA plans 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 contends 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). ■

11-A

TECHNICAL APPENDIX

Favorable selection

The Commission's methodology for estimating favorable selection in MA

The risk-adjustment model that CMS uses to adjust payments to Medicare Advantage (MA) plans predicts Medicare spending using beneficiary characteristics, including demographics and medical conditions. The model is estimated using data from beneficiaries enrolled in the fee-for-service (FFS) program. For any set of characteristics, some FFS beneficiaries with those characteristics will have actual spending that is more than predicted and others will have actual spending that is less than predicted by the risk-adjustment model.

“Favorable selection” refers to the tendency for Medicare’s risk-adjustment model to—on average—overpredict the spending that the MA-enrolled population would have had if they were enrolled in the FFS program, even if medical conditions were recorded with similar coding intensity. Favorable selection can occur due to unmeasured differences in health status but can also result from factors such as differences in beneficiaries’ propensities to seek, or receive, care for reasons that are unrelated to their health.

Chapter 11 presents estimates from two methods of estimating the effect of favorable selection in the MA population. The first is a comprehensive method that we apply to estimate a selection effect for the entire MA-enrolled population—except for those with end-stage renal disease (ESRD)—in each year from 2016 to 2022. We also use estimates from that method to project the effect of favorable selection for 2023 to 2025, years in which we do not yet have data available. The second is a simple method that estimates favorable selection for the portion of MA enrollees in each year who were enrolled in the FFS program in the previous year, referred to as “recent switchers.” We use that simple method, which is described in the main chapter, to estimate selection for the years before 2016 (going back to 2007). We also apply that method to more recent years of data in order to compare estimates for the two methods in similar years and conduct other analyses that examine how favorable selection varies by beneficiary characteristics and geography.

Comprehensive methodology for estimating favorable selection of the MA population

We use our comprehensive method to estimate an aggregate selection percentage for the entire population of non-ESRD MA enrollees in each year, beginning in 2016. That aggregate selection percentage represents the amount by which the predicted spending used for payment for the entire MA population (estimated using the FFS population in Medicare’s risk-adjustment model) underpredicted (or overpredicted) the actual spending that population would have had if those beneficiaries had been enrolled in the FFS program in that year. It is computed as a ratio of (1) the estimated spending that the FFS program would have incurred for the MA-enrolled population had they been enrolled in the FFS program (the numerator) and (2) the estimated FFS spending that the Medicare payment system predicted for that population (the denominator). We label that ratio the “selection percentage.” We cannot directly observe the selection percentage of beneficiaries during their enrollment in MA because we cannot observe what their spending would have been had they instead been enrolled in FFS in that year. We can directly estimate the selection percentage of MA enrollees who were previously enrolled in the FFS program in the year before they switched to MA. Thus, we use data from MA enrollees who were previously enrolled in the FFS program as our study population and model how their selection percentage changed between the year before they enrolled in MA and their most recent year of MA enrollment.

Our study population consists of beneficiaries who had at least two years of prior enrollment in the FFS program before switching to MA (“previous switchers”), approximately 38 percent of non-ESRD MA enrollees in 2021.⁷⁴ For those enrollees, we have complete data on their spending and risk scores while in FFS that we can use as the basis for estimating a selection effect. The remaining non-ESRD MA population either enrolled in MA upon their initial eligibility for Medicare (33 percent in 2021) or had less than two years of prior FFS enrollment (29 percent in 2021).⁷⁵ For those enrollees, we assign a selection percentage using data from switchers who joined MA in the same year and had the same mortality status in the following two years. MA enrollees with ESRD, who accounted for 1 percent of

the MA population in 2023, are assigned a selection effect equal to zero.⁷⁶

We estimate selection for the study population of MA enrollees who were previous switchers using two main components: the selection percentage before each beneficiary was enrolled in MA (“base-year selection”) and the estimated change in selection between the base year and the most recent year of MA enrollment. We describe below how we measure base-year selection and the change in selection for that population.

Study and comparison populations

We include beneficiaries in our study population if they (1) were enrolled in MA for at least one month of the year we are estimating selection for (referred to as the “target year,” which is 2022 for the most recent estimate); (2) had joined MA between 2008 and 2022; and (3) 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. Because hospice enrollees receive their Medicare Part A and Part B coverage only from FFS and not from MA plans, we remove MA enrollment months while the beneficiary is in hospice (unless they were participants in CMS’s value-based insurance design hospice demonstration).⁷⁷ We address the issue of decedents separately (discussed below).

Consistent with our comparisons of MA payments and coding relative to FFS spending, we include beneficiaries enrolled in conventional MA plans (available to all beneficiaries), special-needs plans, and employer plans because the Medicare program makes payments to plans for all of these populations, and they all can experience favorable selection. We require beneficiaries to have at least two full calendar years of FFS enrollment because the CMS hierarchical condition category (HCC) risk-adjustment model calculates risk scores using diagnoses from the prior year’s claims. Thus, we require data on MA beneficiaries with two years of prior FFS enrollment to calculate risk scores for their last year of FFS enrollment.⁷⁸ We divide the study population for each target year into 14 annual cohorts based on the year they previously enrolled in MA (2009 through 2022). The study population of MA enrollees is used to construct the numerator of the selection percentages we estimate.

For the comparison population used to construct the denominator for the selection percentages, we

include nearly all FFS beneficiaries who would have been part of CMS’s MA benchmark calculation and had the necessary data to construct risk scores. We also apply an additional exclusion to the FFS population used for benchmark calculations by requiring the comparison population to have had both Part A and Part B coverage for at least one full calendar year by the end of the base year (the study population’s last year of FFS enrollment). That exclusion is applied to enhance similarity to the MA-enrolled population and to align with the population used to construct the base spending component of the Commission’s comparison of MA to FFS spending. In addition, we exclude beneficiaries with any Part A-only, Part B-only, or MA months during the base year.

We exclude beneficiaries from both the study and comparison populations if they had ESRD, Part A-only coverage, Part B-only coverage, 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 state-based FFS rates for ESRD beneficiaries and adjusts benchmarks and payments for those with Medicare as a secondary payer to remove the secondary-payer effect. In addition, we exclude beneficiaries who did not reside in the 50 states and the District of Columbia.

Base-year selection percentage

Each beneficiary has a selection percentage that represents by how much their predicted spending estimated using Medicare’s risk-adjustment model (“predicted spending”) in year t underpredicts or overpredicts the actual spending they would have had if they were enrolled in the FFS program in that year. That individual-year-level selection percentage is denoted as $S_{i,g,t}$, for individual i , residing in county g , in time t . Time t indexes the time since individuals in each cohort of MA switchers switched from FFS to MA, with $t = 0$ representing the year before the switch occurred and $t = 1$ representing the first year the cohort was enrolled in MA. We use year $t = T$ to denote the “target year” in which we are measuring selection of the MA population. For example, consider a group of MA enrollees in 2022 who previously switched from the FFS program to MA in 2019 (and stayed in MA through at least one month in 2022). For those enrollees, $t = 0$ is 2018, $t = 1$ is 2019, and $t = T$ is 2022.

We refer to a beneficiary's selection percentage in the year before switching to MA as the base-year selection percentage and denote the base year as $t = 0$. Because MA switchers were enrolled in FFS in year $t = 0$, we can use their actual FFS spending to estimate their selection percentage in that year.

We estimate their base-year selection percentage as the ratio of each individual's actual spending relative to an estimate of their predicted spending (which is specific to their county g):

(1)

$$S_{i,g,t=0} = \frac{y_{i,g,t=0}}{\bar{y}_{g,t=0} \times r_{i,g,t=0}}$$

Where $y_{i,g,t=0}$ is the individual's actual FFS spending in year $t = 0$, $\bar{y}_{g,t=0}$ is the average risk-standardized spending of FFS enrollees in the same county g (standardized to a 1.0 risk score), and $r_{i,g,t=0}$ is the individual's risk score in year $t = 0$.⁷⁹ That initial selection percentage represents by how much Medicare's risk-adjustment model underpredicted or overpredicted the actual spending that the MA switchers had during their last year in FFS.

Selection in the base year is measured with a very high degree of accuracy for the population of MA switchers with the requisite two prior years of enrollment in FFS. However, our primary objective is to measure the degree of selection for the population of MA enrollees during the target year in which they were enrolled in MA in time $t = T$.

An individual's selection percentage at time $t = T$ could differ from their selection in the base year for several reasons, which can be seen from considering the terms in the formula above. First, the spending an individual would have had in FFS (the numerator) could get closer to their predicted spending over time, holding constant the risk model and the composition of the FFS population used to calibrate risk scores and calculate average spending. That phenomenon is known as "mean reversion."⁸⁰ Second, an individual's predicted spending in the denominator could get closer to or further from the numerator, holding the numerator constant. That could occur if changes to the risk model between $t = 0$ and $t = T$ improve the accuracy of

predicted spending, or if changes in the composition of the FFS population used to calibrate the risk model and compute predicted spending change over time. The composition of the FFS population can change due to the net effect of inflows of people who newly enroll in FFS and outflows of beneficiaries who die or switch to MA. Our approach to estimating the change in selection accounts for all of those reasons.

Change in selection

We are interested in measuring the selection percentage in year $t = T$, when beneficiaries are enrolled in MA and we cannot directly estimate their selection percentage. To estimate their selection percentage in that year, we note that selection in later years can be expressed as the sum of an individual's base-year selection percentage (which we can directly estimate) and the change in their selection percentage:

(2)

$$S_{i,g,t=T} = \underbrace{S_{i,g,t=0}}_{\text{selection in base year}} + \underbrace{(S_{i,g,t=T} - S_{i,g,t=0})}_{\text{change in selection}}$$

We can estimate the change in selection for each MA enrollee as the average change in selection percentage calculated for a proxy group of similar enrollees who were enrolled in the FFS program between $t = 0$ and $t = T$. We define $P_{b,d}^{c,T}$ as the set of beneficiaries that serve as the proxy group for any given cohort, c , of MA enrollees in year T (defined by the year they first enrolled in MA) who have the same base year ($t = 0$), selection percentage b , and year of death d relative to the target year ($t = T$). The average change in selection for the proxy group is calculated as

(3)

$$\Delta S_T^p = \sum_{i \in P_{b,d}^{c,T}} (S_{i,g,t=T} - S_{i,g,t=0}) \times \alpha_i$$

Each individual's weight in the calculation is represented by α_i .⁸¹ The term $S_{i,g,t=0}$ is defined in equation (1), and $S_{i,g,t=T}$ is defined similarly as the ratio of each individual's actual spending in the target year relative to an estimate of their predicted spending in that same year:

(4)

$$S_{i,g,t=T} = \frac{y_{i,g,t=T}}{\bar{y}_{g,t=T} \times r_{i,g,t=T}}$$

Proxy groups are constructed by segmenting the population of beneficiaries who were enrolled in FFS from $t = -1$ through at least one month of $t = T$ into 50 mutually exclusive groups.^{82,83} Those FFS enrollees are assigned to groups according to two key characteristics. First, they are assigned to one of three mortality groups based on their mortality in year $t = T$, $t = T + 1$, and $t > T + 1$. Second, they are assigned to a group based on their base-year selection percentage at $t = 0$. Each MA enrollee is matched to the proxy group that has the same mortality status and level of base-year selection, and the enrollee is then attributed the average change in selection for their matched proxy group.

For example, consider the set of MA enrollees in 2022 who were last enrolled in FFS in 2017 (including all of 2016), died in 2023, and had a selection percentage of 92 percent in 2017. The proxy group for those enrollees consists of beneficiaries who were enrolled in FFS in 2017 (including all of 2016) through 2022, died in 2023, and had a selection percentage between 90 percent and 100 percent in 2017.⁸⁴ The average change in selection percentage for that proxy group between 2017 and 2022 is used as the estimate for the change in selection percentage for the MA enrollees who match to that proxy group.

Matching on base-year selection percentage is important for capturing the potential for mean reversion because people who begin the period with a large degree of favorable (or unfavorable) selection may be more likely to experience larger changes that bring them closer to the mean. Matching on mortality is important because people closer to death tend to have higher spending on average, both in absolute terms and relative to their predicted spending. The average change in selection for the proxy group also accounts for changes to the Medicare risk-adjustment model, changes in the composition of the FFS population, and secular trends in FFS spending over the period. For example, changes to Medicare's risk-adjustment model are reflected in the calculation through changes in risk scores for the proxy group.

Cohort-level estimates of MA switchers

We construct aggregate selection percentages at the mortality-cohort-group level by aggregating the estimates of individual-level selection effects, weighting by predicted spending and number of months enrolled in MA during year $t = T$.

(5)

$$S_{c,d,T} = \sum_{i \in C^{d,T}} (S_{i,g,t=0} + \Delta S_T^p) \times w_{i,T}$$

Because the risk scores of MA enrollees at year $t = T$ are influenced by the coding practices of their plans, in constructing the weights for this calculation we estimate what each individual's risk score would have been in year $t = T$ had they been enrolled in FFS.⁸⁵ To do this estimate, we take the beneficiary's FFS risk score from the base year before they switched to MA and trend it forward based on the change in risk score for members of their proxy group.

Assigning cohort-level estimates to remaining MA population

About 38 percent of the MA-enrolled population in each year are in our study population and have their selection percentage estimated using the method outlined above. The bulk of the remaining MA population either enrolled in MA upon their initial eligibility for Medicare (33 percent) or had less than two years of prior FFS enrollment (29 percent). For those enrollees, we assign a selection percentage as the estimated selection percentage of switchers who joined MA in the same year and had the same mortality status in the following two years. That is, selection percentages are assigned to MA enrollees outside the study population at the mortality-cohort-group level. (We also assign selection percentages to beneficiaries who enrolled in MA prior to 2008 using the estimated selection percentages for the 2008 cohort of our study population.) The decision to generalize estimates of selection from our study population to those other groups is supported by our own analysis and external studies.

Our analysis suggests that MA enrollees who switched from FFS but had less than two years of prior FFS

coverage had favorable-selection effects that were at least as large as the MA enrollees in our study population with at least two years of prior FFS coverage. In our March 2024 report to the Congress, we used risk scores constructed from concurrent diagnoses to examine the effect of favorable selection for beneficiaries who had only one full year of prior FFS enrollment (before switching to MA). We estimated favorable-selection effects that were consistently larger for these beneficiaries than for our study population of MA switchers (i.e., beneficiaries who had at least two years of FFS enrollment before joining MA) (Medicare Payment Advisory Commission 2024).

For beneficiaries who enroll in MA upon initial Medicare eligibility, the available evidence is also consistent with favorable selection. One study used mortality as a rough proxy for MA favorable selection and found substantially lower mortality rates among enrollees who elected MA during their first year of Medicare eligibility (Newhouse et al. 2019). Further, another group of researchers examined pre-Medicare spending for a sample of about 11,000 beneficiaries who enrolled in MA at age 65 between 2015 and 2019. When comparing the risk-adjusted pre-Medicare spending of these MA enrollees with the pre-Medicare spending of a sample of beneficiaries who elected FFS at age 65, these researchers found about 12 percent to 13 percent lower risk-adjusted spending in the MA sample relative to the sample of FFS beneficiaries (Teigland et al. 2023). That estimate of favorable selection exceeds our estimate of favorable selection for MA switchers throughout the 2015 to 2019 period, which we estimate to be 4 percent to 9 percent using the Commission's simple method, which is most comparable with that study's methods. Our analyses combined with the results of other research suggest that the effect of favorable selection for MA entrants who have less than two years of prior FFS coverage, or none at all, may be even larger than what we observed in our study population.

Final aggregate selection percentage of MA population

The final aggregate selection percentage of the entire MA enrolled population in year $t = T$ is a dollar-weighted average of the individual selection percentages. Each enrollee is weighted by the number of months they were enrolled in MA in year $t = T$ and their projected FFS risk score (using the change in risk

score of the proxy group during MA enrollment). This weighting reflects each individual's predicted spending in year $t = T$ as a share of the MA population's predicted spending in year $t = T$.

Our approach to estimating selection for the MA population in the target year using data from people who were enrolled in MA in that year implicitly accounts for the role of selective attrition out of the MA program. "Selective attrition" refers to the tendency for the beneficiaries who either die or disenroll from the MA program to FFS to have risk scores that underpredict their spending. Analyses by the Commission and other researchers have found evidence of selective attrition, suggesting that the size of favorable selection in the MA population could be higher than estimates using data from all people who initially enrolled in MA. By defining our study population as beneficiaries who are enrolled in MA during the target year, we exclude beneficiaries who disenrolled from MA in earlier years. Those beneficiaries are not relevant for estimating selection in the target year because they are no longer part of the MA population. This approach to accounting for selective attrition implicitly through the construction of the study population remains the same in the current version of the methodology and the methods used in the March 2024 report to the Congress.

Technical changes relative to the methods used for the March 2024 report to the Congress

The methodology outlined above reflects several technical updates to our methods from last year. The Commission's March 2024 report to the Congress used the same analytic framework of using cohorts of people who had previously switched from FFS to MA and were still enrolled in MA in the target year and using the FFS experience of cohorts with the same level of base-year favorable selection to estimate changes in favorable selection during MA enrollment (Medicare Payment Advisory Commission 2024). The analysis described in this chapter continues to use the analytic framework from our March 2024 report but makes several technical improvements to improve the accuracy of the estimated changes in favorable selection during MA enrollment and to improve the ways in which we incorporate decedents and near-decedents into our analysis. We made two sets of changes to address those aims.

First, we now use the broadest population of FFS enrollees possible to construct our proxy groups that are used to estimate changes in selection during MA enrollment (including changes due to mean reversion). Choosing a proxy-group population is challenging because it is unknown how the selection percentage of the actual MA population would have changed if they were enrolled in FFS. Our previous method used the portion of FFS enrollees that were future MA entrants as the proxy-group population, which was motivated by a desire to construct a proxy group that was as similar as possible to the MA-enrolled population. However, there was some concern that using future MA entrants could understate mean reversion if beneficiaries with less mean reversion were more likely to later switch to MA but exhibited a more typical mean reversion tendency once they were enrolled in MA. Although our previous approach may have understated mean reversion, a critique of our new, broader proxy group is that it might overstate mean reversion for the MA-enrolled population (and thus understate selection). As a result, we view our updated proxy group as a more conservative methodological choice. Our additional update to the proxy-group construction to include matching by mortality status (described below) mitigates this concern somewhat by making the FFS proxy populations more similar to the MA population with respect to their mortality.

Second, we made several changes to more thoroughly incorporate decedents and near-decedents into our analysis. Our previous method excluded decedents from the populations used to construct the numerator and the denominator of the selection percentages in many parts of the analysis, for tractability. However, we identified several concerns about the exclusion of decedents, some of which would tend to increase the selection effect and others that would tend to decrease it. Our goal with this set of methodological updates is to more accurately reflect selection and the change in selection for decedents and near-decedents in our estimates.

The first concern was that we were understating the mean reversion for decedents and near-decedents in the MA population (that is, overstating their favorable selection) because decedents were not included in the previous proxy groups used to estimate changes in selection. The second concern arose as we considered the first methodological update to use the broader FFS population for our proxy-group population. Because

there are more decedents and near-decedents in the FFS population than the MA population, we were concerned that the broader FFS population might overstate mean reversion for MA enrollees not close to death. (Our analysis shows that, on average, decedents and near-decedents are highly unfavorable and have large changes in their selection percentages.) Third, we were concerned that decedents were not included in the FFS denominator used to construct our base and change in selection percentages, whereas decedents are included in the population that CMS uses to construct MA benchmarks.

We address the first and second concern jointly by including decedents in the new proxy-group population and by matching the proxy-group populations to the MA-enrolled population by mortality status. We address the third concern by including decedents in the populations used to estimate predicted spending in the denominators for the base- and target-year selection percentages. That is, the populations used to estimate the terms $\bar{y}_{g,t=0}$ in equation (1) and $\bar{y}_{g,t=T}$ in equation (4) now includes people who died in $t = 0$ and $t = T$, respectively. Including decedents in the denominators is also a necessary change to make if we want to include decedents in the proxy-group population (which serves as the numerator for the change in selection estimate). Including decedents in both the numerator and the denominator of all relevant steps of the calculations is necessary for consistency and improves the accuracy of our estimates.

We now describe each of the technical updates more thoroughly:

- Changes to the comparison group (denominator) populations for all components of the estimate: We made two changes to the populations used to estimate predicted spending in the denominators of our selection percentages (that is, the populations used to estimate $\bar{y}_{g,t=0}$ in equation (1) and $\bar{y}_{g,t=T}$ in equation (4)). Previously, the populations used for those calculations included FFS enrollees who were both alive for the entire year and did not switch to MA in the following year. The denominator population now includes FFS enrollees who died during the year and enrollees who switched to MA in the following year. Both those changes are consistent with the populations that CMS uses to calculate benchmarks, and

making those changes allows us to better account for differences in mortality between MA and FFS.

- Changes to the proxy-group populations used for the change in selection component of the estimate: Proxy cohorts now consist of all beneficiaries who remained in FFS during the period of MA enrollment, including beneficiaries who died in the target year $t = T$. Previously, we included only the subset of FFS beneficiaries who switched into MA in the year following the target year in our proxy groups. This update to our method allows our estimate to better account for the change in selection percentage for MA enrollees who die within the target year.⁸⁶
- Matching the MA-enrolled population to proxy groups using mortality status: When modeling changes in selection during MA enrollment, we now match MA cohorts and their proxy cohorts by both mortality (using the number of years to death relative to the target year $t = T$) and the initial selection percentage in year $t = 0$. This modification allows our estimate to better account for larger changes in selection for decedents (MA enrollees who died in the target year, year $t = T$) and near-decedents (who died in year $t = T + 1$). Previously, we assumed that decedents and near-decedents had the same change in selection percentage as MA enrollees who were not near death. That earlier approach likely overestimated the level of favorable selection (that is, understated the selection percentage) for MA enrollees who were close to death because decedents and near-decedents disproportionately have high risk-standardized spending.
- Assigning selection percentages to the rest of the MA population using mortality status: We use estimates of favorable selection for MA enrollees in our study population to assign selection percentages to MA enrollees outside of our study population. Under the previous version of our method, we matched MA enrollees who were outside our study group to those in our study group based on their year of entering MA. For example, individuals who entered MA in 2018 but did not have the required number of years in FFS to be in our sample were assigned the average selection percentage of members of our

study cohort who entered MA in 2018. Under our updated method, we now also match MA enrollees outside our study population to those in our study population by mortality status (using the number of years to death relative to the target year $t = T$) when assigning them a selection percentage. In addition, we trend forward the initial average risk score of each mortality group in each study population cohort by the increase in risk score of their proxy cohort-mortality group. We apply this trended risk score to the broader MA cohort-mortality group. Thus, each MA enrollee receives a selection percentage and expected risk score based on their MA entry year and mortality status in year $t = T$ and $T + 1$. We previously implicitly assumed that the share of decedents and near-decedents was the same between the MA study population and the rest of MA enrollees outside the study population. However, MA enrollees outside our study population have a smaller share of decedents relative to our study population (who were previous switchers and tend to be older). Thus, this update to our method more accurately accounts for mortality differences between MA enrollees included and not included in our study populations.

We compared the estimates that we published in the March 2024 report to the Congress for the MA population in 2021 to our estimates for the 2021 population under the updated methodology. The updates to our method decreased our overall estimate of favorable selection by about 2 percentage points in 2021, from 12.8 percent to 10.9 percent (Table 11-A1).

During the base year $t = 0$, adding decedent spending in the denominator decreases the selection percentage (thereby increasing the base-year effect of favorable selection) for each MA-entry cohort (in year $t = 0$) by 8 percentage points to 13 percentage points. This result is consistent with the expectation of adding decedent spending to average spending for the entire FFS population with Part A and Part B coverage. We compare average risk-standardized spending with and without decedents. We find that including decedents increased average FFS risk-standardized spending by 10 percent in 2021. Between base year $t = 0$ and target year $t = T$, we find that adding decedent spending to the numerator similarly increases the selection percentage (thereby decreasing the effect of favorable selection) by the target year for each MA-entry cohort

**TABLE
11-A1**

Estimated favorable selection in 2021 is similar under the previous and updated methodologies

*(Consecutive years in MA)
MA entrant year*

MA entrant	(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
March 2024 method (survivor-based restrictions and a narrow FFS proxy group of future MA entrants)														
Base spending relative to FFS	77%	74%	79%	74%	74%	80%	83%	81%	83%	87%	87%	90%	88%	91%
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% / 88.6% − 1)														12.8%
March 2025 method (incorporating decedents and a broad FFS proxy group)														
Base spending relative to FFS	64%	66%	67%	64%	65%	68%	72%	71%	73%	76%	76%	79%	79%	79%
Change in selection percentage while in MA	28%	22%	22%	24%	23%	21%	18%	18%	17%	15%	16%	13%	10%	9%
Selection percentage trended forward to 2021	92%	88%	89%	88%	88%	89%	90%	89%	90%	91%	92%	92%	89%	88%
Overall plan spending relative to 2021 average across 14 cohorts (enrollment, risk, and mortality weighted)														90.2%
Overall impact on MA payments relative to FFS spending (100% / 90.2% − 1)														10.9%

Note: MA (Medicare Advantage), FFS (fee-for-service). "MA entrants" are beneficiaries who switched from FFS to MA and who stayed in MA for at least one month of MA enrollment in 2021. "Spending" reflects the year prior to MA entry and is risk adjusted and trended forward using a FFS population that matched the same enrollment criteria, had the same initial level of favorable selection, and had the same mortality status in 2021. Lower MA-entrant spending relative to FFS spending reflects a greater effect of favorable selection. The analysis excludes MA enrollees 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). Estimates for 2008 are used for enrollees who entered MA prior to 2008. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2006–2022.

(in year $t = T$ where $T = 2021$) by 8 percentage points to 18 percentage points. Thus, on net, the updates to our method do not produce markedly different

results for most of the MA cohorts in 2021. Ten of the 14 cohorts that comprise the 2021 estimate of favorable selection have selection percentages that

changed by 1 percentage point or less; 2 of the 14 cohorts have selection percentages that changed by 2 percentage points; 1 of the 14 cohorts has a selection percentage that changed by 3 percentage points; 1 of the 14 cohorts has a selection percentage that changed by 5 percentage points. The 2008 MA-entry cohort experienced the largest increase in selection percentage (5 percentage points). This finding likely results from our applying the selection percentage for 2008 to all MA enrollees who enrolled in MA before 2008, and these enrollees have a larger share of decedents, which we now account for in our analysis. Conversely, the 2021 MA-entry cohort does not experience any change in its estimated selection percentage—even though we now account for the relatively smaller share of decedents among this group.

While it is difficult to separately identify the effect of each of our technical changes on our estimate of favorable selection, we estimate the impact of all our mortality-related changes separately from the impact of constructing proxy groups using a broad population of FFS enrollees (instead of the earlier approach of using a narrower population of FFS enrollees who later enrolled in MA) for our estimate of mean reversion. We compare our prior estimate of favorable selection for 2021 (the most recent estimate reported in the March 2024 report) with our current estimate for 2021.

- First, we estimate the impact from all our mortality-related changes by applying all our technical updates with the exception of using the general FFS population as our proxy-group population for the change in favorable selection during MA enrollment (i.e., mean reversion). Instead, we largely maintain the definition of our previous proxy groups by using the population of FFS beneficiaries who entered MA in the year after target year $t = T + 1$. (Because there are no decedents among the population of FFS beneficiaries who switch to MA in $T + 1$, we used the general population of FFS beneficiaries who died in year T when constructing proxy groups for decedents.) We find that applying our mortality-related changes, while largely holding constant the proxy-group population used in the previous version of the method, results in an overall selection percentage of 86.2 percent in 2021, 3 percentage points lower than our previous estimate (meaning greater favorable selection).

- Second, we estimate the impact of using the general FFS population as our proxy-group population (i.e., the group that we use to estimate mean reversion during MA enrollment). Applying all of our mortality adjustments, we compare our favorable selection estimates when using a general FFS proxy group relative to using a narrower proxy group of FFS beneficiaries who switched to MA in $T + 1$. We find that using a general FFS proxy group results in an overall selection percentage of 90.2 percent in 2021, 4 percentage points higher than the 86.2 percent selection percentage estimated when applying the mortality-related changes alone.

Taken together, our technical updates increased the overall selection percentage by 2 percentage points in 2021 (thereby decreasing the overall estimate of favorable selection by 2 percentage points). The updates have a larger effect on our overall estimates of favorable selection from 2016 to 2020, the other years for which both sets of estimates are available (data not shown). Whereas we had previously estimated that the effect of favorable selection on MA payments increased from 5 percent in 2016 to 13 percent in 2021, we now estimate that the effect of favorable selection was more stable during that period, increasing more slowly from 8 percent in 2016 to 11 percent in 2021. We will continue working to understand the drivers of favorable selection during this period.

Sources of uncertainty in the Commission's estimate of favorable selection

There are four main sources of uncertainty in the Commission's estimate of favorable selection. Below, we discuss those sources. We have tried to make reasonable modeling assumptions where there is uncertainty; however, our estimate of favorable selection could be higher or lower if actual trends differ from those assumptions.

- We have a high degree of confidence in our estimate of favorable selection for beneficiaries in our study population before they enter MA (“base-year selection”). However, there is uncertainty in our estimate of the change in selection while our study population was enrolled in MA because that change cannot be observed directly with available data and must be estimated using a different population of beneficiaries who are enrolled in FFS. We make the best use we can of available data to

estimate the change in selection by matching our study population to FFS “proxy groups” using their base selection before entering MA and mortality status during the year of MA enrollment. Our analysis suggests that this portion of the estimate is conservative because using narrower proxy groups of FFS beneficiaries who later enrolled in MA produces larger selection effects. However, the actual change in selection could be higher or lower than we estimate.

- There is also uncertainty regarding the selection effect for MA enrollees outside our study population. Due to a lack of data, we assign a selection percentage to those beneficiaries using data from MA beneficiaries in our study population. Our analysis, described earlier in the appendix, indicates that assigning selection percentages that we estimate by using our study population to the remaining MA population is appropriate and may be conservative.
- Another source of uncertainty stems from data limitations that require us to exclude beneficiaries who lack a full prior year of FFS enrollment from the FFS comparison population used for the denominators. That method excludes some beneficiaries from the denominator whom studies

have demonstrated to have unfavorable (that is, higher) risk-standardized spending—beneficiaries who have recently disenrolled from MA to FFS (Fuglesten Biniek et al. 2024)—which suggests that our estimated selection effects would be larger if those beneficiaries were included. It also excludes FFS beneficiaries who recently became eligible for Medicare. Their risk-standardized spending may be higher or lower than the population of FFS beneficiaries with complete data who are in our comparison group, so omitting those beneficiaries may cause our estimate of favorable selection to be either higher or lower.

- Finally, there is uncertainty in our assignment of a zero selection effect to MA enrollees with ESRD. We assign this effect because plans are paid for those enrollees using a different payment system, so estimating their selection would require a separate method. Payments to MA plans for ESRD enrollees account for about 6 percent of total payments to MA plans in 2025. Therefore, the exclusion of ESRD enrollees is not expected to have a large effect on our overall estimate. We will consider conducting a separate analysis of the degree of selection among the ESRD population in the future. ■

TECHNICAL APPENDIX

11-B

Coding intensity

The Commission's method for estimating MA coding intensity

The Commission's method for estimating coding intensity is based on the demographic estimate of coding intensity (DECI) method, originally developed by Kronick and Chua (2021). The DECI method implicitly assumes that Medicare Advantage (MA) enrollees are no less healthy than fee-for-service (FFS) Medicare beneficiaries with similar demographic characteristics. Therefore, the DECI method attributes higher demographic-adjusted MA risk scores relative to FFS to higher MA coding intensity rather than worse health acuity or complexity among MA enrollees than FFS beneficiaries. Figure 11-B1 (p. 390) shows how the DECI method estimates coding intensity.

National average CMS hierarchical condition category risk scores

We identify monthly MA or FFS enrollment using the plan identifier in the Medicare common enrollment file, and we require all MA and FFS beneficiaries to have both Part A and Part B using the "Medicare enrollment code" data field. Then we use 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 assign the appropriate community-model risk score using the monthly Medicare-Medicaid dual status code from the enrollment file to adjust for full, partial, or no Medicaid benefits, and we use the beneficiary's age from risk-score data to determine aged or disabled status. In each year, we use the version of the risk model or blend of versions that was used for payment to MA plans. Finally, we aggregate the monthly risk scores to calculate national average MA and FFS CMS hierarchical condition category (HCC) scores for the four groups identified below.

When developing this method, we benchmarked our estimate of the national average risk score for all FFS beneficiaries in 2019 (including those with Part A only) of 1.0682 against 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 calibrate an annual risk model based only on demographic characteristics for FFS beneficiaries with both Part A and Part B (excluding beneficiaries with ESRD) by including age category (CMS-HCC model categories), sex, Medicaid eligibility (full benefits, partial benefits, or no benefits), and institutional status. We use the same enrollment and risk-score indicator variables as in the CMS-HCC risk-score analysis described above.

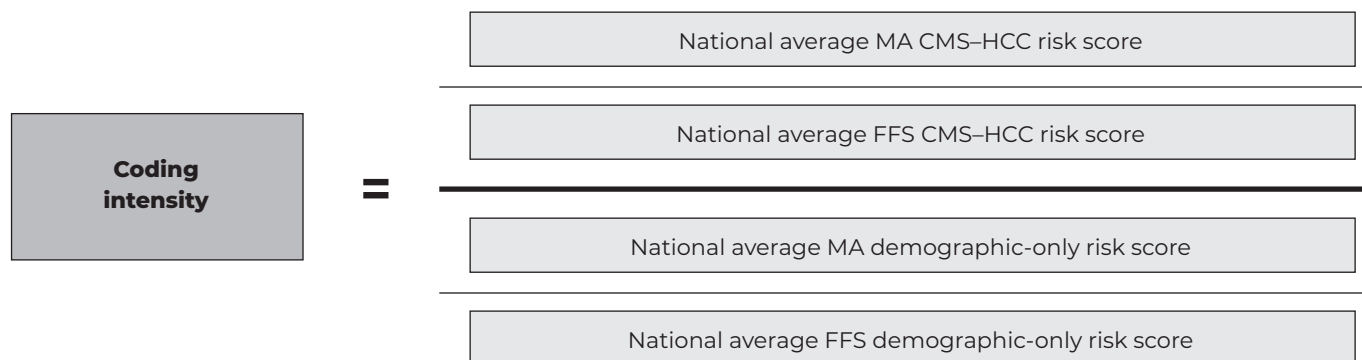
We calculate monthly Medicare spending by summing the annual spending amounts in the Medicare beneficiary summary file (excluding beneficiaries with any hospice use) and dividing by the months of Part A and Part B enrollment in the year. We calculate separate risk models (with dollar-value age and sex coefficients) for beneficiaries with institutional status, full Medicaid benefits, partial Medicaid benefits, and no Medicaid benefits, and then divide each model's coefficients by the average spending for that group to convert the dollar coefficients to risk scores. The average risk score in each model is 1.0. Finally, we apply those demographic risk scores to MA and FFS beneficiaries with both Part A and Part B and aggregate them to national averages for each of the four groups identified below.

Calculation of coding intensity that accounts for Medicaid eligibility and institutional status

For MA and FFS, we calculate average CMS-HCC and demographic risk scores separately for continuing (not new-enrollee) beneficiaries with institutional status, full Medicaid benefits, partial Medicaid benefits, and no Medicaid benefits. We then calculate average CMS-HCC and demographic risk scores for continuing enrollees using the share of MA enrollees in each of the four groups as weights for both the MA and FFS averages. Then we calculate a DECI estimate for continuing enrollees using the formula in Figure 11-B1 (p. 390). Finally, we calculate a DECI estimate for all enrollees, adding together the continuing-enrollee DECI estimate multiplied by the risk-score-weighted share of continuing MA enrollees and the new-enrollee DECI estimate multiplied by the risk-score-weighted share of new enrollees in the analysis. This final step constrains risk scores for new enrollees to

**FIGURE
11-B1**

DECI method estimates coding intensity as the ratio of two ratios



Note: DECI (demographic estimate of coding intensity), MA (Medicare Advantage), CMS-HCC (CMS hierarchical condition category), FFS (fee-for-service).

Source: Kronick and Chua 2021.

have no coding intensity because their risk scores are not based on diagnostic coding. We use a risk-score-weighted new and continuing enrollment share to combine new and continuing enrollee DECI estimates because those weights reflect the share of MA payment associated with each group. Table 11-B1 shows an example of DECI calculation for 2023 which accounts for Medicaid-eligibility and institution-status differences in MA and FFS.

Impact of phasing in the V28 risk-adjustment model

The new risk-adjustment model introduced in 2024 (V28) is expected to reduce MA risk scores, coding intensity, and payments to MA plans. The V28 risk model makes several changes. First, the new model excludes some HCCs with much higher rates of coding in MA relative to FFS Medicare. Second, the new model constrains the coefficients of some HCCs with the same group of related conditions where there are differential rates of MA and FFS coding among the HCCs in the group. Third, the new model implements an entirely new mapping of International Classification of Diseases (ICD)-10 diagnosis codes to HCCs, which

had the effect of removing several diagnoses from the HCCs included in the payment model. The prior mapping was developed from a mapping of ICD-9 diagnoses to HCCs and a diagnosis-code mapping from ICD-9 to ICD-10. (CMS switched from requiring the submission of ICD-9 to ICD-10 diagnosis codes in 2015.)

There are three factors to consider when estimating the impact of a new risk model: the direct impact on MA risk scores, the impact on the normalization factor used to scale risk scores for the model, and changes in MA-plan coding practices.

1. Relative to the prior risk model (V24), the V28 model removes many diagnoses that CMS identified as having high rates of coding in MA relative to FFS. The removal of diagnoses with high rates of MA coding—holding coding practices constant—means that fewer HCCs are identified for MA enrollees, which reduces MA risk scores.
2. A normalization factor is designed to keep the average FFS risk score at 1.0 and is specific to each risk model. Generally, the normalization factor for a given risk model starts at 1.0 in the model calibration year and increases in each subsequent year based on the projected cumulative increase

**TABLE
11-B1****Calculation of MedPAC's coding-intensity estimate, 2023**

Beneficiary group	CMS-HCC risk-score average		Demographic risk-score average		MA share of continuing enrollees
	MA	FFS	MA	FFS	
Continuing enrollees					
No Medicaid	1.063	0.928	0.998	1.006	75.8%
Partial Medicaid	1.373	1.050	1.008	1.003	8.4
Full Medicaid	1.638	1.305	1.044	1.005	14.8
Institutional	2.411	2.136	2.181	2.177	1.0
MA weighted average risk scores	1.187	1.006	1.017	1.017	
Beneficiary group	CMS-HCC MA/FFS risk-score ratio		Demographic MA/FFS risk-score ratio		
Continuing enrollees	1.187 / 1.006 = 1.180		1.017 / 1.017 = 1.000		
Beneficiary group	DECI estimate	MA share of enrollees		MA average HCC risk score	Group weight
Continuing enrollees	1.180 / 1.000 = 1.181 (18.1%)	91.6%		1.187	95.5%
New enrollees	1.000 (0.0%)	8.4		0.605	4.5
All enrollees	1.173 (17.3%)				

Note: CMS-HCC (CMS-hierarchical condition category), MA (Medicare Advantage), FFS (fee-for-service), DECI (demographic estimate of coding intensity). Analysis excludes beneficiaries with end-stage renal disease and beneficiaries residing in Puerto Rico. Risk scores reflect the V24 risk model that was used for payment in 2023. The DECI estimate is the ratio of the MA/FFS CMS-HCC risk score ratio and the MA/FFS demographic risk score ratio. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding. For 2023, we use the most recently available (2022) master beneficiary summary file for the FFS spending used to calculate the demographic risk-score models.

Source: MedPAC analysis of 2023 Medicare enrollment and risk score files and 2022 Medicare enrollment and Master Beneficiary Summary Files.

in average FFS risk scores since calibration. MA risk scores are divided by the normalization factor, so larger factors reduce risk scores by more than smaller factors. Because the V28 model is calibrated using more recent data, the cumulative increase in FFS risk scores since model calibration is smaller, and the V28 normalization factor is smaller than the V24 model. Transitioning from the larger V24 factor to the smaller V28 factor increases MA risk scores.

- Current estimates of the effect of transitioning from V24 to V28 are based on MA risk scores using data from years in which the V24 risk model was

used for payment and the V28 risk model had not yet been announced. Many MA organizations and providers contracting with MA plans identify the diagnostic codes that affect payment and adapt their diagnostic-coding processes to maximize risk scores for a specific risk model (these strategies are sometimes called “diagnostic-code capture” or “HCC-gap closure”). Therefore, current estimates of the impact of the V28 model compare optimized V24 risk scores with nonoptimized V28 risk scores. If MA plans adapt their coding practices in response to the incentives created by the new model, initial comparisons of V24 and V28 risk

scores would overestimate the impact of V28 on MA risk scores and payment to MA plans.

In 2024, payments to MA plans were based on a blend of two-thirds V24 and one-third V28 risk scores. In 2025, payments will be based on a blend of one-third V24 and two-thirds V28 risk scores, and for 2026, CMS has proposed that payments will be based entirely on V28 risk scores. The normalization factor applied to risk scores mirrors the blend of V24 and V28 models used for risk scores.

Comparing V24 and V28 risk scores

In the Advance Notice for 2025, CMS reported that between 2024 and 2025 (reflecting one-third of the V28 phase-in) the V28 model will reduce (non-normalized) MA risk scores by an estimated 4.44 percent due to the removal of diagnosis codes and the constraint on certain HCC coefficients. This reduction will be offset by a 1.99 percent increase in MA risk scores due to a smaller normalization factor, for an estimated net reduction of 2.45 percent. Assuming that this annual effect is the same across the three-year phase-in period implies an estimated net effect on MA risk scores of about 7.5 percent due to the V28 model's exclusion of diagnosis codes and constraint on coefficients, and to the normalization factor.⁸⁷

We conducted our own analysis of the impact of V28 using MA encounter data and FFS claims to identify diagnoses that are eligible for risk adjustment and to calculate V24 and V28 risk scores for 2021, 2022, and 2023.⁸⁸ We first estimated the effect of V28 on MA risk scores if plan coding practices did not respond to the incentives created by the new model. Across all three years, we found that average MA V28 risk scores were about 13.7 percent lower than average MA V24 risk scores, and average FFS V28 risk scores were about 7.3 percent lower than average FFS V24 risk scores (for FFS beneficiaries with both Part A and Part B). (The effect of the V28 model on FFS risk scores is a proxy for the effect on the normalization factor.) By combining those two effects, we estimated a net reduction of MA risk scores of about 6.5 percent if plan coding practices did not respond to the incentives under the new model.

Estimating the impact of V28 on MA coding intensity

To more directly assess the impact of the V28 risk model on differential MA and FFS coding intensity, we

applied MedPAC's DECI method to the V24 and V28 risk scores that we calculated for 2021, 2022, and 2023. Across all three years, we found that the average MA coding-intensity estimate was 7.7 percentage points lower for V28 risk scores than for V24 risk scores. That difference of 7.7 percentage points represents the effect of the V28 risk model on overall MA coding intensity if coding practices were held constant, but it does not reflect MA plans' efforts to optimize coding practices for the V28 model in 2024 and 2025. This coding-intensity estimate incorporates the net effect of the first two factors we consider when estimating the effect of the V28 model: the removal of diagnosis codes and the constraint on certain HCC coefficients in the V28 model, as well as the offsetting effect of the smaller V28 normalization factor. We note that all three ways of estimating the net effect of the first two factors—CMS's analysis of risk-score differences, our analysis of risk-score differences, and our estimates of coding-intensity difference for the two risk models—produce similar results, giving us some confidence in the estimate of the effect of the V28 model from the first two factors.

To estimate the effect of changes in plans' coding behavior (the third factor described above), we began by analyzing how coding changed in the years after CMS transitioned from the V12 risk model to the V22 model in 2014. (We recognize that there are differences between this risk-model transition and the transition from V24 to V28, but this transition is the most recent experience to estimate plans' coding behavior). Similar to the V28 model, the V22 risk model excluded some diagnoses that have much higher rates of coding in MA relative to FFS. Unfortunately, we lack the necessary data to estimate the effect on plans' coding behavior in the first year that the model was introduced. Instead, we estimate how much faster V22 coding intensity grew relative to V12 coding intensity between the first and second years that the V22 model was in effect. To do so, we applied MedPAC's DECI method to the V12 and V22 risk scores for 2014 and 2015 (the only two years of data available during the transition from V12 to V22) to estimate the relative growth in coding intensity between the two models. Coding intensity was lower under the V22 model, but it grew faster between 2014 and 2015 relative to growth under the V12 model, indicating that plans were able to offset some of the reductions in risk scores under the new model by adjusting their coding practices to account for different

incentives under the newer model. We incorporate the faster coding-intensity growth rate from the first and second years of the V22 model into our assessment of coding-intensity growth in the first couple years under the V28 model.

The growth in coding intensity under V28 might be even larger than the growth we estimated during the first two years of the transition from V12 to V22. First, the V22/V12 difference in coding-intensity growth in the first year in which the model was introduced could be larger than the growth in coding intensity we estimated between the first and second years of V22 implementation. Second, compared with 2015 and 2016, when V22 was implemented, we have observed an increased focus on risk adjustment and the potential financial gains from greater diagnostic-coding intensity. There has been a dramatic increase in the number of companies currently selling training programs, diagnostic-coding manuals, and other risk-score-optimization strategies for the transition from V24 to V28.⁸⁹

Incorporating estimates of the V28's impact into MA coding-intensity projections

For 2024 and 2025, we projected under the V24 and V28 models separately and then applied the blend of risk scores that will be used for payment in each year. We started with the 2023 coding-intensity estimates of

17 percent under the V24 model and of about 10 percent under the V28 model (17 percent minus 7.7 percentage points due to lower coding intensity under V28), which reflects no plan response because the V28 model had not yet been used for plan payments.

To calculate the coding-intensity growth rate under V28, we started with the V24 coding-intensity growth rate of 1.6 percentage points annually, which is the average V24 coding-intensity trend from 2019 to 2023. We then applied the V22/V12 coding-intensity growth-rate ratio, adjusting the ratio to account for the greater share of diagnosis codes excluded from the V28 model relative to the V22 model. Based on this analysis, we estimate that coding intensity will grow about 2.4 percentage points annually under the V28 risk model.

We then projected coding intensity under V24 by adding 1.6 percentage points each year and projected coding intensity under V28 by adding 2.4 percentage points each year. After applying the payment-year risk-score blends, we estimate coding intensity to be about 17 percent in 2024, reflecting a blend of two-thirds V24 coding intensity (about 19 percent) and one-third V28 coding intensity (about 12 percent). For 2025, we estimate MA coding intensity to be about 16 percent, reflecting a blend of one-third V24 coding intensity (about 20 percent) and two-thirds V28 coding intensity (about 14 percent). ■

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 2023a, 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' reports, 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 Two plan types enrolling very small numbers of MA enrollees are not described here. Private FFS plans that operate without a network are limited to counties where fewer than two network-based plans are offered (about 3 percent of counties for 2025); by the end of 2024, private FFS plans covered fewer than 32,000 beneficiaries. Medical Savings Account plans combine a high deductible and a Medical Savings Account, and by the end of 2024 they covered about 1,100 beneficiaries.
- 3 HMOs generally do not pay for 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 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 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 Chapter 12 of the Commission's March 2021 report to the Congress (Medicare Payment Advisory Commission 2021b).
- 5 If a plan bids above the benchmark, the plan's base rate is set at the benchmark and enrollees must pay a premium (in addition to the usual Part B premium) equal to the difference between the bid and the benchmark.
- 6 Examples of non-Medicare-covered supplemental benefits include dental, vision, and hearing coverage. Plans can offer such benefits on a mandatory or optional basis. Mandatory supplemental benefits are automatically included in the benefit package for all enrollees in a plan. Plans may use rebates to finance mandatory supplemental benefits and may charge enrollees a premium to cover costs not covered by the rebate. Additionally, plans may offer optional supplemental benefits. Plans are not permitted to apply rebate dollars toward optional supplemental benefits; enrollees pay an additional premium to access these benefits. 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 An MA plan's benchmark may be as high as 125 percent of CMS's local-area projected FFS spending. 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 2016c).
- 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. First, CMS has found that adding diagnoses from these sources does not improve the model's ability to

predict medical expenditures. Second, concerns exist about the reliability of diagnoses from providers with less clinical training (e.g., home health and durable medical equipment providers). Third, a high proportion of reported diagnoses from certain settings (e.g., lab and imaging tests) are used to rule out having a diagnosis (Pope et al. 2004).

- 11 To date, RADV audits have been initiated for plan years 2018 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 the more widespread use of audits would affect plans' coding practices.
- 12 MA enrollees who could potentially have lower cost-sharing liability in FFS would likely have difficulty obtaining a Medigap policy if they switched to FFS, limiting their potential savings. Beneficiaries are only guaranteed access to a Medigap supplemental insurance policy with no underwriting, even if they have a preexisting condition, if they purchase it during the six-month Medigap open enrollment period that begins on the first day a beneficiary is both 65 years old and enrolled in Medicare Part B. Most beneficiaries have only one Medigap open enrollment period during their lifetime. Except 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 (Connecticut, Massachusetts, Maine, and New York) require guaranteed-issue access to Medigap for aged (65 and over) beneficiaries in FFS Medicare, regardless of medical history, meaning that 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 11-month trial period may also have guaranteed access to Medigap coverage with no underwriting (42 U.S.C. Sec. 1395ss).
- 13 In 2023, 15 percent of MA enrollees and 20 percent of FFS enrollees resided in rural areas.
- 14 Our measurement of beneficiary access to plans uses 2025 plan bids and July 2024 county-level enrollment for the Medicare population with both Part A and Part B coverage. Plans are included in a county only if they project enrolling at least one beneficiary in that county.
- 15 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 Prescription Drug 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 supplemental 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 PPO plans. Between 2019 and 2023, the availability of zero-premium local PPO plans increased from 69 percent of Medicare beneficiaries to 96 percent, and the availability of zero-premium HMOs increased from 86 percent to 98 percent.
- 16 We exclude employer group plans because they do not submit bids and so do not receive a rebate in the same manner as bidding plans. Instead, starting in 2019, CMS began paying employer group plans based on the bidding behavior of nonemployer plans in the prior year: The employer group plans receive a base payment rate that is based on the average bid-to-benchmark ratio of nonemployer plans (by quartile of FFS spending and plan type), plus a share of the difference between the base payment rate and a county-specific benchmark.
- 17 In 2025, conventional plans project that 11 percent of the rebate dollars used to reduce cost sharing will be allocated for plan administrative costs and profit. Among dual-eligible SNPs, 14 percent of the plan-projected rebate dollars used to reduce cost sharing is projected to be allocated for plan administrative costs and profit.
- 18 The plan liability for the MOOP cap is generally not comparable with FFS spending because most beneficiaries in FFS Medicare 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 because MA plans are expected to provide supplemental benefits in lieu of Medigap coverage.
- 19 While MA plans have enrolled a growing number of beneficiaries with end-stage renal disease, MA plans' projected MOOP liability remained at 1 percent of projected payments annually from 2023 to 2025. The MOOP liability reported in plan bids is less than half of the 2.8 percent MOOP value estimated by Wakely in a report commissioned by AHIP, which used FFS claims data to estimate the MOOP value (Wakely 2024). The Wakely estimate did not account for the lower MOOP liability accrued by MA plans because of out-of-network care, claims denials, plan switching during the year, and cost-sharing reductions that are financed through plan rebates. In addition, the Wakely estimate did not consider cost-sharing reductions for FFS beneficiaries with supplemental coverage that would have reduced the

- MOOP liability in FFS. Further, Wakely did not adjust for Medicare Part A and Part B services that were financed by FFS on behalf of MA enrollees (e.g., Medicare services during hospice election). Wakely counted these services toward their MOOP estimate even though these types of services were not financed by MA plans.
- 20 Beneficiaries eligible for special enrollment periods include (but are not limited to) those who move outside of their plan's service area, move to a new county with additional plan options, live in or move out of a nursing home or rehabilitation hospital, are eligible for Medicaid coverage, or lose Medicaid coverage.
 - 21 In 2025, conventional MA plans (that is, excluding employer plans and SNPs) project that 12 percent of the \$53 used for non-Medicare-covered supplemental benefits will be allocated for plan administrative costs and profit. Among D-SNPs, 14 percent of the \$234 used for non-Medicare-covered supplemental benefits is projected to be allocated for plan administrative costs and profit.
 - 22 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.
 - 23 MA plans do not allocate administrative expenses or margins for Part D premium buydowns or Part D supplemental benefits when submitting Part C bids.
 - 24 In 2025, changes to the structure of the Part D direct-subsidy amount may have resulted in plans overestimating the amount of Part C rebates needed for their target Part D premium. Part D premium targets are initially calculated before plans know how much rebate funding they need to cover their target Part D premium (which is only known after Part D plans submit bids and CMS calculates the national average bid amount). After plans know how much they will need in rebates to cover their target Part D premium, plans reallocate their rebate to ensure that plan enrollees receive the full value of the rebate. However, CMS restricts changes in projected Part C margins that result from rebate allocations to an average of \$1 per member per month (<https://www.cms.gov/files/document/cy2025-rebate-reallocation-training-handout.pdf>). If an MA plan overestimated the amount of Part C rebates needed for their Part D premium, they would likely need to reallocate rebate funding from the Part D premium buydown to the Part B premium buydown, the only rebate-funded benefit for which plans do not receive a margin.
 - 25 Federal regulations require MA plans to submit encounter records for all items and services provided to enrollees (42 CFR Sec. 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 was not equipped to accept dental claims prior to 2024. 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. Beginning in 2024, CMS required 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, the number of enrollees who used each benefit, total and median instances of use among eligible enrollees, the net spending 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 2024b).
 - 26 The Commission is examining MA rebates and supplemental benefits in greater depth in other reports and presentations during this analytic cycle; the results of that analysis will be presented separately.
 - 27 We estimate total MA payments by using CMS's projected enrollment and incurred payments per enrollee (Boards of Trustees 2024).
 - 28 Our estimate of 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.

- 29 We note that our 2025 estimate of spending on MA relative to the amount Medicare would have spent for comparable FFS beneficiaries (120 percent) reflects some changes from the method used in the Commission's 2024 comparison (reported to be 122 percent in our March 2024 report) (Medicare Payment Advisory Commission 2024). First, in 2024 we conservatively projected that the effects of favorable selection would be similar to prepandemic levels (about 9 percentage points). For 2025, we used estimates of favorable selection from 2021 and 2022 to project the effect of favorable selection in 2023 to 2025. We also made technical updates to refine our methodology for estimating favorable selection; those updates increased our estimates of favorable selection from 2017 to 2020 and decreased our estimate of favorable selection for 2021. We now project that favorable selection accounts for 11 percentage points of the difference in spending. Second, we revised our method of estimating coding intensity to exclude beneficiaries in Puerto Rico because they lack complete data and to weight new enrollees by the share of payments associated with new and continuing enrollees. Also, we revised our estimated effect of phasing in the V28 model when we projected the effects of coding intensity from the most recent analytic year (2023) to subsequent payment years. For 2024 and 2025, we projected coding intensity based on the annual trend from 2019 through 2023, an increase of 1.6 percentage points per year. Then we reduced the annual trend by our estimate of the effect of the V28 phase-in, which is -2.3 percentage points in 2024 and -1.8 percentage points in 2025. See Technical Appendix 11-B, "Impact of phasing in the V28 risk-adjustment model" (p. 390), for more details. The net effect of all of those factors accounts for the -2 percentage point difference in our 2025 and 2024 estimates of MA spending relative to comparable FFS beneficiaries.
- 30 Our projected \$84 billion in MA payments above FFS spending in 2025 does not include spending for beneficiaries with ESRD. MA plans receive separate base payments for these beneficiaries, and MA payments are risk adjusted using a separate risk model. In future years, we will consider how to compare MA payments and FFS spending for ESRD beneficiaries, including the effects of favorable selection and coding intensity.
- 31 We also exclude beneficiaries for whom Medicare is a secondary payer and beneficiaries with ESRD in our comparisons using historical data.
- 32 Our estimates of the base-spending comparison for the years prior to 2016 continue to rely on CMS's projections of FFS spending (including adjustments that eliminate the effect of the sustainable growth rate) because those were the data we used under an older version of our methodology when those estimates were first published in earlier reports. We have not updated those estimates because our analysis indicates that results would be similar under our updated methodology that uses historical data. A more detailed description of the change in methodology for the base payment comparison can be found in the Commission's March 2023 report to the Congress, where it is described as a change from the prospective method to the retrospective method (Medicare Payment Advisory Commission 2023b).
- 33 The Commission's March 2023 report details our methodology for comparing our estimates using CMS's projections with historical spending for MA-eligible beneficiaries (Medicare Payment Advisory Commission 2023b). That report describes several adjustments that should be made when making this comparison. A 2024 analysis by Wakely that was commissioned by AHIP estimated the raw average spending difference between all Medicare beneficiaries and the subset of Medicare beneficiaries with both Part A and Part B coverage (Wakely 2024). This method is inadequate for comparisons of MA payment differences because CMS's payment methodology accounts for (among other things) Medicare as a secondary payer, the geographic differences in risk-standardized FFS spending, the geographic distribution of MA enrollees, and nonclaims FFS spending. The Commission's comparisons adjust for these differences, including the use of county-level FFS-spending data and risk scores, MA enrollment, MA risk scores, and MA payment rates.
- 34 We also report estimates from a simpler, more suggestive method that focuses on the selection percentage of MA entrants who recently switched from FFS compared with beneficiaries who remained in FFS. The advantages of that simpler method are that it can more easily be compared with estimates from the literature that use similar methods, and we can compute it for more years of data (going back to 2007). We use that simpler method for the selection estimates from 2007 to 2015 in Figures 11-3 and 11-4 and use our current, more comprehensive method for the estimates reported starting in 2016.
- 35 Our estimates account for the incentives that beneficiaries have to switch from FFS to MA because of the MOOP limit. However, MOOP limits do not appear to be an important factor in MA plan selection. For example, one study found that more generous OOP 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. 2016, Jacobson et al. 2014, Medicare Payment Advisory Commission 2015, Meyers et al. 2019, Skopec et al. 2019).

- 36 Using the study from Teigland and colleagues, we identified the pre-Medicare spending and risk scores of the MA and FFS populations. We standardized the pre-period spending by the risk scores and converted the risk-standardized spending differences to payments above FFS spending.
- 37 Categories of risk scores were based on the distribution of MA entrants such that we determined a sufficient number of enrollees were in each risk-score category.
- 38 The Commission recognizes that social risk factors are associated with differences in health status and health care use and that switching between MA and FFS may lead to changes in a beneficiary's use of health services and in their Medicaid eligibility. Limited evidence suggests that MA plans do not provide greater access to services overall relative to FFS (Agarwal et al. 2022, Commonwealth Fund 2021, Fuglesten Biniek et al. 2021). In addition, MA plans have a financial incentive to ensure that beneficiaries who are eligible but not enrolled in Medicaid receive those benefits while in MA. These additional Medicaid benefits would potentially reduce the cost-sharing liability for both beneficiaries and MA plans. Further, enrolling beneficiaries in Medicaid who were Medicaid eligible but previously unenrolled also increases beneficiary risk scores because their predicted costs in MA would be under a Medicaid segment in CMS's risk model (rather than a non-Medicaid segment). To the extent that such beneficiaries would have remain unenrolled in Medicaid if still in FFS Medicare, this phenomenon would increase favorable selection in MA. Given our reliance on a beneficiary's FFS experience when estimating favorable selection, we cannot account for these additional changes in a beneficiary's social risk while enrolled in MA.
- 39 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 ESRD. A plan's base rate varies according to the plan's bid and the local area's benchmark.
- 40 International Classification of Diseases, 10th Revision, Clinical Modification guidelines for 2022.
- 41 In the V28 CMS-HCC risk model, introduced in 2024, these three HCCs have been constrained to have the same coefficient due to within-hierarchy coding intensity compared with FFS Medicare.
- 42 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 had a coding-intensity estimate that was about 2.5 percentage points less than under the previous model because the new model removed some diagnoses that were found to be coded more frequently 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 by which MA risk scores were unduly higher than FFS due to differing shares of beneficiaries by Medicaid eligibility status. In 2024, CMS began phasing 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.
- 43 The monthly Medicaid-status indicator that we use to identify eligibility for full, partial, or no Medicaid benefits incorrectly lists the vast majority of beneficiaries in Puerto Rico as not being eligible for Medicaid benefits.
- 44 In some counties, the full 5 percent or 10 percent quality-bonus increase to a plan's benchmark is limited by the ACA benchmark caps.
- 45 This organization-level analysis, like our national estimate of coding differences, uses the same method of estimating coding intensity as described in Chapter 13 of MedPAC's March 2024 report to the Congress, except that the MA risk scores are calculated separately for each MA organization.
- 46 Based on MedPAC's interviews with physicians and reporting from Stat News (Bannow et al. 2024).
- 47 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.
- 48 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 a 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.

- 49 The six HCCs that each generated more than \$900 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, 45 percent; major depressive, bipolar, and paranoid disorders, 44 percent; disorders of immunity, 64 percent; diabetes with chronic complications, 15 percent; chronic obstructive pulmonary disorder, 26 percent; morbid obesity, 37 percent. We note that diabetes with chronic complications has 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.
- 50 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 Inc. 2020).
- 51 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, 32 percent; chronic obstructive pulmonary disorder, 26 percent; diabetes with chronic complications, 17 percent; major depressive, bipolar, and paranoid disorders, 32 percent; congestive heart failure, 23 percent; disorders of immunity, 40 percent; morbid obesity, 33 percent; and rheumatoid arthritis and inflammatory connective tissue disease, 31 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.
- 52 About \$5.2 billion in payments to MA plans was 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.
- 53 For RADV 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.
- 54 Audit-eligible enrollees were also required to have Part B enrollment for the full data-collection year, continuous enrollment in the contract for the full data-collection year and January of the payment year, and no end-stage renal disease or hospice status.
- 55 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).
- 56 Counties in Connecticut are excluded due to changes over time in how the state's counties are tabulated. Employer plans are excluded because employer plans do not compete directly with nonemployer plans.
- 57 The study assessed only whether the parent organization listed for a particular MA contract changed; it did not assess whether the company acquired one or all of the acquired insurer's MA contracts or acquired the other insurer altogether.
- 58 The top three organizations nationally also had the highest share of enrollees in both urban and rural areas in 2024. In urban areas, the top three organizations covered 58 percent of MA enrollees (up from 57 percent in 2023). In rural areas, the top three organizations accounted for 67 percent of the MA enrollees (up from 66 percent in 2023).
- 59 In 2024, 18 percent of MA enrollees were eligible for Medicaid and enrolled in dual-eligible SNPs (D-SNPs). The national D-SNP enrollment is more concentrated than overall MA enrollment (the three largest D-SNPs had 61 percent of enrollment). Enrollment in D-SNPs has been getting more concentrated nationally: The three largest organizations nationally had 60 percent of total enrollment in D-SNPs in 2024, an increase from 57 percent in 2023.
- 60 The HHI 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).
- 61 A "related party" is 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 2023b).
- 62 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 organizations” category in Figure 11-17, p. 369). 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.
 - 63 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 FFS Medicare 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 with an MA star rating, which reflects the joint performance of an MAO and its network of contracted providers, at the contract level.
 - 64 This count includes measures for Medicare Advantage Prescription Drug plan (MA-PD) contracts. MA-only contracts and PDPs are measured on different subsets of measures.
 - 65 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 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 that are being tested before inclusion in the star ratings or that are otherwise reported for informational purposes only.
 - 66 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.
 - 67 The 2025 star-rating values have been updated with data from CMS’s December 2, 2024, release of the 2025 Star Ratings Data Tables.
 - 68 We also include FFS-CAHPS results in Chapter 4 (on physician and other health professionals).
 - 69 Using the beneficiary survey responses, CMS calculates national case-mix-adjusted FFS-CAHPS and MA-CAHPS scores. Scores are adjusted for education, self-reported general health status, self-reported mental health status, proxy completion or assistance with survey completion, dual eligibility or low-income-subsidy eligibility, age, and completion of the survey in an Asian language, all of which have been demonstrated to be associated with patient-experience scores (<https://www.ma-pdpcahps.org/globalassets/ma-pdp/quality-assurance/2025/ma-pdp-cahps-qapts-v15.0.pdf#page=86>). The FFS- and MA-CAHPS survey items and case-mix adjustment are largely the same, which can allow comparison between FFS and MA measure scores.
 - 70 Because MA contracts do not represent uniform geographic units, sampling at the contract level generates an average that is not necessarily geographically representative of the MA population nor geographically comparable with the FFS sample.
 - 71 The Commission discussed this literature at the March 2024 public meeting, <https://www.medpac.gov/wp-content/uploads/2023/10/MA-quality-presentation-FINAL.pdf>.
 - 72 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).
 - 73 Part B spending represents about 60 percent of all FFS Medicare 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.
 - 74 The share of non-ESRD MA enrollees with at least two years of prior enrollment in FFS is based on enrollment months in 2021.
 - 75 We exclude beneficiaries with Medicare as a secondary payer. CMS’s payment rates to MA plans are adjusted with the goal of removing the effects of having Medicare as a secondary payer.
 - 76 CMS sets MA payment rates using a non-ESRD population. MA plans are separately paid a state-based ESRD rate for MA enrollees.
 - 77 MA enrollees who use hospice continue receiving supplemental benefits through their MA plan, but MA plans are immediately no longer paid the base payment for Part A and Part B services for that enrollee. Thus, we remove MA months while a beneficiary uses hospice, but we count the share of the month prior to hospice enrollment as MA

- enrollment. Medicare spending while an MA enrollee is in hospice is excluded from our analysis entirely and is not included in our FFS denominator.
- 78 In 2022, about half of MA entrants (51 percent of enrollment months) 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 30 percent had no prior FFS enrollment (meaning they enrolled directly in MA when they first became eligible for Medicare).
 - 79 The population of FFS enrollees in each county used in the denominator includes all beneficiaries with at least one month of FFS enrollment in time $t = 0$ who were enrolled in FFS for the entire prior year ($t = -1$). It includes people who switched to MA in the following year. That construction is designed to closely align with the population that CMS uses to construct predicted spending while also ensuring that risk scores were constructed using CMS's HCC model. We also require the population of FFS enrollees in the denominator to be enrolled in both Part A and Part B to enhance similarity with the MA population. Average spending in the county is weighted by enrollment months and standardized to a 1.0 risk score (calculated as $\bar{y}_{g,t=0} = \frac{\sum_i y_{i,g,t=0}}{\sum_i r_{i,g,t=0}}$).
 - 80 Mean reversion can occur in two directions. When an individual's spending is initially below their predicted spending, mean reversion can occur if their growth in spending exceeds their growth in risk score. Conversely, when an individual's spending is initially above their predicted spending, mean reversion can occur if their growth in spending is lower than their growth in risk score.
 - 81 The weights represent each individual's share of the total predicted spending in the proxy group. Thus, the individual weight is defined as $\alpha_i = \frac{\bar{y}_{g,t=0} \times r_{i,g,t=0}}{\sum_i \bar{y}_{g,t=0} \times r_{i,g,t=0}}$.
 - 82 Each cohort of MA enrollees and their proxy cohort of FFS beneficiaries were placed into 50 mutually exclusive groups and matched on those groups (an increase from 45 groups in our March 2024 report to the Congress). Beneficiaries were first placed into one of three mortality groups based on the year of death: year $t = T$, $t = T + 1$, and $t > T + 1$. Decedents (death in $t = T$) and near-decedents (death in $t = T + 1$) were assigned to 1 of 10 categories within their respective mortality group based on initial selection percentage in year $t = 0$. Nondecedents (death in $t > T + 1$) were assigned to 1 of 30 categories based on initial selection percentage in year $t = 0$. Categories of initial selection percentage were developed based on the distribution of spending and enrollment, with the goal of having meaningful differences between the categories while sustaining a reliable sample of enrollees within each category.
 - 83 Although there is an insufficient number of observations to match MA enrollees to proxy groups by county of residence, we required beneficiaries in the proxy group to reside in counties with at least one MA enrollee in MA cohort c.
 - 84 Beneficiaries in the proxy group are also required to be enrolled in FFS in the year prior to the base year (2016 in this example) in order to have a populated HCC risk score for 2017.
 - 85 The weights are constructed to reflect each individual's predicted spending in year $t = T$ as a share of the mortality-cohort group's predicted spending in year $t = T$: $w_{i,T} = \frac{\bar{y}_{g,t=T} \times r_{i,t=T} \times m_{i,T}}{\sum_{i \in C^{d,T}} \bar{y}_{g,t=T} \times r_{i,t=T} \times m_{i,T}}$, where $m_{i,T}$ indicates months of enrollment.
 - 86 The denominators for the comparison groups exclude beneficiaries who used hospice in the prior year but include beneficiaries who had hospice during the year of spending.
 - 87 CMS's published normalization-factor data also show that the V28 normalization factor will increase MA risk scores by about 2 percent per year, or about 6 percent in total. The normalization factor applied to MA risk scores in 2023 was 1.127 (V24 only) and was reduced to 1.103 in 2024 (reflecting a two-thirds V24 factor of 1.146 and a one-third V28 factor of 1.015); it will be further reduced to 1.081 in 2025 (reflecting a one-third V24 factor of 1.153 and a two-thirds V28 factor of 1.045).
 - 88 We used CMS's V24 and V28 risk-model software published for 2024 (<https://www.cms.gov/medicare/health-plans/medicareadvantagestates/risk-adjustors/2024-model-software/icd-10-mappings>).
 - 89 Some examples of companies offering services to optimize coding for V28 include Advantmed, AGS Health, Alix Partners, Apixio, Athena Health, CareJourney (by Arcadia), Centauri Health Solutions, Change Healthcare, CodingIntel, Cotiviti (Verscend Technologies Inc.), Credo Health, Creyos, Datavant (formerly Ciox), DoctusTech, Edifecs, Episource, ForeSee Medical, Health Endeavors, Health Information Associates, Healthmine, IKS Health, IMO Health, Inovalon, IQVIA, Lightbeam Health Solutions, Matrix Medical Network, McKinsey & Company, Navina AI, Optum, Pareto Intelligence, Peoples Health (a UnitedHealthcare company), Persivia, PwC, R1 RCM, RAAPID Inc., Reveleer, Signify Health (CVS Health), UST HealthProof (Advantasure), Vatica Health, Vee Healthtek, Veradigm, and Wolters Kluwer.

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CHAPTER 12

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

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

Chapter summary

In 2024, Part D paid for outpatient prescription drug coverage on behalf of more than 54 million Medicare beneficiaries. Medicare's payment system for Part D differs from Part A and Part B in that it does not pay for outpatient prescription drugs directly and instead pays private plans to administer the prescription drug benefit.

In 2023, Medicare and beneficiaries enrolled in Part D made payments to stand-alone Part D plans (known as PDPs) and Medicare Advantage–Prescription Drug plans (MA-PDs) totaling \$128.2 billion (about 12 percent of total Medicare expenditures). Of that amount, Medicare paid \$68.2 billion in subsidies for basic benefit costs and \$43.9 billion in extra financial support for enrollees who receive the low-income subsidy (LIS), while Part D enrollees paid \$16.1 billion in premiums for basic benefits. Not included in this total is an additional \$18.8 billion in cost sharing paid by enrollees and \$0.5 billion in retiree drug subsidies paid by Medicare to employers who provide drug coverage to their retirees. Surveys and focus-group findings suggest high overall satisfaction with Medicare Part D.

Significant changes happening in 2025—The passage of the Inflation Reduction Act of 2022 (IRA) changed many aspects of the Part D program. One of the most important changes, the redesign of the Part D's

In this chapter

- Significant changes to Part D in 2025
- Recent trends in enrollment, premiums, and program spending
- Growth in overall Part D prices driven by single-source brand-name drugs and biologics
- Most Part D enrollees are satisfied with drug coverage

benefit structure, occurs in 2025. The redesign includes key elements of the Commission's 2020 recommendations intended to restore the plan incentives to manage drug spending that were in place at the start of the program. Notably, the redesign reduces the role of Medicare's reinsurance payments—the cost-based reimbursement that had paid for most of the costs incurred by enrollees with high spending—while increasing the role of capitated direct-subsidy payments.

By adding cost-sharing protections such as the \$2,000 annual limit on out-of-pocket costs, the redesign also substantially shifts liability for drug spending from cost sharing paid by beneficiaries at the point of sale (POS) to plans (which increases both enrollee premiums and the premium subsidies paid by Medicare). By lowering POS costs and increasing premiums, the redesign spreads the cost of the prescription drug benefit more broadly among enrollees. Because the IRA also places a limit on the annual increase in average premiums paid by enrollees, Medicare's share of program spending has automatically increased to just over 83 percent (from the original 74.5 percent) in 2025.

The IRA also includes provisions that are expected to affect the broader pharmaceutical supply chain, such as requiring manufacturers to pay rebates when the price of their drug rises faster than inflation and the Medicare Drug Price Negotiation Program, which requires manufacturers of selected drugs to engage in negotiations with the Secretary of Health and Human Services over prices charged under Medicare Part B and Part D. The Commission has not made recommendations related to either of those new policies.

Changes taking place in 2025 and subsequent years are expected to have wide-ranging impacts on Part D plan sponsors and their enrollees as well as participants in the pharmaceutical supply chain. For 2025, the national average plan bid rose by nearly 180 percent. The redesign's increase in plan liability was expected to raise premiums and Medicare's upfront payments for capitated direct subsidies while decreasing the share of spending paid by Medicare's reinsurance and beneficiaries' costs at POS. However, greater variation in bids submitted by Part D plans for 2025 compared with previous years was likely driven by plans' uncertainty regarding the effects of the IRA on benefit costs, for which plans now bear a substantial portion of the insurance risk.

The Premium Stabilization Demonstration that CMS implemented for 2025 reduced some of the largest premium increases observed among PDPs, though premiums continue to vary widely. The demonstration will increase program spending by an estimated \$5 billion in 2025. Over the coming years,

we expect plan sponsors to adjust to the redesigned benefit as they gain claims experience while adapting to the new market dynamics. At the same time, various IRA changes and subsequent policy changes (such as the premium demonstration) are likely to interact in ways that complicate our understanding of the impact of any given policy in isolation. As a result, we provide preliminary information to understand the effects of changes to date and emphasize the importance of continued monitoring as the program continues to respond to policy changes.

Historical trends and concerns about the long-term stability of the PDP market—

We also report on historical data that continue to show Part D enrollment shifting from PDPs to MA-PDs. In 2024, PDPs accounted for less than 43 percent of all Part D enrollees, down from 53 percent in 2020. Trends through 2024 also showed stable average premiums but significant differences between PDPs and MA-PDs, in part due to MA-PDs' ability to use Part C rebates to lower Part D premiums: The average PDP premium in 2025, weighted by 2024 enrollment, is estimated at \$44, while the average MA-PD premium (including both special-needs plans and conventional plans) is \$14. In 2023, Medicare's spending on cost-based reinsurance and the LIS continued to grow.

Some of the recent trends have raised concerns about the long-term stability of the PDP market, which provides drug coverage for FFS beneficiaries and, critically, ensures that premium-free plan options are available for individuals with low income and assets. The shift in Part D's enrollment from PDPs to MA-PDs is consistent with the shift in enrollment from fee-for-service (FFS) to MA in the broader Medicare program. At the same time, however, MA-PDs' ability to use Part C rebate dollars to offer more generous prescription drug coverage at lower premiums may affect insurers' willingness to participate in the PDP market. Misalignment between Medicare's payments to Part D plans and their enrollees' drug costs could also create disincentives for insurers to participate in the PDP market. Part D's risk adjustment has historically paid MA-PDs relatively more compared with their actual average costs, while paying relatively less to PDPs compared with their actual average costs. Those inaccuracies may result from differences in management of drug spending, differences in coding behavior, or some combination of the two. To try to address the inaccuracy in Part D's risk-adjustment model, for 2025 CMS is using a separate normalization factor for MA-PDs and PDPs. Despite a significant drop in PDP offerings across the country, in 2025 each beneficiary continues to have at least 12 PDPs from which to choose and roughly 30 MA-PDs. ■

Background

In 2024, 54.1 million Medicare beneficiaries enrolled in the Part D program for outpatient prescription drug coverage. This coverage is provided by private-plan sponsors, which offer stand-alone prescription drug plans (PDPs) for fee-for-service (FFS) beneficiaries and Medicare Advantage–Prescription Drug plans (MA–PDs), which offer combined medical and prescription drug coverage, for beneficiaries choosing to enroll in Medicare Advantage (MA). (See text box, pp. 414–415, on the roles of plan sponsors and pharmacy benefit managers (PBMs)). In 2025, there are at least a dozen PDPs and roughly 30 MA–PDs available in every region (or county) of the country. In 2023, Part D spending by the Medicare program and enrolled beneficiaries totaled \$128.7 billion, over 12 percent of total Medicare expenditures (Boards of Trustees 2024).

Medicare’s payment system for Part D is different from payment systems under Part A and Part B because Medicare does not pay for outpatient prescription drugs directly. Instead, the Medicare program makes payments to PDP and MA–PD sponsors to provide coverage for each enrolled beneficiary. Medicare makes two payments on behalf of enrollees in their plans:

- **Direct subsidy**—For each enrollee, Medicare pays a monthly (capitated) prospective payment set as a share of the national average bid for Part D basic benefits, adjusted for the risk of the individual enrollee.
- **Reinsurance**—For enrollees in the catastrophic phase of the benefit—who have drug spending above an annual out-of-pocket (OOP) threshold—Medicare makes payments that cover a portion of spending above the threshold.¹

Combined, the direct-subsidy and 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. (Some beneficiaries pay higher premiums for additional coverage beyond the basic benefit.) In addition to monthly premiums, Part D enrollees also pay any cost sharing required by plan sponsors. For enrollees who qualify for Part D’s low-

income subsidy (LIS), Medicare pays plans an additional amount on their behalf that covers most or all cost sharing and premium liabilities.

The Commission had long been concerned that past changes to Part D’s benefit design combined with trends in prescription drug pricing and spending had weakened plan sponsors’ incentives for cost control (Medicare Payment Advisory Commission 2022b, 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 for 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 have made 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 bear more insurance risk, they should also be given tools to manage enrollee spending.²

The passage of the Budget Reconciliation Act of 2022 (commonly referred to as the Inflation Reduction Act (IRA)) changed many aspects of the Part D program, including a redesign of the Part D benefit structure that reflected some of the Commission’s recommendations. The IRA included other provisions that are expected to affect the broader pharmaceutical supply chain, such as requiring manufacturers to pay rebates when the price of their drug rises faster than inflation and establishing the Medicare Drug Price Negotiation Program that requires manufacturers of selected

Roles of plan sponsors and pharmacy benefit managers

When Part D was created, policymakers structured the program using private plans that compete to attract enrollees based on the prescription drugs they cover, pharmacy networks, premiums, cost sharing, and quality of services. One of the key premises behind Part D's competitive approach is that plan sponsors can negotiate for lower prices when there are competing drug therapies.

About 300 organizations operate Part D plans. Most plan sponsors offer Medicare Advantage–Prescription Drug plans (MA–PDs), but only about 50 operate stand-alone prescription drug plans (PDPs). As plan sponsors merged throughout the early years of the program, Part D enrollment grew more concentrated (Medicare Payment Advisory Commission 2019b). In 2023, the top five PDP sponsors ranked by enrollment accounted for 89 percent of all PDP enrollees, while the top five sponsors of MA–PDs accounted for 69 percent of enrollment in that market.³ The largest organizations offering Part D coverage (UnitedHealth Group, CVS Health, and Humana Inc.) offer both stand-alone PDPs and MA–PDs, so there is considerable overlap among organizations participating in the two markets.

Plan sponsors use pharmacy benefit managers (PBMs) to reduce costs by negotiating rebates with pharmaceutical manufacturers, developing drug formularies, and establishing networks of pharmacies. Many of the largest plan sponsors have their own PBMs; other sponsors perform some PBM functions in-house but contract with outside PBMs for services such as rebate negotiations.⁴ As a result, PBMs' market concentration is higher than that of plan sponsors. We estimate that in 2023, the top four PBMs (ranked by Part D–covered lives) negotiated rebates on behalf of roughly 90 percent of all Part D enrollees and prescriptions.

Formulary management and manufacturer rebates

Formularies are a key tool used by plan sponsors to manage drug spending because they are one of the few ways in which plans can encourage patients to use specific drugs. Plan sponsors and PBMs decide which drugs to include on their formularies, 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 the drug is dispensed. 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. Our previous analysis has found that plan sponsors with the most Part D enrollees obtain larger rebates, on average, than their smaller counterparts (Medicare Payment Advisory Commission 2023).

Increasing market concentration among the largest PBMs may have contributed to the rapid growth in aggregate manufacturer rebates negotiated by Part D sponsors. Between 2010 and 2023, the magnitude of aggregate rebates grew from \$8.6 billion (11 percent

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Roles of plan sponsors and pharmacy benefit managers (cont.)

of gross Part D spending) to just under \$70 billion (25 percent).⁵ By reducing costs for Part D sponsors, rebates can help reduce premiums for all enrollees. But because rebates generally are not used to reduce point-of-sale prices, a disproportionate share of benefit costs fall on Medicare's reinsurance and the low-income cost-sharing subsidy, as well as on patients who must pay a percentage coinsurance on a rebated drug.

Vertical integration of PBMs with insurers and pharmacies may increase efficiency—for example, by lowering transaction costs between the upstream and downstream entities. However, it also diminishes price transparency, which may further increase costs for enrollees and taxpayers who subsidize the program. The prices established between upstream and downstream entities (“transfer prices”) of vertically integrated organizations are not visible to CMS, and profits accruing to wholly owned downstream entities may be reflected as higher costs for Part D plans (Herman 2022, Medicare Payment Advisory Commission 2023).

PBMs that own pharmacies may also face conflicting interests as a PBM that manages pharmacy benefits for payers and as an owner of a pharmacy with financial incentives to increase the volume of prescription drugs that their pharmacies dispense (Herman 2022). Vertical integration in a highly concentrated PBM market could also be associated with anticompetitive behavior. For example, a plan sponsor that is vertically integrated with a PBM may undermine competition by raising the costs for competing plans that contract with that PBM (Greaney 2019).

Pharmacy networks

In Part D, plan sponsors must include in their networks any pharmacy that is willing to accept the sponsors' terms and conditions (known as the “any willing pharmacy” (AWP) provision). In addition to the AWP requirement, plan sponsors cannot require enrollees to fill their prescriptions at a particular pharmacy (e.g., at a mail-order or specialty pharmacy owned by its PBM). Sponsors must also demonstrate that their network meets Part D's pharmacy access standards. Sponsors can, however, designate a subset of network pharmacies that offer lower cost sharing as preferred cost-sharing pharmacies. For 2025, if enrollees remained in the same plan as in the previous year, about 75 percent of PDP enrollees (down from over 90 percent in 2024), 38 percent of general MA–PD enrollees, and less than 5 percent of enrollees in special-needs plans would be in plans that use preferred cost-sharing pharmacies.⁶

The strategy of designating certain pharmacies as preferred has the potential to reduce 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.⁷ 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 enrollees with the low-income subsidy do not face any financial incentives to choose preferred pharmacies. ■

drugs to engage in negotiations with the Secretary of Health and Human Services over prices charged under Medicare Part B and Part D. The Commission has not made recommendations related to either of those new

policies. The first of the IRA's Part D–related changes took effect in 2022, while others will not be effective until 2026 or later.

Regulatory change affecting prices paid at the point of sale and its effects on pharmacies

Effective January 1, 2024, Part D plans' payments to their network pharmacies ("negotiated price") must include all possible pharmacy price concessions such that the price at the point of sale (POS) is the lowest possible reimbursement a network pharmacy may receive for a particular drug. Before this change, negotiated prices did not include price concessions that were performance based because they could not "reasonably be determined" at the POS.⁸ As a result, pharmacies typically paid any price concessions to pharmacy benefit managers (PBMs) in lump sum at a later date (e.g., at the end of each quarter) and reported them to CMS as pharmacy direct and indirect remuneration (DIR). Similar to postsale rebates received from pharmaceutical manufacturers, 100 percent of pharmacy DIR must be passed on to Part D plans, which lowers benefit costs for plans and Medicare. At the same time, the higher prices paid at the POS increase costs for Medicare's low-income cost-sharing subsidy and for beneficiaries who pay coinsurance.

The aggregate amount of the net pharmacy DIR that plans received reached over \$21 billion (just under 8 percent of total gross Part D spending) by 2023, up from less than \$500 million in 2014, leading some independent pharmacies to report cash-flow challenges for their Part D business.

The change to the definition of "negotiated price" was expected to increase transparency of prices for beneficiaries and pharmacies and, in the long term, improve the predictability of revenues for pharmacies. However, in the initial months of the policy in 2024, there was an expectation that some pharmacies could experience cash-flow challenges as they simultaneously faced obligations to pay price concessions (pharmacy DIR) from 2023 while also receiving lower reimbursement for prescriptions filled in 2024 consistent with the new definition of negotiated price. Because of this concern, in December 2023, CMS issued a letter urging Part D sponsors and their PBMs "to make necessary cash flow arrangements with network pharmacies in preparations for these upcoming changes [to the pharmacy DIR]" (Centers for Medicare & Medicaid Services 2023d). According to the National Community Pharmacists Association (NCPA), however, the CMS letter was not effective in addressing the anticipated cash-flow issues for independent pharmacies (National Community Pharmacists Association 2024). In the letter to CMS, the NCPA noted that in their survey, nearly one-third of all respondents said they were considering closing because of the "cash crunch in Medicare" and that 93 percent reported that they may "drop out of Medicare Part D in 2025" if the situation did

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Recent and ongoing changes to the Part D program

In addition to the benefit redesign effective this year, in recent years, numerous other policies related to drug pricing and the Part D program have been implemented, affecting plan sponsors, beneficiaries, and drug manufacturers.

The first effective change from the IRA pertaining to the Part D program was related to manufacturers' pricing of all Part D (and Part B) covered drugs:

Beginning in 2022, manufacturers must now pay a rebate equal to any price increase above the rate of inflation for drugs dispensed to Medicare beneficiaries. Next were a series of beneficiary cost-sharing protections: limits on OOP costs applied to insulin products and vaccines, effective in 2023. Additional cost-sharing protections for beneficiaries were applied in 2024 when, for the first time since the program began, beneficiaries no longer faced any cost sharing once they reached the catastrophic phase of the benefit. Further, beneficiaries with income between 135

Regulatory change affecting prices paid at the point of sale and its effects on pharmacies (cont.)

not improve (National Community Pharmacists Association 2024).

Pharmacy closures have been in the news for some time (Gregg and Peiser 2023, Span 2024). One study found that, between 2018 and 2021, there were more pharmacy closures than openings across the U.S., resulting in a 2.1 percent net reduction in the number of pharmacies over the period (Guadamuz et al. 2024). These closures predate the recent policy change. Reports suggest there could be a “surge” in pharmacy closures that are driven by business decisions made by major retailers such as CVS Health, Walgreens, and Rite Aid Corporation (Burris 2024, Higham 2024a).

Both chain and independent pharmacies have seen more closures than openings over the last several years (Guadamuz et al. 2024). Multiple factors may drive pharmacies to close, including low reimbursement rates from PBMs, changes in consumer habits that have affected both the pharmacy and retail side of the business, and increased competition from online retailers such as Amazon and Walmart, each of which has its own pharmacy (Burris 2024, Higham 2024b, Trygstad 2024). The increased demand on pharmacists’ time (for example, to provide medication management or to administer vaccines), particularly after the COVID-19 pandemic, coupled with low payments

from PBMs, may have led to burnout and staff shortages (Cheema 2024, Dee et al. 2023). These issues facing pharmacies are not new, and some have suggested that the challenges facing pharmacies may be a broader retail challenge—a reality that the retail pharmacy model “may be broken” (Becker 2024, Meara 2024).

Pharmacy closures could have negative consequences for beneficiaries, particularly if the closure affects their ability to obtain prescribed medicines. Pharmacy closures could also impede access to vaccinations (Guadamuz et al. 2024, Qato et al. 2019). To date, our focus groups and external surveys continue to indicate high satisfaction with the Part D program and do not suggest widespread issues with access to pharmacies or to their prescribed medicines (Morning Consult 2024, NORC at the University of Chicago 2024). But certain areas may be more at risk of closure than others. For example, nearly 10 percent of rural pharmacies closed between 2003 and 2021, while the number of retail pharmacies in metropolitan areas increased by 15 percent (Lazaro et al. 2022). However, not all metropolitan areas have seen equal growth: Other studies indicate that neighborhoods whose residents tend to be non-White may experience pharmacy closures that can result in beneficiaries no longer having convenient access to pharmacies (Guadamuz et al. 2024, Hunter 2024). ■

percent and 150 percent of the federal poverty level are now eligible for the full LIS rather than a less generous partial subsidy. Also beginning in 2024, the IRA imposed a limit on the annual increase in the base beneficiary premium (BBP) to no more than 6 percent (for more detail, see the section discussing the increase in the average national bid in 2025, p. 421).

A regulatory change (not part of the IRA) affecting pharmacy direct and indirect remuneration (DIR) also went into effect in 2024: This change required

pharmacy DIR payment adjustments to be applied by plan sponsors and PBMs such that pharmacies’ initial reimbursements are the lowest possible amount they could receive for a given drug dispensed (see text box on the recent regulatory change affecting prices paid at the POS and its effects on pharmacies).

Beginning in 2025, the IRA’s redesign of the Part D benefit structure went into effect, the details of which are outlined below. Notably, liabilities for spending were shifted from beneficiaries and the Medicare

program to plans, significantly reducing the share of spending paid by beneficiaries in cost sharing (and Medicare's low-income cost-sharing subsidy (LICS)) and Medicare's reinsurance. Drug manufacturers' cost liability has also shifted, as discussed in the section below describing changes to Part D in 2025.

In 2026, for the first time, the prices of 10 single-source drugs with the highest total gross Part D spending will be set at the price negotiated by the government for all beneficiaries; additional drugs will be selected in subsequent years (see text box (pp. 437–439) on the Medicare Drug Price Negotiation Program for more details).

Significant changes to Part D in 2025

The redesign of Part D's benefit structure, one of the most significant changes to the program, became effective with the 2025 plan year. The redesign and the IRA's broader impact on the pharmaceutical supply chain are expected to affect how Part D plans operate. These changes are shifting liability between the various stakeholders; in particular, beneficiary cost sharing will be reduced, while plan liability—and thus premiums—will increase. Medicare's liability, paid through a variety of subsidies, will also shift, with cost-based subsidies declining while capitated premium subsidies increase.

Plan sponsors have faced significant uncertainty as many of the IRA policies are implemented for the first time this year. For example, plan sponsors expected the IRA changes to increase the use of specialty drugs and other high-cost medicines, but those expectations differed based on assumptions that varied across plans (Cline and Liner 2024). The different assumptions, in turn, likely drove greater variation in plan bids and premiums for 2025, particularly among stand-alone PDPs, than those observed historically. The IRA capped the annual increase in the BBP to no more than 6 percent (for more detail, see the section discussing the increase in the average national bid in 2025, p. 421). Nevertheless, CMS stated that the level of increases in individual plan premiums for PDPs could result in “disruptive enrollment shifts” that could potentially destabilize the PDP market (Centers for Medicare & Medicaid Services 2024f). CMS thus implemented the

Part D Premium Stabilization Demonstration, which lowered participating PDP premiums by up to \$15 and required participating PDPs to limit the annual increase in their total monthly premiums (including both basic and supplemental premiums) to no more than \$35. Under the demonstration, CMS will also provide more generous protection from losses under Part D's risk corridors.⁹ While the lower premiums may have prevented large shifts in enrollment across plans, both within the PDP market and across the PDP and MA–PD markets, the additional subsidies that are paid to PDPs under the demonstration will increase Medicare spending. The Congressional Budget Office estimates that the additional subsidies paid to PDPs under the demonstration will increase federal spending for Part D by about \$5 billion in 2025 (Swagel 2024). Even with virtually all PDPs participating in this demonstration, PDP premiums still vary widely in 2025 (Cubanski 2024). In contrast, most MA–PD enrollees continue to have access to many plans with \$0 premiums, with the total average premium charged by MA–PDs projected to decrease in 2025 (Centers for Medicare & Medicaid Services 2024c).

Consistent with the shift in enrollment from FFS to MA in the broader Medicare program, Part D's enrollment has also shifted from PDPs to MA–PDs. MA–PDs increasingly offer more generous prescription drug coverage (for example, with fewer product exclusions and lower cost sharing) to enrollees at lower premiums (Ippolito and Vabson 2024, Joyce et al. 2024). At the same time, PDPs continue to play an important role since they provide drug coverage for FFS beneficiaries and, critically, they ensure that premium-free plan options (“benchmark” plans) are available for FFS beneficiaries with low income and assets.

However, recent work by the Commission has detailed diverging trends in the PDP and MA–PD markets that raise concerns about the long-term stability of the PDP market. Specifically, we found that (1) premiums charged by PDPs have tended to exceed those of MA–PDs; (2) the number of benchmark plans has continued to decline in certain areas of the country; (3) benefit costs, on average, are higher among PDP enrollees compared with MA–PD enrollees, but Part D's payment system may not adequately adjust for those higher costs; and (4) PDPs are more likely to incur losses in

Part D's risk corridors than MA-PDs. Plan offerings and premiums for 2025 show a continuing decrease in the number of PDPs and benchmark plans as well as continuing divergence in premiums charged by PDPs and MA-PDs.

Changes taking place this year are expected to have wide-ranging impacts on Part D plan sponsors and enrollees, as well as stakeholders in the pharmaceutical supply chain. As a result, some of the historical trends may no longer provide insights that will be useful in understanding trends going forward. However, we continue to provide historical data and describe trends since they could serve as baselines against which to measure the various effects of the policy changes that are implemented in 2025 and subsequent years.

Beginning in 2025, Part D's benefit reflects key changes made by the IRA

Medicare law defines the standard Part D basic benefit that plan sponsors must offer (or coverage that is actuarially equivalent to that standard). The design and actuarial value of the standard basic benefit has changed numerous times over the years. The transition to the IRA's new benefit design for non-LIS beneficiaries is fully implemented in 2025, while the transition for LIS beneficiaries will occur gradually starting this year and continue through 2031. Since the last major reforms to the benefit design in 2010, LIS beneficiaries have had a different benefit design than non-LIS beneficiaries, but that will no longer be the case once the new benefit structure is fully implemented for LIS enrollees. (However, Medicare's LICS will continue to pay most of the cost-sharing liabilities on behalf of enrollees who receive the LIS.)

In 2025, Part D's defined standard benefit for enrollees without the LIS (74 percent of enrollees in 2024), includes a deductible; beneficiaries pay 100 percent of costs until the deductible is met. Next, in the initial coverage phase, beneficiaries are responsible for 25 percent of drug spending until reaching the catastrophic-coverage limit (Figure 12-1, p. 420). There is no longer a coverage gap (or "donut hole"), and beneficiaries now have a maximum OOP cap, which are two of the biggest changes from the historical design. Each year, the standard benefit's parameters change at the same rate as the annual change in

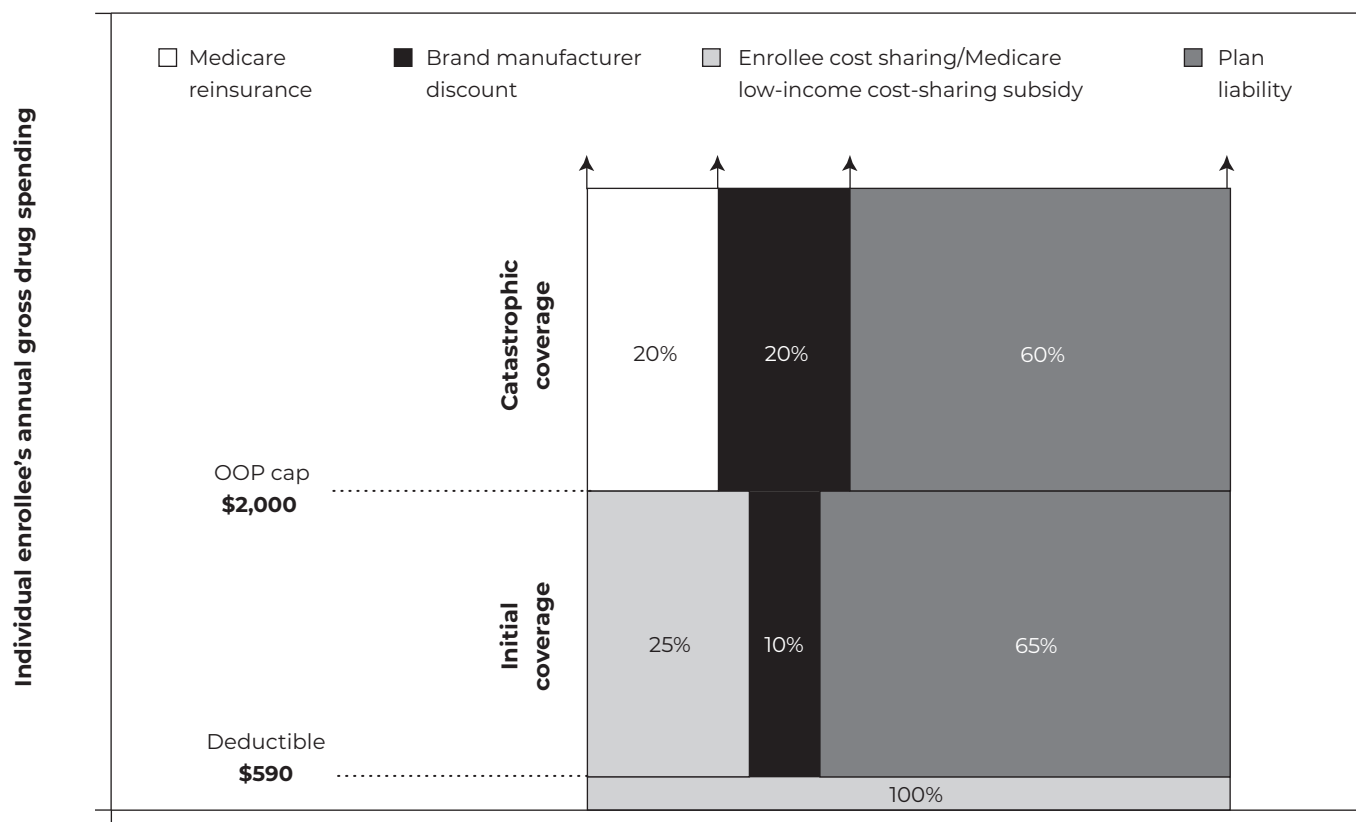
beneficiaries' average drug expenses. For 2025, the deductible in Part D's standard benefit is \$590 and the OOP threshold is \$2,000, which is expected to be reached after a beneficiary incurs approximately \$6,030 worth of drug spending (Centers for Medicare & Medicaid Services 2023b). That threshold is based on "true OOP" costs, referred to as "TrOOP." Before 2025, TrOOP spending excluded beneficiary cost sharing paid by most sources of supplemental coverage, such as employer-sponsored policies and more generous (supplemental) benefits from the beneficiary's Part D plan, but it included the 70 percent discount that manufacturers of brand-name drugs were required to pay in the coverage gap. Beginning in 2025, changes made by the IRA to the TrOOP calculation are expected to improve beneficiaries' access to drugs by limiting cost-sharing liabilities for many beneficiaries without the LIS. At the same time, the change is also expected to increase the number of enrollees who reach the OOP threshold and increase spending (see text box (pp. 422–423) on the new method for calculating TrOOP costs).

For beneficiaries with low incomes and assets, Medicare's LIS pays the difference between cost-sharing amounts set by each plan and nominal copayments set by law. In 2025, individuals receiving the LIS pay between \$0 and \$4.90 per prescription for generics and between \$0 and \$12.15 per prescription for brand-name drugs.¹⁰ Above the OOP threshold, LIS enrollees have never paid cost sharing; Medicare's LICS subsidy paid the 5 percent coinsurance they previously would have owed 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 LICS subsidy, this change has reduced Medicare's costs for the subsidy and increased plans' liability.

Another change included in the IRA affecting beneficiaries' cost sharing in 2025 is the new requirement for plan sponsors to allow enrollees to "smooth" their cost-sharing liabilities over the course of the year. At any time during the plan year, a beneficiary may opt in to a new Medicare Prescription Payment Plan. In addition to making all enrollees aware of the program, plan sponsors are required to specifically notify individuals who could benefit from this program of that likelihood. Enrollees who choose to opt in will pay nothing at the POS

**FIGURE
12-1**

New defined standard benefit design, 2025



Note: OOP (out of pocket). The "defined standard benefit" is depicted as it would apply to brand-name drugs and biologics. Beginning in 2024, beneficiaries have no liability in the catastrophic phase; plan liability will increase to cover the 5 percent that otherwise would have been paid by enrollees. For generic drugs, plan sponsors must pay 75 percent of covered benefits between the deductible and OOP cap. Medicare will pay 40 percent reinsurance above the OOP cap. Total spending at the \$2,000 OOP cap is expected to be \$6,230. For beneficiaries with the low-income subsidy (LIS) and for certain small manufacturers, the new manufacturer discount program will be phased in over time, reaching final levels by 2031. In addition, Medicare's low-income cost-sharing subsidy will continue to pay most of the cost-sharing liabilities on behalf of enrollees who receive the LIS.

Source: MedPAC depiction of Part D benefit structure for 2025.

(instead, plan sponsors will pay the pharmacy the full cost-sharing amount); enrollees will make their cost-sharing payments directly to the plan sponsor over the remainder of the year. The amount owed each month will be based on the total cost-sharing liability owed at the time of the opt-in, the amount of TrOOP already accumulated toward the annual limit, the number of months remaining in the year, and any new charges incurred in subsequent months for additional drugs. Because of all these factors, the formula may result in large fluctuations in payment amounts

throughout the year that do not coincide with when individuals fill their prescriptions. This mismatch, in turn, may cause confusion for some beneficiaries. CMS thus notes that the program may be more helpful for some beneficiaries than others (Centers for Medicare & Medicaid Services 2024g). The Medicare Prescription Payment Plan may also require Part D plans to set up new infrastructure to bill patients and to notify the pharmacy staff in a way that fits with their workflow, a process which could be administratively complex (Dusetzina et al. 2024).

In 2025, the national average plan bid increased by nearly 180 percent

The IRA shifted more of the insurance risk to plans while increasing the generosity of the basic benefit, meaning that Medicare's capitated direct subsidy would rise while the share of benefit costs paid based on actual spending (Medicare's reinsurance) would go down. Changes in the average bid amount, BBP, and the capitated and cost-based subsidies between 2024 and 2025 were all directionally consistent with the changes that were expected due to the IRA's redesign.¹¹ At the same time, the magnitude of the changes may have exceeded some expectations (BGR Group 2024, Cline et al. 2024). This effect likely results, in part, from higher-than-expected spending growth in 2023, which preceded the implementation of the benefit redesign (Congressional Budget Office 2024).¹²

In 2025, the national average bid rose from \$64 to \$179, an increase of nearly 180 percent, while the average expected reinsurance declined from \$90 to \$40 (Table 12-2, p. 424) (Centers for Medicare & Medicaid Services 2024b). The average bid is calculated as the enrollment-weighted average of plan bids that reflect their expectations about benefit costs and about administrative costs and profit margin.¹³ The average bid is used to determine the level of Medicare's capitated direct subsidy for the Part D benefit and the BBP. (The BBP is an enrollee's share of the national average expected cost of basic benefits.)

By law, the BBP is set as 25.5 percent of the total expected benefit cost, unless the annual increase in the BBP is greater than 6 percent, which is the maximum annual increase allowed under the IRA. In 2030, the BBP will continue to be based on the lower of the prior year's BBP plus an increase of 6 percent or the BBP calculated based on the national average bid. However, the BBP cannot be less than 20 percent of the average basic benefit costs (i.e., Medicare's overall subsidy rate cannot exceed 80 percent). For subsequent years, the enrollees' share (percentage) of expected benefit costs will remain at the level set for 2030.

The 6 percent cap so far has had the effect of reducing enrollees' share of the total basic benefit costs from 25.5 percent to less than 20 percent in the two years in which the policy has been in effect. Without the cap, in 2025 the BBP would have risen to \$55.98, an annual

increase of over 60 percent (from \$34.70 in 2024) (Table 12-2, p. 424).¹⁴ Because of the cap, the BBP for 2025 rose to just \$36.78.

To ensure that plans are paid the full amount of the national average bid, Medicare's direct subsidy is increased by the amount of premium growth above the 6 percent cap (\$19.20), or from \$123.47 (without the application of the 6 percent cap) to \$142.67 (Table 12-2, p. 424). The higher direct subsidy increases Medicare's share of the expected total benefit costs (which includes both the direct-subsidy and reinsurance payments). Thus, instead of \$163.55, Medicare's spending per enrollee will average \$182.75 in 2025, an increase in Medicare's overall subsidy of about 12 percent. So, in 2025, Medicare's overall subsidy rate is expected to rise to 83.2 percent, from the 77.5 percent subsidy rate estimated for the 2024 benefit year. Enrollees' share of the expected total benefit cost, on the other hand, decreased to 17 percent from 22.5 percent in 2024.

CMS noted that it observed large increases as well as greater variation in bids submitted by PDP sponsors compared with bids submitted by MA-PD sponsors for 2025, which could result in premium changes that create "disruptive enrollment shifts in the PDP market during the initial implementation of the IRA benefit improvements" (Centers for Medicare & Medicaid Services 2024a). To mitigate the destabilizing effects that large premium changes may have on the PDP market, CMS implemented a new voluntary nationwide demonstration, the Part D Premium Stabilization Demonstration for 2025 (Centers for Medicare & Medicaid Services 2024e). (See p. 418 for more information on the Part D Premium Stabilization Demonstration.) The demonstration, which could be extended for two additional years, is expected to increase federal spending.

Fewer plan offerings for 2025

Beneficiaries' enrollment choices are based on whether the individual receives their medical benefits under FFS Medicare or under the MA program, as well as the region or county in which they reside. FFS beneficiaries may choose from among PDPs offered in their states, while MA beneficiaries may choose from among MA-PDs offered in their county of residence. PDP sponsors must offer a plan that covers an entire PDP region (there are 34 PDP regions that consist of one or

New method for calculating true OOP costs lowers cost sharing but raises concerns about higher costs and polypharmacy

The Inflation Reduction Act of 2022 (IRA) lowered the annual out-of-pocket (OOP) threshold to \$2,000 in 2025 (from \$8,000 in 2024) and changed the method used to calculate the true out-of-pocket (TrOOP) costs for the purpose of determining when a beneficiary reaches the annual OOP threshold.

Before the change in law, TrOOP consisted of cost sharing paid by enrollees as well as coverage-gap discounts paid by manufacturers of brand-name drugs and biological products. In addition, payments made by certain organizations (e.g.,

qualified State Pharmacy Assistance Programs, AIDS Drug Assistance Programs, and certain charitable organizations) also counted as TrOOP. Beginning in 2025, payments by manufacturers of brand-name drugs and biological products under the discount program will no longer count as TrOOP, but the value of supplemental benefits will. This change will have implications for how quickly enrollees reach the OOP threshold.

For example, a beneficiary on two medications, Eliquis and Jardiance, enrolled in an enhanced-benefit plan with a \$47 copay for each drug (totaling

(continued next page)

**TABLE
12-1**

A hypothetical example of how the new TrOOP calculation would work for an individual enrolled in an enhanced plan

	Gross drug cost	Enrollee cost sharing		Estimated value of supplemental benefit	TrOOP	Cumulative TrOOP
		Defined standard	Enhanced plan			
January	\$1,334	\$776	\$94	\$682	\$776	\$776
February	1,334	334	94	240	334	1,110
March	1,334	334	94	240	334	1,443
April	1,334	334	94	240	334	1,777
May	1,334	223	94	129	223	2,000
June	1,334	0	0	0	0	2,000
July	1,334	0	0	0	0	2,000
August	1,334	0	0	0	0	2,000
September	1,334	0	0	0	0	2,000
October	1,334	0	0	0	0	2,000
November	1,334	0	0	0	0	2,000
December	1,334	0	0	0	0	2,000
Total	16,010	2,000	470	1,530	2,000	N/A

Note: TrOOP (true out of pocket), N/A (not applicable). In this hypothetical example, we assumed that an individual is on two medications (Eliquis (5 mg tablet) and Jardiance (25 mg tablet)), which they fill every month, and that the individual is enrolled in an enhanced-benefit plan that charges a cost sharing of \$47 for each 30-day prescription for each drug. The estimated value of the supplemental benefit is calculated as the difference between cost-sharing liability under the enhanced-benefit plan and the defined standard benefit plan, which has a deductible of \$590 and a 25 percent coinsurance on spending above the deductible, until the individual has spent \$2,000 in cost sharing. Components may not sum to totals due to rounding.

Source: MedPAC calculation based on Plan Finder data at www.Medicare.gov.

New method for calculating true OOP costs lowers cost sharing but raises concerns about higher costs and polypharmacy (cont.)

\$94 a month in cost sharing), would reach the OOP threshold in May with just under \$500 in total OOP cost sharing (\$94 × 5 months) (Table 12-1).¹⁵ For this individual, CMS calculates the value of the supplemental benefits by taking the difference between cost sharing that would have applied under the defined standard benefit and the copay charged by the plan (in this case, \$94 (2 × \$47)) for the two drugs, which the individual pays each month. (This plan has no deductible.) Under this scenario, both the \$94 paid OOP and the value of the supplemental benefit (estimated to be \$682 in January, \$240 in February through April, and \$129 in May) would count as TrOOP. In May, the individual would have reached the annual OOP threshold of \$2,000 by paying just \$470 in cost sharing OOP.

In general, for beneficiaries who do not receive the low-income subsidy and are in an enhanced-benefit plan, the amount of cost sharing needed to reach the annual OOP threshold would depend on the plan's benefit design (e.g., use of coinsurance or copay) and the drug(s) an individual is on. Beneficiaries with more generous supplemental coverage for their medication(s) would have lower cost-sharing liability compared with beneficiaries with less generous supplemental coverage for their medications (e.g., nonpreferred brand-name drugs with high coinsurance) (Karcher 2024). As a result, some individuals on expensive medication(s) could reach the OOP threshold earlier in the year, with substantially lower cost-sharing amounts paid OOP than the amount set in law.

One study estimated that, in 2025, nearly 10 million beneficiaries would reach the OOP threshold

(Assistant Secretary for Planning and Evaluation 2024). This amount is more than double the number of beneficiaries with spending above the annual OOP threshold in 2023 (4.8 million), the latest year for which we have data.

The new method for calculating TrOOP costs combined with the IRA change to eliminate cost sharing above the annual OOP threshold could pose a challenge for plans as they take on more insurance risk. With no cost sharing in the catastrophic phase of the benefit, plans will have limited ability to manage spending once a beneficiary has reached the OOP threshold. That could in turn result in higher subsidy costs for Medicare and premiums paid by all enrollees. Although CMS noted that it has not found any significant changes in plan formularies for 2025, some plans appear to have modified their formularies, for example, by increasing the use of coinsurance rather than copays or using narrower formularies (Centers for Medicare & Medicaid Services 2024c, Cubanski and Damico 2024, Friedman 2024, Knable et al. 2024).

Going forward, the new method for calculating TrOOP costs may have implications for the availability of plan offerings and the generosity of enhanced benefits offered (Karcher 2024). Some beneficiaries will reach the annual OOP threshold relatively early in the year yet incur OOP costs that are substantially below the annual OOP limit set in law. Plans then may need to explore new approaches to balance access to needed medications with the concerns about polypharmacy, higher benefit spending, and higher enrollee premiums. ■

more states), while MA-PD sponsors may choose their service area on a county-by-county basis.

The number of PDP offerings has fluctuated over the years but has declined steadily since 2023. In 2025, plan sponsors are offering a total of 464 PDPs, down from 709 plans in 2024.¹⁶ The magnitude of the decrease (a 35 percent drop), driven in part by the declining

number of sponsors participating in the PDP market, is notable (Cubanski and Damico 2024).

In 2025, there are 3,246 conventional MA-PDs available to MA enrollees, down from more than 3,500 plans in 2024 (a 7.4 percent decrease). At the same time, offerings of a specific type of MA-PD, special-needs plans (SNPs), continued to rise. (SNPs are limited to

**TABLE
12-2****Changes in Part D national average monthly bid amount,
base premium, and average subsidies, 2024–2025**

	2024	2025	Percent change
Total expected basic benefit cost	\$154.31	\$219.53	42%
National average monthly bid amount	64.28	179.45	179
National average expected reinsurance	90.03	40.08	–55
Base beneficiary premium			
Before the application of the 6% cap (25.5% of the total expected benefit cost)	39.35	55.98	42
After the application of the 6% cap	34.70	36.78	6
<i>Effect of the 6% cap</i>	–4.65	–19.20	
Medicare's direct subsidy			
Before the application of the 6% cap	24.93	123.47	395
After the application of the 6% cap	29.58	142.67	382
<i>Effect of the 6% cap</i>	4.65	19.20	
Medicare's total subsidy costs			
Before the application of the 6% cap	114.96	163.55	42
After the application of the 6% cap	119.61	182.75	53
<i>Effect of the 6% cap</i>	4.65	19.20	
Medicare's subsidy rate			
Before the application of the 6% cap	74.5%	74.5%	
After the application of the 6% cap	77.5	83.2	

Note: The "national average monthly bid" is the enrollment-weighted average of plan bids, which include plan sponsors' expected benefit liability net of the plan's share of postsale rebates and discounts, administrative costs, and profit margin. The "national average expected reinsurance" is estimated based on the expected reinsurance costs, accounting for Medicare's share of postsale rebates and discounts, and is used to calculate the base beneficiary premium (BBP) before the application of the 6 percent cap. By law, the BBP is calculated as 25.5 percent of the total expected benefit cost per enrollee. Under the changes made by the Inflation Reduction Act of 2022, beginning in 2024, the annual increase in the BBP is limited to 6 percent through 2029. In 2030, the BBP increase will continue to be limited to 6 percent. However, the BBP cannot be less than 20 percent of the average basic benefit costs. For subsequent years, the BBP's share of the expected benefit costs will remain at the level set for 2030. Medicare's direct subsidy is computed as the difference between the national average bid and the BBP. Figures do not reflect the effects of the Part D Premium Stabilization Demonstration discussed on p. 418.

Source: CMS's annual release of Part D national average monthly bid amount and other Part C and Part D bid information.

enrollees who have a chronic condition, are dually eligible for Medicare and Medicaid, or live in an institution.) In 2025, there are 1,417 SNPs, up from about 1,300 plans in 2024 (an 8.5 percent increase).

Despite the decrease in the PDP and conventional MA–PD offerings, beneficiaries in every region continue to have a choice of at least a dozen PDPs, in addition to many MA–PDs. (The number of conventional MA plans—most of which also offer a Part D drug benefit—

that are available to a beneficiary varies by the county of residence, with an average of 28 plans in each county.)

Benchmark plans, which are a subset of PDPs available to LIS enrollees at no premium, have decreased over the years, which generally follows the trend observed for the broader PDP market. Benchmark plans serve a unique role in the Part D program. To qualify as a

benchmark plan, the plan must be a basic-benefit plan and a stand-alone PDP with a premium at or below the regional LIS benchmark, which is calculated as an enrollment-weighted average of plan bids in a region, using LIS enrollment. Because Medicare's low-income premium subsidy covers LIS enrollees' premiums up to the regional benchmark, LIS enrollees in these plans pay \$0 in premiums. In addition, LIS beneficiaries who do not choose their own plan are automatically enrolled in a benchmark PDP in their region.

In 2025, there are 90 benchmark plans, down from 126 in 2024. This year's decrease in the number of PDP offerings has given rise to concerns that a continued decrease could result in regions with no PDPs and thus no benchmark plans.¹⁷ The number of regions with limited choice in benchmark plans grew in 2025: 4 regions have just one benchmark plan, and 11 regions have two, up from 8 regions having a minimum of two plans in 2024.¹⁸ For 2025, CMS expects to reassign over 400,000 LIS enrollees who were in plans that were terminated or lost the benchmark status to a different plan that is premium free for LIS enrollees (Liu and Centers for Medicare & Medicaid Services 2024). (That figure is significantly lower than the 1.4 million LIS enrollees who were reassigned to a benchmark plan in 2024.)

In 2025, the benchmarks varied widely across regions, ranging from just under \$16 in New Mexico to more than \$72 in New York. This range is wider than the historical trend. For example, in 2024, benchmarks ranged from \$28 in Texas to \$49 in New York, a difference of about \$20. The larger variation in the LIS benchmarks across regions is likely due, in part, to the greater variability in PDP bids for 2025 compared with prior years (Centers for Medicare & Medicaid Services 2024e).

Policies helped to keep average premiums stable in 2025 despite the large increase and wide variation in bids for some plans

While the annual increase in the BBP has been limited to 6 percent, changes in individual plan premiums may increase by more (or less) than 6 percent because they reflect any difference between the sponsor's bid and the national average bid. In addition, enrollees choosing an enhanced plan must pay any supplemental premiums charged by their plans.

Overall, average premiums remain stable in 2025, likely due in large part to the implementation of policies that shift premium increases from beneficiaries to the Medicare program. First, the new limit on the annual increase in the BBP effectively limits the extent to which plan sponsors can cover the costs of IRA-required benefit expansions by raising enrollee premiums. Instead, as described above, most of the increase in benefit costs are shifted from enrollees to the Medicare program by automatically increasing Medicare's overall subsidy rate to cover a larger share of basic benefit costs than the 74.5 percent originally set in law. Second, for participating PDPs, the Premium Stabilization Demonstration lowered monthly premiums by up to \$15 and limited their annual increases to no more than \$35. Without these policies, premiums likely would have grown dramatically, with an even greater variation around the average, particularly among PDPs. However, these policies are expected to increase Medicare's subsidy by about 12 percent.

The average total premium for national PDPs in 2025 is about \$44, weighted by 2024 enrollment (as is the case for all average premiums discussed in this section), an amount that is virtually unchanged from 2024. (Premiums reflect the lower BBP applied to all participating PDPs under the Premium Stabilization Demonstration.) However, there is wide variation around that average. For example, in California, among the 16 national PDPs offered in both 2024 and 2025, monthly enrollee premiums increased by \$35 (the maximum total premium increase allowed under the Premium Stabilization Demonstration) for 8 PDPs, while premiums decreased for 6 (Cubanski 2024).

For 2025, most MA-PD enrollees continue to have access to many plans with \$0 or low premiums. The total average Part D premium charged by MA-PDs is projected to decrease from over \$15 in 2024 to \$13.50 in 2025 (Centers for Medicare & Medicaid Services 2024c). (These amounts reflect any Part C rebates that plans applied to lower their basic and/or supplemental premiums.¹⁹) Among the conventional MA-PDs, the average premium for 2025 is estimated to be just over \$7 per month. That premium reflects \$44 of Part C rebates that plan sponsors used, on average, to lower total Part D premiums for their conventional MA-PD plans. The premiums for SNPs are estimated to average

\$31 per month. That premium reflects \$11 of the Part C rebates that plan sponsors apply to buy-down premiums. The majority of the SNPs are D-SNPs (SNPs for beneficiaries who are dually eligible for Medicare and Medicaid) that target the LIS benchmarks in order to remain premium free for their enrollees, all of whom receive the LIS. (These plans are almost exclusively basic plans; thus they do not have supplemental premiums and therefore do not use rebate dollars to buy down supplemental premiums.)

Understanding the full impact of the IRA changes

Changes taking place this year are expected to have wide-ranging impacts on Part D plan sponsors and their enrollees as well as stakeholders in the pharmaceutical supply chain. The redesign of the Part D benefit is expected to improve plan incentives to manage prescription drug spending: Instead of payments relying primarily on cost-based reinsurance and LICs subsidies, payments will depend more on capitated direct subsidies in a way that better aligns with the incentives present at the start of the program. Further, several provisions improve Part D enrollees' access to and affordability of drugs covered under Part D, with savings estimated to be in the thousands of dollars for enrollees with the highest spending (Assistant Secretary for Planning and Evaluation 2024).

These benefits, however, have trade-offs. Lower cost sharing for patients at the point of sale makes medications more affordable but is likely to put upward pressure on overall drug utilization and benefit costs, which in turn increases premiums for beneficiaries and subsidy costs for Medicare. For 2025, many plan sponsors expected an increase in the use of specialty drugs and other high-cost brand medications “as a direct result of the new cost-sharing limits and flexibilities [i.e., M3P] created by the IRA” (Cline and Liner 2024). This significant uncertainty about how much utilization will increase has resulted in assumptions that likely drove the variation in 2025 bids (Cline and Liner 2024).

The changes adopted in the IRA are also likely to affect revenues of pharmaceutical manufacturers and may affect their future investment decisions regarding pharmaceutical research and development and strategies for new-product launches. However, estimates of possible effects have varied widely, with estimates

regarding the number of drugs entering the market ranging from 1 fewer to more than 100 fewer over the next decade (Avalere 2022, Congressional Budget Office 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 research and development (Medicare Payment Advisory Commission 2023, Medicare Payment Advisory Commission 2022a).²⁰ Some also expect that launch prices for new therapies may be higher than they otherwise would be as a result of the IRA's inflation rebate policies that limit manufacturers' ability to increase drug prices after launch (Congressional Budget Office 2023). The Commission has consistently stressed the importance of balancing a drug's net clinical benefit with an appropriate reward for innovation and affordability for beneficiaries and taxpayers, and we will continue to take into account the need for an appropriate balance as we evaluate the Part D program (Medicare Payment Advisory Commission 2023, Medicare Payment Advisory Commission 2022a, Medicare Payment Advisory Commission 2017).

Other changes mandated by the IRA are expected to affect how Part D plans operate through the law's impacts on the broader pharmaceutical supply chain. For example, the new mandatory manufacturer discount program may have financial impacts for pharmaceutical manufacturers that diverge from the impact of the coverage-gap discount program that it replaced (Upchurch and Saliba 2025). Prices negotiated by the Secretary under the new Medicare Drug Price Negotiation Program that will become effective next year may further drive changes in the pharmaceutical supply chain.

An early look at the 2025 plan offerings shows a mix of expected effects, such as an increase in plan bids and lower expected reinsurance costs, as well as some unexpected effects, such as the magnitude of the increase in the national average bid (an increase of nearly 180 percent) while average premiums remain stable. Understanding the full impact of the IRA will take time. Over the coming years, we expect plan sponsors to adjust to the redesigned benefit as they gain claims experience and adapt to the new market dynamics as pharmaceutical manufacturers and other supply-chain

**TABLE
12-3**

Part D's enrollment has gradually shifted toward MA-PDs

	2020	2021	2022	2023	2024	Average annual change 2020–2024
Total Medicare enrollment (in millions)	62.9	63.8	65.0	66.3	68.0	1.8%
Total enrollment in Part D plans (in millions)	47.0	48.3	49.8	51.5	54.1	3.6
<i>As a share of total Medicare enrollment</i>	<i>75%</i>	<i>76%</i>	<i>77%</i>	<i>78%</i>	<i>80%</i>	
Part D plan enrollment by plan type (in millions)						
PDP	25.1	24.0	23.3	22.5	23.0	–2.1
MA-PD	21.9	24.3	26.5	29.1	31.0	9.1
Full LIS enrollment (in millions)						
PDP	6.7	6.0	5.5	5.2	4.7	–8.8
MA-PD	6.1	6.8	7.7	8.6	9.3	11.3
Overall	12.8	12.8	13.3	13.8	14.0	2.2

Note: MA-PD (Medicare Advantage–Prescription Drug [plan]), PDP (prescription drug plan), LIS (low-income subsidy). 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 (0.2 million in 2023) receive partial assistance. Components may not sum to totals due to rounding, and percentage changes were calculated on unrounded data.

Source: MedPAC analysis based on the 2023 Medicare Trustees' report and CMS Part D enrollment data from February 2024.

participants evolve in response to the changes. At the same time, the IRA and subsequent policy changes (such as the Premium Stabilization Demonstration) are likely to interact in a way that complicates our understanding of the impact of any given policy in isolation (Congressional Budget Office 2024). We anticipate the initial year of data to provide an incomplete picture of the effects the IRA has had on the Part D program. The Commission plans to continue to monitor the IRA's effects on the program and its stakeholders beyond the initial years of the implementation.

Recent trends in enrollment, premiums, and program spending

In this section, we discuss historical trends in enrollment, spending, and other aspects of the Part D program. The substantial changes affecting the Part D benefit will likely create departures from many of these

trends, but this analysis will serve as important context and a baseline for measuring those changes as they are implemented.

In 2024, 54.1 million individuals—about 80 percent of all Medicare beneficiaries—were enrolled in Part D plans (Table 12-3). Another 1 percent of beneficiaries obtained drug coverage through their former employers that provided a prescription drug benefit that was at least as generous as Part D's defined standard benefit and received Medicare's retiree drug subsidy (data not shown). We estimate that just under 10 percent of eligible Medicare beneficiaries had creditable drug coverage from other sources. About 11 percent of eligible beneficiaries had no coverage or coverage less generous than Part D (data not shown).²¹

More enrollees in MA-PDs and enhanced plans

Beginning in 2020, the number of enrollees in PDPs has declined as more beneficiaries opt to enroll in MA and accompanying MA-PDs. Enrollees in MA-PD plans

are more likely to be in enhanced plans that have more generous benefits than enrollees in PDPs. Beneficiaries with the LIS are more likely to be in basic-benefit plans.

Enrollment has shifted toward MA-PDs

Consistent with the shift in enrollment from FFS to MA in the broader Medicare program, the distribution of Part D enrollment has moved gradually toward MA-PDs. The number of enrollees in PDPs began to decline in 2020, from 25.1 million to about 23.0 million by 2024 (Table 12-3, p. 427). In 2024, PDPs accounted for less than 43 percent of all Part D enrollees, down from 53 percent in 2020.

In 2024, 14.0 million beneficiaries (26 percent of Part D enrollees) received the LIS. Of these individuals, 9.7 million were eligible for both Medicare and full Medicaid benefits (“dually eligible”) (data not shown) (Boards of Trustees 2024, Boards of Trustees 2023).²² Between 2020 and 2024, LIS enrollment grew more slowly (an average rate of about 2 percent per year compared with 4 percent per year for other enrollees (latter data not shown)). As a result, the share of Part D enrollees who received the LIS declined from 27 percent to 26 percent during that period. At the same time, the share of LIS enrollees in MA-PDs grew from 48 percent in 2020 to 67 percent in 2024, while LIS enrollment in PDPs declined by nearly a third during this period. Much of the LIS enrollment growth in MA-PDs was in D-SNPs.

Majority of beneficiaries without the LIS chose enhanced plans

While statute sets the parameters for the defined standard benefit, in practice, most sponsors use alternative benefit designs that include lower deductibles or tiered copayments for some formulary tiers rather than the uniform coinsurance under the defined standard benefit. Sponsors, however, must demonstrate that their basic benefits have the same average value as the defined standard benefit.

A PDP sponsor must offer a basic-benefit plan in a region before it can offer an enhanced-benefit plan (i.e., a plan that combines basic Part D benefits with supplemental drug coverage). MA-PDs do not have to offer a basic-benefit plan in order to offer an enhanced-benefit plan, which likely explains the difference in plan offerings between PDPs and conventional MA-PDs, with the latter offering nearly

exclusively enhanced-benefit plans (Medicare Payment Advisory Commission 2024a). In 2024, 99 percent of enrollees in conventional MA-PDs were in enhanced plans compared with 61 percent for enrollees in PDPs (Table 12-4).

MA-PD plan sponsors can use a portion of their MA payments to supplement their Part D benefits or to lower Part D premiums. As a result, enrollees in conventional MA-PDs tend to have more generous benefits than enrollees in PDPs. For example, in 2024, 77 percent of conventional MA-PDs enrollees were in plans that had no deductible, compared with just 13 percent for PDPs (Table 12-4).

Beneficiaries with the LIS were more likely to enroll in basic plans

In 2024, about 10 million beneficiaries were enrolled in a benchmark plan or other plans with premiums at or below the regional benchmarks. Just under half of these enrollees (4.7 million) were enrolled in benchmark PDPs, which are PDPs that offer basic benefits that qualify as premium-free to LIS beneficiaries (Table 12-4). In 2024, on average, 79 percent of the enrollees in benchmark PDPs received the LIS (compared with nonbenchmark PDPs, in which only 7 percent of enrollees received the LIS) (data not shown). Benchmark PDPs are the only plans in which LIS beneficiaries may be automatically enrolled.

Another 5.1 million beneficiaries were enrolled in SNPs (Table 12-4). Most SNP enrollees are in D-SNPs that serve dually eligible beneficiaries. Nearly all D-SNPs are basic-benefit plans that use Part D's defined standard-benefit structure, which requires an enrollee to pay a defined standard deductible and 25 percent coinsurance on all covered drugs. Because all dual-eligible beneficiaries receive the LIS, they themselves do not pay the deductible or cost sharing set by plans; they pay nominal copays set in law, and the LICS subsidy pays most of their cost-sharing liabilities. Also, any extra cost for supplemental coverage is not covered by Medicare. Thus, LIS beneficiaries do not typically gain the same value from an enhanced plan with lower cost sharing or no deductible as non-LIS beneficiaries. Further, plan sponsors' value of the low-income premium subsidy they receive for LIS enrollees is maximized when such beneficiaries enroll in a basic plan with a premium equal to the benchmark. These factors contribute to the increased likelihood of LIS

**TABLE
12-4**

Majority of PDP and conventional MA-PD enrollees chose enhanced coverage, 2024

	PDP		Conventional MA-PD		SNP	
	Number of enrollees (in millions)	Percent	Number of enrollees (in millions)	Percent	Number of enrollees (in millions)	Percent
Total	18.1	100%	19.7	100%	6.3	100%
Type of coverage						
Basic	7.0	39	0.1	<1	5.1	81
Enhanced	11.0	61	19.5	99	1.2	19
Type of deductible						
Zero	2.3	13	15.2	77	0.5	8
Reduced	3.6	20	4.0	20	0.1	2
Defined standard (\$480)	12.2	67	0.5	2	5.7	90
Benchmark/premium-free	4.7	26	0.1	1	5.1	81

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage–Prescription Drug [plan]), SNP (special-needs plan). Enrollment excludes employer group waiver plans (EGWPs), 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. Beneficiaries enrolled in EGWPs, a specific type of PDP or MA-PD in which an employer contracts with a Medicare Part D carrier to provide coverage for their Medicare-eligible retirees, totaled 8.9 million. Components may not sum to totals due to rounding.

Source: MedPAC analysis of CMS landscape, plan report, and February enrollment data.

beneficiaries being in a basic plan rather than an enhanced plan.

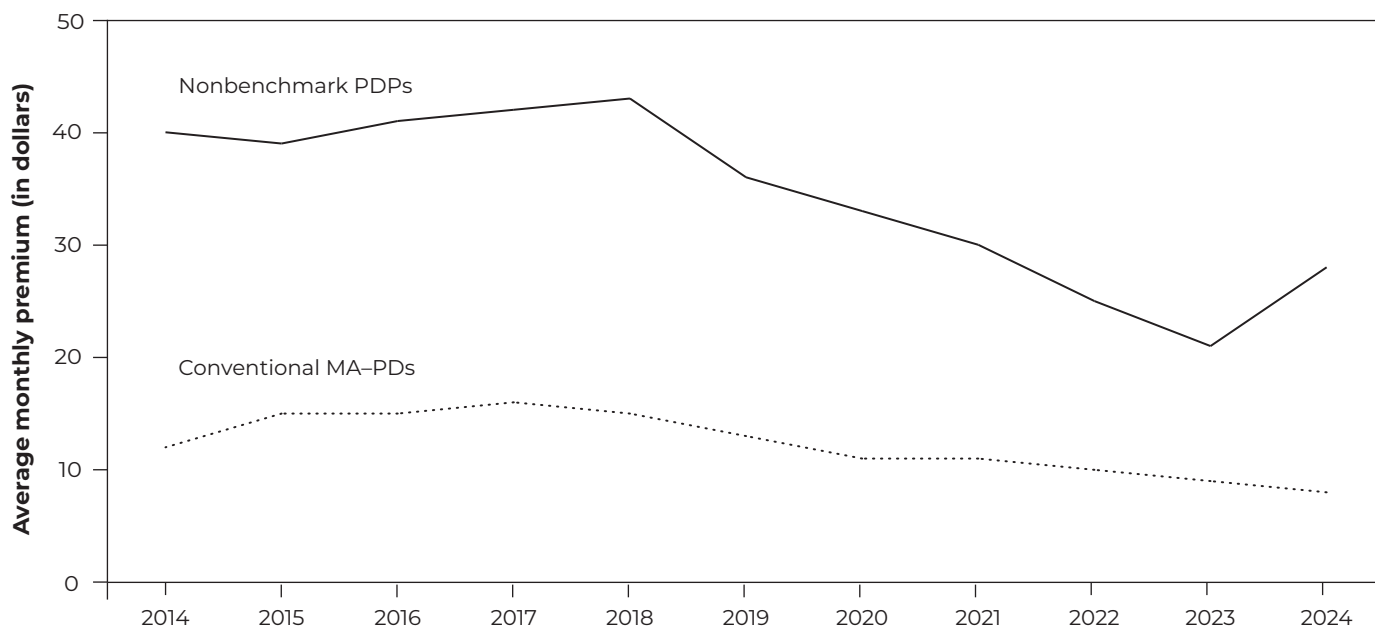
In 2024, overall average premiums remained stable; MA-PDs’ use of Part C rebates helped to lower their average premiums

In 2024, monthly beneficiary premiums averaged about \$27 across all types of plans (basic and enhanced, stand-alone PDP and MA-PD)—increasing slightly from the previous two years. However, premiums for specific plans varied widely around that average, from \$0 for many MA-PDs and a small number of PDPs to \$195 for the most expensive enhanced PDP.

The variation in premiums across plans reflects a multitude of factors that affect plans’ bids, such as assumptions about drug pricing and utilization trends, product development and new market entries, costs, and enrollment. In addition, the ability of MA-PDs to

use Part C rebates to lower their Part D premiums also contributes to the difference across plans.

The overall average MA-PD premium of \$15 reflects the plan sponsors’ use of Part C rebates to offset Part D premium costs. In 2024, premiums for enrollees in conventional MA-PDs averaged \$9 per month compared with \$34 per month for enrollees in SNPs (the majority of whom were in D-SNPs and receive the LIS and thus typically pay no premium) and \$43 per month for enrollees in PDPs. Part C rebates used by MA-PD plans to buy down the Part D premiums for conventional MA-PDs averaged \$58 per month. For SNPs, the amount of Part C rebates used for premium buydowns varied by the type of SNP. For D-SNPs, plan sponsors applied about \$8 per month to lower the Part D premium, an amount substantially lower than the amount used by sponsors of conventional MA-PDs. Because most D-SNPs are basic-benefit plans, most do not have supplemental premiums to buy down. In

**FIGURE
12-2****Average premiums for basic benefits, nonbenchmark PDPs
versus conventional MA-PDs, 2014–2024**

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage–Prescription Drug [plan]). Excludes employer group plans. “Conventional MA-PDs” excludes special-needs plans. Figures are weighted by enrollment in the month of July of each year. Note that premiums are based on plans’ expected costs. As a result, for any given year, there could be systematic over- or underestimation of benefit costs when there is an unexpected event—for example, an unexpected launch of a new drug, an addition of new indications for an existing drug that affects its uptake, or changes in law or Part D policy that were not expected when the bids were prepared more than seven months before the beginning of a benefit year.

Source: Part D premium file and enrollment files from CMS.

addition, because they are bidding to be at or below the LIS benchmark in their region, the amount of Part C rebates used to buy down Part D premiums is typically set equal to the difference between their bids and the LIS benchmark (rather than competing to offer lower or \$0 premiums).

Two other factors, not accounted for in the averages described above, can affect the premiums that enrollees pay. First, higher-income enrollees have a lower federal subsidy of their Part D benefits in 2024; such individuals paid between \$12.90 and \$81.00 in additional monthly premiums, depending on specified income thresholds.²³ In 2024, nearly 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 2024). 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.²⁴ In 2024, about 6 percent of Part D enrollees paid the LEP (Liu and Centers for Medicare & Medicaid Services 2024).

Trends that raise concerns about the long-term stability of the PDP market

At our November 2024 meeting, the Commission discussed program trends related to beneficiary premiums, plan costs, and risk scores for MA-PDs and PDPs. Our discussion focused on differences in MA-PD and PDP trends that may affect competition within and between the two sectors and the benefits they offer to Medicare beneficiaries (Medicare Payment Advisory

Commission 2024d). MA-PDs increasingly offer more generous prescription drug coverage (e.g., lower deductibles) to enrollees at lower premiums. At the same time, PDPs continue to play an important role as they provide drug coverage for FFS beneficiaries and, critically, they ensure that premium-free plan options (“benchmark” plans) are available for FFS beneficiaries with low income and assets. However, there are trends that raise concerns about the long-term stability of the PDP market.

Basic premiums charged by PDPs, on average, exceed MA-PD premiums

For both beneficiaries with and without the LIS, we found that basic premiums charged by PDPs tended to be higher than those of MA-PDs. Between 2014 and 2024, the average basic monthly premium for conventional MA-PDs averaged between \$8 and \$16, far below the average charged by PDPs excluding benchmark PDPs (“nonbenchmark PDPs”), which ranged between \$26 and \$36 during the same period (Figure 12-2). Both nonbenchmark PDPs and conventional MA-PDs primarily enroll beneficiaries without the LIS. As discussed above, some of the difference arises from the ability of MA-PD plans to use Part C rebates to lower Part D premiums. In 2024, Part C rebates used to lower basic Part D premiums for conventional MA-PDs averaged \$24 per month.

Because premiums are one of the key price signals that beneficiaries compare when choosing a plan, this trend likely influences beneficiary enrollment decisions. In general, beneficiaries would be less likely to choose a plan that charges a higher premium without any obvious or perceived difference in benefits (e.g., generosity of drug coverage or breadth of pharmacy networks) relative to another plan with a lower premium. For some beneficiaries without the LIS, the higher premiums charged by PDPs may pose a barrier to remaining in FFS even if that is their preferred option for Medicare coverage.

PDPs, on average, had higher gross costs but lower risk scores than MA-PDs

Risk scores assigned to each enrollee should reflect the expected costliness of that individual relative to the overall average, which would ensure that direct subsidies are adjusted to account for the effects of health status and demographics on the expected plan costs. Given that Part D’s risk-adjustment model

is based on gross plan costs (for basic benefits) for enrollees in both MA-PDs and PDPs, we would expect the trends for average risk scores for PDPs and MA-PDs to reflect the relative expected costs of enrollees in the respective markets. However, our analysis found diverging trends between average risk scores and average gross spending in the two markets that appear counterintuitive to how risk adjustment should work.

Between 2012 and 2023, PDP enrollees, on average, had higher gross costs than MA-PD enrollees (Figure 12-3, p. 432). However, since 2016, the average risk scores for MA-PD enrollees have exceeded that of PDP enrollees. The difference has grown over time, and by 2022, it had grown to nearly 15 percent. (The difference decreased to 13 percent (1.07 divided by 0.94) in 2023.) In contrast, the average gross costs for MA-PDs and PDPs narrowed from over \$20 in 2012 to just \$2 by 2023.

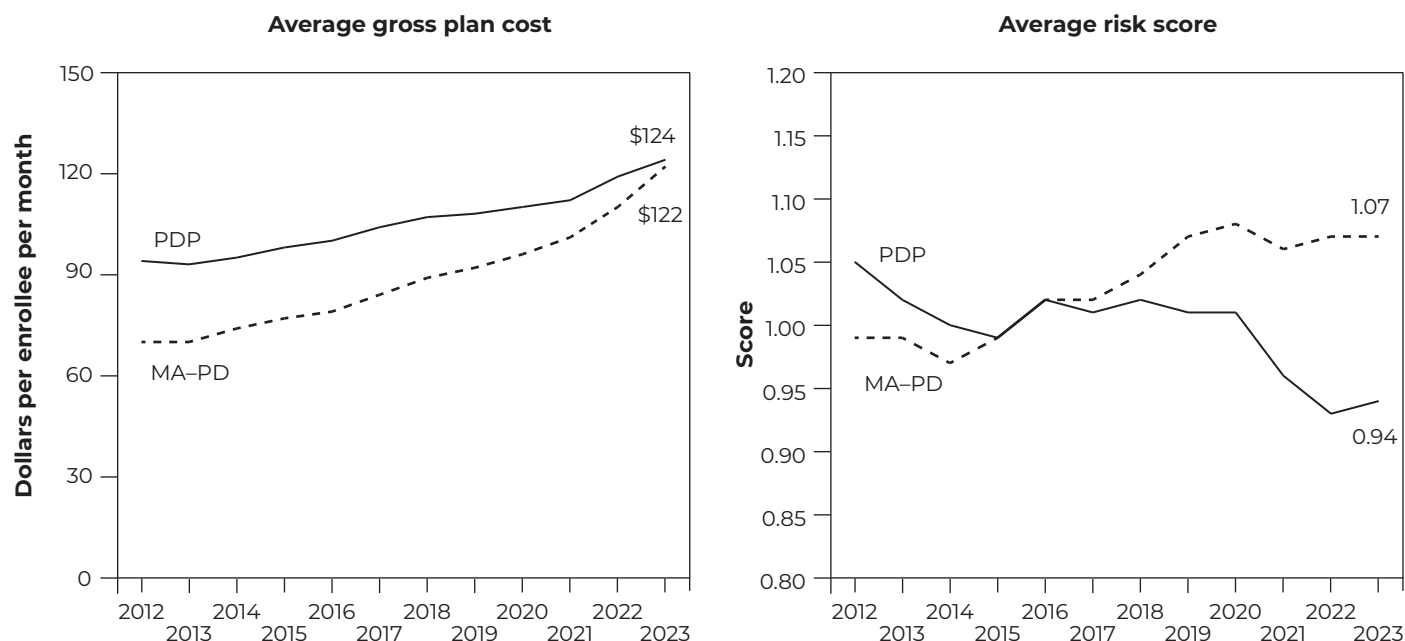
Taken together, these two trends imply that over this period, PDPs continued to have higher gross benefit costs than MA-PDs despite enrolling a population that had increasingly lower expected spending than MA-PDs based on their risk scores. This discrepancy could be explained by PDPs managing benefit costs relatively inefficiently compared with MA-PDs, by differences in diagnostic coding in FFS compared with MA, or by some combination of both.

Under Part D’s payment system, a higher risk score would translate into a relatively higher risk-adjusted direct-subsidy payment. When risk scores, on average, are higher for plans with lower average costs, it raises a question about the accuracy of the risk scores in ensuring appropriate payment for the expected costliness of enrollees across plans.

The Commission’s ongoing work examining structural differences between PDP and MA-PD markets

These program trends all suggest that PDPs may be facing challenges that are not generally present for MA-PDs. CMS’s implementation of the Premium Stabilization Demonstration for PDPs in 2025 suggests that, without the demonstration, the PDP market could have experienced even greater premium increases and enrollment changes.

Even before the implementation of the IRA’s benefit redesign, CMS noted that Part D’s risk-adjustment model, the prescription drug-hierarchical condition

**FIGURE
12-3****Average gross plan cost and risk score by plan type, 2012–2023**

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage–Prescription Drug [plan]). “MA-PD” includes both conventional MA-PDs and special-needs plans.

Source: Part D risk-score file and enrollment files from CMS.

category (RxHCC) model, historically overpredicted costs for MA-PDs and underpredicted costs for PDPs (Centers for Medicare & Medicaid Services 2024f). One factor that may be contributing to the diverging risk scores between PDPs and MA-PDs is the ability of MA plans to submit more diagnoses for their enrollees, which increases payments that plans receive under MA (Medicare Payment Advisory Commission 2024c). While the RxHCC model is separate from the model used to risk adjust Part C payments to MA plans, there is substantial overlap in the diagnoses used in the two models.

Because of the systematic prediction errors CMS had observed across the two markets, in 2025, the agency is applying a separate normalization factor for MA-PDs and PDPs to “more accurately reflect Part D costs in each of these two sectors” (Centers for Medicare & Medicaid Services 2024f). The agency noted that the new normalization factors (0.955 for PDPs and 1.073 for

MA-PDs) are expected to increase PDP risk scores and decrease MA-PD risk scores. However, to the extent that MA-PD risk scores grow at a faster rate than projected, risk scores for MA-PDs could still exceed PDP risk scores on average even after the separate normalization factors are applied.

Prior to 2024, program spending increasingly shifted to cost-based payments

In 2023, Part D expenditures totaled \$128.7 billion. Medicare made payments to Part D plans of \$4.9 billion for the monthly capitated direct subsidy, \$63.3 billion for reinsurance, and \$43.9 billion for the LIS. Medicare also paid \$0.5 billion in retiree drug subsidies to employers who provide drug coverage to their retirees.²⁵ Enrollees paid the remaining \$16.1 billion in premiums for basic benefits (Table 12-5). Between 2019 and 2023, program spending rose from \$88.3 billion to \$112.6 billion, or an average of 6.3 percent per year.

**TABLE
12-5****Medicare spending and enrollee premiums for Part D**

	Annual spending (in billions)					Average annual change, 2019–2023
	2019	2020	2021	2022	2023	
Total Medicare spending on Part D	\$88.3	\$93.0	\$94.8	\$101.6	\$112.6	6.3%
Capitated payments (direct subsidy)	11.8	10.9	7.1	4.9	4.9	–19.7
Cost-based reinsurance payments	<u>46.1</u>	<u>48.5</u>	<u>52.1</u>	<u>56.7</u>	<u>63.3</u>	8.2
Subtotal, basic benefits	57.9	59.4	59.2	61.6	68.2	4.2
Low-income subsidy	29.7	33.0	35.0	39.4	43.9	10.3
Retiree drug subsidy*	0.7	0.6	0.6	0.6	0.5	–8.1
Enrollee premiums for basic benefits**	13.8	13.6	15.0	15.5	16.1	3.9

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 totals due to rounding.

* Subsidy for employers providing prescription drug coverage to their retirees that is comparable with or more generous than Part D's defined standard benefit.

** Excludes low-income premium subsidies.

Source: MedPAC analysis based on Table IV.B10 of the 2024 annual report of the Boards of Trustees of the Medicare trust funds.

(Total Part D enrollment grew by about 3 percent per year on average during this period (data not shown).) Medicare's payments for the monthly capitated direct subsidy have declined sharply in recent years, falling by nearly 20 percent, on average, from 2019 to 2023 (Table 12-5). 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 offset plans' basic benefit costs. Meanwhile, Medicare's cost-based reinsurance payments continued to climb, rising 8.2 percent per year, on average, over the period, as the number of enrollees reaching the catastrophic phase of the benefit increased. As a result, in recent years, over 90 percent of all Medicare's basic-benefit payments took the form of reinsurance (cost-based reimbursement) rather than monthly capitated direct-subsidy payments.

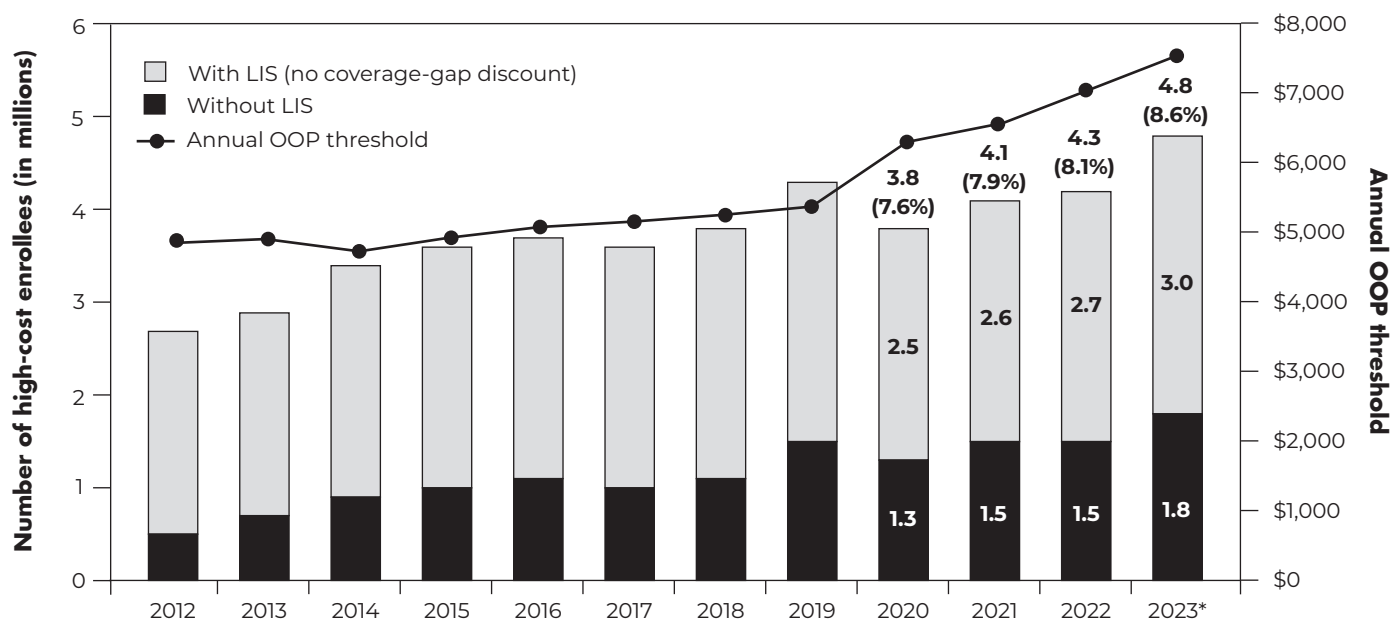
The Commission has been concerned about the misaligned plan incentives that arose from this shift in program spending, from relying primarily on capitated direct-subsidy payments to cost-based reinsurance. The

growth in postsale rebates further undermined plans' incentives to manage spending by shifting more of the costs to Medicare's LICS subsidy and to beneficiaries who paid a percentage coinsurance on prices that did not reflect postsale rebates. In 2020, the Commission recommended changes to the Part D program to restructure its benefits in order to restore stronger financial incentives for plan sponsors to manage drug spending and to protect beneficiaries from unlimited cost-sharing liabilities (described on p. 413).

This trend toward greater reliance on cost-based reinsurance was reversed in 2024 as a combination of legislative and regulatory changes took effect. First, as discussed in our March 2024 report to the Congress, the new requirement to reflect all pharmacy price concessions at the point of sale, which began in 2024, is expected to have reduced POS prices and beneficiary cost sharing, on average. This change, in turn, would tend to slow the progression toward the OOP threshold and reduce the share of spending in the catastrophic phase of the benefit (in which Medicare makes reinsurance payments) (Medicare Payment

**FIGURE
12-4**

Part D enrollees reaching the benefit's catastrophic phase, 2012–2023



Note: LIS (low-income subsidy), OOP (out of pocket). Percentages shown in parentheses are high-cost enrollees as a share of all Part D enrollees. Components may not sum to totals due to rounding.
* Amounts are based on preliminary Part D prescription drug event data.

Source: Enrollee counts for 2012 to 2023 are based on MedPAC analysis of Part D prescription drug event data.

Advisory Commission 2024c). Second, the IRA change to limit the annual increase in the BBP to no more than 6 percent means that any increase in the expected average basic-benefit costs (including expected average reinsurance) in excess of that 6 percent would be paid in the form of a higher direct subsidy from the Medicare program.

In addition to reinsurance, Medicare shares financial risk with plan sponsors 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 (Medicare Payment Advisory Commission 2024b). Aggregate amounts of net risk-corridor payments have fluctuated over the years but have been consistently positive in recent years—meaning that, in the aggregate, Medicare's payments to cover a portion of

plans' losses have exceeded the amount it has received from plans to recoup a portion of plans' profits (Boards of Trustees 2024).

In 2023, total direct-subsidy payments included an adjustment for net risk-corridor payments and additional IRA-related subsidies. Some of the risk-corridor losses are likely related to a class of drugs called glucagon-like peptide-1 receptor agonists (GLP-1s).²⁶ GLP-1s have been used to treat patients with Type 2 diabetes for decades, but Part D could experience an uptick in use as they gain additional indications (see text box on GLP-1 drugs in the context chapter, pp. 14–15). In addition, Medicare paid subsidies to plans related to provisions in the IRA that limited cost sharing for insulins to no more than \$35 and prohibited imposing cost sharing on Part D–covered vaccines (Liu and Centers for Medicare & Medicaid

Services 2024).²⁷ These subsidies accounted for the majority of the additional adjustment costs reported under this category of payments (Liu and Centers for Medicare & Medicaid Services 2024).

In 2023, 4.8 million beneficiaries had spending high enough to reach the catastrophic phase of the benefit ("high-cost enrollees"), an increase of nearly 18 percent from 4.3 million in 2022, following smaller increases in 2021 and 2022 (Figure 12-4).²⁸ In 2023, enrollees with the LIS continued to account for the majority (63 percent) of all high-cost enrollees. Beneficiaries with the LIS tend to use more medications and incur higher average spending compared with beneficiaries without the LIS (Medicare Payment Advisory Commission 2024a).

The annual OOP threshold is set each year based on a formula set in law. Between 2022 and 2023, the annual OOP threshold increased from \$7,050 to \$7,400 (Figure 12-4). For LIS enrollees, because Medicare's LIS pays for nearly all costs in the coverage gap (above any nominal copayments required by law), the effects of the increase in the OOP threshold fell almost entirely on Medicare (taxpayers) rather than beneficiaries themselves. For enrollees without the LIS, the financial impact of a higher OOP threshold differed depending on whether the prescription was for a generic or brand-name drug. For brand-name drugs, the manufacturer's coverage-gap discount was treated as though it were the enrollee's own OOP spending. 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 2023, coverage-gap discounts among high-cost enrollees without the LIS averaged more than \$5,100, accounting for 69 percent of the OOP threshold amount (\$7,400).

In 2023, 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 10 percent to over 532,000 enrollees—about 11 percent of high-cost enrollees—up from just 33,000 enrollees in 2010. High-cost enrollees without the LIS were more likely to have such claims compared with high-cost enrollees with the LIS (about 16 percent compared with just over 8 percent, respectively). This difference in the use of drugs by enrollees' LIS status reflects the underlying difference in the patterns

of drug use between these two populations: In our analysis of the Part D data, we found that many LIS beneficiaries reach the catastrophic phase of the benefit using multiple medications for chronic or more prevalent conditions. High-cost enrollees without the LIS, on the other hand, were more likely to reach the catastrophic phase of the benefit because they used specialty drugs and biologics (Medicare Payment Advisory Commission 2016).

Growth in overall Part D prices driven by single-source brand-name drugs and biologics

Growth in prices at the pharmacy counter—referred to here as “gross prices” or “POS prices”—continues to be an important metric for understanding how drug prices affect Part D program spending and costs faced by beneficiaries. POS prices paid at the pharmacy are an important indicator of Part D's costs because they affect beneficiary cost sharing and the rate at which enrollees reach Part D's catastrophic phase. While most Part D enrollees primarily use generic drugs, and many (but not all) generic prices remain low, 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 can be felt particularly acutely among the relatively small share of enrollees who use high-priced specialty drugs.

All levels of the drug supply chain include incentives that drive up POS prices of brand-name drugs and biologics, particularly when payments among the supply-chain participants 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

**TABLE
12-6****Part D point-of-sale prices, after accounting for generic substitution, continued to rise in 2023**

	2019	2020	2021	2022	2023
Price index as of 4th quarter (1st quarter 2014 = 1.00)					
All drugs and biologics					
Before accounting for generic substitution	1.29	1.33	1.38	1.43	1.48
After accounting for generic substitution	1.08	1.10	1.13	1.16	1.18
Generic drugs	0.56	0.51	0.47	0.43	0.41
Single-source brand-name drugs and biologics	1.58	1.66	1.78	1.88	1.98
Net of manufacturer rebates	1.32	1.38	1.46	1.54	1.60
Annual percentage change*					
All drugs and biologics					
Before accounting for generic substitution	2.9%	2.6%	4.1%	3.8%	3.4%
After accounting for generic substitution	-2.1	1.3	3.4	2.6	1.9
Generic drugs	-8.9	-8.9	-8.3	-7.4	-5.7
Single-source brand-name drugs and biologics	5.7	5.2	6.7	5.9	5.0
Net of manufacturer rebates	3.9	4.5	5.8	5.5	3.9

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 2014. Prices reflect total amounts paid to pharmacies before rebates or discounts from manufacturers and pharmacies with the exception of the price index for single-source brand-name drugs and biologics net of manufacturer rebates, which accounts for the effects of postsale manufacturer rebates and discounts negotiated by Part D plans. Indexes shown are rounded. Price indexes reflect changes in the prices of products that existed in both the measurement period and the preceding period. They 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 on unrounded data.

Source: Acumen LLC analysis for MedPAC.

amounts paid to pharmacies for Part D prescriptions (i.e., POS prices) as well as prices for single-source brand-name drugs net of postsale manufacturer discounts. The indexes reflect prices (of existing products) measured at the median of the distribution for each grouping of products associated with a specific drug or biologic.²⁹

High generic penetration has helped moderate the growth in overall Part D prices at the point of sale

Between 2014 and 2023, prices for all drugs and biologics, measured by individual national drug codes (NDCs), grew by nearly 50 percent (an index value

of 1.48) (Table 12-6).³⁰ Overall, growth in drug prices slowed in 2023 to an annual rate of 3.4 percent, down from 4.1 percent in 2021; however, it still exceeded price growth observed prior to 2021.

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 2023 (Table 12-6). As a result, our overall price index that takes generic substitution into account has grown at a more moderate rate, growing by 1.9 percent in 2023 compared with 3.4 percent before accounting for generic substitution.³¹

The Medicare Drug Price Negotiation Program and the drugs selected for 2026

The Inflation Reduction Act of 2022 (IRA) established the Medicare Drug Price Negotiation Program (“the negotiation program”), under which the Secretary of Health and Human Services has new authority to negotiate directly with manufacturers for the prices of drugs covered under Medicare Part B and Part D.

The law sets forth specific criteria for selecting products for the negotiation program (the “selected drugs”). For example, the product:

- must have been on the market for 7 years for a small-molecule drug and 11 years for a biological product,
- must be a single-source drug without therapeutically equivalent generic or biosimilar alternatives that are approved or licensed and marketed, and

- must be among the top-selling drugs in Medicare, based on total expenditures.

Certain single-source brand-name drugs and biologics (“single-source drugs”) that would otherwise be selected drugs may be exempted from the negotiation program. For example, the law specifically excludes plasma-derived products or drugs that are approved and designated for only one rare disease or condition.³² The Secretary may also exclude a drug if they determine that there is a “high likelihood” of imminent biosimilar competition. Manufacturers that fail to comply with the requirements of the negotiation program may be subject to an excise tax of up to 95 percent. Because manufacturers would be prohibited from deducting the excise tax payments in determining their income taxes, the combination of income taxes and excise taxes on sales in the U.S. could cause the drug manufacturer to lose money for those sales (Swagel 2019).

(continued next page)

Going forward, take-up of biosimilars and the new Medicare Drug Price Negotiation Program will affect Part D prices

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 brand-name drugs and biologics produced by a single manufacturer (“single-source drugs”). While the introduction of single-source drugs can be important advances in pharmacological therapy, their high prices can pose barriers to access.

In 2023, single-source drugs accounted for about 10 percent of the prescriptions but nearly 80 percent of gross Part D spending, up from 70 percent in 2014 (data not shown). Between 2019 and 2023, POS prices of single-source drugs have grown by between 5.0 percent and 6.7 percent per year (Table 12-6), down

from an average growth rate of nearly 9 percent per year before 2018 (latter data not shown).

For many single-source drugs, plans negotiate postsale rebates and discounts from manufacturers that reduce prices after the POS transactions. Those “net prices” affect the premiums paid by Part D enrollees and subsidies paid by the Medicare program. Manufacturer rebates and discounts have grown from about \$16 billion in 2014 to nearly \$70 billion in 2023 (an average growth of 17 percent per year) (data not shown). Even with the rapid growth in postsale rebates and discounts, net prices of single-source drugs still grew by between 3.9 percent and 5.8 percent during this period (Table 12-6).

Pipeline shifts also mean that, going forward, restraining growth of drug prices in Part D will increasingly depend on successful launch and adoption of biosimilars by prescribers and beneficiaries. Several

The Medicare Drug Price Negotiation Program and the drugs selected for 2026 (cont.)

The price negotiations for the first 10 drugs (all covered under Part D) began with the announcement of the selected drugs on August 29, 2023, and ended a year later with the publication of the negotiated prices that would be applicable in 2026. (The Secretary is required to select 15 Part D drugs for 2027; starting in 2028, selections must be made from among both Part D and Part B, beginning with 15 from either program in that year and 20 for 2029 and subsequent years.³³) On January 17, 2025, CMS announced the selection of 15 additional Part D-covered drugs for the negotiation program (Centers for Medicare & Medicaid Services 2025). The selected drugs included glucagon-like peptide-1 receptor agonists (GLP-1s), used to treat Type 2 diabetes, obesity and overweight, and cardiovascular conditions, which have seen an uptick in use among Part D enrollees (see text box on GLP-1s in the context chapter, pp. 14–15).³⁴ Prices negotiated for these 15 drugs will become effective in 2027.

By law, the negotiated prices, referred to as the “maximum fair price” (MFP), for selected Part D drugs cannot be greater than the lower of:

- the average Part D price, net of all price concessions and rebates, weighted by plan enrolment;³⁵ or
- the applicable percentage of a drug’s average nonfederal average manufacturer price, where the applicable percentage ranges from 40 percent for drugs that have been on the market for more than 16 years to 75 percent for drugs that have been on the market for 9 years to 12 years.

The Secretary may consider prices of therapeutic alternative(s), if available, as well as information submitted by the manufacturers of the selected drugs related to research and development costs, prior federal financial support, unit costs of production and distribution, revenue and

sales data, and information on patents and market exclusivity granted by the Food and Drug Administration (Centers for Medicare & Medicaid Services 2024d). After the Secretary submits an initial offer, the negotiation process may involve counteroffer exchanges (by both the manufacturer and the Secretary) and multiple meetings with the manufacturers until an agreement is reached on the final offer.

Gross Part D spending for the first 10 selected drugs totaled \$55.7 billion in 2023, accounting for about 20 percent of total gross Part D spending, or just over a quarter of gross spending for single-source drugs in that year (Table 12-7). (Note that gross spending reflects point-of-sale (POS) prices paid at the pharmacy. For brand-name drugs, POS prices are on average about 6 percent below a list price known as the wholesale acquisition cost (WAC) (Congressional Budget Office 2021a).)

The final negotiated prices that would apply to prescriptions filled under Part D in 2026 were published on August 15, 2024 (Table 12-7). CMS estimates that, relative to the WACs, the negotiated prices achieved discounts ranging from 38 percent for Imbruvica to 79 percent for Januvia. Beginning in 2026, these discounts are expected to have a material impact on the POS price trends for single-source drugs.

At the same time, there is uncertainty about the magnitude of savings achieved by the negotiation program because Medicare’s program spending and enrollee premiums are affected by the prices net of all rebates and discounts. Because many of the drugs selected for the negotiation program are in classes with therapeutic alternatives, pharmacy benefit managers (PBMs) have been able to negotiate substantial rebates on some of the therapies (which are fully passed on to Part D plan sponsors and are shared with Medicare to lower program spending).

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The Medicare Drug Price Negotiation Program and the drugs selected for 2026 (cont.)

As a result, for most products, net prices were lower than their gross prices and, in some cases, substantially so.

Savings from price reductions must be considered relative to net prices. In 2023, manufacturer rebates and discounts negotiated by PBMs for selected products achieved an overall discount of about 40 percent relative to gross prices (though average discounts varied across those products). When combined with other discounts (e.g., the coverage-gap-discount program that was in place in 2023), the net prices for some selected drugs in 2023 may not have differed substantially from the price

reductions achieved under the negotiation program. At the same time, because net prices typically grow over time, the prices resulting from the negotiation program, effective in 2026, may achieve savings relative to the prices that would have prevailed absent the negotiation program. Further, there may be spillover effects for drugs with brand-name competitors in the therapeutic class; makers of a competing product may feel pressure to offer greater discounts to remain financially competitive with the selected product and maintain or improve its formulary status. ■

**TABLE
12-7**

Drugs selected for the Medicare Drug Price Negotiation Program, 2026

Drug name	Commonly treated conditions	CMS announcement of negotiated prices published on August 15, 2024 (per 30-day supply)			Total Part D gross spending in 2023 (in billions)
		Negotiated price	List price (WAC)*	Discount from the list price (in percent)	
Eliquis	Prevention and treatment of blood clots	\$231	\$521	56%	\$18.3
Jardiance	Diabetes, heart failure, chronic kidney disease	197	573	66	8.8
Xarelto	Prevention/treatment of blood clots, reduction of risk for patients with coronary or peripheral artery disease	197	517	62	6.3
Januvia	Diabetes	113	527	79	4.1
Farxiga	Diabetes, heart failure, chronic kidney disease	179	556	68	4.3
Entresto	Heart failure	295	628	53	3.4
Enbrel	Rheumatoid arthritis, psoriasis, psoriatic arthritis	2,355	7,106	67	3.0
Imbruvica	Blood cancers	9,319	14,934	38	2.4
Stelara	Psoriasis, psoriatic arthritis, Crohn's disease	4,695	13,836	66	3.0
Fiasp / Novolog	Diabetes	119	495	76	2.6
Total					55.7

Note: WAC (wholesale acquisition cost). Components may not sum to totals due to rounding.

* List prices are WACs for the selected drugs based on a 30-day supply using prescription fills in Part D in 2022.

Source: Assistant Secretary for Planning and Evaluation 2023, Centers for Medicare and Medicaid Services 2024d, Centers for Medicare and Medicaid Services 2023c, and gross spending based on MedPAC analysis of the Part D prescription drug event data.

**TABLE
12-8****Relative contributions of price and quantity trends on the total expenditure growth, Medicare Drug Price Negotiation Program's selected drugs compared with single-source brand-name drugs and biologics, 2014–2023**

	Single-source brand-name drugs and biologics			
	All		Selected drugs*	
Aggregate gross spending in 2023 (billions)	\$210.7		\$55.7	
	Index value	Average annual growth	Index value	Average annual growth
Indexes as of 4th quarter of 2023 (1st quarter of 2014 = 1.0)				
Expenditure index	3.54	13.9%	10.30	27.0%
Price index	1.98	7.2	2.21	8.5
Quantity index	1.79	6.2	4.66	17.1

Note: Indexes are calculated using chain-weighted Fisher indexes and are measured at the median of the distribution relative to prices as of the first quarter of 2014. Expenditure and price indexes reflect total amounts paid to pharmacies before rebates or discounts from manufacturers and pharmacies. Index values shown are rounded. The quantity index measures the percentage change in the number of units dispensed, weighted by prices (using chain weights). Price indexes reflect changes in the prices of products that existed in both the measurement period and the preceding period. They do not reflect the effect of launch prices of new products.

* Drugs selected for 2026 price-applicability year under the Medicare Drug Price Negotiation Program.

Source: Acumen LLC analysis for MedPAC.

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. However, in 2024, nearly all plans continued to cover Humira products, with most plans placing the biosimilar product on the same cost-sharing tier as Humira (i.e., if a plan used a copay on that tier, enrollees would pay the same cost sharing for both Humira and its biosimilar product(s) (Medicare Payment Advisory Commission 2024c)). In 2025, some plans no longer include Humira products on their formularies.³⁶

Beginning in 2026, Part D plans will pay no more at the POS for drugs selected for the Medicare Drug Price Negotiation Program than the prices negotiated by the Secretary of Health and Human Services (see text box on the Medicare Drug Price Negotiation Program and the drugs selected for 2026, pp. 437–439). Because

the drugs are selected based on total gross spending, we constructed expenditure indexes that measure the percentage change in Part D gross spending relative to a reference period. (Gross prices at the POS are often used for determining beneficiary cost sharing for brand-name drugs and biologics with high prices.) The expenditure indexes allow us to examine the relative contributions of price and quantity trends to the growth in total expenditures.

Between 2014 and 2023, our expenditure indexes show that gross spending for the selected drugs grew much more rapidly compared with overall growth in single-source drugs, growing at an average annual rate of 27 percent (an index value of 10.30) compared with an average annual rate of about 14 percent (an index value of 3.54) for all single-source drugs (Table 12-8). During this period, prices of the selected drugs grew by 8.5 percent per year (an index value of 2.21), on average, compared with an average of 7.2 percent per year (an index value of 1.98) for single-source drugs.³⁷

At the same time, we also found that, between 2014 and 2023, Part D enrollees' use of the selected drugs grew more rapidly, by about 17 percent per year, on average (an index value of 4.66) compared with an average growth of about 6 percent for all single-source drugs (an index value of 1.79) (Table 12-8). That is, on average, an increase in the use of the selected-drug therapies by Part D enrollees has had a greater impact on overall spending growth across the selected products during this period than the growth in prices. However, there was wide variation in the extent to which trends in prices or quantities consumed contributed to the overall growth in spending. For example, for four products (Januvia, Enbrel, Imbruvica, and Fiasp/Novolog), growth in prices had a larger impact on spending growth than did the quantity consumed.

Finally, the estimate of the effects of price increases on expenditure growth (both measured using gross prices at the POS) overstates the contribution of prices to program spending. Under Part D, any postsale rebates or discounts negotiated by the PBMs are passed on to Part D plans to lower benefit costs. For selected drugs, because many of the therapies were in highly competitive classes, postsale rebates and discounts have helped slow the growth in net prices. Between 2014 and 2023, prices net of postsale manufacturer rebates and discounts for the selected drugs grew at an average annual rate of just over 3 percent, which is lower than the 5 percent annual growth for all single-source drugs.³⁸

Most Part D enrollees are satisfied with drug coverage

Measuring the quality of the pharmacy benefit is critical for assessing the value of Part D plans. However, it is a task that requires nuance since there is no single metric to determine the quality of the pharmacy benefit for all enrollees. 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 may be on multiple medications, which tends to increase the risk of adverse drug events associated with polypharmacy.

To promote 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 that plans apply 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.³⁹ 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.⁴⁰ 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, if necessary, 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 are 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 programs and programs to manage opioid use.

Plans offered in 2025 have lower average overall star ratings for the third straight year, though some plans have had their ratings adjusted since the official release of ratings from CMS, following lawsuits filed that accused CMS of inaccurately scoring some metrics (Centers for Medicare & Medicaid Services 2024b, Pifer 2024). Eleven percent of PDPs offered in 2025 received 4 or more stars, and these plans enrolled 5 percent of PDP beneficiaries in 2024. MA-PDs, on the other hand, enrolled 76 percent of MA-PD beneficiaries in the 40 percent of such plans that earned 4 or more stars, reflecting high enrollment concentration in high-performing plans (before ratings adjustments

**TABLE
12-9**

MA-PD and PDP enrollee experience with the drug-plan CAHPS performance scores, 2023

CAHPS measure	MA-PD	PDP
Rating of drug plan	88%	82%
Getting needed prescription drugs	90	88

Note: MA-PD (Medicare Advantage–Prescription Drug [plan]), PDP (prescription drug plan), CAHPS (Consumer Assessment of Healthcare Providers and Systems). “Rating of drug plan” is a global rating measure in which a survey question has a response of 1 to 10, which CMS converts to a national linear mean score on a 0 to 100 scale. “Getting needed prescription drugs” is a composite measure of multiple survey questions with “never,” “sometimes,” “usually,” and “always” responses. CMS converts these to a national linear mean score on a 0 to 100 scale. The MA-PD–CAHPS response rate was 33 percent, and the PDP–CAHPS response rate was 38 percent in 2023.

Source: MA-PD and PDP–CAHPS mean scores published by CMS, 2023.

were made; it is estimated that after adjustments, another 7 percent of enrollees were in plans with 4 or more stars). The number of MA-PDs receiving 5 stars declined significantly, with just 7 MA-PDs earning the highest rating, down from 31 in 2024 (2 additional plans received 5 stars after ratings were adjusted). The number of PDPs earning 5 stars remained at two. All but one plan that received a 5-star rating in 2025 also received 5 stars in 2024, showing consistency among the high performers, while the overall rating decreased for the majority of plans.

MA-PD and PDP star-rating calculations include performance on two measures of enrollee experience with the plan (“rating of drug plan” and “getting needed prescription drugs”). These scores are based on Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey responses from a random sample of each contract’s enrollees.⁴¹ Table 12-9 presents national CAHPS measures of drug-plan experience for both MA-PD and PDP contracts in 2023.

Enrollees in both MA-PD and PDP contracts rated their coverage and experiences favorably overall in 2023 (Table 12-9). The 2023 MA-PD CAHPS score for “rating of drug plan” was 88 (scored on a scale of 0 to 100), which is higher than the 82 for stand-alone PDPs. The 2023 MA-PD CAHPS score for “getting needed prescription drugs” was 90, which is similar to the PDP score of 88. These results have been relatively stable over the past few years.

Consistent with CAHPS results, in focus groups convened for the Commission, Medicare beneficiaries generally rated their prescription drug coverage highly and reported being able to access their prescriptions when needed (NORC at the University of Chicago 2023). Beneficiaries who rated their drug coverage below “excellent” commonly cited the costs of prescriptions as the reason. This information coincides with findings that the satisfaction rate pertaining to the affordability of cost sharing for brand-name medicines is lower (76 percent) than for generic medicines (84 percent) (Morning Consult 2024). 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. ■

Endnotes

- 1 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.
- 2 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).
- 3 While market concentration at the national level among MA-PDs is lower than that of PDPs, local (county-level) competition is more relevant for MA-PD enrollees. Our analysis of MA enrollment at the county level suggests that the MA market is more concentrated at this level than at the national level (see Table 11-6 (p. 367)). For example, in 2024, enrollment in the top three organizations in each county accounted for 81 percent of all MA enrollment compared with 58 percent at the national level. Because nearly all MA plan enrollees are in plans that also offer Part D drug coverage, the patterns of market concentration for MA-PDs would be nearly identical to those of MA plans (Freed et al. 2024).
- 4 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).
- 5 The Commission's calculation is based on data from CMS on Part D prescription drug events and direct and indirect remuneration.
- 6 Among plans that have them in 2025, preferred pharmacies make up an average of 42 percent, 48 percent, and 44 percent of all network pharmacies for PDPs, MA-PDs, and special-needs plans, respectively.
- 7 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 Swanson 2021b).
- 8 Examples of pharmacy performance measures that have been used by Part D plan sponsors and their pharmacy benefit managers to determine the amount of postsale price concessions include generic dispensing rates, patient adherence rates, and/or generic effective rate contracting that requires retroactive adjustments to ensure the achievement of pricing targets across all or most generic drugs dispensed over a given period of time.
- 9 The demonstration made no change to the risk corridors for profit sharing.
- 10 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 receive full subsidy benefits.
- 11 Before the 2025 bids were submitted, CMS estimated that the IRA changes would roughly double gross plan liability, and many, including CMS, expect Part D's risk adjustment to take on much greater importance (Centers for Medicare & Medicaid Services 2023a, Robb et al. 2024).
- 12 Several factors contributed to the higher-than-expected spending in 2023, including an uptick in the use of glucagon-like peptide-1 receptor agonists and IRA provisions related to the coverage of insulins and vaccines. See pp. 434–435 for more discussion.
- 13 Sponsors of all types of plans (stand-alone PDPs, MA-PDs, and special-needs plans) that are generally available for individual purchase must submit bids in order to participate in Part D. Plans sponsored by employers and unions and plans in the Program of All-Inclusive Care for the Elderly are exempt from bidding.
- 14 The 60 percent increase reflects the cumulative effects of the IRA's change to limit the annual increase in the BBP to no more than 6 percent in 2024 and 2025. Had the 6 percent cap not been in effect in 2024, the BBP would have been \$39.35, and the annual increase in the BBP (without the 6 percent cap) would have been 42 percent (which is the increase in the total expected basic benefit cost as reflected in plan bids and the expected average reinsurance amount).
- 15 In this hypothetical example, we assumed that an individual is on two medications (Eliquis (5 mg tablet) and Jardiance (25 mg tablet)), which they fill every month, and that the individual is enrolled in an enhanced-benefit plan that charges a cost sharing of \$47 for each 30-day prescription for both drugs.

- 16 The number of plan offerings for 2025 excludes 60 plans offered by Clear Spring Health that were included in the 2025 landscape files but have been terminated by CMS due to consistently low star ratings disqualifying them from the program.
- 17 When the Part D program was created, the Congress contemplated such a scenario and included in the legislation a contingency plan to ensure beneficiaries would always have a minimum of two options for prescription drug coverage. If that minimum requirement is not met, the law allows the Secretary to approve plan(s) that administer Part D's prescription drug benefit without taking insurance risk (or only assuming limited insurance risk). In 2025, however, all regions continued to meet the minimum number of required plans, with all enrollees having at least five qualifying PDPs.
- 18 The four regions with just one benchmark plan available in 2025 include Florida, Illinois, Nevada, and Texas.
- 19 Under Part C, MA plans that bid below the MA benchmark receive a portion of the difference between the benchmark and the plan bids as rebates. MA plans must use these rebates to provide supplemental benefits, which may include reduced Part D premiums (Medicare Payment Advisory Commission 2024c).
- 20 Other factors that affect investment in biopharmaceutical research and development include federal regulatory policies related to drug approval, 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 2021b). 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).
- 21 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.
- 22 The remainder qualified either because they received benefits through the Medicare Savings Program or Supplemental Security Income program or because they were eligible after they applied directly to the Social Security Administration.
- 23 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 in 2024; these thresholds are updated annually.
- 24 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.
- 25 The retiree drug subsidy is paid to employers that provide prescription drug coverage to their retirees that is comparable with or more generous than Part D's defined standard benefit.
- 26 The Medicare Trustees' report noted that, in 2023, Part D experienced faster-than-expected growth in spending due to "unanticipated rapid growth in the use of antidiabetic drugs," which accounted for a 4.4 percent increase in drug spending that year (Boards of Trustees 2024).
- 27 Because the IRA, enacted after Part D plans had submitted bids for 2023, expanded Part D's benefit beginning in 2023 to cover certain vaccines at no cost and limit cost sharing for insulins to no more than \$35 per month, CMS provided additional subsidies to cover the higher benefit costs that plans incurred due to the IRA changes that were not reflected in the bids.
- 28 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. As a result, in 2020, there was an unusually large increase in the OOP threshold from its 2019 level, which likely contributed to the slower growth in the number of Part D enrollees reaching the OOP threshold in 2021 and 2022.
- 29 The price index measures changes in the prices of products that existed in both the measurement period and the preceding period. 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 across products.

- 32 Under the IRA, certain drugs used for the treatment of a rare disease, referred to as “orphan drugs,” are exempted from price negotiation if that orphan drug treats exactly one rare disease.
- 33 Part B drugs will be eligible for selection beginning in 2028.
- 34 Selected drugs also include other drugs used to treat Type 2 diabetes (Janumet/Janumet XR and Tradjenta), asthma and chronic obstructive pulmonary disease (Trelegy Ellipta and Breo Ellipta), and several types of cancer (e.g., Xtandi used for the treatment of prostate cancer). Under Part D’s protected class policy, plans must cover all or substantially all drugs in six protected classes, which includes antineoplastics (cancer drugs). This coverage requirement has limited Part D plans’ ability to negotiate lower prices or rebates for drugs used for cancer treatment. Because the Medicare Drug Price Negotiation Program sets a ceiling price that requires mandatory discounts based on the number of years the drug has been on the market, prices negotiated under the program could provide substantial discounts relative to the prices obtained by Part D plans.
- 35 For Part B drugs, the MFP cannot be greater than the lower of average sales price or the applicable percentage of a drug’s average nonfederal average manufacturer price.
- 36 Plans that no longer include Humira products on their formularies accounted for just under 30 percent of all Part D enrollment in 2024. About 90 percent of those enrollees were in PDPs.
- 37 Annual growth was calculated based on price index values as of the fourth quarter of 2023.
- 38 The growth rate does not include the effects of postsale discounts and fees that Part D plans negotiated with their network pharmacies or the mandatory coverage-gap discounts paid by pharmaceutical manufacturers.
- 39 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.
- 40 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 documentation, 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).
- 41 CAHPS surveys generate standardized and validated measures of patient experience. MA organizations and Part D plan sponsors are required to contract with a third-party survey vendor to collect CAHPS survey responses from a random sample of each contract’s enrollees.

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CHAPTER 13

Eliminating Medicare's coverage limits on stays in freestanding inpatient psychiatric facilities

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

- 13** The Congress should eliminate both:
- the 190-day lifetime limit on covered days in freestanding inpatient psychiatric facilities; and
 - the reduction of the number of covered inpatient psychiatric days available during the initial benefit period for new Medicare beneficiaries who received care from a freestanding inpatient psychiatric facility on and in the 150 days prior to their date of Medicare entitlement.

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

Eliminating Medicare's coverage limits on stays in freestanding inpatient psychiatric facilities

Chapter summary

In Medicare, coverage of treatment in freestanding inpatient psychiatric facilities (IPFs) is subject to limitations—a 190-day lifetime limit on days in IPFs and a reduction of inpatient psychiatric benefit days available in the initial benefit period for beneficiaries who are in freestanding IPFs on their first day of Medicare entitlement. (Under Part A, a beneficiary's initial Medicare benefit period can span 150 days: 60 full-benefit days, 30 days with Part A coinsurance, and 60 lifetime reserve days.) These provisions were established in 1965 (with the implementation of Medicare), when most inpatient psychiatric care took place in state- and locally run freestanding facilities. However, the landscape has changed substantially in the last 60 years, and the provision of inpatient psychiatric services has shifted away from longer-term custodial-type care in government-run facilities to acute psychiatric care in privately owned facilities. In 2023, only 4 percent of Medicare-covered IPF days were in government-run freestanding IPFs, while 35 percent were in privately owned freestanding IPFs. The remaining 60 percent of Medicare inpatient psychiatric days took place in hospital-based IPFs, which are not subject to these limitations.

A small but highly vulnerable group of beneficiaries is affected by Medicare's coverage limits on freestanding IPFs. As of January 2024, since

In this chapter

- A small but highly vulnerable group of beneficiaries is affected by Medicare's limits on psychiatric hospitalizations
- The 190-day limit creates access issues for some beneficiaries with chronic and severe behavioral health conditions
- Illustrative effect on use and spending if the coverage limit on care in freestanding IPFs were removed
- Removing the coverage limits on care in freestanding IPFs
- Importance of continued work to address the needs of Medicare beneficiaries with severe behavioral health conditions

their initial enrollment in Medicare, about 40,000 Medicare beneficiaries had exhausted their coverage in freestanding IPFs. An additional 10,000 Medicare beneficiaries were within 15 days of the 190-day limit. In 2023, among the Medicare beneficiaries who were near or at the 190-day limit, over 70 percent were under 65 (disabled) and 84 percent had low incomes. Eighty percent of fee-for-service (FFS) Medicare beneficiaries near or at the limit had a diagnosis of schizophrenia in the prior year. These beneficiaries also were more likely than other IPF users to have “dual” diagnoses of schizophrenia or depressive disorder and substance use disorders. Although Medicaid or Medicare Advantage (MA) plans with supplemental IPF benefits could serve as alternative sources of coverage for beneficiaries affected by the 190-day limit, Medicaid funding restrictions and low MA enrollment by these beneficiaries limit their use.

Medicare beneficiaries reaching the limit may still obtain psychiatric care from hospital-based IPFs or general acute care hospitals, but an alternative setting may be difficult to find, be disruptive to care, and potentially be a less appropriate setting for the beneficiary. We compared beneficiaries who were near or at the 190-day limit with a group of beneficiaries who were further away from the limit but had a similar history of previous freestanding IPF use. We found that beneficiaries affected by the limit had an average of 2.4 covered days in a freestanding IPF compared with 7.6 covered days for the comparison group, suggesting that freestanding IPF days could increase by about 5 days on average if the limit were removed. However, beneficiaries affected by the limit had 5.0 covered days in a hospital-based IPF compared with 2.8 days for those in the comparison group, indicating that some substitution away from hospital-based IPFs would occur in the absence of the limit. Similarly, beneficiaries affected by the limit had more covered psychiatric days in general acute care hospitals compared with those not affected by the limit (2.0 days vs. 1.3 days). Beneficiaries affected by the limit had an average of 2.2 fewer days of covered inpatient psychiatric care than beneficiaries in the comparison group, indicating that overall covered days for inpatient psychiatric services would likely increase if the limit were removed.

We multiply the estimated changes in the number of inpatient psychiatric days between beneficiaries affected and not affected by the 190-day limit and the average Medicare per diem spending on the various types of inpatient psychiatric care. This yielded an estimated \$40 million increase in FFS Medicare program spending from eliminating the limit in 2023. The amount could be higher or lower depending on a variety of other factors we did not

account for, including spending on other types of Medicare services and changes in behavior by IPFs that could result from the limit being removed. Removing the limit would also increase Medicare spending for MA enrollees because MA plans would be required to expand coverage days for beneficiaries using freestanding IPFs.

The Commission recommends that the Congress eliminate the 190-day lifetime limit on covered days in freestanding IPFs and the reduction in the number of covered inpatient psychiatric days available during the initial benefit period for new Medicare beneficiaries who received care from a freestanding IPF on and in the 150 days prior to their date of Medicare entitlement. Eliminating the limits on psychiatric services in freestanding IPFs would improve access to inpatient psychiatric care for some of the most vulnerable Medicare beneficiaries and would better align Medicare's coverage of inpatient psychiatric services with coverage for other types of medical care. Aside from the elimination of these limits, the Medicare benefit structure related to IPF coverage would not change: Eligibility requirements for IPF admission, such as patients requiring "active" treatment, would still apply. In addition, beneficiaries would still be subject to the spell-of-illness rule under Part A, which specifies the length and frequency of Medicare-covered benefit periods.

Eliminating these coverage limits is just one step in addressing the unmet needs of beneficiaries suffering from serious behavioral health conditions. Continued work to ensure that Medicare beneficiaries are receiving high-quality inpatient psychiatric care and are transitioned appropriately to the community upon discharge is critically important. The Commission will continue to monitor access and quality of care for beneficiaries who use IPF services. ■

When Medicare was implemented in 1965, the legislation specified limited coverage of stays in freestanding inpatient psychiatric facilities (IPFs), which were the predominant form of psychiatric hospital at the time. The limitation was intended to restrict Medicare's coverage to the "active phase" of psychiatric treatment and curb the federal government's financial responsibility for long-term custodial care (Frank 2000).

Medicare imposed both lifetime limits and higher cost sharing for ambulatory behavioral health services than for other medical services, both of which were common practice among commercial insurers at the time. Over time, changes in Medicare legislation eliminated the differential cost sharing for ambulatory behavioral health services, but two limits on inpatient psychiatric hospitalizations persist: a 190-day lifetime limit on days in freestanding IPFs and a reduction of inpatient psychiatric benefit days available in the initial benefit period for beneficiaries who are in a freestanding IPF on their first day of Medicare entitlement.

In January 2022, the chair of the House Committee on Ways and Means requested that the Commission conduct an analysis on the utilization and availability of behavioral health services for Medicare beneficiaries, including the impact of the 190-day lifetime limit on freestanding IPF use. In response, the Commission reported in June 2023 on Medicare's coverage of behavioral health services; Medicare beneficiaries' use of, and spending on, behavioral health services provided by clinicians and outpatient facilities; and trends and issues in IPF services provided to Medicare beneficiaries, including the impact of the 190-day limit (Medicare Payment Advisory Commission 2023). Since then, the Commission has continued to examine the impact of the 190-day limit—and of a required reduction to IPF users' initial benefit period based on prior IPF use—on the highly vulnerable beneficiaries who need IPF care.

In this chapter, we discuss changes in the provision of inpatient psychiatric care since Medicare's inception and the impact of the IPF coverage limitations on beneficiaries' access to care. We describe the beneficiaries who are affected by these limits and review the options available to them when they have exhausted their Medicare coverage. Finally, we

recommend the removal of these limits on Medicare coverage of care in freestanding IPFs and discuss the implications of this recommendation.

Background

Medicare beneficiaries experiencing an urgent, acute mental health or substance use disorder–related crisis may be treated in specialty IPFs that provide 24-hour care in a structured, intensive, and secure setting. IPFs can be freestanding hospitals or specialized units within general acute care hospitals. Patients who need inpatient behavioral health care can be admitted to an IPF where they may receive individual and group therapy, psychosocial rehabilitation, illness-management training, family therapy, electroconvulsive therapy, and other treatments. In addition, a majority of IPF patients receive drug therapy in the form of antipsychotics, mood stabilizers, antidepressants, and anticonvulsants. Patients can also receive care for medical comorbidities such as diabetes, infectious disease, wounds, and cardiac conditions. The goal of IPF care is to stabilize the individual's condition and enable a safe return to the community.

Medicare's coverage limits on care in freestanding IPFs

As is the case for general acute care hospital stays, IPF stays are covered under Medicare Part A. Each stay is subject to the Part A deductible (\$1,676 in 2025) and coinsurance (none for Days 1–60; \$419 per day for Days 61–90). After the 90th day, beneficiaries can draw from up to 60 lifetime reserve days (with a coinsurance amount of \$838 per day).^{1,2}

Uniquely in Medicare, coverage of treatment in psychiatric hospitals under Part A is subject to additional limits:

- **A 190-day lifetime limit on days in freestanding IPFs:** Medicare coverage of treatment in freestanding IPFs is subject to a lifetime limit of 190 days. Inpatient psychiatric days in hospital-based IPFs or general acute care hospitals do not count toward this limit (Centers for Medicare & Medicaid Services 2017).

- **A reduction of inpatient psychiatric benefit days available in the initial benefit period for beneficiaries who are receiving inpatient psychiatric care from a freestanding IPF participating in Medicare as of their first day of Medicare entitlement:**³ For these beneficiaries, the length of the initial Part A benefit period is dependent upon IPF days used during a pre-entitlement look-back period—any days of freestanding IPF care in the 150 days preceding Medicare entitlement are subtracted from the initial benefit period. The reduction applies to all inpatient psychiatric hospitalizations (including in hospital-based IPFs and general acute care hospitals) occurring during the initial benefit period, but not nonpsychiatric general hospital stays.⁴ Subsequent benefit periods are not affected by this reduction (Centers for Medicare & Medicaid Services 2017).⁵

These provisions were established in 1965 (with the implementation of Medicare)—when the majority of inpatient psychiatric care was provided by freestanding facilities run by state and local governments—to ensure that states, rather than the federal government, continued paying for inpatient psychiatric services.

Since Medicare's inception, the provision of inpatient psychiatric services has shifted away from state and local government-run facilities

The psychiatric hospital sector has undergone dramatic changes since Medicare's implementation in 1965. At that time, state and local psychiatric hospitals were the predominant providers of inpatient psychiatric services (Lave and Goldman 1990). The “deinstitutionalization” movement that began in the 1960s was partly in response to concerns about the inhumane treatment of long-term patients in some public psychiatric hospitals. The movement resulted in a push for community-based treatment (Fuller et al. 2016, Mechanic 2014, Salinsky and Loftis 2007, Sisti et al. 2015). This policy shift led to the downsizing and closure of many state- and county-owned psychiatric hospitals and a significant decrease in the total number of inpatient psychiatric beds, while also shifting capacity to the private (nongovernment) sector (Salinsky and Loftis 2007). From 1970 to the early 2000s, the share of nationwide psychiatric beds at state and county psychiatric hospitals declined

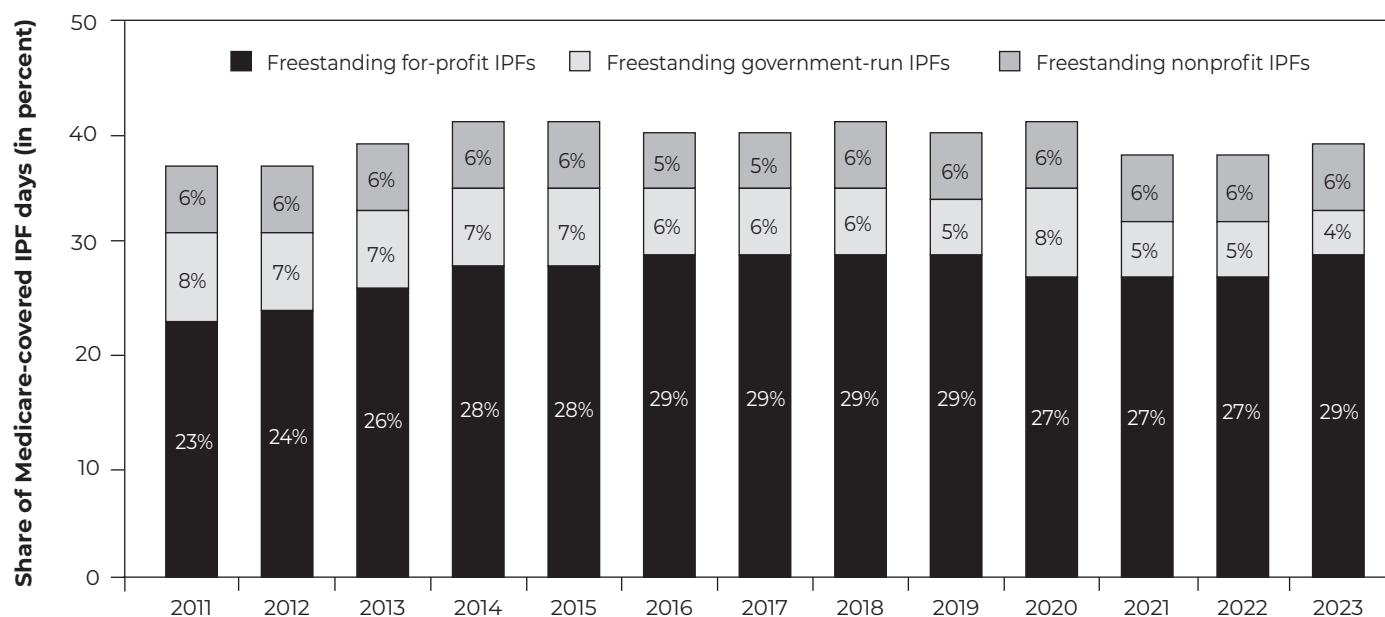
from 80 percent to 30 percent, and overall inpatient psychiatric hospital capacity fell substantially from over 427,000 beds to 86,000 (Hutchins et al. 2011, Salinsky and Loftis 2007). The total number of residents in state psychiatric hospitals declined by 87 percent over the same time (Luttermann 2022). The closures particularly affected elderly residents at state psychiatric hospitals; the total number of elderly residents in these hospitals declined by 96 percent (Luttermann 2022).

The number of private hospital-based and freestanding IPFs grew dramatically in the 1980s and early 1990s (encouraged by the cost-based payment method Medicare used to pay for IPF services at that time) (Salinsky and Loftis 2007). In fact, currently, most Medicare beneficiaries who receive inpatient psychiatric services obtain them from private entities. In 2023, only 4 percent of Medicare beneficiaries' inpatient psychiatric days were in freestanding government IPFs. An additional 12 percent received services from hospital-based government IPFs. The remaining 84 percent of fee-for-service (FFS) Medicare beneficiaries' inpatient psychiatric days were at nongovernment hospitals (including both hospital-based and freestanding facilities).

A small but highly vulnerable group of beneficiaries is affected by Medicare's limits on psychiatric hospitalizations

In 2023, about 40 percent of all Medicare IPF days were in freestanding IPFs and therefore subject to the 190-day limit (Figure 13-1). The share of Medicare days in freestanding for-profit IPFs has increased since 2011 from 23 percent to 29 percent, while the share of government days declined from 8 percent to 4 percent during the same period. About 6 percent of Medicare IPF days were in freestanding nonprofit IPFs, an amount that has been consistent since 2011 (Figure 13-1).

As of January 2024, 813,970 Medicare beneficiaries had used at least one day in a freestanding IPF since their initial enrollment in Medicare (Table 13-1, p. 460). Of these, 39,170 Medicare beneficiaries had exhausted their coverage in freestanding IPFs; another 10,100 were approaching the 190-day limit. Sixty-three

**FIGURE
13-1****Share of Medicare beneficiaries' days in freestanding inpatient psychiatric facilities, by ownership, 2011-2023**

Note: IPF (inpatient psychiatric facility). "Medicare-covered days" includes both fee-for-service and Medicare Advantage IPF days. The remaining (unshown) share of Medicare-covered IPF days are in hospital-based IPFs.

Source: MedPAC analysis of Medicare cost reports from CMS.

percent of beneficiaries near or at the limit as of 2023 were FFS beneficiaries, and the remaining 37 percent were Medicare Advantage (MA) enrollees. In 2023, about 1,300 beneficiaries newly exhausted the 190-day limit (data not shown).

Beneficiaries affected by the reduction in available inpatient psychiatric benefit days in their initial benefit period are more difficult to identify. We have neither data on the use of IPFs in the period before Medicare eligibility nor data on how the first benefit period after entitlement is affected by prior IPF use. To estimate the number of Medicare beneficiaries who may have been affected by prior IPF use in 2023, we counted the number of beneficiaries with a freestanding IPF stay that occurred in the same month as their Medicare entitlement. In 2023, we found that fewer than 100 beneficiaries had any IPF stays that occurred in the month of Medicare entitlement. However, not all these beneficiaries would have had any freestanding IPF

days in the 150 days prior to Medicare entitlement, and so not all of them would have had their first benefit period reduced. Further, not all of them would have had inpatient psychiatric stays in the first benefit period that were long enough to be affected by any reduction by prior use. On the other hand, this amount does not capture the individuals who may have had no covered inpatient psychiatric days during their entire initial benefit period because they had used 150 days of freestanding IPF care in the period immediately preceding Medicare entitlement. Overall, we estimate that the restriction on the initial benefit period likely applies to very few beneficiaries each year. Moreover, the beneficiaries to whom it does apply would not continue to be affected past the initial benefit period (since the limitation reduces only the initial benefit period). Due to the uncertainty about who is affected and the fact that only beneficiaries' first benefit periods would be affected, we do not assess the impact of the initial benefit reduction.

**TABLE
13-1**

Number of Medicare beneficiaries who neared or reached the 190-day limit as of January 2024

	Number of beneficiaries		
	Any freestanding IPF days since Medicare enrollment	Reached 190-day limit	Within 15 days of 190-day limit
FFS	456,630	25,310	5,900
MA	357,340	13,860	4,190
Total	813,970	39,170	10,100

Note: IPF (inpatient psychiatric facility), FFS (fee-for-service), MA (Medicare Advantage). Table figures include Medicare beneficiaries who were enrolled in FFS Medicare or MA in 2023 and had at least one day in a freestanding psychiatric hospital as of January 2024. Components may not sum to totals due to rounding.

Source: Medicare enrollment data from CMS.

Beneficiaries near or at the 190-day limit are highly vulnerable

Medicare beneficiaries (whether enrolled in FFS or MA) who used IPF care are far more likely to be disabled and have low incomes compared with other beneficiaries who did not have any covered days in freestanding IPFs since their enrollment in Medicare (Table 13-2). They were also more likely to be Black. In comparison with beneficiaries who had a history of using freestanding IPFs but were not near the 190-day limit, the beneficiaries who were near or at the 190-day limit in 2023 were more likely to be disabled (75 percent vs. 61 percent), male (61 percent vs. 50 percent), Black (26 percent vs. 18 percent), and have low incomes (84 percent vs. 69 percent).

Using data on chronic conditions in 2022, we found that FFS Medicare beneficiaries near or at the limit were more likely to have schizophrenia compared with other FFS IPF users—80 percent compared with 58 percent among those who used freestanding IPFs but were not near the limit (Table 13-3, p 462).⁶ Beneficiaries near or at the limit were less likely to have depressive disorders (54 percent vs. 61 percent) but more likely to have a substance use disorder (34 percent vs. 27 percent).⁷ FFS beneficiaries near or at the limit were also more likely to have “dual” diagnoses

(schizophrenia or depressive disorder and a substance use disorder) (Table 13-3, p. 462).

Other coverage options for beneficiaries who reach the 190-day limit

Some Medicare beneficiaries may have other sources of health care coverage to assist with the costs of IPF days past the 190-day limit. In 2023, about 9 percent of MA plans provided additional IPF days as a supplemental benefit. For full-benefit dually eligible Medicare beneficiaries, Medicaid may provide additional coverage.⁸ In fact, in some states, Medicaid has more generous behavioral health coverage than Medicare (Medicare Payment Advisory Commission 2023). However, in the 1965 implementation of Medicaid, the Congress also limited the federal government’s involvement in long-term psychiatric care by prohibiting federal matching funds for Medicaid beneficiaries in hospitals that have 16 or more beds and primarily treat mental health or substance use disorders—called the “institutions for mental diseases” (IMD) exclusion (see text box on p. 464). The IMD exclusion applies to care that adults under age 65 receive in these facilities, though many states receive waivers. Federal funding is available in most states for individuals 21 or younger and for those 65 and over.

**TABLE
13-2**

Medicare beneficiaries near or at the 190-day limit were more likely to be disabled, have low incomes, and be Black, 2023

Characteristic	Medicare beneficiaries		
	Near or at the limit of covered freestanding IPF days	With a history of freestanding IPF use but not near the coverage limit	All other (no freestanding IPF use since enrollment in Medicare)
Current eligibility status and demographics			
Aged	25%	39%	89%
Disabled	75	61	11
Female	39	50	54
Male	61	50	46
<45	20	19	2
45–64	53	41	8
65–79	22	32	67
80+	5	8	23
Non-Hispanic White	63	69	73
Black	26	18	11
Asian/Pacific Islander	2	1	4
Hispanic	7	8	9
American Indian/Alaska native	1	1	<1
Other or unknown	1	2	4
Geography			
Metropolitan	87	83	83
Micropolitan	9	11	10
Other rural	4	6	7
Dually eligible for Medicaid or receiving LIS during the year			
No	16	31	78
Yes	84	69	22

Note: IPF (inpatient psychiatric facility), LIS (low-income subsidy). "Near or at the limit of covered freestanding IPF days" includes fee-for-service (FFS) and Medicare Advantage (MA) beneficiaries who were within 15 days of exhausting the 190-day lifetime limit on covered days in freestanding IPFs or who had already exhausted the limit. "With a history of freestanding IPF use but not near the coverage limit" includes FFS and MA beneficiaries who had between 16 days and 189 days remaining (i.e., these beneficiaries had at least one day in a freestanding IPF since Medicare enrollment). "All other (no freestanding IPF use since enrollment in Medicare)" includes beneficiaries who had not used any days in a freestanding IPF since Medicare enrollment (but might have used a hospital-based IPF or psychiatric services in a general acute care hospital). "Dually eligible for Medicaid or receiving LIS during the year" includes beneficiaries who had full or partial dual eligibility for Medicare and Medicaid or were enrolled in the Part D low-income subsidy in the year; these statuses serve as proxies for low-income status. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare enrollment data from CMS.

As shown in Figure 13-2 (p. 463), 20 percent of Medicare beneficiaries near or at the 190-day limit are either enrolled in an MA plan with supplemental IPF benefits

or are dually eligible for full-benefit Medicaid and are 65 years or older. The remaining 80 percent are dually eligible for Medicaid but are under age 65 and thus

**TABLE
13-3**

FFS Medicare beneficiaries near or at the 190-day limit were more likely to have schizophrenia and substance use disorders, 2022

Behavioral health condition	Share of FFS Medicare beneficiaries		
	Near or at the limit of covered freestanding IPF days	With a history of freestanding IPF use but not near the coverage limit	All other (no freestanding IPF use since enrollment in Medicare)
Schizophrenia	80%	58%	4%
Depressive disorders	54	61	20
Substance use disorders	34	27	4
Schizophrenia or depressive disorders and substance use disorders (dual diagnoses)	33	25	2

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility). "Near or at the limit of covered freestanding IPF days" includes FFS Medicare and Medicare Advantage (MA) beneficiaries who were within 15 days of exhausting the 190-day lifetime limit on covered days in freestanding IPFs or who had already exhausted the limit. "With a history of freestanding IPF use but not near the coverage limit" includes FFS and MA beneficiaries who had between 16 days and 189 days remaining (i.e., these beneficiaries had at least one day in a freestanding IPF since Medicare enrollment). "All other (no freestanding IPF use since enrollment in Medicare)" includes beneficiaries who had not used any days in a freestanding IPF since Medicare enrollment (but might have used a hospital-based IPF or psychiatric services in a general acute care hospital). "Schizophrenia" includes schizophrenia and other psychotic disorders, bipolar disorder, and personality disorders. "Depressive disorders" includes major depressive affective disorder, anxiety disorders, and post-traumatic stress disorder. "Substance use disorders" includes alcohol use disorders, drug use disorders, and opioid use disorders. Conditions were defined by the presence of a diagnosis as of the end of 2022 (using, generally, a two-year look-back period; see <https://www2.cdwdata.org/web/guest/condition-categories-other>). Table includes beneficiaries enrolled in FFS Medicare in 2023 with chronic condition data available in 2022.

Source: MedPAC analysis of Chronic Condition Warehouse data from CMS.

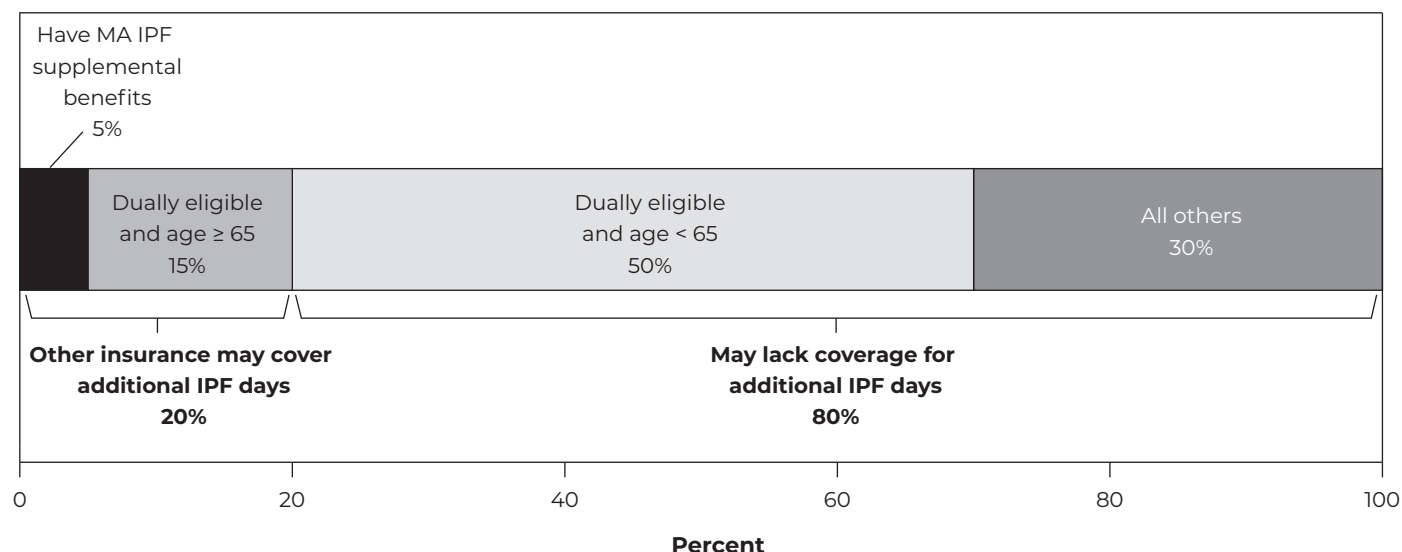
may be subject to the IMD exclusion (depending on whether their state has a waiver) or are not covered by Medicaid.⁹

The 190-day limit creates access issues for some beneficiaries with chronic and severe behavioral health conditions

Researchers, policy analysts, and providers generally agree that demand for inpatient care for people with the most difficult-to-treat behavioral health conditions far outstrips supply, in large part because community-based treatment for such people is often inadequate (Fuller et al. 2016, Lamb and Weinberger 2014, McBain et al. 2022a, Mechanic 2014, Sharfstein and Dickerson 2009, Sisti et al. 2015). Lack of capacity to serve patients with serious behavioral health conditions has also contributed to a substantial burden on the criminal justice system (Lamb and Weinberger 2014, Lamb et al.

2004, Lurigio and Harris 2022, Lutterman 2022, McBain et al. 2022b, Sisti et al. 2015). For example, McBain and colleagues noted that, in one state, the shortage of psychiatric beds resulted in over 1,000 individuals being housed in county jails despite being deemed mentally incompetent to stand trial (McBain et al. 2022b).

As the number of public IPFs has declined, private IPFs have become the predominant site of care for Medicare beneficiaries needing acute inpatient psychiatric care (with freestanding private IPFs serving a large share of FFS Medicare beneficiaries using IPFs (Figure 13-1, p. 459)). However, freestanding private IPFs are likely less willing and able to take patients who have reached or are close to Medicare's 190-day lifetime limit. In interviews conducted with a small set of IPFs, some interviewees stated that the 190-day limit can present significant issues for patients who need longer-term care or those who have multiple periodic inpatient stays because of chronic serious behavioral health conditions such as schizophrenia (L & M Policy

**FIGURE
13-2****Many Medicare beneficiaries near or at the 190-day limit
may have lacked additional coverage, 2023**

Note: MA (Medicare Advantage), IPF (inpatient psychiatric facility). Medicare beneficiaries who are full-benefit dually eligible and age 65 or older may have Medicaid coverage of additional IPF days beyond the 190-day limit. Dually eligible beneficiaries between ages 18 and 64 may be subject to the “institutions for mental diseases” exclusion and have limited coverage through Medicaid beyond the 190-day limit. “All others” includes non-full-benefit dually eligible Medicare beneficiaries and non-dually eligible Medicare beneficiaries who are not enrolled in an MA plan with IPF supplemental benefits. These beneficiaries may also have limited coverage beyond the 190-day limit.

Source: MedPAC analysis of Medicare enrollment data and MA plan benefit package data from CMS.

Research 2023, Medicare Payment Advisory Commission 2023).¹⁰ A few of the IPF interviewees reported that after a patient passes the 190-day limit, IPFs provide uncompensated care and help the patient obtain Medicaid coverage. One noted that they try to get patients who meet the 190-day limit into hospital-based IPFs so that they can receive Medicare-covered care there. Most IPFs considered the 190 days to be insufficient coverage, especially for patients with chronic behavioral health conditions, and stated that the limit increased the difficulty of finding suitable postdischarge placement options.

Although some beneficiaries who reach the 190-day limit can be transferred to hospital-based facilities, changing hospitals during a stay or course of care can be disruptive and result in fragmented care. Moreover, the number of hospital-based IPFs has declined in recent years, exacerbating difficulties in

finding alternative placement for patients nearing their 190-day limit (we previously reported that from 2017 to 2021, the number of hospital-based IPFs declined by 4 percent annually (Medicare Payment Advisory Commission 2023)). In addition, some IPF interviewees discussed how higher-needs and older patients (who are more likely to be frail and have more medical comorbidities) tend to be placed in “geriatric units” that occupy only a subset of beds within the IPF due to the greater resources required (such as higher staff-to-patient ratios and longer lengths of stay) (L & M Policy Research 2023).

Beneficiaries may also receive inpatient psychiatric services from general acute care hospitals (referred to as “scatter-bed” stays). Our analyses have found that scatter-bed stays compose about a third of all Medicare inpatient psychiatric stays, and thus they meaningfully supplement the number of IPF beds (Medicare Payment

Medicaid's "institutions for mental diseases" exclusion

Medicaid is a joint federal and state program that covers medical costs for individuals with limited income and resources. Each state implements its own Medicaid program subject to certain federal rules and regulations, and the federal government shares in a portion of the costs. Under a policy known as the institutions for mental diseases (IMD) exclusion, the federal government does not make matching payments to states for services to Medicaid enrollees ages 21 to 64 in IMDs. An IMD is defined in the Medicaid program as a "hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services" (Social Security Act Sec. 1905(i)).

Like the limits on inpatient psychiatric coverage, the IMD exclusion was intended to ensure that states, rather than the federal government, continued paying for inpatient psychiatric services since state- and locally run psychiatric hospitals were

the predominant form of psychiatric hospital in 1965 (Medicaid and CHIP Payment and Access Commission 2019, National Association of Medicaid Directors 2022). States can still pay for these services without federal matching funds and, in recent years, almost all states have made use of available exceptions to obtain federal funds for Medicaid enrollees receiving inpatient psychiatric services from IMDs. Such exceptions include Section 1115 demonstration waivers, disproportionate-share-hospital payments, a state-plan option for services for substance use disorders, and managed care "in lieu of" arrangements (Congressional Budget Office 2023).¹¹ Although these exceptions promote access for inpatient psychiatric services in participating states, they are subject to restrictions, for example, on the type of services covered or length of stay. The Congressional Budget Office estimated that if the IMD exclusion were eliminated, federal spending would increase by \$38.4 billion from 2024 to 2033, even after accounting for spending on exceptions and waivers currently used by states (Congressional Budget Office 2023). ■

Advisory Commission 2024). However, we found that the types of beneficiaries who use scatter-bed stays differ from those who use IPFs: Scatter-bed users tended to be older, with more medical comorbidities (Medicare Payment Advisory Commission 2024). Moreover, prior research found fewer psychiatric visits and shorter lengths of stay among scatter-bed stays compared with IPF stays, calling into question whether scatter beds are an appropriate setting of care for individuals with severe behavioral health conditions (Mechanic and Davis 1990).

To understand how the 190-day coverage limit might affect access to care, we compared utilization of inpatient psychiatric services by beneficiaries "affected by the limit" (proxied by beneficiaries who reached the limit or were within 15 days of reaching the limit in 2023 and had had at least one freestanding IPF stay

in the previous five years) with a comparison group of similar beneficiaries not affected by the limit in 2023. We constructed the comparison group as beneficiaries who in 2023 had 16 days to 90 days remaining before reaching the limit and who also had had at least one freestanding IPF stay in the previous five years.¹² The goal was to identify comparison beneficiaries who were likely to have similar propensities for using inpatient psychiatric care as beneficiaries affected by the limit, but who were not (or were less) influenced by the 190-day limit itself.

Our analysis suggests that beneficiaries who were affected by the 190-day limit substituted freestanding IPF care with inpatient psychiatric services in hospital-based units and in scatter beds of general acute care hospitals. As shown in Table 13-4, in 2023, beneficiaries affected by the limit had an average of 2.4 covered days

**TABLE
13-4**

Setting of FFS Medicare-covered inpatient psychiatric care differed for beneficiaries affected by the limit compared with similar beneficiaries not affected by the limit, 2023

	Mean covered days per FFS Medicare beneficiary		Difference between the comparison group and those affected by the limit
	Affected by the 190-day limit (N = 14,590)	Comparison group (N = 17,770)	
Freestanding IPF	2.4	7.6	5.2
Hospital-based IPF	5.0	2.8	-2.2
Psychiatric stay in a general ACH	2.0	1.3	-0.8
All inpatient psychiatric stays in 2023	9.4	11.7	2.2

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility), ACH (acute care hospital). "Affected by the 190-day limit" includes FFS beneficiaries who had exhausted or were within 15 days of exhausting the 190-day limit and had at least one freestanding IPF stay between 2018 and 2022. "Comparison group" is composed of FFS Medicare beneficiaries who were within 16 days to 90 days of meeting the 190-day limit and had at least one freestanding IPF stay between 2018 and 2022. All differences were statistically significant at the 1 percent level.

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

in a freestanding IPF compared with 7.6 covered days for the comparison group. By contrast, beneficiaries affected by the limit had 5.0 covered days in hospital-based IPFs compared with 2.8 days for those not affected by the limit. Similarly, beneficiaries affected by the limit had more covered psychiatric days in general acute care hospitals compared with those not affected by the limit (2.0 days vs. 1.3 days).

As shown in Table 13-4, in 2023 beneficiaries affected by the 190-day limit had an average of 2.2 fewer days of total covered inpatient psychiatric care than beneficiaries in the comparison group, which could suggest that beneficiaries affected by the 190-day limit face constraints on their use of services.

Illustrative effect on use and spending if the coverage limit on care in freestanding IPFs were removed

Over the years, stakeholders have called for the Medicare program to eliminate the 190-day limit on coverage of treatment in freestanding IPFs and legislative attempts have been made (AARP 2024,

Commonwealth Fund 2023). Stakeholders point out inequities with the limit. For instance, beneficiaries with chronic behavioral health conditions, particularly younger individuals who are eligible for Medicare due to disability, are more likely to reach the limit during their lifetime and face barriers to IPF care (Commonwealth Fund 2023).

As an illustrative example of how Medicare spending could change if the 190-day limit were removed, we calculated the change in Medicare spending in 2023 associated with the differences in psychiatric hospital use discussed above. As shown in Table 13-4, we found that freestanding IPF days could increase if the limit were removed and that, although use of hospital-based IPFs and scatter-bed stays could decrease, the overall number of covered days for inpatient psychiatric services could increase if the limit were removed. We multiplied these estimated differences by the average per diem Medicare payment in 2023 for comparison-group beneficiaries who were not affected by the limit (Table 13-5, p. 466). By totaling those amounts, we estimate that Medicare would spend an additional \$1,260 per beneficiary currently affected by the 190-day limit if the limit were removed. That is, if beneficiaries affected by the limit were to change their psychiatric

**TABLE
13-5****Illustrative change in per beneficiary FFS Medicare spending on inpatient psychiatric services if the 190-day limit were eliminated, 2023**

	Change in number of covered days per beneficiary	Per diem average FFS Medicare payment	Increase in FFS Medicare payments per beneficiary
Freestanding IPF	5.2	\$800	\$4,200
Hospital-based IPF	-2.2	\$900	-\$2,000
General acute care hospital	-0.8	\$1,200	-\$930
Total FFS Medicare spending per beneficiary	2.2	—	\$1,260

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility). "Change in number of covered days per beneficiary" was estimated by comparing FFS Medicare beneficiaries affected by the 190-day limit with a group of similar beneficiaries who were between 16 days and 90 days away from the limit (see Table 13-4, p. 465). "Per diem average FFS Medicare payment" was the average Medicare payment per day for beneficiaries in the comparison group. "Increase in FFS Medicare payments per beneficiary" was calculated by multiplying the preceding two columns. Services provided by freestanding IPFs and hospital-based IPFs are paid under the IPF prospective payment system; inpatient psychiatric services provided in general acute care hospitals are paid under the inpatient prospective payment system. Components may not sum to totals due to rounding.

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

hospital use to be the same as similar beneficiaries not affected by the limit, Medicare would spend an additional \$1,260 for each beneficiary.

To estimate the total impact, we multiplied the increase in FFS spending per beneficiary (\$1,260) by the number of FFS beneficiaries near or at the limit in 2023 (31,210, shown in Table 13-1 (p. 460)). We estimate that eliminating the 190-day coverage limit would have increased FFS Medicare spending by approximately \$40 million in 2023.¹³

Actual changes in Medicare spending could be higher or lower depending on a variety of considerations. Not all beneficiaries at or near the 190-day coverage limit would change their use of psychiatric services (some beneficiaries may no longer need inpatient psychiatric services or may have established alternative, long-term care). The comparison group of beneficiaries we defined as "not affected by the limit" might also change their use of inpatient psychiatric services in response to removing the limit (as may providers). Medicare spending on other services such as Part D prescription drugs and Part B clinician services might be affected as well, though the direction of effects is unclear.¹⁴ Finally, freestanding IPFs (including government-

run IPFs) might change their behavior by accepting more Medicare patients and keeping them for longer periods if the limit were removed; such a change would increase spending relative to our estimate (but, importantly, may also increase needed access).

We previously found that IPF occupancy rates declined from 76 percent to 70 percent between 2017 and 2021, indicating that, overall, IPFs could accommodate additional use if the limit were removed (Medicare Payment Advisory Commission 2023). However, we noted that occupancy rates varied significantly across IPFs and that some of the interviewees in the small set of IPFs we interviewed indicated difficulty in staffing all licensed beds; thus, occupancy rates measured from cost reports may be underestimated (L & M Policy Research 2023, Medicare Payment Advisory Commission 2023). It would be important to continue to monitor IPF use and access.

Implications for Medicaid

Eliminating the 190-day limit would decrease Medicaid spending (as well as federal Medicaid matching payments) for dually eligible beneficiaries who currently have exceeded the 190-day limit and now

receive coverage through Medicaid. Because of the IMD exclusion (see text box on the exclusion, p. 464), this decrease in spending would be more limited in states that do not have an exception to the IMD exclusion. Medicaid spending reductions would be greater in states that do have an exception.

Removing the coverage limits on care in freestanding IPFs

Beneficiaries who reach the 190-day lifetime limit on covered days in freestanding IPFs may still obtain psychiatric care from hospital-based IPFs or general acute care hospitals, but an alternative setting may be difficult to find, disruptive to care, and potentially a less appropriate setting for the beneficiary. Eliminating the 190-day lifetime limit, as well as the reduction of inpatient psychiatric benefit days available in the initial benefit period for beneficiaries who are receiving inpatient psychiatric care on their first day of Medicare entitlement, would improve access to IPFs for some of the most vulnerable Medicare beneficiaries. While removing the limit will likely lead to increased use of (and Medicare spending on) freestanding IPF services, use of other types of inpatient psychiatric care, to the extent that they substitute for care in freestanding IPFs, would decrease.

Existing relevant aspects of the Medicare benefit would remain the same if the 190-day limit were eliminated. These features include:

- **Active treatment criteria for eligibility for IPF care:** Medicare patients must still meet eligibility criteria to be admitted to any IPF. Criteria specify that IPFs can admit only patients with a psychiatric principal diagnosis who require active treatment of an intensity that can be provided appropriately only in an inpatient hospital setting (Centers for Medicare & Medicaid Services 2018).
- **Spell of illness:** Each Part A Medicare benefit period or spell of illness begins at admission to an inpatient facility and is limited to 90 days (with deductible and copayment) and 60 nonrenewable lifetime reserve days (which have higher beneficiary cost sharing). A new benefit period starts only when the beneficiary has been

discharged for at least 60 days. Thus, even with the 190-day limit eliminated, beneficiaries using IPFs would still be subject to Medicare's benefit period structure and total lifetime reserve days.

RECOMMENDATION 13

The Congress should eliminate both:

- **the 190-day lifetime limit on covered days in freestanding inpatient psychiatric facilities; and**
- **the reduction of the number of covered inpatient psychiatric days available during the initial benefit period for new Medicare beneficiaries who received care from a freestanding inpatient psychiatric facility on and in the 150 days prior to their date of Medicare entitlement.**

RATIONALE 13

The limitations on Medicare coverage of care in freestanding IPFs were implemented in 1965 when public hospitals were the primary providers of inpatient psychiatric care. Nearly 60 years later, a substantial share of inpatient psychiatric care is provided at private freestanding psychiatric hospitals, which may be less willing and able to treat beneficiaries who have exceeded the 190-day limit and have exhausted their Medicare Part A coverage. Alternative insurance options such as certain MA plans and Medicaid may cover additional days, but our analysis found that only about 20 percent of beneficiaries who were near or at the limit in 2023 would have had this additional coverage (this is likely higher if accounting for waivers of the IMD exclusion among many states). Beneficiaries affected by this limit are among the most vulnerable; the majority are disabled and have low incomes and severe chronic behavioral health conditions. Beneficiaries reaching the limit may obtain care from hospital-based IPFs—and our analysis finds that they do—which are not subject to these limitations. However, the declining number of hospital-based IPFs may diminish these facilities' ability to serve as a substitute setting for beneficiaries who need inpatient psychiatric care and have exceeded the 190-day limit. Moreover, shifting care settings in response to the limit may lead to fragmented or less appropriate care. Eliminating the limits on psychiatric services in freestanding IPFs would promote access to inpatient psychiatric services and better align the

coverage of inpatient psychiatric services with the coverage of other types of medical care. Aside from the elimination of these limits, the Medicare benefit structure related to IPF coverage would not change: Eligibility requirements for IPF admission, such as patients requiring “active” treatment, would still apply. In addition, beneficiaries would still be subject to the spell-of-illness rule under Part A, which specifies the length and frequency of Medicare-covered benefit periods.

IMPLICATIONS 13

Spending

- Relative to current law, we expect that this recommendation would increase federal spending by less than \$50 million in one year and by less than \$1 billion over five years.

Beneficiary and provider

- We expect that this recommendation will increase Medicare beneficiaries’ access to inpatient psychiatric care at freestanding IPFs by increasing freestanding IPFs’ willingness to treat beneficiaries with chronic and severe behavioral health conditions.

Importance of continued work to address the needs of Medicare beneficiaries with severe behavioral health conditions

Eliminating the 190-day limit would improve access to IPFs for some of the most vulnerable Medicare beneficiaries. However, removing Medicare limitations on inpatient psychiatric hospitalizations is just one step in addressing the unmet needs of beneficiaries suffering from serious behavioral health conditions. Continued work is needed to ensure that Medicare beneficiaries are receiving high-quality inpatient psychiatric care and are appropriately transitioned out of the hospital. Per requirements set forth in the Consolidated Appropriations Act (CAA), 2023, CMS is planning to collect more information on the services provided by IPFs and the patients who use them. It will be important to continue to monitor access, quality of care, and payments to IPFs for Medicare beneficiaries.

Concerns about care provided in certain freestanding IPFs

IPFs serve vulnerable patients with complex needs, and the type and quality of care these patients receive in some psychiatric hospitals has been a longstanding concern (Fuller et al. 2016, Mechanic 2014, Salinsky and Loftis 2007, Sisti et al. 2015). More recently, two large IPF chains (together accounting for 250 freestanding psychiatric hospitals) were investigated by the Department of Justice for practices at some of their facilities (Department of Justice 2024, Department of Justice 2020). Allegations included improper detainment of patients who were not eligible for inpatient care; inadequate staffing, training, and supervision of staff; improper use of restraints and seclusion; and billing for services not provided. Greater transparency in the services provided at IPFs, how they vary based on patient characteristics, and the quality of the care provided is critical for this population.

In our June 2023 report to the Congress, we discussed concerning trends in the data provided by freestanding for-profit IPFs (Medicare Payment Advisory Commission 2023). These IPFs tended to have lower costs per stay than other types of IPFs, but they also had low use rates or missing information on ancillary services (such as the use of prescription drugs, laboratory services, and medical supplies), making it difficult to know whether patients were receiving these services (as well as hampering the ability of the payment system to align payments to the costs of care). For example, while nearly all FFS Medicare beneficiaries treated in hospital-based IPFs had some amount of drugs and laboratory services on the claim, only 40 percent of freestanding for-profit IPF stays had any ancillary services on the claim (Medicare Payment Advisory Commission 2023). It is not clear why certain IPFs fail to report ancillary charges, and CMS has attempted to address the poor reporting over the years, most recently in the fiscal year 2025 final rule, in which CMS said that Medicare administrative contractors would be instructed to reject cost reports that do not include information on ancillary services (with exceptions granted to government-owned or tribally owned IPFs only) starting on October 1, 2024 (Centers for Medicare & Medicaid Services 2024). We will continue to track ancillary services provided to Medicare beneficiaries by IPFs.

In addition, there is little information on the mix (and amount) of staff employed by IPFs and how staff spend their time across various IPF tasks (such as inpatient assessment, counseling, drug management, nursing care, and behavioral monitoring). IPF staffing data could provide useful insights into the variation in costs and quality of care across providers, enabling CMS and Medicare beneficiaries to better understand the services that they are purchasing and using. There is a precedent for regularly collecting staffing information: Skilled nursing facilities (SNFs) are required to submit detailed staffing data through the Payroll-Based Journal. Payroll data are considered the gold standard for measuring staffing; the data are submitted electronically and can be audited by other data sources (Centers for Medicare & Medicaid Services 2023). Researchers have found the SNF payroll data to be consistent and accurate; the data serve as an important tool for policymakers and researchers to assess staffing and its relationship to patient outcomes (Geng et al. 2019, Zheng et al. 2022).

Challenges in transitioning from IPFs to the community

Transitioning from the psychiatric hospital back to the community can be particularly challenging. Studies have found that during the period immediately following IPF discharge, individuals are highly vulnerable and at risk for poor outcomes, leading to a “revolving door” of hospital readmissions (Bravo et al. 2022, Fonseca Barbosa and Gama Marques 2023, Tyler et al. 2019). We previously reported on the substantial use of emergency departments (EDs) and hospital visits in the period after IPF discharge: Using claims data from 2018, we found that 29 percent of FFS Medicare beneficiaries discharged from an IPF had an ED visit or hospital admission (including IPF readmission) within 30 days (Medicare Payment Advisory Commission 2023). This figure rose to 47 percent in the 90 days following IPF discharge. In interviews conducted with a small set of IPFs in 2022 and 2023, interviewees noted persistent challenges in finding discharge placement options, which lengthened stays and resulted in discharging some patients with long-term behavioral health conditions back into the community despite significant social, behavioral, and medical needs and inadequate support (L & M Policy Research 2023). Many of these patients were eventually readmitted.

Care coordination with outpatient providers is vital to improve the transition from an IPF: Communication between inpatient and outpatient behavioral health providers during an inpatient psychiatric stay has been associated with increased odds of attending timely outpatient behavioral health appointments (Smith et al. 2020). Continuation of care and follow-up after discharge is especially important for IPF patients discharged to their homes, the most common setting to which IPF patients are discharged (Assistant Secretary for Planning and Evaluation 2019). Indeed, our prior analyses using 2018 data found that only 15 percent of beneficiaries had ambulatory visits with behavioral health practitioners within seven days of IPF discharge (and only 30 percent within a month of discharge) (Medicare Payment Advisory Commission 2023). IPF interviewees also noted difficulty in obtaining appropriate follow-up care for their IPF patients after discharge, particularly with psychiatrists (L & M Policy Research 2023). One stated:

We'll refer them to see a therapist, and they might have to see them two or three times before they can get in with a psychiatrist. It could be two or three months to actually see the psychiatrist because they have to see the therapist so many times—that's how much there is a shortage of psychiatrists. The need is just growing and growing.

The high rate of ED visits and acute care hospital admissions before and after IPF admission and the relatively low rate of visits with behavioral health clinicians suggest that many of these patients do not receive effective, well-coordinated behavioral health care.¹⁵ Starting in 2027, CMS will begin reporting a new risk-standardized claims-based measure on ED visits occurring in the 30 days following discharge (Centers for Medicare & Medicaid Services 2024). We will continue to track transitions from the IPF to the community and the use of post-IPF follow-up care.

Ongoing monitoring of the FFS Medicare IPF payment system and quality of care is needed

In our June 2023 report to the Congress, we noted that more information is needed to improve the accuracy of payments under the IPF prospective payment system. Notably, our analysis of IPFs' costs and margins suggested that Medicare payments were not well-aligned to costs of efficient care delivery. The available

data used to develop the payment system do not enable policymakers to adequately capture variation in patient severity and resource use to accurately set payments. Moreover, as discussed above, we found that many IPFs were not reporting ancillary services provided to patients, information that is needed to accurately calculate costs from the Medicare cost reports to set payments appropriately.

CMS continues to address these shortcomings. More recently, per the CAA, 2023, CMS will begin to collect data in the following areas: resource use and the need for patient monitoring (e.g., violent behavior, physical restraint); interventions (e.g., detoxification services, respirator); and patient characteristics (e.g., functional status, cognitive function, comorbidities, and impairments). A standardized tool will be used to collect patient assessment data, beginning by 2028.

CMS requires IPFs to report quality measures through a pay-for-reporting program and has recently made

several improvements to the reporting program. Starting in 2026, patient-experience survey data must be reported. CMS is also developing several claims-based outcome measures: a measure of 30-day all-cause ED visits following an IPF discharge and 30-day all-cause mortality rate following discharge. Many of the measures in the reporting program are based on chart-abstracted data, meaning that facilities calculate the measure based on their own medical records and report the results in aggregate without validation of the underlying patient-level data. Starting in 2024, CMS requires submission of patient-level data for chart-abstracted measures. These changes align with the Commission's principles that Medicare's quality payment programs should include a small set of performance measures tied to clinical outcomes, patient experience, and value (Medicare Payment Advisory Commission 2018). We will continue to monitor updates to the IPF payment system and quality reporting program. ■

Endnotes

- 1 Patients must also pay any Part B cost sharing for services from physicians and other clinicians received during the stay.
- 2 Days in inpatient facilities, including IPFs, count toward a beneficiary's use of lifetime reserve days (if the beneficiary is in the inpatient facility for more than 90 days during a benefit period). Lifetime reserve days are nonrenewable.
- 3 Only beneficiaries receiving psychiatric treatment from a Medicare-certified freestanding IPF on the day of entitlement are subject to a reduction in the length of this initial benefit period. Inpatient psychiatric use of hospital-based IPFs or general acute care hospitals on the day of entitlement would not trigger a reduction to the initial benefit period.
- 4 For example, if an individual spent 150 days in a Medicare-certified freestanding IPF ending on the first day of Medicare entitlement, Medicare would not cover any inpatient psychiatric days during the beneficiary's initial benefit period. However, Medicare would cover nonpsychiatric medical services received at general acute care hospitals up to the full initial benefit period.
- 5 Use of freestanding IPFs during the pre-entitlement period does not count toward the 190-day life limit. Medicare-covered days of freestanding IPF use during the initial benefit period would count toward the beneficiary's 190-day limit.
- 6 "Schizophrenia" includes schizophrenia and other psychotic disorders, bipolar disorder, and personality disorders. Conditions were defined by the presence of a diagnosis as of the end of 2022 (using, generally, a two-year look-back period; see <https://www2.ccwdata.org/web/guest/condition-categories-other>).
- 7 "Depressive disorders" includes major depressive affective disorder, anxiety disorders, and post-traumatic stress disorder. "Substance use disorder" includes alcohol use disorders, drug use disorders, and opioid use disorders. Conditions were defined by the presence of a diagnosis as of the end of 2022 (using, generally, a two-year look-back period; see <https://www2.ccwdata.org/web/guest/condition-categories-other>).
- 8 Full-benefit dually eligible beneficiaries include those with a status of "qualified Medicare beneficiaries," "specified low-income Medicare beneficiaries," and other types of full-benefit Medicaid coverage who meet eligibility criteria under the state plan. Other dually eligible beneficiaries receive partial benefits, in which Medicaid covers varying portions of Medicare Part A and Part B premiums and cost sharing (see <https://www.cms.gov/medicare-medicare-coordination/medicare-and-medicare-coordination/medicare-medicare-coordination-office/downloads/medicaremedicaidenrolleecategories.pdf>).
- 9 Our understanding is that Medigap does not provide coverage beyond the 190-day limit. We note that for about 5 percent of beneficiaries at or near the limit, Medicare is not the primary insurer; thus, additional IPF coverage from those beneficiaries' primary insurance is a possibility.
- 10 The Commission hired a contractor to conduct telephone interviews with officials at 10 IPFs between November 2022 and February 2023 to better understand services provided, patient mix, and challenges facing IPFs.
- 11 States with Medicaid managed care plans can pay for treatment in IMDs as an in-lieu-of service, which is a service that is not included under the state plan but is a clinically appropriate, cost-effective substitute for a similar, covered service. Under that authority, federal matching funds are available for the monthly payments to managed care plans for enrollees ages 21 to 64 who have an IMD stay if certain criteria are met (Congressional Budget Office 2023).
- 12 FFS Medicare beneficiaries affected by the limit and the comparison group of FFS Medicare beneficiaries were relatively similar on key characteristics such as the percent disabled (82 percent vs. 78 percent), percent under age 65 (81 percent vs. 77 percent), and percent with low-income status (89 percent vs. 86 percent).
- 13 When FFS spending increases, payments to MA plans also increase (reflecting the additional care that plans would be required to cover for their enrollees). The amount of increase depends on how much plans' bids increase in relation to the benchmark, their rebate percentage, and the share of MA beneficiaries in the county, among other factors.
- 14 Any increase in IPF stays would also increase Part B clinician services provided during the stay (for example, psychiatrist visits during the IPF would be billed under Part B). However, associated Part B services would decrease to the extent that there would be fewer stays in hospital-based IPFs or general acute care hospitals. Part D prescription drugs may also be affected: FFS Medicare

payments to IPFs and acute care hospitals include medications. Thus, to the extent that Medicare-covered inpatient days increase with the elimination of the 190-day limit, Part D drug spending could decrease.

15 Recent legislation through the CAA, 2023, sought to increase the supply of behavioral health practitioners by allowing services by licensed marriage and family therapists and licensed professional counselors to be covered by Medicare.

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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

The Congress should:

- for 2026, update the 2025 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1 percent; and
- redistribute existing disproportionate-share-hospital and uncompensated-care payments through the Medicare Safety-Net Index (MSNI)—using the mechanism described in our March 2023 report—and add \$4 billion to the MSNI pool.

Yes: Barr, Casale, Casalino, Chernew, Cherry, Damberg, Dusetzina, Konetzka, Liao, Navathe, Poulsen, Rambur, Riley, Sarran, Upchurch

No: Kan, Miller

Chapter 4: Physician and other health professional services

The Congress should:

- for calendar year 2026, replace the current-law updates to Medicare payment rates for physician and other health professional services with a single update equal to the projected increase in the Medicare Economic Index minus 1 percentage point; 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, Casale, Casalino, Chernew, Cherry, Damberg, Dusetzina, Kan, Konetzka, Liao, Miller, Navathe, Poulsen, Rambur, Riley, Sarraan, Upchurch

Chapter 5: Outpatient dialysis services

For calendar year 2026, the Congress should update the 2025 Medicare base payment rate for outpatient dialysis services by the amount determined under current law.

Yes: Barr, Casale, Casalino, Chernew, Cherry, Damberg, Dusetzina, Konetzka, Liao, Navathe, Poulsen, Rambur, Riley, Sarraan, Upchurch
Abstain: Kan, Miller

Chapter 6: Skilled nursing facility services

For fiscal year 2026, the Congress should reduce the 2025 Medicare base payment rates for skilled nursing facilities by 3 percent.

Yes: Barr, Casale, Casalino, Chernew, Cherry, Damberg, Dusetzina, Kan, Konetzka, Liao, Miller, Navathe, Poulsen, Rambur, Riley, Sarraan, Upchurch

Chapter 7: Home health care services

For calendar year 2026, the Congress should reduce the 2025 Medicare base payment rate for home health agencies by 7 percent.

Yes: Barr, Casale, Casalino, Chernew, Cherry, Damberg, Dusetzina, Kan, Konetzka, Liao, Miller, Navathe, Poulsen, Rambur, Riley, Sarraan, Upchurch

Chapter 8: Inpatient rehabilitation facility services

For fiscal year 2026, the Congress should reduce the 2025 Medicare base payment rate for inpatient rehabilitation facilities by 7 percent.

Yes: Barr, Casale, Casalino, Chernew, Cherry, Damberg, Dusetzina, Kan, Konetzka, Liao, Miller, Navathe, Poulsen, Rambur, Riley, Sarraan, Upchurch

Chapter 9: Hospice services

For fiscal year 2026, the Congress should eliminate the update to the 2025 Medicare base payment rates for hospice.

Yes: Barr, Casale, Casalino, Chernew, Cherry, Damberg, Dusetzina, Kan, Konetzka, Liao, Miller, Navathe, Poulsen, Rambur, Riley, Sarran, Upchurch

Chapter 10: Ambulatory surgical center services: Status report

No recommendations

Chapter 11: The Medicare Advantage program: Status report

No recommendations

Chapter 12: The Medicare prescription drug program (Part D): Status report

No recommendations

Chapter 13: Eliminating Medicare's coverage limits on stays in freestanding inpatient psychiatric facilities

The Congress should eliminate both:

- the 190-day lifetime limit on covered days in freestanding inpatient psychiatric facilities; and
- the reduction of the number of covered inpatient psychiatric days available during the initial benefit period for new Medicare beneficiaries who received care from a freestanding inpatient psychiatric facility on and in the 150 days prior to their date of Medicare entitlement.

Yes: Barr, Casale, Casalino, Chernew, Cherry, Damberg, Dusetzina, Kan, Konetzka, Liao, Miller, Navathe, Poulsen, Rambur, Riley, Sarran, Upchurch

Acronyms

Acronyms

A-APM	advanced alternative payment model	CMG	case-mix group
AAGR	average annual growth rate	CMI	case-mix index
ACA	Affordable Care Act of 2010	CMMI	Center for Medicare and Medicaid Innovation (now the CMS Innovation Center)
ACH	acute care hospital	CMS	Centers for Medicare & Medicaid Services
ACO	accountable care organization	CMS-HCC	CMS hierarchical condition category
ACS	ambulatory care sensitive	CON	certificate of need
ADL	activity of daily living	COVID-19	coronavirus disease 2019
AHIP	America's Health Insurance Plans	CPT	Current Procedural Terminology
AHRQ	Agency for Healthcare Research and Quality	CRNA	certified registered nurse anesthetist
AIDS	acquired immunodeficiency syndrome	C-SNP	chronic-condition special-needs plan
AKI	acute kidney injury	CT	computed tomography
ALOS	average length of stay	CY	calendar year
ALS	amyotrophic lateral sclerosis	DECI	demographic estimate of coding intensity
AMA	American Medical Association	DGME	direct graduate medical education
APC	ambulatory payment classification	DIR	direct and indirect remuneration
APM	alternative payment model	DME	durable medical equipment
APRN	advanced practice registered nurse	DMEPOS	durable medical equipment, prosthetics, orthotics, and supplies
ASC	ambulatory surgical center	DO	doctor of osteopathic medicine
ASCQR	ASC Quality Reporting	DOJ	Department of Justice
ASP	average sales price	DRG	diagnosis-related group
AWP	average wholesale price	DSH	disproportionate share
AWP	any willing pharmacy	D-SNP	dual-eligible special-needs plan
BBA	Balanced Budget Act	E&M	evaluation and management
BBA	Bipartisan Budget Act	ECP	endoscopic cyclophotocoagulation
BBP	base beneficiary premium	ED	emergency department
BLS	Bureau of Labor Statistics	eGFR	estimated glomerular filtration rate
CAA	Consolidated Appropriations Act	EGWP	employer group waiver plan
CAH	critical access hospital	EMTALA	Emergency Medical Treatment and Active Labor Act of 1986
CAHPS	Consumer Assessment of Healthcare Providers and Systems	ESA	erythropoiesis-stimulating agent
CARES	Coronavirus Aid, Relief, and Economic Security [Act]	ESRD	end-stage renal disease
CBO	Congressional Budget Office	ETC	ESRD Treatment Choices
CC	complication or comorbidity	FDA	Food and Drug Administration
CCI	chronically critically ill	FFS	fee-for-service
CCP	coordinated-care plan	FPL	federal poverty level
CDC	Centers for Disease Control and Prevention	FQHC	federally qualified health center
CEO	chief executive officer	FY	fiscal year
CFR	Code of Federal Regulations	g/dL	grams per deciliter
CHC	continuous home care	GAO	Government Accountability Office
CHIP	Children's Health Insurance Program	GDP	gross domestic product
CKD	chronic kidney disease		

GI	gastrointestinal	KFF	(formerly) Kaiser Family Foundation
GIP	general inpatient care	LCD	local coverage determination
GLP-1	glucagon-like peptide-1 receptor agonist	LDO	large dialysis organization
GME	graduate medical education	LEP	late-enrollment penalty
H-CAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems	LICS	low-income cost sharing
HCBS	home- and community-based services	LIP	low-income patient
HCC	hierarchical condition category	LIS	low-income subsidy
HCPCS	Healthcare Common Procedure Coding System	LLC	limited liability corporation
HH	home health	LOS	length of stay
HHA	home health agency	LPN	licensed practical nurse
HH-CAHPS	Home Health Care Consumer Assessment of Healthcare Providers and Systems	LTC	long-term care
HHI	Herfindahl–Hirschman Index	LTC-DRG	long-term-care diagnosis-related group
HHS	Department of Health and Human Services	LTCH	long-term care hospital
HI	Hospital Insurance (Medicare Part A)	LTSS	long-term services and supports
HIV	human immunodeficiency virus	LUPA	low utilization payment adjustment
HMO	health maintenance organization	LVI	low-volume and isolated
HMO-POS	HMO point-of-service	LVPA	low-volume payment adjustment
HOPD	hospital outpatient department	M3P	Medicare Prescription Payment Plan
HOPE	Hospice Outcomes & Patient Evaluation	MA	Medicare Advantage
HPRD	hours per resident day	MA-CAHPS	Medicare Advantage Consumer Assessment of Healthcare Providers and Systems
HRSA	Health Resources and Services Administration	MACPAC	Medicaid and CHIP Payment and Access Commission
HSA	hospital service area	MACRA	Medicare Access and CHIP Reauthorization Act of 2015
HUD	Department of Housing and Urban Development	MAO	Medicare Advantage organization
ICD	International Classification of Diseases	MA-PD	Medicare Advantage Prescription Drug [plan]
ICH-CAHPS	In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems	MCBS	Medicare Current Beneficiary Survey
ICL	initial coverage limit	MCCM	Medicare Care Choices Model
IMD	institutions for mental diseases	MCO	managed care organization
IME	indirect medical education	MD	doctor of medicine
IOL	intraocular lens	MDS	Minimum Data Set
IPF	inpatient psychiatric facility	MedPAC	Medicare Payment Advisory Commission
IPO	inpatient only	MedPAR	Medicare Provider Analysis and Review [file]
IPPS	inpatient prospective payment systems	MEI	Medicare Economic Index
IRA	Inflation Reduction Act of 2022	MFP	maximum fair price
IRC	inpatient respite care	MGMA	Medical Group Management Association
IRE	independent review entity	MIPS	Merit-based Incentive Payment System
IRF	inpatient rehabilitation facility	MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
IRF-PAI	Inpatient Rehabilitation Facility–Patient Assessment Instrument	MRI	magnetic resonance imaging
I-SNP	institutional special-needs plan	MSA	metropolitan statistical area
JAMA	(formerly) Journal of the American Medical Association	MSN	Medicare safety net
KDE	kidney-disease education	MSNI	Medicare Safety-Net Index
		MTM	medication therapy management

N/A	not applicable	QMB	qualified Medicare beneficiary
NA	nurse aide	QRP	Quality Reporting Program
NCPA	National Community Pharmacists Association	RADV	risk-adjustment data validation
NDA	new-drug application	RAPS	Risk Adjustment Processing System
NDC	national drug code	RBCS	Restructured BETOS Classification System
NF	nursing facility	RDS	retiree drug subsidy
NORC	(formerly) National Opinion Research Center	REH	rural emergency hospital
NP	nurse practitioner	REIT	real estate investment trust
NPI	national provider identifier	RHC	routine home care
OASIS	Outcome and Assessment Information Set	RHC	rural health clinic
OB/GYN	obstetrics and gynecology	RN	registered nurse
OIG	Office of Inspector General	RTI	(formerly) Research Triangle Institute
OON	out of network	RUC	Relative Value Scale Update Committee
OOP	out of pocket	RUG	Resource Utilization Group
OPPS	outpatient prospective payment system	RVU	relative value unit
OQR	Outpatient Quality Reporting	RxHCC	prescription drug–hierarchical condition category
OR	operating room	S&P	(formerly) Standard & Poor's
OT	occupational therapy	SCH	sole community hospital
PA	physician assistant	SCHIP	State Children's Health Insurance Program
PAC	post-acute care	SEC	Securities and Exchange Commission
PACE	Program of All-Inclusive Care for the Elderly	SEP	special enrollment period
PAMA	Protecting Access to Medicare Act of 2014	SLMB	specified low-income Medicare beneficiary
PBM	pharmacy benefit manager	SLP	speech–language pathology
PCP	primary care provider	SMI	Supplementary Medical Insurance
PD	peritoneal dialysis	SNF	skilled nursing facility
PDGM	Patient-Driven Groupings Model	SNP	special-needs plan
PDP	prescription drug plan	SSI	Supplemental Security Income
PDPM	Patient-Driven Payment Model	SSI	surgical-site infection
PE	private equity	TBD	to be determined
PFFS	private fee-for-service	TDAPA	transitional drug add-on payment adjustment
PFS	physician fee schedule	TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
PHC4	Pennsylvania Health Care Cost Containment Council	TMR	targeted medication review
PHE	public health emergency	TPNIES	transitional payment adjustment for new and innovative equipment and supplies
P.L.	Public Law	TrOOP	true out of pocket
PLI	professional liability insurance	UIC	urban influence code
POS	point of sale	U.S.	United States
POS	point of service	USC	United States Code
PPO	preferred provider organization	USRDS	U.S. Renal Data System
PBD	provider-based department	VA	Department of Veterans Affairs
PPS	prospective payment system	VBID	value-based insurance design
PT	physical therapist	VBP	value-based purchasing
Q	quarter	WAC	wholesale acquisition cost
QBP	quality-bonus program		

More about MedPAC

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Commissioners' biographies

Lynn Barr, MPH, is the director of the Barr-Campbell Family Foundation, which focuses on rural health, the underserved, education, and the environment. Previously, she recruited and organized small rural hospitals across three states to form the first National Rural accountable care organization (ACO). To manage the ACO's services, she founded and led Caravan Health 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 Health to Signify, a division of CVS Health. Prior to forming Caravan Health, Ms. Barr shepherded four start-up companies and 12 medical inventions through the Food and Drug Administration and worldwide markets. Prior to that, 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. Ms. Barr earned her master of public health degree from the University of California, Berkeley.

Paul N. Casale, MD, MPH, is a professor of population health sciences in the Division of Health Policy and Economics and a professor of clinical medicine in the Division of Cardiology at Weill Cornell Medicine (originally Cornell University Medical College), as well as an adjunct professor of medicine at Columbia University Vagelos College of Physicians and Surgeons. He has been the executive director of NewYork Quality Care, an ACO that is a joint initiative of NewYork-Presbyterian, Columbia University, and Weill Cornell Medical College for the past eight years. Dr. Casale has served on many national committees, including the chair of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and a member of the Advisory Council of the Agency for Healthcare Research and Quality. Dr. Casale's research focuses on clinical cardiology, value-based care, and payment reform. He has held multiple leadership positions in a variety of health care settings, including a rural private practice, a regional health system, and a large urban academic medical center. Dr. Casale earned his medical degree from Weill Cornell Medicine and his master of public health from the Harvard School of Public Health.

Lawrence Casalino, MD, PhD, is emeritus professor of public health at Weill Cornell Medicine, 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 adviser to the director of the Agency for Healthcare Research and Quality, as chair of the Academy Health Annual Research Meeting, as a member of the Panel of Health Advisers 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, before that, as a community organizer.

Michael E. Chernew, PhD, is the Leonard D. Schaeffer Professor of Health Care Policy and the director of the Healthcare Markets and Regulation Lab in the Department of Health Care Policy at Harvard Medical School. Dr. Chernew's research examines several areas related to improving the health care system, including studies of novel benefit designs, Medicare Advantage, alternative payment models, low-value care, and the causes and consequences of rising health care spending. He is also a member of the Congressional Budget Office's Panel of Health Advisors and a member of the Massachusetts Health Connector Board. Dr. Chernew is a member of the National Academy of Sciences, a research associate at the National Bureau of Economic Research, and a MITRE fellow. He is currently a coeditor of the *American Journal of Managed Care*. He has served on a number of CMS technical advisory panels reviewing the assumptions used by Medicare actuaries to assess the financial status of the Medicare trust funds. Dr. Chernew previously served on the Commission from 2008 to 2014 and was vice chair from 2012 to 2014. He earned his undergraduate degree from the University of Pennsylvania and his PhD in economics from Stanford University.

Robert A. Cherry, MD, MS, is chief medical and quality officer at UCLA Health in Los Angeles, CA. Dr. Cherry has extensive experience in quality and safety improvements and value-based care in health systems located in different parts of the U.S. He has coordinated innovative analytical methods to increase clinical quality of care, improve patient experience, and provide value to patients. He also has served on the board of many organizations, including the California Community Foundation, and was appointed to the California Health Facilities Financing Authority, which helps nonprofit organizations with financing, construction, and remodeling of health facilities. A trauma and critical care surgeon, Dr. Cherry earned his medical degree from Columbia University and a master in health care management degree from Harvard University.

Cheryl L. Damberg, PhD, is director of the RAND Center of Excellence on Health System Performance, distinguished chair in health care payment policy, and a principal senior economist at the RAND Corporation in Santa Monica, CA. Her research explores the impact of strategies to drive cost and quality improvements in health care. She also studies how providers are redesigning health care delivery in response to new payment models and increased accountability for cost and quality and the effects of health care consolidation on health care spending and quality performance. Her work has focused on improving the design of value-based payment systems to address disparities and improve health equity. Dr. Damberg is an international expert in value-based payment reforms and has advised the Congress and federal agencies on these and other issues. She earned her PhD in public policy from the Pardee RAND Graduate School of Public Policy Studies and a master of public health degree from the University of Michigan.

Stacie B. Dusetzina, PhD, is a professor of health policy and an Ingram Professor of Cancer Research at Vanderbilt University Medical Center in Nashville, TN. She has conducted extensive research on topics related to Medicare coverage for prescription drugs, including studies focused on drug pricing, Medicare Part D benefit design, and Medicare formulary coverage policies. Dr. Dusetzina has served as a committee member for the National Academies of Sciences, Engineering, and Medicine on the topic “Ensuring Patient Access to Affordable Drug Therapies” and as an expert witness for the Senate Special Committee

on Aging. She received her PhD in pharmaceutical sciences from the Eshelman School of Pharmacy at the University of North Carolina at Chapel Hill and postdoctoral training in the Department of Health Care Policy at Harvard Medical School.

Kenny Kan, FSA, CPA, CFA, MAAA, is vice president and chief actuary of Horizon Blue Cross Blue Shield (BCBS) of New Jersey in Newark, where he recently helped launch a Medicare Advantage plan. Prior to joining Horizon BCBS, Mr. Kan was chief actuary for two other large health plans, where he oversaw efforts to assess payment and delivery innovations designed to improve quality and reduce cost. He also served for six years on the Maryland Health Care Commission. He is a fellow of the Society of Actuaries and a member of the American Academy of Actuaries. Mr. Kan earned his master's degree in professional accounting from the University of Texas.

R. Tamara Konetzka, PhD, is the Louis Block Professor of Public Health Sciences at the University of Chicago, with a secondary appointment in the Department of Medicine, Section of Geriatrics and Palliative Medicine. She is also the codirector of the Health Policy Data Lab and an associate director of the Center for Chronic Disease Research and Policy at the University of Chicago. She also serves as the editor-in-chief of *Medical Care Research and Review*. Her research addresses the incentives created by health care payment policy on the quality of post-acute and long-term care, including the effects of public reporting of quality and the costs and benefits of home-based care. She received her PhD in health economics from the University of North Carolina at Chapel Hill and completed a postdoctoral fellowship at the University of Pennsylvania and the Philadelphia VA.

Joshua Liao, MD, MSc, is professor of medicine and division chief of general internal medicine at the University of Texas Southwestern Medical Center. He also leads the Program on Policy Evaluation and Learning, holds the Walter Family Distinguished Chair in Internal Medicine, and serves on the faculty at the University of Texas Southwestern O'Donnell School of Public Health. In addition, Dr. Liao is an adjunct senior fellow at the Leonard Davis Institute of Health Economics at the University of Pennsylvania. He is an internal medicine physician with research and evaluation interests in health care payment, care-

delivery redesign, and practice transformation. Dr. Liao earned his medical degree from Baylor College of Medicine, completed his clinical training at Brigham & Women's Hospital/Harvard Medical School, and obtained his master of science in health policy research from University of Pennsylvania.

Brian Miller, MD, MBA, MPH, is an associate professor of medicine at Johns Hopkins University and a nonresident fellow at the American Enterprise Institute. His research focuses on the Medicare Advantage program, the Food and Drug Administration's (FDA's) regulation of pharmaceutical products and medical devices, and competition in health care markets. His research leverages his previous experience at CMS, the FDA, and the Federal Trade Commission. A practicing hospital-medicine physician, Dr. Miller earned his medical degree from Northwestern University, a master of public health degree from Johns Hopkins University, and a master's degree in business administration from the University of North Carolina at Chapel Hill.

Amol Navathe, MD, PhD, is founding director of The Parity Center, codirector of the Healthcare Transformation Institute, and associate director of the Center for Health Incentives and Behavioral Economics in the Department of Medical Ethics and Health Policy at the University of Pennsylvania's Perelman School of Medicine. He is also a professor at Penn and staff physician at the Corporal Michael J. Crescenzo VA Medical Center in Philadelphia, PA. Dr. Navathe's research center designs, tests, and evaluates payment models for public and private payers, including national insurers and state Blue Cross Blue Shield plans. His work led to the founding of Embedded Healthcare, a health care-technology company that accelerates high-value practice using behavioral economics. Dr. Navathe received his MD from the University of Pennsylvania and his PhD in health care management and economics from the Wharton School at the University of Pennsylvania.

Gregory P. Poulsen, MBA, is senior vice president at Intermountain Healthcare, an integrated health system based in Salt Lake City, UT. He has vast experience in strategy and policy for providing higher-quality health care while reducing health care costs. In addition, Mr. Poulsen was a key architect of many innovations at Intermountain Healthcare, including

offering a Medicare Advantage plan and assisting with the transition to a value-based integrated health care delivery system. Mr. Poulsen was a founding member of the Commonwealth Fund Commission on a High Performance Health System, has been a board and executive committee member for the American Hospital Association, and a trustee for the American Board of Internal Medicine Foundation. He is a national guest scholar at Stanford University. He has also been a member of several other value-focused boards and task forces. He earned his master of business administration degree from Brigham Young University.

Betty Rambur, PhD, RN, FAAN, is the Routhier Endowed Chair for Practice and professor of nursing in the College of Nursing at the University of Rhode Island, where she has conducted research on such topics as alternative payment models, telehealth nursing, and value-based workforce redesigns. Before joining the University of Rhode Island, Dr. Rambur served on the Green Mountain Care Board—a five-member regulatory, innovation, and evaluation board that has broad responsibility for cost containment and oversight of Vermont's transition to post-fee-for-service provider reimbursement. Previously, Dr. Rambur served as dean of the College of Nursing and Health Sciences at the University of Vermont and was chairperson for the North Dakota Health Task Force, a statewide health care-financing reform initiative. Dr. Rambur received her PhD in nursing from Rush University.

Wayne J. Riley, MD, MPH, MBA, is president of the State University of New York (SUNY) Downstate Health Sciences University, tenured professor of internal medicine and of health policy and management, and the chair of the board of the New York Academy of Medicine. Immediately prior to joining Downstate, Dr. Riley served as clinical professor of medicine and adjunct professor of health care management at Vanderbilt University and as the 10th president and chief executive officer of Meharry Medical College. He began his career at Baylor College of Medicine, where he completed residency training in internal medicine and held several key administrative posts, including vice president and vice dean for health affairs and governmental relations, assistant dean for education, and assistant chief of medicine at Ben Taub Hospital—a leading public safety-net teaching hospital. Dr. Riley is a member of the National Academy of Medicine

(NAM) of the National Academy of Sciences, where he served as vice chair and chair of the NAM section on the Administration of Health Services, Education and Research. He is also president emeritus of the American College of Physicians, and president of the Society of Medical Administrators. He is an independent director of HCA Healthcare Inc., Compass Pathways PLC, and HeartFlow Group Inc. Dr. Riley earned a BA in anthropology from Yale University, an MPH in health systems management from the Tulane University School of Public Health and Tropical Medicine, an MD from Morehouse School of Medicine, and an MBA from Rice University's Jesse H. Jones Graduate School of Business.

Scott Sarran, MD, MBA, 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. Dr. Sarran is also the principal at Triple Aim Geriatrics, where he provides consultative services to managed care entities (payers and providers) to improve systems of care and outcomes for Medicare and dually eligible beneficiaries. His leadership experiences include chief medical officer roles across the payer sector—both large (Blue Cross Blue Shield IL, Health Care Service

Corporation) and small (MoreCare IL, Fidelis Senior Care)—and provider sectors (Advocate Health Care, University of Chicago, Cook County Health). In all these roles, his focus has been the intersection of improving care for high-risk patients while enabling win-win payer-provider partnerships.

Gina Upchurch, RPh, MPH, 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 residency in geriatric pharmacy practice 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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