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## MEDICARE PAYMENT ADVISORY COMMISSION RELEASES REPORT TO CONGRESS ON MEDICARE PAYMENT POLICY

**Washington, DC, June 12, 2025**—Today, the Medicare Payment Advisory Commission (MedPAC) releases its June 2025 *Report to the Congress: Medicare and the Health Care Delivery System*. Each June, as part of its mandate from the Congress, MedPAC reports on improvements to Medicare payment systems, issues affecting the Medicare program, and changes to health care delivery and the market for health care services. This year's report covers the following topics:

**| Reforming physician fee schedule updates and improving the accuracy of relative payment rates.** The Commission recommends replacing the current-law updates, which are fixed in statute, with an annual adjustment based on a portion of the Medicare Economic Index (MEI), such as MEI minus 1 percentage point. The Commission assesses beneficiaries' access to clinician care as part of its annual assessment of the adequacy of fee-for-service (FFS) payments made under the Medicare physician fee schedule (PFS). For many years, the Commission has found that this access has been as good as, or better than, that of privately insured individuals; the share of clinicians who accept new Medicare patients has been comparable with the share who accept new privately insured patients; and the volume of, and spending on, fee schedule services per beneficiary has consistently grown. At the same time, growth in clinicians' input costs (as measured by the MEI) exceeded payment updates under the PFS by an average of just over 1 percentage point per year (from 2001 to 2020), suggesting that full MEI updates have not been necessary to maintain Medicare beneficiaries' access to care. Looking ahead, clinicians' input costs are expected to exceed current-law updates by 1.5 to 2.0 percentage points, which is more than the 1 percentage point historical average. This could create incentives for clinicians to reduce the number of Medicare beneficiaries they treat, stop participating in Medicare entirely, or consolidate with hospitals, which could increase spending for beneficiaries and the Medicare program. The Commission also recommends improving the accuracy of relative values for clinician services by collecting and using timely data that reflect the cost of delivering care. The Commission is concerned about misvaluation of the PFS's relative value units (RVUs), which determine how Medicare spending is distributed among clinician services and places of service. This misvaluation likely leads to overpayment for some services and underpayment for others, which can have undesirable effects on the distribution of program spending and amount of beneficiary cost sharing and on clinicians' decisions about how and where to practice medicine.

**| Supplemental benefits in Medicare Advantage.** Medicare Advantage (MA) plans receive rebates from Medicare to offer supplemental benefits such as reduced cost sharing, premium reductions, and non-Medicare services (e.g., dental, vision, and hearing services). These rebates have grown from \$21 billion in 2018 to \$86 billion in 2025. Based on 2025 bid projections, conventional MA plans primarily use rebates to reduce cost sharing for Part A and Part B services, while special-needs plans (SNPs) allocate most of their rebate dollars to offering non-Medicare services. Despite rapid growth in MA rebates and expanded supplemental benefits, current data

are insufficient for assessing how these benefits are used and what value they provide to enrollees and taxpayers. CMS requires MA organizations (MAOs) to submit encounter records for all health care items and services, including supplemental benefits, provided to their enrollees. We analyze encounter data for 2021 to assess whether plans are submitting records for non-Medicare services and whether the submission rates are suggestive of problems with the reliability of the data. We identify significant limitations to using encounter data to assess supplemental benefits. First, few encounter records have been collected for dental services, which are one of the largest categories of supplemental benefits. Second, MA plans have reported that the supplemental-benefit encounter records that they do submit are incomplete because of confusion regarding reporting requirements and how to populate records for services that do not have well-established procedure codes. Third, the encounter data do not distinguish between basic and supplemental benefits or between optional and mandatory supplemental benefits. We find that MA plans have submitted encounter records for hearing and vision services and that it may be feasible to use encounter data to assess MA enrollees' use of these services; for most other supplemental benefits, however, plans have submitted few records, and the data appear to be incompletely reported. CMS has introduced new reporting requirements to improve transparency, but the new data will take years to become fully available. Overall, our review of numerous data sources pertaining to MA supplemental benefits reveals a lack of transparency about enrollees' use of supplemental benefits and plans' spending for the benefits.

**| Examining home health care use among Medicare Advantage enrollees.** There is limited understanding of how MA enrollees use home health care compared to FFS beneficiaries. The Commission finds that home health use rates in 2021 among MA enrollees were slightly lower than among FFS beneficiaries (8.3 percent vs. 8.6 percent) using a combined dataset of the encounter and home health assessment data. Among those with a hospitalization during the year, MA enrollees had a higher probability of using home health care, which could suggest that home health care is sometimes used in MA as a substitute for other types of post-acute care. We also found that enrollment in MA was associated with fewer average visits per beneficiary per year compared with FFS (18.2 vs. 20.4 visits per user, respectively), after controlling for beneficiary characteristics. We examine how home health care use differed among MA enrollees by plan attributes and find that beneficiaries enrolled in plans with home health cost sharing had lower use rates and fewer visits. Enrollment in preferred provider organization (PPO) plans was associated with more visits per user compared with health maintenance organization (HMO) plans, but there was no difference between the plan types in the probability of any home health care use. We emphasize that it is not possible to draw conclusions on the appropriateness of care based solely on observing differences in use.

**| Part D prescription drug plans for beneficiaries in fee-for-service Medicare and Medicare Advantage.** Beneficiaries may obtain prescription drug coverage by enrolling in a stand-alone prescription drug plan (PDP)—available to FFS Medicare enrollees—or through an MA Prescription Drug plan (MA-PD) included in an MA enrollee's plan. The Part D program has evolved, with numerous changes altering the dynamics in the PDP and the MA-PD markets. Consistent with the shift in enrollment from FFS to MA in the broader Medicare program, enrollment in Part D has shifted from PDPs to MA-PDs. The Commission finds recent historical trends that raise concerns about the long-term stability of the PDP market. First, the Commission finds that Part D premiums for basic benefits for PDPs tended to exceed those of MA-PDs. Second, the number of PDPs qualifying as benchmark plans has generally declined over time, with beneficiaries receiving the low-income subsidy (LIS) in some regions having just one premium-free benchmark plan in 2025. The Commission also finds that drug costs, on average, have been higher among PDPs compared to MA-PDs, but average risk scores for PDPs have been lower. Finally, the Commission finds that PDPs have been more likely to incur losses in Part D's risk corridors compared with MA-PDs. These last two trends may suggest that Part D's payment

system has not adequately adjusted for PDPs' higher costs. At the same time, MA-PDs may have had lower risk-standardized costs due to differences in the effectiveness of plans' management of drug spending (which lowers costs), coding intensity (which raises risk scores), or other factors. Our analysis of plans' formularies does not find evidence that MA-PDs achieved lower costs compared with PDPs by having more narrow formularies, higher cost sharing, or greater use of utilization management. The Commission's analysis also finds that coding intensity produced higher risk scores for MA-PD enrollees and lower risk scores for PDP enrollees on average (a 7.6 percentage point differential in 2023). In 2025, CMS began applying separate normalization factors for MA-PDs and PDPs to address diverging risk-score trends. However, these adjustments alone may not address the challenges to Part D's risk-adjustment model, and differences affecting enrollee premiums and payments to plans could continue.

**| Medicare beneficiaries in nursing homes.** About 1.2 million Medicare beneficiaries with functional and/or cognitive impairments live in nursing homes (NHs). Nearly all NHs operate as both nursing facilities that provide long-term custodial care and as skilled nursing facilities that provide short-term skilled care. Medicare's coverage of NH care is largely limited to short-term skilled care after hospitalization, while Medicaid is the predominant payer of NH beneficiaries' long-term care. Evaluators have found that the public reporting of NH star ratings has modestly helped beneficiaries select higher-rated NHs and encourage NH improvement. In FFS Medicare, the payment system for skilled nursing care includes a value-based purchasing program that raises or lowers a facility's payment rates based on quality performance. Since the Commission examined this program's design and recommended that it be replaced, CMS has made several improvements. However, the program still has other design flaws that would require congressional action to address, such as incentives that are too small to change behavior. In the MA program, institutional special needs plans (I-SNPs) cover about 12 percent of Medicare NH residents. These plans aim to improve the quality of care that beneficiaries receive and reduce the use of expensive services—such as inpatient care—by using physician and nurse practitioner teams to deliver preventive and coordinated care and reimbursing NHs in ways that encourage facilities to deliver more care on-site. Available evidence suggests that I-SNPs reduce inpatient care use and emergency department visits and that they perform better on some quality measures. However, the evidence is somewhat limited, and there is little information on important areas such as patient experience.

**| Medicare's measurement of rural provider quality.** The Commission supports Medicare's measurement of the quality of care furnished by providers to monitor performance, inform patients and payers, and incentivize high-quality care. However, there are challenges in measuring individual rural providers' quality of care and holding these providers accountable through quality reporting programs. Many rural health care settings experience low patient volumes, creating difficulties in producing reliable and valid estimates on quality measures. Additionally, these providers may have limited staff and funds to invest in quality-improvement activities. Acknowledging the difficulties faced by rural providers in quality reporting, the Commission established principles to guide expectations on the quality of care, including expectations that quality in rural and urban areas should be equal for nonemergency services and that providers' performance on quality measures should be evaluated, collected, and reported publicly. Certain rural providers are not required to participate in Medicare's quality payment programs; however, the majority of them have some Medicare quality results publicly reported. Using Care Compare data files, we review quality reporting program requirements (in FFS Medicare) and program participation by rural providers. We find that hospitals, clinicians, and inpatient rehabilitation facilities had comparable shares of rural and urban providers with publicly reported quality results. Rural skilled nursing facilities and dialysis facilities had lower shares of publicly reported quality results compared with their urban counterparts. In contrast,

rural home health agencies and hospices had higher shares of publicly reported quality results compared with their urban counterparts.

**| Reducing beneficiary cost sharing for outpatient services at critical access hospitals.**

Beneficiaries in FFS Medicare receiving outpatient care at critical access hospitals (CAHs) face disproportionately high cost sharing due to coinsurance based on providers' charges rather than Medicare's payment amounts. In 2022, FFS beneficiaries' coinsurance averaged 52 percent of total Medicare payments for CAH outpatient services. The Commission finds wide variation in cost sharing across CAHs and services. For some services, cost-sharing liability was less than 30 percent of total payment. In other cases (when charges were highest relative to cost), cost sharing was equal to 100 percent of the total payment amount. This variation creates inequities in beneficiaries' cost-sharing liability, depending on providers' charges. Further, under the outpatient prospective payment system (OPPS), coinsurance for an outpatient procedure provided at most hospitals cannot exceed Medicare's inpatient hospital deductible (\$1,676 in 2025). However, there is no cap on cost sharing for beneficiaries who receive outpatient services at CAHs. We find that, in 2022, about 200,000 CAH outpatient line items (out of 26 million) had coinsurance exceeding the OPPS cap. The Commission recommends that for FFS Medicare beneficiaries, coinsurance for outpatient services at CAHs equals 20 percent of the payment amount for services that require cost sharing (rather than 20 percent of charges) and be subject to a cap per service equal to the inpatient deductible. We expect this recommendation would reduce cost-sharing liability for FFS beneficiaries and make coinsurance fairer for FFS patients receiving care at CAHs.

The full report is available at MedPAC's website (<http://www.medpac.gov>).

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*The Medicare Payment Advisory Commission is an independent, nonpartisan Congressional agency that provides policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and health plans fairly, rewards efficiency and quality, and spends tax dollars responsibly.*