MEDPAC

Advising the Congress on Medicare issues

Improving payment incentives in Medicare

Rachel Burton, Luis Serna, Stuart Hammond

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Presentation roadmap

1. Introduction
2. Drivers of Medicare's spending growth
3. Incentives in FFS Medicare, APMs, and MA
4. Recommendations to improve Medicare's incentives
5. Discussion

Note: FFS (fee-for-service), APM (alternative payment model), MA (Medicare Advantage).

Introduction

Introduction

- Medicare uses three approaches to pay for health care:
  - Stand-alone fee-for-service (FFS) Medicare
  - Alternative payment models (APMs) layered on top of FFS Medicare
  - Medicare Advantage (MA) plans operated by private insurers
- Each creates different sets of incentives
  - Some are inherent to a given payment approach
  - Others reflect current design decisions, could be modified
- Medicare's annual survey finds that FFS and MA beneficiaries experience broadly similar access to care and satisfaction; evaluators generally do not find major differences in quality in APMs and FFS

MedPAC's guiding principles

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

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

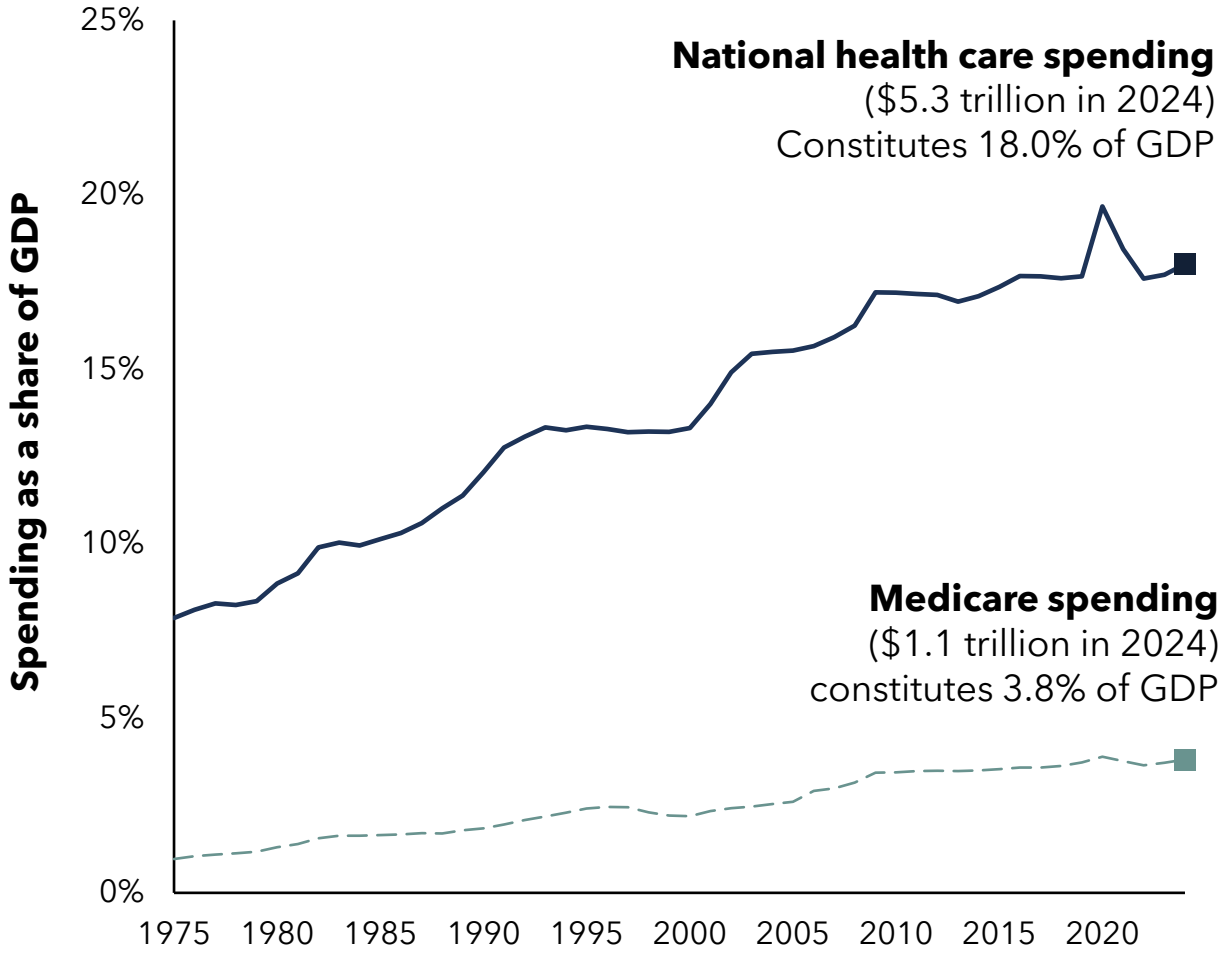
Purpose of this chapter

- Orient readers to the incentives for health care providers in:
  - FFS Medicare
  - APMs
  - MA
- Recap our recommendations for improving these incentives

Note: FFS (fee-for-service), APM (alternative payment model), MA (Medicare Advantage).

Drivers of Medicare's spending growth

Medicare spending constitutes growing shares of GDP and national health care spending



Note: GDP (gross domestic product). Medicare spending includes spending for beneficiaries in both fee-for-service (FFS) Medicare and Medicare Advantage. 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. Medicare spending includes spending for beneficiaries in both FFS Medicare and Medicare Advantage.

Source: MedPAC analysis of CMS's national health expenditure data (projected data released in June 2025 and historical data released in January 2026).

Part B spending is projected to be driven by increasing volume & intensity and other factors

PROJECTIONS

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

Note: Includes fee-for-service and Medicare Advantage enrollees. "Medicare prices" reflects Medicare's annual updates to payment rates (not including inflation, as measured by the Consumer Price Index), total-factor productivity reductions, and any other reductions required by law or regulation. "Beneficiary demographic mix" adjusts for age, sex, and time to death. "Other (e.g., volume and intensity of services used)" refers to the residual after the other three factors shown in the table (Medicare prices, number of beneficiaries, and beneficiary demographic mix) are removed. "Medicare spending" is the product of the other columns in the table.

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

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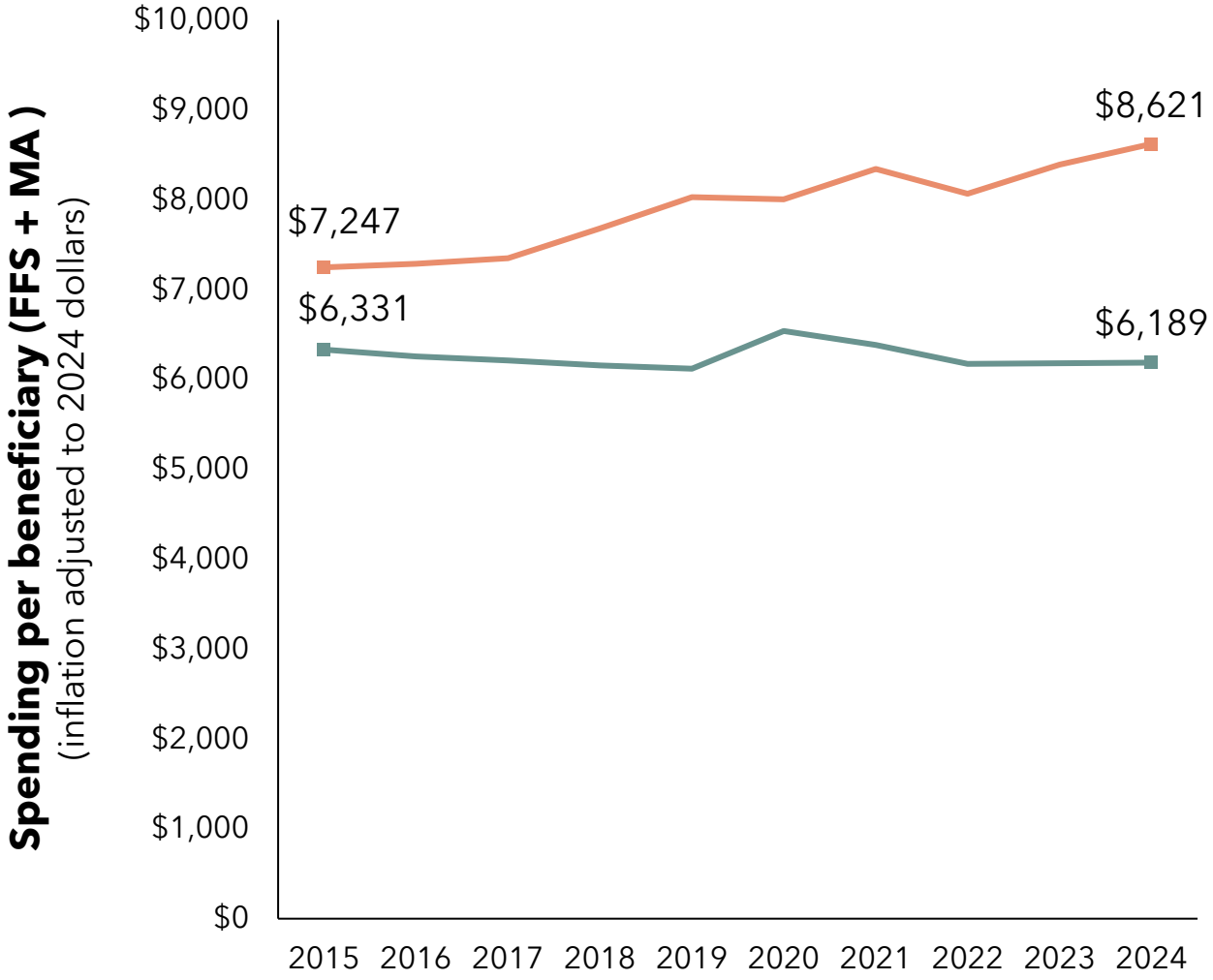
Source: MedPAC analysis of data from the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

Medicare spending per beneficiary has grown faster for Part B than for Part A



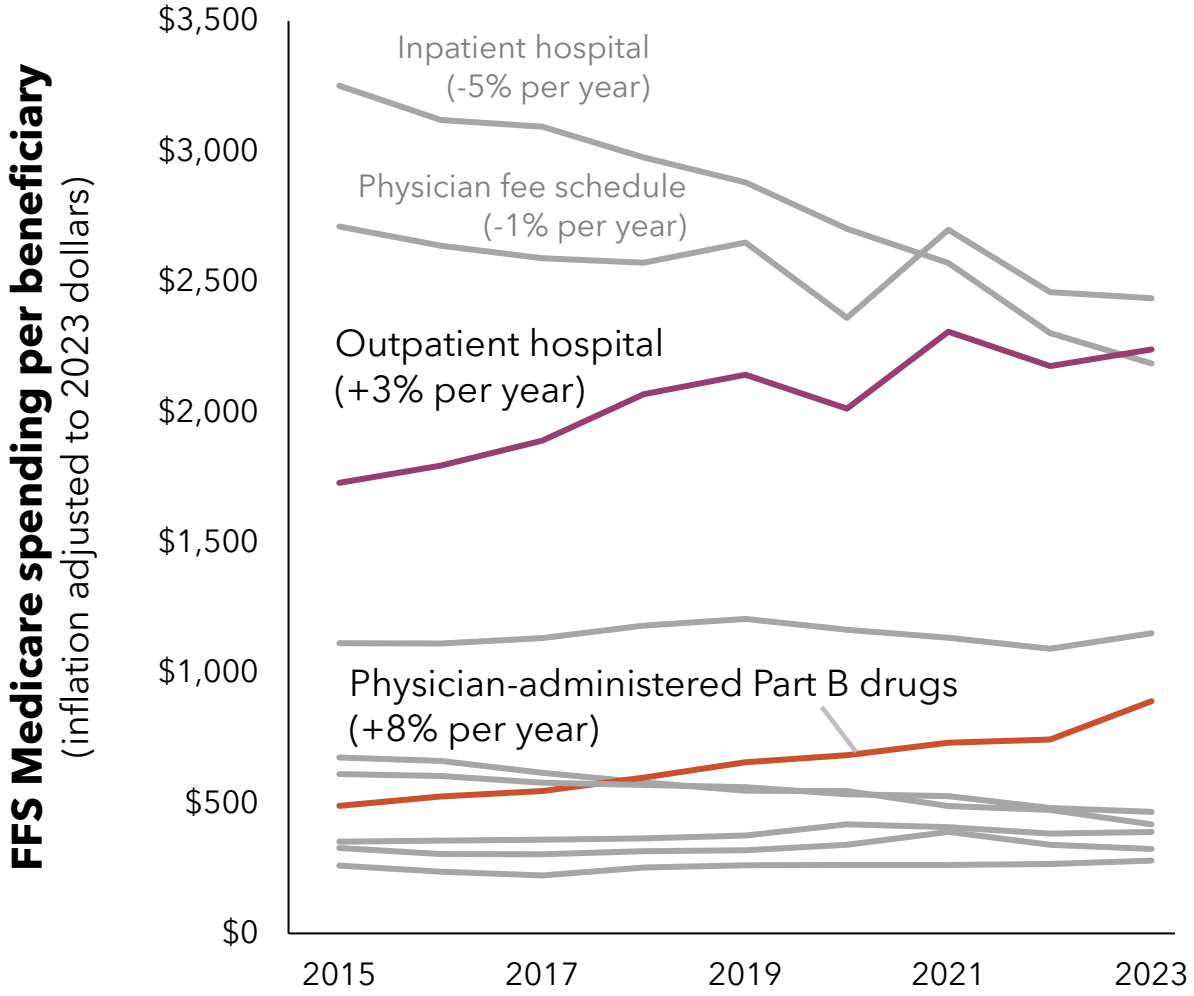
Inflation-adjusted spending per beneficiary increased 19% for Part B
(e.g., clinician services, hospital outpatient encounters, physician-administered drugs)

Inflation-adjusted spending per beneficiary declined 2.2% for Part A
(e.g., inpatient hospital stays, skilled nursing facility stays, hospice)

Note: Includes enrollees in both FFS Medicare and MA. (The share of funds transferred from Part A and Part B to pay for MA enrollees' coverage is based on the shares of total FFS Medicare spending on Part A and Part B.) Amounts were calculated as total spending on a Medicare part (inflation adjusted to 2024 dollars using the Congressional Budget Office's annualized Consumer Price Index for All Urban Consumers), divided by the number of beneficiaries enrolled in that part. Figure shows Medicare program spending, not including spending financed by beneficiary premiums or cost sharing.

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

FFS Medicare spending per beneficiary has grown fastest for physician-administered drugs covered under Part B



Note: FFS (fee-for-service). For each line, figure shows FFS spending on a type of service or item (inflation adjusted to 2023 dollars using the Congressional Budget Office's annualized Consumer Price Index for All Urban Consumers), divided by the number of eligible FFS Medicare beneficiaries. For the "inpatient hospital" and "skilled nursing facility" lines, the denominator is FFS beneficiaries enrolled in Part A; for the "physician fee schedule," "durable medical equipment," "clinical lab services," "physician-administered Part B drugs," "outpatient hospital," and "other" lines, the denominator is FFS beneficiaries enrolled in Part B; for the "home health" line, the denominator is all FFS beneficiaries enrolled in Part A and/or Part B; for the "hospice" line, the denominator is all Medicare beneficiaries enrolled in Part A, including both FFS and Medicare Advantage enrollees. The "physician-administered Part B drugs" line does not include payments for Part B drugs furnished in outpatient hospitals; these payments are instead included as part of the "outpatient hospital" line. "Other" includes FFS Medicare payments for Part B services such as ambulatory surgical center services, ambulance services, federally qualified health center services, rural health clinic services, and outpatient dialysis services. Figure shows Medicare program spending, not including spending financed by beneficiary premiums or cost sharing. Percentages in parentheses are compound annual growth rates from 2015 to 2023.

Source: MedPAC analysis of spending amounts and beneficiary enrollment numbers in the 2025 Medicare Trustees' report (Table IV.A3, Table IV.B6, Table IV.B10, and Table V.B3).

Incentives in FFS Medicare, APMs, and MA

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

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

Note: FFS (fee-for-service), APM (alternative payment model), MA (Medicare Advantage).

Incentives in stand-alone FFS Medicare

Basic design

- Medicare makes a separate payment for each item/service/stay, which gives providers an incentive to increase volume & intensity
- In some FFS payment systems (e.g., IPPS), bundling helps mitigate incentive to increase volume & intensity
- Beneficiaries have wide access to FFS Medicare providers
- Beneficiaries face relatively high cost-sharing, which can be a barrier to care
- FFS Medicare has very low administrative costs

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Overall payment levels

- Hard to get Medicare's FFS prices "right"
- If payments are too high, encourages overuse of services
- If payments are not high enough, providers might not participate in Medicare and beneficiary access to care could suffer
- Can be difficult to set payment rates for new technologies

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Relative payments

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

Note: FFS (fee-for-service), IPPS (inpatient prospective payment system).

Incentives in alternative payment models (APMs)

Basic design

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

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

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- Hard to get APM payment levels right
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- If APM payments too low, providers won't voluntarily participate (but mandatory models can get around this issue)
- Voluntary models induce self-selection by providers likely to earn bonuses
- Clinician-level compensation arrangements tend to continue to reward maximizing volume and intensity, which dulls APMs' clinician-level incentives

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Relative payments

- Providers in APMs have higher (easier) spending targets if they code patient diagnoses more intensively, or curate their participating provider list
- Providers in certain geographic areas may have easier spending targets

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

Incentives in Medicare Advantage (MA)

Basic design

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

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Overall payment levels

- Setting payment levels in a way that appropriately balances program goals is challenging
- Issues with MA payment policies have made it difficult for Medicare to realize savings from MA (Medicare payments to plans tend to exceed FFS spending per enrollee)
- High payments to plans have prompted many insurers to offer plans
- High payments have enabled plans to offer low cost-sharing and extra benefits, which has attracted many beneficiaries

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Relative payments

- Medicare's process for setting benchmarks and risk adjusting payments creates variation in MA payment rates. Plans have an incentive to:
  - code patients' diagnoses more intensively
  - offer plans where benchmarks are increased the most
  - curate their provider network to maximize their quality score
  - attract beneficiaries likely to use less care than expected
- Some plans have responded to these incentives more than others
  - CMS's uniform across-the-board adjustment to risk scores results in unwarranted payment differences across insurers

FFS Medicare, APMs, and MA would all benefit from policy changes MedPAC has suggested

- Opportunities to improve the incentives created by stand-alone FFS, APMs, and MA differ:
  - Stand-alone FFS Medicare tends to promote volume and intensity growth
  - APMs and MA plans have incentives and tools to manage spending but designing systems by which Medicare can realize savings is challenging
- The Commission has recommended improvements to each payment approach and has ongoing work to identify additional ways to improve their incentives, guided by our principles

Note: FFS (fee-for-service), APM (alternative payment model), MA (Medicare Advantage).

Recommendations to improve Medicare's incentives

Improving stand-alone FFS Medicare

Basic design

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

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

Improving stand-alone FFS Medicare

Basic design

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

Overall payment levels

- FFS payment rates should be increased for hospital and clinician services and decreased for post-acute care providers

Source: "Reforming Medicare's benefit design," in MedPAC's June 2012 report to the Congress; various chapters in MedPAC's March 2026 report to the Congress.

Improving stand-alone FFS Medicare

Basic design

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

Overall payment levels

- FFS payment rates should be increased for hospital and clinician services and decreased for post-acute care providers

Relative payments

- New data sources and processes should be used to set FFS Medicare payment rates
- Revise Medicare's hospital payment systems to better support teaching and safety-net hospitals' higher costs of care and account for geographic differences in staff wages
- Payments for ambulatory services that can be safely delivered in more than one setting should be "site-neutral"

Source: "Reforming Medicare's benefit design," in MedPAC's June 2012 report to the Congress; various chapters in MedPAC's March 2026 report to the Congress; "Reviewing the work relative values of physician fee schedule services," in MedPAC's March 2006 report to the Congress; MedPAC's 2011 letter to chairmen and ranking members re: moving forward from the sustainable growth rate (SGR) system; "Graduate medical education financing: Focusing on educational priorities" in MedPAC's June 2010 report to the Congress; "Revising Medicare's indirect medical education payments to better reflect teaching hospitals' costs" in MedPAC's June 2021 report to the Congress; "Hospital inpatient and outpatient services," in MedPAC's March 2023 report to the Congress; "Reforming Medicare's wage index systems," in MedPAC's June 2023 report to the Congress; "Aligning fee-for-service payment rates across ambulatory settings," in MedPAC's June 2023 report to the Congress.

Improving alternative payment models

Basic design

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

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

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Overall payment levels

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

Source: "Streamlining CMS's portfolio of alternative payment models," in MedPAC's June 2021 report to the Congress; "An approach to streamline and harmonize Medicare's portfolio of alternative payment models" in MedPAC's June 2022 report to the Congress; MedPAC's 2022 comment letter on CMS's proposed rule for the CY 2023 physician fee schedule.

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Overall payment levels

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Relative payments

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

Source: "Streamlining CMS's portfolio of alternative payment models," in MedPAC's June 2021 report to the Congress; "An approach to streamline and harmonize Medicare's portfolio of alternative payment models" in MedPAC's June 2022 report to the Congress; MedPAC's 2022 comment letter on CMS's proposed rule for the CY 2023 physician fee schedule; MedPAC's 2023 comment letter on CMS's proposed rule for the CY 2024 physician fee schedule.

Improving Medicare Advantage

Basic design

- Larger geographic markets should be used for MA plan payment areas

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

Improving Medicare Advantage

Basic design

- Larger geographic markets should be used for MA plan payment areas

Overall payment levels

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

Source: "The Medicare Advantage program: Status report," in MedPAC's March 2014 report to the Congress; "Medicare Advantage payment areas and risk adjustment," in MedPAC's June 2005 report to the Congress; "Rebalancing Medicare Advantage benchmark policy," in MedPAC's June 2021 report to the Congress.

Improving Medicare Advantage

Basic design

- Larger geographic markets should be used for MA plan payment areas

Overall payment levels

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

Relative payments

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

Source: "The Medicare Advantage program: Status report," in MedPAC's March 2014 report to the Congress; "Medicare Advantage payment areas and risk adjustment," in MedPAC's June 2005 report to the Congress; "Rebalancing Medicare Advantage benchmark policy," in MedPAC's June 2021 report to the Congress. "Replacing the Medicare Advantage quality bonus program" in MedPAC's June 2020 report to the Congress; "The Medicare Advantage program: Status report," in MedPAC's March 2016 report to the Congress.

Future work

- MedPAC will continue to study Medicare payment approaches and identify ways to improve their incentives
- Future work could include analyzing:
  - Medicare spending trends to better understand sources of spending growth
  - Opportunities to harmonize FFS Medicare payments across settings and service types
  - Alternative methods for calculating payments to MA plans
  - MA plans' incentives to balance access to care with efficiency through networks and denials
  - Potential improvements to the design and methods used to set APM payments
  - New tools that could be used in FFS Medicare to reduce the use of low-value care

Discussion

Discussion

- Will be published in June 2026 report to the Congress
- Suggested changes to the draft chapter?

MEDPAC

Advising the Congress on Medicare issues

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