

Estimated association between Medicare Advantage enrollment and hospitals' and post-acute care providers' finances

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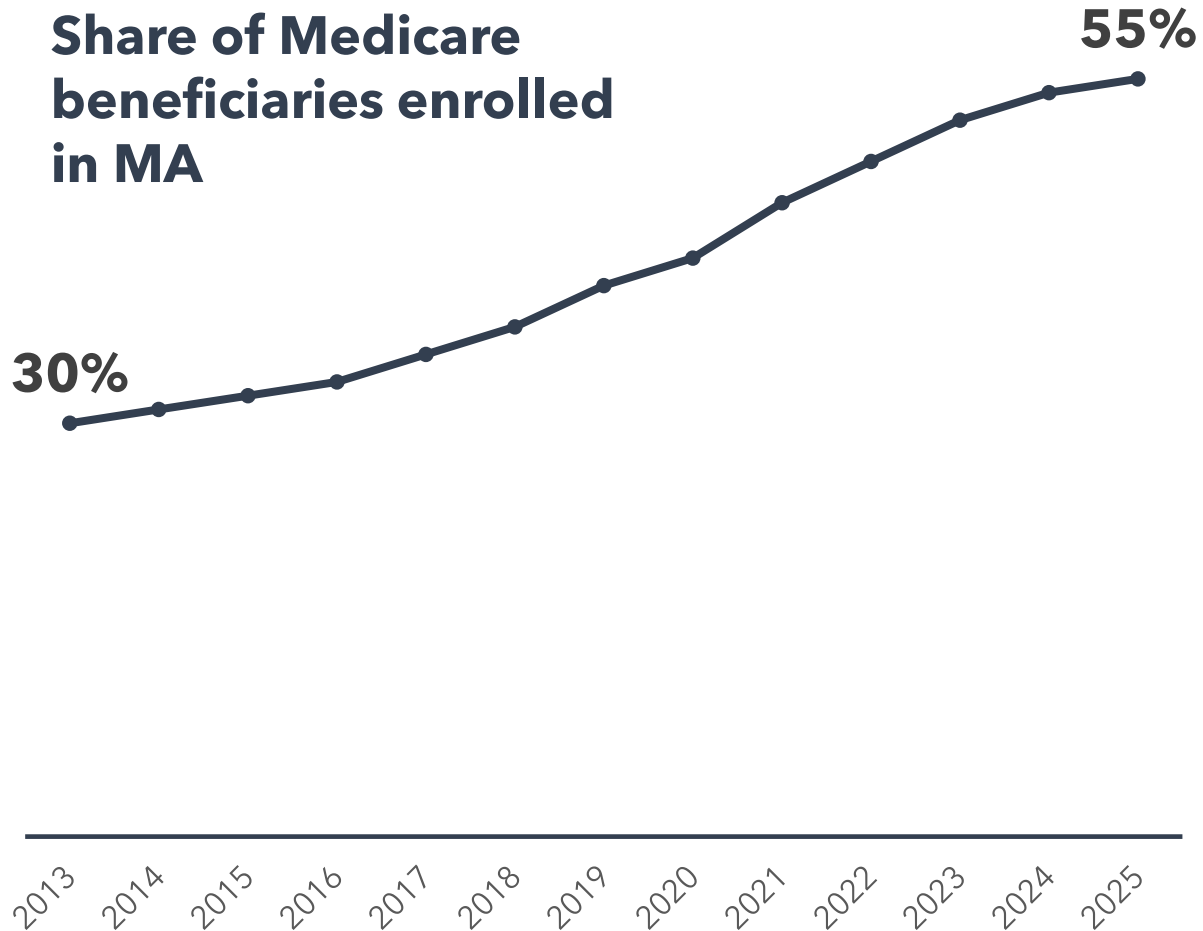
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Presentation roadmap

- 1 Background on MA enrollment and plan incentives
- 2 MA enrollment and hospitals' finances
- 3 MA enrollment and PAC providers' finances
- 4 Discussion

Notes: MA (Medicare Advantage), PAC (post-acute care).

Share of Medicare beneficiaries enrolled in Medicare Advantage (MA) has increased rapidly



- From 2013 to 2025, the share of Medicare beneficiaries enrolled in MA has grown from 30% to 55%
- Both CMS and CBO project continued growth

Note: CBO (Congressional Budget Office). Beneficiaries must have both Part A and Part B coverage to enroll in an MA 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. Congressional Budget Office. 2026. *Baseline projections - Medicare*. Washington, DC: CBO. <https://www.cbo.gov/system/files/2026-02/51302-2026-02-medicare.pdf>. Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2025. *The 2025 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Washington, DC: Boards of Trustees. <https://www.cms.gov/oact/tr/2025>.

MA plans have an incentive to find lower-cost ways to provide care, which can affect providers

- Research shows that MA plans spend less on medical care than FFS, and beneficiaries report broadly similar access and satisfaction with care
- Suggests that at least some of MA plans' lower medical spending is attributable to appropriate reductions
- In theory, MA can affect providers':
 - Patient volume
 - Revenues per patient
 - Costs per patient
- The goal of Medicare is not to ensure provider profitability. At the same time, it is important to understand whether the growth in MA affects provider finances, as beneficiary access to care depends on an adequate supply of providers

Notes: MA (Medicare Advantage), FFS (fee-for-service).

Source: MedPAC's March 2026 report to the Congress and MedPAC's March 2023 report to the Congress.



MA enrollment and hospitals' finances

Approach to analyzing MA and hospitals' finances

- We conducted several complementary analyses:
 - Site visits and interviews with stakeholders
 - Comparison of MA and FFS beneficiaries' lengths of stay
 - Implications of the structure of uncompensated care payments
 - Association between changes in MA penetration and hospitals' all-payer operating margins, revenues, and costs

Notes: MA (Medicare Advantage), FFS (fee-for-service).

In conversations with MedPAC, stakeholders expressed different perspectives on the effect of MA on hospitals' finances

Hospitals' perspective

- Greater difficulty discharging MA beneficiaries to post-acute care
- Increased administrative costs
- Increased denials and downgrades
- MA sometimes pays less than FFS

MA plans' perspective

- Utilization management tools can be clinically appropriate
- Hospitals may be inappropriately billing higher severity services than warranted
- MA plans often match FFS rates and may use other types of compensation to reward providers

Note: MA (Medicare Advantage), FFS (fee-for-service).

MA beneficiaries had longer estimated hospital stays than comparable FFS beneficiaries

MA longer length of stay varied by discharge destination, fiscal year 2024

Category	MA length of stay vs. FFS
All	11.2%
<i>Discharge destination</i>	
Home under self care	4.9%
Home health agency	8.4%
Skilled nursing facility	19.6%
Inpatient rehabilitation facility	32.3%

Note: MA (Medicare Advantage), FFS (fee-for-service). "Discharge destination" reflects the intended discharge destination. Stay-level regressions controlled for the hospital used, services received, comorbidities, and discharge destination. Data for hospitals paid under the inpatient prospective payment systems (IPPS) and critical access hospitals.

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

- In general, longer hospital stays for MA beneficiaries:
 - Increase hospitals' costs per stay
 - Shift costs from MA plans to MA beneficiaries (since MA cost sharing is usually per diem)
 - Do not change IPPS hospitals' revenues per stay (since MA payment is generally per stay)

Structure of uncompensated care (UC) payments leads to misalignment with hospitals' UC costs

- MA plans often match the FFS UC dollar add-on per stay
- All else equal, add-on higher at hospitals with higher shares of MA patients
- This results in hospitals' FFS + MA UC payments becoming misaligned with each hospital's share of UC costs
- MedPAC has recommended an approach to improve targeting of Medicare safety-net payments

Association with a 10-percentage-point increase in hospital's MA share of inpatient stays

FFS UC dollar add-on per stay	+15%***
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Note: MA (Medicare advantage), FFS (fee-for-service). Our regression analyzed the correlation between the share of Medicare inpatient stays that were for MA patients in fiscal year 2024 and the log of fiscal year 2026 FFS UC add-ons per stay (because CMS uses lagged historical stay data to compute the FFS add-on) and controlled for each hospital's share of UC costs (which also affects the FFS UC dollar add-on per stay).

*** Significant using p-values less than 1 percent.

Source: MedPAC analysis of inpatient prospective payment system final rule files and Medicare Provider Analysis and Review data.

Prior research on association between MA and hospitals' finances is limited and mixed

- Hospital industry analysis suggests that MA patients have lower payment-to-cost ratios than FFS patients (American Hospital Association 2025)
- Two regression-based peer-reviewed papers concluded that MA penetration was associated with:
 - Improved financial conditions for rural hospitals (Henke et al. 2023)
 - Lower all-payer inpatient revenue at rural hospitals but higher at urban hospitals (Cataife and Liu 2025)

Note:

MA (Medicare Advantage), FFS (fee-for-service).

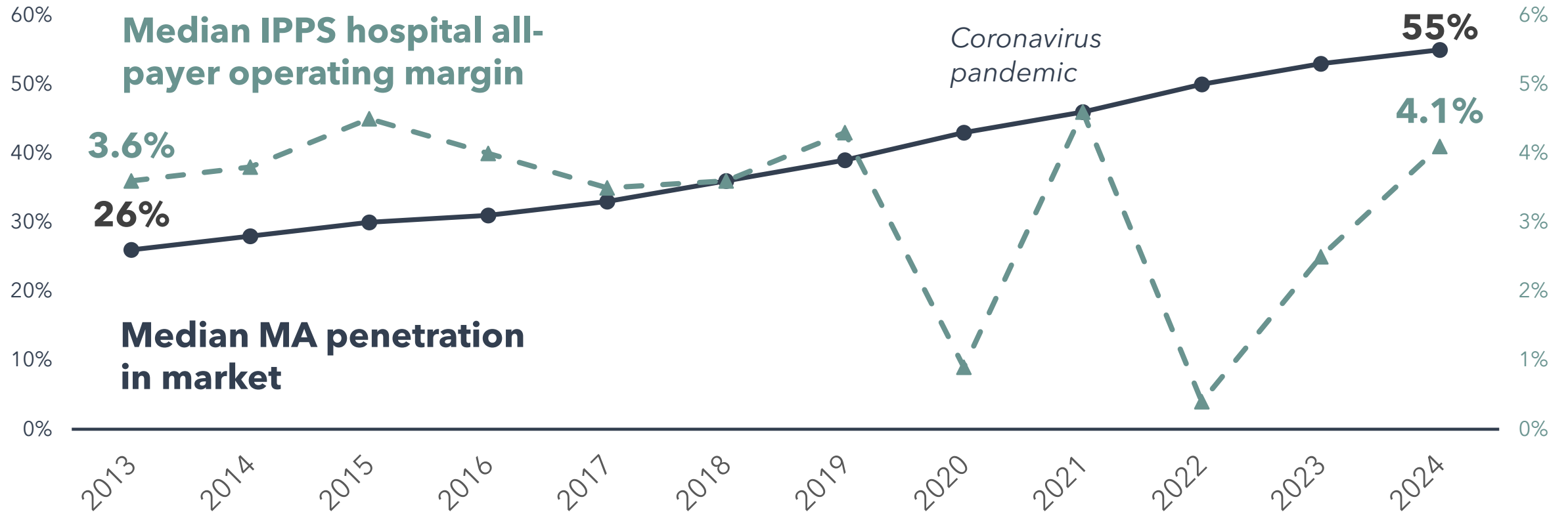
Source:

Hospital Association. 2025. The growing impact of Medicare Advantage on rural hospitals across America. <https://www.aha.org/guidesreports/growing-impact-medicare-advantage-rural-hospitals-across-america>.

Henke, R. M., K. R. Fingar, L. Liang, et al. 2023. Medicare Advantage in rural areas: Implications for hospital sustainability. *American Journal of Managed Care* 29, no. 11 (November): 594-600.

Cataife, G., and S. Liu. 2025. Medicare Advantage penetration and the financial distress of rural hospitals. *Health Economics Review* 15, no. 1 (February 12): 9.

Nationally, no clear relationship between MA penetration and IPPS hospitals' all-payer operating margin



Note: MA (Medicare Advantage), IPPS (inpatient prospective payment systems). "MA penetration in market" refers to the share of Medicare beneficiaries in a health service area (HSA) with Part A and Part B coverage who were enrolled in MA. "All-payer operating margin" excludes reported investment income, donation income, and federal or other coronavirus relief funds. Data are from fiscal years.

Source: MedPAC analysis of hospital cost-report, Medicare enrollment, and National Cancer Institute HSA data.

Estimated association between MA penetration and hospitals' finances: MedPAC's methods

- Main explanatory variable is market-level MA penetration (i.e., the share of eligible beneficiaries enrolled in MA)
 - Markets are NCI-modified health service areas (HSAs), which are groups of counties
- Main outcomes are hospitals' all-payer operating margins, revenues, and costs
 - MA-specific financial data are not available on hospital cost reports
- Study period from 2013 to 2024, excluding 2020 and 2021
- IPPS and critical access hospitals examined separately

Note: MA (Medicare Advantage), NCI (National Cancer Institute), inpatient prospective payment systems (IPPS). "All-payer operating margin" excludes reported investment income, donation income, and federal or other coronavirus relief funds.

Source: MedPAC analysis of hospital cost-report, market basket, and Medicare enrollment data, as well as supplemental data sources.

Estimated association between MA penetration and hospitals' finances: MedPAC's methods (cont.)

- Linear regression estimating the association between market-level MA penetration and hospital finances
- Hospital fixed effects, meaning models use within-hospital changes
- Year fixed effects, state time trends, and some time-varying market controls
- Weighted by hospital bed count
- Standard errors clustered at the market level

Note: MA (Medicare Advantage).

$$Y_{hmt} = \beta MA_{mt} + X'_{mt}\gamma + \alpha_h + \delta_t + \lambda_s \cdot t + \varepsilon_{ht}$$

where

- Y_{hmt} is hospital h in market m 's all-payer margin, revenues, or costs in year t
- β is the association with MA market penetration
- MA_{mt} is the MA penetration in market m (defined as one of ~900 health service areas)
- X'_{mt} is a vector of time-varying market-level controls
- α_h and δ_t are hospital and year fixed effects
- $\lambda_s \cdot t$ are linear state-specific time trends

Estimated association between MA penetration and hospitals' finances: Advantages of MedPAC's methods

- All-payer hospital data allow us to capture the net result from all the potential ways MA can be associated with provider finances
- Controls for all hospital- and market-level factors that are *fixed* over the study period
- Controls for some state and market factors that *changed* over the study period

Note: MA (Medicare Advantage).

Estimated association between MA penetration and hospitals' finances: Limitations of MedPAC's methods

- Estimates should be interpreted as associations, not causal effects
- Cannot control for *all* hospital- and market-level factors that changed over the study period
 - Associations we estimate could be due to factors omitted from our models (due to lack of data)
 - Other literature is also affected by these concerns
 - Different trends between markets with larger vs smaller changes in MA penetration could bias estimates

Note: MA (Medicare Advantage).

Markets with smaller vs larger changes in MA penetration differed in some ways, which are difficult to fully control for

	Quartiles of market-level MA penetration change, 2013 - 2024			
	1st	2nd	3rd	4th
MA penetration change, 2013 - 2024 (pp)	13	23	30	38
<i>Median market characteristic, 2013</i>				
All-payer IP stays per thousand residents	69	82	81	91
Population (in thousands)	51	157	137	107
Uninsured (%)	15	15	18	18
MA penetration (%)	12	21	18	17

Note: MA (Medicare Advantage), pp (percentage point), IP (inpatient). "Markets" were defined at the health service area (HSA)-level, and HSAs were divided into quartiles based on MA penetration changes from 2013 - 2024. Values are median market-level characteristics in each HSA subgroup in 2013. This table includes 945 HSAs, although the table values were very similar when we included only the roughly 900 HSAs with hospitals in our sample. All differences were statistically significant at the 0.1 percent level.

Source: MedPAC analysis of Medicare enrollment, American Community Survey, Small Area Health Insurance Estimates, hospital cost-report, and National Cancer Institute HSA data.

IPPS hospitals: Estimated association between MA penetration and all-payer finances, 2013 - 2024

- Did not find a statistically significant association between MA penetration and all-payer operating margins, revenues, and costs, on average
- Estimated associations of MA penetration and margins were consistently near zero under multiple sensitivity analyses

Association with a 10-percentage-point increase in market MA penetration (no results statistically different from zero)

All-payer margin	0.4pp
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All-payer revenues	-0.5%
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All-payer costs	-0.9%
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Note: MA (Medicare Advantage), IPPS (inpatient prospective payment systems), pp (percentage point). "All-payer margin" excludes reported investment income, donation income, and federal or other coronavirus relief funds. No estimates were significant at the 10 percent level.

Source: MedPAC analysis of hospital cost-report, market basket, and Medicare enrollment data, as well as supplemental data sources.

Estimated association between MA penetration and hospitals' finances: IPPS hospital subgroups and CAHs

- Because changes in MA penetration could have different effects on different types of hospitals, we examined different subgroups
- IPPS subgroups:
 - Included splits by size, system membership, and extent of vertical integration
 - Margins associations were generally consistent with the overall results across all the subgroups
 - Revenues and costs associations were more prone to change
- For critical access hospitals, we found no statistically significant associations, on average

Note: MA (Medicare Advantage), IPPS (inpatient prospective payment systems), CAH (critical access hospital).

Source: MedPAC analysis of hospital cost-report, market basket, and Medicare enrollment data from CMS, as well as supplemental data sources.



MA enrollment and PAC providers' finances

Commissioners expressed interest in learning how the effects of MA vary across settings

- We examine MA and Medicare post-acute care (PAC) providers (SNFs, HHAs, and IRFs)
- PAC providers deliver recuperative care generally after a patient leaves the acute care hospital to help patients recover, regain or maintain function, and safely transition back to the community
- SNFs, HHAs, and IRFs all provide rehabilitation, skilled nursing, and personal care, but the level of care varies, with each having distinct features

Notes: PAC (post acute care), MA (Medicare Advantage), SNFs (skilled nursing facilities), HHAs (home health agencies), IRFs (inpatient rehabilitation facilities).

Financial effects of increasing MA enrollment may differ for PAC providers than hospitals

- Medicare accounts for large share of revenues for IRFs and HHAs
- MA plans may be able to exert more influence on PAC (IRFs, SNFs, HHAs) spending by:
 - Steering patients towards lower-cost PAC settings
 - Negotiating lower payment rates relative to FFS (FFS payments exceed costs in aggregate)
 - Reducing utilization relative to FFS (FFS financially rewards greater use)
- The Commission has long recommended lower FFS payment rates for SNF, HHA, and IRF services; lower MA payment rates for some PAC providers may better align payments with costs

Notes: PAC (post acute care), IRFs (inpatient rehabilitation facilities), HHAs (home health agencies), MA (Medicare Advantage), SNFs (skilled nursing facilities), FFS (fee-for-service)

Source: MedPAC's annual Reports to the Congress on Medicare payment policy <https://www.medpac.gov/document-type/report/>

Stakeholders' perspectives on MA enrollment and PAC providers' finances

PAC providers' perspective

- Delayed discharge from hospital, denied care, and shortened PAC stays
- Unwillingness of some MA plans to contract with providers
- Lower payments for SNF and HHA care

MA plans' perspective

- Efforts to remove prior authorizations for HHA visits
- HHA payments close to FFS per-visit rates
- PAC availability can affect time-to-placement

Note: PAC (post acute care), MA (Medicare Advantage), SNFs (skilled nursing facilities), HHAs (home health agencies), FFS (fee-for-service), IRFs (inpatient rehabilitation facilities).
Source: MedPAC interviews with SNF, IRF, and HHA providers; hospital discharge planners; and MA plans regarding Medicare HHA services; Thomas, K. S., M. Daus, C. Jones, et al. 2025. Prior authorization and utilization management for post-acute home health in Medicare Advantage. *Health Affairs Scholar* (February 4).

Prior research on MA enrollment and PAC finances is limited

- One study found substantial declines in SNF all-payer revenues, costs, margin, and volume associated with higher MA penetration from 2012 – 2019 (Marr and Shen, 2024)
- Other studies primarily focused on PAC use and outcomes in MA relative to FFS
 - Lower SNF and IRF use and greater HHA use among MA enrollees (NORC 2025)
 - Fewer home health visits in MA but similar overall use compared to FFS (MedPAC 2025)
 - Higher rates of denied requests for prior authorizations in IRFs and SNFs under MA (OIG 2022, MedPAC 2024)

Notes: MA (Medicare Advantage), PAC (post acute care), SNF (skilled nursing facility), FFS (fee-for-service), IRF (inpatient rehabilitation facility), HHA (home health agency).

Source: Marr, J., and K. Shen. 2024. Medicare Advantage growth and skilled nursing facility finances. *Health Services Research* 59, no. 3 (June); NORC. 2025. *Analysis of hospital discharges to PAC settings among Medicare beneficiaries*. Washington, DC: NORC; MedPAC. 2025. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC; OIG, Department of Health and Human Services. 2022. *Some Medicare Advantage organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care*. Washington, DC: OIG., MedPAC. 2024. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Methods for analyzing MA and PAC providers' finances

- Applied the regression framework used to analyze hospitals' all-payer finances to SNFs and HHAs
 - Estimated associations between market-level MA penetration and all-payer finances and volume, controlling for market characteristics, provider fixed effects, year fixed effects, and state trends (2013 - 2024)
 - Present results as the change in the all-payer metric associated with a 10-percentage-point increase in MA penetration
- Restricted the study sample to freestanding providers, for which all-payer financial metrics are available (in 2024: 97% of SNFs, 93% of HHAs)
- Regression framework not applied to IRFs since freestanding IRFs only account for a third of all IRFs
 - Provide descriptive information on IRFs' volume and types of stays

Notes: MA (Medicare Advantage), PAC (post acute care), SNFs (skilled nursing facilities), HHAs (home health agencies), IRFs (inpatient rehabilitation facilities). Markets were defined using health service areas from the National Cancer Institute.

Source: MedPAC analysis of Medicare cost reports from CMS.

SNFs: Estimated association between MA penetration and all-payer finances and volume, 2013 - 2024

- Small decrease in all-payer margin was not statistically significant
 - Small and statistically significant decreases in both revenues and costs
- Small and statistically significant decrease in all-payer facility days is consistent with the estimated decrease in revenue and costs

Association with a 10-percentage-point increase in market MA penetration

All-payer margin	-0.1pp
All-payer revenues	-0.6%*
All-payer costs	-0.5%*
All-payer facility days	-0.6%**

Note: SNFs (skilled nursing facilities), MA (Medicare Advantage), pp (percentage point). "All-payer margin" and "all-payer revenue" excludes reported federal or other coronavirus relief funds. Statistical significance levels is indicated with indicates a *p*-value less than 10 percent (*) and 5 percent (**).

Source: MedPAC analysis of SNF cost-report, market basket, and Medicare enrollment data from CMS, as well as supplemental data sources.

HHAs: Estimated association between MA penetration and all-payer finances and volume, 2013 - 2024

- Small decrease in the all-payer margin was not statistically significant
 - Statistically significant decreases in both revenues and costs
 - Estimated decrease in all-payer volume was not statistically significant
- Estimates are larger for HHAs than SNFs, likely reflecting HHAs' higher Medicare share of all-payer volume

Association with a 10-percentage-point increase in market MA penetration

All-payer margin	-0.1pp
All-payer revenues	-2.7%*
All-payer costs	-2.7%*
All-payer volume	-1.8%

Note: HHAs (home health agencies), MA (Medicare Advantage), pp (percentage point). "All-payer margin" and "all-payer revenue" excludes reported federal or other coronavirus relief funds. "All-payer volume" is measured by the number of unique all-payer patients treated by the HHA in the year.
* Significant using p-values less than 10 percent.

Source: MedPAC analysis of HHA cost-report, market basket, and Medicare enrollment data from CMS, as well as supplemental data sources.

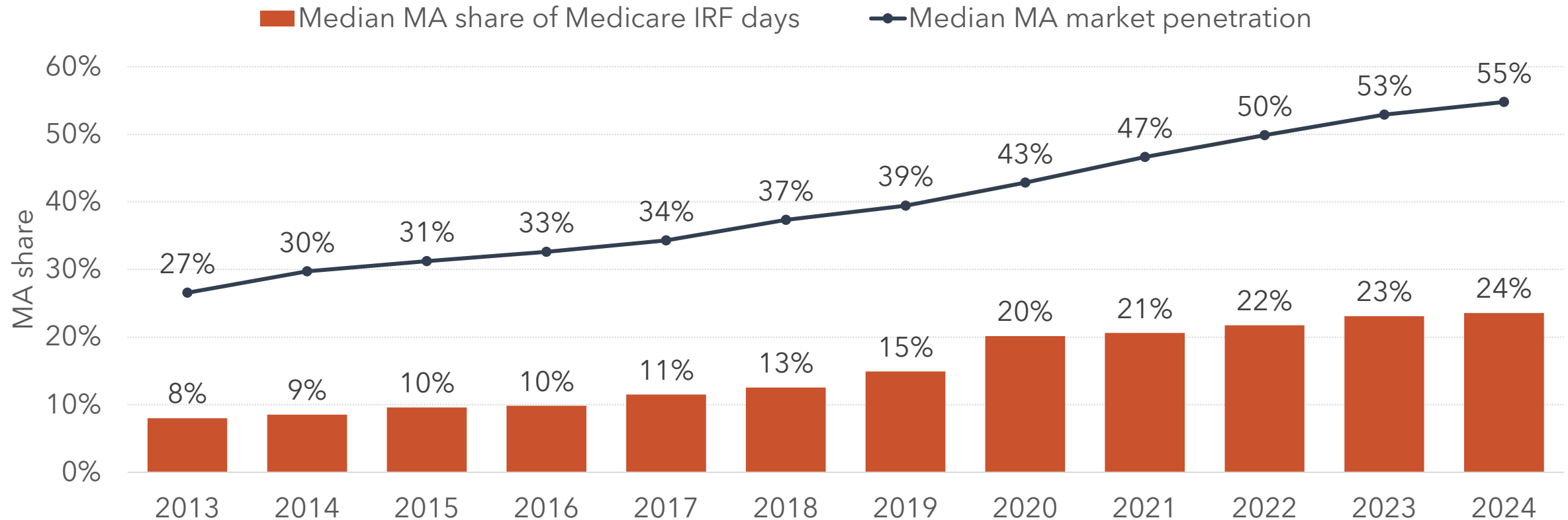
Association between MA penetration and providers' finances varied across some provider subgroups

- Timing: Associations between MA penetration and provider finances were stronger in recent years (2022 - 2024) than in earlier years (2013 - 2019)
- Provider size: Variation by size, with small HHAs tending to have larger negative associations than larger HHAs, while the opposite was found for SNFs
 - Suggests different underlying mechanisms by size that should be further explored
- We did not find statistically significant associations between MA penetration and all-payer margins for SNFs and HHAs when stratifying by rural vs. urban and a measure of provider-plan vertical integration

Notes: MA (Medicare Advantage), HHAs (home health agencies), SNFs (skilled nursing facilities). Provider size was measured by the number of available beds in the SNF's first year in the study sample and the average number of all-payer patients during the study period for HHAs. For SNFs, provider-plan vertical integration was measured by the number of a SNF's long-stay patients that were enrolled in an Institutional Special Needs Plan (I-SNP). For HHAs, we used data from the AHRQ Compendium of U.S. health systems and NAIC Schedule Y reports to calculate the share of HHAs' MA patients enrolled in plans that were vertically aligned with the HHA. (The NAIC does not endorse any analysis or conclusions based upon the use of its data.)

Source: MedPAC analysis of Medicare cost reports, enrollment, home health encounter, home health claims, and MA plan data from CMS, AHRQ Compendium of U.S. health systems, and NAIC Schedule Y reports from 2023.

IRFs: MA share of Medicare IRF days was substantially lower than overall MA market penetration, 2013-2024



Note: IRFs (inpatient rehabilitation facilities), MA (Medicare Advantage). Markets are defined as health service areas (there are approximately 800 health services areas nationally).

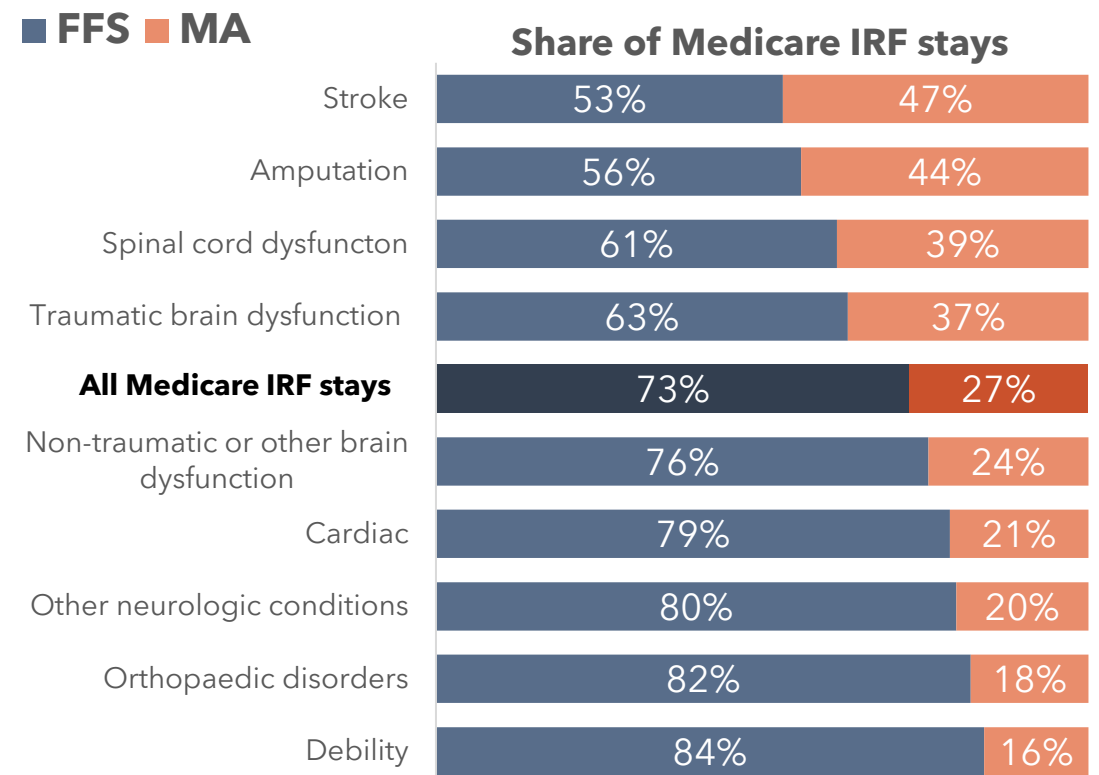
Source: MedPAC analysis of hospital cost-report data from CMS.

MA share of Medicare IRF patients varied by clinical condition at admission, 2024

- MA IRF patients tended to be admitted for stroke, amputations, spinal cord dysfunction, and traumatic brain dysfunction
- Patients with these conditions may have more limited treatment options in other PAC settings

Note: MA (Medicare Advantage), IRF (inpatient rehabilitation facility), FFS (fee-for-service). The figure shows the share of MA and FFS IRF stays for conditions for which there were at least 10,000 Medicare stays in the year (these conditions account for 95 percent of all Medicare stays in the year). "All Medicare IRF stays" includes stays for all conditions. The 60-percent threshold requires that at least 60 percent of IRFs' patients be admitted for treatment of one or more of 13 conditions. IRF Conditions are defined as the Impairment Group Code on admission.

Source: MedPAC analysis of the IRF Patient Assessment Instrument (IRF-PAI) and enrollment data from CMS.



Summary: MA enrollment and providers' finances

- **Hospitals:** We did not estimate a statistically significant association between MA penetration and all-payer operating margins, on average
 - MA inpatient stays tend to be longer and increases in MA enrollment can lead to a misalignment in uncompensated care payments
- **PAC providers:** We did not estimate a statistically significant association between MA penetration and SNFs' and HHAs' all-payer margins, on average
 - MA accounts for a smaller share of IRF use than overall MA penetration, and MA and FFS patients differ in clinical mix
- Our methods have limitations, so results should be interpreted as associations, not causal effects

Notes: MA (Medicare Advantage), PAC (post acute care), SNFs (skilled nursing facilities), HHAs (home health agencies), IRFs (inpatient rehabilitation facilities).

Discussion

- Questions
- Feedback on materials
- This work is intended as an information chapter in MedPAC's June 2026 report to the Congress
- Potential next steps
 - Assess how PAC use varies by beneficiary and preceding hospital-stay characteristics and by payer

Notes: PAC (post-acute care).

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