CHAPTER 2

Assessing payment adequacy and updating payments in fee-for-service Medicare

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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, generally 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. We then make a recommendation about what, if any, update to payments is needed in the policy year in question (for this report, 2027) 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.

Our goal is to make a payment-update recommendation for each sector that balances beneficiary access to high-quality care with good stewardship of taxpayer and beneficiary resources. We use the

In this chapter

best available data to examine indicators of payment adequacy and update information and estimates from prior years to make sure our recommendations for 2027 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, 2024). We use preliminary data from 2025 when available. In developing our update recommendations, we generally apply consistent criteria across settings. However, in analyzing evidence, we acknowledge that factors differ across settings, including data availability, underlying payment policy, and forthcoming policy changes. Therefore, our analyses of payment adequacy, and our recommended updates, will vary to reflect those differences.

The recommendations in this report, if adopted, could significantly change Medicare payment rates to providers. Ideally, payment rates will be set at a level sufficient to support efficient delivery of high-quality care for beneficiaries, thereby helping the Medicare program achieve greater value for its spending. Our focus is on appropriate FFS payment rates that support FFS beneficiaries' access to care, so we do not adjust our update recommendations based on other payers' policies. However, the Commission is aware that FFS Medicare's payment rates have broader implications for health care spending because they are often used as a benchmark for rate setting by other federal and state government programs and private health insurers. Consequently, if Medicare payments are too low to support the 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), Part D (outpatient prescription drug coverage), and ambulatory surgical center services in the March report each year and makes recommendations as appropriate. Those sectors, however, are outside the scope of this chapter. ■

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 Medicare 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 2027). For each sector, we analyze the most recently available data (2024 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 2026. Finally, we recommend how overall FFS Medicare payments for a given sector should change in aggregate for 2027, including whether payments should increase, decrease, or remain the same. We update our payment recommendations annually based on the most recent information and assuming current law remains in place. We avoid speculating on whether and how changes in external circumstances might lead to different recommendations.

Within each of the seven payment systems, we also 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. However, often the Commission's work to address those types of concerns falls outside of the annual payment-update exercise.

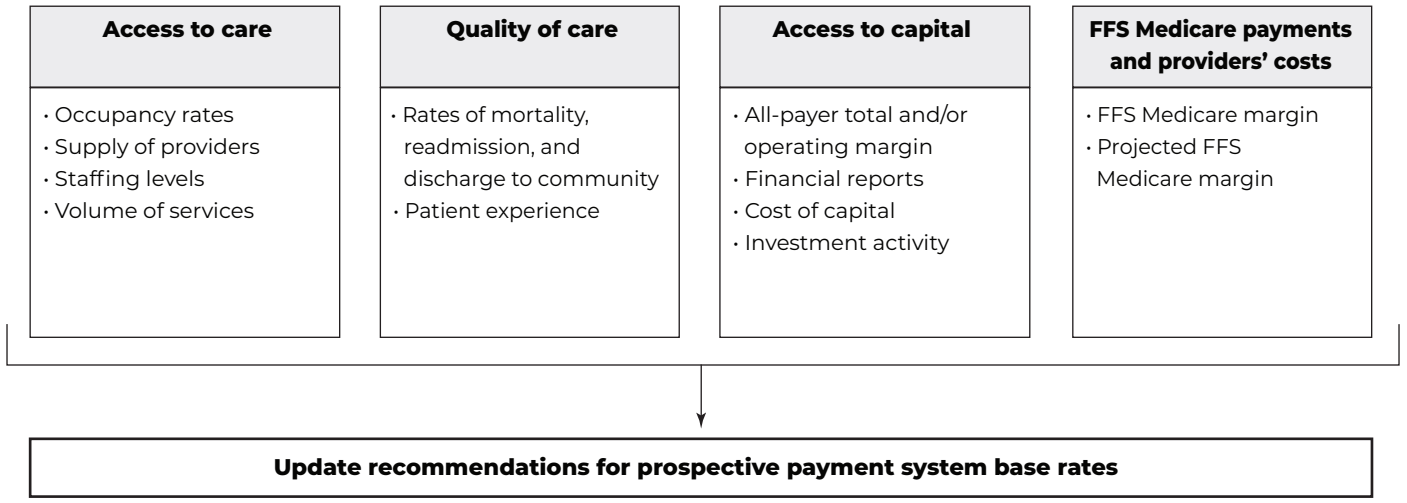
We compare our update and other policy recommendations for 2027 with the base FFS Medicare payment rates specified in law to understand the implications for beneficiaries, providers, and the Medicare program. This chapter details our analytic framework for assessing payment adequacy, as well as our principles underlying that framework.

Notably, our update work and related recommendations are setting specific. That said, in our broader work, the Commission has maintained that, for services that are safe and appropriate to apply across settings, 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 ambulatory settings and when doing so does not pose a risk to access (Medicare Payment Advisory Commission 2023a). 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 recommendations and thus is not discussed in this chapter.

Important context for payment-adequacy analysis

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 FFS 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.

FIGURE 2–1 The Commission's framework for assessing FFS Medicare payment adequacy



Note: FFS (fee-for-service). Payment-adequacy indicators are used as available and applicable. We use multiple measures of margins for different purposes in our payment-adequacy analysis (see text box, p. 55). 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.

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. 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. While the direct and indirect effects of the pandemic on beneficiaries, PHE-related policy changes, and emergency funding for providers have made it challenging to interpret some of our indicators of the adequacy of Medicare's payment rates in the past, our most recent measures of payment adequacy (using data from 2023 and 2024) indicate that the most pronounced effects of the pandemic have passed. Nonetheless, certain changes in practice patterns in response to the pandemic may persist. For instance, many of the temporary telehealth policies intended as an alternative to some in-person appointments during the pandemic were still in effect at the end of 2025. In our 2025 survey of Medicare beneficiaries ages 65 and over, 35 percent of beneficiaries reported using telehealth in the past year; among those who had a telehealth visit, more than 90 percent of beneficiaries expressed satisfaction.[2] We will continue to monitor the impacts of the telehealth expansions as beneficiaries continue to access care via telehealth outside the context of the PHE.

Growth of Medicare Advantage

Enrollment in Medicare Advantage (MA) plans continued to increase in 2025, 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

or policies of other health insurers, including MA plans. Instead, in Chapter 12 of this report, we present our current assessment of the MA program. Additionally, the Commission is continuing to analyze how growth in MA may or may not affect providers' operations and the health care landscape more broadly.

The Commission's principles for assessing payment adequacy

For each respective payment system, the overarching goal of our payment-update recommendation is to determine the aggregate level of payments that balances competing objectives. Payment rates should be sufficient to support efficient delivery of high-quality care for beneficiaries. Payment rates should also maintain fiscal pressure on providers to constrain their costs and to ensure value for taxpayers. Of course, in many sectors there is widespread heterogeneity among providers, with some performing much better on our indicators than others. However, because we are focused on making recommendations to ensure that there are sufficient resources in a payment system overall to support beneficiary access to care, we aim to make recommendations that are appropriate for the sector on average. When different performance from providers creates challenges for beneficiary access to care, we develop targeted policies outside of the payment update to address them.

That said, the Commission is also committed to the accuracy of payments, which might lead us to make additional recommendations that redistribute FFS Medicare payments within a sector to better target them. For instance, in 2018, the Commission recommended that the payment weights in the skilled nursing facility (SNF) prospective payment system (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 2018). 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). Such recommendations are generally developed outside of our update work and, to the extent feasible, integrated into our update recommendations.

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 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 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 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 FFS Medicare payments. Poor access could indicate that Medicare payments are too low, either in aggregate or for certain types of cases. 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 supply, as well as FFS Medicare service volume (and changes in volume) 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 FFS 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 how information for this domain should influence recommendations.

Provider capacity and supply

FFS Medicare beneficiaries' access to care depends in part on providers' ability to meet demand. 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, in many cases, 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. 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 be less indicative of the adequacy of FFS Medicare payments.

Volume of services

The Commission analyzes the volume of services provided to FFS beneficiaries as an indirect 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 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.

Quality of care

The quality of care provided to FFS Medicare beneficiaries is an indirect indicator of the adequacy of FFS Medicare payments. 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 incentive 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 two decades, 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

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 ((revenue – costs) / 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 the Commission are calculated in aggregate across all included providers. We use several definitions of "margin" when assessing fee-for-service (FFS) Medicare payment adequacy:

Fee-for-service 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.

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. ■

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.

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. A sector's all-payer margin can inform our assessment of a sector's overall financial condition and hence its access to capital. Other indicators, such as bond rating and investment in the sector, may also be relevant.

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 FFS Medicare payments in hospitals for which the plurality of patients are FFS Medicare patients. 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. Access to capital may be more reflective of conditions in 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, our primary financial analysis assesses 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 we analyze and 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 2024 (2023 for hospices), due to standard 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] 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 the hospital sector, where coronavirus 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).

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.

Multiple factors can contribute to changes in the FFS Medicare margin, including changes in providers' efficiency and changes in providers' coding practices that may influence payments (but not their costs). 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 FFS 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.

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 2021). 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 health care providers continue to consolidate in order to bolster their negotiating power. 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.

Anticipated payment and cost changes in 2026

For most payment sectors, we estimate a FFS Medicare margin for 2026 to inform our update recommendations for 2027. In general, to estimate payments, we first apply the annual payment updates specified in law for 2025 and 2026 to our base data (2024 for most sectors). We then incorporate the effects of other policy changes that will affect the level of FFS Medicare payments in 2026. To estimate 2026 costs, we first consider the rate of input price inflation or historical cost growth, and, as appropriate, we adjust for other changes that might affect providers' expected costs, including forthcoming policy changes. When considering the change in input price inflation, we refer to the price index that CMS uses for that sector.[6] For each sector of facility providers (e.g., hospitals, SNFs), we use the forecasted increase in a sector-specific index of national input prices, called a "market basket 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, as well as anticipated effects of policy changes. For clinician services, we consider a CMS-derived weighted average of price changes for inputs used to provide clinician services (the Medicare Economic Index), inclusive of productivity changes, but are unable to estimate margins because clinicians do not submit cost reports.

Recommendations for FFS Medicare payment in 2027

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 recommendation is the amount (usually expressed as a percentage change) by which the base payment for all providers in a FFS payment system is changed. Sometimes, these recommendations are expressed relative to the level in the prior year. For example, if the statutory base payment for a sector was $100 in 2026, an update recommendation of a 1 percent increase to the 2026 base payment rate for a sector means that we are recommending that the base payment in 2027 for that sector be 1 percent greater, or $101. Alternatively, they may be expressed relative to current law. For example, if the statutory payment update under current law were 2 percent for 2027 and our recommendation called for an update of 0.5 percent above the current-law amount, that would result in a payment update of 2.5 percent in 2027.

If adopted, the Commission's recommendations may result in an increase, decrease, or no change in 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.

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 continues 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 includes information about 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 needed 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 These indexes are estimated quarterly; we use the most recent estimate available when we conduct our analyses.

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