CHAPTER 1

Improving payment incentives in Medicare

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Chapter summary

Medicare largely relies on three approaches to pay for health care services—stand-alone fee-for-service (FFS) Medicare, alternative payment models (APMs) layered on top of FFS Medicare, and Medicare Advantage (MA). The underlying financial incentives in these three payment approaches differ and can shape provider behavior, influence Medicare spending, and affect the value that beneficiaries and taxpayers receive from the program.

Medicare spending totaled $1.1 trillion in 2024, equivalent to 18 percent of national health care spending and 3.8 percent of gross domestic product (GDP); by 2032, Medicare spending is projected to increase to over 5 percent of GDP, putting pressure on the federal budget, the country's tax revenues, and Medicare beneficiaries' premiums. Increases in the volume and intensity of services and items delivered to beneficiaries (including clinicians prescribing more services and/or more expensive services over time and changes in the use and price of physician-administered drugs) account for the majority of projected spending growth over the next 10 years.

The Commission has supported payment approaches that dampen providers' incentives to increase volume and intensity while maintaining

In this chapter

- Drivers of Medicare's spending growth
- Incentives in Medicare's three main payment approaches
- Commission recommendations to improve Medicare's incentives
- Appendix 1-A: Quality incentives in Medicare

quality of care by making providers accountable for their patients' health care spending and care quality. When developing recommendations, the Commission is guided by the following principles:

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

Each of Medicare's three approaches to paying for health care creates different sets of incentives. Some of these incentives are inherent in the payment approaches, and others reflect current design decisions. All three approaches play an important role in Medicare, and all could be improved to better promote efficient, high-quality care, such as through many of the Commission's prior recommendations highlighted in this chapter.

Some design features are present in more than one of Medicare's payment approaches. For example, although MA plans receive monthly payments per enrollee, they often pay the providers who care for their enrollees on a FFS basis. Although there are commonalities across Medicare's three payment approaches, we focus this chapter on the features that differentiate these approaches.

FFS Medicare

In 2025, less than a fifth of full-benefit Medicare beneficiaries (i.e., beneficiaries enrolled in both Part A and Part B) received their coverage through stand-alone FFS (that is, in FFS Medicare without assignment to an APM). For services provided to these beneficiaries, Medicare typically makes a separate payment for each service or item a beneficiary receives. This approach generally gives health care providers an incentive to increase the volume and intensity of services they provide, though this incentive can be reduced by bundling services, such as in ambulatory payment classifications under FFS Medicare's outpatient prospective payment system. FFS financially rewards providers who furnish more care than might be necessary and generally financially disadvantages providers who furnish lower-paid services instead of higher-paid ones. The result may be Medicare spending and beneficiary cost sharing that are higher than necessary.

Some features of FFS Medicare reflect current design choices rather than inherent characteristics. For example, in FFS Medicare, beneficiaries who do not have supplemental coverage through an employer, Medigap, or Medicaid may face relatively high cost sharing since there is currently no cap on FFS beneficiaries' out-of-pocket spending. (While cost sharing can serve as a useful tool since it results in reduced utilization of low-value services, it can also inadvertently hinder access to high-value services.) Similarly, the approaches that FFS Medicare uses to set clinicians' payment rates, adjust wages geographically, and measure and pay for practice expenses reflect current design decisions and could be improved.

Setting prices in FFS payment systems is inherently challenging because tying prices to average costs can often cause prices to be too high, while tying prices to marginal costs can result in prices that are too low. Payment rates tied to average costs ensure that providers can cover fixed costs. However, they create strong incentives to increase volume when those prices exceed providers' marginal costs. Setting prices for new technologies poses additional challenges because cost data may be limited or unreliable and payment rates may inadvertently encourage overuse (if set too high) or underuse (if set too low).

Relative FFS payment rates can become misaligned across services and settings due to the use of multiple payment systems with different data sources and formulas. As a result, FFS Medicare may pay more for the same service depending on the site of care, and some services may become mispriced relative to others, distorting incentives.

Alternative payment models

APMs were introduced on a large scale beginning in 2012 and now cover about one-quarter of all full-benefit Medicare beneficiaries. Most beneficiaries in APMs are attributed to total-cost-of-care models, such as the Medicare Shared Savings Program. A key feature of these models under their current design is passive beneficiary attribution, which assigns FFS beneficiaries to APM-participating providers based on where they receive the plurality of their primary care. (This approach complicates beneficiary engagement and CMS's setting of spending targets.) Models then hold providers accountable for the total Part A and Part B spending of their attributed Medicare beneficiaries and reward or penalize providers based on performance relative to a spending target. (APMs generally do not hold providers accountable for their FFS

beneficiaries' Part D drug spending, which is paid for through separate private insurance plans.)

Most beneficiaries are in APMs that aim to encourage more efficient care delivery by making incentive payments if providers generate spending below CMS's spending target (or levying financial penalties if providers exceed spending targets). This arrangement creates an incentive for providers to use a more efficient mix of services and reduce the use of low-value care. Providers may use incentive payments to support infrastructure that improves care coordination. Beneficiaries in APMs often receive additional services—such as enhanced care management—that are not available in stand-alone FFS Medicare. However, APMs generally lack tools to control payment rates for individual services and items, including Part B drugs, and instead rely on providers' willingness to respond to incentives by choosing lower-cost options. Providers' responsiveness to incentives may vary based on the design of the APM, the extent to which provider organizations in APMs transmit model incentives to individual clinicians, and the scale of bonuses relative to clinicians' traditional FFS revenues. Evaluations find that some APMs generate net increases in spending for Medicare (after accounting for bonus payments); some have no statistically significant impact on spending; and some yield modest net savings for Medicare, emphasizing that design is crucial to APMs' success.

Medicare Advantage

MA plans receive monthly payments for each enrollee, adjusted for the enrollee's recorded health conditions and demographic characteristics. This payment structure creates strong incentives to manage utilization, coordinate care, and reduce unnecessary services. MA plans also have powerful tools such as prior authorization and network design to influence care patterns.

Our analyses of MA plans' projected medical spending indicate that their spending on medical services (before including plans' administrative costs) is 15 percent to 18 percent below what would have occurred in FFS Medicare. However, under current payment policy, Medicare spends more for MA enrollees than it would have if the same enrollees were enrolled in FFS Medicare. The key drivers of higher MA payments are favorable selection and diagnostic coding intensity—pricing errors that cause CMS's risk-adjustment system to set payments higher than intended for MA enrollees, thereby increasing Medicare's payments to plans. These factors, among others, have made it difficult to achieve budgetary savings from MA. However, the higher

payments to MA plans allow them to offer additional benefits not available under FFS Medicare—including lower cost sharing, an out-of-pocket maximum on covered services, and lower premiums—which are valued by enrollees.

Improving incentives across all three payment approaches is essential

Medicare's three main payment approaches create different incentives that shape provider behavior, influence spending growth, and affect the value delivered to beneficiaries and taxpayers. FFS Medicare gives providers an incentive to increase the volume and intensity of services they provide; APMs encourage efficiency, but their success has been modest and contingent on their design; and MA has strong cost-management incentives but currently costs Medicare more than what would have been incurred in FFS, stemming largely from issues with risk adjustment. Improving all three approaches is essential to ensure that Medicare spending supports high-quality, efficient care and remains sustainable in the face of rising enrollment and increasing service intensity. Improving the accuracy of FFS Medicare's prices is important for all three approaches since they are not only used to pay providers participating in FFS Medicare but are also the basis for payment in APMs and MA.

The Commission regularly reviews Medicare's various payment systems with the goal of ensuring that they are structured to create incentives for the efficient practice of medicine. When we find that payment systems cause financially driven distortions to the mix of services and items that providers deliver or to the choice of clinical setting, we try to identify changes to payment systems that will dampen or eliminate such perverse incentives. The Commission's recommendations are generally aimed at reducing FFS Medicare incentives that lead to the overprovision of unnecessary services and decreasing APMs' and MA plans' incentives to engage in behaviors that inflate their payments from Medicare. The Commission will continue to evaluate these payment approaches and recommend refinements that promote efficient care delivery, protect beneficiary access to care, and ensure prudent use of taxpayer resources. ■

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, and Medicare Advantage (MA) plans operated by private insurers. Each of these payment approaches creates different sets of incentives—some that are inherent in the payment approaches and others that reflect current design decisions and could be modified. Medicare's annual survey of beneficiaries suggests that those in FFS and MA experience broadly similar levels of access to care and satisfaction, and evaluators usually do not find major differences in quality in APMs and stand-alone FFS (Medicare Payment Advisory Commission 2026, Medicare Payment Advisory Commission 2021b). Yet the three payment approaches involve different trade-offs.

FFS Medicare allows beneficiaries to receive care from any provider that participates in the program, with very limited utilization management. While this may promote broad access, it also contributes to fragmented care and higher utilization of both high- and low-value services. If not coupled with other coverage, FFS Medicare has no limit on total annual cost sharing under its current design—exposing beneficiaries to substantial financial risk.

APMs are typically based on FFS but can use a variety of approaches to hold providers accountable for a patient's spending and care quality for a year or a shorter episode of care following a triggering clinical event. Due to heterogeneity in specific models' parameters, making generalizations about the effects of APMs is difficult. That said, after bonus payments, APMs usually do not yield net savings for Medicare. However, beneficiaries in APMs typically receive extra services not available in stand-alone FFS Medicare (e.g., closer care management), and some successful APMs have reduced Medicare spending (even after bonus payments) without adversely affecting quality, demonstrating their potential.

MA plans include strong incentives and tools to achieve lower average medical spending relative to FFS, but under current payment policy, MA costs the Medicare program more per beneficiary than stand-alone FFS Medicare. However, the higher payments to MA plans allow them to cover more types of services—including vision, dental, and hearing services—and to pay for a greater share of beneficiaries' cost sharing (including for Part D coverage).

To help CMS refine FFS Medicare, APMs, and MA, the Commission reviews Medicare's payment approaches and makes recommendations. The Commission has supported payment approaches that dampen providers' incentives to maximize spending by making providers accountable for their patients' health care spending and care quality. These approaches have been tried across MA, APMs, and, in a more limited way, in some parts of FFS Medicare (e.g., Medicare's diagnosis-related group (DRG) payments to hospitals).

When developing recommendations, the Commission is guided by three principles:

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

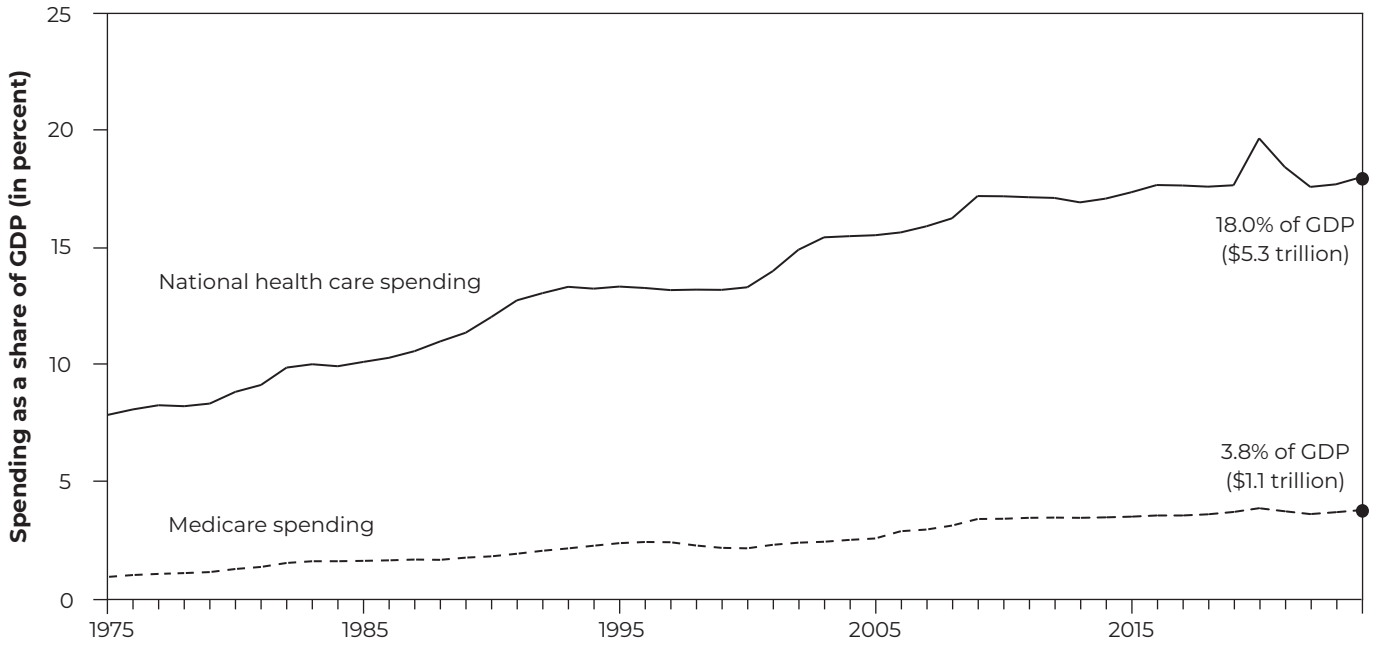
In this chapter, we first review Medicare spending trends to help contextualize why encouraging efficiency in Medicare is so important, and then we explore the incentives for health care providers in stand-alone FFS Medicare, APMs, and MA and how these incentives can be improved. (We generally do not discuss drugs, which are nevertheless an important driver of spending and health outcomes, since Medicare's payment approaches for drugs differ substantially from FFS Medicare, APMs, and MA, and past APMs generally have not targeted drugs. We defer analogous discussions of the incentives created by Medicare's approaches to paying for drugs to potential future work.)

Drivers of Medicare's spending growth

Medicare spending totaled $1.1 trillion in 2024, equivalent to 3.8 percent of GDP (Figure 1-1).

FIGURE 1–1

Medicare spending constitutes a growing share of U.S. GDP



Note: GDP (gross domestic product). "Medicare spending" includes spending for beneficiaries in both fee-for-service (FFS) Medicare and Medicare Advantage (MA). Pandemic relief funds are counted as national health care spending rather than Medicare spending because they were meant to offset pandemic-related revenue losses from all payers, not just Medicare. Medicare spending excludes COVID-19 Accelerated and Advance Payments (short-term loans paid to providers in 2020 that were subsequently repaid) since this graph shows expenditures on an incurred basis rather than a cash basis.

Source: MedPAC analysis of CMS's national health expenditure data (projected data released in June 2025 and historical data released in January 2026), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html.

By 2032, Medicare spending is projected to increase to over 5 percent of GDP (data not shown). This spending growth puts pressure on the federal budget, the country's tax revenues, and Medicare beneficiaries' premiums.

As shown in Table 1-1, several factors will contribute to expected increases in Medicare spending over the next decade. (In Table 1-1, Medicare's Part A and Part B payments to MA plans are captured in these respective rows.[1]) One driver is general inflation, the projected effect of which is excluded from Table 1-1 since it is not a factor that health policymakers can easily influence. A second driver of Medicare's projected spending growth is increasing enrollment in the program as the baby-boom generation continues to reach Medicare's eligibility age. Medicare's payment rates are not projected to grow faster than inflation (shown by the fact that the numbers in the first column of Table 1-1 are negative). Changing beneficiary demographics are also not expected to be a driver of Medicare spending growth over the next decade (although demographics will eventually accelerate Medicare spending per beneficiary as enrollees from the baby-boom generation age). Instead, Table 1-1 shows that the spending driver expected to exert the most influence in the next 10 years is growth in "other" factors—such as growth in the volume and intensity of the services and items that providers deliver, including growth in the average price Medicare pays for Part B drugs and biologics.

TABLE 1–1

Medicare Trustees' projections of the influence of different drivers of FFS Medicare's and MA's projected spending growth (after accounting for general inflation), 2025–2034

	Average annual percent change in:				
Medicare Part	**Medicare payment rates for services (minus inflation)**	**Number of beneficiaries**	**Beneficiary demographic mix**	**Other**	**Medicare's projected 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: FFS (fee-for-service), MA (Medicare Advantage). Table includes beneficiaries in both FFS Medicare and MA. Medicare's Part A and Part B payments to MA plans are captured in those respective rows. "Medicare payment rates for services" reflects Medicare's annual updates to payment rates (not including inflation, as measured by the Consumer Price Index for All Urban Consumers), 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" refers to the residual after the other three factors shown in the table (Medicare payment rates for services, number of beneficiaries, and beneficiary demographic mix) are removed. "Medicare's projected spending" is the product of the other columns in the table, but components may not produce totals in this column due to rounding.

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

As shown in Table 1-1, Medicare's Trustees project that spending on Medicare Part B services (which include clinician services in all settings, hospital outpatient services, physician-administered drugs, and other types of services) will grow faster than spending on Part A (which covers inpatient hospital stays, skilled nursing facility (SNF) stays, hospice stays, and other services). This projection is a continuation of a trend we have observed in recent years: Between 2015 and 2024, real (inflation-adjusted) spending per beneficiary on Part A declined 2.2 percent, while spending per beneficiary on Part B climbed 19 percent (Figure 1-2, p. 12).

As shown in Figure 1-3 (p. 13) (which displays only FFS Medicare spending, since MA encounter data are less complete), physician-administered Part B drugs (a category of drugs that includes treatments for cancer, macular degeneration, and arthritis, for example) have been the fastest-growing component of Part B spending in recent years (although spending on Part B physician-administered drugs started at a lower base). (Spending on physician-administered drugs has also contributed to growth in the line in the figure.) The growth in the average annual payment per Part B drug reflects (1) increases in the prices of existing drugs; (2) the launch of new, higher-priced drugs; and (3) shifts in the mix of drugs (Medicare Payment Advisory Commission 2025a).[2] In general, Medicare pays for drugs in a very different way than it pays for other medical items and services.

Incentives in Medicare's three main payment approaches

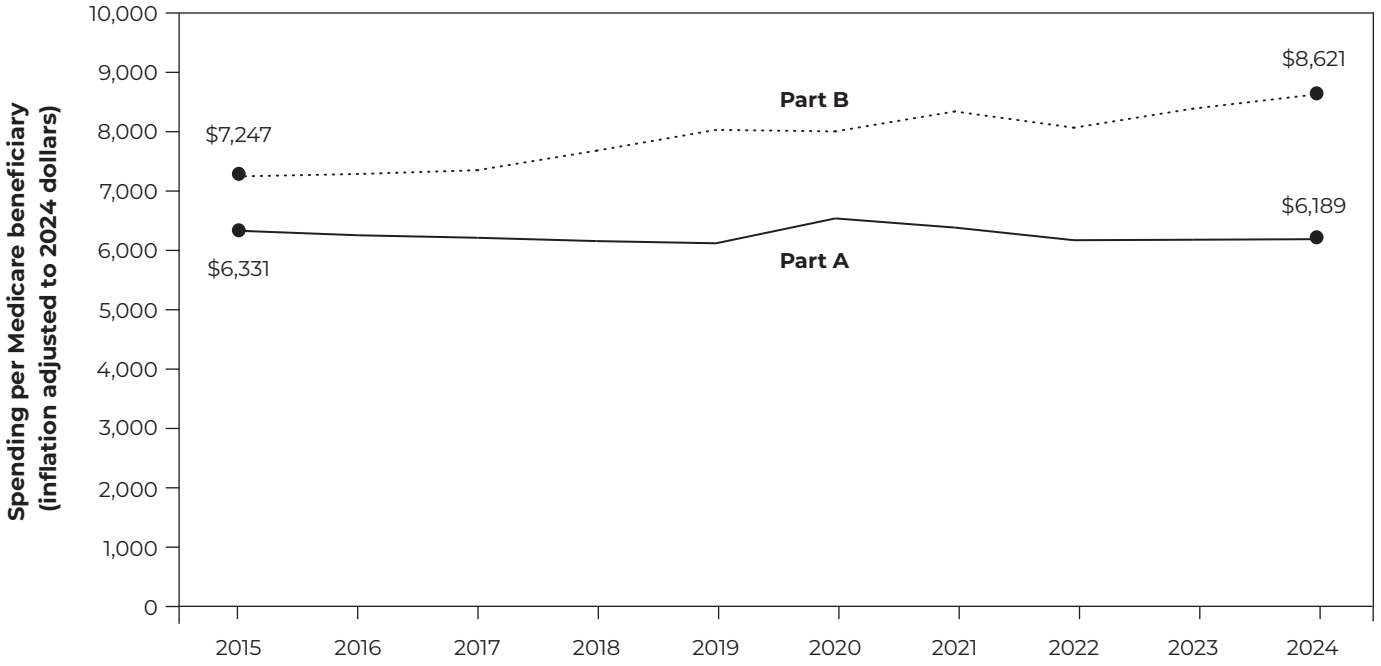
To lower Medicare spending per beneficiary (or at least slow its growth), policymakers must either change Medicare's payment formulas or try to influence the volume and intensity of covered services and items that Medicare beneficiaries receive. Payment policy is a primary (though not the only) lever available to policymakers to influence this latter factor.

Policymakers have different levers for affecting payment rates and volume and intensity in FFS Medicare, APMs, and MA:

- ***Basic design.*** Paying for each item or service, as in FFS Medicare, typically incentivizes providers to furnish more items and services, though this

FIGURE 1–2

Inflation-adjusted spending per beneficiary in FFS Medicare and MA grew faster for Part B than Part A, 2015–2024



Note: FFS (fee-for-service), MA (Medicare Advantage). Figure includes enrollees in both FFS Medicare and MA and shows Medicare program spending, not including spending financed by beneficiary premiums or cost sharing. (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 for calendar years), divided by the number of beneficiaries enrolled in that part. Part B services include clinician services in all settings, hospital outpatient services, physician-administered drugs, and other services. Part A services include inpatient hospital stays, skilled nursing facility stays, hospice stays, and other types of services.

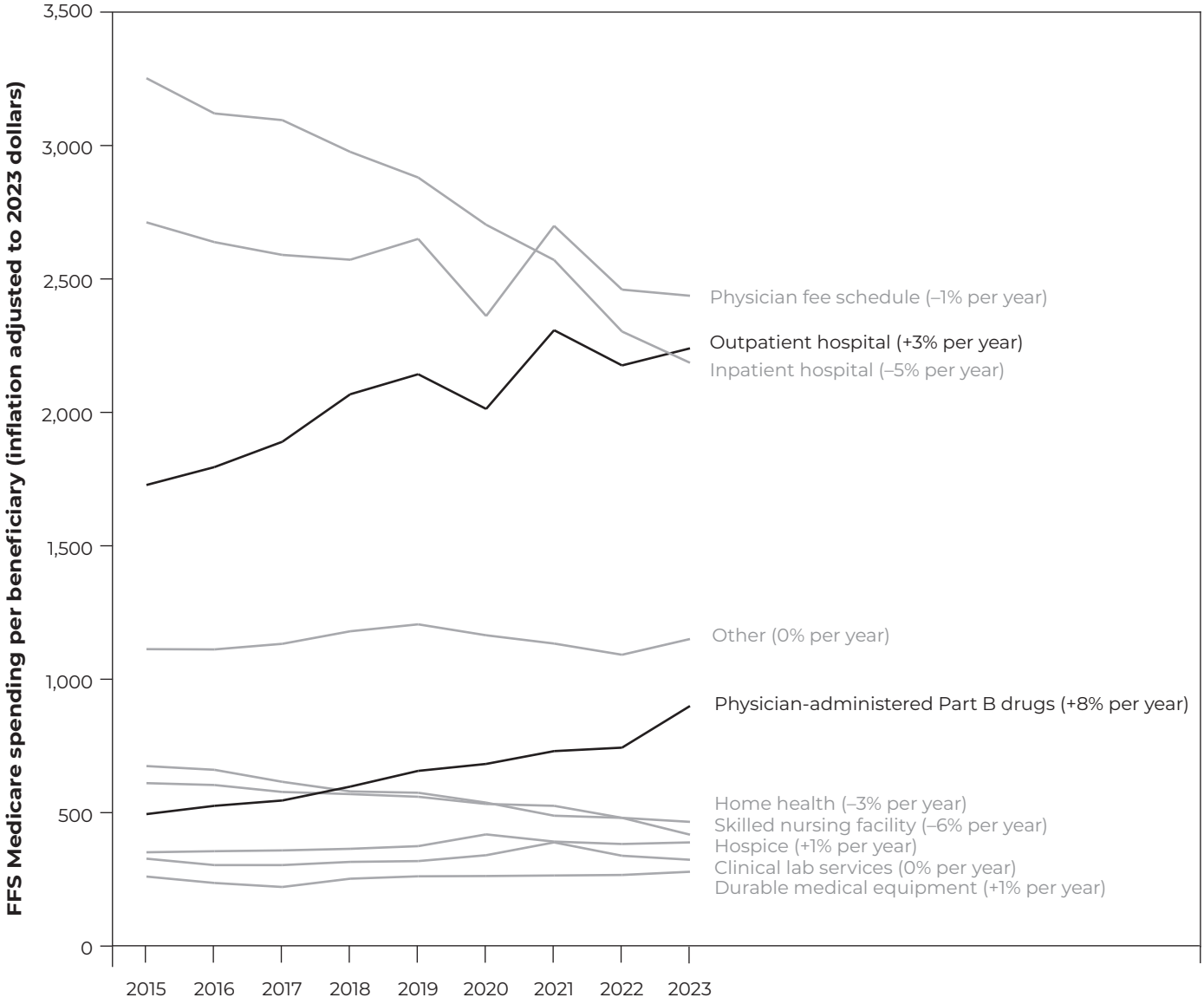
Source: MedPAC analysis of data from the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

incentive can be reduced by bundling services, such as through ambulatory payment classifications under FFS Medicare's outpatient prospective payment system. Per person payments (i.e., capitated payments with adjustments for recorded health conditions), which are used in MA and some APMs, create incentives to provide fewer items and services. However, because each eligible diagnosis is assigned a predetermined payment amount, per person payments typically increase when providers and plans document additional health conditions for each patient. Thus, per person payments incentivize providers and plans to spend time and resources on coding patient diagnoses to maximize their risk-adjusted payments per beneficiary, which can lead to pricing distortions.

- ***Overall payment rates.*** Payments that are too high can lead to overprovision of care (in FFS Medicare), unintended subsidies (in APMs and MA), and higher-than-necessary costs to beneficiaries and taxpayers. Payments that are too low can threaten provider or plan participation, which could reduce beneficiaries' access to care and limit the added benefits that APMs and MA plans provide; reduced participation in APMs and MA could further result in the Medicare program missing out on potential efficiencies that those payment models might eventually generate. Payment rates that are too low can also result in lower-quality health care and worse patient outcomes (Wu and Shen 2014). In many cases, there is not an objectively "right" price.

FIGURE 1–3

Inflation-adjusted FFS Medicare spending per beneficiary grew fastest for physician-administered drugs covered under Part B, 2015–2023



Note: FFS (fee-for-service). For each line, the 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. Part B spending on physician-administered drugs grew more rapidly in 2023, largely due to increased spending on COVID-19 vaccines and skin substitutes (not shown) (Medicare Payment Advisory Commission 2025a). "Other" includes Part B payments to ambulatory surgical centers, ambulance providers and suppliers, federally qualified health centers, rural health clinics, critical access hospitals, and dialysis facilities; spending trends for each of these various "other" components vary from the aggregated "other" total shown above. 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).

- ***Relative payment rates.*** FFS Medicare payments that are too high for some services relative to others can lead to unintended shifts in which services are delivered and in what clinical setting they are provided. Payments that are too high for some MA plans or APM participants relative to others can produce unwarranted competitive advantages.

We describe the features of Medicare's three main payment approaches and the incentives they create in the section that follows. Some design features are present in more than one of these payment approaches. For example, although prior authorization is commonly used in MA plans, it is now starting to be used more in FFS Medicare. And although MA plans receive monthly payment rates per enrollee, they can pay the providers who care for their enrollees on a FFS basis.

A common thread running through all three of Medicare's payment approaches (FFS Medicare, APMs, and MA) is that they are all susceptible to strategic behavioral responses that can inappropriately increase payments (sometimes known as "gaming"). For example, health care providers paid through FFS Medicare can maximize their Medicare revenues by offering beneficiaries services that are of limited value. Providers can also intensively code services delivered or strategically code patients to increase revenue in certain FFS payment systems. Similarly, under current policy, MA plans and APM participants can increase the payments they receive per beneficiary by encouraging their contracted providers to document as many diagnoses as possible in beneficiaries' medical records. MA plans and APM participants can also strategically curate their provider networks to improve their cost and quality performance on paper without actually changing cost or quality outcomes of individual beneficiaries.

Another commonality across Medicare's three payment approaches is that they all try to incentivize providers to perform well on health care quality measures (see Appendix 1-A on quality incentives in Medicare, p. 26). However, incentivizing providers to improve care quality is challenging. The Commission has recommended quality-incentive programs that would more closely tie payment to measures of clinical outcomes, patient experience, and value (Medicare Payment Advisory Commission 2018a).

Although there are some commonalities across Medicare's three payment approaches, we focus this chapter on the features that differentiate these approaches. We also try to separately identify features that are inherent in a given type of approach versus merely reflective of current design decisions or market dynamics and thus could change in the future. Before we begin this discussion, a diagram describing how funds flow to and from health care providers in FFS, APMs, and MA may provide a helpful orientation for some readers (Figure 1-4).

Incentives in stand-alone FFS Medicare

The Medicare program has used a FFS payment approach since the program began in 1966. In 2025, less than a fifth of full-benefit Medicare beneficiaries (i.e., beneficiaries enrolled in both Part A and Part B) received their coverage through stand-alone FFS (that is, in FFS without assignment to an APM).

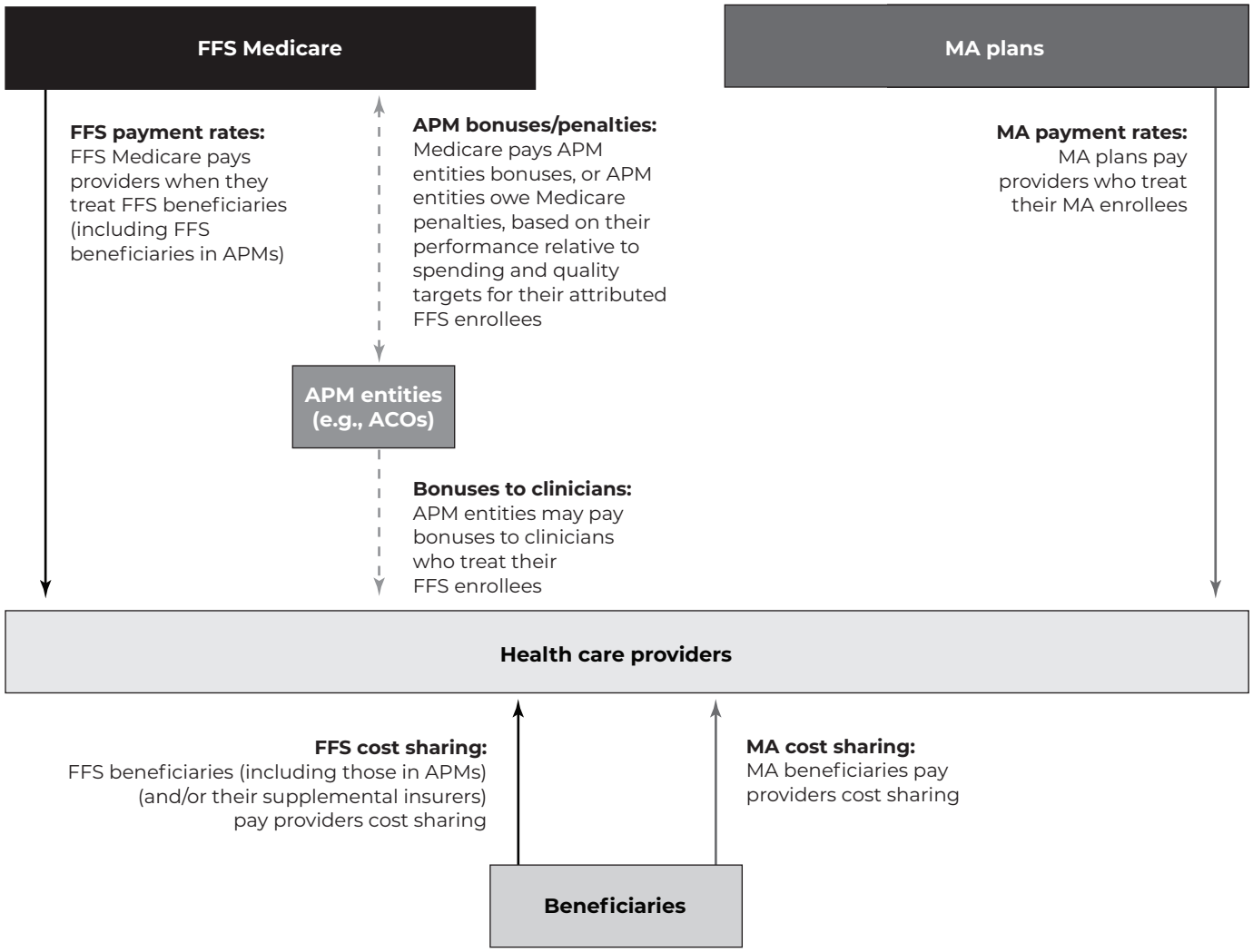
Basic design

For beneficiaries with FFS Medicare coverage, Medicare typically makes a separate payment for each service, item, or stay that a beneficiary receives. This approach requires CMS to set prices for most services covered under Part A and Part B. (An exception is physician-administered drugs covered under Part B; for most of these drugs, FFS Medicare is a "price taker"—paying drug manufacturers their average sales price plus 6 percent.[3])

Making a separate payment for each service, item, or stay that a beneficiary receives generally gives health care providers an incentive to increase the volume and intensity of services they provide, though this incentive can be reduced by bundling services, such as in ambulatory payment classifications under FFS Medicare's outpatient prospective payment system. The incentive to increase volume and intensity is a drawback of FFS payment. FFS financially rewards providers who furnish more care than might be necessary and financially disadvantages providers who deliver lower-paid services (which are generally less profitable) instead of higher-paid ones. For example, clinicians currently receive higher payments for administering a higher-priced Part B drug than a lower-priced one. The result may be higher-than-necessary Medicare spending and beneficiary cost sharing (Medicare Payment Advisory Commission 2025b). At the same time, encouraging providers to

FIGURE 1–4

Flow of funds for health care providers delivering Part A and Part B services in FFS Medicare, APMs, and MA



Note: FFS (fee-for-service), APM (alternative payment model), MA (Medicare Advantage), ACO (accountable care organization). MA plans may have their own APM arrangements with health care providers (not shown). If an MA enrollee obtains care from an out-of-network provider who participates in Medicare, the provider receives the FFS Medicare payment amount. Beneficiaries in FFS (including those in APMs) and MA may have supplemental health insurance coverage (e.g., through an employer, through their state's Medicaid program, or that they purchased on their own) that pays some or all of their cost sharing. The flow of funds for Part D coverage is not shown.

Source: MedPAC analysis.

furnish more services can increase access to health care and reduce providers' disincentives to treat sicker patients (who may need more services).

Some aspects of FFS Medicare reflect design decisions that could be changed. In FFS Medicare, beneficiaries who do not have supplemental coverage through an employer, Medigap, or Medicaid face relatively high cost sharing since there is currently no cap on FFS beneficiaries' out-of-pocket spending. While cost sharing can serve as a useful tool since it results in reduced utilization of low-value services, it can also inadvertently hinder access to high-value services (RAND Corporation 2006).

Under its current design, FFS Medicare also has far lower administrative costs than private plans do since it uses standardized processes for claims submission and adjudication, employs relatively few utilization-management tools, and spends very little on marketing, for example. CMS's actuary estimates that the administrative costs per beneficiary in FFS are 0.2 percent of FFS Part A and Part B spending (Centers for Medicare & Medicaid Services 2025a). We verified this estimate using CMS's budget-justification document, finding that CMS's FFS-related expenses were 0.2 percent of FFS Part A and Part B spending in 2024 (Centers for Medicare & Medicaid Services 2025b).[4] In comparison, MA plans projected that 14 percent of their expenses for Part A and Part B spending in 2024 were for administrative costs and profit (Medicare Payment Advisory Commission 2026).[5]

Overall payment levels

Medicare increases or decreases the payment rates in each of its various FFS payment systems each year using inflationary factors or percentages specified in law. As required by law, the Commission annually makes payment-update recommendations to the Congress for providers paid under FFS Medicare's payment systems. As described in our annual March report to the Congress, the Commission assesses a wide range of indicators and seeks to balance the need for Medicare to be a prudent steward of taxpayer funds with the need to ensure that FFS Medicare beneficiaries maintain relatively good access to health care. At the extremes, payments that are set too high could encourage providers to prescribe unnecessary services, and payments that are set too low could cause providers to stop providing services to FFS Medicare beneficiaries.

Setting the "right" payment rate for a service (such that the payment is closely aligned with cost) is difficult since there are two concepts of cost to consider: the average cost and the marginal cost of delivering a service.

- *Average cost* captures both the fixed costs and variable costs involved in delivering a service, so it includes expenses that have already been incurred (e.g., a portion of the cost of purchasing a machine three years ago) and expenses that will be incurred only if a service is actually provided (e.g., the cost of the health care staff labor needed to operate the machine this Friday).
- *Marginal cost* refers only to the costs associated with producing an additional unit of a service—that is, the costs that vary with volume (e.g., labor costs).

FFS payment rates generally try to reflect average Medicare-allowed costs rather than marginal costs. Paying for the average cost of a service means that the full cost of the service, on average, is reimbursed, which gives providers an incentive to make investments in fixed expenses like equipment. Average cost will vary across providers, even if they are in the same market, due to differing cost structures; for example, providers with lower volume tend to have higher average costs. Thus, even when FFS payment rates are adjusted for local market features, some providers' average costs will exceed payment rates while other providers' average costs may fall below payment rates.

Payment rates that reflect average costs can create a strong incentive to increase volume because a provider's profit from furnishing an additional service is the difference between the payment rate they will receive for that service and their marginal cost of providing that service. Since average costs are generally higher than marginal costs, payment rates based on average costs give providers an incentive to increase volume to increase their profits—especially for services that have high fixed costs but relatively low marginal costs (e.g., advanced imaging).

Setting payment rates tied to marginal costs would eliminate this problematic incentive. However, payment rates tied to marginal costs are generally undesirable because they reduce incentives for investment, may be insufficient for providers to continue operating, and would result in Medicare not paying its share of fixed expenses such as certain facility costs and practice expenses.

Setting prices informed by providers' costs is also challenging as costs can respond to prices (from FFS Medicare and other payers). For example, the Commission has found that hospitals under higher fiscal pressure—that is, those with lower non-FFS Medicare margins and slower growth in net worth—faced more pressure to constrain their costs and therefore had higher FFS Medicare margins (Medicare Payment Advisory Commission 2026).

It can be especially difficult for the FFS program to set payment rates for new technologies (e.g., software

that detects diabetic retinopathy) for several reasons. First, data on the cost of a new technology may be limited, nonexistent, or inaccurate. (Developers of new technologies have an incentive to report that the cost of their product is very high to maximize the payment rate that CMS sets.) Those costs may also change over time in a way that is difficult to reflect in payment rates without timely data. Another issue is that the fixed cost to develop a new technology might be very high while the marginal cost of producing the technology might be nearly zero, meaning payment rates tied to average costs of production would create very strong volume incentives. Fees charged to providers by makers of new technologies may reflect those high fixed costs and low marginal costs—requiring a monthly subscription and/or a low fee for each use instead of a one-time up-front payment. At the same time, use of a new technology may obviate the need for other tools or labor, which could result in some offsetting savings from the technology if fewer other items and services are billed. It could also result in some offsetting reductions in providers' costs that would need to be factored into payment-rate setting.

It can also be difficult for FFS Medicare to set payment rates for drugs, such as physician-administered drugs covered under Part B. Medicare pays physicians and hospital outpatient departments for Part B drugs based on the manufacturer's average sales price (ASP), which reflects the average price realized by the manufacturer for sales to most U.S. purchasers, net of rebates, discounts, and price concessions, with certain exceptions. CMS sets each product's payment rate based on the ASP data that manufacturers report to the agency, and the agency updates Part B drug payment rates quarterly. Manufacturers' pricing decisions may reflect external factors that include policies of other public and private payers, federal law, agencies' regulations (e.g., law and policies established by the Food and Drug Administration for approving drugs), states' policies, biomedical research and development investment, and manufacturing costs. These external environmental factors have a significant influence on the prices Medicare pays for drugs (Medicare Payment Advisory Commission 2017).

Some aspects of how CMS updates FFS Medicare payment rates each year reflect current design decisions or market dynamics and could change in the future. Currently, FFS Medicare administratively sets payment rates for most services, and the vast majority of providers accept these payment rates, even when they are lower than private insurers', in part to gain access to FFS Medicare's large number of enrollees (their potential patients). (Providers may also value the fact that FFS Medicare is a prompt and reliable payer.) Because so many providers accept FFS Medicare, FFS beneficiaries typically have a wide network of providers to choose from. This situation could change, however, if the number of beneficiaries in FFS Medicare declines to a low enough level that more providers feel they can stop seeing FFS Medicare beneficiaries and still have enough privately insured patients to fill their schedules.[6] By contrast, under its current design, FFS Medicare tends to set payments to post-acute care providers that are substantially above the costs of providing services to FFS Medicare beneficiaries.

Relative payments

CMS sets payment rates for various services and encounters through its FFS payment systems. For example, when services are performed in a facility (which is common), FFS Medicare's physician fee schedule pays for the clinician's labor (e.g., $165 for a colonoscopy, $1,162 for a hip replacement plus postoperative visits). FFS Medicare also makes a separate payment for the facility's costs (such as nursing and support staff, equipment, supplies, and rent) through the prospective payment system (PPS) for a given type of facility (e.g., the outpatient PPS for hospitals). FFS Medicare's payments, in turn, vary based on how many resources are expected to be needed during a stay or visit—meaning they are higher for a procedure that is expected to require more labor and supplies (e.g., the hip replacement) and higher if a patient has more comorbidities that could complicate treatment (e.g., obesity, diabetes, cardiovascular disease, anemia).

Some aspects of how CMS sets relative payment rates for different services and encounters reflect current design decisions that could be changed. CMS currently uses various data sources and formulas to set payment rates in its FFS payment systems. For example, hospitals' relative payment rates are largely based on cost reports and claims that hospitals submit to CMS each year, while clinicians' relative payment rates are largely based on estimates of the time and

intensity involved in delivering a service according to American Medical Association-approved surveys of small, convenience samples of clinicians who may have financial incentives to overestimate their effort. FFS Medicare's payment systems plug these and other data sources into complex formulas to generate payment rates for different services (see our *Payment Basics* for the formulas used in each of FFS Medicare's payment systems, available at www.medpac.gov/document-type/payment-basic).

A problem with administratively setting thousands of payment rates is that some services may inadvertently become mispriced (meaning that their payment rates become higher than needed to maintain access to the service). In the physician fee schedule, one source of mispricing includes its lack of objective data on the amount of time clinicians spend delivering different types of services; the amount of time and effort needed to deliver a service can also change over time. When some services are overpriced relative to other services, it can incentivize the provision of higher-priced services over the provision of lower-priced services, which can lead to unnecessary spending on some services and limited access to other services.

Another problem with setting payment rates using multiple FFS payment systems is that it can result in payment rates that are not "site neutral." Total Medicare payments can vary for a given service depending on whether it is performed in an office-based surgical suite, an ambulatory surgical center, or a hospital outpatient department. This variation can occur because the medical complexity of, and amount of resources expected to be needed to treat, the average patient varies across clinical settings for the same service. A lack of site-neutral pricing can also occur because payment rates in FFS Medicare's PPSs are set (and updated) using different data sources and formulas. Paying different rates for the same service depending on where it is provided creates incentives to shift the provision of services (or even just the billing of services) to higher-paid settings, which can increase Medicare spending and beneficiary cost sharing without improving patient outcomes.

Incentives in alternative payment models

Medicare began using APMs on a large scale in 2012. APMs include payment models that hold providers accountable for all FFS Medicare Part A and Part B spending for an attributed population of beneficiaries for a year, as well as models that target narrower episodes of care. In 2025, about a quarter of full-benefit Medicare beneficiaries were attributed to an APM using a total-cost-of-care model (Medicare Payment Advisory Commission 2025a).[7,8] (The vast majority of FFS beneficiaries in APMs are in this type of APM.)

Basic design

CMS operates numerous APMs that providers in the FFS Medicare program can participate in. The theory behind APMs is generally that, by holding provider organizations accountable for spending and quality, APMs will give providers a financial incentive to furnish a more efficient mix of services and improve the care they deliver. APMs have some tools to limit spending (e.g., referrals to preferred providers, additional care-management services to keep patients healthy). In addition, providers have flexibility in how they spend APM incentive payments, which can be used to build the infrastructure for care coordination. Because providers in APMs continue to receive FFS payment rates, APMs generally do not have tools for controlling the payment rates of services (such as those for Part B drugs), though providers in APMs could be incentivized to be more judicious in their choice of which drugs they prescribe.

CMS's largest APM is the Medicare Shared Savings Program (MSSP), a population-based payment model that began in 2012 and will assign a projected 45 percent of FFS Medicare beneficiaries to model participants in 2026.[9] Providers who voluntarily form ACOs to participate in this model agree to receive bonuses or owe penalties based on whether total annual per capita spending for a group of attributed FFS Medicare beneficiaries is below or above a specified spending target. Auxiliary models such as the ACO Primary Care Flex Model allow ACOs the flexibility to provide prospective payments to primary care physicians.

Unlike in MA, in which beneficiaries actively enroll in a plan, beneficiaries are attributed (i.e., assigned) to an ACO based on whether an ACO's participating clinicians provided the most primary care services to a beneficiary. This passive attribution is a core challenge for CMS when designing ACO models in setting

spending targets, assessing risk, engaging provider participants, and evaluating savings. Beneficiaries are not restricted by provider networks, and attribution may be inconsistent from year to year if a beneficiary receives the plurality of their primary care from a different provider. In addition, passive attribution results in many beneficiaries being unaware that they are in an ACO, making it difficult to engage them.

An additional type of APM is an episode-based payment model, which holds providers accountable for the cost and quality of care received by attributed beneficiaries during a limited period of time following a triggering clinical event. Currently, the most prevalent episode-based model is the Transforming Episode Accountability Model (TEAM), which seeks to hold hospitals accountable for spending and quality during a postdischarge period (30 days) for five high-volume surgical categories in selected geographic regions; approximately one-quarter of hospital markets are mandated to participate in TEAM from 2026 to 2030. CMS's Innovation Center has also tested a number of other episode-based payment models geared toward specialists providing care for orthopedic, cardiac, gastrointestinal, neurological, spinal, and other types of conditions.

Some aspects of APMs reflect current design decisions and are not necessarily inherent to APMs. CMS has wide latitude in how it incentivizes quality, sets spending targets, and tries to incentivize voluntary participation (through higher payments) or make participation mandatory (to achieve greater savings). Currently, providers in "advanced" APMs agree to bear more-than-nominal financial risk if their patients' spending exceeds a spending target, to have some of their payment tied to quality measures, and to use electronic health records. Incentives in some APMs have been modest, especially for specialists in ACOs, who are typically paid a smaller share of incentive payments than primary care clinicians by their ACO (Khullar et al. 2024, Schulz et al. 2015).[10] In addition, many provider organizations historically have compensated their clinicians based primarily on the volume and intensity of the services and items clinicians prescribe—counter to the goal of APMs. The combination of modest clinician-level APM bonuses and productivity-based clinician compensation arrangements results in many clinicians (especially specialists) being able to earn more money by focusing on their core FFS incentive to maximize the volume and intensity of services they deliver.

Generally, APMs have generated modest gross savings by slowing the growth in spending on certain services for Medicare beneficiaries. APM bonuses paid to participants have often exceeded these gross savings, however. Some APMs, such as the MSSP during its initial years, have nevertheless generated modest net savings for the Medicare program (Congressional Budget Office 2023, Medicare Payment Advisory Commission 2021b).[11] These savings have generally been achieved without harming care quality, and in some cases, care quality improved (Medicare Payment Advisory Commission 2021b). APMs are still relatively young and evolving, and these models could eventually generate net savings on a larger scale if designs are improved. CMS's Innovation Center has announced plans to test new ACO models that will attempt to enhance incentives to reduce volume and intensity by providing greater stability in spending targets.[12]

Overall payment levels

The challenge for most APMs is setting spending targets that are "correct" at the episode or population level. Optimal spending targets would allow APM participants to be rewarded for efficiencies in care delivery without being paid more than what Medicare spending would have been without APMs. If APM spending targets are too high, then they may result in incentive payments that exceed gross savings—resulting in no net savings for Medicare. If APM payments are too low in voluntary models, providers may not participate; voluntary models also may induce self-selection by providers who are most likely to earn high incentive payments or bonuses. If payments are too low in mandatory models, some providers may not have the financial support to invest in a new care-delivery model and beneficiaries' access to care may suffer.

Relative payments

The spending targets set by CMS differ depending on the APM's mix of attributed beneficiaries. Core challenges include fairly accounting for patients who are expected to have higher spending without rewarding coding intensity and incentivizing participation both from providers with relatively high spending and providers with relatively low spending.

Some aspects of how CMS calculates APM payments reflect current design decisions that could be changed. CMS currently sets higher (easier) spending targets in APMs if participating providers code their patients' diagnoses more intensely; for example, ACOs in the MSSP can increase their spending targets by up to 3 percent for risk-score increases above and beyond changes in demographics.[13] In addition, the spending targets based (in part) on an entire geographic market that are currently used in some APMs allow providers who historically have low spending within their market to more easily achieve bonuses without substantially changing their delivery of care; in the MSSP, this design has resulted in most participants being providers who historically performed well relative to their market average.

Incentives in Medicare Advantage

Medicare beneficiaries have the option of receiving their benefits from private plans rather than from providers paid directly through traditional FFS Medicare. Medicare started using private plans in 1985, and the current iteration of the program, MA, was created in 1997.[14] In 2025, more than half of full-benefit Medicare beneficiaries (55 percent) were enrolled in MA.

Basic design

In contrast to FFS Medicare's per service payment approach, Medicare pays MA plans a fixed monthly rate for each enrolled beneficiary. The plans, in turn, make payments to health care providers for the care their enrollees receive. The monthly per person payment approach creates strong incentives for plans to manage enrollees' spending—including by managing the volume and intensity of the services they use. Our analyses of MA plans' projected medical spending indicate that spending on medical services (before including administrative costs) is 15 percent to 18 percent below what would have occurred in FFS (Medicare Payment Advisory Commission 2026). However, challenges related to setting prices for benchmark levels (per person spending targets based on the FFS average spending in a county) and risk adjusting payments have distorted the promising incentive structure at the core of the program.[15]

Medicare's payments to MA plans are determined by comparing a plan's bid with a county-specific spending benchmark. "Benchmarks" are an amount, set by law, equal to a certain percentage (typically above 100 percent) of the projected average per capita FFS Medicare spending for a county's beneficiaries.[16] Bids, which plans submit annually, are intended to represent the dollar amount that a plan estimates will cover its costs of providing the Part A and Part B benefit package for a beneficiary of average spending. For plans that bid below the benchmark, Medicare pays the plan an amount equal to the bid plus a "rebate," which the plan must use to provide supplemental benefits to enrollees in the form of lower cost sharing (including a maximum out-of-pocket cap on all covered services), lower premiums, or coverage of non-Medicare services (benefits not covered by Part A or Part B).[17] For plans that bid above the benchmark, Medicare pays the plan an amount equal to the benchmark and enrollees must pay a premium equal to the difference between the bid and the benchmark.[18] Either way, Medicare's per enrollee payments to a plan are risk adjusted to account for differences in the plan's mix of enrollees—increasing the payment rate for plans whose enrollees are expected to have higher medical expenses and decreasing the payment rate for plans whose enrollees are expected to have lower medical expenses.

Under this payment approach, plans that effectively manage their enrollees' care can submit lower bids, resulting in lower overall payments but larger rebates, which can be used to fund supplemental benefits that enrollees find attractive. Plans that manage spending less effectively will have higher bids, resulting in higher overall payments but lower rebates with which to provide supplemental benefits. Overall, the system is designed to incentivize insurers to bid competitively enough to garner rebates and attract enrollees without bidding below a sustainable level. If MA plans manage care inefficiently relative to payments, they, as opposed to Medicare, bear the financial risk.

MA plans have powerful tools to manage their enrollees' use of services. These include prior authorization, step-therapy requirements, referral requirements, provider networks, and alternative cost-sharing structures. These tools enable plans to manage their enrollees' spending more intensively than might be done in FFS Medicare or APMs. However, overuse (or poorly targeted use) of these tools could make it more difficult for enrollees to access services. The incentives for MA plans to reduce enrollees' spending are counterbalanced by statutory and regulatory guardrails

intended to protect beneficiaries, incentives to receive high quality ratings, and competitive market dynamics in which MA enrollees can change plans if they are dissatisfied with their current plan and an appealing alternative is available to them.

The MA program also gives plans the ability to negotiate with providers about how (and how much) they will pay for care. Plans can pay providers on a FFS basis or can establish alternative payment arrangements. Relatively little is known about MA payments to providers, but evidence suggests that many MA plans pay providers on a FFS basis (America's Health Insurance Plans 2025). Plans manage enrollees' use of services through their benefit designs (i.e., cost-sharing structure), utilization-management tools (e.g., requiring prior authorization for certain services), and by enforcing coverage rules for each service (e.g., denying payment for services that are found not to be medically necessary). Plans using alternative payment arrangements may (depending on the arrangement) have a reduced need for service-specific utilization controls since the incentives to control volume and intensity are passed on to the providers (e.g., through two-sided risk-sharing arrangements).

Some groups of Medicare beneficiaries, such as institutionalized beneficiaries or those who are dually eligible for Medicare and Medicaid, have care needs that may be better addressed through more targeted incentives. In many instances, the incentive structure in FFS Medicare is poorly aligned with the unique needs of these beneficiaries. Accordingly, Medicare has created three types of specialized MA plans, called special-needs plans (SNPs), to try to provide care more efficiently. These plans target beneficiaries who are dually eligible for Medicare and Medicaid, have certain chronic diseases, or need institutional care. Through MA, SNPs are given additional requirements and flexibilities that can encourage them to better address these beneficiaries' needs.

Overall payment levels

Setting the level of overall payment for the MA program requires deciding what spending benchmarks to have plans bid against, how to risk adjust payments, how to incentivize quality, and whether to subsidize forms of supplemental coverage (e.g., by reducing beneficiaries' cost sharing or covering non-Medicare services such as dental, vision, and hearing services and items). As currently implemented, Medicare's payments to MA are higher than what would have occurred in FFS. This illustrates the trade-offs present in MA's current design: Those higher payments have encouraged plan participation, giving enrollees many plans from which to choose, and facilitated access to low-cost forms of supplemental coverage for MA enrollees, but they have failed to produce program savings.

Since the introduction of private plans into Medicare, the program has faced challenges in setting overall payment levels in a way that appropriately balances program goals. Policymakers contemplating MA's overall payment levels face trade-offs with regards to rewarding efficiency, producing program savings, incentivizing voluntary plan participation, incentivizing high-quality care, and providing access to low-cost supplemental coverage and added benefits. Generally speaking, insurers can be expected to offer MA plans only if their payments exceed their costs of paying medical claims and administering benefits. If payment levels are too low, plans are unlikely to offer supplemental coverage or benefits. If payment levels are too high, many plans may participate but the government will not realize any savings from plan efficiencies. Similarly, if Medicare retains the full difference between plan bids and benchmarks, plans will have little incentive to lower their bids—eliminating the potential for government savings and a source of funding for supplemental benefits (which may be important for encouraging beneficiaries to participate in MA plans).

MA's design is based on the theory that capitated payments incentivize plans to deliver Medicare benefits at a lower cost than the traditional FFS Medicare program and that a well-designed payment system should be able to generate budgetary savings for the government from those efficiencies without harming quality of care. MedPAC's analysis of MA, as well as studies by other researchers, suggests that MA plans are able to reduce their enrollees' medical spending below what would have been spent for those enrollees had they been enrolled in FFS Medicare (Inovalon 2025, Jung et al. 2025, Teigland et al. 2025). In our March 2026 report to the Congress, we estimated that plan bids in 2026 are 95 percent of what FFS spending would have been for MA enrollees (after accounting for coding intensity and favorable selection, which are discussed

below)—indicating that plans are offering the standard Medicare benefit for an estimated 5 percent less than it would cost Medicare to cover those enrollees in the FFS program (Medicare Payment Advisory Commission 2026). Those cost reductions are the net result of lower medical spending for MA enrollees, partially offset by plans' administrative costs and profit margins. Our 2026 projections are consistent with insurers' costs for medical expenses being about 18 percent less than what would have been spent if the same enrollees had been in FFS Medicare.[19]

Despite these efficiencies, however, we estimate that other aspects of the MA payment system result in Medicare spending more for MA enrollees than it would have if those beneficiaries were in FFS Medicare.[20] The additional costs arise from aspects of how Medicare sets MA benchmarks and risk adjusts MA payments. The two largest factors responsible for higher average payments to plans are favorable selection and coding intensity (although the extent of favorable selection and coding intensity in MA varies substantially by MA plan).

"Favorable selection" is a pricing error that occurs when beneficiaries with risk scores that overpredict their spending enroll in MA more often than beneficiaries whose risk scores underpredict their spending. Favorable selection is the extent to which, without any management or other intervention from MA plans, the spending of MA enrollees is lower than what Medicare would spend if they were in FFS. This selection may stem from a variety of factors, including beneficiaries' propensities to use care for reasons unrelated to their health and differences in health status that are not accounted for by risk scores (e.g., mortality, functional impairment), among other reasons.

"Coding intensity" is a pricing error that pertains to the tendency for MA plans to record more diagnosis codes for their enrollees, which causes risk scores—and payments—for the same beneficiaries to be higher when they are enrolled in MA than they would be in FFS Medicare.

Together, favorable selection and higher MA coding intensity cause CMS's risk-adjustment system to set payment rates too high for MA enrollees, thereby making it difficult to get the overall level of payment to MA plans "right." To achieve budgetary savings from MA, the benchmarks against which plans bid would need to roughly reflect the amount it would cost to cover those beneficiaries under the FFS Medicare program. However, under the current system, we estimate that benchmarks in 2026 are 124 percent of what FFS spending would have been, indicating that MA plans bid against an amount that is 24 percent more than what their enrollees would have cost if they were in FFS Medicare. The high benchmarks that Medicare uses to pay plans have resulted in large rebate payments to plans since rebates are based on the difference between plans' bids and the benchmarks. In 2026, the Medicare program will pay MA plans, on average, $2,660 per beneficiary per year in rebates, which plans use to provide supplemental benefits for their enrollees.[21] These rebates have more than doubled since 2018 and now account for a projected 15 percent of Medicare's total payments to MA plans. Once favorable selection and coding intensity are accounted for, we estimate that, for 2026, Medicare will spend 14 percent—a projected $76 billion—more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare.[22]

Relative payments

As discussed in the FFS and APM sections, relative differences in Medicare's payment rates create incentives for entities (such as providers or insurers) to do more of some activities and less of others. In MA, Medicare's payments to MA plans vary across geographies (beyond the geographic adjustments in FFS Medicare's payment rates) and beneficiaries, rather than across services. That variation creates incentives for MA plans to focus their activities in certain geographic areas and on certain enrollees. Additionally, differences in relative payments can affect how Medicare's payments are distributed across insurers, beneficiaries, and providers. Policymakers considering the relative payment rates in MA face trade-offs with respect to incentivizing plan participation, rewarding efficiency, producing program savings, incentivizing high-quality care, and providing access to low-cost supplemental coverage.

Two elements of the MA payment system are central to creating variation in MA payments: benchmarks and risk adjustment. The approach used to set MA benchmarks creates geographic variation in MA

payment rates, thereby creating stronger incentives for plans to participate in counties with low FFS spending (where MA benchmarks are increased the most). The Commission has previously concluded that benchmarks are likely higher than needed to induce plan participation in many geographic areas and are out of balance with the intended policy goal of allocating savings from MA plan efficiencies to beneficiaries and the Medicare program.

Medicare's risk-adjustment system also introduces variation in Medicare's payments to MA plans. Risk adjustment is an essential component of per person payment arrangements like MA: It is intended to guard against forms of adverse or favorable selection that can cause insurance markets to malfunction. Without risk adjustment (e.g., if plans were paid an equal amount for all enrollees), plans would be incentivized to avoid types of beneficiaries who are likely to have higher medical costs and geographic areas where those beneficiaries are more likely to live. By paying more for enrollees who are expected to need more care, risk adjustment can lessen the extent to which plans are incentivized to avoid them. However, when risk-related payment adjustments are poorly aligned with actual differences in risk, those errors in pricing adjustments can distort plan incentives. In their current form, Medicare's policies for risk adjusting MA payments are misaligned with plans' true levels of risk, and the system creates a strong incentive to focus on recording diagnoses rather than on other aspects of managing care. Under MA's risk-adjustment system, documenting additional diagnosis codes raises plan enrollees' risk scores, generating two distinct benefits for MA plans: (1) increasing the monthly payments that MA plans receive from Medicare and (2) increasing the rebates that plans receive and use to provide supplemental benefits to enrollees.[23] Thus, plans that code more intensively have a competitive advantage over other plans—providing a strong incentive to record diagnoses as thoroughly as possible.[24] Some plans have responded to these incentives and used the available tools (e.g., chart reviews and health risk assessments) more aggressively than others, resulting in large variations in risk scores and payments across plans. Because CMS applies a uniform across-the-board adjustment to risk scores to account for the coding differences between MA and FFS, current policy does not resolve the problem of unwarranted payment differences across insurers or plans.[25] CMS's across-the-board adjustment underestimates coding intensity for most of the largest insurers while penalizing many smaller insurers, including some insurers with lower coding intensity than what would have occurred in FFS.[26]

Overall, coding intensity illustrates the challenge of setting relative payment rates in MA appropriately. Relative payment rates are a tool with which policymakers can encourage plan participation, incentivize quality, and address favorable selection; however, getting the details right can be difficult, and it is easy to produce unintended consequences. Relative payment rates that are poorly set can create poor incentives, distorting the nature of competition in MA and undermining the promising incentives on which the program is based.

Commission recommendations to improve Medicare's incentives

The Commission regularly reviews Medicare's various payment systems with the goal of ensuring that they are structured to create incentives for the efficient practice of medicine. When we find that payment systems cause financially driven distortions to the mix of services and items that providers deliver or to the choice of clinical setting, we try to pinpoint the mechanism causing these distortions and identify changes to payment systems that will dampen or eliminate such perverse incentives. Past Commission recommendations are generally aimed at reducing FFS Medicare incentives that lead to the overprovision of unnecessary services and reducing APMs' and MA plans' incentives to engage in behaviors that inflate their payments.

Improving incentives in FFS Medicare

To improve the basic design of FFS Medicare, the Commission has recommended redesigning this benefit by lowering or eliminating cost sharing for high-value services (while preserving cost sharing for low-value services since cost sharing can reduce utilization of services). We have also recommended adding an annual out-of-pocket maximum for FFS beneficiaries (which could mean beneficiaries would not need to purchase supplemental insurance to obtain protection

from catastrophic out-of-pocket spending), and we recommended adding a charge on supplemental insurance plans (to recoup some of the costs that result from the higher service use that these plans promote by shielding beneficiaries from cost sharing) (Medicare Payment Advisory Commission 2012).

To bring FFS Medicare's overall payment levels closer in line with providers' costs, the Commission currently recommends slightly increasing (above current law) payment rates for the hospital outpatient and inpatient PPSs and the physician fee schedule, modestly decreasing payment rates for outpatient dialysis services and hospice services, and substantially decreasing payment rates for post-acute care providers (i.e., SNFs, home health agencies, and inpatient rehabilitation facilities, which have high Medicare profit margins of 24 percent, 21 percent, and 17 percent, respectively) (Medicare Payment Advisory Commission 2026).[27] We also recommend collecting cost-report data from ambulatory surgical centers to help inform decisions about annual updates to the payment rates for these facilities (Medicare Payment Advisory Commission 2022c).

To improve how relative payments are set in FFS Medicare, the Commission has recommended using new data sources and formulas. For example, to establish more accurate physician fee schedule payment rates, we have recommended collecting data on service volume and work time from a cohort of efficient practices and improving the valuation of fee schedule services through various technical corrections (e.g., by reducing overpayments for overhead costs when services are furnished in a facility, no longer paying for postoperative visits that do not occur during 10- and 90-day global surgical periods) (Medicare Payment Advisory Commission 2025b, Medicare Payment Advisory Commission 2011). We have also recommended that CMS convene an independent committee of experts to review data and methods and help set values for fee schedule services (Medicare Payment Advisory Commission 2006). To improve relative payments across hospitals, we have recommended revising the formulas used in the inpatient and outpatient PPSs to support teaching and safety-net hospitals' higher costs of care and account for geographic differences in support-staff wages (Medicare Payment Advisory Commission 2023a, Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2021b).

We have also recommended that FFS Medicare adopt site-neutral payment rates for certain services that can be safely provided in more than one ambulatory setting (i.e., a freestanding clinician office, an ambulatory surgical center, and/or a hospital outpatient department) (Medicare Payment Advisory Commission 2023a).

Improving incentives in APMs

To improve the basic design of Medicare's APMs, the Commission has recommended that CMS operate a smaller number of APMs designed to work together. For example, CMS could operate one ACO model with different tracks for different-size providers and a mandatory episode-based payment model for proven episodes (Medicare Payment Advisory Commission 2021b). CMS has taken steps toward this recommendation with the ACO Primary Care Flex Model, which allows for prospective payments for primary care clinicians through an MSSP ACO.

Regarding improvement in how overall payment levels are set in Medicare's APMs, the Commission has expressed concerns about spending targets that are periodically ratcheted down when ACOs become more efficient (Medicare Payment Advisory Commission 2022a, Medicare Payment Advisory Commission 2022b). CMS has taken steps toward addressing this concern by introducing a prospective growth rate for ACO spending targets for all ACO models (MSSP, LEAD, and Geo AHEAD ACOs).[28]

To improve how relative payments are set in Medicare's APMs, the Commission has expressed concerns about spending targets in the MSSP that incentivize coding diagnoses and favorable selection of provider practices that are likely to generate lower-than-expected spending (Medicare Payment Advisory Commission 2022a, Medicare Payment Advisory Commission 2021a). CMS has taken steps to address these concerns by allowing spending targets to increase due to demographic factors while still capping the increase in spending targets due to the coding of diagnoses. In addition, CMS has improved participation incentives for providers who have historically treated patients with high spending relative to their market average.

Improving incentives in MA

To improve the basic design of MA, the Commission has recommended using geographic market areas that improve reliability for both setting payment areas and evaluating quality (Medicare Payment Advisory Commission 2021b, Medicare Payment Advisory Commission 2020). In addition, the Commission has recommended that CMS take additional steps to ensure that MA plans submit accurate and complete encounter data for services provided to MA enrollees. Improving MA encounter data would allow the Medicare program to better understand how efficiencies are gained in MA, including how FFS Medicare can become more efficient (Medicare Payment Advisory Commission 2019a).

To improve how overall payment levels are set in MA, the Commission has recommended improving the calculation of the benchmarks that MA plans bid against by using only MA-eligible FFS beneficiaries (i.e., full-benefit beneficiaries, who have both Part A and Part B coverage) in the calculation of benchmarks, adjusting local-area payment rates by blending local-area and national per capita spending on a continuous scale, removing the double-quality bonus specific to certain urban areas, removing the cap on benchmarks, removing quality scores from the calculation of plan rebates, and incorporating a benchmark discount rate that reduces overall payment rates (Medicare Payment Advisory Commission 2021b).

To improve how relative payments are set in MA, the Commission has recommended reducing disparities in plan-level coding intensity by developing a risk-adjustment model that uses two years of FFS and MA diagnostic data and does not include diagnoses from health risk assessments from either FFS or MA and then applies a coding adjustment that fully accounts for the remaining differences in coding between FFS Medicare and MA plans (Medicare Payment Advisory Commission 2016). In addition, the Commission has recommended overhauling the MA quality-bonus program by replacing it with a new MA value-incentive program that scores a small set of population-based measures, evaluates quality at the local-market level, uses a peer-grouping mechanism to account for differences in enrollees' social risk factors, establishes a system for distributing rewards with no "cliff" effects, and distributes plan-financed rewards and penalties at a local-market level (Medicare Payment Advisory Commission 2020).

Future work

The Commission will continue to study Medicare payment approaches and identify ways to optimize the incentives they create. Possible future work on this topic includes 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 payments in APMs, and
- new tools that could be used in FFS Medicare to reduce the use of low-value care. ■

APPENDIX 1–A

Quality incentives in Medicare

Each of Medicare's three payment approaches includes incentives that may improve or worsen health care quality for Medicare beneficiaries.

Fee-for-service (FFS) Medicare includes incentives for providers to provide a relatively greater volume and intensity of services to patients. This incentive can promote greater use of services, including both high- and low-value care. It can also minimize the risk of stinting on care. FFS Medicare also includes few incentives for providers to coordinate their patients' care. The overall effect of these incentives on quality of care is indeterminate.

By contrast, Medicare Advantage (MA) plans have more of an incentive to restrain the volume and intensity of services that providers deliver since plans are paid on a capitated basis. As a result, plans may seek to reduce the provision of low-value services that offer little to no clinical benefit or have the potential to actually cause harm. At the same time, excessive use of utilization-management tools like requiring prior authorization or denying claims can harm beneficiaries' access to care, including high-value care. MA plans do have an incentive to keep their enrollees healthy to reduce use of and spending for health care services. However, it is not clear how strong that incentive is—especially since beneficiaries generally enroll in an MA plan for one year at a time, and it may take years for preventive care and other high-value services to yield avoided costs. One study suggests that about half of MA enrollees voluntarily disenroll from their plan within five years—reducing plans' incentives to invest in efforts to keep beneficiaries healthy over the long term and making it difficult to assess the change in health outcomes of a plan's enrollees (Meyers et al. 2023).

The types of incentives faced by providers in alternative payment models (APMs) fall somewhere in between those faced by providers in stand-alone FFS Medicare and MA plans. Providers in APMs have an incentive to manage their patients' care in order to perform well on quality measures and earn performance bonuses, but incentives are often relatively weak since APM bonuses often constitute a relatively small share of total revenues and provider organizations often continue to pay clinicians based primarily on the volume and intensity of services they deliver.

Medicare has tried to boost incentives for providers to furnish higher-quality care through its quality payment programs. Broadly speaking, there are two types of quality payment programs in Medicare:

- ***Pay-for-reporting programs***—Providers are financially rewarded (or not penalized) if they successfully report their performance on designated quality measures.
- ***Pay-for-performance programs***—Providers' payment rates are adjusted upward or downward based on how well they perform on quality measures. (A provider's performance during an assessment period is compared either with that of other providers or with some performance scale and then converted to a provider-specific payment adjustment. This payment adjustment is applied to all payments for that provider in a later fiscal year.)

Medicare has generally taken a phased approach by implementing pay-for-reporting programs for specific providers before pay-for-performance programs. In FFS Medicare, the Congress has enacted quality-reporting programs for provider types that account for a large majority of the services furnished to Medicare beneficiaries. For some other types of providers, the Congress has gone a step further and implemented pay-for-performance programs (for clinicians, hospitals, skilled nursing facilities, home health agencies, and dialysis providers). CMS often requires FFS providers participating in APMs to report their performance on quality measures and uses those results to determine the size of their APM bonuses or penalties. The Congress has mandated a pay-for-performance program for MA plans.

The quality data from both pay-for-reporting and pay-for-performance programs can be used for public reporting of provider performance data, to hold providers accountable to consumers and to encourage improvement. Currently, CMS reports data from Medicare's quality programs on its website (medicare.gov/care-compare) as summary star ratings and detailed measure results.

In their early stages, some of Medicare's quality payment programs focused on process measures, but over time programs have begun to include more measures of outcomes and patient experience (Centers for Medicare & Medicaid Services 2023, Centers for Medicare & Medicaid Services 2018).

Although the Commission has recommended that Medicare link payment to quality of care, we have expressed concern that some of Medicare's quality-measurement programs are "overbuilt," relying on hundreds of measures (Centers for Medicare & Medicaid Services 2025c, Medicare Payment Advisory Commission 2018a). The proliferation of measures has resulted in an increase in providers' burden to collect data, confusion among consumers and purchasers who see conflicting measure results, and operational difficulties among payers.[29] The overabundance of measures and other issues with Medicare's quality programs led us to develop principles for measuring quality in Medicare (Medicare Payment Advisory Commission 2018a):

- Quality measurement should be patient oriented, encourage coordination across providers and time, and promote relevant change in the nature of the delivery system.
- Quality measurement should not be unduly burdensome for providers.
- Medicare quality programs should include population-based measures such as outcomes, patient experience, and value (e.g., Medicare spending per beneficiary, measures of services that have little or no clinical benefit). Providers may choose to use more granular measures to manage their own quality improvement.
- Medicare quality programs should give rewards based on clear, absolute, and prospectively set performance targets (as opposed to "tournament models," under which providers are scored relative to one another).
- The Medicare program should take into account, as necessary, differences in a provider's patient population, including social risk factors. Because adjusting measure results for social risk factors can mask disparities in clinical performance, Medicare should account for social risk factors by directly adjusting payment through peer grouping.
- Medicare should target technical-assistance resources to low-performing providers.
- Medicare should support research and data collection to reduce measurement bias, including, for example, the effects of social risk factors.

Since elements of Medicare's current quality programs are inconsistent with these principles, we have recommended replacing Medicare's quality programs for clinicians, inpatient hospitals, skilled nursing facilities (SNFs), and MA plans with programs that focus on measures of outcomes, patient experience, and value (Medicare Payment Advisory Commission 2021b, Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2019b, Medicare Payment Advisory Commission 2018b).

In recent years, CMS has constructed various frameworks for developing new quality measures, designing public reporting programs, and delivering technical assistance. These frameworks consistently focus on (1) alignment of measures across programs and (2) prioritization of outcome measures. Although the Commission supports the direction that CMS is moving in, we have called for the development of more quality measures tied to clinical outcomes and patient experience. For example, we recommended that the Secretary of the Department of Health and Human Services finalize the development of, and begin to report, patient-experience measures for SNFs (Medicare Payment Advisory Commission 2021b); we have also discussed developing new outcome measures for ambulatory surgical centers (Medicare Payment Advisory Commission 2025c). ■

Endnotes

1 In Table 1-1 (p. 11), we note that payments made to MA organizations come from both the Part A and Part B Medicare trust funds, and the shares from each trust fund are calculated based on FFS Medicare spending (with roughly 40 percent coming from the Part A trust fund and 60 percent coming from the Part B trust fund). Thus, the Medicare Trustees' projections for the FFS Medicare population are extrapolated to the entire Medicare population (including MA enrollees).

2 Between 2009 and 2023, nominal Medicare spending on separately payable Part B drugs excluding Part B–covered preventive vaccines grew at a rate of 10.6 percent per year. Growth in the average price that Medicare Part B paid per drug was the largest factor contributing to increased spending for separately payable Part B drugs excluding vaccines between 2009 and 2023. During that period, the average annual payment per drug grew 7.5 percent per year on average, reflecting increases in the prices of existing drugs; the launch of new, higher-priced drugs; and shifts in the mix of drugs. Growth in the number of beneficiaries using nonvaccine Part B drugs (about 2.9 percent per year on average) also contributed to increased spending. The number of Part B drugs received per user was stable (Medicare Payment Advisory Commission 2025a).

3 As with other Medicare services, the current 2 percent sequester reduces Medicare program payments for Part B drugs. From the perspective of the provider, the statutory payment rate of average sales price (ASP) + 6 percent becomes a net payment of ASP + 4.3 percent after application of the sequester. Because the sequester applies to the Medicare program's payment and not beneficiary cost sharing, the Medicare beneficiary continues to pay 20 percent of ASP + 6 percent and the Medicare program pays 80 percent of ASP + 3.9 percent when the 2 percent sequester is in effect.

4 We summed CMS's 2024 historical calculations for expenses directly related to the operations of the FFS program for Part A and Part B (Medicare administrative contractor operations, operational support for Part A and Part B, FFS claims processing, competitive bidding for durable medical equipment, and Part A and Part B appeals) (Centers for Medicare & Medicaid Services 2025b). We used Part A and Part B spending in 2024 from the Medicare Trustees' report (Boards of Trustees 2025). All administrative costs related to CMS in the Trustees' report were 0.5 percent of total Medicare expenses in 2024, but those administrative costs include administration for MA, Medicaid, and non-Medicare plans under the federal and state-based marketplaces (Boards of Trustees 2025, Centers for Medicare & Medicaid Services 2025b).

5 Administrative costs for MA plans consist of nonbenefit expenses, which CMS defines as bid-specific administrative and other nonbenefit costs incurred in the operation of the MA bid. Nonbenefit expenses include efforts to reduce fraud, waste, and abuse. CMS specifies that nonbenefit expenses exclude income taxes, investment expenses, and the cost of lobbying activities. Disease- and care-management activities performed by providers are considered medical (benefit) expenses. A plan's profit margin is for additional required revenue beyond medical and nonbenefit expenses. The margin must exclude noninsurance revenues pertaining to investments, lobbying activities, the costs of non-Medicare discounts given to beneficiaries, and capital and infrastructure costs and investments directly incurred or paid by the MA plan relating to additional telehealth benefits.

6 Insurers other than FFS Medicare will often negotiate payment rates with providers and pay higher or lower rates than FFS Medicare's, depending on a provider's market share. Insurers are especially likely to offer higher payment rates if a provider organization includes a scarce or unique type of provider or facility (e.g., a city's only dermatology practice) and more likely to offer low payments if a provider is not a "must have" provider (e.g., if they are one of many primary care practices in an area and treat a small number of patients).

7 APMs that hold providers at risk for total Medicare Part A and Part B spending include risk arrangements in the Medicare Shared Savings Program that begin with no risk of shared losses when spending targets are not met. Participants in these arrangements are generally required to assume some risk of shared losses by year three. During the first two years of participation, providers in these arrangements are at risk for the potential additional administrative costs associated with being in the APM.

8 Estimates of the share of beneficiaries attributed to an APM are based on having both Part A and Part B coverage.

9 The 45 percent of FFS beneficiaries being assigned to MSSP ACOs is based on the share of FFS beneficiaries with both Part A and Part B coverage in January 2026. This estimate uses CMS enrollment data from January 2026 and incorporates CMS's estimate of 12.6 million beneficiaries assigned to MSSP ACOs in January 2026 (Centers for Medicare & Medicaid Services 2025d). Similar to 2025, more than half of FFS Medicare beneficiaries with both Part A

and Part B coverage are projected to be in an ACO model, including demonstrations outside of the MSSP (Medicare Payment Advisory Commission 2025a).

10 CMS's Innovation Center announced the Ambulatory Specialty Model (ASM), which aims to improve coordination between specialists and primary care physicians. The ASM will be mandatory in selected geographic areas for specialists who commonly treat FFS Medicare beneficiaries for heart failure or lower back pain.

11 The Congressional Budget Office (CBO) estimated the budgetary effects of the 49 models run by CMS's Innovation Center from 2011 to 2020. These models produced gross savings of $2.6 billion, but spending on these models was $7.9 billion—resulting in a net loss of $5.4 billion. These net losses would have likely been higher when considering the effects on increases to MA benchmarks and advanced APM bonus payments to clinicians for participation in some models that meet a threshold for more-than-nominal risk. However, CBO's estimates did not include Medicare's largest APM—the MSSP. Early evaluations of the MSSP indicated modest net savings of 1 percent to 2 percent from 2012 to 2016 (McWilliams et al. 2020, McWilliams et al. 2018, Medicare Payment Advisory Commission 2019a). More recent estimates of the MSSP are far less clear on whether the MSSP has continued to generate net savings as shared-savings bonuses have substantially increased. Between 2013 and 2017, shared-savings bonuses per assigned beneficiary in the MSSP increased by 1 percent. In comparison, between 2017 and 2020, shared-savings bonuses per assigned beneficiary in the MSSP increased by 148 percent (Medicare Payment Advisory Commission 2022a). Between 2017 and 2024, shared-savings bonuses per assigned beneficiary increased by an average annual rate of 24 percent. Studies indicate that this increase in shared-savings bonuses is at least in part driven by favorable selection and coding—indicative of pricing errors when setting benchmarks (Chernew et al. 2021, Lyu et al. 2023). One recent study suggests that the MSSP continued to generate gross savings through 2019, but the impact on net savings remains unclear (Bond et al. 2025, Ryan and Markovitz 2023).

12 In 2027, CMS will test the Long-term Enhanced ACO Design (LEAD) model, which is designed to reward investments in care by contracting with participants for 10 years—a longer period than the 4- to 5-year contracts of prior ACO models. Spending targets in the LEAD model will maintain the same historical baseline of spending—allowing for participants to be rewarded for efficiencies in care delivery throughout the duration of the model. In addition, in 2028, entities in the Achieving Healthcare Efficiency through Accountable Design (AHEAD) model will have the opportunity to submit bids and be accountable for the total cost of care for all beneficiaries who are unassigned to ACOs within an entire geographic market. These "Geo" AHEAD entities will submit a bid that—if selected by CMS—will be the spending target for four years and will be updated using FFS Medicare growth rates.

13 CMS's allowance of a 3 percent increase in risk scores after accounting for changes in demographics is designed to balance the concerns of ACOs that the hierarchical-condition-category model does not properly account for regional variation with the agency's concerns about coding-intensity incentives.

14 MA was originally named Medicare+Choice; the program was renamed Medicare Advantage in 2003. In 2006, plans began submitting bids relative to benchmarks set by CMS. In 2007, 100 percent of payments were risk adjusted using diagnosis data (i.e., hierarchical condition categories).

15 The inherent incentives for private plans to manage care and challenges in setting rates for those plans are not unique to MA. States have also grappled with "correct" rate setting for managed care plans in Medicaid, and CMS experienced similar challenges with Medicare–Medicaid plans in CMS's financial alignment demonstrations. For Medicaid managed care, the evidence of improved quality and program savings has been mixed and unclear (Duggan and Hayford 2013, Franco Montoya et al. 2020, Medicaid and CHIP Payment and Access Commission 2023, Perez 2018, Sparer 2012). For private Medicare–Medicaid plans in CMS's financial alignment demonstrations that spanned nine states, evaluations found that these demonstrations tended to result in statistically significant increases in Medicare spending, had mixed effects on service use, and either increased Medicaid costs or had no significant impact on Medicaid costs (Center for Medicare & Medicaid Innovation 2024).

16 The percentage adjusts benchmarks upwards in areas with low FFS spending and downwards in areas with high FFS spending using a percentage ranging from 95 percent to 115 percent, subject to benchmark growth caps. Plans that are highly rated under the CMS star-ratings program are rewarded via benchmarks that are adjusted upwards by up to 5 percentage points (and, in certain counties, up to 10 percentage points, subject to benchmark growth caps).

17 Rebates are set equal to a share of the difference between the plan's bid and the benchmark (as low as 50 percent but typically either 65 percent or 70 percent, depending on a plan's quality ratings).

18 Any premium resulting from an MA plan's bid being above the benchmark is in addition to the Part B premium.

19 The Commission's estimates of MA plans' medical-spending reductions relative to FFS are aligned with estimates from the literature. We found three recent studies that estimated such reductions; estimates ranged from 12 percent to 16 percent—similar to MedPAC's estimate of 15 percent to 18 percent (Inovalon 2025, Jung et al. 2025, Teigland et al. 2025).

20 When risk-based payment for private plans was first added to Medicare in 1985, payments to private plans were set at 95 percent of FFS payments because it was expected that plans would share savings from their efficiencies (relative to FFS) with taxpayers. But in total, private plans have never been paid less than FFS Medicare because of policies that increase payments to MA above FFS payments and distort the nature of plan competition in MA. For example, MA benchmarks are set above FFS spending in many markets in part to encourage more uniform plan participation across the country. Payments under the quality-bonus program further increase MA payments above FFS without producing meaningful information on plan quality for Medicare beneficiaries or the Medicare program.

21 The benefits that rebates finance reduce out-of-pocket costs for MA enrollees and have the potential to address health challenges that many seniors face as they age (such as vision and hearing issues) and for which there is limited coverage under FFS Medicare. Beneficiaries in MedPAC's annual focus groups have cited the supplemental benefits MA offers as one of the leading reasons they chose MA over FFS.

22 The higher payments that we estimate relative to FFS vary significantly across MA parent organizations and are not an estimate of plan profits and administrative expenses.

23 We can illustrate how coding additional hierarchical condition categories (HCCs) increases payment to a plan for Medicare-covered services using average FFS Medicare spending. For example, in 2022, the annual Medicare payment to an MA organization for a non-Medicaid-eligible 80-year-old male (where the demographic component of the risk score is valued at $6,726) with diabetes without complication (HCC 19, valued at $1,284) would have been $8,010. If the same 80-year-old male with diabetes were also found to have vascular disease (HCC 108, valued at $3,620), the Medicare annual payment to the MA organization would increase to $11,630.

24 The higher level of coding intensity in MA causes risk scores—and payments—for the same beneficiaries to be higher when those beneficiaries are enrolled in MA than they would be in FFS Medicare. For 2026, we project that MA risk scores will be about 10 percent above risk scores for comparable FFS beneficiaries. By law, CMS reduces MA risk scores by a minimum amount to make them more consistent with FFS coding. In 2026, the adjustment will reduce MA risk scores by the minimum amount, 5.9 percent. We project that, after the adjustment, MA risk scores will remain about 4 percent higher than they would have been if MA enrollees were in FFS Medicare, leading to $22 billion in higher projected payments to MA plans in 2026.

25 CMS has the authority to impose a larger reduction than the minimum required by law but has never done so. Thus, overall coding intensity is only partially offset by CMS's coding-intensity adjustment.

26 MedPAC regularly assesses how coding intensity varies across insurers. In our recent March report to the Congress, we found that, in 2024, about half of MA insurers (covering 16 percent of MA enrollees) had coding intensity below CMS's minimum coding adjustment and were thereby penalized by the adjustment, while the other half of insurers (covering 84 percent of MA enrollees) had coding intensity that increased their payment even after accounting for the coding adjustment. These differences demonstrate that CMS's across-the-board adjustment for coding intensity perpetuates inequity across contracts by reducing net revenue for plans with lower coding intensity and allowing other plans to retain a significant amount of revenue from higher coding intensity.

27 We are not able to calculate Medicare profit margins for physician fee schedule services since clinicians do not report cost data to CMS. Instead, we look at a number of indicators of payment adequacy, described in Chapter 4 of our March 2026 report to the Congress, when recommending by what percentage to update this fee schedule's payment rates.

28 Prospective growth rates in ACO models are blended with the actual change in spending in ACO markets.

29 One study of the volume and cost of quality reporting at an academic medical center identified 162 unique quality metrics, which required an estimated $5 million in personnel costs to prepare and report (Saraswathula et al. 2023). Another study estimated that physicians and their staff spend, on average, 785 hours per physician per year dealing with various payers' quality-measure reporting programs and that physicians could care for an additional nine patients per week if they did not have these obligations (Casalino et al. 2016).

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