
Executive summary

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As part of its mandate from the Congress, each June the Commission reports on potential improvements to Medicare payment systems and issues that affect the Medicare program, including changes to health care delivery and the market for health care services. The six chapters of our June 2026 report cover the following topics:

- **Improving payment incentives in Medicare.** We describe incentives in fee-for-service (FFS) Medicare, alternative payment models (APMs), and Medicare Advantage (MA) and challenges in improving them.
- **The complexity of Medicare enrollment decisions for beneficiaries.** We explore the complex coverage choices that beneficiaries must make during initial and subsequent Medicare enrollment periods as well as the various resources available to help make those decisions.
- **Medicare payment operations and their role in identifying improper payments.** We detail the processes for making payments to Medicare providers and the measures in place to identify and reduce improper payments and fraud.
- **Estimated association between MA enrollment and hospitals' and post-acute care providers' finances.** We examine how changes in MA enrollment are associated with the finances of various health care providers, including hospitals, skilled nursing facilities (SNFs), home health agencies (HHAs), and inpatient rehabilitation facilities (IRFs).
- **Access to hospice and certain complex palliative services for beneficiaries with end-stage renal disease or cancer.** We describe potential approaches to improve the accuracy of Medicare's hospice payments and address potential concerns about access to certain complex palliative services for hospice beneficiaries.
- **Mandated report: Assessment of the Medicare Ground Ambulance Data Collection System.** We assess and analyze information recently collected by CMS from ground ambulance service providers and recommend the continued collection of such

data, though with a more streamlined approach to focus on data essential to assessing the accuracy of Medicare payments and Medicare beneficiaries' access to care.

Improving payment incentives in Medicare

In Chapter 1, the Commission describes incentives in the three approaches that Medicare largely relies on to pay for health care services—stand-alone FFS Medicare, APMs layered on top of FFS Medicare, and 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.

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 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 pay 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 through 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 cost. 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—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.

The complexity of Medicare enrollment decisions for beneficiaries

In Chapter 2, the Commission examines the complex coverage choices that beneficiaries must make during initial and subsequent Medicare enrollment periods,

as well as the various resources available to assist with making those decisions.

Once an individual becomes eligible for Medicare and during certain times of the year or after specified situations occur, they must make several complex enrollment decisions about their coverage. Beneficiaries often report confusion about enrolling in Medicare and their different coverage options, and concerns have been raised about the growth in marketing by insurers and third-party organizations. The complexity of the choices and numerous sources of information make it increasingly difficult for individuals to understand the requirements and relevant time frames for enrollment. Given both the complexity of these choices and the potentially high stakes involved, access to clear and accurate information is especially important.

Generally, Medicare is for people 65 and older and certain people under 65 who are eligible due to disability or end-stage renal disease. The Medicare eligibility notification process is tied to eligibility for Social Security. Individuals already receiving Social Security benefits are notified of their eligibility and automatically enrolled in Medicare Part A and Part B. Historically, eligibility for both Medicare and Social Security full retirement benefits generally began at age 65. However, a growing number of individuals become eligible for Medicare before they begin collecting Social Security benefits. For these individuals, there is no automatic enrollment in Medicare and, unless they have registered an email with the SSA, they are not notified of their eligibility for coverage when they turn 65. Individuals who do not enroll in Medicare Part A, Part B, or Part D during their initial enrollment period will owe late-enrollment penalties (unless a special enrollment period applies), typically for the rest of their lives, after they eventually do enroll.

Once enrolled in Medicare, beneficiaries must choose between receiving benefits from FFS Medicare or from private plans through MA. Most MA plans include Part D prescription drug coverage, an out-of-pocket cap, and supplemental benefits such as reduced cost sharing as part of their benefit package. Beneficiaries enrolling in FFS Medicare may select a stand-alone Part D prescription drug plan (PDP) for coverage and may also obtain secondary insurance through a retirement plan,

Medicaid, or Medigap insurance to protect themselves against cost-sharing liabilities. Beneficiaries generally have few opportunities to enroll in a Medigap plan with guaranteed-issue protections, so their initial decision of whether to enroll in FFS Medicare with Medigap or in MA can have long-lasting implications.

Beneficiaries consider numerous factors when making a choice of FFS Medicare or MA and the plans within those options, including financial protection, access to care, and extra benefits. Beneficiaries who enroll in MA are typically subject to provider networks and utilization-management tools in exchange for lower premiums and a maximum out-of-pocket cost. By contrast, FFS Medicare offers a broader choice of providers with limited use of utilization-management tools but can expose beneficiaries to high out-of-pocket costs or higher premiums if they choose to acquire supplemental insurance such as Medigap. MA plans typically offer a variety of extra benefits not available in FFS Medicare, such as dental, vision, and hearing benefits. While it can be challenging for beneficiaries to understand each plan's package of supplemental benefits, especially when the package can change substantially from year to year, these extra benefits fill gaps in Medicare coverage and thus appeal to beneficiaries. Beneficiaries must weigh these factors, considering their current health needs as well as potential future health needs that may not be evident at initial enrollment.

Beneficiaries make enrollment and coverage decisions at different times throughout the year, and the requirements for each period often differ by the part of Medicare. Beneficiaries may want to change their Medicare coverage, including switching from MA to FFS Medicare and vice versa, or change their MA plan for a wide variety of reasons, but Medicare has some features that make it harder for beneficiaries to switch MA plans or return to FFS Medicare. Many of those features, including limited enrollment periods, were designed to combat adverse selection both within MA and between MA and FFS.

Beneficiaries rely on a variety of sources for information and advice, including:

- **CMS tools.** CMS has several tools designed to provide free, accurate, and objective information to help navigate enrollment and coverage choices. Medicare.gov provides a wealth of resources about

Medicare enrollment and benefits, including the *Medicare & You* handbook, *Choosing a Medigap Policy* guide, and the Medicare Plan Finder tool. Plan Finder allows beneficiaries to compare the features of MA plans, stand-alone Part D plans, and Medigap plans offered in their area.

- **The federally funded State Health Insurance Assistance Program (SHIP).** The SHIP is a federal program that provides grants to states and territories to deliver objective Medicare counseling, information, and assistance at no cost to beneficiaries. SHIP counselors can be especially helpful to beneficiaries because they have knowledge of local health care resources and are able to provide one-on-one assistance specific to individual beneficiary needs. However, SHIP funding has not kept pace with growth in Medicare enrollment, and individuals involved with the SHIP report capacity constraints as call volumes have risen and the growing complexity of enrollment decisions has led to longer counseling sessions that may require special expertise.
- **Insurance agents.** Many beneficiaries rely on licensed individuals who are paid by insurance companies to enroll people in insurance products. Virtually all MA and Part D plans report using agents to sell their plans. Agents typically secure contracts with multiple insurance companies, but a single agent will not necessarily present every available plan to a beneficiary, something that may not be understood by the beneficiary. The ways in which agents are compensated for their services vary and can be complex. Commonly, insurance carriers pay commissions tied to initial enrollment and retention in the MA, Medigap, or Part D plans they sell. CMS has established maximums on compensation per enrollment that MA and Part D plans can pay agents, but agents may also receive supplemental compensation (such as a bonus for meeting enrollment benchmarks), which is not subject to federal limits. In our annual focus groups, many beneficiaries report positive experiences working with agents, but some stakeholders have voiced concern that agents have financial incentives to steer beneficiary decision-making toward certain plans over others.

The Commission is concerned about the complexity of Medicare enrollment choices and the sufficient availability of free, objective, and accurate resources to help beneficiaries navigate their choices without facing unintended consequences. There may be a need for additional updates to Plan Finder and greater support for SHIP, as well as an increased role for technology to help reduce the complexity of the choices that beneficiaries face. The Commission will continue to monitor this issue and explore potential policy options.

Medicare payment operations and their role in identifying improper payments

In Chapter 3, the Commission details the processes for making payments to Medicare providers and the measures in place to identify and reduce improper payments and fraud.

The Department of Health and Human Services' annual agency financial report for fiscal year (FY) 2025 stated that Medicare was responsible for an estimated \$56.7 billion in improper payments, including \$28.8 billion from FFS Medicare, \$23.7 billion from MA, and \$4.2 billion from Medicare Part D. Improper payments include overpayments, underpayments, payments for ineligible services or recipients, and payments lacking sufficient documentation to determine appropriateness. These payments are not necessarily fraudulent but represent a significant challenge to program integrity.

CMS processes FFS Medicare claims with the assistance of Medicare administrative contractors (MACs), which are private entities assigned to geographic jurisdictions. In FY 2023, CMS reported that MACs processed over 1.1 billion claims, totaling \$431.5 billion. MACs process claims with multitiered verification, including front-end edits for completeness, duplicate detection, and edits for applicable coverage policies. Claims are verified, including removing duplicate claims, and may be screened for medical necessity and other statutory and regulatory requirements using applicable national and local coverage determinations. MACs must pay clean claims within 30 days of receipt and conduct postpayment reviews to identify improper payments and initiate recovery efforts.

In addition to the pre- and postpayment reviews conducted by the MACs, CMS employs limited prior

authorization, targeted preclaim and prepayment reviews, and postpayment audits to reduce improper payments, targeting services with high risk for unnecessary utilization. Currently, CMS is testing preclaim reviews with expanded use of its Fraud Prevention System models and in two limited demonstrations for home health agencies and inpatient rehabilitation facilities in specified states. The Wasteful and Inappropriate Service Reduction (WiSeR) Model started in 2026 and is using artificial intelligence and data analytics to test new prior authorization for selected services. Participating data companies conduct medical reviews and will be rewarded for reducing unnecessary spending.

CMS engages three types of contractors to identify and recover improper payments. Unified program-integrity contractors investigate suspicious claims and refer cases to law enforcement. Recovery audit contractors perform targeted audits. A supplemental medical review contractor conducts medical record reviews for CMS and other agencies. The Comprehensive Error Rate Testing Program measures the improper payment rate in FFS Medicare, which was 6.55 percent in FY 2025, representing \$28.8 billion in improper federal payments, stemming primarily from insufficient documentation.

Medicare makes capitated monthly payments to MA plans for their Medicare enrollees. Those payments are risk adjusted to account for differences in enrollees' expected costliness. CMS estimated that 6.1 percent of payments to MA plans were improper in FY 2025, representing \$23.7 billion. CMS's primary corrective action for MA improper payments are the MA risk-adjustment data validation (RADV) audits, which review medical records to validate diagnosis codes used for risk-adjustment purposes. Recent audit results indicated that medical-record discrepancies, including documentation not submitted, accounted for 85 percent of all improper payments in MA, but more results are expected this year. CMS plans to expand RADV audits and apply extrapolation to recover MA overpayments.

In Part D, payments are reconciled based on prescription drug event records. CMS estimated a 4.0 percent Part D payment error rate in payment year 2023, representing \$4.23 billion in improper federal payments, mostly due to missing documentation.

Medicare Drug Integrity Contractors investigate potential improper payments and conduct audits of plan sponsors.

Across the Medicare program, most improper payments are due to lack of documentation or other errors, but some result from fraud, which is intentional deception or misrepresentation of the information submitted on claims. Within CMS, the Center for Program Integrity (CPI) has the lead in preventing and detecting fraudulent activities. The CPI has a broad range of responsibilities for both Medicare and Medicaid. The Department of Health and Human Services Office of Inspector General has responsibility for investigating and detecting fraud and for provider exclusions, barring an individual or entity from billing Medicare. The Department of Justice investigates and prosecutes fraud. Fraudulent activities have more than financial implications: Beneficiaries who are victims of Medicare fraud may experience real harm in addition to their own financial losses.

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

In Chapter 4, the Commission examines how changes in MA enrollment are associated with the finances of various health care providers, including hospitals, SNFs, HHAs, and IRFs.

Medicare's capitated payments to MA plans create incentives for plans to find lower-cost ways to provide care. When used appropriately, these practices have the potential to promote more efficient care. Indeed, research shows that MA plans spend less on medical care compared with FFS Medicare while maintaining broadly similar levels of access to and satisfaction with care, suggesting that at least some of MA plans' lower medical spending is attributable to appropriate reductions and that FFS spending on medical care might be higher than needed to maintain access and satisfaction.

To reduce medical spending, MA plans typically have flexibility to use alternative payment arrangements, negotiate with individual providers, coordinate care to fill potential gaps in care delivery, manage the use of some services through tools such as prior authorization, and provide incentives for beneficiaries to seek care from lower-cost providers. While plans' actions may

be consistent with efficient care, providers have raised concerns about detrimental effects on their finances and potential impacts on patient care. These concerns have intensified now that MA enrollees make up a substantial share of many providers' patients and revenues.

To analyze the relationship between MA enrollment changes and providers' finances, we conducted several complementary analyses, focusing on hospitals, SNFs, and HHAs, along with descriptive analyses of IRF volume and patient mix. Although our analysis is subject to limitations and cannot isolate causal effects, we do not find evidence of a statistically significant association between MA penetration and hospital, SNF, or HHA margins, on average. Margins changed by similar amounts for providers located in markets that experienced greater increases in MA enrollment relative to markets that experienced smaller increases over the study period. However, for reasons noted in the chapter, we urge caution in attributing the estimated associations between providers' all-payer profit margins, revenues, and costs to the causal effect of greater MA penetration.

There could be several reasons for the lack of association between MA and providers' margins, on average, even if MA plans have exerted financial pressure in the areas identified by providers in our interviews. First, for some providers, the effects of increases in MA enrollment might be relatively modest (on average) in the context of providers' all-payer revenues and costs. Second, providers might have responded to financial pressures from MA growth over time by reducing staffing or other costs (and therefore maintaining margin levels). Third, while MA plans might reduce revenues to providers in some ways, providers might benefit from higher payments that could partially offset those reductions, such as through higher uncompensated care (UC) payments (for hospitals with a high share of their Medicare patients from MA) or payments from MA plans to engage in certain activities.

MA enrollment and hospital finances

In interviews we conducted, hospital representatives reported that MA plans denied or downgraded claims at a higher rate than FFS Medicare, made discharging MA enrollees to post-acute care (PAC) more difficult,

and did not match certain FFS payments in the prices they paid hospitals. From MA plans' perspective, tools such as prior authorization can prevent inappropriate, wasteful, or fraudulent care from being delivered; some providers may be inappropriately billing higher-level visits than warranted; MA plans often match or exceed FFS payment rates on average; and MA plans often make payments above and beyond FFS rates for activities such as increased diagnostic coding and meeting certain quality metrics.

Our empirical analyses found:

- MA enrollees had a longer average hospital length of stay compared with FFS beneficiaries. After controlling for key characteristics, we found that MA enrollees had an average length of stay in FY 2024 that was 11.2 percent longer than that of FFS beneficiaries.
- The structure of FFS Medicare's UC payments may benefit hospitals with more MA patients, leading to mistargeted UC payments. We estimated that, all else equal, if a hospital's MA share of Medicare inpatients were 10 percentage points higher, the hospital would have had a 15 percent higher estimated FFS UC add-on per stay.
- Using data from 2013 to 2024 (excluding 2020 and 2021 due to the coronavirus pandemic), we did not estimate a statistically significant association, on average, between market-level MA penetration and all-payer operating margins, revenues, and costs for inpatient prospective payment systems hospitals or critical access hospitals, though MA may affect some subgroups of hospitals differently.

MA enrollment and PAC providers' finances

PAC representatives identified similar channels by which MA enrollment may affect providers' finances as found in acute care hospitals. IRF interviewees told us that MA plans' use of prior authorization to initiate and extend PAC services can reduce PAC volume relative to FFS Medicare and is the most significant MA-related challenge they face. SNF and HHA interviewees noted that MA plans typically had lower payment rates than FFS. Across the three PAC settings, interviewees consistently reported higher administrative costs associated with obtaining authorization to start or extend care and to appeal denials. MA plans told us that

they apply prior-authorization tools in settings where there is wide variation in use (such as IRF use) and that they tend to pay FFS prices (or above), though they may pay on a different unit than FFS (for example, per visit for home health care rather than episodic rates).

MA enrollment may have different effects on PAC providers' finances compared with acute care hospitals for several reasons, including potential substitutability across PAC settings for some patients, enabling shifts to lower-cost settings. In addition, FFS payments to PAC providers tend to be high relative to costs, and some MA plans may be able to negotiate payment rates with PAC providers that are lower than FFS rates. For many IRFs and HHAs, Medicare payments account for a relatively large share of all-payer revenue. To the extent that MA payment rates differ from FFS rates, expanded MA enrollment may have implications for these providers' overall financial performance.

For freestanding SNFs and HHAs, we estimated the association between changes in market-level MA penetration and providers' finances and found that:

- Increases in MA penetration were associated with small declines in total facility days at SNFs but with no statistically significant declines in HHA total visits or patients.
- Increases in MA penetration were associated with small declines in revenue and costs among SNFs and HHAs. However, we did not find statistically significant effects on all-payer margins, on average.
- Changes in MA penetration affected some subgroups of SNFs and HHAs differently.

Since only about a third of IRFs are freestanding and we are able to calculate only all-payer margins for freestanding providers, we instead show that the MA share of IRF days is substantially lower than overall MA enrollment in the IRF markets and that the clinical conditions differ between MA and FFS beneficiaries admitted to IRFs.

Lower volume and revenues under MA relative to FFS Medicare should not be interpreted as evidence of inappropriate reductions in care. The Commission has long documented persistently high FFS Medicare margins across the three PAC settings, reflecting payment levels that create strong financial incentives to furnish higher volume and intensity of services.

Thus, lower utilization under MA may reflect active care management that improves PAC efficiency rather than diminished access to clinically appropriate care. At the same time, reductions in use do not automatically imply improvements in efficiency, and it is essential to ensure that beneficiaries have timely access to medically necessary PAC services. Ongoing monitoring of access, outcomes, and beneficiary experience is therefore critical as MA enrollment continues to grow.

Access to hospice and certain complex palliative services for beneficiaries with end-stage renal disease or cancer

In Chapter 5, the Commission describes potential approaches to improve the accuracy of Medicare's hospice payments and address potential concerns about access to certain complex palliative services for hospice beneficiaries.

The Medicare hospice benefit covers palliative and supportive services for terminally ill beneficiaries who choose to enroll. Hospice is a model of care focused on symptom management and quality of life and can enable beneficiaries to receive end-of-life care at home. While it is important that eligible beneficiaries have the option to enroll in hospice care, it is also important that beneficiaries can choose not to enroll in hospice and remain with conventional care if they prefer.

When a beneficiary enrolls in hospice, the hospice provider assumes all financial risk for costs of services that are reasonable and necessary for palliation of the patient's terminal illness and related conditions. FFS Medicare generally pays the hospice provider a fixed prospective daily rate, regardless of services furnished on a given day, for beneficiaries enrolled in either traditional FFS Medicare or MA.

In the hospice proposed rules for FY 2024 and FY 2025, CMS raised questions about access under the hospice benefit to certain "complex palliative treatments," that is, certain high-cost complex services that may be palliative (i.e., provide symptom relief) for some hospice beneficiaries—specifically, dialysis for beneficiaries with end-stage renal disease (ESRD) and radiation, blood transfusions, and chemotherapy for beneficiaries with cancer. Given current claims practices, policymakers lack information to assess hospice enrollees' use of such services and whether

Medicare's payment policy serves as a barrier to accessing such services.

From interviews we conducted with clinicians, hospice providers, dialysis providers, and family caregivers in 2024 and 2025, we found general consensus that dialysis, radiation, and blood transfusions can provide symptom relief for some hospice patients, but there was less consensus around the role of chemotherapy in symptom relief for hospice patients. Interviewees reported that dialysis and blood transfusions may extend life expectancy by weeks or months for hospice-eligible beneficiaries. Three commonly reported reasons for furnishing these services include symptom relief, easing the transition to hospice, or helping patients reach specific goals. Interviewees indicated that some patients with ESRD or cancer do not enroll in hospice or enroll very near the end of life due to concerns about ceasing treatments. Interviewees also reported that the cost of dialysis, radiation, blood transfusions, and some chemotherapy generally exceeds the Medicare hospice daily payment rate (for routine home care), though costs varied by a hospice's ability to negotiate rates with service providers. The cost of ambulance transportation, if needed, can significantly increase costs.

Our analysis found that Medicare beneficiaries with ESRD receiving maintenance dialysis who are near the end of life are less likely than other terminally ill beneficiaries to enroll in hospice, and we found that a majority of FFS decedents with blood cancer in 2019 used hospice, though at lower rates and for shorter stays than those with other cancers.

To better understand how Medicare's current payments to hospices compare with the costs of these services over a hospice stay, we estimated the cost of providing dialysis treatments, blood transfusions, and radiation for palliative purposes during a hospice stay relative to Medicare's payment to hospices for a stay under different hypothetical scenarios. The comparisons rely on assumptions about service utilization and costs and are meant to be illustrative only. Over the course of a hospice stay, estimated treatment costs, as a share of total hospice payments, could range from roughly 40 percent to 50 percent for dialysis, roughly 30 percent to 50 percent for blood transfusions, and less than 10 percent to over 30 percent for radiation. Treatment costs accounting

for such a substantial portion of Medicare's payment is not necessarily problematic in a prospective payment system (PPS) like the one used by Medicare to pay for hospice services. A PPS assumes that providers will earn a profit on some cases and incur a loss on others but that, on average, payment will be reasonably aligned with costs. However, if patients with certain conditions or characteristics are predictably more costly than others, a PPS can create incentives for providers to avoid those costs by not admitting such patients or by not furnishing costly services.

Policymakers concerned about hospice beneficiaries' access to certain complex palliative services could consider a number of approaches. First, CMS could, for a limited period, collect data from hospice providers about the use of certain high-cost complex palliative services. Next, if policymakers determined that changes were warranted to improve payment accuracy for hospice patients receiving complex palliative services, two options to change the hospice PPS in a budget-neutral manner (funded by a percentage reduction to the hospice base rate for all providers) could be considered:

- **An outlier policy to direct additional payments to hospice providers that incur higher costs for providing certain palliative services.** This approach would improve payment accuracy while maintaining the bundled nature of the hospice PPS and ensuring that financial risk is shared between hospice providers and the Medicare program. However, some stakeholders might view outlier payments as insufficient.
- **Add-on payments for the provision of certain high-cost palliative services.** This approach would increase incentives for hospices to furnish these services to beneficiaries who need them, but it would also create incentives to furnish costly services even when they are not palliative or not aligned with the patient's plan of care. Incorporating ways to minimize adverse financial incentives, such as by limiting the amount of add-on payments a hospice could receive, may help safeguard against this possibility.

As an alternative to changing the hospice PPS, policymakers could consider a voluntary transitional program through the CMS Innovation Center that

would allow hospice enrollees the option to receive certain services for some transitional period, or up to a specified number of treatments, paid for outside of the hospice benefit. Such a program could help ease the transition to hospice for dialysis- and transfusion-dependent beneficiaries, and it could give the Secretary the opportunity to directly test transitional concurrent care for hospice enrollees for services that have raised access concerns for stakeholders.

Overall, in considering approaches to improve the accuracy of Medicare's payments for hospice services and address potential concerns about access to care, policymakers should maintain payment incentives for efficiency, target any additional payments toward providers that are furnishing high-cost, complex services, and structure any changes to minimize vulnerability to fraud and abuse.

Mandated report: Assessment of the Medicare Ground Ambulance Data Collection System

In Chapter 6, the Commission evaluates the cost and revenue data that CMS collected from suppliers and providers of ground ambulance services in its Medicare Ground Ambulance Data Collection System (GADCS). The Commission used the GADCS data to evaluate the extent to which payments for ground ambulance services align with the costs of providing those services to patients with different needs in different locations. The Commission recommends the continued collection of ground ambulance cost and revenue data, though with a more streamlined approach to focus on data essential to assessing the accuracy of Medicare payments and Medicare beneficiaries' access to care.

Since 2002, Medicare has paid for ground ambulance services provided to FFS Medicare beneficiaries using the ambulance fee schedule (AFS). Medicare makes a single payment for the transport to the nearest appropriate facility, including necessary items and services. Payments under the AFS have two components: one for the service itself and one for mileage. The payment for the service reflects the intensity of the transport, calculated using a relative-value unit (RVU), a conversion factor, and a geographic adjustment for differences in costs. The mileage component reflects the distance traveled with the patient. Both components are adjusted with add-on

payments reflecting whether the transport begins in an urban, rural, or super-rural area.

The RVUs and add-on payments in the AFS generally were not based on cost data and have remained largely unchanged since they were implemented. In 2013, in response to a congressional mandate, the Commission examined the use of ambulance services under Medicare's AFS and other information and found that AFS payments might not accurately reflect variation in costs. However, no cost data were available to comprehensively assess the overall adequacy of ambulance payments or their accuracy across patient severity levels or geographic locations.

To support analysis of whether the AFS payments are appropriate, the Congress directed CMS—through the Bipartisan Budget Act (BBA) of 2018—to implement the GADCS. CMS collected a broad range of data for 2022 and 2023 from a sample of ambulance organizations. MedPAC was also directed to report on geographic variation in the cost of furnishing ambulance services and the adequacy of Medicare's payments under the AFS, to assess the burden on ambulance organizations of reporting the data, and to recommend whether CMS should continue the data collection effort or revise it.

The GADCS contains a rich set of variables, and the data are sufficient to allow policymakers to assess the appropriateness of the AFS payment adjustments (RVUs; urban, rural, or super rural; and geographic differences in costs). However, measures of ambulance organizations' revenues relative to costs should be viewed cautiously because a majority of these organizations receive a large share of their overall revenue from sources such as local government funding that are unrelated to billing for ground ambulance services. CMS has expressed concern that organizations may have made reporting errors on revenue from these sources. In addition, we found extremely large differences between revenues and costs for some organizations, which suggests likely reporting errors. These data issues suggest that GADCS-based measures of revenues relative to costs might not be reliable indicators of payment adequacy.

With this caveat in mind, we used the GADCS data to calculate revenue-to-cost ratios (RCRs) for ambulance organizations. We found that low-volume organizations had much lower RCRs than high-volume organizations.

In addition, urban organizations had higher RCRs than rural organizations, and for-profit organizations had higher RCRs than nonprofit and government organizations. However, RCRs varied widely within each of these categories.

We found that the strongest driver of ground ambulance cost per transport was the volume of transports that an organization provides. As the number of transports increased, costs grew at a much lower rate, which suggests economies of scale. In addition, we found that cost per transport was lower for for-profit organizations relative to nonprofit and government-owned organizations. Cost per transport was also lower for organizations that used a dynamic staffing model (meaning that the number of fully staffed ambulance units varies by day, time, or season) compared with those that used a static staffing model. Finally, regression results suggested that, when controlling for other factors that affect costs (such as volume of transports), organizations with rural service areas had lower cost per transport than organizations with urban service areas. However, rural organizations were more likely to be low volume and isolated than urban organizations. Hence, rural organizations would be more likely to benefit from payment adjustments targeted to low-volume organizations that serve isolated areas.

The GADCS is a good first step toward a dataset that policymakers can effectively use to evaluate the adequacy of AFS payments, and all stakeholders we spoke with supported continued data collection. However, the GADCS includes over 600 variables (though organizations often were not required to address all the questions, due to the structure of the data-collection instrument). Many variables are not pertinent to assessing the adequacy or accuracy of AFS payment rates or Medicare beneficiaries' access to ambulance services. Also, many of the variables are quite granular. Because of the size of the GADCS, there is strong support among the stakeholders to reduce the burden of data collection by streamlining the GADCS.

As ambulance organizations become more experienced with collecting and submitting cost data to CMS, the GADCS should be sufficient to allow analysts to evaluate whether aggregate AFS payments are adequate to ensure beneficiary access and whether AFS payments are accurate across patient severity levels or geographic locations. Therefore, the Commission recommends that the Congress direct the Secretary to continue to collect cost and revenue data from suppliers and providers of ground ambulance services, focusing on information essential to assessing both the accuracy of Medicare payments and access to ambulance services for Medicare beneficiaries while pursuing opportunities to minimize burden on suppliers and providers. ■

